Safeguarding Vulnerable Dependent Drinkers England and Wales

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Executive summary

The majority of dependent drinkers are not engaged with alcohol treatment services. However, within that population there is a smaller group of drinkers who are not only hard to engage but are also vulnerable and having a repeated and significant impact on their community and on public services.

These people can be helped by the range of interventions highlighted by Alcohol Change UK's Blue Light initiative e.g. assertive outreach, harm reduction and multi-agency management. An even smaller group will require a more robust management framework built on legal powers.

However, the understanding of legal frameworks, such as the Care Act 2014, the Mental Capacity Act 2005 and the Mental Health Act 2007, needs improvement so that they can be used to help this client group.

The use of these powers is also hampered by misconceptions and myths that need to be dispelled. In particular, suggestions that this client group "chooses" or "likes" an abusive or self-neglecting lifestyle need to be challenged.

Other legal frameworks such as the Human Rights Act 1998, the Anti-social Behaviour, Crime and Policing Act 2014, the Criminal Justice Act 2003 and various pieces of environmental health legislation also need to be understood and considered.

The use of these legal frameworks should be a last resort and needs to be governed by a robust management framework. Multi-agency management will be particularly important.

Professionals need to understand the nature of a positive intervention with chronic dependent drinkers. This is likely to be built on assertive relationship building, harm reduction and motivational interventions.

The Care Act does apply to people with alcohol problems and in particular the inclusion of self-neglect as a form of neglect will encompass many in this client group.

The Mental Capacity Act covers people impaired by the effects of alcohol but it is challenging to apply to chronic dependent drinkers because of a lack of specific guidance. However, understanding concepts such as *executive capacity* will help.

The Mental Health Act is a last resort and excludes use with people who are solely dependent on alcohol, however, there are circumstances where it could be used on people who have other mental or behavioural disorders arising from dependency.

This briefing provides examples of the positive use of these powers with chronic dependent drinkers.

Section 1 – Introduction

What this briefing is about

The aim of this briefing is:

- to improve the wellbeing and safety of adults who are chronic and change resistant or change ambivalent, dependent drinkers.

It does this by targeting four objectives:

- Clarifying how and when to use the Care Act (2014) in England or the Social Services and Well-being Act 2014 in Wales, the Mental Capacity Act (2005), and the Mental Health Act (1983 revised 2007) to protect and support this group of clients.
- Identifying other legal powers which could be used, e.g. The Anti-social Behaviour, Police and Crime Act (2014)
- Describing the practice that will make these powers work most effectively
- Describing the governance, agency management and inter-agency arrangements that will support this work.

This briefing is not "the answer" to the challenges posed by chronic, dependent drinkers. Most of these individuals will be better managed through motivational and harm reduction interventions built around assertive outreach and multi-agency working. Those responses have already been described in the Blue Light practitioner manual and the Blue Light commissioning guide (link required). This document addresses the specific issue of using legal powers with this group.

This briefing has been developed as part of a broader project that has also developed:

- a training programme with support materials that delivers the key messages of the briefing to professionals who encounter these clients;
- a document addressed to governmental bodies highlighting the lessons learned in the project and the perceived requirements for national action.

Both of these are informed by this briefing. Information on these two elements is available at www.alcoholchange.org.uk/xxx (TBA)

Who this briefing is for

This briefing is targeted at those working directly with dependent drinkers (and their managers). This will include staff in specialist substance misuse and mental health services, but also, for example, those working in adult social care, housing and homelessness, primary and secondary healthcare, police, domestic violence, probation and community safety.

It will also be useful to those who commission services and those in political and strategic roles who will need to argue for the resources to support the use of these legal frameworks.

This briefing focuses on chronic dependent drinkers; however, much of what it says can apply to people who are chronic users of other psychoactive substances.

Methodology

This briefing and the accompanying resources were developed through a national multi-partner project initiated by Alcohol Change UK. Eighteen partners supported this project, these covered 23 separate local authorities and a major service provider (CGL). Another twelve local authorities expressed interest in the project. This alone highlights the importance of this issue. The partners are listed on the inside front cover.

This briefing was developed through:

- Interviews with national experts and local stakeholders (see appendix 2)
- Development workshops in each partner area where the local impact of chronic dependent drinkers was discussed
- An online survey of professionals in health, social care, criminal justice and housing settings which received 201 responses nationally
- Desk research, particularly into the learning from Safeguarding Adults Reviews
- Presentations to Safeguarding Adults Boards.

The challenge: applying legal frameworks to chronic dependent drinkers

Within the 650,000 dependent drinkers in England and Wales[1] there is a small group whose chronic drinking, harmful lifestyle and chaotic behaviour pose a significant challenge to services. In particular, this group is unwilling or unable to change. Alcohol Change UK's *Blue Light* initiative has set out effective strategies and techniques for working with this group.[2] In addition, our handbook on alcohol assertive outreach shows how we can reach out to people with serious, chronic drinking problems, work with them to start making positive changes to their lives, and engage them in alcohol treatment.

For some people, however, these approaches do not work. Both professionals and families are left asking what can be done to protect them and those around them.

The central message of this briefing is that:

- England and Wales do have legal frameworks which enable professionals to protect chronic dependent drinkers and that professionals should be using those frameworks whenever they are appropriate.

However, the starting point is that:

- Too often those frameworks are not being used and people are not receiving the help they need.

A single case highlights the challenge:
A 54 year old man with high levels of alcohol consumption was referred to an alcohol team by his GP. He was a high volume hospital user and lived in sheltered accommodation. He had Chronic Obstructive Pulmonary Disease and poor mobility resulting in the use of a mobility scooter. He had been brought back by the police on numerous occasions for being intoxicated and unsafe on his scooter. He was aggressive towards staff and neighbours. He was also a frequent and significant fire risk.

The situation worsened with numerous calls to the ambulance service and an increasing number of admissions to hospital for confusion, chest pain and inability to cope with daily life. He was increasingly aggressive and in trouble with the police due to shoplifting. He showed no concern or recognition that his tenancy might be in danger due to his behaviour.

The alcohol team visited him at his property and raised concerns with adult social care regarding his physical state. He had:

- *A very unkempt appearance: wearing a hospital gown and cardigan with large holes.*
- *Set fires, including accidently setting fire to himself with a cigarette and using vodka to extinguish it.*
- *No carers supporting him with daily living activities.*
- *No means of storing food safely in his flat as he had no fridge.*
- *No cooker or other means of cooking food due to the high risk of fire.*
- *Paper all over the living room floor while dropping lit cigarette ends.*

- *A disposable barbeque to cook with in his living room which on one occasion had filled the house with smoke leading a neighbour to call the fire service.*[3]

This man used significant resources from the police, health services, social care and other organisations; but it would rarely be felt appropriate to take him through the criminal justice system. The question is: what other powers are available to manage him?

Three legal frameworks were considered with this client:

- Those assessing him under the Care Act (2014) suggested that the way he was living was a "lifestyle choice".
- The Mental Capacity Act (2005) was considered – however, when interviewed he was usually deemed able to understand and take decisions. Unfortunately, he repeatedly failed to execute any of these decisions.
- Due to the high risk of harm to himself and others local specialist alcohol services referred him on two occasions for an assessment under the Mental Health Act (2007). Although the risk was high it was not felt that he could be sectioned because his main problem was dependence on alcohol.

This case study presents a negative picture of the care provided to complex dependent drinkers. Nonetheless, the basic message of this briefing is positive. Professionals can have a positive impact on such people. With this man, assertive outreach and intensive support paid dividends. However, his case also highlights the need to improve "legal literacy"; to help professionals understand how to use relevant legal frameworks in the care of this client group.

Challenging common myths and misconceptions

However, the role of this briefing is not simply to impart information about the law but also to challenge a variety of myths and beliefs that have grown up around the management of this group. In consultations on the development of this briefing, professionals identified common myths or misconceptions about the use of legal powers with dependent drinkers that impede their care.

Common myths and misconceptions

One: If someone says they don't have a problem and don't want help, there is never anything you can do.

Two: People are not vulnerable because they are <u>choosing to</u> live like this,* or *<u>like</u> living like this.

Three: People are not vulnerable / self-neglecting if they have mental capacity.

Four: Once people are sober they no longer have care and support needs or lack capacity.

Five: If people have capacity, there is nothing we can do.

Six: People have the right to make unwise decisions.

Seven: Alcohol dependency is not covered by the Mental Health Act.

Eight: Mental health services don't need to assess someone if the main problem is alcohol.

Nine: Assessment is impossible if people never turn up for appointments.

Ten: People can't be assessed if they are always intoxicated.

Eleven: There is no treatment available for this client group – so people can't be treated under the Mental Health Act.

Twelve: Once someone stops drinking the problems always go away, so this isn't a mental health issue.

The whole briefing aims to challenge these misconceptions but section 10 provides specific responses to each of these myths and misconceptions.

How this briefing works

The core of this briefing (sections 5-8) is a description of the important elements of the key legal powers which impact on dependent drinkers. Section 2 sets out reasons why greater legal literacy is needed. Sections 3 & 4 set out frameworks that will make these powers most effective: a framework to guide agency and multi-agency work and one to professional practice. Section 9 contains case studies of the powers in practice. Section 10 provides the responses to the myths and misconceptions. The final section looks at developing a local action plan.

Section 2 – The need for change: choice, discrimination and cost

Alcohol Change UK's report *Learning from Tragedies* called for greater "legal literacy" around chronic dependent drinkers.[4] Therefore, most of this briefing focuses on improving knowledge and skills. First, though, we set out three reasons why this matters so much. If we are to move forward, we need to:

- challenge the belief that chronic drinking is a lifestyle choice;
- explore the possibility that the attitudes to this group are discriminatory; &
- understand the huge resource and cost impact this group can have on public services.

Challenging the *Choice* paradigm

Chronic dependent drinkers may not have a diagnosed mental illness such as schizophrenia; but they are functionally mentally disordered at a level where choice is largely removed from the equation. **It would be easy to say that not using legal powers is respecting their personal choice; in reality it may be allowing them to *die with their rights on*.**[5]

The Leanne Patterson Safeguarding Adult Review (SAR) comments that: *A number of agencies identified in their contact with Leanne that she was 'making choices' around lifestyle that were increasing her risk and made her difficult to engage…*[6] The needs of dependent drinkers are often mistakenly seen as "self-inflicted" or a "personal choice". This leads to two different approaches. It may be that because people are choosing to behave in this way, they do not *deserve* the same response as people with a mental illness. Secondly, the choice paradigm may suggest that any imposition of care is an infringement of people's rights.

However, we are not intervening solely for their benefit but also for the safety of others. Moreover, while it is true that each of these individuals began by choosing to drink, at this late stage in a drinking 'career', choice may have disappeared.

Chronic dependent drinkers are often at the centre of an almost "perfect storm" of physical conditions that will challenge the idea that their drinking is a self-determined choice. The most obvious of these is that they are dependent on alcohol. The origin of the word "addiction" is a Latin word that implies enslavement. It can be argued that "addiction" is by definition a loss of the ability to make choices.[7] As one of our interviewees said: *Someone's addiction itself should question their capacity.*[8] At the very least, addiction will remove an element of choice about drinking because of the serious risk of unmanaged withdrawals.

Beyond addiction, many other physical barriers impair the ability of dependent drinkers to make choices about their lives:

- 60-70% may be depressed due to the chronic depressant effect of alcohol.[9]
- They may have alcohol related brain injury (which effects at least 35-40% of this client group).[10] [11] In Scotland, Drink Wise Age Well identified that 50% of clients admitted to services for older drinkers (50+) had cognitive impairment; after treatment this had fallen to 25%.[12]
- They may have head injuries due to fits, fights or falls.
- They may have physical health problems which impair judgement e.g. the low energy levels that result from liver disease or the confusional states that result from pancreatitis and urinary tract infections.[13]
- They may have poor sleep patterns due to alcohol misuse (or lifestyle) which again will lead to depression or low mood.
- Poor nutrition will lead to depression.[14]
- Foetal alcohol damage may have led to learning disabilities or behavioural disorders (see article by Dr Raja Mukherjee in appendix 1).

The barriers to change are not just physical. In the Ms. H and Ms. I SAR, the partner of a woman who had died having experienced multiple exclusion homelessness[1], commented that she had been unable to maintain abstinence from substance misuse because past traumas and adverse life experiences "kept bubbling up." This captures quite graphically how individuals can be governed by impulses to distance themselves from emotional distress. She was caught in a life-threatening double-bind, driven to avoid suffering through ways that only deepened her suffering.[15]

Discrimination? – the comparison with anorexia

In a 2018 article in the *Medical Law Review*, Craigie and Davies raise the question of whether there is a difference in the way that anorexia nervosa and alcohol problems are treated with regard to mental capacity. The article states that *"value judgements associated with alcohol dependency and anorexia are playing a significant, unrecognised, and inappropriate role in driving the interpretation of mental incapacity tests."*[16] More significantly, it questions whether this is linked to stereotypes associated with the client groups.

CQC has issued *Guidance on the treatment of anorexia nervosa under the Mental Health Act 1983* (This guidance relates to England only).[17] NICE guideline 69 on *Eating disorders: recognition and treatment* also includes a section on the use of legal powers.[18] NICE has not issued similar guidance about using these powers with alcohol dependency.

[1] "multiple exclusion homelessness" comprises extreme marginalisation that includes childhood trauma, physical and mental ill-health, substance misuse and experiences of institutional care.

Craigie and Davies go on to say that: *…values play a crucial part in establishing mental incapacity standards... It also may be the case that stereotypes associated with substance dependency and anorexia play a role in traditional patterns of blame. The mental picture of a person with anorexia is likely to be a well-mannered young woman; while the mental picture associated with alcohol dependency is likely to be a dishevelled older man.* [19]

Decisions about interventions should never be informed by stereotyped or negative attitudes about the client group.

The cost and impact of this client group

I estimate that dependent drinkers are 10-20% of the adult safeguarding caseload.[20] Quote from adult social care manager in interview for this briefing.

The need for a robust legal framework around these clients is underlined by their cost and impact on services and the community. The case study client in Section 1 was estimated to have cost £138,000 in just one year, to health and fire services alone.[21] An alcohol outreach service in the south east of England identified a client who cost public services £250,000 in a year.[22] ACUK's *Blue Light* project estimated that in a population of 200,000, there will be at least 250 high impact and change resistant / ambivalent dependent drinkers who cost at least £12m per year across a range of agencies.[23]

Perhaps more than the cost, is the vulnerability associated with this client group. Alcohol dependence has a significant role in serious case reviews. Alcohol features as a contributory factor in over 50% of domestic homicide reviews and 60-70% of inquiries into homicides by mentally ill people.[24] [25] *Learning from tragedies* highlighted 11 deaths of vulnerable adults from 2017 where alcohol misuse was a significant issue. These clients tended to be change-resistant, dependent drinkers and again highlight both the cost of these clients and their vulnerability and social exclusion.[26] Since 2017, SARs have continued to criticise assumptions about *lifestyle choice* or prejudice about the misuse of alcohol, with consequent failure to explore the meaning behind these patterns of behaviour.[27]

Beyond even cost and vulnerability, the failure to adequately manage these individuals impacts on other stakeholders:

- The police are spending significant amounts of time safeguarding these individuals or managing their behaviour: as in the initial case study.
- Alcohol and mental health services are struggling to solve the problems of clients with both mental health and substance misuse problems because the legal frameworks around the two problems are not equivalent.
- Family members are desperately struggling to help people whose needs are well beyond what they can cope with.

An international comparison – Australian Legal Frameworks

Other Westernised countries do have legislation which specifically allows the compelled, protective, detention of dependent drinkers like the client in the introduction above. In some jurisdictions this is called "civil commitment" (e.g. USA). [28] [29] [30] *Indeed Article 5 of the European Convention on Human Rights specifically recognises this possibility.*[31]

Legislation in four Australian jurisdictions has long provided for the involuntary commitment of non-offenders into alcohol or drug assessment and/or treatment. In New South Wales,

the Drug and Alcohol Treatment Act 2007 came in to force in September 2012.[32] *This allows for the 28 day detention (extendable by a further 28 days) of someone who meets the following four criteria:*

- *Severe dependence (tolerance, withdrawals, loss of capacity to make a decision); AND*
- *At risk of serious harm (physical or psychological, or to children or other dependents in their care); AND*
- *Likely to benefit from treatment but refuses; AND*
- *No less restrictive treatment available.*

The presentation describes the typical client as:

- *A 59 year old man*
- *Calling emergency services when intoxicated, crying, physical pain, threatening suicide*
- *114 Emergency Department presentations (56 in past 6 months)*
- *Severe alcohol problem*
- *Living in squalor*

This is a very similar description to the client at the start of this paper.

The most significant feature of the Australian legislation is the evidence of its effectiveness. At follow-up 60% had shown significant improvement of whom just under half were abstinent.[33]

The voices of lived experience

Although this aspect was hampered by coronavirus, we have drawn on lived experience at various points in developing this briefing. The case studies in section 9 are all based on real people although disguised to provide anonymity to all involved. During the latter stages of the project we received a powerful statement about the challenges of caring for a chronic dependent drinker from his two sisters. This was written as a document addressing the Coroner after their brother's death. This is available on Alcohol Change UK's website as a blog and it provides a powerful summary of the need for action with this client group.

Section 3 – Using the legal powers: governance

(There is) a lack of legal literacy in relation to a number of relevant powers and duties that were engaged in Mr A's case. In particular the challenge of when to use the Care Act, Mental Health Act and Mental Capacity Acts in these challenging cases. East Sussex Safeguarding Adults Board - Safeguarding Adults Review: Adult A 2017[34]

Sections 5 to 7 of this briefing discuss the three main pieces of legislation which can be used to protect and support the most chronic dependent drinkers:

- The Care Act 2014 (England) or the Social Services and Well-being (Wales) Act 2014
- The Mental Capacity Act 2005 (England and Wales)
- The Mental Health Act 1983 (amended 2007) (England and Wales)

Section 8 offers briefer reviews of other useful legislation: the Human Rights Act, the anti-social behaviour powers, the alcohol treatment requirement and environmental health

legislation. However, this is not a general guide to the use of these powers; it focuses on whether and how they can be applied to chronic dependent drinkers.

These powers are not simple solutions, and they cannot be used in isolation.

- A partnership level governance framework needs to support their application.
- Professionals need to adhere to key principles.
- A stepped approach should be followed when using them.
- Professionals need to think about how their practice can maximise the impact of these powers.

This section and section 4 set out frameworks that will make these powers most effective. This section explores the framework that should guide agency and multi-agency work. Section 4 offers a framework to guide professional practice.

A governance framework

To make most effective use of these powers a five-pronged governance framework could be adopted:

Governance: Strategic oversight

A local, senior, multi-agency group will need to take on responsibility for ensuring that chronic dependent drinkers (and indeed other chronic substance misusers) are being protected and supported by the appropriate use of these powers. This could be located in the Safeguarding Adults Board. Alternatives might be the Health and Wellbeing Board or Community Safety Partnership or the Area Planning Boards in Wales. This group should:

- review whether these powers are being used appropriately with substance misusers;
- undertake annual reviews that this is still happening;
- be a focus for the discussion of any problems;
- be a point where concerns about repeated or serious problems with the care of this group can be raised.

It would be positive if Safeguarding Adults Boards reported on the safeguarding of this client group in their annual report.

Governance: Internal agency procedures
Managers of all agencies who encounter chronic, dependent drinkers need to be familiar with the appropriate application of these legal powers and be able to support their staff to use them. In particular, through supervision, managers must ensure that the care of these clients is not undermined by stigmatised perceptions of them as "undeserving" or "making lifestyle choices".

Governance: Multi-agency management
Beyond the strategic multi-agency oversight, there need to be structures or systems which allow the multi-agency management of this client group. This might involve:

- the development of a standing multi-agency group for the management of chronic dependent drinkers (as has happened in, for example, Sandwell or Northumberland); or
- the allocation of this task to an existing multi-agency group (e.g. a multi-agency safeguarding hub); or
- having good systems which allow the swift convening of a multi-agency risk management meeting around a particular person.[35]

Governance: Commissioning services
In commissioning alcohol treatment services, commissioners and partner agencies need to ensure that services are available to meet the requirements imposed by this legislation.

The Carol SAR (Teesside) highlights the importance of service commissioning. Carol, a chronic dependent drinker, had some engagement with her local alcohol team, but the services were not well designed to meet her needs and were withdrawn.[36] The report also comments on the commissioning process. *…[C]ontracts for this service change because of commissioning decisions every few years...[W]hen the provider changes those who had been cared for within the service lose established contacts and rapport with workers…*[37]
The Andrew SAR (Waltham Forest) makes a similar point.[38]

The Adult D SAR (South Tyneside) expresses concern that because of *"…outsourcing the provision of drug and alcohol services… the current provider of those services did not appear to have the capability or appetite to manage cases which carried higher risks.*[39]

If professionals are to use these legal frameworks effectively with this client group, it will be necessary to commission and develop alcohol services that meet the identified needs.

- Can the commissioned alcohol services meet the needs of clients who require safeguarding or lack mental capacity e.g. persistent, assertive services built on relationship building, harm reduction and motivational interventions?
- Is a specific professional role required that is able to provide assessment and expertise on applying the legislation to this client group?
- Is there access to inpatient facilities which can meet the needs of people detained under the Mental Health Act? Can such places by purchased from the private sector if not from statutory services?

Governance: Professional development
All staff who work with chronic dependent drinkers either in a specialist or a generic setting (including police officers) will need relevant training on the use of legal frameworks with this group. The oversight body (e.g. the SAB) should ensure that this is happening and that such training is included in the professional development programmes of all relevant agencies. This is in accordance with the general guidelines in NICE Guidance 108.[40]

Section 4 – Using the legal powers: guidance for professionals

Principles guiding the use of these powers with individual clients
Any use of these legal powers with dependent drinkers should adhere to the following nine principles. These build on the adult safeguarding principles in the 2014 Care Act statutory guidance[41].

Empowerment
• Approaches to this client group should be built on the recognition that there are things that we can do to help these people. • The response to chronic dependent drinkers should be non-discriminatory. They have as much right to protection from harm as anyone else. Services should not be denied or adjusted because of disapproval of their lifestyle or the workload they may require.
Proportionality
• The use of coercive legal frameworks with this client group should be a last resort, and used rarely, after all other approaches have been exhausted.
Protection
• Managers and management systems must support staff to take a positive and assertive approach to this client group.
Partnership
• Use a multi-agency approach. • Wherever possible actions and decisions should involve the person being supported.
Accountability
• A governance framework is required for the management of this area of need, an identified local body such as the Safeguarding Adults Board or Health and Wellbeing Board should ensure that this group is being well managed.
Prevention
• Use SARs and other serious case reviews to continually learn, so as to improve how this group is supported. • If people have needs that cannot be met by existing resources, this unmet need should be identified, recorded and reported to commissioners.

A stepped process

The more coercive of these powers (e.g. Mental Health Act or the Deprivation of Liberty Safeguards within the Mental Capacity Act) must be used rarely and as a last resort. If they are to be used, it should be as part of **a stepped process**.

Once it is clear that agencies are struggling to support an individual, a multi-agency approach should be considered. This partnership will ensure that community options such as assertive outreach and harm reduction have been tried and will probably draw on the assessment and care planning powers and duties within the Care Act 2014 or the Social

Services and Well-being (Wales) Act 2014. Alternatively, the safeguarding powers in these Acts will provide a structure for intervention. (Section 5)

If these interventions fail to enable positive change, workers will need to consider whether someone has the mental capacity to, for example, make decisions about their care and support needs and whether someone else needs to act in their best interests. (Section 6)

In rare and extreme cases, the Deprivation of Liberty Safeguards (Section 6), the protective powers of the Mental Health Act (Section 7), or in cases of coercion, the inherent jurisdiction of the Court of Protection (section 6) may be required.

Making the legal powers work – Tools

Tools exist which will help professionals decide whether to take action under the legislation and to evidence the case for action. The following table sets out assessment tools which professionals will find useful.

Assessing cognitive function
https://www.alzheimers.org.uk/sites/default/files/migrate/downloads/alzheimers_society_cognitive_assessment_toolkit.pdf
This toolkit contains (and explains) a number of tools for assessing cognitive function. This includes tools such as the Addenbrooke's Cognitive Examination and the Montreal Cognitive Assessment which can also be accessed separately.
Foetal Alcohol Spectrum Disorder screening tool
https://store.samhsa.gov/product/TIP-58-Addressing-Fetal-Alcohol-Spectrum-Disorders-FASD-/SMA13-4803
Treatment Improvement Protocol 58 from the US Substance Abuse & Mental Health Services Administration covers FASD from prior to conception to adulthood. It contains (pp21-22) a screening framework for FASD in adults.
Generalised Anxiety Disorder Scale (GAD-7)
http://pathways.nice.org.uk/pathways/common-mental-health-disorders-in-primary-care
The NICE guidance document: *Identifying and assessing common mental health disorders* contains details on a number of screening tools for anxiety and depression, and includes a copy of the GAD-7 tool
MUST – Malnutrition Universal Screening Tool
https://www.bapen.org.uk/pdfs/must/must_full.pdf
MUST is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan.
Hoarding – clutter image ratings
https://hoardingdisordersuk.org/wp-content/uploads/2014/01/clutter-image-ratings.pdf
To help accurately describe a clutter problem, a series of pictures of rooms in various stages of clutter are provided and graded so that professionals can describe the degree of clutter on a standard scale.
Severity of Alcohol Dependence Questionnaire (SADQ)
https://www.smartcjs.org.uk/wp-content/uploads/2015/07/SADQ.pdf
This tool offers 20 questions to assess the degree of alcohol dependence.

AUDIT
https://www.gov.uk/government/publications/alcohol-use-screening-tests
A 10 question general alcohol screening tool which will give an indication of alcohol dependence but is not as accurate as SADQ.
Gambling
https://responsiblegambling.vic.gov.au/for-professionals/health-and-community-professionals/problem-gambling-severity-index-pgsi/
A 9 question online tool to assess the presence of gambling problems

In addition, visit: https://www.integration.samhsa.gov/clinical-practice/screening-tools for a selection of other screening tools covering issues such as suicidality, trauma, anxiety disorders and bi-polar disorder.

Making the legal powers work - practice checklists

Using legal powers that deprive people of some or all of their liberty should not be easy. It is essential that there are challenges and questions about whether this is the right thing to do. Sometimes those challenges may be due to concern for the person's freedom of choice. In others it may be because professionals are not equipped to, or do not want to, work with a very difficult situation. Either way these powers will work more effectively if professionals make sure they are following the steps in these checklists:

'Working with other professionals' checklist
Ensure that the care plan for a complex client is built on a multi-agency approach.
This will help ensure that all voluntary/community options have been exhausted. It will also ensure that consensus exists on the move towards and through the use of legal frameworks.
Ensure that information is shared as far as is legally possible
This may include sharing chronologies and contextual information to help understand the client and include information on how faith, ethnicity or gender impact.
Workers will need to be persistent in arguing for a more robust response.
It should not be easy to take control of aspects of a person's life. Workers should expect other professionals to resist or question the need. Therefore, if it is justified, professionals will need to be persistent.
Workers will need to be prepared to challenge other professionals.
When a more robust response is justified and legal, it may be necessary to challenge other professionals in order to overcome blockages. This will be much easier to do with the support of managers or in a multi-agency setting with the support of other professionals.
Agencies need to be willing to escalate concerns and make complaints.
If professional challenge does not yield results then agencies will need to escalate their concerns and, where necessary, use formal complaint procedures with relevant services or their commissioners. This is time-consuming, but it is the way

the system is designed to work. Without such complaints, services will not change.
Agencies and their staff need to build positive relationships with workers who gatekeep these powers.
It will be much easier to argue for the use of these powers if professionals already have a positive and informed relationship with the people who administer the powers e.g. adult social care or mental health professionals.
Good recording is required.
Recording needs to be explicit concerning which legal rules were considered and the reasons for decision-making regarding their appropriateness to the circumstances of the case.
Unmet need should be recorded.
If it proves impossible to access the protection and support offered by these powers, agencies need to record that information, collate it, and feed it into commissioners so that they can consider the need for change.

It is also important to think about how professionals relate to the people who are the focus of our concern. The following are likely to ensure the best relationship:

'Working with people' checklist
Take the time needed to assess someone, even if this requires multiple meetings.
Undertake a comprehensive risk assessment, especially in situations of service refusal.
Use a person-centred approach that demonstrates proactive rather than reactive engagement.
Recognise how the person's faith, gender or ethnicity can impact on the nature and presentation of their needs.
Undertake a detailed exploration of the person's wishes, feelings, views, experiences, needs and desired outcomes.
Recognise the person's assets as well as their needs and risks.
Maintain contact so that trust can be established, even when the person is not engaging.
Take time to address the impact of adverse experiences, including issues of loss and trauma. It should also explore repetitive patterns.
Express concerned curiosity characterised by gentle persistence, skilled questioning, conveyed empathy and relationship-building skills.
Build up a picture of the person's history to help to uncover what is driving and maintaining self-neglect, here in the form of alcohol abuse.
Consider whether and how family involvement may be of benefit.
Explore what may appear a lifestyle choice to understand what might lie behind a person's refusal to engage e.g. loss, trauma, shame and fear.
Undertake a thorough mental capacity assessment, which includes understanding and consideration of executive capacity (see section 6), recognising that a person's articulate skills and good cognition test results can mask difficulties.
Undertake a thorough mental health assessment, with particular attention at points of transition, for example hospital discharge or placement in supported accommodation.[42]
Ensure responses are creative and make use of peer support, text messaging and online technologies if possible.

Section 5 – The Care Act and the Social Services and Well-being (Wales) Act

This section covers the legislation in the Care Act (England) and the Social Services and Well-being (Wales) Act. These acts are separate but broadly equivalent.

The Care Act 2014

Summary

- **The Care Act 2014 applies to people with alcohol problems.**
- **Dependent drinkers with care and support needs have a right to assessment under the Act and, if they meet certain criteria, the right to have those needs met.**
- **Dependent drinkers with care and support needs who are, or at risk of being, abused or neglected, or being victims of self-neglect, require safeguarding by local authorities.**
- **Self-neglect (and/or living with abuse and exploitation) should never be regarded as a "lifestyle choice".**
- **Safeguarding alerts should be submitted to the local authority about such cases.**
- **Local authorities have a duty to make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect.**
- **An enquiry should establish whether any action needs to be taken to stop or prevent abuse or neglect, and if so, by whom.**
- **In the wake of a serious incident, a Safeguarding Adult Board (SAB) may arrange for there to be a Safeguarding Adults Review involving an adult in its area with needs for care and support. In certain circumstances a SAB has a duty to do so.**

Safeguarding is a relatively frequent concern. We see people who are struggling to look after themselves or are being abused. We do raise safeguarding alerts. But too often this is frustrating because it is not seen as a serious risk by Social Services. (From: Interview with a Housing Association manager for this briefing)

Does the Act apply to dependent drinkers?
The Care Act 2014 applies to people who have care and support needs, including those related to substance misuse.[43] The Department of Health and Social Care has stated that: *To meet the national eligibility threshold for adults needing care… local authorities … must consider…if the adult has a condition as a result of…* (among others) …*substance misuse or brain injury.* This section also emphasises that a formal diagnosis is not required to prove eligibility.[44]

How does the Act help dependent drinkers?
The Act covers assessment of need / care planning and, in some cases, safeguarding.

Assessment of need / care planning
Section 9 of the Act requires a local authority to assess a person who appears to have needs for care and support, regardless of the level of need. These needs should arise from or be related to physical or mental impairment or illness including substance misuse.[45] The

duty is to complete an assessment of needs, decide what those needs are, determine their impact on wellbeing, and identify the outcomes the person wishes to achieve and what contribution care and support could make to maintaining or improving wellbeing. If the needs are urgent, care and support can be provided before an assessment is completed (section 19(3)).

Section 11(2) requires a local authority to complete an assessment where the individual lacks capacity to refuse and an assessment is in their best interests, or the adult is experiencing or is at risk of abuse or neglect, including self-neglect. A written record of this must be provided for the individual (section12 (3)).

Following an assessment, if the person has *eligible needs* this would trigger a duty to provide care and support (see section 13 of the Care and Support (Eligibility Criteria) Regulations 2014). Eligibility requires the person to be unable to meet two or more of a number of specified outcomes, with a consequent significant impact on wellbeing. The outcomes include problems: managing and maintaining nutrition; managing toilet needs; being appropriately clothed, being able to maintain a habitable home environment and being able to use facilities and services in the community. (NB Authorities can also meet needs that are not deemed to be eligible if they chose to do so (section 6.100).

Section 67 requires the local authority to arrange for an independent advocate to be involved in assessment and care planning if it is believed that clients will have difficulties in understanding, retaining, using / weighing information or communicating their views.

Section 76 requires the local authority in which a prison is situated to assess prisoners when they appear to have care and support needs. Eligible needs must be met whilst in prison and plans prepared to meet eligible needs on release.

Safeguarding

The Act places a duty on local authorities to *protect people from abuse and neglect*.[46] This includes *those who self-neglect*.[47] These duties *apply equally to those adults with care and support needs regardless of whether those needs are being met*[48], and *regardless of whether the adult lacks mental capacity or not.*[49]

Because of the inclusion of self-neglect (and because people do not need to lack capacity), these safeguarding duties will encompass a large number of chronic dependent drinkers.

There is no single operational definition of self-neglect, however SCIE describes self-neglect as *an extreme lack of self-care*, and says *that it… may be a result of other issues such as addictions*.[50] [51]

This duty is not always recognised by local authorities. The Andrew SAR highlights that - *It is not routine or shared practice to accept that chronic alcohol misuse is a form of self-neglect...This directly affects the response by professionals and the support that is offered and provided to service users.*[52] **Nonetheless, local authorities have a duty to safeguard self-neglecting dependent drinkers with care and support needs**.

This group may also be victims of abuse and exploitation by others. Again, the need to protect abused drinkers has not always been recognised. The Carol SAR notes that: *Carol's drinking put her at risk of exploitation…. This did not result in a safeguarding alert at the time, although there was ongoing financial exploitation. (2.55)*

Section 42 of the Care Act requires that each local authority must *make enquiries, or cause others to do so, if it believes an adult has care and support needs, is experiencing, or is at*

risk of, abuse or neglect, and as a result of their care and support needs is unable to protect themselves. An enquiry should establish whether any action needs to be taken to stop or prevent abuse or neglect, and if so, by whom. [53]

The person's consent is not required to raise an adult safeguarding concern. The Howard SAR, for example, found that police officers and ambulance crews did not submit referrals because Howard asked them not to, despite evidence that he was the victim of physical and/or financial abuse, and making decisions under undue influence from others.[54]

Section 44 of the Care Act requires the local Safeguarding Adults Board to undertake a Safeguarding Adults Review (SAR) where an adult with care and support needs has died and the SAB knows or suspects that the death resulted from abuse or neglect, or an adult is still alive and the SAB knows or suspects that they have experienced serious abuse or neglect, and there is reasonable cause for concern about how the SAB, its members or others worked together to safeguard the adult. This is true even if the local authority is not meeting those care and support needs. SARs are about providing learning and can generate important evidence about how to manage this client group.

What actions flow from these duties?

Many chronic dependent drinkers require a care package or safeguarding under the Care Act. [55] However, unlike the Mental Health Act, the Act does not dictate the specific action to be taken or give local authorities powers to ensure care is delivered.

It will be impossible to say precisely what a care package should look like. The interventions will vary with the specific needs. However, it is possible to provide some broad guidance.

- The response is likely to be built on a foundation of multi-agency management.[56] [57] [58] [59] [60] This may be through an ad hoc group focused on this person, or part of a standing group that manages people with complex needs e.g. a multi-agency safeguarding hub. Whichever group is chosen, it must be able to support longer term management of the person.
- The person's needs are likely to require the persistent and assertive approach used by assertive outreach teams. [61] [62]
- The initial task may be to build a relationship with the person that will then allow other tasks to be performed including assessment.
- A thorough assessment will be required, and this may require persistence and joint working to find an appropriate opportunity. However, assessment should not become a barrier to beginning to build a relationship with this person.
- Alcohol Change UK's Blue Light project manual will be the best guide to the types of practical intervention to be used. These will include harm reduction, dietary approaches and motivational interventions that work with these clients.
- In some cases, the response will require residential rehabilitation. Systems for accessing the funding for such placements should not place unreasonable requirements on these clients e.g. tests of motivation.

The Social Services and Well-being (Wales) Act 2014

Summary

- **The Social Services and Well-being (Wales) Act 2014 applies to people with alcohol problems.**
- **Dependent drinkers with care and support needs have a right to assessment under the Act and, if they meet certain criteria, the right to have those needs met.**

- **Dependent drinkers who are vulnerable, abused or self-neglecting require safeguarding by local authorities**
- **Self-neglect (and/or living with abuse and exploitation) should never be regarded as a "lifestyle choice".**
- **Safeguarding alerts should be submitted to the local authority about such cases.**
- **Local authorities have a duty to make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect.**
- **An enquiry should establish whether any action needs to be taken to stop or prevent abuse or neglect, and if so, what and by whom.**
- **An Adult Practice Review should be undertaken by the Safeguarding Adults Board in cases of serious failure to support a vulnerable person.**

The Social Services and Well-being (Wales) Act 2014 is equivalent to the Care Act 2014 in England. Specific information about the legislation can be found at:

- https://socialcare.wales/hub/statutory-guidance

Does the Act apply to dependent drinkers?
Yes. Although alcohol misuse is not mentioned in the Act, section 3a of The Care and Support (Eligibility) (Wales) Regulations 2015 clarifies that adults whose needs arise from dependence on alcohol or drugs are entitled to have those needs met by a local authority.[63]

How does the Act help dependent drinkers?
The Act covers assessment of need and care planning as well as safeguarding.

Assessment of need / care planning
The Act imposes a duty on local authorities to assess people who appear to have care and support needs.[64] This covers alcohol and drug dependence.[65] In carrying out a needs assessment under this section, the local authority must (a) seek to identify the outcomes that the adult wishes to achieve in day to day life (b) assess whether, and if so, to what extent, the provision of (i) care and support (ii) preventative services, or (iii) information, advice or assistance, could contribute to the achievement of those outcomes or otherwise meet needs identified by the assessment.[66]

A local authority **must** provide and keep under review care and support plans for people who have needs which meet the eligibility criteria and for people where it appears to the local authority that it is necessary to meet the person's needs in order to protect the person from abuse or neglect or the risk of abuse or neglect.[67]

Some people may need additional support to ensure that they understand what is available to them and how to access this support. In such cases advocacy **must** be made available. [68]

Local authorities **must** undertake assessments of those in prison just as they would for anyone living in their area but may need to adapt the delivery of the assessment arrangements to suit prison restrictions. [69]

Safeguarding
Section 126 (1) identifies an "adult at risk", as an adult with care and support needs who is experiencing or is at risk of abuse or neglect and is unable to protect himself or herself against the abuse or neglect. As a result, a local authority must make enquiries to enable it to decide whether any action should be taken…and, if so, what and by whom. [70]

The Act itself does not identify self-neglect as a form of neglect.[71] However, *the Wales Safeguarding Procedures for children and adults at risk of abuse and neglect* (published as an app) identifies self-neglect as a *form of maltreatment*.[72]

Section 127 provides for adult protection and support orders to authorise entry to premises (if necessary by force) for the purpose of enabling an authorised officer of a local authority to assess whether an adult is at risk of abuse or neglect and, if so, what to do about it.[73] (The English framework does not contain such powers.)

Section 128 places **a duty** on local authority partners to report when an adult is suspected of being at risk of abuse, neglect or other harm. (Also different from the English Act).

Section 139 sets out arrangements for Safeguarding Adults Boards to undertake a multi-agency Adult Practice Review following a significant incident where abuse or neglect of an adult at risk is known or suspected.[74] These are the equivalent of Safeguarding Adult Reviews under the English legislation.

What actions flow from these duties?
Please refer to the equivalent section under the Care Act 2014 above.

Section 6 - The Mental Capacity Act 2005

Summary

- **The Mental Capacity Act 2005 applies to people with mental impairments due to the symptoms of alcohol or drug use**
- **The compulsion associated with an addictive behaviour can be seen as over-riding someone's understanding of information about the impact of their drinking. This can imply a lack of capacity.**
- **Executive capacity should be included explicitly in assessments, linked to the person's ability to use and weigh information.**
- **The presence of coercion may render a person unable to make a material decision at a relevant time point. Both the Mental Capacity Act 2005 and the High Court's inherent jurisdiction should be considered in such circumstances.**
- **If uncertain whether and how to proceed in a person's best interests, the case should be presented before a judge, with care and safeguarding plan options.**

…alcohol treatment workers get frustrated because they have clients who are very poorly and self-neglecting and are being assessed as having capacity and therefore people are walking away. Those people are being left alone to die at home. [75] (From: Interview with a specialist social work researcher for this briefing)

The Mental Capacity Act 2005, covering England and Wales, provides a statutory framework for people who lack capacity to make decisions for themselves. It sets out who can take decisions, in which situations, and how they should go about this.[76] A person who lacks capacity means a person who lacks capacity to make a particular decision or take a particular action for themselves at the time the decision or action needs to be taken. [77] The Act does not, as is sometimes suggested, give a right to make unwise decisions; however, it

requires professionals to demonstrate that the person does not have capacity to take a decision at a particular point in time.

Does the Act apply to dependent drinkers?
The Act can apply to dependent drinkers.[78] However, our research identified that, at times, this client group may be wrongly viewed as having mental capacity and that this puts them at risk. In particular, a view exists, often mistaken, that clients are choosing this lifestyle.

The Leanne Patterson SAR comments: *[A]gencies …(believed) that Leanne was making a capacitated decision, without any evidence of this having been assessed… Leanne's long-standing history of substance misuse, domestic violence, reported coercion, mental health concern, physical health concern, and reported exploitation gave reasonable and sufficient evidence for capacity assessments to have been considered.*[79]

The Lee Irving SAR recognised that [*some*] *agencies will see Lee as more troublesome than troubled, a nuisance offender, an abuser of alcohol and drugs who chose a lifestyle that laid him open to risk. The fact that he did not have the mental capacity to make such choices was not recognised by some of the professionals who had contact with him.*[80]

The Act is clear that: *A lack of capacity cannot be established merely by reference to... a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about his capacity.*[81]

Case law *(London Borough of Croydon -v- CD [2019] EWHC 2943 (Fam))* has demonstrated that a chronic dependent drinker, can be viewed as lacking capacity with regard to decisions about his care. The question is, therefore, under what circumstances do chronic, dependent drinkers lack capacity to make key decisions about e.g. their care, treatment or living conditions?[82]

Making an assessment
Assessing capacity requires a two stage test of capacity. Stage 1 requires proof that the person has an impairment of the mind or brain, or some sort of or disturbance that affects the way their mind or brain works. If a person does not have such an impairment or disturbance of the mind or brain, they will not lack capacity under the Act.[83] These impairments include *the symptoms of alcohol or drug use*.[84] Neither the Act nor the Code of Practice clarify whether this means the immediate symptoms of intoxication or the longer-term symptoms, e.g. brain injury, or both of these.

Under Stage 2, a person is unable to make a decision if they cannot:
1. understand information about the decision to be made
2. retain that information in their mind
3. use or weigh that information as part of the decision-making process, or
4. communicate their decision.[85]

(NB. Practically it may be more appropriate to undertake Stage 2 first, i.e. determine if the person can make a decision, and then determine whether this is caused by an impairment or disturbance of the mind or brain.)

Any one of these four might apply to a chronic, dependent drinker. For example, someone with cognitive impairment might not meet either of the first two criteria. However, with this group the more relevant issue may be the third criteria: whether they can *use* information in a decision-making process.

The Code of Practice does not provide any guidance or examples specific to a drinker, but eating disorders provide a useful parallel. The Code says: *a person with the eating disorder*

anorexia nervosa may understand information about the consequences of not eating. But their compulsion not to eat might be too strong for them to ignore.[86] [87]

This appears to be a situation that will be commonplace with many dependent drinkers: their compulsion to drink means that they are unable to use information that they are given, even if they understand it.

It is also appropriate to take a long view when assessing capacity. The Code of Practice states that: *Information about decisions the person has made, based on a lack of understanding of risks or inability to weigh up the information, can form part of a capacity assessment – particularly if someone repeatedly makes decisions that put them at risk or result in harm to them or someone else.*[88]

NICE guidance highlights that not only is the person's decision-making history[89] important but that, with consent, other people can be spoken with in order to inform the capacity assessment. For example, this may include the person's family or friends. [90]

Things to think about – Assessing mental capacity, frontal lobe damage and dependent drinkers

Undertaking mental capacity assessments with dependent drinkers poses a very specific challenge. Approximately 50% of dependent drinkers many have frontal lobe damage as a result of brain injury. In the general population the figure is only 8.5%. The frontal lobe is the behavioural centre of the brain which has a key role in impulse control. Many patients with frontal lobe damage are wrongly considered to have capacity, because in a simple assessment environment they know the correct things to say and do. When they need to act upon that knowledge in the complex setting of the real world they are driven by impulse and, therefore, can no longer weigh up options.[91]

Professor Ken Wilson provides invaluable insights into the impact of alcohol related brain damage and mental capacity in this video: https://vimeo.com/259124220

Fluctuating capacity

One challenge with assessing the capacity of dependent drinkers is "fluctuating capacity". [92] The Code of Practice says that: *an assessment must only examine a person's capacity to make a particular decision when it needs to be made. It may be possible to put off the decision until the person has the capacity to make it* [93]…and *If the person's capacity is likely to improve in the foreseeable future, wait until it has done so – if practical and appropriate.* [94] One of the factors that mean a person may regain or develop capacity in the future is where loss of capacity is *caused by the effects of medication or alcohol*…[95]

This is a feature of chronic dependence on alcohol. At some points, e.g. early in the morning, the individual may be less intoxicated and able to have a more coherent conversation. Later in the day they will be intoxicated again and fail to follow any actions they agreed during the earlier conversation.

In cases of fluctuating capacity, the courts and NICE have advised taking a long-term perspective on someone's capacity rather than simply assessing the capacity at one point in time.[96] [97] This will primarily apply to decisions that need to be enacted over a long period of time e.g. residence or care. It is only going to be useful to assess a person at a point of clearer thinking, if there is a discrete decision which can be taken at that point.

The Andrew SAR raises a more specific point about fluctuating capacity and dependent drinkers.[98] *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… Therefore, is someone who is a chronic alcohol user ever in a space where their addiction is not impacting on their ability to reason? [99]

Dealing with executive capacity
The Carol SAR says that: *the concept of "executive capacity" is relevant where the individual has addictive or compulsive behaviours. This highlights the importance of considering the individual's ability to put a decision into effect (executive capacity) in addition to their ability to make a decision (decisional capacity).*[100]

Both the Howard SAR and the Ms H and Ms I SAR highlight people who are driven by compulsions that are too strong for them to ignore. Their actions often contradicted their stated intention to control their alcohol use: i.e. they were unable to execute decisions that they had taken.

With some chronic drinkers, an objective assessment will quickly identify that they lack capacity to take key decisions, for example, because of cognitive impairment. This fits readily within the Mental Capacity Act. For others, e.g. those with fluctuating or executive capacity issues, the assessment will be more complex. As one interviewee for this report said: "these assessments need to be marathons not sprints."[101] At one point in time a person may appear to have the capacity to make an unwise decision; but when looked at in the longer view, it is clear that the person is not, for example, using information about likely harms from their drinking and, therefore, appears to lack capacity.

The Ruth Mitchell SAR says that: *To assess Ruth as having the mental capacity to make specific decisions on the basis of what she said only, could produce a false picture of her actual capacity. She needed an assessment based both on her verbal explanations and on observation of her capabilities, i.e. "show me, as well as tell me". An assessment of Ruth's mental capacity would need to consider her ability to implement and manage the consequences of her specific decisions, as well as her ability to weigh up information and communicate decisions*.[102]

Professionals must continue to link executive dysfunction to the Stage one and Stage two criteria in the Mental Capacity Act. It will be necessary to show that the person's executive dysfunction means that they cannot understand, retain, use and weigh the information relevant to the decision. NICE has commented that it can be difficult to assess capacity in people with executive dysfunction. It recommends that assessment should include real world observation of a person's functioning and decision-making ability[103], with a subsequent discussion to assess whether someone can use and weigh information, and understand concern about risks to their wellbeing.

Taking time to assess and understand what is happening may also identify other reasons for unwise decisions such as fear (of not being allowed to drink or smoke) or embarrassment (because they are incontinent).

The Court of Protection, in the case RB Greenwich vs CDM, has provided another way of thinking about capacity. This case addresses *Micro-* and *Macro-capacity.* The case does not concern a dependent drinker, but rather a woman (CDM) who manages her diabetes very poorly. The judgement recognises that CDM may have micro-capacity to manage specific aspects of her diabetes but lacks the macro-capacity to manage the major issue: the life-saving medication. Details of the judgement can be found at:
https://www.39essex.com/cop_cases/rb-greenwich-v-cdm-3/

Dealing with capacity when there is coercion by others Coercion by others may also affect someone's capacity. The Carol SAR states that: *not all professionals or agencies are*

aware of how factors such as duress or coercion can affect a person's mental capacity and that further expertise and/or legal advice may need to be sought.[104]

In another case: *Tom was situationally incapacitated by exploitative and drug using peers - a fact that was known to many professionals who did not question the absence of mental capacity assessments.*[105]

The Court of Protection (which has oversight of the Mental Capacity Act) has permitted best interest interventions where a person has been unable to take a decision because of the presence and actions of a third party (Redbridge LBC v GC [2014] EWCOP 485). The question to address is whether the person can understand, retain, use and weigh the fact that another individual may have contrary interests and, if not, whether this inability is caused by mental impairment.

If there is no mental impairment, but decision-making is impacted by coercive and controlling behaviour, or undue influence, the High Court's inherent jurisdiction (its right to hear any matter that comes before it unless specifically prevented from hearing it by rule or statute) may be available (DL v A Local Authority [2012] EWCA Civ 253). However, this would require the case being taken to court.

Deprivation of Liberty Safeguards / Liberty Protection Safeguards

- The Deprivation of Liberty Safeguards (DoLS) are an amendment to the Mental Capacity Act 2005.
- The Mental Capacity Act allows restraint and restrictions to be used – but only if they are in a person's best interests. Extra safeguards are needed if the restrictions and restraint used will deprive a person of their liberty. These are the *Deprivation of Liberty Safeguards*.
- The DoLS can only be used if the person will be deprived of their liberty in a care home or hospital. In other settings the Court of Protection can authorise a deprivation of liberty.
- Care homes or hospitals must ask a local authority if they can deprive a person of their liberty. This is called requesting a standard authorisation.
- A person may need to be deprived of their liberty more swiftly. In these situations, the managing authority can use an urgent authorisation. The managing authority can deprive a person of their liberty for up to seven days using an urgent authorisation.
- There are six assessments which have to take place before a standard authorisation can be given.
- If a standard authorisation is given, one key safeguard is that the person has someone appointed with legal powers to represent them. This is called the relevant person's representative and will usually be a family member or friend.
- Other safeguards include rights to challenge authorisations in the Court of Protection, and access to Independent Mental Capacity Advocates (IMCAs).[106]

In May 2019, the Mental Capacity (Amendment) Bill became law. It replaces the Deprivation of Liberty Safeguards (DoLS) with a scheme known as the Liberty Protection Safeguards. This will introduce a streamlined process for authorising deprivations of liberty. However, the introduction of these powers is still pending and will not be until 2022 at the earliest and, therefore, this briefing only includes information on the DoLS.[107]

For more information on DoLS visit:
https://www.scie.org.uk/mca/dols/at-a-glance
For more information on Liberty Protection Safeguards visit:
https://www.scie.org.uk/mca/dols/practice/lps

What actions flow from these duties?
Circumstances will arise, and possibly far more frequently than practice suggests, where chronic dependent drinkers lack the capacity to take key decisions for themselves. This begs the question: "How does the Act benefit the client?" As with the Care Act and the Social Services and Well-being (Wales) Act 2014, the Mental Capacity Act does not dictate any specific response to the individual. This will be dictated by the person's specific situation and what they are deemed to lack capacity to do.

Therefore, the structure of the response is likely to follow the model described in the equivalent section under the Care Act 2014 above. However, the Mental Capacity Act does require that subsequent decisions and actions are undertaken in the "best interests" of the person lacking capacity. It will also allow specific actions such as, taking control of the finances of someone deemed to lack the capacity to control their money or enforcing the cleaning of a house that has become squalid.

In some cases, the Deprivation of Liberty Safeguards (DoLS) may be used with dependent drinkers. This is very likely to be with people who are in a very poor physical state and need to be detained in a hospital or nursing home to enable them to be physically stabilised and probably detoxified.

Things to think about – Mental capacity and the detoxified dependent drinker
A 59 year old man is repeatedly ending up in a chaotic and degraded state. He is, for example, found at home in his armchair, poorly nourished and covered with his own urine and faeces. He is deemed not to have mental capacity and is held under a DOLS. As part of that he is detoxified. After detoxification, he is very clear about his future: he wants to go home and is not going to drink again. He is deemed to be capacitous, he is no longer held under the DOLS and he goes back home, and the cycle starts again. A few weeks later he is in the same state.

It is comparatively simple to argue that chaotic dependent drinkers lack capacity when they are heavily intoxicated and found in a degraded and neglected state. The challenge is how to act in their best interests and how to assess capacity when they are newly detoxified.

In the immediate aftermath of a detoxification people will often seem clear-thinking and "capacitous"; however, it is important to consider four other factors:

- The chronic relapsing nature of alcohol dependence
- The "pink cloud" of positive feelings post detoxification
- Worker optimism (so-called), and
- Kindling – the damage caused by repeated detoxification.

To assume that once someone is detoxified, they are going to pursue long-term abstinence is to ignore that, by definition, alcohol dependence is a **chronic relapsing condition**. One of the DSM IV criteria for alcohol dependence is "…unsuccessful efforts to cut down or control alcohol use." At some point after detoxification people will again feel intense cravings for alcohol.

This problem is exacerbated because in the immediate aftermath of a detoxification, clients can feel unrealistically positive about their situation. Alcoholics Anonymous call this the "**pink cloud**". People may believe that they are going to do far better than past history or the nature of their condition suggests is likely.

This is exacerbated by "**worker optimism**": workers take an unrealistically positive view of the person's prospects. This has been commented on in various Safeguarding Adult Reviews and is a particular problem with substance misusers (e.g. the child protection worker who believes the client who declares she never uses when looking after her child). It is more correctly called "worker over-optimism". Optimism is positive and may be particularly appropriate the first time someone encounters a client; however, after several cycles of detoxification and relapse, this is hard to justify and becomes "over-optimism".

These three factors together can create a repeating cycle of *relapse – detoxification – abstinence – service withdrawal – relapse.* This matters because of "**kindling**". This is the harm caused by repeated detoxes which can ultimately increase cognitive damage. Repeated withdrawal increases the risk of very severe withdrawal symptoms, up to and including seizures, cognitive damage and death.

Capacity assessments after alcohol detoxification need to recognise the complex reality of alcohol's effects on the body and on cognition and ensure that they reflect the client's best long term interests. For many, the decisions that require a capacity assessment are not those in the immediate aftermath of detoxification, but those further along the journey.

Is this person able to make a capacitous decision about their care and support when the cravings for alcohol return and the psychological factors that have driven their addiction resurface through the positive sensations experienced in the immediate aftermath of withdrawal?

A long-term view is required. The client's current state needs to be set against the past history of relapse. If not, because of kindling, the decision that the person is now capacitous has the potential to cause greater harm and will not be in the person's "best interest".

Section 7 - The Mental Health Act 1983 (amended 2007)

Summary

- **The Mental Health Act (2007) defines a mental disorder as "any disorder or disability of the mind".**
- **The Act's definition of a mental disorder includes "Mental and behaviour disorders caused by psychoactive substances".**
- **It is possible to detain someone under the Act if they have disordered mental functioning due to their chronic drinking.**
- **Such actions are likely to be rare and current practice does not make much use of this option. It would need to be a last resort and represent the least restrictive option now available to meet the person's treatment needs.**
- **Models of interventions in the detained setting are available in other countries.**
- **The challenge in England and Wales is that there needs to be a facility in which this treatment can occur.**
- **This may need to be purchased from the private sector if places cannot be made available in the local context.**

Does the Act apply to dependent drinkers?
The 1983 Mental Health Act stated that: *"Nothing (in this Act) …shall be construed as implying that a person may be dealt with under this Act as suffering from…any form of mental disorder described in this section, by reason only of…dependence on alcohol or drugs."*[108]

However, the 2007 revisions to the Mental Health Act amended this, substituting the following wording: *"Dependence on alcohol or drugs is not considered to be a disorder or disability of the mind for the purposes of subsection (2) above."*

This is a significant change. The 1983 wording appears to exclude any mental disorder that arises from alcohol dependence. The 2007 wording only excludes alcohol dependence itself. The focus of this briefing is the management of mentally disordered behaviour that arises because of alcohol dependence, not dependence alone.

The 2007 Mental Health Act Code of Practice confirms this view. A mental disorder is "any disorder or disability of the mind" (2.4) and clinically recognised conditions which could fall within the Act's definition of mental disorder include "Mental and behaviour disorders caused by psychoactive substances" (2.5).

Therefore, although dependence itself is not a mental disorder, conditions which arise from the alcohol use could be considered mental disorders. This is confirmed in section 2.9-2.10 of the Code of Practice. The Code goes on to identify circumstances under which action related to alcohol dependence can be taken under the Act:

2.11 Alcohol or drug dependence may be accompanied by, or associated with, a mental disorder which does fall within the Act's definition. If the relevant criteria are met, it is therefore possible, for example, to detain people who are suffering from mental disorder, even though they are also dependent on alcohol or drugs. This is true even if the mental disorder in question results from the person's alcohol or drug dependence.

2.12 The Act does not exclude other disorders or disabilities of the mind related to the use of alcohol or drugs. These disorders – e.g. withdrawal state with delirium or associated psychotic disorder, acute intoxication, organic mental disorders associated with prolonged abuse of drugs or alcohol – remain mental disorders for the purposes of the Act.

2.13 Medical treatment for mental disorder under the Act (including treatment with consent) can include measures to address alcohol or drug dependence if that is an appropriate part of treating the mental disorder which is the primary focus of the treatment."

While it would be unlawful to detain or attempt compulsory treatment simply because a person is dependent on alcohol, the wording of the Act indicates that it is possible to detain someone who is severely mentally disordered because of the effects of alcohol such as cognitive impairment, serious depression and acute confusion. The International Classification of Disease Codes (ICD-10) related to alcohol misuse provide a useful list of mental and behavioural disorders due to psychoactive substance use.[109]

How does the Act help dependent drinkers?

Action under the Mental Health Act must pursue the *least restrictive* possible option compatible with their treatment.[110] Therefore, the Act is likely to be used as a last resort with dependent drinkers. However, action is possible under the Act to treat the most damaged drinkers.

It is likely that any action under the Mental Health Act will be taken under:

- Section 2 – Assessment (hospital detention for assessment up to 28 days) - A 28 day period of detention would provide an almost ideal framework for assessing whether the person's behaviour was the result of alcohol dependence alone, or whether it had some other origin e.g. cognitive impairment.
- Section 3 – Treatment (hospital detention for treatment for an initial period of up to six months). This period of time would be more than adequate to deliver the type of interventions that form part of compulsory interventions in New South Wales (see above) or in Sweden or the USA. [111] [112] [113]

However, the challenge is that to undertake these interventions, suitable inpatient facilities need to exist. More specifically, the Mental Health Act requires that for detention under Section 3, there is *treatment* available. The Act describes treatment as referring to medical treatment, the purpose of which is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations.[114] It "includes nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care…" the purpose of which is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations."[115]

That a suitable package of interventions exists is demonstrated by the examples of Sweden or New South Wales (see Section 2 above) where enforced alcohol treatment programmes have been developed for this client group. This will be hard to re-create in England and Wales, largely because the provision of specialist NHS alcohol inpatient treatment units has been cut back severely from its peak in the 1970s and 1980s. At present there are only six such NHS units in England. Clinicians usually recommend that this group are not placed on general psychiatric wards.

However, this has created a situation in which interventions are being dictated by the available services not by people's needs.

Three alternative pathways exist:

- Considering on a case by case basis whether specific clients can be managed within the existing mental health or general hospital service structure
- Purchasing appropriate facilities from the private sector
- Gathering evidence on unmet need to justify commissioning services in the longer term.

NB - Section117 of the Act has a duty to provide aftercare to people who have been detained under the treatment sections (e.g. S.3). This imposes a duty on health and social care services to provide support, including appropriate supported accommodation, and at no cost to the client.

Section 8 – Other legal frameworks and guidance

Four other areas of legislation bear on this client group:

- The Human Rights Act 1998
- The Anti-social Behaviour, Crime and Policing Act 2014 (anti-social behaviour powers)
- The Criminal Justice Act 2003 (court ordered and probation led alcohol treatment requirements)

- Environmental health legislation

This section provides brief summaries of these powers. We have not provided detailed guidance on these four areas because this guidance is focused on the three main powers outlined above. However we would expect these to be considered as alternatives in multi-agency groups and more information can be sought from partners – in most cases the local authority - but also the police or environmental health.

The Human Rights Act 1998

The Human Rights Act 1998 incorporated the European Convention on Human Rights into UK law. Article 5e of the Convention on the *Right to liberty and security* states that:
Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:
…(e) the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants;[116]

The Department of Constitutional Affairs' publication *A Guide to the Human Rights Act 1998: Third Edition* indicates that this element is technically included in UK law.[117] However, the UK has not chosen to enact legislation which allows for the deprivation of liberty of chronic dependent drinkers, and is not under any legal obligation to do so.

In the short term, other articles of the Convention are more relevant:
Article 2 - Right to life
Article 3 – Freedom from…inhuman or degrading treatment[118]

A case could be built that leaving someone to drink in a fashion that leads to their physical or environmental decline or which leaves them open to abuse and exploitation is a breach of either Article 2 or Article 3. See e.g. Rabone & Anor v Pennine Care NHS Foundation [2012] UKSC 2[119]

The Anti-social Behaviour, Crime and Policing Act 2014 (anti-social behaviour powers)

The Anti-social Behaviour, Crime and Policing Act 2014 introduced new powers to support frontline agencies in tackling anti-social behaviour. These include the *Civil Injunction* which is a civil order issued by the courts and the *Criminal Behaviour Order (CBO)* which is available on conviction of any offence. These replaced, and represented a step change from, anti-social behaviour orders (ASBOs). The new orders not only allow courts to ban behaviours (e.g. drinking in a particular location), but also allow the imposition of *positive requirements* which will help encourage permanent change.[120]

The Injunctions and CBOs are generic tools. They have been granted for behaviours ranging from aggressive begging, through poor management of rented premises to persistent public drunkenness. The Government's guidance is clear that these powers are appropriate for people whose anti-social behaviour is due to alcohol problems and that the positive requirements can include treatment-type interventions, e.g. to receive *support and counselling* or attend *alcohol awareness classes.* Therefore, these powers do offer an opportunity to empower responses to a treatment resistant and disruptive client group.[121]

It has to be acknowledged that police and community safety staff across the country are struggling to develop orders and requirements for people with alcohol problems. Challenges range from securing orders in the courts to finding wording that maximises the likelihood that the recipient will benefit from help. Nonetheless, these powers do represent an opportunity to

influence the behaviour of chronic dependent drinkers, engagement with services and, potentially, initiate change.

The Act also includes other powers which may be of use with this group:

- Community Protection Notice – which can require people to cease anti-social behaviour and take reasonable steps to rectify or address it. [122]
- ASB community trigger which gives victims of ASB and communities the right to request a review of their case where a local threshold is met, and to bring agencies together to take a joined up, problem-solving approach to find a solution for the victim.[123]
- Closure Orders which can be used to protect victims and communities by quickly closing premises that are causing nuisance or disorder. This can include a partial closure to prevent people who are exploiting someone from entering tier property.[124]

A non-statutory, Acceptable Behaviour Contract, might also be considered at an earlier stage with these people.[125]

The best introduction to the A*nti-social Behaviour, Crime and Policing Act 2014.* is the Home Office statutory guidance which is available at:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/679712/2017-12-13_ASB_Revised_Statutory_Guidance_V2.1_Final.pdf

More detailed, but still generic guidance is available from:
http://www.cps.gov.uk/legal/a_to_c/criminal_behaviour_orders/

The Civil Justice Council, a senior group within the judiciary, has also recently published a report on the use of these powers:
https://www.judiciary.uk/wp-content/uploads/2020/10/ASBI-final-accessible.pdf

The Criminal Justice Act 2003

This Act introduced the Alcohol Treatment Requirements. These are effectively probation orders with conditions of alcohol treatment and mirror two other similar orders Drug Rehabilitation Requirements and Mental Health Treatment Requirements.[126] They are, therefore, only applicable to people who have committed an offence that warrants a probation order. Potential recipients of an order could also choose to go to prison rather than undergo the order. Once on an order, someone would receive a period of community treatment, most likely one to one interventions and / or groupwork. However, it is possible to require a period in a residential rehabilitation facility.

Environmental Health legislation

Environmental health legislation can be useful in managing self-neglect. However, the Adult D SAR recognised that understanding of this may not be particularly widespread.[127]

A number of pieces of environmental legislation impact on this client group:

- **Public Health Act 1936** - Contains the principal powers to deal with filthy and verminous premises. Under sections 83/84, the local authority can require an owner or occupier to remedy the condition of premises that are filthy, verminous or unwholesome and therefore prejudicial to health. The powers include cleansing and disinfecting, and the destruction and removal of vermin, which the local authority may carry out and charge for. Section 85 allows cleansing to free a person and their clothing from vermin.

- **Prevention of Damage by Pests Act 1949** - Local Authorities have a duty to take action against occupiers of premises where there is evidence of rats or mice.
- **The Public Health Act 1961** - Section 36 gives the power to require vacation of premises during fumigation.
- **The Public Health (Control of Disease) Act 1984** - Provides powers to intervene in situations of disease or infection posing significant risk of harm.
- **The Building Act 1984 Section 76** - The local authority has the power to deal with any premises which are in such a state as to be prejudicial to health where the owner or occupier refuses to take remedial action.
- **The Environmental Protection Act 1990 -** Sections 79/80 empower the local authority to issue an abatement notice with regard to any premises in such as state, including through 'accumulation or deposit', as to be prejudicial to health or a nuisance, thus requiring the home conditions to be improved. The Act provides a power of entry, and a notice can also apply to the area outside a property.
- **The Housing Act 2004** - Allows the local authority to carry out a risk assessment of any residential premises to identify any hazards that would likely cause harm and to take enforcement action where necessary to reduce the risk to harm. If the hazard is a category 1 there is a duty by the LA to take action. If the hazard is a category 2 then there is a power to take action. There is ultimate recourse to injunctions (Housing Act 1996) or possession proceedings (Housing Act 1985).[128]
- **Fire and Rescue Services Act 2004 –** this defines the circumstances under which a fire officer can enter premises and the powers they have on entry.[129]

It may also be relevant to consider **the Homelessness Reduction Act 2017** which amends the existing homelessness legislation in **the Housing Act 1996**. It adds two new duties to the original statutory rehousing duty:

- Duty to prevent homelessness
- Duty to relieve homelessness

The legislation and a briefing are available at the links below:

- https://www.legislation.gov.uk/ukpga/2017/13/contents/enacted
- https://england.shelter.org.uk/__data/assets/pdf_file/0007/1494871/Homelessness_HRA17_Implementation_Briefing_FINAL.pdf

People with No Recourse to Public Funds[130]

Individuals who are subject to immigration control have no entitlement to welfare benefits or public housing. This includes homelessness assistance.[131] However, access to other publicly funded provision is still available, including adult social care. Some individuals with no recourse to public funds may be given assistance under the Care Act 2014 if their eligible needs are the result of disability, illness or a mental health condition, or if the local authority exercises its power to meet non-eligible needs. Put another way, their needs must not be the result solely of destitution.[132] Provision can include accommodation owing to the individual's need for care and attention.[133]

For those who are excluded from this support[134], for instance if they are unlawfully present in the UK or are failed asylum seekers, and if there is nothing to prevent their return to their country of origin, then a Human Rights Act 1998 assessment is required to determine whether support is necessary to prevent a breach of their human rights, especially the right to live free of inhuman and degrading treatment (Article 3, European Convention on Human Rights). In the context of homelessness, this equates to intense mental suffering and physical harm. Provision should then be considered under the Localism Act 2011.[135]

Extract from Preston-Shoot, M. (2020) Adult Safeguarding and Homelessness: A briefing on Positive Practice. London: Local Government Association and ADASS

Other relevant guidance

Alongside the Acts of Parliament, other documents may assist professionals:

- The Care Act 2014 Statutory Guidance[136]
- The Mental Capacity Act 2005 Code of Practice[137]
- The Mental Health Act 1983 (amended 2007) Code of Practice[138]
- NICE guideline 108 - Decision-making and mental capacity - October 2018[139]
- PHE / NHSE – Better care for people with co-occurring mental health and alcohol and drug use conditions - 2017[140]
- NICE – National Guidance 58 – Co-existing severe mental illness and substance misuse - 2016[141]
- NICE - Clinical Guideline 120 - Psychosis with coexisting substance misuse - 2011[142]
- NICE - Clinical Guideline 115 -Alcohol-use Disorders: Diagnosis, Assessment and Management of Harmful Drinking and Alcohol Dependence - 2011[143]
- The ICD-10 Classification of Mental and Behavioural Disorders: Clinical descriptions and diagnostic guidelines[144]
- The King's Fund - Delivering health and care for people who sleep rough – 2020[145]
- LGA / ADASS - Adult safeguarding and homelessness: A Briefing on Positive Practice -2020[146]
- Care Quality Commission - Guidance on the treatment of anorexia nervosa under the Mental Health Act 1983 – 2008[147]
- NICE – Nice Guideline 69: Eating disorders: recognition and treatment - 2017[148]
- Braye, S., Orr, D. and Preston-Shoot, M. (2014) Self-Neglect Policy and Practice: Building an Evidence-Base for Adult Social Care. London: SCIE [149]
- Preston-Shoot, M. (2019) 'Self-neglect and safeguarding adult reviews: towards a model of understanding facilitators and barriers to best practice.' *Journal of Adult Protection*, 21 (4), 219-234[150]

Section 9 – Making the legal powers work. Case studies

This section looks at four chronic dependent drinkers and how the powers could be used to protect them. These have been modified to be unidentifiable, but each is based on a real person.

Case study - PB

PB is a 60 year old white British male who has been street drinking for at least 20 years. Little is known about his earlier life, but it is believed he had children from whom he has long been estranged. He had been homeless, but a charity sector homelessness agency worked with him to secure accommodation. However, he is now not using this because of fears of abuse by his neighbours and is sleeping rough again.

He has a history of aggressive behaviour towards professionals and people in the community and as a result has spent several short periods in prison. However, the main concerns are now his self-care. He is spending a lot of time outside a major railway

station, where he is often doubly incontinent in public. As a result, he is subject to frequent 999 calls from concerned passers-by and has repeated A&E attendances.

He has physical health problems related to alcohol and looks much older than his years and his workers are concerned that he may be at risk of death. There may be underlying mental health issues; his workers suspect that he has memory issues and possibly Korsakoff's Syndrome. He has had frequent falls, he was assaulted and was not remembering the incidents.

His worker in the homelessness agency tried to link him into local substance misuse services. However, they require him to attend a timed appointment and to arrive relatively sober. This has proved beyond him. Efforts to have his cognitive function assessed have met a similar response.

A safeguarding alert was raised with adult social care expressing concern about both his self-neglect and vulnerability to abuse by others. However, the initial response was that this was not a safeguarding issue because the drinking was a choice and that the situation would improve if he stopped drinking.

Because of the level of concern, his housing worker took his case to a local multi-agency safeguarding hub meeting. The adult social care lead on the meeting agreed he was in need of safeguarding under the Care Act. After assessment, care and support was agreed based on intensive, assertive outreach, which was flexible and focused on rapport building. He was taken home, bought new clothes and provided with food. Vitamin B1 supplements were made available. A care package was provided with staff who cooked and cleaned for him. Ultimately, the council placed him in suitable accommodation rather than in multiple occupancy with other drinkers.

Case study – MK

MK is a 52 year old mixed race (Black British and White British) female. She has had a lifelong physical problem that impairs her mobility and ability to work. Her intellectual abilities are on the borderline of being classed as having a learning disability. It is suspected that she was born with foetal alcohol syndrome and she certainly had a disrupted childhood and spent some periods in foster care. She has drunk heavily since her teenage years.

She has been a fiery character and has had a series of, at times, chaotic relationships. These have bordered into anti-social behaviour, neighbour nuisance and, at times, domestic conflict. However, the general sense from professionals was that these were relationships that she was choosing rather than abusive or exploitative.

However, in the last couple of years her physical health has deteriorated, and she has peripheral nerve damage and liver cirrhosis as a result of her drinking. This has further restricted her lifestyle and she now lives alone in increasingly squalid circumstances. She increasingly struggles to go out and buy alcohol, cigarettes and food.

As a result, she has become dependent on other people to shop for her. She started offering money to passers-by to buy her alcohol. This culminated in a teenager assaulting her and stealing her purse. The police became involved and raised a safeguarding alert.

Adult social care assessed her and agreed she was both vulnerable and self-neglecting. A care package was put together involving a clean of the house, help with shopping and

referral to the alcohol service. Although, she agreed to engage with alcohol treatment, she never attended an appointment, she continued to drink heavily and the situation in the house deteriorated again. This pattern was repeated a couple more times over the next months.

It became clear that MK did not have mental capacity to manage her finances and personal care. A new package of care and support was put together involving regular personal care, an appointeeship to manage her finances and assertive work to address her drinking.

The social worker discussed the case with the local alcohol service, and with the approval of the alcohol service commissioner, agreed with them that the risk required a more assertive response than they usually provided. An alcohol worker visited her with the social worker and began to build a relationship that was not focused immediately on her alcohol use, but on helping her with her money management now that she had an appointeeship. This allowed the worker to begin to develop a trusting relationship that eventually led to a discussion about alcohol and the need for change.

Ultimately, MK was introduced to a peer mentor who volunteered with the alcohol service and over time this relationship became her main support. MK has not stopped drinking, but she is much more controlled in her drinking and her self-care. There is now some discussion about whether she would be appropriate for some form of residential rehabilitation.

Case study - DN

DN is a 53 year old white British male dependent drinker. Although he had a job and a partner up until 10 years ago, he is now living alone in a privately rented studio flat. At times he is drinking up to 6 litres of white cider per day and in the past, this led to very out of control behaviour with police and ambulance call outs. This, in turn, led to safeguarding alerts and involvement from both adult social care and alcohol services.

Eventually he was found by a social worker lying intoxicated in a urine and faeces soaked bed. This led to an admission to hospital where he was detoxified and then moved to a respite placement funded by social care. During this placement he was able to stop drinking and his flat was deep cleaned. He was offered the chance to go to rehab but preferred to return to his flat.

However, on returning to his flat he also returned to drinking. As a result, this pattern of drinking, squalor, hospital admission, respite and relapse was repeated three times. Workers involved in the case became increasingly frustrated: one worker felt he simply liked living in his own faeces.

Because of the complexity involved, a multi-agency group was convened to discuss his case. This was attended by adult social care, police, alcohol services, hospital and mental health services. It was agreed that at the next point of crisis a referral would be made to the crisis team for assessment under the Mental Health Act. As a result, he was ultimately detained under section 2 on a psychiatric ward with the aim that he would be detoxified, be free of alcohol and then be kept long enough to assess his real mental health state.

Case study – CR

CR is a female dependent drinker in her 40s living in very poor circumstances. She is of East European heritage. A few months ago, she tried to burn some rubbish in her sink; neighbours smelled smoke and called the fire service. This led to a fire service home safety check. The officer described the situation as the worst he had encountered. In addition to rubbish, cigarette ends, empty bottles and discarded food, there were animal faeces everywhere including on her feet. There were at least three cats in the property.

This led to a safeguarding alert to the local authority. Adult social care attempted to call or visit CR on three occasions but she either failed to answer the door or when spoken to on the phone insisted that she was fine and did not need any help. As a result, the adult social care inquiries ceased. However, the fire officer remained very concerned about the risk posed to, and by, this woman and the Fire Service decided to make a referral to the local authority under Article 2 of the Human Rights Act citing a threat to her right to life and a threat to the lives of her neighbours because of the danger of fire. This encouraged and supported social care becoming actively involved.

Section 10 – Making the legal powers work - Challenging myths and misconceptions

In section 1, we identified twelve common myths and misconceptions that prevent these powers being used with dependent drinkers. On the basis of the information provided in this briefing, this section challenges these beliefs.

One: If someone says they don't have a problem and don't want help, there is never anything you can do.

Dependent drinkers will frequently deny they have a problem and reject help. However, this should not be an end to attempts at intervention.

- If someone is being exploited, neglected or is self-neglecting, then consent is not required to raise an adult safeguarding concern. As a result, the local authority will need to make enquiries and determine what action is required.
- If someone is clearly at risk but is denying the need for help, that should raise questions about the person's mental capacity and the need for a mental capacity assessment.
- Assessments with this client group will need time – the process should be viewed as a marathon not a sprint. Any assessment should look at the person's behaviour over a period of time not just at a single moment.

Two: People are not vulnerable because they are <u>choosing to</u> live like this,* or *<u>like</u> living like this.

The simplest answer to this is that no-one chooses to sit in their own faeces, to be exploited, or to live in a property that is infested with insects. Such views need to be challenged. In addition:

- As above, if someone is being exploited, neglected or is self-neglecting, then consent is not required to raise an adult safeguarding concern.
- Such a situation should raise questions about mental capacity and in extreme cases about the potential for using the Mental Health Act or the Human Rights Act.

Three: People are not vulnerable / self-neglecting if they have mental capacity.
The answer to this is very simple. Under the Care Act 2014 and the Social Services and Well-being (Wales) Act 2014, you do not need to lack mental capacity to be vulnerable or self-neglecting. Even if someone appears to be making unwise choices that lead to self-neglect, it is still self-neglect and action is required under the English or Welsh Acts.

Four: Once people are sober they no longer have care and support needs or lack capacity.
In developing this briefing, the authors came across a case in which a social worker had stated that a very chaotic and vulnerable dependent drinker did not have care and support needs because in the brief periods when he was sober he could care for himself. This needs to be challenged. Alcohol dependency is, by definition, a chronic relapsing condition. People will have, possibly hard won and probably brief, periods of sobriety or stability. To assess people on those moments, rather than on the whole picture of their condition, may not only not help the client but actually perpetuate or worsen the problem. A long-term and evidence-based view is required in any assessment.

Five: If people have capacity, there is nothing we can do.
Assessing that someone has capacity is not the end to an intervention. As the Ruth Mitchell SAR says:

- *Whilst capacitated adults are considered self-determining, and in law (MCA 2005) have the right to make unwise decisions, a duty of care still exists on professionals to explore why the adult is making an unwise choice and what can be done to support them in caring for themselves. … In order to be able to work with a person who is self-neglecting and very reluctant to engage with support, it is necessary to create a relationship with them.* [151]

The combination of capacity and risky behaviour is an indicator that a different route is required to meet the concerns. If someone appears to have capacity but is still allowing abusers in to their flat or is sitting in her own faeces, then an alternative route outside the mental capacity framework will be required.

Six: People have the right to make unwise decisions
The Mental Capacity Act Code of Practice states that "*People have the right to make decisions that others might think are unwise."* [152] However, this sentence is often taken out of context. The Act itself has a more measured statement: *The following principles apply for the purposes of this Act… A person is not to be treated as unable to make a decision merely because he makes an unwise decision.* [153] [154]

The principle applies "*for the purposes of this Act*"; this is not a general statement about unwise decisions. Secondly, the word "*merely*" impacts on this principle. The fact that a decision is unwise is not sufficient to conclude that the person lacks capacity, but it may be a relevant consideration to take into account in determining whether a person is unable to make a capacitous decision.[155]

The subsequent sentence in the Code of Practice is far more accurate in stating that: *"A person who makes a decision that others think is unwise should not automatically be labelled as lacking the capacity to make a decision."* [156] [157]

Seven: Alcohol dependency is not covered by the Mental Health Act.
This is only partially correct. The Mental Health Act does not allow detention solely on the grounds of alcohol dependency. However, action is possible for people with mental disorders which arise from psychoactive substances. If someone has a disorder of the mind related to alcohol use, e.g. alcohol related brain damage, acute confusion, severe depression, and even psychosis, then it is possible to build a case for action under the Act.

However, this will not be, and should not be, a simple or frequent option. It will probably require considerable multi-agency discussion to demonstrate the need for this route.

Eight: Mental health services don't need to assess someone if the main problem is alcohol.
This is usually a comment made by mental health services based on the view that because alcohol dependency is not a ground for action under the Mental Health Act, therefore, it is not part of their remit. The simple answer to this is: "How does someone know whether the cause is alcohol, a head injury or a mental illness without taking time to assess?" It is also relevant to note that it is only alcohol dependency that is excluded from the mental health service remit. As above, disorders of the mind related to alcohol use are covered by the Mental Health Act.

Nine: Assessment is impossible if people never turn up for appointments. If someone is vulnerable, at risk of abuse and neglect (including self-neglect) or having a significant impact on the community, it is unhelpful, if not self-defeating, to require someone to leap a hurdle like attending an appointment with a stranger in a distant part of town. Assessment structures need to accommodate the difficulties faced by the client rather than be convenient for the worker. In particular, assessment should not be seen as a point in time, but rather as a process whereby services work with someone to enable an assessment to be undertaken. Without a process focus, services will fail the most challenging clients.

Ten: People can't be assessed if they are always intoxicated.
The Mental Health Act Code of Practice (2015) requires Approved Mental Health Professionals faced with an intoxicated person in a crisis, to either wait until the person has sobered up sufficiently or to base an assessment on other information that is available. This advice is specific to AMHPs and crisis situations; but also provides a realistic approach to this group generally. Professionals will have to identify the best time to assess someone through discussions with those who know them best. If that is not possible assessments may need to be based on available information.

Eleven: There is no treatment available for this client group – so people can't be treated under the Mental Health Act.
The treatment sections (e.g. section 3) of the Mental Health Act do require that a treatment is available in an inpatient hospital setting. This has become very difficult to find in the England and Wales context. The network of inpatient alcohol treatment units that existed in the 1970s and 1980s has largely disappeared. Mental health wards are generally not appropriate places for the management of dependent drinkers. Nonetheless, in other countries packages of inpatient detoxification, stabilisation, vitamin therapy and rehabilitation do exist for this client group. Whether that can be reconstructed in England and Wales will depend on local negotiation and resources. It would be possible, for example, to purchase such a package of care from the private sector.

Twelve: Once someone stops drinking the problems always go away, so this isn't a mental health issue.
Many mental health problems improve once other action is taken. Depressed people may improve markedly if they are helped to eat properly, sleep and provided with support. At the point of crisis, many drinkers are functionally mentally disordered in terms of the Mental Health Act. In the longer term, mental health services may not be the best support route, but in the short term their skills may be very valuable.

Section 11 - What happens next? A local action plan

Change will not happen without local action. We recommend six straightforward steps which can be used to move this agenda forward.

A local action plan
1. The Safeguarding Adult Board in each area should ensure that there is a senior strategic level group that takes on oversight of this agenda. This is most likely to be the SAB itself but could be another body.
2. The oversight group should ensure that all key local agencies have received and considered this briefing and indicated what steps, if any need to be taken to ensure the safeguarding, protection and support of this client group.
3. The oversight group should identify any service gaps that need to be considered by local substance misuse commissioners.
4. Substance misuse commissioners should ensure that the needs of this group are addressed in any needs assessments and commissioning plans
5. Substance misuse commissioners should consider establishing a specialist post, probably a social worker or mental health nurse, who is expert in both the assessment of this client group and the use of the available powers, to advise on or undertake the management of this client group.
6. The oversight group should ensure that training on the use of these powers is available for those working with chronic dependent drinkers.

Appendix 1 - Foetal Alcohol Spectrum Disorders and the MCA and MHA

Raja Mukherjee Clinical Lead, National FASD Specialist Behaviour Clinic

What are Foetal Alcohol Spectrum Disorders (FASD)

FASD represents a range of conditions that are caused when a foetus is exposed to alcohol. The early understanding of the condition was more linked to its physical characteristics. It is now recognised that it is the brain and its ability to function that is most affected. Less than 5% of individuals with FASD's cognitive deficits also had standard facial characteristics.

How common is it and why is it not recognised?

FASD was once thought to be a rare disorder. However, the consumption of alcohol during pregnancy remains significant and, in the UK, around 40% of women have been reported to drink during pregnancy. A 2018 FASD prevalence study identified rates of between 6 and 17% of the population.

What are the common cognitive impairments and functional impairments linked to FASD?

The cognitive difficulties linked to FASD are often subtle. Whilst there are issues relating to executive function, working memory, language, social communication, sensory processing alongside other adaptive behavioural difficulties, it is not that simple.

In situations where there is no anxiety and stress, an individual can score and function better than in situations where there is an emotional context. They often do least well when a multi-level cognitive demand is placed upon them. An example on testing would be that simple tasks can be completed but as the task increases in complexity and different aspects of the cognitive function and ability are required of the individual, it leads to them simply not being able to cope.

How do these impact on the use of the MHA and MCA?
The neurocognitive deficits, and especially the problems with multiprocessing, have an impact on capacity and decision-making. In order for a capacitous decision to be made, the individual must be able to understand, retain, recall and weigh up information and make decisions based upon it.

For these individuals, where they can do simple processing in non-stimulating environments answering single questions, it may appear that they have capacity. However, in a high arousal situation where there is an emotional component and multitasking is required without support, evidence would suggest their functioning is less clear. The situation makes them less likely to consider wider issues and also act on impulse or be influenced by others. All of these factors would lead to their capacity being questioned.

In brain injury cases, the paradox of executive abilities has been described and these are also seen in individuals with FASD. Where patterns of behaviour are consistently not in keeping with what is stated in an assessment scenario, it should be questioned whether capacity exists for that decision.

When the individual lacks capacity and is not making decisions for themselves, where the behaviour puts themselves and others at risk, the Mental Health Act may be needed in order to protect themselves or others. Guardianship under the Mental Health Act has been recommended in scenarios, for example, where significant risk to the individual through their cognitive vulnerabilities which are missed through a lack of diagnosis is required.

Appendix 2

Jeanette Hansen	Hostel manager	Westminster
Sue Atkins	Nurse	Portsmouth
Sally Davies	Social worker	Cardiff
Vicky Boxer	Substance misuse	Herts
Jo Grimshaw	Police	Surrey
Pauline Chowns	AMHP/ Social worker	Sandwell
Julie Shaw	MEAM	Surrey
Jane Ward	Catalyst	Surrey
Jean Coates-Topping	Addaction	Wigan
Jessica Allen	Hertfordshire social services	Herts
Feyi Alabi	Hertfordshire social services	Herts
Nikki Mustafa	Street Outreach Team	Islington
Claire	Carer	Medway
Sarah Wadd	University of Bedfordshire	National
Emma Harvey	West Kent HA	Medway
Anne Thompson	Adult Safeguarding	Northumberland
Jamie Brenchley	Homelessness	IOW
Lisa Naisbet	Safeguarding manager	South Tyneside
Gurjit Brring	Blue Light Project Coordinator	Sandwell
Irene O'Brien	Outreach worker	Sandwell
Matt Rumsey	Police	IOW
Frankie Clifford	Mental Health	Devon

Jacquie Bates	Social worker	Bristol
Janine Hale-Brown	Psychiatrist	Bristol

Inside back cover text

The authors

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Professor Michael Preston-Shoot has been a social work academic since 1988. He joined the University of Bedfordshire in 2003, as Head of Department of Applied Social Studies. He was Executive Dean of the Faculty of Health and Social Sciences between 2005 and 2016. He specialised in teaching law to non-lawyers, principally social workers and social work students. He completed a research project for the Department of Health on the governance of adult safeguarding and a series of studies on self-neglect for the Department of Health and Skills for Care. These studies were influential in shaping the adult safeguarding provisions in the Care Act 2014. He was Independent Chair of Luton Local Safeguarding Children Board between 2009 and 2015 and Luton Safeguarding Adults Board between 2008 and 2015. He is now the Independent Chair of both Lewisham and Brent Safeguarding Adults Boards. He is the author of several serious case reviews and safeguarding adult reviews.

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[1] Figure created by combining Public Health England (600,00) and Alcohol Change UK estimate for Wales (50,00)
[2] https://alcoholchange.org.uk/help-and-support/get-help-now/for-practitioners/blue-light-training/the-blue-light-project
[3] Case study provided by Nottinghamshire Long Term Conditions Team in 2017
[4] Alcohol Change UK - Learning from Tragedies - 2019
[5] http://www.youtube.com/watch?v=DA_3uou6nyQ&index=2&list=PLSEhy70YpU5tZyaoHxz5UTuOUyJokMdFD
[6] Northumberland SAB – Leanne Patterson – Safeguarding Adults Review - 2019
[7] Rosenthal R. – The etymology and early history of "addiction" – Addiction Research and Theory – February 2019
[8] Interviewee 2
[9] Davidson K. – Diagnosis of depression in alcohol dependence – British Journal of Psychiatry (1995) 166, 199-204
[10] Wilson K. - *Alcohol related brain damage in the 21st century* Br J Psychiatry. 2011 Sep;199(3):176-7.
[11] http://www.youtube.com/watch?v=DA_3uou6nyQ&index=2&list=PLSEhy70YpU5tZyaoHxz5UTuOUyJokMdFD
[12] Interviewee 5
[13] E.g. http://www.britishlivertrust.org.uk/liver-information/living-with-liver-disease/looking-after-yourself/
[14] E.g. http://www.nchpad.org/606/2558/Food~and~Your~Mood~~Nutrition~and~Mental~Health
[15] Preston-Shoot, M. (2020) Ms H and Ms I: Thematic Safeguarding Adults Review. Tower Hamlets SAB
[16] Craigie J. & Davies A. - Problems of Control: Alcohol Dependence, Anorexia Nervosa, and the Flexible Interpretation of Mental Incapacity Tests - Medical Law Review, Vol. 27, No. 2, pp. 215–241
[17] CQC - Guidance on the treatment of anorexia nervosa under the Mental Health Act 1983 - undated but after 2008
[18] Eating disorders: recognition and treatment NICE guideline 69 – 2017
[19] Craigie J. & Davies A. - Problems of Control: Alcohol Dependence, Anorexia Nervosa, and the Flexible Interpretation of Mental Incapacity Tests - Medical Law Review, Vol. 27, No. 2, pp. 215–241
[20] Interviewee 7
[21] Alcohol Concern - An evaluation of The Nottinghamshire Alcohol-related Long Term Condition Team - 2015
[22] Information provided to the authors by Catalyst in Surrey
[23] Ward M. & Holmes M. – The Blue Light project – Project Manual – Alcohol Concern - 2014
[24] Ward M. & Applin C. – The Unlearned Lesson – Alcohol Concern and Drugscope - 1998

[25] Alcohol Concern / AVA – Domestic Violence and Change-resistant Drinkers - 2016
[26] https://www.tsab.org.uk/wp-content/uploads/2017/06/Carol-Final-Report-for-Publication-TSAB.pdf
[27] Preston-Shoot, M. (2020) 'Safeguarding Adult Reviews: informing and enriching policy and practice on self-neglect?' *Journal of Adult Protection* (forthcoming)
[28] http://www.emcdda.europa.eu/attachements.cfm/att_142550_EN_SE-NR2010.pdf
[29] http://www.legislation.govt.nz/act/public/2017/0004/latest/DLM6609057.html?search=ts_act%40bill%40regulation%40deemedreg_substance+addiction_resel_25_a&p=1
[30] http://www.namsdl.org/IssuesandEvents/NEW%20Involuntary%20Commitment%20for%20Individuals%20with%20a%20Substance%20Use%20Disorder%20or%20Alcoholism%20August%202016%2009092016.pdf
[31] Article 5 of the *European Convention on Human Rights* (the *Right to liberty and security)* states that:
Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:
(e) the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants;
[32] http://www.youtube.com/watch?v=DA_3uou6nyQ&index=2&list=PLSEhy70YpU5tZyaoHxz5UTuOUyJokMdFD
[33] http://www.youtube.com/watch?v=DA_3uou6nyQ&index=2&list=PLSEhy70YpU5tZyaoHxz5UTuOUyJokMdFD
[34] East Sussex Safeguarding Adults Board - Safeguarding Adults Review: Adult A - Suzy Braye & Michael Preston-Shoot – 24th June 2017 (6.5.1)
[35] Such as Leicester Safeguarding Adults Board, and Leicestershire and Rutland Safeguarding Adults Board's joint Vulnerable Adult Risk Management (VARM) process
http://www.llradultsafeguarding.co.uk/varm/?hilite=%27varm%27
[36] https://www.tsab.org.uk/wp-content/uploads/2017/06/Carol-Final-Report-for-Publication-TSAB.pdf (3.4.12 & 3.4.22)
[37] https://www.tsab.org.uk/wp-content/uploads/2017/06/Carol-Final-Report-for-Publication-TSAB.pdf (3.4.23)
[38] Waltham Forest Safeguarding Adults Board - Safeguarding Adults Review on Andrew - June 2017
[39] South Tyneside – Adult D: The response of partner agencies to severe self-neglect Safeguarding Adults Review Executive Summary – May 2017 (6.6)
[40] NICE guideline 108 - Decision-making and mental capacity - October 2018 (1.1.1)
[41] DHSC - Care and Support Statutory Guidance: Issued under the Care Act 2014. London: Department of Health and Social Care - 2018
[42] Preston-Shoot, M. (2020) 'Safeguarding Adult Reviews: informing and enriching policy and practice on self-neglect?' *Journal of Adult Protection* (forthcoming)
[43] https://www.scie.org.uk/care-act-2014/assessment-and-eligibility/eligibility/criteria-adults-care.asp
[44] Department of Health and Social Care – Care Act 2014 Care and Support statutory guidance – 2 March 2020 (6.104)
[45] Department of Health and Social Care – Care Act 2014 Care and Support statutory guidance – 2 March 2020 (6.104)
[46] Department of Health and Social Care – Care Act 2014 Care and Support statutory guidance – 2 March 2020 (1.14)
[47] Department of Health and Social Care – Care Act 2014 Care and Support statutory guidance – 2 March 2020 (1.14)
[48] Department of Health and Social Care – Care Act 2014 Care and Support statutory guidance – 2 March 2020 (14.6)
[49] Department of Health and Social Care – Care Act 2014 Care and Support statutory guidance – 2 March 2020 (14.6)
[50] https://www.scie.org.uk/self-neglect/at-a-glance
[51] London Multi-Agency Adult Safeguarding Policy & Procedures Final Version *(As Agreed By The London Safeguarding Adult Board)* April 2019
[52] Waltham Forest Safeguarding Adults Board - Safeguarding Adults Review on Andrew - June 2017 (Finding 2)
[53] Department of Health and Social Care – Care Act 2014 Care and Support statutory guidance – 2 March 2020 (14.10)
[54] Isle of Wight SAB - Howard Safeguarding Adult Review - 2019
[55] See ACUK's Learning from Tragedies (2019), Howard (Isle of Wight 2019), and Leanne Patterson (Northumberland 2019) among others
[56] E.g. Waltham Forest Safeguarding Adults Board - Safeguarding Adults Review on Andrew - June 2017 (Finding 1)
[57] Worcestershire Adults Safeguarding Board - Safeguarding Adult Review RN - 9th January 2017 (6.8)
[58] Somerset Safeguarding Adults Board The death of 'Tom': A Serious Case Review - June 2017 (42 & 43)
[59] Plymouth Safeguarding Adult Board – Safeguarding Adult Review - Ruth Mitchell -2017
[60] Lincolnshire Safeguarding Adults Board - Safeguarding Adults Review: A Thematic Review of Financial Exploitation (TH19) Overview Report – 2017
[61] Somerset Safeguarding Adults Board The death of 'Tom': A Serious Case Review - June 2017 (42 & 43)

[62] Lincolnshire Safeguarding Adults Board - Safeguarding Adults Review: A Thematic Review of Financial Exploitation (TH19) Overview Report – 2017
[63] The Care and Support (Eligibility) (Wales) Regulations 2015 (3a & the Explanatory Note)
[64] The Social Services and Well-being (Wales) Act 2014 (section 19)
[65] The Care and Support (Eligibility) (Wales) Regulations 2015 (3a & the Explanatory Note)
[66] http://www.legislation.gov.uk/anaw/2014/4/section/19
[67] Social Services and Well-being (Wales) Act 2014 Part 4 Code of Practice (Meeting Needs) para. 60
[68] Social Services and Well-being (Wales) Act 2014 Part 11 Code of Practice (Miscellaneous and General) p. 16
[69] Social Services and Well-being (Wales) Act 2014 Part 11 Code of Practice (Miscellaneous and General) p. 16
[70] http://www.legislation.gov.uk/anaw/2014/4/section/126
[71] E.g. Section 197's definition of *neglect*
[72] https://www.safeguarding.wales/int/i1/i1.p1.html
[73] http://www.legislation.gov.uk/anaw/2014/4/section/127
[74] http://www.legislation.gov.uk/anaw/2014/4/section/139
[75] Interviewee 5
[76] Mental Capacity Act 2005 Code of Practice (p.1)
[77] Mental Capacity Act 2005 Code of Practice (p.3)
[78] Mental Capacity Act 2005 Code of Practice (4.12)
[79] Northumberland SAB – Leanne Patterson – Safeguarding Adults Review - 2019
[80] Newcastle Safeguarding Adults Board - The Death of Lee Irving - Safeguarding Adults Review - June 2017
[81] Mental Capacity Act 2005 Para 2(3)(b)
[82] LB of Tower Hamlets v PB [2020] EWCOP 34 also contributes to this debate
[83] Mental Capacity Act 2005 Code of Practice (4.11)
[84] Mental Capacity Act 2005 Code of Practice (4.12)
[85] Mental Capacity Act 2005 Code of Practice (4.14)
[86] Mental Capacity Act 2005 Code of Practice (4.22)
[87] See also: Clough B. - Anorexia, Capacity, And Best Interests: Developments in The Court of Protection Since The Mental Capacity Act 2005 - Medical Law Review, Vol. 24, No. 3, pp. 434–445. (Clough Identifies three cases regarding anorexia that went before the Court of Protection. In each case it was decided that the person with anorexia nervosa did lack capacity.)
[88] Mental Capacity Act 2005 Code of Practice (4.30)
[89] NICE guideline 108 - Decision-making and mental capacity - October 2018 (1.4.11)
[90] NICE guideline 108 - Decision-making and mental capacity - October 2018 (1.4.13)
[91] https://www.basw.co.uk/resources/repairing-shattered-lives-brain-injury-and-its-implications-criminal-justice
[92] Mental Capacity Act 2005 Code of Practice (4.26)
[93] Mental Capacity Act 2005 Code of Practice (4.27)
[94] Mental Capacity Act 2005 Code of Practice (3.14)
[95] Mental Capacity Act 2005 Code of Practice (5.28)
[96] For example, Greenwich RLBC v CDM [2019] EWCOP 32 or Cheshire West and Chester Council v PWK [2019] EWCOP 57
[97] NICE guideline 108 - Decision-making and mental capacity - October 2018 (1.4.11)
[98] Waltham Forest Safeguarding Adults Board - Safeguarding Adults Review on Andrew - June 2017
[99] Waltham Forest Safeguarding Adults Board - Safeguarding Adults Review on Andrew - June 2017 (pp.17&18)
[100] Teeswide Adult Safeguarding Board - Safeguarding Adult Review "Carol" – 2017 *(3.6.10)*
https://www.tsab.org.uk/wp-content/uploads/2017/06/Carol-Final-Report-for-Publication-TSAB.pdf
[101] Interviewee 7
[102] Plymouth Safeguarding Adult Board – Safeguarding Adult Review - Ruth Mitchell -2017
[103] NICE (2018) *Decision Making and Mental Capacity*. London: National Institute for Health and Clinical Excellence.
[104] Teeswide Adult Safeguarding Board - Safeguarding Adult Review "Carol" – 2017 *(3.6.16 & 3.6.18)*
[105] Somerset Safeguarding Adults Board The death of 'Tom': A Serious Case Review - June 2017 (42 & 43)
[106] https://www.scie.org.uk/mca/dols/at-a-glance
[107] https://www.scie.org.uk/mca/dols/practice/lps
[108] Mental Health Act 1983 section 1.3
[109] https://www.who.int/substance_abuse/terminology/ICD10ClinicalDiagnosis.pdf
[110] Mental Health Act Code of Practice 2015 p.23
[111] http://www.emcdda.europa.eu/attachements.cfm/att_142550_EN_SE-NR2010.pdf
[112] http://www.legislation.govt.nz/act/public/2017/0004/latest/DLM6609057.html?search=ts_act%40bill%40regulation%40deemedreg_substance+addiction_resel_25_a&p=1
[113] http://www.namsdl.org/IssuesandEvents/NEW%20Involuntary%20Commitment%20for%20Individuals%20with%20a%20Substance%20Use%20Disorder%20or%20Alcoholism%20August%202016%2009092016.pdf

[114] Mental Health Act 2007 7(3))
[115] Mental Health Act 2007 (section 145)
[116] The European Convention on Human Rights
[117] Department for Constitutional Affairs - A Guide to the Human Rights Act 1998: Third Edition - 2006
[118] Department for Constitutional Affairs - A Guide to the Human Rights Act 1998: Third Edition – 2006: https://webarchive.nationalarchives.gov.uk/+/http:/www.dca.gov.uk/peoples-rights/human-rights/pdf/act-studyguide.pdf
[119]http://www.mentalhealthlaw.co.uk/Rabone_v_Pennine_Care_NHS_Foundation_Trust_(2012)_UKSC_2,_(2012)_MHLO_6
[120]https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/679712/2017-12-13_ASB_Revised_Statutory_Guidance_V2.1_Final.pdf
[121]https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/679712/2017-12-13_ASB_Revised_Statutory_Guidance_V2.1_Final.pdf
[122] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/679712/2017-12-13_ASB_Revised_Statutory_Guidance_V2.1_Final.pdf (p.58)
[123] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/679712/2017-12-13_ASB_Revised_Statutory_Guidance_V2.1_Final.pdf (p.3)
[124] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/679712/2017-12-13_ASB_Revised_Statutory_Guidance_V2.1_Final.pdf (p.58)
[125]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/219663/asbos9.pdf
[126]
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/426676/Supporting_CO_Treatment_Reqs.pdf
[127] South Tyneside – Adult D: The response of partner agencies to severe self-neglect Safeguarding Adults Review Executive Summary – May 2017 (6.6)
[128] Ward M. & Holmes M. The Blue Light Project Manual – Alcohol Concern – 2014 & Mental Capacity Act 2005 and the Mental Health Act 2007
[129] Fire and Rescue Services Act 2004
[130] Ramezankhah, F. and Brammer, A. (2019) 'The interface between the Care Act 2014 and asylum law: exclusions and innovations.' In S. Braye and M. Preston-Shoot (eds) The Care Act 2014: Wellbeing in Practice. London: Sage. (pp. 144-158)
[131] Section 115, Immigration and Asylum Act 1999.
[132] Section 21, Care Act 2014; R (Westminster City Council) v National Asylum Support Service [2002] UKHL 38.
[133] Section 8, Care Act 2014; SL v Westminster City Council [2013] UKSC 27.
[134] Schedule 3, nationality Immigration and Asylum Act 2002.
[135]R (GS) v Camden LBC [2016] EWHC 1762.
[136] Department of Health and Social Care – Care Act 2014 Care and Support statutory guidance – 2 March 2020
[137] Mental Capacity Act 2005 Code of Practice
[138] Mental Health Act Code of Practice 2015
[139] NICE guideline 108 - Decision-making and mental capacity - October 2018
[140] PHE / NHSE – Better care for people with co-occurring mental health and alcohol and drug use conditions - 2017
[141] NICE – National Guidance 58 – Co-existing severe mental illness and substance misuse - 2016
[142] NICE - Clinical Guideline 120 - Psychosis with coexisting substance misuse - 2011
[143] NICE - Clinical Guideline 115 - Alcohol-use Disorders: Diagnosis, Assessment and Management of Harmful Drinking and Alcohol Dependence - 2011
[144] https://www.who.int/substance_abuse/terminology/ICD10ClinicalDiagnosis.pdf
[145] The King's Fund - Delivering health and care for people who sleep rough – 2020
[146] LGA / ADASS - Adult safeguarding and homelessness: A Briefing on Positive Practice -2020
[147] Care Quality Commission - Guidance on the treatment of anorexia nervosa under the Mental Health Act 1983 – 2008
[148] www.nice.org.uk/guidance/ng69
[149] Braye, S., Orr, D. and Preston-Shoot, M. (2014) Self-Neglect Policy and Practice: Building an Evidence-Base for Adult Social Care. London: SCIE
[150] Preston-Shoot, M. (2019) 'Self-neglect and safeguarding adult reviews: towards a model of understanding facilitators and barriers to best practice.' *Journal of Adult Protection*, 21 (4), 219-234.
[151] Plymouth Safeguarding Adult Board – Safeguarding Adult Review - Ruth Mitchell -2017 (p.30)
[152] Mental Capacity Act 2005 Code of Practice (Chapter 2 introduction p.19)
[153] https://www.legislation.gov.uk/ukpga/2005/9/data.pdf (page 2)
[154] https://www.communitycare.co.uk/2019/06/28/misinterpretation-unwise-decisions-principle-illustrates-value-legal-literacy-social-workers/
[155] https://www.communitycare.co.uk/2019/06/28/misinterpretation-unwise-decisions-principle-illustrates-value-legal-literacy-social-workers/

[156] Mental Capacity Act 2005 Code of Practice (Chapter 2 introduction p.19)
[157] https://www.communitycare.co.uk/2019/06/28/misinterpretation-unwise-decisions-principle-illustrates-value-legal-literacy-social-workers/