



How to use legal powers to safeguard highly vulnerable dependent drinkers in England and Wales

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ALCOHOL

CHANGE^{UK}

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Executive summary

Amongst the broader population of dependent drinkers is a smaller group of drinkers whose alcohol dependency is particularly entrenched and chronic.

This group can have a significant negative impact on their community and on public services, as well as on their own quality of life. The good news is that these people can be helped by Alcohol Change UK's Blue Light initiative, including interventions such as assertive outreach, harm reduction and multi-agency management.

However, an even smaller sub-group is particularly vulnerable and faces significant safeguarding risks, to themselves and others.

Without action, these people and those around them can experience serious dangers, including neglect, abuse, and untimely deaths. This group of people often requires more robust support, by using legal powers.

Practitioners (police officers, social workers, substance use workers, health professionals, probation officers, and others) have consistently reported that they are aware that certain legal frameworks, such as the Care Act 2014, Mental Capacity Act 2005 and Mental Health Act 2007, could be used to help these people, but that they are unsure how to properly, proportionately and confidently use those powers.

This guide provides an accessible introduction to three pieces of legislation that can be applied to chronic, highly vulnerable, dependent drinkers so as to improve outcomes for them, their families and their communities.

The guide also outlines the limits of these legal frameworks and when they should not be used.

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 can be used with people impaired by the effects of alcohol. There are challenges of applying this Act to chronic dependent drinkers because of a lack of specific guidance. However, the concept of *executive capacity* can be useful.

The Mental Health Act should be used as a last resort. It specifically excludes people who are solely dependent on alcohol, but there are circumstances in which the Act may be used with people who have other mental or behavioural disorders arising from alcohol dependency.

Other legal frameworks can also be useful for practitioners who work with chronic, vulnerable drinkers, 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. So these are briefly covered too.

This guide considers the governance of the use of these legal powers and recommends using a robust management framework such as multi-agency management. It provides advice on how such frameworks can be implemented.

Finally, this guide explains how certain 'myths' can hamper practitioners' work with highly vulnerable, chronic, dependent drinkers.

In particular, it encourages practitioners to challenge the assumption that these people 'choose' or 'like' an abusive or self-neglecting lifestyle; and outlines alternative ways of thinking about these people and the reasons for the challenges they face.

By combining the power of positive interventions (assertive relationship building, harm reduction and motivational interventions) with the effective and careful use of legal powers, practitioners can help vulnerable, chronic, dependent drinkers to be safer, healthier, and stand a better chance of achieving positive longer-term outcomes. We hope this guide provides both practical advice and inspiration.



Introduction

What this guide is about

This guide aims to help practitioners to improve the well-being and safety of adults who are highly vulnerable, chronic, dependent drinkers. It does this in four ways:

- 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 people;
- identifying other legal powers which can be used, for example the Anti-social Behaviour, Police and Crime Act (2014);
- describing how to use these powers effectively in practice; and
- proposing governance, agency management and inter-agency arrangements that will support this work.

This guide is not the sole answer to the challenges posed by chronic, highly vulnerable, dependent drinkers. Many of these people can be effectively supported through motivational and harm reduction interventions and using assertive outreach and multi-agency working.

These interventions are described in the [Blue Light practitioner manual](#), the Blue Light commissioning guide (2022) and our guide to assertive outreach (2021). This guide addresses the specific issue of using legal powers with this group.

This guide is part of a broader project that has also produced:

- a training programme for professionals who encounter these types of drinkers; and
- a manifesto for change to the legislative frameworks, so that practitioners are better supported by the law when they need to take action to try to save someone from neglect, abuse or an untimely death.

Who this guide is for

This guide is targeted at those staff and volunteers and their managers working directly with dependent drinkers. This will include staff employed in specialist substance misuse and mental health services, but also those working in adult social care, housing and homelessness, primary and secondary healthcare, police, probation, environmental health, and on domestic violence 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 resources to support the use of these legal frameworks.

Although, this briefing focuses on chronic, highly vulnerable, dependent drinkers, much of it applies to people who are chronic users of other psychoactive substances.

How it was produced

This guide and the accompanying resources were developed through a national multi-partner project initiated and led by Alcohol Change UK. Eighteen partners supported this project, covering 23 separate local authorities and a major service provider (CGL) as listed on the inside front cover.

This briefing was developed through:

- interviews with national experts and local stakeholders (see appendix 2);
- facilitated 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;
- desk research into learning from Safeguarding Adults Reviews; and
- presentations to and feedback from Safeguarding Adults Boards.

The challenge: applying legal frameworks to chronic, highly vulnerable, dependent drinkers

Amongst the estimated 650,000 dependent drinkers in England and Walesⁱ there is a small group whose chronic drinking, harmful lifestyle and chaotic behaviour pose a significant challenge to themselves and to others. In particular, this group can appear to be unwilling or unable to change. Alcohol Change UK's [Blue Light](#) initiative has set out effective strategies and techniques for working with this group.¹ In addition, our handbook on alcohol assertive outreach (2021) shows how we can reach people with serious, chronic drinking problems and work with them to start making positive changes to their lives.

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

ⁱ Total created by adding Public Health England (2018) estimate (586,780 rounded to 600,000) to the Alcohol Change UK estimate for Wales (50,000).

The central message of this briefing is that, in England and Wales, there are legal frameworks which enable professionals to protect chronic, highly vulnerable, dependent drinkers and the people around them; and that professionals should know about and use those frameworks whenever appropriate.

However, too often these frameworks are not well enough understood or are not being used. As a result people, are not receiving the help they need, in some cases with tragic consequences.

Who we are talking about

By dependent drinkers, we are talking about those people with an alcohol addiction and who are, primarily, drinking at levels that mean they are physically dependent and would require managed withdrawal.

By chronic dependent drinkers, we are talking about people who have been alcohol dependent for a long time, often decades.

By highly vulnerable chronic dependent drinkers, we mean those people who present a very high level of risk to themselves and others partly as a result of their drinking and its long-term negative effects on their well-being.

They may be causing criminal damage, at risk of fires, experiencing significant self-neglect, subject to or at risk of abuse from others, making extensive use of emergency services or more than one of these.

Navigating this guide

- Section 2 challenges 12 myths and the concept of 'lifestyle choice'.
- Section 3 sets out why greater legal literacy is needed.
- Sections 4 and 5 set out two frameworks that will make these powers most effective: one to guide agency and multi-agency work and the other to guide professional practice.
- Sections 6 to 9 are the core of this guide, describing the main elements of the key legal powers which impact on highly vulnerable, dependent drinkers.
- Section 10 provides case examples of the powers being put into practice.
- Section 11 summarises how to develop a local action plan.

Case study

A 54-year-old man with high levels of alcohol consumption was referred to an alcohol team by his GP. He lived in sheltered accommodation but was a frequent visitor to hospital. He had Chronic Obstructive Pulmonary Disease and poor mobility, resulting in the use of a mobility scooter. He had been taken home by the police on numerous occasions for being intoxicated and unsafe on his scooter. He was said to be aggressive towards staff and neighbours. He had also been assessed as posing 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 became increasingly aggressive and got into trouble with the police for shoplifting. He showed no 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. The team noted that he had:

- a very unkempt appearance: wearing a hospital gown and cardigan with large holes;
- paper across the living room floor while dropping lit cigarette ends;
- set fires, including accidentally setting fire to himself with a cigarette and using alcohol to extinguish it;
- no means of storing food safely in his flat, as he had no fridge;
- no cooker or other means of cooking food, as these had been removed due to the high risk of fire;
- 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; and
- no carers supporting him with daily living activities.ⁱⁱ

He was requiring significant resources from the police, health services, social care, fire service and other organisations but it was rarely felt appropriate to take him through the criminal justice system.

Three legal frameworks were considered with this client, but they were not used well:

- 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, but when interviewed he was usually deemed able to understand and take positive decisions. In reality, 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

Better use of legal powers would almost certainly have made a difference to this man's safety and outcomes. Improving 'legal literacy' amongst professionals caring for people in similar situations will reap positive rewards and is the goal of this guide.

ii Case study provided by Nottinghamshire Long Term Conditions Team in 2017.

Challenging myths and the 'choice' concept

This guide provides information about the law and how it can be applied to better support chronic, highly vulnerable drinkers. But it also challenges common 'myths' (misconceptions) that have grown up around the care of and support for this group of people.

Twelve common myths were identified in our discussions with expert practitioners. **These are all inaccurate and create barriers to care and support**; but they are unfortunately quite commonly held. Below we explain why these assumptions are false.

1 "If someone says they don't have a problem and doesn't want help, there is nothing we can do."

Dependent drinkers will frequently deny they have a problem and reject help. However, this should not stop our attempts to intervene.

- If someone is being exploited, neglected or is self-neglecting, then consent is not required to raise an adult safeguarding concern. The local authority will need to make enquiries and determine what action is required.
- If someone is clearly at risk but is refusing help, that raises questions about the person's mental capacity and should prompt a mental capacity assessment.
- Assessing people in this situation requires time and should be viewed as a marathon not a sprint. In particular, assessments should look at the person's behaviour over multiple occasions, not just a single moment.

2 "If the person is choosing to live like this, or likes living like this, we can't define them as vulnerable."

The simplest response to this view 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. In addition:

- 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.

3 "A person is not vulnerable or self-neglecting if they have mental capacity."

This is simply wrong. 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 'free' choices that lead to self-neglect, it is still self-neglect and action is required under the English and Welsh Acts.

4 "Once someone is sober they no longer lack capacity or have care and support needs."

In developing this briefing, we came across a case in which a social worker had stated that a 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 is a dangerous perspective. Alcohol dependency is, by definition, a chronic relapsing condition. People will have, possibly hard-won and probably brief, periods of sobriety or stability. To rely on assessments taken only at those moments, rather than over the whole trajectory of their condition, is unlikely to help the person and may even perpetuate or worsen their problem. A long-term, evidence-based view is required in any assessment process.

5 "If a person has capacity, there is nothing we can do."

Assessing that someone has capacity does not automatically mean there is no longer a case for taking action to safeguard them. Ruth Mitchell's Safeguarding Adult Review (SAR) stated:

*"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."*²

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 into their flat or is sitting in her own faeces, then an alternative route outside the mental capacity framework will be required.

6 "A person has 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."*³ 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."*^{4 5}

"For the purposes of this Act" is a critical caveat. This is not a general statement about the right to make unwise decisions in all contexts. The word *"merely"* is also important. 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.⁶ As the Code of Practice itself states: *"A person who makes a decision that others think is unwise should not automatically be labelled as lacking the capacity to make a decision."*^{7 8}

7 "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, for example alcohol-related brain damage, acute confusion, severe depression, and even psychosis, then it is absolutely possible to build a case for action under the Act. This will not be, and should not be, a simple or frequent option. It will generally require considerable multi-agency discussion to demonstrate the need for this route. But it is an option.

8 "Mental health services don't need to assess someone if their main problem is alcohol."

This comment is sometimes made by professionals working in mental health services, based on the view that because alcohol dependency is not grounds for action under the Mental Health Act, it is not part of the remit of a mental health service. However, without taking the time to assess someone, we can't know whether the cause is alcohol, a head injury or a mental illness. And it is only alcohol *dependency* that is excluded from the remit of mental health services. Disorders of the mind related to alcohol use are absolutely covered by the Mental Health Act and people requiring mental health support should not be excluded just because the cause of their mental health issues is alcohol-related.

9 "Assessment is impossible if someone never turns up for their appointments."

If someone is vulnerable, at risk of abuse or neglect (including self-neglect) or having a significant impact on the community, it is unhelpful, if not self-defeating, to require someone to attend an appointment with a stranger in what might be a distant or unknown place. This unhelpfully erects a barrier in the way of the person we are there to support. Assessment structures need to accommodate the difficulties faced by the person we are supporting, rather than be convenient for the worker. Assessment should be seen as a process in which services work with the person over time to really understand their needs, not something at a single point in time. Without this 'process focus', services risk failing the people with the greatest needs.

10 "A person can't be assessed if they are always intoxicated."

The Mental Health Act Code of Practice (2015) requires Approved Mental Health Professionals (AMHP) who are faced with an intoxicated person in a crisis to either to wait until the person is sufficiently sober *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 other available information.

11 “There is no treatment available for vulnerable dependent drinkers, so people can’t be treated under the Mental Health Act.”

The treatment sections (for example section 3) of the Mental Health Act require that treatment is available in an inpatient hospital setting. In reality this treatment has become very difficult to find in England and Wales. 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 people in this situation. 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.

12 “Once someone stops drinking the problems 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 are 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 the skills of mental health practitioners may prove invaluable.

Challenging alcohol dependence as a ‘lifestyle choice’

Since 2017, Safeguarding Adult Reviews (SARs) have regularly identified the problematic tendency amongst some professionals and practitioners to assume that the people who died had made ‘a lifestyle choice’. This assumption can lead to a failure to explore the deeper problems driving their patterns of behaviour.⁹

Chronic, highly vulnerable, dependent drinkers may not have a diagnosed mental illness such as schizophrenia, but they are often functionally mentally disordered at a level where freedom of choice over their behaviours is largely absent. Not using legal powers may be seen as respecting their personal choice, but in reality it may be allowing them to “die with their rights on”.¹⁰

Leanne Patterson’s SAR commented: “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...”¹¹

This idea that alcohol addiction is self-inflicted or a personal choice can lead to two mistaken beliefs:

- that these people do not deserve our care; and
- that any imposition of care is an infringement of their rights.

We reject this thinking for three reasons. First, we believe that everyone with a drinking problem deserves care and support whoever they are. Second, whether or not there is any truth in the idea that people choose to drink at the beginning of their drinking ‘career’, at the later stages of addiction, choice is certainly all but absent. Third, we are intervening not just for their benefit but also for the safety of others around them.

Chronic, highly vulnerable, dependent drinkers are often at the centre of a ‘perfect storm’ of physical and emotional conditions that challenge the idea that their drinking is a self-determined choice. The most obvious of these is that they are alcohol dependent. The origin of the word ‘addiction’ is a Latin word that means enslavement. Indeed, ‘addiction’ is, by definition, a loss of the ability to make

choices.¹² The serious risk of unmanaged withdrawals also means that the option to ‘just stop drinking’ is unavailable.

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

- Between 60% and 70% are depressed due to the chronic depressant effect of alcohol.¹³
- At least 35% of this group has alcohol-related brain injury.^{14 15} In Scotland, Drink Wise Age Well identified that 50% of clients admitted to services for older drinkers (50+) had cognitive impairment. After treatment this fell to 25%.
- They may have head injuries due to fits, fights or falls.
- They may have physical health problems which impair judgement for example the low energy levels that result from liver disease or the confused states resulting from pancreatitis and urinary tract infections.¹⁶
- They may have poor sleep patterns due to alcohol misuse which can exacerbate depression or low mood.
- Poor nutrition can exacerbate depression.¹⁷
- Foetal alcohol damage may have led to learning disabilities or behavioural disorders (see article by Dr Raja Mukherjee, Appendix 1).

“Someone’s addiction itself should lead us to question whether they have capacity.”

Practitioner interview

There are also barriers beyond the physical. In Ms. H and Ms. I’s SAR, the partner of a woman who had died having experienced multiple exclusion homelessnessⁱⁱⁱ commented that she had been unable to maintain abstinence from substance misuse because past traumas and adverse life experiences ‘kept bubbling up’. She was caught in a life-threatening double-bind, driven to avoid suffering through ways that only deepened her suffering.¹⁸ Any of us can be affected by impulses to distance ourselves from emotional distress.

iii “Multiple exclusion homelessness” comprises extreme marginalisation that includes childhood trauma, physical and mental ill-health, substance misuse and experiences of institutional care

The need for change

Why does better use of legal powers for chronic, highly vulnerable, dependent drinkers matter so much? In short, we can save lives and resources. We also know from international comparisons that better use of legal powers is possible. Furthermore, people with lived experience support the better use of legal powers.

We can save lives... and resources

“I’d estimate that dependent drinkers are 10–20% of the adult safeguarding caseload.”

Interview with adult social care manager

Alcohol dependence is a significant factor in serious case reviews. Alcohol features in over 50% of domestic homicide reviews and up to 70% of inquiries into homicides by mentally ill people.^{19,20} Alcohol Change UK’s report [Learning from Tragedies](#)²¹ highlighted 11 deaths of vulnerable adults from 2017 where alcohol misuse was a significant issue. These people were often highly vulnerable, dependent drinkers and the reviews highlighted their vulnerability and social exclusion.²² Better use of legal powers could enable us to intervene and save lives.

The man described in the case example in Section 1 was estimated to have cost the health and fire services £138,000 in just one year.²³ An alcohol outreach service in the south east of England identified someone who was costing public services £250,000 in a year.²⁴ Alcohol Change UK’s *Blue Light* project estimated that in a population of 200,000, there will be around 250 so-called change-resistant dependent drinkers costing at least £12m per year between them across a diverse range of statutory agencies.²⁵ So better use of legal powers could save significant resources, especially where we can make an earlier intervention.

Properly supporting these individuals can also have a positive impact on other stakeholders, such as family members desperately struggling to help, and neighbours and members of the local community who may be worried about and find their quality of life negatively affected by a chronic, highly vulnerable dependent drinker.

An international comparison: Australian Legal Frameworks

Other countries have legislation which specifically allows the compelled detention and treatment of chronic, highly vulnerable, dependent drinkers, for their protection. In some countries, like the USA, this is called “civil commitment”.^{26,27,28}

Article 5 of the European Convention on Human Rights specifically recognises this possibility.^{iv,29}

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 into force in September 2012.³⁰ This allows for the 28-day detention (extendable by a further 28 days) of someone who meets all of these criteria:

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

The presentation describes the typical client as:

- A 59-year-old man
- Calling emergency services when intoxicated, crying, in physical pain, threatening suicide
- 114 emergency department presentations a year (or 56 in six months)
- Severe alcohol problem
- Living in squalor

Recalling our case example in Section 1, this sounds familiar.

This Australian legislation is effective. At follow-up, 60% of people had shown significant improvement, of whom just under half were abstinent.³¹

The voices of people with lived experience

Although this aspect of this project was hampered by COVID-19, we were able to successfully draw on the lived experience of people at some points in the development of this guide. The case studies in Section 10 are all based on real people. We also received a [powerful testimony](#) about the challenges of caring for a chronic, highly vulnerable, dependent drinker from his two sisters, which was originally addressed to the coroner after their brother’s death. It provides a powerful summary of the need for action.

iv 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;”.

A governance framework for using legal powers

"[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, [there is] the challenge of when to use the Care Act, Mental Health Act and Mental Capacity Act in these challenging cases."

Adult A, Safeguarding Adults Review (2017) East Sussex Safeguarding Adults Board³²

Sections 6 to 8 of this guide discuss the three main pieces of legislation that can be used to protect and support chronic, highly vulnerable, 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 9 offers a brief overview of other useful legislation such as the Human Rights Act, anti-social behaviour powers, the alcohol treatment requirement and environmental health legislation.

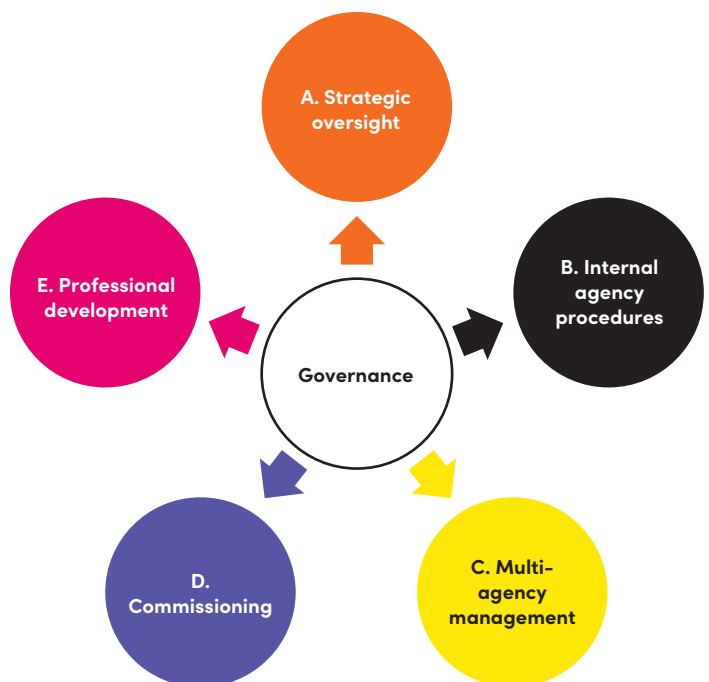
However, these powers are not simple solutions and they cannot be used in isolation. In particular, it is essential that they are supported by:

- a partnership-level governance framework;
- practitioners adopting key principles;
- practitioners using a stepped approach to the powers; and
- practitioners considering tools that can maximise the impact of these powers.

This section proposes a governance framework to guide agency and multi-agency work. Section 5 introduces the key principles, the stepped approach and tools for practitioners.

A governance framework

We propose a governance framework consisting of five elements.



A. Strategic oversight

A local multi-agency group with senior representatives from key agencies will need to take responsibility for ensuring that chronic, highly vulnerable, dependent drinkers are protected and supported by the appropriate use of these powers. This responsibility could be located in the Safeguarding Adults Board, the Health and Well-being Board, the Community Safety Partnership or the Area Planning Boards in Wales. This group should:

- review whether powers are being used appropriately with substance misusers;
- undertake annual reviews;
- be a focus for the discussion of any problems; and
- be a place for raising concerns about repeated or serious problems with the care of this group.

It would also be constructive for Safeguarding Adults Boards to report on the safeguarding of chronic, highly vulnerable, dependent drinkers in every annual report.

B. Internal agency procedures

Managers of all agencies who encounter chronic, highly vulnerable, dependent drinkers need to be familiar with the appropriate application of these legal powers and need to support their staff to use them, in particular through supervision. More specifically, managers must ensure that the care of these people is not being undermined by stigmatised perceptions of them as 'undeserving' or 'making lifestyle choices' (see Section 4).

C. Multi-agency management

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

- developing a standing multi-agency group for the management of chronic dependent drinkers (as has happened in, for example, Sandwell and Northumberland); or
- allocating this task to an existing multi-agency group (for example a multi-agency safeguarding hub); or
- having good systems which allow for the swift convening of a multi-agency risk management meeting around a particular person.³³

D. Commissioning

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

Carol's 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 designed to meet her needs and were withdrawn.³⁴ 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 have been cared for within the service lose established contacts and

rapport with workers."³⁵ Andrew's SAR (Waltham Forest) makes a similar point.³⁶

Adult D's SAR (South Tyneside) expressed 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.*"⁷

If professionals are to use these legal frameworks effectively with this group of people, 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? Are these persistent, assertive services built on relationship building, harm reduction and motivational interventions?
- Is a specific professional role required that can provide assessment and that has expertise in applying the diverse legislation to this group?
- Is there access to inpatient facilities which can meet the needs of people detained under the Mental Health Act? Can places be purchased from the private sector if they are not available from statutory or civil society providers?

E. Professional development

All staff who work with chronic, highly vulnerable, dependent drinkers, whether in a specialist or generic setting (including police officers), will need relevant training on the use of legal frameworks with this group of people. The oversight body (for example the SAB) should ensure that good quality training happens regularly and is included in the professional development programmes of all relevant agencies. This is in accordance with the general guidelines in NICE Guidance 108.³⁸

Practitioner approaches for using legal powers

This section describes some approaches that can help practitioners to make the best use of legal powers when working with chronic, highly vulnerable, dependent drinkers.



It covers:

- Key principles
- A stepped process
- Assessment tools and practice checklists.

Key principles

Any use of legal powers with dependent drinkers should adhere to the following six principles. These build on the adult safeguarding principles in the 2014 Care Act statutory guidance.³⁹

Empowerment

- Approaches to this group of people should be based on the premise that there are measures we can take 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 group of people.

Partnership

- Use a multi-agency approach.
- Wherever possible, actions and decisions should involve the person being supported.

Accountability

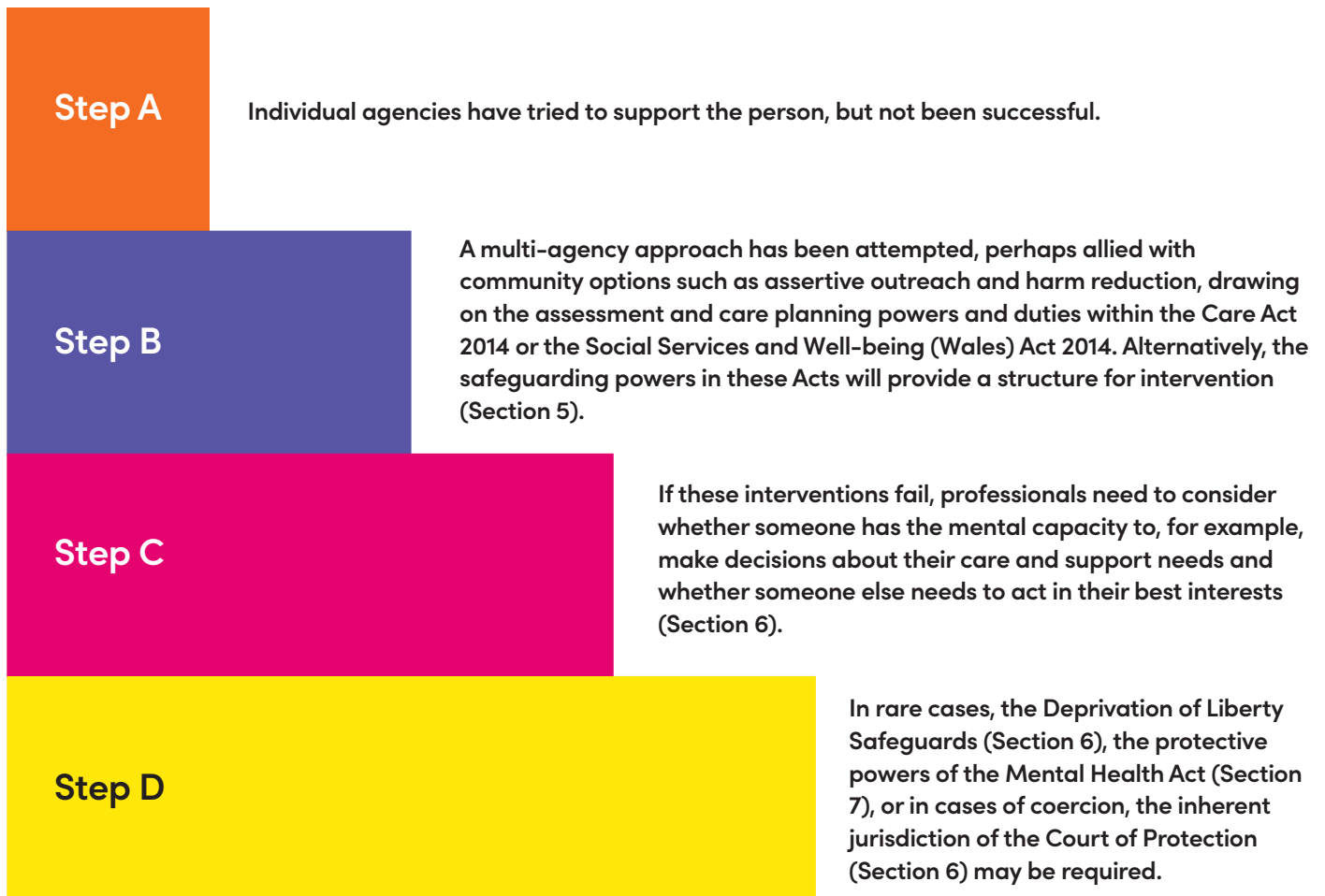
- A governance framework is required for the management of this area of need. An identified local body such as the Safeguarding Adults Board or Health and Well-being Board should ensure that this group is being well managed.

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, unmet needs should be identified, recorded and reported to commissioners.

A stepped process

The more coercive of these powers (for example 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**.



Tools

Many assessment tools exist which can help professionals to decide whether to take action under the legislation and which can evidence the case for action. Some of these are listed here:

Assessing cognitive function
https://liverpoolclinicalskills.com/wp-content/uploads/2019/08/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 <i>Identifying and assessing common mental health disorders</i> 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 nine question online tool to assess the presence of gambling problems

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.



Practice checklists

Using legal powers that deprive people of some or all of their liberty must always be considered very carefully and should not be easy to implement. 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, professionals will want to reassure themselves that they are working in a rigorous and structured way. These two checklists are designed to help professionals to reassure themselves (and others) that they are making sound decisions.

'Working with other professionals' checklist

Is the care plan based 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.	
Have I shared information as far as is legally possible?	
This may include sharing chronologies and contextual information to help understand the person being supported and include information on faith, ethnicity, sexuality, gender, age or other relevant matters.	
Have I been persistent in arguing for a more robust response?	
It should not be easy to take a degree of compulsion over an aspect of a person's life. Practitioners should expect other professionals to resist or question the need. Therefore, if it is justified, professionals will need to be persistent.	
Am I 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.	
Is my agency prepared to escalate concerns?	
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 often the way the system is designed to work. Without such complaints, services will not change.	
Do I have positive (but not cosy) relationships with the professionals who are the gatekeepers of these powers?	
It will be much easier to argue for the use of these powers if practitioners have a positive and informed relationship with the people who administer the powers, for example adult social care or mental health professionals.	
Am I keeping good records?	
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.	
Am I recording any unmet need?	
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 to enable them to consider the need for change.	

The 'Working with drinkers' checklist aims to help professionals to develop the best relationship with and intervention for the person they are supporting.

'Working with drinkers' checklist

Have I taken the time needed to assess the person I'm supporting, usually across multiple meetings, at least once in their home?	
Have I expressed 'concerned curiosity', characterised by gentle persistence, skilled questioning, conveyed empathy and genuine relationship-building?	
Have I undertaken a detailed exploration of the person's wishes, feelings, views, experiences, needs and desired outcomes?	
Have I undertaken a thorough mental capacity assessment, which includes understanding and consideration of executive capacity (see section 6), recognising that being articulate and scoring well in cognition tests can mask difficulties?	
Have I undertaken a thorough mental health assessment, with particular attention at points of transition, for example hospital discharge or placement in supported accommodation? ⁴⁰	
Have I undertaken a comprehensive risk assessment, especially in situations of service refusal?	
Have I avoided assuming that negative behaviours are 'a lifestyle choice' and developed a deeper understanding of what might lie behind their refusal to engage for example loss, trauma, shame and fear?	
Have I taken time to consider the impact of adverse experiences, including issues of loss and trauma, and explored any repetitive patterns?	
Have I understood how the person's faith, age, gender, sexuality and ethnicity may be impacting on the nature and presentation of their needs?	
Have I built up a picture of the person's history to help to uncover what is driving and maintaining self-neglect in the form of alcohol abuse?	
Have I recognised the person's assets as well as their needs and risks?	
Have I used a person-centred approach that demonstrates proactive rather than reactive engagement?	
Have I considered whether and how family involvement may be of benefit, to both the drinker and to them?	
Have I considered how to ensure our response is creative, for example making use of peer support, text messaging, online technology, playfulness, etc?	
Have I maintained contact and been reliable, even when the person appears not to be engaging?	

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

“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.”

Interview with a Housing Association manager

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 they believe 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 a Safeguarding Adults Review involving an adult in its area with needs for care and support. In certain circumstances an SAB has a duty to do so.

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.⁴¹ 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.⁴²

How does the Act help dependent drinkers?

The Act covers assessment of need and care planning and, in some cases, safeguarding.

Assessment of need and 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.⁴³ The duty is to complete an assessment of needs, decide what those needs are, determine their impact on well-being, identify the outcomes the person wishes to achieve and agree what contribution care and support could make to maintaining or improving well-being. 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 (section 12 (3)).

Following an assessment, if the person has *eligible* needs this triggers 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 well-being. 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.

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, or 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.⁴⁴ This includes those who **self-neglect**.⁴⁵ These duties apply equally to those adults with care and support needs regardless of whether those needs are being met⁴⁶, and **regardless of whether the adult lacks mental capacity or not**.⁴⁷

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, highly vulnerable dependent drinkers.

There is no single operational definition of self-neglect, however the Social Care Institute for Excellence (SCIE) describes self-neglect as “*an extreme lack of self-care*” and specifies “*that it... may be a result of other issues such as addictions*”.^{48, 49}

This duty is not always recognised by local authorities. Andrew’s 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*”.⁵⁰ **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. Carol’s 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.”⁵¹

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.⁵²

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.^{v, 53 54 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 for example 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 practitioner manual](#) will often 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 for example tests of motivation.

v See Alcohol Change UK’s Learning from Tragedies (2019), Howard (Isle of Wight 2019), and Leanne Patterson (Northumberland 2019) among others.

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 they believe 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 and 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, and (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?

Refer to the equivalent section under the Care Act 2014 above.

The Mental Capacity Act 2005

“Alcohol treatment workers get frustrated because they have clients who are very poorly and self-neglecting, yet are being assessed as having capacity, and therefore [practitioners] are walking away. Those people are being left alone to die at home.”

Interview, specialist social work researcher

Summary

- The Mental Capacity Act 2005 does apply 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 overriding 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 point in time. 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.

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.⁷⁵ 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.⁷⁶

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 people who are alcohol dependent.⁷⁷ However, our research identified that, at times, these dependent drinkers may be wrongly viewed as having mental capacity, which places them at risk. This can relate to the mistaken view, discussed in Section 2, that these people are making a 'lifestyle choice'.

Leanne Patterson's 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.”⁷⁸

Lee Irving's 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.”⁷⁹

The Act is clear: “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.”⁸⁰

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 their care.⁸¹ The question, therefore, is under what circumstances do chronic, highly vulnerable, dependent drinkers lack capacity to make key decisions about their care, treatment or living conditions?



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.⁸² These impairments include *symptoms of alcohol or drug use*.⁸³ Neither the Act nor the Code of Practice clarify whether this means the immediate symptoms of intoxication or the longer-term symptoms, for example 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;
3. use or weigh that information as part of the decision-making process; or
4. communicate their decision.⁸⁴

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

Note that it may be more practical 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.⁸⁵

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, vi}

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 the 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: *“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.”*⁸⁷

NICE guidance highlights that not only is the person's decision-making history⁸⁸ important but that, with consent, other people can be consulted in order to inform the capacity assessment, such as the person's family or friends.⁸⁹

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.^{95 96}

Factors to consider: 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 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 process they know the correct things to say and do. But when they need to act upon their knowledge in the complex settings of the real world they are driven by impulse and, therefore, can no longer weigh up options.⁹⁰

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”.⁹¹ The Code of Practice states: *“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... If the person's capacity is likely to improve in the foreseeable future, wait until it has done so – if practical and appropriate.”*^{92 93} One of the factors that is listed as potentially causing a person to regain or develop capacity in the future is where the current loss of capacity is *“caused by the effects of medication or alcohol...”*⁹⁴

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

This will primarily apply to decisions that need to be enacted over a long period of time for example 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.⁹⁷ *“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?”*⁹⁸

Dealing with executive capacity

Carol's SAR states: *“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).”*⁹⁹

vi 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.

Both Howard's SAR and Ms H and Ms I's 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, for example 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." 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.

Ruth Mitchell's SAR states: "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."¹⁰⁰

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,¹⁰¹ with a subsequent discussion to assess whether someone can use and weigh information, and understand concern about risks to their well-being.

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.¹⁰²

Dealing with capacity when there is coercion by others

Coercion by others may also affect someone's capacity. Carol's SAR states: "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."¹⁰³

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."¹⁰⁴

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 requires the case to be 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 must 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 often 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).¹⁰⁵

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, at the publication date of this guide (August 2021) the introduction of these powers is still pending and is unlikely to come into effect until 2022 at the earliest. Therefore this briefing only covers the DoLS.¹⁰⁶

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. How does the Mental Capacity Act benefit them?

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 based on the person's specific situation and what they are deemed to lack capacity to do.

Therefore, 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 also allows 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 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.

Factors to consider: Mental capacity and the detoxified dependent drinker

A 59-year-old man is repeatedly ending up in a chaotic and degraded state. He is found at home in his armchair poorly nourished and covered in 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, he goes back home, and the cycle starts again. A few weeks later he is in the same state.

It is relatively simple to argue that highly vulnerable, chronic 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 appear clear-thinking and capacitous. However, it is important to consider:

- 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 detoxification, people can feel unrealistically positive about their situation. Alcoholics Anonymous calls 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 can take an unrealistically positive view of the person's prospects. This has been identified in numerous Safeguarding Adult Reviews and has been suggested as a particular problem with substance misusers. For example, a child protection worker might take the statement "I never use when looking after my child" at face value. We should perhaps call this "worker over-optimism". Optimism is an essential trait in assertive change-oriented work with people with chronic alcohol problems, maintaining a belief that they can change and indeed helping them to believe that. What must be guarded against is naivety or over-optimism, for example expecting someone who has had several cycles of detoxification and relapse to automatically make a positive change after another detoxification, without a new form of support or intervention being added.

These three factors together can create a repeating cycle of *relapse – detoxification – abstinence – service withdrawal – relapse*. This matters because of '**kindling**', the harm caused by repeated detoxes, which includes 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, ensuring that the client's best long-term interests are being served. For many people, a capacity assessment is best conducted not in the immediate aftermath of detoxification, but further along the journey when the cravings for alcohol return and the psychological factors that have driven their addiction resurface. That's when we should be asking if they can make a capacitous decision.

A long-term view is required. The client's current state needs to be set against the past history of relapse. Because of the risk of kindling, a premature decision that a person has capacity might cause greater harm later and not be in the person's best interest.



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 chronic drinking.
- Such actions are likely to be rare and current practice does not make much use of this option. It should 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.”¹⁰⁷

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). Clinically recognised conditions which 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 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 – for example 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.¹⁰⁸

How does the Act help dependent drinkers?

Action under the Mental Health Act must pursue the *least restrictive* possible option compatible with their treatment.¹⁰⁹ 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, for example cognitive impairment or unmanaged trauma.
- 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, Sweden or the USA.^{110 111 112}

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.¹¹³ 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.”*¹¹⁴

That a suitable package of interventions exists is demonstrated by the examples of Sweden or New South Wales 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 said to be 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 and 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.

Section 117 of the Act has a duty to provide aftercare to people who have been detained under the treatment sections (for example 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.



Other relevant legal frameworks and guidance

Four other areas of legislation relate to 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.”¹¹⁵

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.¹¹⁶ 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 treatment¹¹⁷

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 for example *Rabone and Anor v Pennine Care NHS Foundation* [2012] UKSC 2.¹¹⁸

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 (for example drinking in a particular location), but also allow the imposition of *positive requirements* which will help encourage permanent change.¹¹⁹

The Injunctions and CBOs are generic tools. They have been granted for behaviours such as aggressive begging, poor management of rented premises and 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, for example to receive *support and counselling* or attend *alcohol awareness classes*. Therefore, these powers do offer an opportunity respond to people who may be resistant to treatment.¹²⁰

However, 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, their 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.¹²¹
- 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.¹²²
- 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 their property.¹²³



A non-statutory Acceptable Behaviour Contract might also be considered at an earlier stage with this group.¹²⁴

The best introduction to the *Anti-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 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.¹²⁵ 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 or group work. 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, Adult D's SAR recognised that understanding of this is not particularly widespread.¹²⁶

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

- **Public Health Act 1936.** This 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 a 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.** This 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 of harm. If the hazard is a category 1, there is a duty on the local authority 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).¹²⁷
- **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.¹²⁸

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

- A duty to prevent homelessness
- A 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 funds¹²⁹

Individuals who are subject to immigration control have no entitlement to welfare benefits or public housing. This includes homelessness assistance.¹³⁰ 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.¹³¹ Provision can include accommodation owing to the individual's need for care and attention.¹³²

For those who are excluded from this support,¹³³ 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 2011.¹³⁴

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, these other documents may assist professionals:

- [The Care Act 2014 Statutory Guidance](#)¹³⁵
- [The Mental Capacity Act 2005 Code of Practice](#)¹³⁶
- [The Mental Health Act 1983 \(amended 2007\) Code of Practice](#)¹³⁷
- [NICE guideline 108 - Decision-making and mental capacity - October 2018](#)¹³⁸
- [PHE / NHSE – Better care for people with co-occurring mental health and alcohol and drug use conditions - 2017](#)¹³⁹
- [NICE – National Guidance 58 – Co-existing severe mental illness and substance misuse - 2016](#)¹⁴⁰
- [NICE - Clinical Guideline 120 - Psychosis with coexisting substance misuse - 2011](#)¹⁴¹
- [NICE - Clinical Guideline 115 -Alcohol-use Disorders: Diagnosis, Assessment and Management of Harmful Drinking and Alcohol Dependence - 2011](#)¹⁴²
- [The ICD-10 Classification of Mental and Behavioural Disorders: Clinical descriptions and diagnostic guidelines](#)¹⁴³
- [The King's Fund - Delivering health and care for people who sleep rough - 2020](#)¹⁴⁴
- [LGA / ADASS - Adult safeguarding and homelessness: A Briefing on Positive Practice -2020](#)¹⁴⁵
- [Care Quality Commission - Guidance on the treatment of anorexia nervosa under the Mental Health Act 1983 - 2008](#)¹⁴⁶
- [NICE – Nice Guideline 69: Eating disorders: recognition and treatment - 2017](#)¹⁴⁷
- [Braye, S., Orr, D. and Preston-Shoot, M. \(2014\) Self-Neglect Policy and Practice: Building an Evidence-Base for Adult Social Care. London: SCIE](#)¹⁴⁸
- [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](#)¹⁴⁹

Practical case studies

This section introduces four chronic dependent drinkers and how the powers could be used to protect them. These have been modified for confidentiality and the names used are fictional, but each is based on a real person.

Don

Don is a 53-year-old white British man and a dependent drinker. Although he had a job and a partner up until 10 years ago, he now lives alone in a privately rented studio flat. He drinks up to six litres of white cider a day and this has led to some very out of control behaviour, involving 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 chose to return to his flat.

However, on returning to his flat he also returned to drinking. This pattern of drinking, squalor, hospital admission, respite and relapse was repeated three

times. Workers involved in the case became increasingly frustrated: one worker argued that Don 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, Don was detained under section 2 on a psychiatric ward with the aim that he would be detoxified, be free of alcohol and then kept long enough to assess his underlying mental health state with a view to addressing his long-term mental health.

Cal

Cal is a female dependent drinker in her 40s of East European heritage, living in very poor circumstances. A few months ago, she tried to burn some rubbish in her sink. Neighbours smelled smoke and called the fire service. At the subsequent 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 was 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 visit Cal on three occasions but she failed to answer the door; and when spoken to on the phone, she 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 social care services to become more actively involved.

Peter

Peter is a 60-year-old white British man 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 has been homeless, but a charity sector homelessness agency worked with him to secure accommodation. However, he is now not using this accommodation, because of fears of abuse by his neighbours, so he 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 and was assaulted but does not recall these incidents.

His worker in the homelessness agency tried to connect

him to the local substance misuse service. However, they required him to attend a timed appointment and to arrive relatively sober. This has proved beyond him. Efforts to assess his cognitive function have also not been completed due to his non-attendance at set appointments.

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 his drinking is 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 who was at the meeting agreed that he needed safeguarding under the Care Act. After an assessment, a package of care and support was agreed based on assertive outreach which was flexible and focused on rapport building. He was taken to his 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. The council then placed him in more suitable accommodation, not in multiple occupancy with other drinkers. He has stayed in his new home, with continued care visits.

Mel

Mel is a 52-year-old mixed race woman with a lifelong physical problem that impairs her mobility and ability to work. Her intellectual abilities are on the borderline of being classed as a learning disability. It is suspected that she was born with foetal alcohol syndrome and she had a disrupted childhood, spending periods in foster care. She has drunk heavily since her teenage years.

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

However, in the last couple of years her physical health has deteriorated and she has suffered 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 and continued to drink heavily. The situation in the house deteriorated again. This pattern was repeated a couple more times over the next few months.

It became clear that Mel 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 alcohol service commissioner, agreed 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 initially focused on her alcohol use, but rather helping her with her money management. This allowed the worker to develop a trusting relationship that eventually led to a discussion about alcohol and the need for change.

Ultimately, Mel was introduced to a peer mentor who volunteered with the alcohol service and over time this relationship became her main support. Mel has not stopped drinking, but she has much more control over her drinking and looks after herself much better. There is now a discussion about whether she would benefit from some form of residential rehabilitation.



What happens next? A local action plan

So, change is both desirable and possible. What is needed next is action and we argue that this is best done through a local action plan.

Whether or not this draft plan is right for you, we wish you good luck in your efforts to ensure that highly vulnerable, chronic, dependent drinkers are being supported using all the legislation that is available: saving lives, saving resources, and improving communities.

Draft local action plan

1	Our Safeguarding Adult Board will ensure that there is a senior strategic level group that takes on oversight of this agenda to ensure that highly vulnerable, chronic, dependent drinkers are being supported using all the legislation that is available. This is most likely to be the SAB itself but could be another body.
2	This oversight group will ensure that all key local agencies have received and considered this briefing and the associated training; and indicated what steps need to be taken to ensure the safeguarding, protection and support of this client group.
3	Our oversight group will identify any service gaps that need to be considered by local substance misuse commissioners.
4	Substance misuse commissioners will ensure that the needs of this group are addressed in all needs assessments and commissioning plans.
5	Substance misuse commissioners will 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 legal powers, to advise on or undertake the management of this client group.
6	The oversight group will ensure that training on the use of these powers is available for those working with highly vulnerable, 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, particularly facial characteristics. It is now recognised that it is the brain and its ability to function that is most affected. Fewer than 5% of individuals with FASD's cognitive deficits also have the standard facial characteristics of the disorders.

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.

In the UK around 40% of women report drinking 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. There are issues relating to executive function, working memory, language, social communication, and sensory processing alongside other adaptive behavioural difficulties.

In situations where there is no anxiety and stress, an individual can score and function better than in situations where there is a higher emotional load. People with FASD often do least well when a multi-level cognitive demand is placed upon them. Simple tasks can often be completed well, but as the task increases in complexity and multiple aspects

of cognition and ability are required, their performance tends to deteriorate and they can find themselves unable to cope.

How does this 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, they may appear to have capacity. However, in a high arousal situation, with heightened emotional elements, where multitasking is required and where there is little support, their mental capacity may be less clear. In such situations, people with FASD are less likely to consider the wider issues and implications of a decision and may also act on impulse or be influenced by others. All of these factors would lead to their capacity being questioned.

The paradox of executive abilities has been described in brain injury cases, and this is also seen in people with FASD. Where patterns of behaviour are consistently not in keeping with what is stated in an assessment scenario, professionals should question whether capacity exists for this 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 them or others. Guardianship under the Mental Health Act has been recommended in scenarios, for example, where there is significant risk to the individual through their cognitive vulnerabilities which are missed through a lack of diagnosis.

Appendix 2.

List of interviewees

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

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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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