Alcohol Related Deaths Review

Summary Report

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1. Introduction

This review was undertaken at the suggestion of GHNHSFT, due to a notable increase in the numbers of people dying of alcohol related conditions during the past year. As this coincided with the Covid pandemic, it was questioned whether lockdown restrictions and the NHS overwhelm may have discouraged people from seeking treatment. From the information received on the seven people considered in this review, it did not seem likely that Covid was a factor, although this was not overtly stated. Brief descriptors of the individuals are provided in appendix 1 and a list of contributing agencies can be found in appendix 2.

2. Methodology

GHNSFT provided the names of 7 people who had died during 2020 from alcohol related conditions. Three were well known to multiple agencies and died at home. The remaining four were known to several agencies and died in Cheltenham General Hospital. Only 7 of a cohort 18 were selected as the other individuals had little or no agency input prior to their deaths. A questionnaire was circulated to partner agencies (see appendix 3) and the responses were grouped into themes.

Using the information provided, each theme has raised key questions posed for consideration and further analysis.

3. Themes linked to: Challenges

3.1 Resistance to accepting support and readiness to change

Although two of the seven people were very much “out of sight” of services, it was evident that five people had been offered support from a breadth of services but remained resistant to accepting help and their engagement was intermittent. Frontline professionals commented on a person’s general reluctance to change, not wishing to engage with support services and making unwise decisions in their choice of how to live. In relation to specialist support (drug and alcohol treatment) in some cases encouragement to engage by services can help with engagement, but their (CGL) insight showed an understanding of still needing a ‘readiness to want to change’ if treatment were to have any impact. Professionals expressed uncertainty about people ‘falling through gaps’ in service provision; there was consensus by agencies in the availability, flexibility and readiness of alcohol support offered, including self-referral. However, where some people may obtain support from AA or other self-help voluntary groups, Covid-19 restrictions limited these (usually) face to face services.

It was felt that P7 had not fallen through the gaps, as he was choosing to make unwise decisions in how he wished to live his life. P7 did not wish to engage with services to address his substance misuse

Unfortunately P7 was not ready for Change Grow Live to be involved in his care at that time and so we were unable to have any significant input into his treatment and therefore are unable to comment as to whether he 'fell through the gaps'

Some can be encouraged to engage with services, but others do not accept that they need treatment. Some successfully seek help with AA or other self-help and/ or voluntary groups. This has been limited by the Covid 19 pandemic whilst at the same time people have been drinking more.

P2 did not want support with stopping drinking alcohol and this is something I talked to him about on many occasions.

I do not think that P4 "fell through" the gaps-he kind of chose to not engage on some level. He was well aware of how to access services and knew that he could self refer at anytime to CGL. He also chose not to engage with any Veteran support-however this was offered to him many times and this would have continued to be the case.

*The theme **Resistance to accepting support and readiness to change** raised key questions:*

- ***What is the expectation on professionals, staff and volunteers 'working with' this as a challenge?***
- ***What are the ways to continue supporting, with compassionate persistence – i.e. MDT and multi agency communications?***

3.2 ASC involvement

Professionals from a range of agencies referred into Adult Social Care because they deemed that a person had needs for care and support. The audit questionnaire highlighted that in one case the expectations of ASC from other agencies were not met; this group of people are frequently assessed as not having eligible needs under the Care Act 2014. In one case, despite the tenacity of the referrer (to ASC) making a joint visit with ASC, evidencing poor functional ability and cognition not related to intoxication, the assessment outcome was that he did not have eligible needs under the Care Act 2014.

ASC continued to say that P2 did not have any care and support needs even though the evidence from assessments showed that his level of functional ability and cognition was questionable and it was clear from all other professionals

> *involved that he was not managing and this was not solely due to him being intoxicated.*

However in one case (P5) there was extensive involvement from ASC, including the Enablement team and a section 42 enquiry regarding financial abuse and exploitation. He had residential reablement stays, as well as some short residential placements. A care package was provided for when he was at home.

*The theme **ASC involvement** raised key questions:*

- ***How is the wellbeing principle considered?***
- ***Does alcohol use 'mask' underlying care and support needs?***

3.3 Multi agency working

Professionals understand and value how multi agency working is a beneficial approach to supporting individuals and collectively managing risk. The audit highlighted some situations where a lack of joined up working meant that key information was missing or not recorded on systems:

> *It is not clear what multi-agency meetings took place to discuss the risks and ensure safeguarding as it not recorded on our systems. If these did not take place then I would recommend that in future cases a multi-agency meeting should be called to agree the best way to support individuals such as this.*

This comment was made by the Police and related to a case where multi agency meetings had been held but the Police had not been invited. It has been reported recently that GPs are also a group who are sometimes not considered for involvement in multi agency working, however both agencies may have helpful contributions to make.

*The theme **Multi agency working** raised key questions:*

- ***Are we always considering and actively linking with other agencies working with people, including the Police and Primary Care?***
- ***At what point should there be a decision to ensure the Multi Disciplinary Team and multi agency discussions link the team around the person?***

3.4 Mental Health Services

The audit emphasised that access to mental health services can be problematic and, furthermore, mental health services are reported as being unavailable unless a person is abstaining from alcohol. In these situations, substance misuse is frequently a symptom of underlying mental health issues and mental health needs are not addressed in partnership due to their substance misuse.

When substance misuse is a symptom of underlying mental health issues and mental health needs are not addressed in partnership due to their substance misuse.

*The theme **Mental Health Services** raised key questions:*

- ***How do mental health services respond effectively to those with combined mental health issues and alcohol dependency?***
- ***Is there a culture of healthy challenge if a referral to mental health services is declined and the referring agency disagrees with the decision?***

3.5 GHC Response

GHC advised that Mental Health Services have evolved in relation to this issue, especially over the past year, and provided the following response:

"It is recognised that there is a link for some people between poor mental health and alcohol misuse/dependence. With reference to the group looked at for this review, they were all people who were engaged in harmful drinking (high risk drinking).

Addressing mental health problems in combination with chronic substance misuse problems can be challenging to services not least because they are most often commissioned as separate services. Having substance misuse problems is not an exclusion criterion for people with serious mental illness who need secondary care services. Service specifications for secondary care mental health services include reference to working jointly with CGL for clients with co-existing conditions.

When an individual is drinking to harmful levels/is alcohol dependent, it may mean that certain therapies are not suitable. This may be because things like memory, learning and habituation (in anxiety disorders) can be significantly impaired while they are drinking at such levels. It may also mean there are risks in having certain medications due to risk of sedation or respiratory depression.

NICE Clinical Guidelines 115 (2011) suggest that for people who misuse alcohol and have comorbid depression or anxiety disorders, the alcohol misuse should be treated first. Reduction or abstinence from alcohol can have a marked impact on reduction of depression and anxiety. If however, after 3-4 weeks of abstinence from alcohol, symptoms have not improved sufficiently, then the individual should be offered referrals for anxiety or depression in line with the relevant clinical guidelines. That said, there may be instances where a person has sufficiently reduced their alcohol intake meaning they are able to engage with treatments and agencies can work jointly with the individual.

This is likely more applicable to people with mild to moderate conditions that would likely be treated in the first instance in primary care settings (locally through the

Mental Health Intermediate Care Team which includes the Improving Access to Psychological Therapies Service). The caveat to this would be if the individual is expressing suicidal intent in which case they should be assessed in line with the NICE guidance.

If agencies make referrals that are declined by mental health services because of alcohol misuse, and the referring agency feels this is wrong, they can challenge the decision with the relevant team".

3.6 Lack of specialist services/1:1 support including specialist accommodation needs

There is common opinion from those completing this audit that Gloucestershire lacks specialist services for those with alcohol related problems, including alcohol related brain damage (ARBD); this is highlighted further in cases where alcohol use co-exists with physical and mental health support needs. For some professionals this was identified as a lack of funding and resources and for others it linked to a need for more coordinated services. Colleagues felt that better training may be beneficial for those agencies and providers involved in complex care needs.

ARBD was evident in some cases. However, even though ABRD was identified, those agencies and professionals working to support the complexity and intensity of needs that ARBD brings expressed a need for early diagnosis, earlier intervention and specialist one-to-one for individuals to be best helped. Health and social care workers agreed that a 'tailored' service would probably address improved engagement and improve access. For many agencies, providing such a service falls outside of their current working remit and is not resourced.

> *A greater 'presence' of services for alcohol/illicit substance use where there are physical and mental health needs also present. There appears to be a significant shortage of funding/resources for people who have a dependence upon drug and alcohol, and other services struggle to support people in these situations. I believe more coordination of services and training for all agencies and providers involved in complex and severe needs is required.*

> *P2 did have alcohol related brain damage (ARBD)-there is no formalised service to support those with these issues-all assessments were completed by myself or High Intensity Network (Pilot). There needs to be a specialist service that can offer advice and support to clinicians and clients in regards to managing ARBD. CGL are not in position to do this. If this service could have seen P2 sooner then some of these assessments may well have taken place sooner and some changes could have been made in a more timely way.*

> *Lack of resources for a tailored-style service, lack of engagement from service users, lack of access to services and "real help" when service users need it.*

> *Lack of appropriate accommodation for people with alcohol issues. People often living in shared accommodation which can leave them at risk of exploitation and relapse due to presence of others. For the one female, her poor living conditions and wider environmental problems (with ASB etc.) seemed to contribute significantly to her poor mental health.*

Finally, one person's situation highlighted a concern about the suitability and availability of housing for those with ARBD and related care and support needs.

> *P2 could not move house [due to arrears] keeping him in a situation where there was high risk of self neglect and falls. If there could have been a way to expedite the situation and get him moved sooner the outcome may have been different.*

*The theme **Lack of specialist services/1:1 support including specialist accommodation needs** raised key questions:*

- ***What specialist services does Gloucestershire provide to support ARBD?***
- ***How do providers of housing services identify and support these needs?***

4. Responses linked to: What could help?

Responders were asked to make suggestions about what in their view could help when working with individuals with complex lives. The following suggestions were made:

4.1 Ability of services to work with people in a flexible way. Trauma-informed approaches needed.

> *Those that are homeless, often have complex and in-depth needs. This maybe health related, social, substance misuse, etc. Health needs aren't always their priority. If there was a service that anyone who was homeless/in temp accommodation had a 1:1 support worker who could then liaise with other agencies as needed including informing other agencies of patients where about, that would be fantastic. I know this is a tall ask, but patients need intense support, they need the opportunity to build a relationship and put trust in others….If they had 1 person who was a consistent figure for them, I feel it would help them immensely.*

4.2 Mental health support to people with substance misuse

Respondents identified the need to address the two issues in tandem as poor mental health and alcohol/substance misuse are often closely linked.

4.3 Specialist accommodation for people with ARBD and high care/support needs

This is an area that respondents identified as lacking in Gloucestershire.

One respondent talked in terms of overall service design:

> *"People are individuals with individual needs. Vulnerable people tend to lead chaotic lives which leads to them being be less able to 'fit in' with the services that are available to them, particularly if they have to wait to speak/see someone or if the service is simply not available when they need it. We need to design services in such a way that they meet the individuals needs rather than offering them something which does not meet their needs then labelling them as someone who 'doesn't engage in services offered' if the 'offer' was the right one, they would engage and no one should therefore fall through the gaps".*

From this information about **w*hat could help?*** it can be summarised as:

- ***1:1 intensive support and intervention work that has the potential to be supportive, available and consistent.***
- ***The availability of specialist accommodation which can meet the complex needs of people with alcohol misuse issues and high care needs.***
- ***The ability of agencies to respond swiftly; at the point that the person is ready to accept or asks for help.***

4.4 Initiatives from other Local Authority areas

The following is an example of an initiative set up by another Local Authority in an attempt to address some of the key issues faced by people with complex lives, including drug and alcohol misuse:

The Doncaster Complex Lives Alliance:

This has developed with the support of the Making Every Adult Matter partnership: www.meam.org.uk Doncaster has a dedicated team, which comprises a Team Manager, Senior Case worker, 5 x MEAM Intensive Support Workers; 6 Navigators. The team works with people who are rough sleeping and have complex lives, including chaotic drug and alcohol use.

They aim to work in a more trauma informed way by:

- Working together
- Providing support quickly without barriers
- Being inclusive, not exclusive
- Listening to what people need
- Responding to an individual's needs not a service need
- Providing support based on safety, rather than risk

The team works closely with South Yorkshire Police, Town Centre Officers, Housing Support/Hostel Providers and Primary Care Doncaster; weekly meetings are held to discuss people with multiple disadvantages. This initiative has been included as an illustration of what could be considered locally.

5. Conclusion

This review was undertaken in response to a notable increase in alcohol related deaths, identified by the Acute Trust. The question was asked whether this was attributable to the pandemic restrictions, meaning that people presented later than they may have done in "normal" circumstances.

From the seven people considered in this review, it did not seem likely that Covid was a factor, although this was not overtly stated. Their difficulties and reluctance to engage generally seemed to be more deep rooted than just due to Covid. The people selected for review were all people who had particularly complex needs and it may be that if a different cohort had been selected from the individuals who died, we may have found that the restrictions due to the pandemic did play a part in their late presentation and subsequent death. This has been reported elsewhere and Public Health England has reduced a report on this issue, available at: https://www.gov.uk/government/publications/alcohol-consumption-and-harm-during-the-covid-19-pandemic

This review has highlighted some themes which are becoming familiar when considering how to work more effectively with people with complex lives. In addition, it has reinforced the need to be alert to the possible existence of underlying physical and mental health conditions, and so better guard against the risk that alcohol misuse maybe masking a person's actual needs. The themes include:

- Challenges when trying to work with people who are reluctant or unwilling to change their behaviour and so refuse offers of support.

- Lack of specialist services for people with ARBD, and shortage of suitable accommodation.

- The need to understand how local services join and address the two issues of mental health support and substance misuse in tandem as they are often closely linked.

- The need for intensive support – one worker who is a consistent figure and able to build a relationship of trust, over time.

- The need for services to be flexible in order to be able to respond quickly when an individual may be ready to accept support.

Additionally, a professional who was involved in this review raised a point about the need to understand how traditional support services work for men as well as for women (e.g. talking therapies), and questioned whether different approaches are needed to make it easier for men to accept support.

While this review does not propose changes to the systems currently in place, it will hopefully contribute to the wider conversations regarding how to provide more effective support to people with complex lives.

Appendix 1: Descriptors

P1: (CH) – 49 year old white female. Known to GHNHSFT

P2: (IB) – 67 year old white male. Known to CGL and Blue Light Project

P3: (PJ) – 47 year old white male. Known to GHNHSFT and Blue Light Project

P4: (SF) – 59 year old white male. Known to GHNHSFT and Blue Light Project

P5: (EK) – 52 year old white male. Known to GHNHSFT

P6: (MS) – 53 year old white male. Known to GHNHSFT

P7: (RV) – 52 year old white male. Known to GHNHSFT and Adult Social Care

Appendix 2: Contributing agencies

Adult Social Care, Gloucestershire County Council

Change, Grow, Live (CGL)/ARA

District Council (Cheltenham and Forest of Dean)

Gloucestershire Constabulary

Gloucestershire Health and Care NHS Foundation Trust (GHC)

Primary Care (GP's)

South West Ambulance Service Trust (SWAST)

Turning Point

Appendix 3: Questionnaire

Safeguarding Adults Review Alcohol Related Deaths Questionnaire

Thank you for completing this questionnaire. The information you give will help to identify how we can develop good practice in working with people in their situation.

Please provide your name and email contact details, you may be contacted for a conversation to clarify or expand on your responses. We may also invite you to participate in any future stages of the Safeguarding Adult Review.

Name of the patient/service user:

Your Details

Your service:

Your role:

Your name:

Your contact details:

Sections 1 and 2 are about information you have in your service about the individual. Section 3 is about your views on other provisions.

Use the following questions as prompts and tell us as much as you can. Use case records, plans and assessments (including risk assessments) to help us to get a better picture of the contact or work they were doing with your service. If you are completing this on behalf of other staff, can you try and ensure that all staff who worked with the person are spoken to. **We know that not all services will have in depth contact with service users.**

Section 1 For All Services to Complete

How did you know the individual and how were they known to your service?

What did your service think were the primary risks that they faced?

How did you manage these risks?

Were you aware of any other services supporting them and can you list them here please?

Section 2 - Complete only if your service had engaged in on-going contact

How long were they in contact with the service and how often did you have contact with them?

What type of work was your service doing with them? i.e. medical /social , individual appointments , groups etc.

What did you consider that they wanted or expected from contact with you?

Tell us about parts of work or service provided that went well for this person

What was challenging or seemed did not work well?

Were you aware of all occasions when they came into contact with services on a more ad hoc or short term basis e.g. police, ambulance or hospitals?

Can you state whether there was a multi-disciplinary or multi-agency discussion to support them?

Section 3

This is an opportunity for you to tell us your thoughts about local service provision. So, using these questions as a guide, please use this section to tell us anything else you feel will help.

Did you and other services share similar views about how best to support then or was there conflict?

How do you work with other services to support them?

What would have helped you as a service to work differently with them? From your perspective are there any gaps or difficulties within other services that need addressing?

How, why and when would you say that people 'fall through the gaps'?