

7-minute Learning

Safeguarding Adult Review (SAR) Homelessness – Andrew Waltham Forest Safeguarding Adults Board¹

Case Summary

Andrew was an independent and private man. He had long standing alcohol dependency, which he had managed for a number of years, and allowed him to work and retain a tenancy until the later part of 2014. The drinking eventually led to significant physical and emotional health challenges in the last year of his life. At this point he had lost his tenancy and was effectively homeless, living in supported housing provided by Single Homeless Project (SHP) organisation.

Andrew was supported by professionals at different times, the most consistent being from the social Housing Provider. He also had a long-standing relationship with a drug and alcohol worker in an outreach service, which was decommissioned during 2016. Andrew preferred practical support to any meaningful emotional engagement. Support was focussed on harm reduction and practical targets. Andrew was firmly of the belief that he could stop drinking himself when the time was right.

In the spring of 2015, a fellow resident and close friend of Andrew's died suddenly and unexpectedly. This death had a profound impact on Andrew's emotional well-being and marks the onset of a steady decline in his physical and emotional well-being and his eventual death from alcohol related conditions arising from his self-neglect. He was always considered to have mental capacity.

During the last year of his life professionals tried to support Andrew. He was referred between services for his emotional well-being, self-neglect and alcohol dependency but organisations didn't work holistically with his complex situation. He was supported by a GP at the end of his life, who focussed on harm reduction, rather than End-of-life planning. There were limited palliative care options available to Andrew.

He died in hospital in February 2016 from alcohol related illnesses, aged 39 years old.

¹ The RWSAB would like to acknowledge the SAR on Andrew prepared by Waltham Forest (Link to full report [Andrew SAR](#)).

Findings

Substance Misuse as a form of self-neglect

It is not routine or shared practice to accept that chronic alcohol misuse is a form of self-neglect and a safeguarding issue, particularly when the person has capacity. This directly affects the response by professionals and the support that is offered and provided to service users. It is particularly emotionally demanding and stressful for professionals working with adults who have capacity, who are self-neglecting and continuing to make unwise decisions and declining support. The adult safeguarding system does not presently enable practitioners to clearly and easily identify adult safeguarding concerns when a person is self-neglecting and a chronic alcohol user which directly affects the response service users receive from practitioners.

Lack of effective care pathway

There is no widely used care pathway, or allocation of role or responsibility for the palliative care of self-neglecting adults who are terminally ill as a consequence of their addictions. This leaves frontline workers trying and often not succeeding to respond appropriately, increasing the risks that homeless people with alcohol dependencies die with no support or dignity.

Multi-agency engagement

Outside of the safeguarding framework, there are limited mechanisms that bring together staff from across agencies in high risk cases to plan and review work, increasing the chances of interventions being less effective.

Addressing multiple dependencies/issues

People with alcohol dependency and emotional distress are left with limited options because services are not equipped or commissioned to provide support for both issues together, which ignores the interconnected nature of people's dependency and emotional distress. The evidence suggests that commissioners and commissioned services are not provided in line with what is required by service users. Services tend to assume single issue scenarios, leaving a poor fit for people like Andrew. Services need to respond and reflect on the complexity and variety of people's needs to ensure that they can receive the right support at the right time, and we do not increase the risk and probability of service users falling between services.

Questions for consideration and feedback

1. *How can you use this SAR to improve practice in your team/organisation?*
2. *What could the RWSAB do to help your organisation achieve this?*