

The audit of 23rd April 2025 reviewed the records of six adults who were identified as adults who misuse substances including alcohol. The aim of the audit was to ascertain whether there were good multiagency standards for managing cases and whether organisations have implemented a robust and consistent response in line with statutory and good practice guidance, SGSAB policies and procedures and the six key principles underpinning all adult safeguarding work.

The adults reviewed for this multi agency audit are aged between 18 and 62.

2 are female and 4 are male.

All of the adults misused alcohol, and two other substances as well.

The adults in the audit have a range of issues in addition to substance misuse, including frequent falls, self neglect, mental health, diabetes, wider family alcohol misuse, domestic abuse, physical health conditions

What we are worried about?

The audit group saw concerns in terms of:

- No evidence of multi agency conversations between GP and other organisations, and GP knew the adult well and this would have been helpful. This was true for several adults.
- Some organisations did not know that one adult posed risk to professionals and should not be visited or seen alone
- Police recognition of vulnerability not consistent especially when an adult is also suspected of committing a crime
- Support for a carer was missing and not identified
- GP only aware of parental alcohol misuse and not of the young adult themselves
- Slow response for one adult who was left in terrible conditions with a physical injury, and dehydration alongside a mental health crisis and was eventually helped by a neighbour – lack of escalation and curiosity
- Some silo working where a shared approach would help, multi agency meeting needed
- Most of the adults in this audit didn't want to work with professionals

Refer to DHI for Drug & Alcohol support click here

Theme: Recognising Trauma

- This audit found that when an adult is identified as a 'perpetrator' it is a barrier for them to be seen in the light of their own vulnerabilities
- There was evidence that practitioners from a variety of agencies did not consider past trauma or consider the adult to also be a victim
- There were identified gaps in trauma informed practice

Anyone can escalate when they are worried about a response from another organisation
Click to access the policy

If a risk to others is identified about an adult who should not be seen alone this must be shared with all organisations who work with the adult so this can recorded on all systems.

Be mindful about stigma
If you need to alert people
about risk then add context
and helpful information eg.
Good times of day or support
that works

Multi Agency
Quality Assurance Audit:
Substance Misuse
April 2025

There are resources on the SAB website for practitioners and managers – you can access them by clicking on this box

Bitesize Trauma Awareness Training is available to watch by clicking this box

What Good Practice did we see?

- GP followed up after a missed appointment and rebooked it
- Other agencies added information to AWP records
- Persistent work by social care, repeated calls and unannounced visits to try and engage with adults
- Police referral for a fire safety visit from the fire service
- Referral to Next Link made where there were concerns about DA
- Use of Resolution of Professional Differences (escalation) policy seen for one adult

Click these circles for more information

Avon Fire and Rescue Resources about hoarding/self neglect

Self Neglect Guidance is here



Organisations that audited their involvement with the six adults were: Adult Social Care, Sirona, Police, GPs, AWP, DHI, NBT & Voiceability