# Learning Brief

# Adult G

In 2018, The Wolverhampton Safeguarding Adult Board (WSAB) Safeguarding Adult Review Committee (SARC) undertook a Table Top Review focusing on the care and treatment of Adult G during their contact with Health & Social Care agencies in August 2016.

The SARC determined that a review of the circumstances surrounding Adult G's contact with agencies would provide learning for the partners of Wolverhampton.

A Table Top Review (TTR) panel comprising Safeguarding Leads from the Black Country Mental Health Trust (BCPFT) Wolverhampton Domestic Violence Forum (WDVF) and The Royal Wolverhampton Hospitals Trust (RWT) was created. The Panel was informed by detailed chronologies and individual reports and from the agencies involved and contributions from Mental Health Professionals that had been involved with Adult G.

Adult G has been known to the Mental Health Services since the age of 10 years. As a child Adult G experienced severe neglect and abuse which impacted their mental well-being, ability to regulate emotions in response to life experiences and maintain their own safety.

During Adult G's contact with Mental Health Services Adult G has accessed support from Community Mental Health Teams, Forensic Community Mental Health Nurses and Mental Health in-patient facilities on both a formal and an informal basis, otherwise known as 'Detained under the Mental Health Act'; and as a voluntary patient. Adult G has a diagnosis of Emotionally Unstable Personality Disorder.

In August 2016 Adult G attended the Acute Hospital Emergency Department (ED) having been conveyed there from the home address by ambulance. On arrival Adult G described themselves as feeling low and depressed, a feeling Adult G reported was 6 months in duration but was worse that particular day. In total Adult G was in the Acute Hospital for 3 hours 11 minutes, within which time Adult G had been seen and assessed in 2 separate departments, Emergency Department and the Urgent Care Centre and a management plan proposed. However, Adult G declined this plan, left the ED and made their way upstairs from ED into the Urgent Care Centre where they sought an appointment with them. An hour later Adult G returned to the

toilets in the public area of the hospital; adjacent to the ED reception area and proceeded to ignite their clothing, sustaining burning to their ankle.

Having thoroughly and sensitively considered the events on the day in question, it is the observation and conclusion of the TTR Panel that there was professionalism and consideration shown towards Adult G at a point where their levels of distress had escalated to a point they were not able to manage them independently. Every opportunity was explored to engage Adult G in a further assessment of their mental health distress from which a supportive management plan could have been devised. The fact that Adult G declined that offer by the staff in the Emergency Department and then sought input from the Urgent Care GP services, that again at a significant point in the referral process to the Acute Hospital based Mental Health Team Adult G disengaged from before inflicting injury on themselves, is a reflection of the condition Adult G lives with. All the practitioners who came into contact with Adult G on the day in question were sensitive and responsive to Adult G's needs however; further awareness around Adult G's diagnoses would be of benefit to staff and individuals who live with Personality Disorder.

For many years it was believed that Personality Disorder was both untreatable because it didn't respond to pharmacological treatment and it was means by which people sought attention. Clearly, this is not the case and it is now more widely understood to be a condition that is treatable, more so by receiving Psychological support than by pharmacological treatments. There are now many support groups and agencies that provide help, guidance and therapeutic intervention to individuals living with Personality Disorder, yet current literature suggests that there is still a long way to go before Personality Disorder is truly understood, recognised and responded to in the same way as other notable mental illnesses.

Where the mental health presentation of an individual to the Emergency Department sits outside the knowledge and skill of medical professionals in the Emergency Department, referrals can be made to MHLS for advice and support.

Although there was nothing from the TTR that indicated Adult G's condition was not fully understood and responded to, it is the suggestion of the TTR Panel that multi-agency Mental Health training incorporates material relating to living with a diagnosis of Personality Disorder would be prudent. The aim would be to reframe any residual belief that an individual living with Personality Disorder is not 'challenging' or 'attention seeking' but is in fact mentally unwell and when in Crisis, perceived or otherwise by on lookers, including professionals; care, compassion and understanding is required.

Worthy of note also is that there is increasing research and associated literature available relating to the correlation of aggression and the use of cocaine and alcohol. In many violent acts, including murder and in cases of domestic abuse, the perpetrator was noted to have used these substances immediately or just prior to the incident. It was noted from the reports provided by the Mental Health Team that Adult G had used cocaine and alcohol. It was not clear if these substances were used together and/or whether they had been used on or just prior to the date in question. However, it is worthy of acknowledgement that the increasing availability

of studies identify that the concurrent use of both can lead to poor judgement, increased violence and even sudden death; and this learning would benefit from being shared.

## Combined use of Alcohol & Cocaine

When using alcohol and cocaine together, the liver produces a toxin called **'Cocaethylene'**. This toxin is only ever produced when using alcohol and cocaine together; it does not occur with any other drug and alcohol mix.

When cocaine and alcohol are used together it is difficult for the person to identify how drunk they are. This is because cocaine decreases the feeling of intoxication; therefore more alcohol is consumed, raising the risk of **alcohol poisoning.**

**Sudden death** is 20 times greater when alcohol and cocaine are used together compared to cocaine use alone. When Cocaethylene builds up in the body it produces a euphoric effect but also increases blood pressure and has the propensity to put stress on the major organ systems, which can and does lead to death. Where death doesn't occur, serious physical illnesses can happen, for example, Stroke, brain haemorrhage, seizures, cardiac arrhythmias, heart muscle weakening and heart attack. It is also reported that when this toxin leaves the body it exacerbates feelings of **depression**.

There is increasing research and associated literature available relating to the correlation of **aggression and the use of cocaine and alcohol**. In many violent acts, including murder and in some cases of domestic abuse, the perpetrator was noted to have used these substances immediately or just prior to the incident.
It is suggested that the link between these incidents and using alcohol and cocaine at the same time is because they increase the **'high' and intensity of feeling self-confident and disinhibited.** Whilst these effects are prolonged, the side effect of 'coming down' is decreased.

It is recognised from research undertaken to date that not all individuals who use alcohol and cocaine together will die suddenly or will indeed become aggressive and harm others. What the research does note is that people who choose to use the substances together and the practitioners who come into contact with those people are not as informed as they should about the potential ill-effects and risks and more should be done to raise awareness.

More information on this topic can be found at:
http://www.alcoholacademy.net/

https://www.talktofrank.com/drug/cocaine