Serious Case Management Review

'Family K'

Redacted Report

Independent Author: Sylvia Manson

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Contents

1. Introduction and Terms of Reference for the Review

1.1. This Serious Case Management Review (SCMR) concerns the homicide of Mrs K and a serious assault to her husband Mr K by their son Mark. Mark was mentally unwell at the time of the incidents. He was convicted for Manslaughter of his mother. Mark remains in secure psychiatric care.

1.2. In the weeks leading up to the homicide, Mrs K and a friend of Mark's had contacted mental health services on five occasions, concerned about his behaviour. Mark did not engage in an assessment. In the weeks leading up to the fatal incident, agencies had also been involved with Family K in relation to the care and support needs of a relative who was temporarily staying with them.

1.3. The Isle of Man Safeguarding Board (IOMSB) will convene a SCMR in circumstances where:

(a) there is cause for concern about how the Safeguarding Board, it's partner agencies or any other relevant body have worked together to safeguard the vulnerable adult, and
(b) a vulnerable adult has died or suffered serious harm and
(c) where abuse or neglect is known or suspected.

1.4. The purpose of SCMRs is to promote learning and improvement with the aim of reducing risk of deaths or serious harm to others. A SCMR is not about apportioning blame. The review seeks to understand the systems in which agencies operate and explore factors that aid and present barriers to delivering best practice. The review was led by an Independent Chair and Author.

• Terms of Reference

1.5. In the context of the fatal domestic abuse incident, to explore whether there were opportunities by individual or collective agencies to have provided support, interventions and safety measures to family members that potentially may have averted events leading to Mrs K's death. Specifics are as follows:

Terms of Reference: Areas of Enquiry
1. What was the quality of assessments undertaken of individual's needs? (Were assessments holistic? Did practitioners 'Think Family,' taking due account of historical information; wider environmental and familial factors as well as the individual's presenting needs? Did assessments consider assets/ protective factors and stress/risk factors? Was appropriate professional curiosity exercised?) 2. What was the quality of decisions and actions arising from those assessments? 3. Were there earlier opportunities to identify and reduce risk of abuse (including identifying previous episodes of abuse) and if so, how effective was the response to identified risks?

4. Did assessments consider whether individuals' decision making may be impaired due to mental capacity and/or coercion and undue influence and did appropriate actions follow?

5. How effectively did agencies collaborate and coordinate care/responses with other services and agencies?

6. How effectively did agencies engage with members of the family, to understand their perspectives and wishes and to support their decision making in relation to wellbeing and safety?

7. Was the work in this case consistent with each organisation's policies and procedures for safeguarding (including domestic abuse) and promoting wellbeing, and with wider professional standards?

8. Was there evidence of positive practice by the agencies involved?

9. How well did agencies consider equality and diversity and adapt intervention accordingly?

10. Are there wider systems issues that present a barrier to effective practice?

11. What are the learning points from this review and recommendations for single agencies and the partnership that will strengthen multi-agency working and reduce the likelihood of a similar situation occurring in the future?

1.6. The scope period for the review focused upon the last 2 years of Mrs K's life. However, agencies were asked to highlight any other relevant events outside of this scope period. The following agencies contributed:

Participating Agencies and Context of Involvement	
IOM Constabulary	Police had had previous involvement with Mr and Mrs K, responding to a domestic abuse incident where Mrs K was the victim. Police had minor contact with Mark prior to the fatal incident
Education Sports and Culture	Provided some pre-scope period information relating to Mark at secondary school
Manx Care: Health Services	The Manx Care report related to health care provided to Family K by Mental Health services; GP; Ambulance; Community Health and re-enablement services;
Manx Care: Adult Social Care	Mr K had been supported historically by the Adult Generic Team. The Adult Safeguarding Team became involved due to safeguarding concerns about a relative.

1.7. The review benefitted from the perspectives of Mr K. Mark declined to be involved in the review. Pseudonyms have been used for all family members and dates and places have been deliberately generalised to protect the privacy and dignity of those involved.

1.8. The following sections provide background to the family circumstances and then analysis of agency involvement.

2. Background and Key Events Relevant to This Review

2.1. Mrs K lived with her husband, Mr K and their son 'Mark.' Mrs and Mr K were described by professionals as having chaotic lifestyles secondary to alcohol use. Neither of them accepted they had problematic alcohol use.

2.2. Mr K had care and support needs due to a physical disability and an acquired brain injury.

2.3. Historically, the Social Care, Adult Generic Team had provided homecare support for Mr K. The records during this period give some insight into the difficult family dynamics. There were problems with debt and the family were under threat of eviction. There were concerns about Mr K's drinking and reported mood swings including an incident of assault to his Consultant. Mr K declined referrals to drug and alcohol services.

2.4 The Social Work records referenced persistent verbal abuse together with physical assaults from Mr K to Mrs K. The Social Worker advised Mrs K to contact the police and signposted her to the domestic abuse refuge, as well as trying to mediate between the couple.

2.5 Mrs K had a long-term depressive illness alongside alcohol use. She spent a lot of time away from home leaving Mr K to be cared for by Mark who was a young teenager.

2.6. Mark's teenage years were marked by pressures of being a young carer and instability at home due to his parents' chaotic lifestyle, their problematic alcohol use and the continued conflict and domestic abuse. Mark was registered at school as being a young carer. His attendance had been good but in his last 3 years of schooling, this attendance deteriorated affecting his grades. School did write to Mr and Mrs K about his attendance. Mr K responded by explaining they were going through a difficult period and needed Mark to drive them to appointments.

2.7. The school were unaware of Mark's home circumstances. There was an occasion while Mark was of school age, when Mrs K attended the hospital minor injuries clinic, stating she had been physically assaulted by Mr K. Mrs K described long standing domestic abuse by Mr K including a previous arm fracture. She had not wanted to report previous incidents, or the current incident to the police. Mrs K declined further treatment and discharged herself against medical advice.

2.8. Mrs K did agree to a referral to Children's Social Care though said that their Adult Social Worker, was already aware of the abuse. Children's Social Care wrote to Mrs K, advising her of the possible impact of domestic abuse on Mark but made no further enquiries. The referral was then sent on to

the police for information. Mark's school was unaware of the incident and soon after, Adult Social Work ended their involvement with Mr K.

2.9. Mark left home. During the next 2 years, incidents of domestic abuse from Mr K to Mrs K continued, usually in the context of alcohol. When Police attended, the couple were intoxicated. Neither wanted to separate from the other. They declined offers of referrals to drug and alcohol services, denying they had any problem with alcohol. Police attempted to de-escalate. The domestic abuse risk assessment was completed and assessed as a standard risk.

2.10. On one occasion, Mrs K acknowledged to the police that she was having a difficult time being Mr K's full-time carer, and that they were both struggling. She consented to a Multi-Agency Referral Form (MARF) being sent to the Adult Social Care. When the Adult Safeguarding Team (AST) contacted Mr K, he confirmed he was able to self-care. The AST tried to speak to Mrs K but got no response. The couple were provided with information about Drug and Alcohol services and Community Adult Therapy and then the referral was closed.

2.11. Mrs K did attend her GP. The GP noted her history of agitated depression and referred her to the mental health Duty and Referral Team (DART). Mrs K talked to DART about her relationship with Mr K; that she was a carer for him and of the verbal abuse and past physical abuse. She did not wish to pursue this and said there was no current abuse.

2.12. DART's assessment indicated Mrs K had mild symptoms of anxiety and depression. She declined psychological therapies and wanted to continue with medication prescribed through her GP. DART liaised with her GP who agreed to provide Mrs K with a carer's assessment. DART made no reference to Mrs K's disclosure of domestic abuse.

2.13. The following month, Nobles Hospital raised a safeguarding alert to the AST, regarding a relative who had come to stay. District Nurse (DN) discussed concerns about how able the family were to provide care for the relative. Much of the caring had fallen to Mark. The relative returned to her home where she was already known to local Adult Social Care.

2.14. Three months later, concerns were first raised regarding Mark's mental health. One of his friends phoned Manx Care mental health Crisis Resolution and Home Treatment Team (CRHTT). They described Mark as having '*a schizophrenic episode.*' The friend said that Mark had had a similar episode three months earlier, describing him as '*paranoid*' including thoughts that his girlfriend was plotting to kill him.

2.15. The friend spoke of Mark's stress factors from difficult family dynamics. The friend said that Mark had a high level of cannabis use. They did not feel he was an immediate risk to himself or others. Mark was not willing to engage with CRHTT, but the friend agreed to make an appointment for Mark with a GP. The friend was advised they could contact Emergency Department (ED) or the police if necessary. The case was then closed.

2.16. Two weeks later, Mrs K rang the CRHTT. She was concerned that Mark's presentation had changed recently to being agitated, abrupt and guarded. Mrs K was unsure if Mark was using substances. No risks were identified to himself or others. Mark was still not willing to talk with CRHTT but Mrs K agreed to get him an appointment with his GP. She was given advice about other points of contact.

2.17. The CRHTT sent a letter to the GP Practice where Mark had been registered prior to leaving home. This summarised the contact from Mrs K and Mark's friend and that Mark was unwilling to engage with CRHTT. However, unbeknown to the CRHTT, Mark was no longer registered at that GP Practice. The GP Practice returned the communication to Manx Care to be passed on to his current GP.

2.18. A month later, Mrs K again phoned the CRHTT. She described a crisis with Mark – he had threatened to punch her, and she had been frightened. The CRHTT were unable to speak to Mark so advised Mrs K to take him to the GP, reiterating advice about other contact points if needed.

2.19. A few days later, Mark's friend rang CRHTT, describing Mark as uncharacteristically aggressive. The friend was advised about points of contact. CRHTT emailed a GP (again mistakenly believing Mark was registered there.) The GP Practice returned the email to Manx Care to be passed onto his correct GP.

2.20. The following month, District Nurse(DNs) alerted the AST that the relative had returned to live with Family K. This period was during the Covid Pandemic restrictions. The DN raised a Safeguarding Adult alert due to further concerns of neglect.

2.21. Mark had been arrested by police for repeated breach of isolation requirements during the Covid restrictions. Police spoke to Mr and Mrs K who did not raise any concerns about him. Mark had spent a brief period in Custody before being released home. During his period in Custody, Mark did not disclose any mental health needs nor show any concerning behaviours. He did not appear to be under the influence of any substances.

2.22. The Safeguarding Adult referral about Family K's relative was discussed at the Inter-agency Referral Discussion group (IRDG). DN's reported the family were sleeping all day and were intoxicated. Mrs K was concerned about Mark, but he would not engage in discussion. The DN had advised Mrs K to contact the GP but was concerned that Mrs K was too intoxicated to do so.

2.23. AST spoke with the relative who denied any problems and declined assistance. The AST planned a joint home visit with the DN. Prior to this visit occurring, and unbeknownst to AST, Mark had been seriously abusive to Mrs K, pushing Mrs K out of his room and stamping on her back. The family did not contact the police or inform any other agency at the time. This information only came to light when Mr K shared it in interview, after the fatal incident.

2.24. When the AST and DN visited a few days later, they discussed their concerns about the relative's care. Mrs K declined the offer of ASC support and denied any problems with alcohol use. She did talk about being concerned about Mark's mental health but did not discuss the incidents of aggression that had occurred a few days earlier. There were no obvious signs of neglect of the relative and DNs were visiting daily and could alert AST if they were concerned. The AST officer made the Police Public Protection Unit aware that Mrs K had raised concerns about her son's mental health.

2.25. Ten days later, the fatal incident occurred. The day before, Mark had become agitated and hit Mrs K around the head. Neither Mrs K nor Mr K reported this incident to the Police or the CRHTT.

2.26. The relative phoned Police in the early hours, saying Mark had assaulted Mr K. When Police attended, Mr K said Mark had tried to strangle him with a towel. When officers went to rouse Mrs K, they found her to be deceased. Both Mr K and Mark were initially arrested on suspicion of murder, but Mr K was then released.

2.27. Mark was assessed in custody by the Police Forensic Medical Examiner (FME). Mark showed no signs of mental disorder. However, a further mental health assessment by a Consultant Psychiatrist made a preliminary diagnosis of schizophrenia, recommending further assessments to rule out a schizophreniform disorder[1] and a substance induced psychotic disorder.

2.28. Mark was detained in a secure psychiatric hospital for psychiatric assessment. Mark was subsequently diagnosed as having schizophrenia. The Court accepted the forensic psychiatric assessments that Mark was mentally unwell at the time of the offences. Mark remains in a secure psychiatric hospital.

3. Analysis and Learning

The following section provides analysis of the events and interactions between agencies and Family K:

1. Context of Adult Family Violence (AFV) including factors known to be prevalent in AFV and their relevance to Family K.
2. Opportunities for earlier, preventative intervention
3. Responses to concerns regarding Family K in the four months leading up to the homicide.

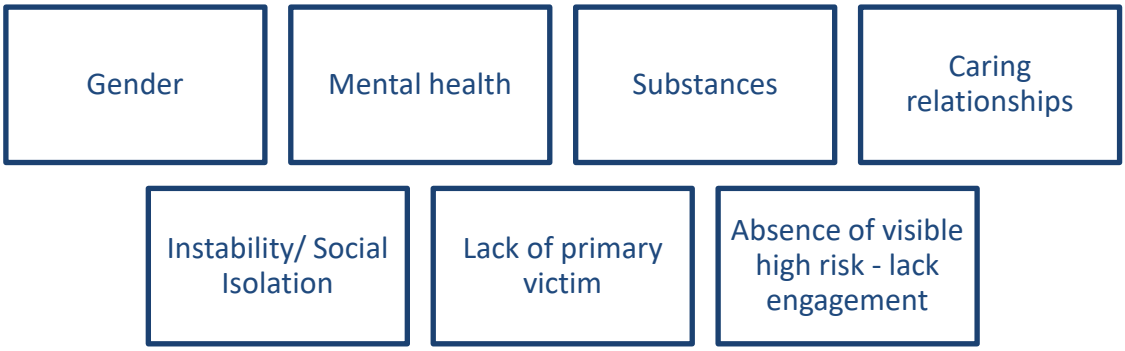
3.1. Context of Adult Family Violence

3.1.1. Domestic abuse in the Isle of Man is defined as
'*any incident of threatening behaviour, violence or abuse between any persons aged 16 or over who are, or who have previously been in a relationship, are intimate partners, or who are family members; regardless of gender or sexuality*.'[2]

3.1.2. Understanding the factors surrounding both victims and perpetrators of domestic abuse, is key to examining opportunities to intervene to support the victim and reduce risks from the perpetrator.

[1] Symptoms of schizophrenia but short duration
[2] Isle of Man Constabulary https://www.iompolice.im/advice/domestic-abuse/ [Accessed December 2021]

3.1.3. Data from Domestic Homicide Reviews in the UK,[3] highlights that approximately a quarter of homicides involved adult family members, the majority being adult children killing their parents. Research has highlighted the following dynamics and risk factors:[4]



3.1.4. These factors are described below, along with the relevance of this to Family K.

- Gender

3.1.5. Adult Family Violence (AFV) is gendered both in terms of victimisation and perpetration with 90% of perpetrators of adult family homicides being male and mothers and sisters being the main victims of fatal violence. This supports earlier research that found that matricide, though rare is most commonly perpetrated by adult sons.[5]

- Mental health issues

3.1.6. Mental health issues are the most common feature of perpetrators of AFV. This includes depression, self-harm, psychosis and paranoid schizophrenia. The Courts determined the homicide was directly attributable to Mark's schizophrenic illness.

3.1.7. As well as mental ill health being a risk factor for abuse perpetration, experiencing domestic abuse often leads to mental health problems.[6] Having mental ill health can also make a person more vulnerable to abuse.[7] Despite these strong associations, domestic abuse is often undetected within

[3] Domestic Homicide Reviews are part of the England and Wales Domestic Violence, Crime and Victims Act 2004 and became law from 13th April 2011. IOM do not have equivalent requirements for Domestic Homicide Reviews but use the Serious Case Management Review to identify learning where that criteria are met.
[4] Standing Together Against Family Violence: Adult Family Violence (AFV) Briefing Sheet https://static1.squarespace.com/static/5ee0be2588f1e349401c832c/t/5efcb376866b33242d04c3cb/1593619318736/AFV+Briefing+Sheet.pdf [Accessed December 2021] - Summarised dynamics and risk factors
[5] Heide KM, Frei A. (2010) '*Matricide: a critique of the literature. Trauma Violence Abuse.*' Jan;11(1):3-17. doi: 10.1177/1524838009349517. Epub 2009 Oct 28. PMID: 19875385. https://pubmed.ncbi.nlm.nih.gov/19875385/
[6] Oram, S., Khalifeh, H., & Howard, L.M. (2016). Violence against women and mental health. The Lancet Psychiatry, 4 (2): 159-170. https://DOI.org/10.1016/S2215-0366(16)30261-9
[7] Devries, K.M., Mak, J.Y., Bacchus, L.J., Child, J.C., Falder, G., Petzold, M., & Watts, C.H. (2013). Intimate partner violence and incident depressive symptoms and suicide attempts: A systematic review of longitudinal studies. PLoS Med 10(5): e1001439. DOI:10.1371/journal.pmed.1001439

mental health services.[8]SafeLives data, demonstrates that victims and survivors can have complex and interrelated mental health needs with multiple areas of disadvantage.[9] The areas of disadvantage highlighted within the data, such as financial difficulties, alcohol misuse and disability were all evident in Family K, as well as the long term depression that Mrs K experienced.

- Substance misuse issues

3.1.8. Drug and alcohol issues are a common feature in perpetrators of AFV. The role that substances played in Mark's life is not clear. Mr and Mrs K reported they were unsure whether Mark used substances, although his friend had described him as using cannabis heavily. The side effects of cannabis use can include feelings of confusion, anxiety and paranoia, agitation, and mild hallucinations.[10] From information presented to the Court, it is understood that Mark was not using substances at the time of the incident. However, there is substantial research regarding the adverse effect that substances can have in precipitating mental illness, particularly in young people.[11] His use of substances may have been a precipitating factor in him developing mental illness.

3.1.9. Mark also experienced living with parental problematic alcohol use. There is substantial research into the impact of problem drinking by parents on adolescent development. This includes the adverse impact on the young person's emotional development and modelling use of alcohol as a (ineffective) coping strategy.[12]

3.1.10. In relation to victims/survivors of domestic abuse, research highlights that many people use alcohol and substances as a mechanism to try and cope with abusive relationships. However, the use of drugs and alcohol, may increase their vulnerability to domestic abuse as well as create other problems in their lives.[13] This may have been relevant to Mrs K's experience.

- Caring relationships

3.1.11. Caring responsibilities linked to mental health and problematic substance use were a crucial feature in the background of the family relationship in AFV. This manifested in circumstances where the victim parent was a carer of the abusive adult child and where the abusive adult child

[8] SafeLives Spotlight 7 Safe and Well: Mental health and domestic abuse 2019 https://safelives.org.uk/sites/default/files/resources/Spotlight%207%20-%20Mental%20health%20and%20domestic%20abuse.pdf [Accessed December 2021]
[9] Ibid
[10] NHS: Cannabis the Facts https://www.nhs.uk/live-well/healthy-body/cannabis-the-facts/ Mephedrone, https://www.talktofrank.com/drug/mephedrone#the-risks ; NHS UK https://www.nhs.uk/conditions/anabolic-steroid-misuse/
[11] National Institute on Drug Abuse: Common Comorbidities with Substance Use Disorders Research Report Part 1: The Connection Between Substance Use Disorders and Mental Illness https://nida.nih.gov/publications/research-reports/common-comorbidities-substance-use-disorders/part-1-connection-between-substance-use-disorders-mental-illness [Accessed May 2022]
[12] Windle, Michael. "Effect of Parental Drinking on Adolescents." *Alcohol health and research world* vol. 20,3 (1996): 181-184. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6876511/ [Accessed December 2021]
[13] Alcohol Concern's information and statistical digest Grasping the nettle: alcohol and domestic violence Revised edition, 2010 Sarah Galvani, University of Bedfordshire https://equation.org.uk/wp-content/uploads/2012/12/Factsheet-Alcohol-and-Domestic-Violence.pdf [Accessed November 2021]

was a carer of a family member. Mark had been a young carer for his father from young adolescence until he left home. It is likely that Mark may have also provided a young carer role to his mother, Mrs K at times when she had been drinking heavily. Research highlights the adverse impact on physical and mental wellbeing of being a young carer.[14] Mark's responsibilities as a carer continued into his adult life, with the additional responsibility of caring for a relative, when his parents were incapacitated by alcohol.

3.1.12. Mrs K's role as a carer, was both in relation to Mr K and to the relative. She spoke of struggling with the role of caring for Mr K and it appeared she also struggled to consistently care for her relative**.**

- Instability, dependence, and social isolation

3.1.13. The research into AFV indicated a high degree of instability in the lives of those who committed the murders: inability to sustain employment due to mental health and associated issues, lack of stable, long-term relationships, transience; breakdown of intimate relationships; work-related stress etc. This in turn increased their financial and emotional dependence on their parents and other family members. Social isolation was an additional poignant feature in the lives of perpetrators.

3.1.14. Mark was coping with the challenges of life transitions that many young adults face. Potentially, the prospect of returning to the family home after a period of living away, presented additional stress for him, particularly when magnified by the imposed social isolation due to Covid restrictions.

3.1.15. It is not clear what Mrs K's experience was – the degree of financial and emotional dependence or the social networks she could draw upon. Police interactions suggest she had some friends that she could go to. She had regular periods away but it is thought this was to visit a relative, which brought further caring responsibilities.

- Lack of a clearly defined 'primary' victim

3.1.16. Abusive behaviours most often take place within a wider context of family violence, with the perpetrator offending against other family members and siblings, as well as displaying patterns of threatening behaviour towards intimate partners. The research indicates risk needs to be considered for all family members living in the home, for example in considering bail arrangements.

3.1.17. In Family K situation, there was no known history of abuse from Mark until the weeks preceding the homicide. His behaviours on the night of the index offence, and subsequent information from him about his beliefs at that time, indicate that the whole family were at severe risk from him.

[14] Scottish Government Young carers: review of research and data 2017 https://www.gov.scot/publications/young-carers-review-research-data/pages/4/ [Accessed December 2021]

3.1.18. Mark had been living with parental domestic abuse for at least his adolescent years. There has been substantial research into the adverse impact of domestic abuse on children and young people – the impact extends well beyond the immediate physical risks of being caught up within a violent episode. Domestic abuse impacts upon the young person's development and whole wellbeing. The adverse psychological and emotional can have enduring effects.

3.1.19. Children are individuals and may respond to witnessing abuse in different ways, but gender seems to play a role. For example, older boys may play truant and start to use alcohol or drugs to try and block out disturbing experiences and memories.[15]

3.1.20. Children may feel angry, guilty, insecure, alone, frightened, powerless or confused. They may have ambivalent feelings towards both the abuser and the non-abusing parent. Witnessing abuse can impact on the child's relationships as an adult. Some studies referenced the heightened risks of a boy who sees their mother being abused, being ten times more likely to abuse their female partner as an adult.[16]

3.1.21. However, Women's Aid challenged this intergenerational theory of domestic abuse i.e. that children growing up with parental domestic abuse are more likely to continue the cycle within their own relationships, either as victims or as perpetrators. They highlighted that the research findings are inconsistent, and there is no automatic cause and effect relationship, advocating for improved educational programmes focusing on healthy relationships as part of standard school curriculum.[17]

- Absence of 'visible' high risk and lack of engagement

3.1.22. Family members affected by abusive behaviours are often less likely to engage in support with police, prosecution, or Independent Domestic Violence Advisors (IDVA). They are more likely to minimise their safety concerns and less able to formally articulate their experience as 'abuse'. This could in turn reinforce assumptions made by key professionals, such as police, about their level of risk. Not all questions on the DASH RIC[18] are fit-for-purpose in cases of AFV: analysis of Adult Family Homicides found that risk assessments had only been completed with a third of victims.

3.1.23. While in latter months, Mrs K had talked to some professionals about Mark's changing behaviours, sadly, his incident of violence toward Mrs K just prior to the fatal incident, was not known until Mr K disclosed this following the homicide.

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[15] Royal College of Psychiatrists Factsheet https://www.rcpsych.ac.uk/mental-health/parents-and-young-people/information-for-parents-and-carers/domestic-violence-and-abuse-effects-on-children [Accessed December 2021]

[16] Vargas, L. Cataldo, J., Dickson, S. (2005). Domestic Violence and Children. In G.R. Walz & R.K. Yep (Eds.), VISTAS: Compelling Perspectives on Counseling. Alexandria, VA: American Counseling Association; 67-69. Quoted in Office on Women's Health Effects of domestic violence on children https://www.womenshealth.gov/relationships-and-safety/domestic-violence/effects-domestic-violence-children [Accessed December 2021]

[17] Women's Aid https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/impact-on-children-and-young-people/ [Accessed December 2021]

[18] The Domestic Abuse, Stalking and Harassment and 'Honour'-based violence **Risk** Indicator Checklist

3.1.24. Psychiatric assessment has identified Mark's mental illness as the primary factor that led to the homicide. However, the prevalent features identified from research into AFV appear to have also been relevant in Family K, particularly in understanding precipitating factors for mental illness.

Learning Point 1: Use Research from Domestic Homicide Reviews

- Understanding the factors surrounding both victims and perpetrators of domestic abuse, is key to examining opportunities to intervene to support the victim and reduce risks from the perpetrator.
- If learning from Domestic Homicide Reviews is going to make a difference to practice, there is a need for Safeguarding partnerships to disseminate that learning.
- Use research to strengthen policy and practices responses in domestic abuse involving Adolescent to Parent Violence, Adult Family Violence as well as within Intimate Partner Relationships.

3.2. Opportunities for Earlier Intervention with Family K

3.2.1. The review considered whether there were earlier opportunities to have intervened with Family K in relation to the dynamic and risk factors described in 3.1. above.

• Earlier Support to Mark

3.2.2. It has not been possible to hear from Mark and understand what life was like for him. It seems clear that Mark had multiple adverse childhood experiences (ACEs) including family instability, domestic violence, caring responsibilities, and long-term parental alcohol misuse. It is not clear whether this had been a lifelong experience for Mark or whether this had worsened following his father's injury.

3.2.3. Experiencing ACEs is not an excuse for perpetration of abuse, but building an understanding helps to identify potential ways that services can reduce future risks of young people perpetrating abuse.

3.2.4. Policy emphasises the important role that schools can play in mitigating against ACEs.[19] However, Mark's school were largely unaware of his home life. Mark was described as a quiet, stable, well turned out 'normal' boy with no presenting concerns. He engaged well with his tutors and there was no indication he needed additional support. The only area of concern in his later school years was his attendance, which was seen as the reason for his deterioration in academic results.

[19] NHS Scotland Tackling the attainment gap by preventing and responding to Adverse Childhood Experiences (ACEs) 2017 http://www.healthscotland.scot/media/1517/tackling-the-attainment-gap-by-preventing-and-responding-to-adverse-childhood-experiences.pdf [Accessed December 2021]

3.2.5. Mark was identified in the school electronic records as being a Young Carer, but it is not clear how this assessment was made, nor what difference this made to the support he then received.

3.2.6. The author of the Department of Education, Sport and Culture report to this review, observed that while the school had taken the expected steps to address Mark's school attendance, e.g. writing to his parents, there was a general lack of professional curiosity in exploring further the reasons for the fall off in his attendance.

3.2.7. The contacts that were made with Mr K relating to Mark's attendance, referenced on one occasion to Mark having an '*undiagnosed illness'* and on another occasion, Mark having a '*difficult time'* and supporting his parents with their health issues. It is not clear whether his tutor was able to follow this up with Mark, giving him the opportunity to talk about home life.

3.2.8. School was also unaware of any parental domestic abuse although this had been known to other services. Mrs K had spoken to the Adult Generic Team Social Worker about domestic abuse from Mr K. The records indicate the social worker provided advice and support to her, signposted her to a refuge, and tried to mediate with Mr K. The fact that this meeting with Mr K, was with Mrs K and Mark present was not well-informed practice. It was not appropriate to involve a young person in this discussion. Raising the disclosure of abuse, can also increase the risk of further violence and requires careful planning, working with the survivor.[20] The social worker did talk to Mrs K about the potential impact of domestic abuse on Mark as a young adolescent – there was no record of a referral to Children's Social Care and no communications with school.

3.2.9. Mr K appeared to be drinking heavily over this period. Within a few months, he was convicted of public affray against a hospital consultant. There was no evidence that hospital or police considered what it must be like to live in this environment, and nor was there any liaison with school, Children's Services or his Adult Generic Team Social Worker.

3.2.10. When Mrs K attended hospital with domestic abuse injuries, the hospital did alert Children's Social Care. They wrote to Mrs K providing contact points for support and outlining the potential impact on children living with domestic abuse. This was a standard response for a first referral, taking account of risk factors such as Mark's age. At the time, Mr K's social worker from the Adult Generic Team Social Work team was still involved. However, there did not appear to be any interaction between Children's Services and Adults Social Care. Mr K's social worker would have had a wealth of information regarding previous incidents of domestic abuse while Mark was in the household. They could also have commented on parenting capacity along with family/environmental factors relevant to a risk assessment. One month after this referral, Adult Social Care ended their involvement, apparently unaware that Children's Services had been involved.

3.2.11. Contributors to the review, reflected that Adult Social Care and Children's Services were both working in isolation. The fact that the services use different recording systems did not make cross working easy, but there also appeared to be an absence of 'Think Family' approach.

[20] LGA ADASS Adult safeguarding and domestic abuse – a guide to support practitioners and managers https://www.local.gov.uk/sites/default/files/documents/adult-safeguarding-and-do-cfe.pdf [Accessed February 2022]

3.2.12. Think Family is '*making sure that the support provided by children's, adults' and family services is co-ordinated and focused on problems affecting the whole family –it is important for everyone and is the only effective way of working with families experiencing the most significant problems*.'[21]

3.2.13. The aims of Think Family approach were wholly relevant to Family K:

- Identify families at risk of poor outcomes to provide support at the earliest opportunity
- Meet the full range of needs within each family they are supporting or working with
- Develop services which can respond effectively to the most challenging families
- Strengthen the ability of family members to provide care and support to each other.

3.2.14. Had the information about family circumstances been known to Children's Services, this *may* have triggered further inquiry with school and led to support being offered for Mark through Early Help services. Findings regarding Think Family have also been highlighted in another recent SCMR within IOM – 'Child J' highlighting the need for professionals to use 'reachable moments' to intervene.[22]

3.2.15. Children's Services did notify the Police about the referral, but Mark's school remained unaware of this, or previous incidents of domestic abuse.

3.2.16. In recent years, many Safeguarding Children Partnerships have initiated an automatic notification system for domestic abuse incidents where school age children are in the household. Police send the relevant school a secure notification of all domestic incidents. This enables the school to be aware of safeguarding concerns and to provide advice, care and support to the child, liaising with partner agencies if required.

3.2.17. Many areas including the IOM did not have this system in place at that time (section 4 details recent implementation). Had this notification system been in place within the IOM, Mark's school would have had greater insight into his home circumstances – the emotional impact of domestic abuse and the contextual circumstances in which it occurred including parental alcohol use and carer strain. This would have offered his tutors the opportunity to provide that crucial additional nurturing response that we know can make the vital difference to reducing long-term impact of adverse childhood events. School could have mobilised support services such as for Young Carers and young people's mental health. It is positive to note the developments since this time, in responding to incidents of domestic abuse. However, the IOMSB should assure itself that these measures are leading to positive outcomes i.e. relating to information sharing and multi-agency responses following a domestic abuse incident.

Learning Point 2: Think Family

- Taking wider family needs into account when helping individual family members is key to achieving successful outcomes for children and adults experiencing difficulties.
- Practitioners need to embody a Think Family approach, both in early preventative support and in safeguarding responses to families.

[21] Department for Children Schools and Families 2009 Think Family Toolkit Improving support for families at risk Strategic overview https://dera.ioe.ac.uk/9475/93/Think-Family_Redacted.pdf [Accessed December 2021]
[22] Isle of Man Safeguarding Board Child J-SCMR 2021

- 'Think Family' is a key message in working with domestic abuse. All practitioners need to consider the risks and vulnerabilities of all people within the household, particularly children and young people and ensure there is robust information sharing and multi-agency responses.

Recommendation 1:
The IOMSB should assure itself that there are robust measures in place for responding to incidents of domestic abuse, including considering the risks and vulnerabilities of all people within the household, particularly children and young people.

3.2.18. Contributors to the review emphasised the need to do more to raise awareness of young carers needs, to ensure young carers are identified and supported. Manx Care has also identified a need to map out the provision of carer support services in the IOM. This will inform the development of a carers' strategy, discussed in section 4 below.

3.2.19. There is substantial research into the prevalence of adverse childhood events and adults with schizophrenia.[23] It is not possible to say whether earlier intervention would have reduced the risk of Mark subsequently developing mental illness or whether this would have changed the course of events that followed. Nonetheless, it does reinforce important learning. It also reinforces learning outlined in the IOM SCMR, Child J, and a recommendation relating to an early help strategy with a professional framework to improve professional's knowledge and understanding of the impact of ACE's. This review supports that recommendation.

Learning Point 3: Mitigating against Adverse Childhood Experiences

Schools can play a vital role in mitigating against Adverse Childhood Experiences.

- Children and young people may mask difficulties they are experiencing in their home lives. Grasp opportunities to use professional curiosity to explore what is happening within a family rather than accepting things at face value.

- Identifying a child or young person as a carer within the school records needs to be followed by a dynamic assessment of the impact of caring, and lead to a support plan.

- Systems that notify schools of domestic abuse incidents where children are within the household, enable schools to provide early help to children living with domestic abuse.

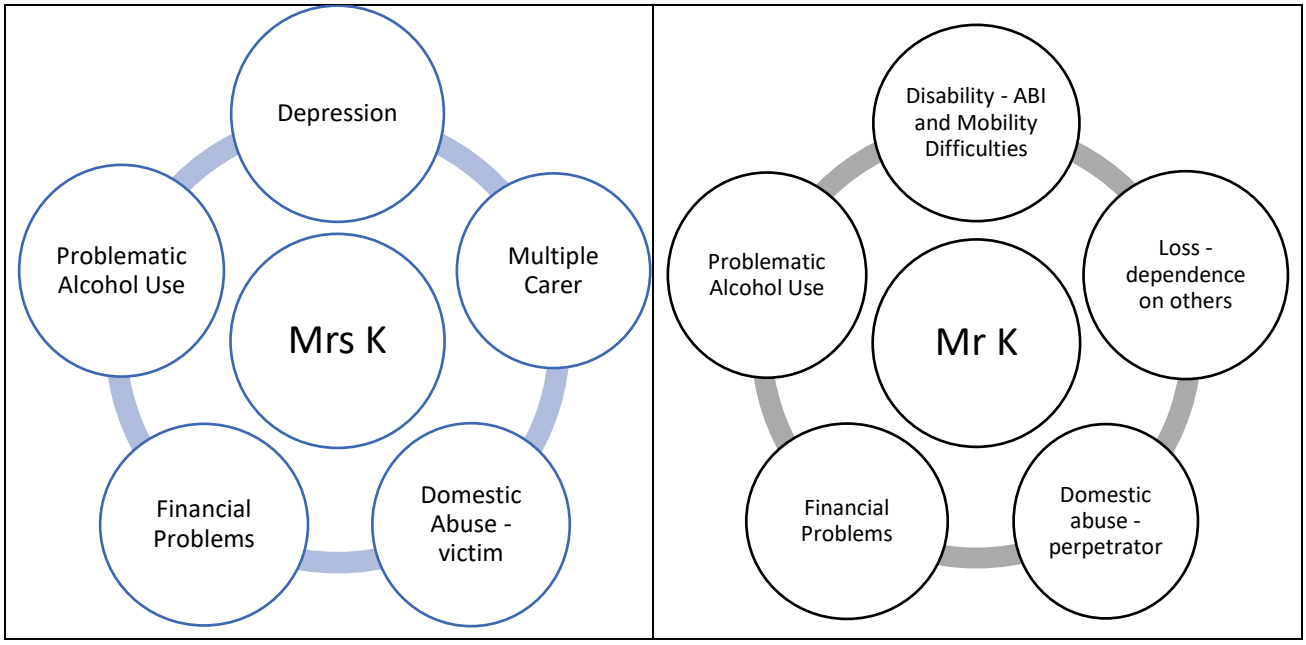
Recommendation 2:
Manx Care Social Care should lead an awareness raising campaign about being a young carer. The campaign should target key services for children and young people and provide:
i) Information on the impact of being a young carer

[23] Vallejos M, Cesoni OM, Farinola R, Bertone MS, Prokopez CR. Adverse Childhood Experiences among Men with Schizophrenia. Psychiatr Q. 2017 Dec;88(4):665-673. doi: 10.1007/s11126-016-9487-2. PMID: 27957657. https://pubmed.ncbi.nlm.nih.gov/27957657/ [Accessed January 2022]

ii)	Guidance on the difference that agencies can make to the young carer
iii)	Tools and aids to help agencies generate support plans and signpost to support services

- Earlier Support to Mr and Mrs K

3.2.20. Mr and Mrs K had many inter-related stress factors:



3.2.21. Records indicate that Mr K was struggling to adjust to his disability acquired through an injury. His disability left him without work, he had lost mobility and his independence. There were reports of aggressive behaviours from Mr K toward hospital staff while intoxicated, as well as to Mrs K – it is not clear how much his behaviours were associated with his acquired brain injury or how long there had been problematic alcohol use.

3.2.22. There was support provided to Mr K at that time from the Adult Generic Team Social Work team, as well as from Health services. As noted above, the records indicate the Social Worker provided some responses to Mrs K's disclosures of domestic abuse – offering advice about options and holding a family meeting to discuss his behaviours, (and the potential legal consequences of this) and his alcohol use.

3.2.23. Alcohol seemed to be a significant feature in both Mr and Mrs K's lives and was reported in all incidents of domestic abuse. The World Health Organisation highlights that '*alcohol consumption, especially at harmful and hazardous levels is a major contributor to the occurrence of intimate partner violence and links between the two are manifold.*'[24]

[24] World Health Organisation Intimate partner violence and alcohol https://www.who.int/violence_injury_prevention/violence/world_report/factsheets/fs_intimate.pdf [Accessed December 2021]

3.2.24. The review considered whether professionals used opportunities to support Mr and Mrs K to address their alcohol use. The cycle of behavioural change is well established in alcohol and substance misuse services – this plots the different stages of motivation in addressing problematic use.[25] Tackling problematic alcohol use, must be driven by the person. However, professionals can provide an important role in the pre-contemplative stage, using opportunities where the person may be more open to change, to build their motivation and engage in harm reduction measures.

3.2.25. There were multiple references to different agencies talking to Mr and Mrs K about their drinking and offering referral onto specialist services. Both repeatedly denied having any problems with drinking and declined any offers of support to control their drinking. Neither Mr nor Mrs K appeared to be ready, or able to change.

3.2.26. It may be that Mrs K would not have been ready to address her alcohol use while living with domestic abuse. Survivors of domestic abuse can become caught up in a dichotomy where alcohol provides some short-term relief from an intolerable life, but alcohol also increases vulnerability and dependency, trapping them within an abusive lifestyle. The Stella Project Toolkit[26] discussed the prevalence of co-occurring problematic alcohol misuse and being a survivor of domestic abuse. It highlights the need for services to work with women to limit the harm caused to themselves and others by the alcohol use.

3.2.27. Motivational Interviewing is an evidence-based intervention, addressing ambivalence to change. Motivational interviewing may have been a useful intervention with Mr and Mrs K. However, this is not an area that Health or Social Care practitioners in the IOM were generally skilled in other than those working in specialist areas such as drug and alcohol services. Whilst this is an essential skill set for substance misuse practitioners, other professionals also need to be skilled in Motivational Interviewing techniques as a first step in the pathway to support people to engage in those specialist services.

3.2.28. The IOM Substance Misuse Strategy 2018-2023[27] includes within its strategic objectives:

- Review the existing treatment and rehabilitation system by using an evidence-based approach
- Ensure all relevant agencies work together to enhance the chances of a meaningful and sustained recovery

3.2.29. The strategy acknowledged gaps in the provision of brief advice interventions. Agencies across IOM need to apply the public health ethos of 'Making Every Contact Count,'[28] using opportunities when interacting with people who may have problematic drug and alcohol use, to support behaviour change, in a purposeful and informed way. Extending training on Motivational Interviewing to

[25] World Health Organisation (2003) Intervention for Substance Use: Brief Intervention for Substance Use: a Manual for Use in Primary Care -Draft https://www.who.int/substance_abuse/activities/en/Draft_Brief_Intervention_for_Substance_Use.pdf [Accessed November 2021]
[26] Stella project Toolkit https://avaproject.org.uk/wp/wp-content/uploads/2016/08/Stella-Project-Toolkit-2007.pdf [Accessed November 2021]
[27] Isle of Man Government Substance Misuse Strategy 2018 – 2023 https://www.gov.im/media/1374063/substance-misuse-strategy.pdf [Accessed December 2021]
[28] Making Every Contact Count https://www.makingeverycontactcount.co.uk/ [Accessed February 2022]

some key professionals such as nurses, GPs, social workers and third sector, may support the strategic objectives and prove effective in engaging more people in specialist substance misuse services.

3.2.30. The police reflected on their responses to the three incidents of domestic abuse in the 2 years leading up to Mrs K's homicide.

3.2.31. There were many aspects of good or expected practice. Police attended all incidents and spoke with Mr and Mrs K separately. Mrs K was clear she did not wish to pursue any charges and neither wanted to separate from the other. Police carried out appropriate risk assessments, including history of violence, aggravating factors such as mental health, drugs and alcohol use and whether either party was being coerced and controlled. Officers took steps to diffuse the situation and tried to encourage engagement in support services, gaining consent to refer on for Social Care.

3.2.32. The author of the police report to this review, felt that the risk assessments had been graded appropriately though questioned whether the last incident should have been rated as medium risk given it was the third incident within a twelve-month period.

3.2.33. It was positive that police gained consent to send a MARF to Social Care. The MARF to the AST, referenced the current incident of domestic abuse but did not reference the two earlier incidents the previous year and so the AST was unaware of that history. Police clarified that their ability to collate domestic abuse incidents, had been impeded by lack of Domestic Abuse legislation i.e. unless there had been physical assault, police could not record a crime. This made it hard for police to build a picture of risk in non-physical abuse incidents of domestic abuse.

3.2.34. The MARF from the police, did reference the many stress factors within the household – difficulties arising from Mr K's medical conditions -acquired brain injury, his mobility issues, domestic abuse, alcohol misuse, self-neglect and poor physical environment and carer stress.

3.2.35. The author of the Social Care report to this review, felt that the response by Social Care fell below expected practice. The MARF should have led to further assessment, given the range of stress factors within the family environment. The AST did attempt to contact Mrs K but then made no further attempts. This was based on practice at that time of follow up to 'no responses', only after three MARFs. Repeat referrals is one risk indicator but should not be the sole risk factor taken into account. As noted in section 4, this practice has subsequently been revised.

3.2.36. The Social Care author felt that the AST had considered the MARF in isolation from other information and there should have been more discussion with Adult Social Care teams before closure. They raised concerns, (shared by the Independent Reviewer), that the current recording system within the AST was not being used effectively to collate a chronology from significant events recorded elsewhere on the system.

3.2.37. The author also commented that the response reflected findings from an independent review of Safeguarding Adults in 2020.[29] This raised concerns about over-reliance on unqualified workers within the AST, recording systems not being fit for purpose and the poor inter-face between Adult

[29] Isle of Man Safeguarding Board Interim Report Review of Multi-agency Safeguarding Adults Arrangements in Isle of Man 2020

Safeguarding and domestic abuse. Recommendations from that review are being addressed through the IOMSB processes and so are not reiterated here.

3.2.38. It seemed that different agencies had different pockets of information about domestic abuse. This was not brought together to give a clear chronology that could then inform risk assessment and protection planning. This is fundamental to effective responses to domestic abuse.

3.2.39. The SaferLives DASH[30] is a risk assessment tool that is adopted across the UK. This provides a standardised, and universally understood means of assessing risks. Use of DASH helps agencies to build a chronology that highlights escalation in frequency and severity. Agencies confirmed that at the time, DASH was used by the police in the IOM, but not by other agencies.

Recommendation 4

3.2.40. When Mrs K attended hospital with domestic abuse injuries, there is no indication that professionals used this disclosure to assess risks, including grounds to share information without consent based on degree of risk and children within the household. There was no evidence that her disclosure was recognised as a reachable moment to help her consider options and supports. A recommendation has been made regarding IOMSB assurance relating to responses to domestic abuse.

3.2.41 The fact that only one agency was using DASH, undermined the effectiveness of this risk assessment tool as a multi-agency response to domestic abuse. Key professionals, such as the GP, were unaware of the domestic abuse. The referral by Mrs K's GP to mental health services for a review of her long-term depression, was good practice. The response by mental health services also demonstrated good practice in the timeliness of their response and their repeated attempts to engage Mrs K. Their assessment explored possible psychosocial stress factors, such as her role as carer and the past incidents of domestic abuse, including physical abuse a year earlier. Mrs K had not wanted to discuss the domestic abuse further. However, the fact that Mrs K had shared that information, did present as an opportunity to try and draw her out more about her experience of domestic abuse and help her explore supports and options for her safety. The worker had discussed support options for Mrs K as a carer and talking therapies for her – an appropriate response to her assessed mild depression and anxiety. However, Mrs K declined.

3.2.42. In the follow up liaison between mental health and Mrs K's GP, it was good practice that the GP offered to arrange for a Carer's Assessment by the Practice – trying different avenues to support Mrs K. However, there is no record that the carer's assessment was followed up. It is not clear whether this was because the carers assessment was not requested, or that an assessment was offered to Mrs K and declined.

3.2.43. Mental Health services omitted to share the information about domestic abuse with the GP and it is not clear whether consent to do so was sought. GPs can play a central role in supporting victims of domestic abuse. Domestic abuse was likely to be an underlying factor in Mrs K's long-term depression and was important for the GP to understand for her ongoing mental health treatment. The GP was also in a prime position to assess escalating risks and to try and engage Mrs K in

[30] Domestic Abuse Stalking Harassment and 'Honour based' Violence Risk Indicator Checklist https://safelives.org.uk/sites/default/files/resources/Dash%20for%20IDVAs%20FINAL_0.pdf

support services. Mr K was also registered with the GP Practice. Understanding the family dynamics could help explore and address underlying factors for his abusive behaviours – for example, counselling/anger management; alcohol risk reduction; assessment and treatment for acquired brain injury.

3.2.44. The author of the Manx Care report for Health services highlighted the significant gap in the IOM that GPs are not notified of domestic abuse incidents, and that GPs did not share disclosures about domestic abuse with health colleagues. In their experience, GPs were also not routinely asked for patient information for Adult Safeguarding enquiries relating to domestic abuse (as evidenced on this occasion). The Health author called for improved information sharing of domestic abuse incidents with Health professionals.

Learning Point 4: Role of GPs in Safeguarding Adults and Children

GPs play a key role in safeguarding and working with adults and children affected by domestic abuse and there needs to be effective arrangements in place to ensure their involvement including information sharing.

Recommendation 3

DHSC, working in partnership with Manx Care, should assure there are robust processes in place to correctly identify an adult or child's registered GP. Assurance should also be sought that GP's are involved as key multi-agency partners in responses to safeguarding and domestic abuse concerns and that information is shared in line with the permissive provisions of GDPR, IOMSB policies and professional guidance[31]

3.2.45. Information sharing is important across the partnership. The College of Policing references that '*Cooperation between agencies is important to help reduce the risk of cases slipping through the safeguarding system and stopping domestic abuse at an early stage or preventing it from happening in the first place. It makes it possible to see the whole picture, facilitating:*

- *early effective risk identification*
- *improved information sharing*
- *joint decision making*
- *coordinated action to assess, manage and reduce risk.*'[32]

3.2.46. Multi-agency Risk Assessment Conferences (MARAC) have been in place across the UK since 2006 with over 290 MARACs managing approximately half a million cases a year.[33] MARACs are meetings where information on the highest risk domestic abuse cases is shared between local agencies with the aim of safeguard victims (including children), manage perpetrators' behaviour, safeguard professionals, and make links with all other safeguarding processes.

[31] Royal College GP: Adult Safeguarding Toolkit https://elearning.rcgp.org.uk/mod/book/view.php?id=12530&chapterid=349. Royal College GP Child Safeguarding Toolkit https://elearning.rcgp.org.uk/mod/book/view.php?id=12531

[32] College of Policing Major investigation and public protection Partnership working and multi-agency responses/mechanisms https://www.app.college.police.uk/app-content/major-investigation-and-public-protection/domestic-abuse/partnership-working-and-multi-agency-responses/ [Accessed December 2021]

[33] https://safelives.org.uk/practice-support/resources-marac-meetings/latest-marac-data

3.2.47. Research by CAADA (Coordinated Action Against Domestic Abuse) referenced MARACs as '*the single most important advance in protecting adult victims and their children since the introduction of refuge provision in the 1970s. They combine the best that specialist services have to offer in terms of working with victims, together with the resources and authority of a range of statutory agencies. They represent the most effective use of public resources; focusing on the highest risk victims while addressing the needs of children early*.'

3.2.48. The economic cost of domestic abuse is substantial. A Home Office Report from 2019, estimated the annual cost in England and Wales to be £66 billion.[34] CAADA's cost analysis in 2010, estimated that MARACs save on average at least £6100 per victim.[35]

3.2.49. A review of the IOM Multi-Agency Public Protection Arrangements in 2016 recommended the introduction of a MARAC in the IOM and although this is not yet in place, work is actively ongoing to set up appropriate public protection arrangements. . As noted, MARACs are aimed at managing the highest risk domestic abuse cases and it is unlikely that the reported domestic abuse incidents to Mrs K would have reached this threshold. However, many areas in the UK are developing systems that facilitate information sharing below the MARAC threshold[36] giving opportunity for support and risk reduction. The review heard that the IOM has been hindered by the lack of legislation to share information, (although some information can be shared lawfully within the parameters of the General Data Protection Regulations). Section 4 below outlines developments that will enable this crucial function to be established. This work needs to be progressed at pace as part of a range of measures for domestic abuse.

3.2.50. Identification of domestic abuse needs to be followed by meaningful support – supporting survivors emotionally, giving time to talk through their experience of abuse; reviewing different options to keep them safe, and working across agencies to coordinate safety plans.

3.2.51. Independent Domestic Abuse Advisors (IDVA) provide a key role in all these areas. IDVAs are a core part of domestic abuse services within the UK. IDVA's are increasingly based in services such as ED departments, so that they can be available at crucial points to engage with people presenting with domestic abuse injuries. There is no commissioned IDVA provision on the IOM.

3.2.52. The lack of IDVA provision in IOM is very concerning. Mrs K had disclosed abuse to police, to nurses at the hospital, to Mr K's social worker and to the mental health service but the support options that any of those professionals could offer her were extremely limited.

3.2.53. Research repeatedly demonstrates the barriers that victims face in disclosing. Many may not be ready or able to report incidents to police. Leaving their homes to go to a refuge is a massive

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[34] Home Office 2019 The economic and social costs of domestic abuse Research Report 107 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/918897/horr107.pdf [Accessed January 2022]

[35] CAADA Saving Lives, Saving Money 2010 https://safelives.org.uk/sites/default/files/resources/Saving_lives_saving_money_FINAL_REFERENCED_VERSION.pdf [Accessed January 2022]

[36] Example: https://equation.org.uk/product/domestic-abuse-referral-team-dart-process/

under-taking, that many victims are not able to contemplate. IOM does have a Victim Support service – one member of staff opted to be trained as an IDVA. However, this is neither a dedicated service and nor is it resilient. Working with survivors of domestic abuse is a specialist role and requires dedicated and trained practitioners.

3.2.54. A large-scale evaluation of IDVA services across England and Wales[37] assessed the efficacy of IDVAs in enhancing the safety of victims and children. The findings confirmed the positive effect IDVAs had in the cessation of abuse (57% of victims) and that 79% of victims felt safer following the support by IDVAs. This indicates value both in reducing the human cost, and the economic cost of domestic abuse.

3.2.55. The IOM is due to enact the Domestic Abuse Act but there is currently no timeline for its implementation and the regulations/statutory guidance behind it. Legislation is an essential component in supporting victims and controlling perpetrators but is not a panacea to keeping people safe from domestic abuse. It must be supplemented by systems that support multi-agency information sharing, specialist support and effective protection planning.

3.2.56. Contributors to the review described the limited training provision in domestic abuse. Some agencies such as police, provide training to all probationers. Other agencies such as hospital, have provided training to staff in higher risk areas such as Emergency Department and neo-natal care. However, other agencies such as Adult Social Care and Mental Health have very limited training provision. This is concerning, particularly given the prevalence of domestic abuse to people with mental health needs[38]and other care and support needs. The representative from schools, also raised the limited training they received in domestic abuse which, given the relevance to ACE outlined in 3.2, is a significant gap.

3.2.57. Community Safety Partnerships (CSP)were established in statute in England and Wales.[39] This provides the multi-agency senior leadership that is necessary to drive a strategic response to domestic abuse. CSP set priorities for development as well as holding accountability for the quality of services provided to survivors. There appears to be no such function within the IOM.

Learning Point 4: Responding to Domestic Abuse in the IOM

Effective responses to domestic abuse require a multi-faceted approach if risks to victims are to be reduced.

Domestic abuse needs a multi-agency strategic approach. Legislation needs to be accompanied by specialist services; shared risk assessment tools; effective muti-agency communication and protection planning. This is wholly lacking in the IOM and constrains the ability of practitioners to support victims and disrupt perpetrators.

[37] Howarth, E.; Stimpson, L.; Barran, D. and Robinson, A. (2009) Safety in Numbers: A Multi-site Evaluation of Independent Domestic Violence Advisor Services. London: CAADA. https://www.london.gov.uk/sites/default/files/gla_migrate_files_destination/Appendix%20F%20IDVA%20Literature%20Review.pdf [Accessed January 2022]
[38] SafeLives Spotlight 7 Safe and Well: Mental health and domestic abuse 2019 https://safelives.org.uk/sites/default/files/resources/Spotlight%207%20-%20Mental%20health%20and%20domestic%20abuse.pdf [Accessed December 2021]
[39] Crime and Disorder Act 1998

Recommendation 4

This review has highlighted that the IOM lacks the basic infra-structure required to respond to Domestic Abuse. This will seriously compromise the safety of IOM citizens experiencing domestic abuse and there is a pressing need to address this.

i) The review recommends this review is shared with the IOM Department of Home Affairs to inform the implementation of its Domestic Abuse strategy.

ii) The review highlighted the following components that should be factored into the IOM Department of Home Affairs implementation planning:

- Legislation enacted
- Strategic forum for multi-agency senior leadership to drive forward the strategy
- Specialist and dedicated support services including IDVAs
- Adoption across agencies of a shared, evidence- based risk assessment tool e.g. SafeLives DASH risk checklist, and agencies building chronologies of incidents
- Establish structures for multi-agency risk management meetings
- Develop workforce competence in domestic abuse to enable proactive contribution in identification of domestic abuse and multi-agency protection plans.

iii) The implementation of the strategy should access the expertise of Domestic Abuse sector specialists and survivors of domestic abuse, to inform prioritisation and implementation.

3.3. Responses Leading up to the Fatal Incident

3.3.1. Sections 3.1. and 3.2. explored the risk factors that statistically are known to increase risks of AFV (actuarial risk factors). Learning from this is important for earlier preventative involvement. As noted, the Court accepted the psychiatric assessment that Mark was experiencing a psychotic episode at time of the fatal assault.

3.3.2. Mr K's view was that there was evidence of Mark repeatedly breaching the Covid isolation requirements and that had Mark been arrested and imprisoned for this, he would have been unable to have killed his Mother. Mr K did not offer a view about Mark's mental illness or whether the fatal incident could have been foreseen. Learning from this review had to consider Mark's clinical risk factors in the weeks leading up to the homicide i.e. whether Mark's history and presenting behaviours indicated he was a risk of violence to others.

3.3.3. Reviews must be cautious of hindsight bias – evaluating actions on an outcome which could not have been seen at the time.

3.3.4. Four months prior to the homicide, the CRHTT had five phone calls within a five-week period, expressing concerns about Mark's behaviours. Four of these calls were responded to by the same practitioner so the escalation of concerns was known.

3.3.5. The factors that CRHT had to weigh in assessing risk included:

Severity and Likelihood	**History**	• Mark had no known history of mental illness • Mark had no known history of aggression or violence
	Presenting Behaviours	Change in behaviours identified. Potential explanations for behaviours may include: • Emerging mental illness • Substance misuse • Psycho-social family dynamics e.g. tense relationships following return home after University • Combination of those or other factors
	Current harm to self or others	• Initial reports from Mark's friend and mother that there was no identified risk to Mark or from Mark to others • Calls four and five referenced i) Threat of punching mother ii) Head butted a friend while drunk
	Mitigation – Support Networks	• Mark appeared to have support from a friend and his mother. • CRHT believed he was registered with a GP

3.3.6. CRHT recognised that further assessment was needed. However, options for this were limited. Mark was not willing to engage with CRHTT. There was nothing to indicate lack of capacity and given the presenting risks, there were no grounds to pursue compulsory assessment/treatment under the IOM Mental Health Act 1998.

3.3.7. Given these circumstances, the response by CRHTT was reasonable i.e. that the friend and Mrs K would encourage Mark to see the CRHTT; try and take Mark to his GP; advice given if matters deteriorated – police, Mental Health Act assessment, ED. Arguably, given the repeated calls and escalation of concerns, it may have been desirable for the CRHTT to have provided an outreach role. It may also have been desirable for CRHTT to have made direct contact with the GP to discuss concerns (as the DART team had done with Mrs K's referral). This would have alerted CRHTT to the fact that Mark was not registered, and they could then have factored this into their assessment, advice and responses to Mrs K.

3.3.8. At the time, CRHTT did not have the resources nor the function to be able to make more proactive outreach. CRHTT followed expected practice of notifying the person's GP. The fact that their electronic system did not have Mark's current GP highlighted, is a systems issue for Manx Care. It is

concerning that though the GP Practice attempted to re-direct the communication to Mark's registered GP via Manx Care, this was never received by that GP and nor was CRHTT as the referrer, notified of the miscommunication.

3.3.9. It is unlikely that in this instance, this break in communication would have made the substantive difference to the outcome. Even had Mark's GP been aware of the communications, it seems unlikely that Mark would have attended an appointment, and the GP would not have had grounds for more assertive outreach. Nonetheless it is important for future clinical and safeguarding practice, that Manx Care investigate and resolve this systems issue.

Recommendation 3

3.3.10. A further opportunity to understand Mark's risk factors was through the Safeguarding Adult response to concerns about Family K's relative, three weeks before the homicide. District Nurses had tried to engage with Mark when they recognised the limitation of other family members in providing care to the relative. Their attempts to establish a relationship with him, as well as identifying and escalating concerns through safeguarding, was good practice.

3.3.11. Social Care identified some general learning points regarding the response to the relative, including the need to strengthen considerations of capacity within Making Safeguarding Personal and to improve the structure, timeliness and quality of the protection plans arising from the concerns.

3.3.12. In relation to the terms of reference for this review, contributing agencies felt that 'Think Family' needed to be more prominent in the multi-agency safeguarding response i.e.:

- What was known about others within the care environment?
- Were there others with care and support needs?
- What was known about assets and the risks to/from those providing care?

3.3.13. The review considered how effective the Inter-Agency Referral Discussion Group (IRDG) was in understanding the family dynamics and drawing out issues of risk. It is not feasible nor legally justifiable for every Safeguarding Adult referral to gather information about others within the household. However, those agencies involved in that meeting, did hold information that was very relevant to the concerns being raised about Family K's abilities to meet the relative's care needs:

- Reliance on Mark to provide care to the relative
- Recent concerns reported to mental health services about Mark's behaviours.
- The longitudinal picture of carer stress, domestic abuse and problematic alcohol use by Mr and Mrs K

3.3.14. Mental health services and Adult Social Care share the same recording systems and the records of Mrs K and Mark's involvement with mental health services were available. Contributors acknowledged that there needed to be greater professional curiosity demonstrated and a more structured approach to safeguarding strategy meetings and protection plans by qualified and experienced safeguarding practitioners.

3.3.15. It is feasible that a strengthened Think Family response may have prompted more inquiry about Mark when the AST Officer and DN carried out a joint visit a week before the homicide occurred. Had the AST explored Mark's role in providing care, this *may* have prompted Mrs K to disclose his very recent aggressive behaviour i.e. that he had stamped on her back. This escalation in his risk

behaviours, alongside the recent concerns about his mental health, *may* have triggered further mental health assessment.

3.3.16. These issues are important to highlight to improve future Safeguarding Adult practice. However, even had all the information been brought together, it is questionable whether this of itself would have averted the tragic incident.

3.3.17. While it is now clear that Mark was mentally ill at the time of the homicide, it is less clear what Mark's mental health was like in those weeks leading up to the homicide, and how obvious any symptoms were to others. The experience of the FME (who had knowledge of the fatal incident), suggests that even if Mark had been experiencing symptoms of psychosis prior to the incidents of assault, it may have been difficult to identify those symptoms without more in-depth specialist mental health assessment and Mark's willing participation.

3.3.18. Ultimately, neither Mark's history nor what was known about his current presentation had indicated a high risk of violence toward others. The assault to Mr K and homicide of Mrs K could not have been predicted. However, wider learning from Domestic Homicide Reviews relating to Adult Family Violence, has highlighted some key points of learning that resonate with the circumstances of Mrs K's death.

Learning Point 5: Adult Family Violence and Risk: Key Take-Aways[40]

1. Never equate victim(s)' lack of engagement with an absence of risk
2. Consider all the key risk factors (mental health, substance misuse, caring relationships, history of violence towards partners and other family members, and various aspects of instability) when assessing risk
3. Look beyond the 'primary' victim in the incident for risk to other family members, especially if there is a vulnerable adult in the family
4. Always consider risk and safety when bailing perpetrators to their parents' address
5. Always offer the support of an IDVA
6. Always consider an Adult Safeguarding referral, and provide information on mental health and substance misuse support

4. What's Changed?

- ### Domestic Abuse

4.1. In 2020, the IOM established a system for police to notify the relevant school where school age children are within a household of a domestic abuse incident. Schools are reporting benefits from this.

4.2. The IOM is in the early stages of developing a multi-agency risk assessment meeting for domestic abuse. This broadly follows the functions of MARAC but is likely to receive referrals for medium

[40] Standing Together Against Family Violence: Adult Family Violence (AFV) Briefing Sheet https://static1.squarespace.com/static/5ee0be2588f1e349401c832c/t/5efcb376866b33242d04c3cb/1593619318736/AFV+Briefing+Sheet.pdf [Accessed December 2021]

risk, as well as higher risk cases. This has built on learning that other Island communities have developed. Manx Care has used the SafeLives Dash risk checklist in training, but this has not yet been embedded in day-to-day practice.

4.3. The IOM Justice Reform Act 2021 is introducing provisions allowing information sharing including to prevent crime and to safeguard the welfare of a person. The Domestic Abuse Act 2020 also received Royal Assent. This will provide police with more powers in response to domestic abuse. However, at time of this review, the Act had not been implemented and the statutory guidance and secondary legislation behind the Act was still to be completed.

4.4. The Department of Home Affairs has been developing a Domestic Abuse strategy to support the new powers in the Act as well as the broader objectives to reduce harm and improve education. An implementation plan was issued in March 2022 and presented to the IOMSB.[41] The implementation plan references the requirement for all parts of Government to work together. It commits to developing a stable framework for domestic abuse services to be delivered, engagement with stakeholders and a clear and legal basis for information to be shared between key parties.

4.5. The Department of Home Affairs appointed a Domestic Abuse Strategic Coordinator in February 2022, to lead the Domestic Abuse Strategy and action plan. Meeting the key deliverables within the implementation plan will be a significant task. As outlined in 4.2, there is a pressing need to develop the infra-structure for Domestic Abuse. Incorporating learning from this review is a key recommendation.

Recommendation 4

- Care Provision

4.6. Manx Care has improvement work underway that is relevant to the findings in this review. Manx Care is in the early stages of developing a single Manx Care record that will improve integrated care and information sharing across the Manx Care services.

4.7. Manx Care mental health services are looking to develop counselling within GP Practices. The model and resource for CRHTT is also being extended so that CRHTT will be able to provide greater outreach when concerns are being raised about an individual's mental health.

4.8. Manx Care is establishing an Integrated Care Service Partnership Hub in each of the IOM's geographic areas. This is a new meeting structure that will bring together professional disciplines/services, such as District Nursing, Mental health, Social Care and GPs where information can be shared about people with more complex needs and vulnerabilities, including domestic abuse.

4.9. Manx Care is also developing strategic work relating to Carers/Young Carers. They are in the process of mapping provision of Carers on the IOM. This work will be used in developing a 10 year strategy. Contributors to the review noted interim work was required to raise the profile of carers, particularly young carers as outlined in recommendation 1.

[41] Isle of Man Government Domestic Abuse Act 2020 Implementation plan March 2022 https://www.gov.im/media/1376008/domestic-abuse-act-2020-implementation-plan-24032022.pdf [Accessed May 2022]

- Safeguarding

4.10. The IOM is establishing Integrated Safeguarding Hubs which includes representatives from social care, mental health, and district nursing. This is already in place in the South of the IOM. Contributors to the review commented on the value of establishing a Multi-Agency Safeguarding Hub (MASH) for children and adults. There are plans to establish this in 2023.

4.11. The structure for Safeguarding Adults has been strengthened. The AST now has an allocated, qualified worker dedicated to screen referrals, with the Integrated Safeguarding Hub then providing more robust strategy and protection planning meetings. The practice of AST has shifted toward carrying out more home visits, including ending the practice of only following up 'no responses' on the third referral.

4.12. The IOMSB has developed an information sharing protocol that will govern information sharing between agencies.

5. Conclusion

5.1. This review has considered the very sad circumstances surrounding the death of Mrs K.

5.2. Family K's circumstances mirrored many of the risk factors that are known to be prevalent in Adult Family Violence based Domestic Homicides. The review highlighted the importance of early help for young people who are experiencing adverse childhood events. It exemplified the importance of 'Think Family.' It reinforced learning that is common to many safeguarding reviews: the need to share information across the partnership; build chronologies and use in robust risk assessments and protection plans.

5.3. The review also highlighted significant gaps in the basic infra-structure for domestic abuse responses in the IOM. This seriously compromises the ability of practitioners to provide effective responses.

5.4. Despite the value of this learning, it is difficult to see how Mrs K's homicide could have been predicted or prevented. Nonetheless, addressing the learning is fundamental to reducing risks to others.

6. Recommendations

The following recommendation take account of individual agencies own recommendations and improvements already made since Mrs K's death.

Recommendations
Recommendation 1: IOMSB Assurance on Responses to Domestic Abuse The IOMSB should assure itself that there are robust measures in place for responding to incidents of domestic abuse, including considering the risks and vulnerabilities of all people within the household, particularly children and young people.
Recommendation 2: Developing Responses to Young Carers Manx Care Social Care should lead an awareness raising campaign about being a young carer. The campaign should target key services for children and young people and provide: i) Information on the impact of being a young carer ii) Guidance on the difference that agencies can make to the young carer iii) Tools and aids to help agencies generate support plans and signpost to support services
Recommendation 3: Assuring Involvement of GPs in Safeguarding and Domestic Abuse DHSC, working in partnership with Manx Care, should assure there are robust processes in place to correctly identify the adult/child's registered GP. Assurance should also be sought that GP's are involved as key multi-agency partners in responses to safeguarding and domestic abuse concerns and that information is shared in line with the permissive provisions of GDPR, IOMSB policies and professional guidance[42]
Recommendation 4: Building Responses to Domestic Abuse This review has highlighted that the IOM lacks the basic infra-structure required to respond to Domestic Abuse. This will seriously compromise the safety of IOM citizens experiencing domestic abuse and there is a pressing need to address this. i) The review recommends this review is shared with the IOM Department of Home Affairs to inform the implementation of its Domestic Abuse strategy. ii) The review highlighted the following components that should be factored into the IOM Department of Home Affairs implementation planning: • Legislation enacted • Strategic forum for multi-agency senior leadership to drive forward the strategy • Specialist and dedicated support services including IDVAs • Adoption across agencies of a shared, evidence- based risk assessment tool e.g. SafeLives DASH risk checklist, and agencies building chronologies of incidents • Establish structures for multi-agency risk management meetings

[42] Royal College GP: Adult Safeguarding Toolkit https://elearning.rcgp.org.uk/mod/book/view.php?id=12530&chapterid=349. Royal College GP Child Safeguarding Toolkit https://elearning.rcgp.org.uk/mod/book/view.php?id=12531

- Develop workforce competence in domestic abuse to enable proactive contribution in identification of domestic abuse and multi-agency protection plans.

iii) The implementation of the strategy should access the expertise of Domestic Abuse sector specialists and survivors of domestic abuse, to inform prioritisation and implementation.

Sylvia Manson

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Glossary

ACE Adverse Childhood Experience

AFV Adult family Violence

ASC Adult Social Care

AST Adult Safeguarding Team

CSC Children's Social Care

CSP Community Safety Partnership

DASH RIC Domestic Abuse Stalking Harassment and 'Honour based' Violence Risk Indicator Checklist

DHR – Domestic Homicide Review

DN District Nurse

ED Emergency Department

FME Forensic Medical Examiner

IDVA Independent Domestic Violence Advisor

IRDG Inter-agency Referral Discussion Group

MARF Multi Agency Referral Form

MARAC Multi-Agency Risk Assessment Conference

MASH Multi Agency Safeguarding Hub

SAR Safeguarding Adult Review

SAB Safeguarding Adult Board

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