

# Working with alcohol dependant ARBD sufferers in community settings.



This Document is informed by the current literature and clinical work undertaken by Dr Julia Lewis and the clinical team of the Gwent Specialist Substance Misuse Service.



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## **Background:**

The four constituent nations of the UK have legal frameworks catering for the management of people who are incapacitated in decision making because of mental impairment. Within these frameworks it is feasible to generate a pathway of care for people suffering from incapacitating ARBD. Typical patients may present with acute withdrawal, Wernicke's encephalopathy and other confusional states secondary to alcohol dependency in hospital settings. Such patients can be protected under the relevant legislation from further alcohol exposure and high-risk behaviours until it is deemed that capacity to make the relevant decisions has returned.

Despite a significant proportion of alcohol dependents experiencing some degree of ARBD, the great majority are usually assessed as having capacity to make their own decisions. These decisions include further exposure and consumption of alcohol and care and treatment that might be needed. Consequently, there is a significant proportion of alcohol dependents with ARBD continuing to drink alcohol to excess. It is the purpose of this paper to bring together some of the recommendations relating to the provision of alcohol treatment services for these individuals.

## **Common cognitive problems encountered in people with ARBD in the community**

A comprehensive review (and meta-analyses) of the literature (143 papers from 250 countries covering 1997-2011) identified four profiles of cognitive impairment in heavy drinkers (Ihara H et al, 2000).

1. No cognitive impairment
2. Isolated executive deficits with normal memory and global cognitive efficiency
3. Mild executive dysfunction with memory impairment and preserved global efficiency
4. Global impairment (problems with executive function, memory impairment and impaired cognitive efficiency)

These problems manifest through difficulties in mental flexibility, ability to pay attention, problem solving and decision making, slowness in intellectual processing and difficulties in planning. Other problems of executive dysfunction include disinhibition and problems in multitasking. Short term memory is affected through problems in encoding (registering information) and recall (Pitel AL et al, 2007, Noel X. et al, 2012).

Frequently there are visuo-spatial impairments, problems in visual learning and undertaking constructional tasks (Oscar-Berman N. et al, 2007, Ratti MT. et al 2002).

There is an increased risk of developing dementia.

Examples of studies include:

Problems in concentration (DeFranco *et al*, 1985)

Problems in learning new information (short term memory) (Alterman *et al*, 1989; Mann *et al*, 1999; Zinn *et al*, 2004; Schmidt *et al*, 2005)

Problems in reasoning (Beatty *et al*, 1996; Mann *et al*, 1999; Zinn *et al*, 2004)

Problem-solving difficulties (Beatty *et al*, 1996; Mann *et al*, 1999)

Difficulties in explaining actions and reasons (Beatty *et al*, 1996)

Problems in understanding complex information and concepts (such as alcohol dependency and implications for behaviour) and difficulty in acquiring drink refusal strategies (Smith & McCrady, 1991)

Reduced ability to change from one stream of thought to another with normal degrees of flexibility (difficulty in working in groups or following complex discussions) (Beatty *et al*, 1996)

Increased proneness to make impulsive decisions and less awareness of the longer-term implications of decisions and actions (Weissenborn & Duka, 2003; Davies *et al*, 2005; Parks *et al*, 2010)

Problems in understanding risk related to actions and decisions (Blume *et al*, 2005)

Reduced organisational skills (Parks *et al* 2010), planning, and managing arrangements (Weissenborn & Duka, 2003)

Poor compliance to treatment programs (Copersino *et al*, 2012)

Lower confidence (Bates & Pawlack 2006)

Breakdown of interpersonal relationships (Patterson *et al*, 1988)

Cognitive problems of this nature have a significant impact on attendance, compliance, and outcome in terms of interventions intended to reduce or manage alcohol dependence. (Bates & Pawlak 2006)

### **Screening and recognition of ARBD in community settings**

It is recommended that all clients referred to alcohol treatment services undergo a mental health screening. (National Institute for Health and Clinical Excellence, 2011). As part of this, cognitive screening can be carried out using simple texts which include the MoCA (Nasreddine *et al* 2005) or the ACE R. (Mioshi E, *et al*. 2006)

Individuals of high risk of developing severe cognitive damage may be identified through a history of weight loss, low BMI, recurrent vomiting, and an increase in carbohydrate intake. Obvious signs include early memory loss. As ARBD is associated with thiamine deficiency (which can affect the neurological system), a history of pins and needles, numbness and periods of double vision are all potential warning signs (Thomson 2000). Cognitive impairment is also associated with problems in attendance and compliance in treatment programs, suggesting that people that drop out or fail to attend may be of high risk (Bates & Pawlak 2006).

### **Adaptations in service provision**

The literature provides examples of a variety of modifications that can be made to cater for these cognitive deficits.

### ***Engagement and planning***

There should be a focus on achieving abstinence (McCrary and Smith 1986). Strategies to achieve this and drinking strategies in general should be made as simple as possible. Community alcohol treatment services frequently follow protocols relating to the engagement of referred clients. Poor compliance or appointment failure may be due to cognitive impairment. An active engagement strategy should be considered (Wilson et al 2011, McCrary & Smith, 1986). This could include more frequent visits to the individual's home, phone contact, leaving written messages, and contacting carers or friends (when appropriate). Transport and social support may be indicated. Staff introduction at each interview, the use of name badges, (McCrary & Smith, 1986), preferably with a photograph of the therapist (Drinkwise age well 2020) is advised.

When working with the cognitively impaired, collaborative, and structured scheduling and planning is recommended (Acquired Brain Injury Services 2011). This may involve enhanced support and planning, and the provision of a timetable may be useful (Arbias 2007). As cognition is likely to improve (if drinking can be reduced or managed) more complex interventions and educational approaches can be delayed until the individual is more receptive (McCrary & Smith, 1986). In the first few weeks, particular emphasis should be placed on reducing exposure to risk as there is an increased likelihood of impulsive decision making (Weissenborn & Duka 2003, Davies et al 2005, Parks et al 2010). Individuals with cognitive impairment frequently require longer contact sessions because of the cognitive problems (VanDamme & d'Ydrewalle, 2008) and the clinician should allow for a cognitively individual to take longer to benefit from interventions (McCrary & Smith 1986).

### ***Therapeutic adaptations***

The simplification of educational materials is recommended (McCrary & Smith, 1986) and providing information through a varying media, (written, visual, etc) (McCrary & Smith, 1986) and memory aids can be useful. Learning texts and materials can be used to ensure that one concept is understood and learned before going on to another (McCrary & Smith, 1986).

In ARBD, powers of concentration may be reduced, consequently, educational discussions should be time limited (DeFranco et al 1985) and focus on clearly defined, single topics at a time (Beatty et al 1996). Frequent changes in topics of conversation may lead to confusion.

As already mentioned, cognitively impaired sufferers may take longer to learn and undertake tasks (DeFranco. et al 1985). Learning may be facilitated by encouraging individuals to repeat information (Kessels 2007) and explain it as soon as it is given to them (Zinn, S 2004). If the individual is unable to remember the information, guessing should be discouraged (Mann et al. 1999). Memory cues have been advocated (Morgan et al 1990). Diary keeping may help in memory prompting and may also be used for the planning of activities (Wilson et al 2012). Learning can be facilitated through reinforcement and role play. The provision of rewards for appropriate behaviour may be of benefit. Rewards may be psychological or social and tailored for the individual (Hochalter & Joseph 2001).

When confronted with problems, simple rules can be applied in order to offer help (Bardenhagen et al. 2007). These include five steps (D’Zurilla & Goldfried 1971)

- Identify the problem
- Collect information concerning the problem
- Generate solutions
- Select the appropriate solution
- Implement the solution

### ***Prescribing in ARBD for Alcohol Dependence***

Medication has two main roles in the management of alcohol dependence:

1. The medical management of alcohol withdrawal
2. Prescribing to support abstinence

### **Medically Managed Alcohol Withdrawal (MMAW)**

NICE Clinical Guidance 100 states that individuals considered at risk of complicated alcohol withdrawal (such as seizures, delirium tremens and Wernicke’s encephalopathy) should be receive MMAW as an inpatient. (NICE, 2010). The presence of ARBD is a risk factor for complicated withdrawal and so individuals with ARBD requiring MMAW should be admitted to an inpatient facility where staff can identify and appropriately manage any emerging complications.

As with any medical procedure, fully informed consent must be obtained prior to MMAW. If, as a result of cognitive impairment, the patient lacks the capacity to make this decision, then the appropriate legal framework must be employed (e.g., Mental Capacity Act, 2005). It is important to present the necessary information in a clear way, delivering it in short chunks and asking the patient to repeat what they have been told, in order to maximise understanding. Patients must be supported to make their own decisions as much as possible and being sensitive to their cognitive needs when discussing treatments options with them is very important. The duty of clinicians to ensure that patients have accurate information and adequate space and time to make decisions has been highlighted by recent case law (Thefaut vs Johnson, 2017).

When using standardised assessments of alcohol withdrawal symptoms (e.g., Clinical Institute Assessment of Withdrawal, CIWA-Ar, Sullivan et al, 1989), consideration must be given to how cognitive impairment can impact on these. For instance, short term memory impairment may affect the recollection of withdrawal symptoms experienced since the previous assessment. Patients may be aware that they have felt tremulous and sweaty but may not recall exactly when that was during the withdrawal process. Difficulty with describing abstract concepts can mean that they struggle to articulate the level of anxiety they are experiencing. If it is felt that the patient will find it difficult to engage with such standardised assessment scales, then protocols for MMAW that do not rely on such measures of withdrawal need to be employed (e.g., fixed reduction schedules).

All patients with a history of ARBD will need appropriate nutritional support during MMAW which will include thiamine supplementation (most likely to be parenteral) (Thomson et al, 2002; Lingford-Hughes et al, 2012). It is important to avoid a carbohydrate load and magnesium supplementation may be required (Glen, 1994; Turner et al, 1989). Hydration can be overlooked; patients who have been taking almost the entirety of their daily fluid intake in the form of alcohol may neglect to replace this with other fluids, especially where there is dysexecutive syndrome.

#### Prescribing to Support Abstinence

NICE Clinical Guidance 115 (NICE, 2011) recommends that, after successful withdrawal from alcohol, individuals with moderate to severe dependence can appropriately be offered either acamprosate or naltrexone alongside psychosocial interventions. If these drugs are not suitable, or if the patient prefers, the guidance then suggests the use of disulfiram. Increasingly in practice, baclofen is also being used as relapse prevention medication, especially in those with hepatic impairment (Gache et al, 2014).

Once again, informed consent must be obtained before commencing relapse prevention medication. In addition, the prescriber needs to be assured that the patient understands the way in which the medication is taken and the expected outcomes. This is particularly important for disulfiram and, if there is any concern that the patient does not fully understand the risks, then it should not be prescribed.

If there are issues with short term memory, then consideration should be given to the use of a dosette box if not already being used for other medication and the use of prompting (such as the use of smart phone apps).

#### **Overview**

It is evident that a variety of cognitive impairments can manifest in individuals that are under the care of alcohol treatment services. These can vary from subtle reasoning problems through to an obvious global impairment. Hence, it is necessary for the therapist to assess the specific needs of an individual in designing interventions. This can be aided through formal and repeat assessments using the mini-Ace or ACE-111 for cognitive testing. The informal clinical identification of high-risk individuals is likely to play an important role.

Indicators have already been mentioned but include physical issues such as weight loss and self-neglect, poor diet and vomiting and neurological disorders. Other practical warning signs may include memory and reasoning problems, poor compliance, difficulty in managing group settings and understanding the educational issues. Evidence of an on-going history of impulsive or antisocial history may be considered to warrant further investigation. Appropriate adaptations to prescribing policies may be required in catering for patient with ARBD.

Flexibility is the key in terms of adaptation of therapeutic interventions. The modification of engagement, support and educational and drug treatment approaches should be driven by the need of the individual.

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