ARBD & Capacity Assessment

Background

Several of the characteristics of ARBD can be problematical in the assessment of capacity, particularly when complex decisions are being considered.

Firstly, ARBD is frequently characterised by memory impairment. Usually **working memory** is well preserved. In this context, this refers to that component of memory that enables the immediate processing of information. Consequently, the individual may not, at a superficial level, appear to have a memory problem as they can follow a conversation and answer questions plausibly. However, short- and long-term memories are frequently affected. An attempt should be made to examine the implications of these memory problems in terms of the decision-making process.

Short term memory (STM) refers to the individual's ability to learn new information and hold it for more than the few seconds or minutes.

Practical suggestions: Other than a formal test of STM, provide the individual with information, (for example: relating to their condition) and encourage them to learn it by repeating it back to you. Having done this, change conversational topic, or better still, take a break in the interview and then when returning, explore whether the individual can recall the information. Individuals with STM problems frequently fail to recall that you had the conversation, or at least, have forgotten its content. STM loss of this degree is likely to incapacitate the person in terms of the decision under examination, even though they may have agreed to an arrangement during the conversation.

Long term memory (LTM) refers to the individual's ability to recall long-standing memories from the past, usually of a biographical nature. Many individuals with ARBD experience loss of LTM to varying degrees. In many cases the individual's history of very heavy drinking, multiple hospital admissions, social and financial problems, break-up of family, loss of jobs

and a police or criminal record will be lost to the individual in totality or in part. It is very easy for the capacity assessor to assume that the ARBD sufferer can recall these events and has learned from their experiences; potentially influencing future decisions. However, with LTM loss of up to twenty-five years, this may not be the case. The problem of memory loss is frequently complicated by confabulations. These are false memories that the sufferer believes. They may be plausible.

Practical suggestions: It is important to have some familiarity with the individual's biographical history. An attempt should be made to establish the drinking history and relevant medical and social histories prior to assessing the individual. A corroborative history from a family friend/carer/relative can play a very important role. Long term memory loss can then be informally evaluated and its potential impact on decision making can be judged. It is important to make the individual aware of his/her past issues, discuss them and see if they are likely to influence the decision under question. It is often the case that the individual may not believe that these problems have arisen in the past.

Secondly: ARBD sufferers will often present with **dysexecutive syndrome**. This syndrome is characterised by problems in reasoning. **Planning** things and **problem solving** and sorting out more complicated aspects of daily living can become problematical. This may be obvious to relatives, friends, and carers. Common examples include difficulty in making joint arrangements and sorting of bills. Other features of the dysexecutive syndrome include problems in paying **attention** and concentrating on things with a tendency to fail to complete tasks. In addition to these reasoning problems, noticeable changes become evident in speech. More-than-usual difficulties in finding words and completion of sentences are frequently experienced.

Increasing problems in managing day-day tasks and personal environment may become evident. Often here is an impact on the individual's appreciation of **risk** relating to decisions and their implications. **Impulsive** behaviour is common. The individual may become disinhibited. This may be of a sexual nature. **Apathy** and an increasing **lethargy** with **lack of self-awareness** and **self-neglect** may become more obvious.

These signs are usually couched in the context of loss of **emotional and social awareness**. The individual loses the ability to understand other people's emotional states, anticipate their desires, beliefs and knowledge. They lose their ability to **empathise.**

It is obvious that some, if not all these issues may impinge upon the process of decision making (depending on the nature of the decision), particularly in disrupting the processes of understanding and the use and weighing up of information.

Practical suggestions: Again, information relating to the individual's recent past may help to define how problematical these more subtle cognitive deficits are. Examples of difficulty in arranging things, managing household bills and budgets and a frequent history of failing to complete tasks may all provide additional and important information for the assessor to consider. A corroborative history is usually of great value.

Thirdly, the issue of trying to assess whether the cognitive damage is likely to affect future behaviour and compliance with agreed interventions/actions may prove problematical. Apart from the obvious problems of STM difficulty (remembering what has been planned or agreed), there are the more subtle influences of dysexecutive syndrome. Problems of social awareness, increased risk taking and being unable to anticipate implications of actions can cause future difficulties in maintaining compliance with previously agreed arrangements. These issues tend to be less obvious in the context of a structured interview in which prompts, directive questioning, and clear expectations are evident. Likewise, a structured social environment with explicit rules and monitoring (such as a nursing home, residential setting or hospital setting) will strongly influence behaviour. In the context of the less well-defined rules and obligations of general society, without the obvious imposition of social constraints, people with dysexecutive syndrome will often run into significant difficulties that are not evident in a more structured environment

Practical suggestions: The individual's personal history, the events and problems they have encountered in the more recent past, prior to any institutionalisation should be considered within the assessment process. Relevant indicators of future problematical behaviour (because of cognitive damage) may include past, recurrent difficulties in managing relationships, evidence of vulnerability (social, financial or physical), self-neglect and other risky behaviours (not necessarily associated with alcohol consumption). This information is best recruited through a corroborative history of a carer/family member or friend.

Lastly, loss of LTM, the inability to learn new information (STM) and problems of reasoning may well contribute to **lack of insight**. This should be differentiated from the tendency of the alcohol dependent to be in 'denial' of their history or drinking behaviour. Denial can be considered as a psychological mechanism by which the individual refuses to accept the problems they have. In denying the issues, the individual protects themselves from anxiety, guilt or other psychologically discomforting experiences they might have if they were to accept responsibility for their problems. In the context of ARBD, lack of insight

is a consequence of cognitive damage. The individual is neither consciously nor unconsciously aware of their problems. The relationship between 'denial' and 'lack of insight' is certainly complicated. As cognitive damage increases over time, it is likely that denial becomes less of a problem and lack of insight becomes more likely.

An individual lacking insight will obviously experience significant problems in understanding and weighing up the pros and cons relating to a decision, particularly if this decision concerns the need for help and future limitation of drinking.

Practical suggestions: When assessing 'lack of insight' several pointers are useful: If there is significant evidence of long-term memory problems, reasoning difficulties and problems with learning new information then there is a significant likelihood of some degree of loss of insight.

If a person has difficulty in understanding the implications of on-going drinking (even when it is explained to them) then there may be cognitive problems relating to understanding and self-awareness. Has the individual got alternative explanations regarding their health problems, or do they believe that they have no problems despite the obvious evidence?

The Capacity Assessment

In order to undertake a comprehensive capacity assessment of a person suffering from ARBD it is essential to be familiar with his or her personal history and have access to a corroborative history.

This document refers to the COP3-eng document as a template
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/958044/cop3-eng.pdf

The background

Section 4 of the document provides a section for a comprehensive explanation of the circumstances in which the assessment is taking place. **This is an often-under-utilised section:**

Section 4: 'Please provide any further information about the circumstances of the person to whom the application relates that would be useful to the practitioner in assessing his or her capacity to make any decision(s) that is the subject of your application'.

It refers the assessor to note 2: Please provide any further information about the circumstances of the person to whom the application relates that would be relevant in assessing their capacity.

Practical suggestions: This section provides an opportunity for the assessor to furnish evidence relating to the individual's past and issues that might have arisen because of cognitive deficits. It gives financial problems and decision-making difficulties as an example. Other issues known to be affected by cognitive impairment include poor compliance with treatment programs, self-neglect, and other risky behaviours. Evidence of appropriate behaviour in institutions, compared with decompensated or antisocial behaviour in less structured environments may be a consequence of cognitive damage. Recent/current examples of cognitive damage may be entered here, including observations from nurses, carers and family.

The presence of mental impairment

The next section requires the assessor to provide a diagnosis (where there is one), but the document implies that a general statement of mental impairment is acceptable when there is no formal diagnosis.

Section 7.1: 'The person to whom the application relates has the following impairment of, or disturbance in the functioning of, the mind or brain. Where this impairment or disturbance arises out of a specific diagnosis, please set out the diagnosis or diagnoses here' requires.

Practical suggestions: in the case of ARBD, the general term; 'alcohol related cognitive impairment 'could be acceptable in the absence of a clear diagnosis such as Wernicke-Korsakoff syndrome.

The next part of 7.1 is the recording of the decision(s) relating to the capacity assessment.

Practical suggestions: An assessor will be aware that an assessment of capacity is decision specific, and these will vary from person to person and situation to situation. However, ARBD sufferers are often confronted with two major decisions when being assessed:

1. *Is the cognitive damage of such a degree that the individual is unable to make a decision concerning further alcohol drinking?*
2. *Is the cognitive damage interfering with the person's capacity to make a decision relating to the care that they need?*

Section 7.2 requests information as to why individuals may not be able to make a specific decision. The first subsection requires information regarding the person's ability to **understand** the relevant information.

Practical suggestions: It is not usually sufficient to limit the assessment of 'understanding' to asking the person if they understand without probing and examining the issue in more depth. Questions might include:

- *What is wrong with you that means you might need help?*
  - *Explore the person's understanding of their problem:*
  - *Do they have any insight into a diagnosed condition and related cognitive difficulties?*
  - *Explore the possible implications of their decisions/behaviour and the effects on other people/society*
- *What are the practical issues with which you need help?*
- *Focusing on the practical (related to presentation) for example:*
  - *Why is there no food in the house?*
  - *How are you going to get out of debt?*
  - *How do you feel about your sexual behaviour in public?*
  - *What do other people feel about your behaviour?*
- *What sort of help do you think you need*
- *How much help do you need?*
- *Who is going to help you?*
- *How is this help going to be organised?*

The next sub section of 7.2 addresses the issue of memory by asking if the person can retain the information that has been furnished.

Practical suggestions: As already mentioned, it is important not to be misled by a 'working memory' when STM may be compromised. Helping the individual to learn the information, providing written material and rehearsal are all aspects of good practice. It is then important to test that the individual can recall the information some few minutes later. This could be done in the context of a second or 'split' assessment, incorporating a short period of rest or change of subject. It is now well established that even if an individual makes a decision within the interview context but is later unable to remember the decision that has been made due to cognitive damage, then capacity should be questioned.

The next sub-section asks: 'Is he or she is unable to use or weigh the following relevant information as part of the process of making the decision(s) (please give details);'

Practical suggestions: *as is the case with 'understanding', weighing up and using the information not only draws on memory but also requires an intact executive function. It is recommended that the assessor attempts to interrogate the process and 'depth' of weighing up the information and the implications and risks associated with the decision. Relevant questions may include:*

- *Why would you not want support?*
  (Are reasons weighty enough to balance against the need for support?)
- *What happens if you do not get support?*
  (What are the risks you face if you do not get support?)

The last sub section of 7.2 requires a comment regarding the ability of the individual to communicate his/her decision.

Practical issues: *Language can be affected in cases of ARBD. In more severe cases, of confusion, attention and concentration problems may prove intrusive and disruptive of normal conversation. ARBD can affect the front part of the brain, rendering difficulty in sentence completion and problems in word finding. In cases in which there are communication difficulties, written material may be helpful.*

Section 7.3 of the document asks for a summary of the issues that have contributed towards the assessor's decision of incapacity.

Practical issues: *This section enables the assessor to present information relating to the history of the patient. A summary of the memory problems and their implications, and evidence relating to understanding, memory, weighing up and communicating the decision. It is an important section in that it brings the evidence together in a reasoned and logical fashion, demonstrating a thorough assessment and substantiated reasoning.*

Summary

In assessing the capacity of an individual with ARBD, the assessor is likely to make a mistake if the assessment is confined to the information gleaned from the assessment interview alone. Preparatory work is essential and includes familiarity with the individual's current circumstances and history. A corroborative history is strongly recommended in view of the LTM loss, confabulations, and potential lack of insight. Likewise, due to the issues relating to dysexecutive syndrome, background information will also provide a strong indicator regarding how the individual will cope in the context of general society, outside institutional settings. in addition, clarifying the degree of memory impairment, emphasis should be placed on and exploring problems in understanding and weighing up information as crucial components of the decision-making process.