arbd network

Alcohol, ARBD & Motivation

Principles of ARBD management

A network to raise awareness of **alcohol related brain damage (ARBD)** amongst healthcare professionals and the public through education and **information to improve clinical outcomes**

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Principles of ARBD management

There are several principal issues that are worth summarising

1. One of the first issues to consider is whether the individual has the capacity to make decisions. Pertinent decisions may include:
deciding about:
   a. Future alcohol drinking

   b. The care and help that is needed regarding the management of his or her health and safety.

Issues regarding capacity assessment in cases of ARBD can be found under 'resources' on this web site (ARBD.net). If the individual is deemed not to have capacity with regard to the relevant decision, then the employment of the Mental Capacity Act should be considered.

2. Individuals that are deemed to be capacitated should be referred to the appropriate alcohol treatment services. Recovery hinges on the maintenance of abstinence, support for this is vitally important and that, as long as treatment services can adapt their approach to the needs of someone with cognitive impairment, there's no reason why community services wouldn't be able to work with them (see document Working with ARBD sufferers in the community: ARBD.net : resources).

3. Provided a person with ARBD maintains abstinence and receives a well-balanced nutrition, (supplemented by oral thiamine in the first few months) then there is a very good chance that cognition will improve.
   a. Rapid improvement may occur within the first three months of abstinence (Cox et al 2004).

   b. Residual cognitive deficits may continue to improve over the following 1-3 years as the brain re-grows. (Sullivan & Pfefferbaum, 2005; Bartels *et al*, 2007)

4. Improvement in cognition can be expected in 75% of cases, with a significant majority living relatively independently after this time (Wilson et al 2012). Smith and Hillman (1999) reported that 25% make a complete recovery, 25% make a significant recovery, 25% make a slight recovery, and the remaining 25% make no recovery.

5. Therapeutic and rehabilitative processes have been informed by the rehabilitation of patients with acquired brain injury. However, it is important to note that the active management of a person with severe ARBD may take an average of 1-3 years and in complex cases, longer periods of time may be required. (Wilson et al 2012)

6. Management is best undertaken in the context of a multidisciplinary team with some experience in working with patients with cognitive damage. A close working relationship with social services is required.

7. Principal themes of intervention include:
a. Development of the individual's optimum level of autonomy (Ylvisaker and Feeney 1998). This is a holistic approach including the development of the emotional, intellectual, social, physical, financial and behavioural function of the individual in the context of natural recovery process (Prigatano, et al 1996).

b. The programme should be facilitative; the individual should be given as much control of the management of their own rehabilitation as possible in the context of on-going risk management (Ylvisaker and Feeney 1998, Bates, et al. 2002).

c. The rehabilitation of the individual's life skills must be tailored to the individual's needs and priorities and is carried out in the context of the development of a therapeutic relationship (Ylvisaker and Feeney 1998, Bates et al. 2002).

d. Rehabilitation is an active process, and may demand therapeutic time, on-going re-assessment (with defined goals), care planning and long-term engagement (Wilson et al 2012).

e. Rehabilitation should focus on life skill development and can take place in the home, institutions and other 'real world' settings (Ylvisaker and Feeney 1998).

f. Non-experienced, care workers, family and community agents can be supervised in facilitating the rehabilitation process (Wilson et al 2012).

g. Baddeley et al (2002) advocates memory and orientation aids as playing an important role in rehabilitation.

8. Five management phases have been described (Wilson et al 2012)
a. Stabilisation Phase: This concerns the acute physical management and stabilisation of the individual going through withdrawal or being treated for encephalopathy and other alcohol related problems.

b. Assessment Phase: during the first three months cognition is likely to improve, during which on-going assessment is undertaken.

c. Therapeutic phase: This can last up to three years during which the brain regrows, and cognition can further improve. During this phase alcohol education and facilitating progression in activities of daily living are emphasised.

d. Adaptive Phase: Rate of cognitive and behavioural improvement has slowed or ceased; social and physical environment is adapted to optimize independence.

e. Social integration and relapse prevention phase. This phase may require long term follow-up.

A detailed description of the five therapeutic phases can be found in the reference document section of this website (ARBD.net)

9. Flexible accommodation and support: The patient may have been placed in a highly supportive and structured environment after phase 1 (Physical stabilisation and treatment) (e.g. a mental health nursing home). As cognition improves, independence increases, and protective and support needs will change. These changes should be reflected in changes in the living circumstances of the patient, with transfer to less dependent environments, such as residential, supported living or return to their own homes.

10.On-going assessment of Mental Capacity: The patient's capacity to make critical decisions concerning their management is likely to change over time. Consequently, it is necessary to frequently re-assess capacity, and facilitate decision making.

References

Baddeley AD, Kopelman MD, Wilson BA. (2002) Handbook of Memory Disorders. 2nd edn. Chichester: Wiley;.

Bartels C, Kunert H, Stawicki S, et al (2007) Recovery of hippocampus-related functions in chronic alcoholics during monitored long-term abstinence. Alcohol and Alcoholism, 42: 92–102.

Bates M, Bowden S, Barry D (2002) Neurocognitive impairment associated with alcohol use disorders: implications for treatment. Experimental and Clinical Psychopharmacology, 10: 193–212.

Cox S, Anderson I, McCabe L (eds) (2004) A Fuller Life: Report of the Expert Group on Alcohol Related Brain Damage. Dementia Services Development Centre, University of Stirling.

Prigatano GP, Glisky EL, et al (1996) Cognitive rehabilitation after traumatic brain injury. In PW Corrigan and S C. Yudofsky (eds) Cognitive rehabilitation for neuropsychiatric disorders. Washington DC: APA

Smith I, Hillman A. (1999) Management of Alcohol Korsakoff 's syndrome. Advances in Psychiatric Treatment, 5, 271–8.

Sullivan EV, Pfefferbaum A (2005) Neurocircuitry in alcoholism: a substrate of disruption and repair. Psychopharmacology, 180: 583–94.

Wilson K., Halsey A., Macpherson H., Billington J., Hill S., Johnstone G, Rajue K., Abbot P (2012) The psychosocial rehabilitation of patients with alcohol-related brain damage in the community. Alcohol and Alcoholism 47, (3) 304-11.

Ylvisaker M. Feeney TJ. (1998) Collaborative brain intervention: positive Everyday routines. San Diago, CA: Singular.