# Alcohol Use and the Mental Capacity Act

| Questions from the chat | Answers |
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| **Hepatic encephalopathy - just a bit more clarity around assessing capacity in relation to this? I note that it is reversible from the diagram but this appears to impact on impulse control?** | Bruce: Hepatic encephalopathy is an acute confusional state caused by toxins which enter the brain, the dysfunctional liver having failed to clear them. Any acute confusional state has a high likelihood of impinging negatively on capacity, although as was stressed at the end you would have to assess this through the legal first stage (functional) test to see if it was the case in the 'individual'. It is often reversible through treatment of the underlying liver failure and through prescription of medication which flushes the toxins from the gut thus reducing the amount which reaches the brain. However, it is not always fully reversible – more detail than that would have to be provided by a specialist in hepatology. Can it impact on impulse control? I'm sure it could as well as a large number of brain functions, but this is not the context in which we were discussing impulse control which was more specific to the effects of alcohol itself on the reward centre within the limbic system and on the prefrontal cortex in terms of reduced ability to control those impulses.<br><br>James: Both a longitudinal and performative approach to assessing capacity would ensure any short term or long term capacity is considered and these considerations include micro decision, whilst remaining focused on the macro (overall) decision.<br><br>Therefore, it is essential that capacity assessments are recorded and when the adult seems to have "changed their minds" or there are concern of "unwise decision making", to return to the previous capacity and check whether the adult is truly able to weigh up the available salient information. |
| **Is the diagnosis from the DSM a "mental disorder" as defined in the MHA? in your view. I'm thinking of the requirement for medical evidence of mental disorder for DoL/DoLS.** | Bruce: That's a very good question and I am not completely clear as to the answer. I think this question relates to whether the DSM-5 primary diagnosis of Alcohol Use Disorder can be considered the equivalent of the ICD-10/11 diagnosis of Alcohol Dependence; a diagnosis of Alcohol Dependence cannot count as the primary diagnosis associated with the need for hospital treatment without consent under the Mental Health Act (MHA). As the DSM-5 diagnosis of Alcohol Use Disorder (AUD) can sometimes be made in the absence of any symptom of the ICD-10 diagnosis of Alcohol Dependence it is not possible to state that it would always be excluded from consideration under the MHA; however, as the DSM-5 diagnosis of AUD will often include symptoms of the ICD-10 'Alcohol Dependence' there is much room for confusion and I think the pragmatic answer is that we should stick with the UK/WHO/ICD terminology and avoid use of the DSM-5 terminology if we are discussing things in a formal UK legal context. |
| **What is the correct terminology to use for the type of alcohol misuse and subsequent effects, that can be reversed** | Bruce: In ICD-10 there are a number of diagnostic subtypes such as 'Alcohol dependence – currently abstinent'; that may go some way to answering this question if we are looking for a formal term. In everyday discussions we often still use the term 'in recovery' which indicates that someone is currently abstinent from alcohol but also acts to point out that relapse is |

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| **through abstinence/good nutrition etc** | always a risk, so we do not usually use 'has recovered' for example. I am not aware of a specific term which is formally used in a diagnostic sense to categorise complications of alcohol use which arise related to nutritional deficiency, but we will often refer to these loosely as 'nutritional complications of alcohol use/misuse'. |
| **May I have some clarity around raising a safeguarding referral to ASC. Regarding consent? Also, how to make a 'good referral' what to include in order to meet threshold, for a patient they may have previously had a Needs Assessment, and deemed as 'not having a need'. Meaning case was closed.** | James: Consent is not required to make a referral. It is good practice to seek the person view, wishes and outcomes (wherever possible). but under the Care Act and the Caldicott duties, consent is not required.<br><br>What makes a good referral is to;<br><br>• give in-depth information on what is causing you concerns.<br>• To evidence where the concerns comes from (i.e. home situation, lack of ability to care for self etc)<br>• and then to, where you feel confident, provide a rational/ justification for any concerns, recommendation and/or decisions you have taken. |
| **If a person is assessed to lack capacity to make decisions re. support with alcohol support services, can CGL accept professional referrals for ongoing support in this instance? As I understand currently, client consent for referral is required for CGL support and often self-referral is encouraged?** | Bruce: If you have found a client lacks capacity to consent to a referral to CGL then you would need to decide whether it was in the person's best interests to make a referral to CGL. If you concluded it was in their best interests then I'm sure CGL would consider the referral as for any other referral. |
| **Going back to the original case review. Would a capacity act assessment resulted in a different outcome? Just from the brief description we were given it appears he would probably have had capacity?** | Bruce: That's a very interesting question and one that James may wish to answer. From my knowledge of SAR Robert and the case law I presented towards the end of the webinar it seems to me it could well be the case that a judge in the Court of Protection (CoP) may well have concluded that he had capacity for whatever the decision in question was. However, the equally important point is that no definitive decision has been made by the CoP which would always exclude a diagnosis of 'alcohol dependence' from consideration as the basis of the Stage 2 (diagnostic) test. As such every case has to be considered on its own merits by considering the Stage 1 test and linking the diagnosis in a causal way to your findings.<br><br>James: This is a great question to ask, and one that cannot be truly answered. But my answer to this would be, if a Mental Capacity Assessment was conducted, we would have:<br><br>• explored statue that gives us both a power and responsibility to intervene, where an adult lacks capacity. |

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| | • also, on the reveres if that adult retained capacity, we would have evidence their right to make an unwise decision, even if this decision is in conflict to what we believe is in the adult's best interest.<br><br>We need to remember the Mental Capacity act is there to protect adults' rights, whether this is their right<br><br>• to live free from abuse (this includes self-neglect) – article 3 rights<br>or<br>• their right to liberty and private family life – article 5 and 8 rights.<br><br>But furthermore, the Act provides us as professionals, a defence when acting in the person best interest. But also, not necessary within the act, but the practice of completing an assessment, where the adult retains capacity, provides us a defence. In that we have explored this, and we have discounted this statute as not being applicable, therefore the adult is the decision maker, including any risks they face. |