Navigating The Law to Help People with Alcohol Dependence (including neuropathology, diagnosis and application of the MCA)

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Summary

Webinar Outcomes
Part 1: Consider the Context
Part 2: Develop Knowledge
Past 3: Bridge Theory to Practice

Webinar Outcomes

Main outcomes

- More proactive safeguarding referrals
- Better informed contributions to professionals' meetings
- Greater confidence in mental capacity assessment

Underlying outcomes

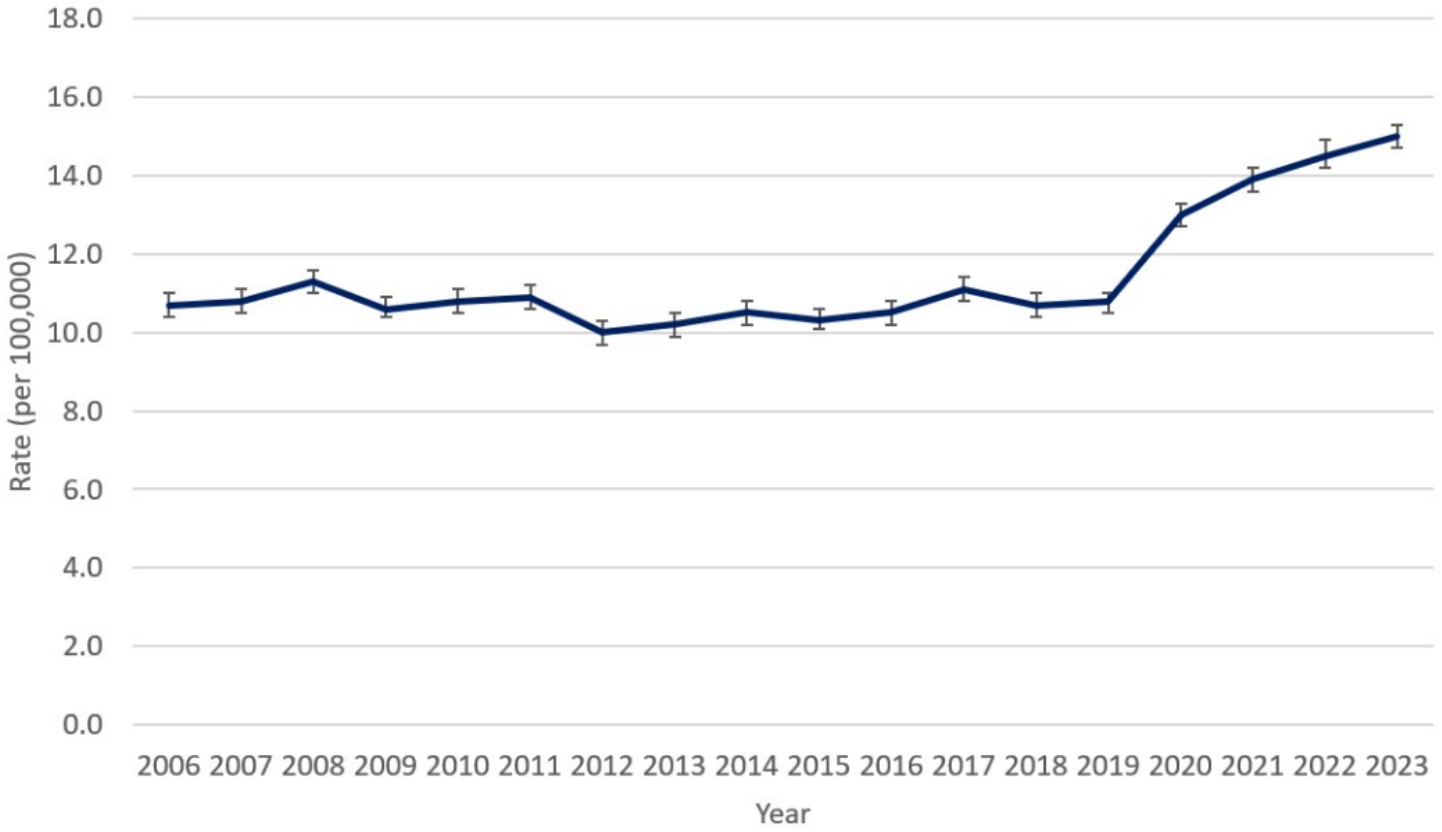
- Improved knowledge around the relevant law
- Improved knowledge around neuropathology and diagnosis of alcohol disorders
- Improved knowledge around the interaction of neuropathology and diagnosis with the law

Part 1:
The Context

- Alcohol-specific mortality
- Complexities of mental capacity assessment

Alcohol-specific mortality – increasing since COVID

Figure 1: age-standardised alcohol-specific mortality rate per 100,000 population (all ages): single year, England, 2006 to 2023



Source: calculated by OHID Population Health Analysis (PHA) team from Office for National Statistics (ONS) death registration data and ONS mid-year population estimates.

Why is MCA assessment challenging?

- None of us are ‘complete’ experts – it can be a multidisciplinary, multiagency, multisector process
- We may lack confidence in conducting a legal assessment as opposed to our more usual medical, nursing or care needs assessments
- We may feel a tension between concerns around a patient’s health related risks and their right to liberty
- Different professionals (decision-makers) can reach different conclusions around capacity – there is an element of subjectivity.
- Uncertainty can be compounded by fear our actions could give rise to career-changing complaints
- Removal of immunity from prosecution for expert witnesses (2011)

Part 2: Develop Knowledge

The Law

Neuropathology

Diagnosis

The Law

- Professor Michael Preston-Shoot and Mike Ward: How to use legal powers to safeguard highly vulnerable dependent drinkers in England & Wales (How to use legal powers to safeguard highly vulnerable dependent drinkers | Alcohol Change UK)
- Combine the power of positive interventions (assertive relationship building, harm reduction and motivational interventions) and multi-agency working with the effective and careful use of legal powers.

The Acts

The Care Act (2014) governs adult social care in England and promotes 'well-being'.

- It sets out the responsibilities of local authorities and care providers in providing care and support and places a legal duty on local authorities to protect adults at risk of abuse or neglect.
- It applies to some people with alcohol problems and in particular the inclusion of self-neglect as a form of neglect will encompass many in this client group.

The Mental Capacity Act (2005) provides a legal framework for making decisions on behalf of adults (aged 16 and over) who **lack the capacity** to make specific decisions for themselves

- It can be used with people impaired by the effects of alcohol.

The Mental Health Act (1983 amended 2007) allows people with a mental disorder to be detained, assessed, and treated without their consent, when necessary.

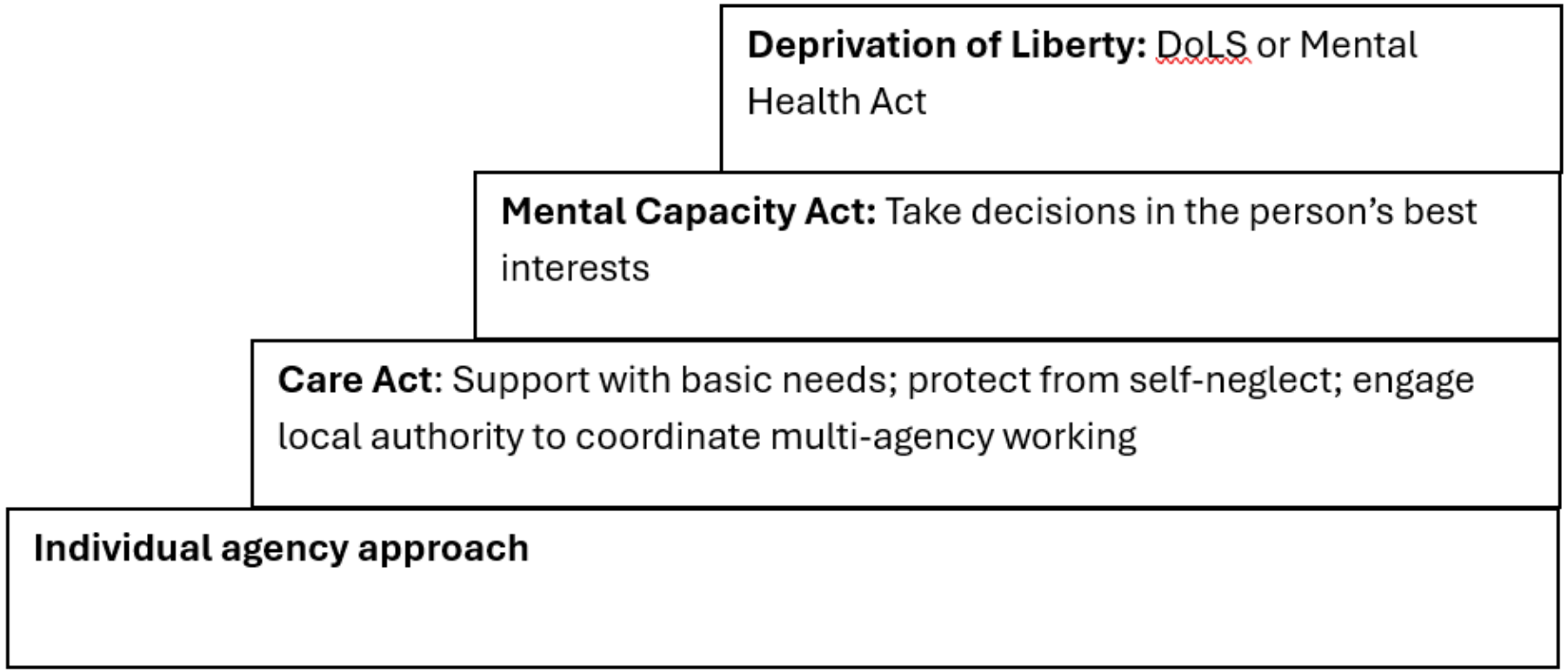
- The diagnosis of 'alcohol dependence' is explicitly excluded as a mental disorder for the purposes of the MHA, but other alcohol-related diagnoses are not excluded.

Other legislation may also be relevant including the Human Rights Act 1998, the Anti-social Behaviour, Crime and Policing Act 2014, the Criminal Justice Act 2003.

Common law may also be of relevance for example in urgent situations the 'Doctrine of Necessity'.

	Care Act 2014	MCA 2005	MHA Act 1983
Fundamentals	Are there care & support needs which arise from a **physical or mental impairment**?	Is there a **mental impairment** leading to dysfunction of mind or brain	Does the person suffer from a **mental disorder**
Question 1	Does the person have care and support needs?	Is the person's capacity to reach a decision impaired as a result of the dysfunction of mind or brain?	Is there a risk of harm to the person or others?
Question 2	Is the person at risk of abuse or neglect and as a result of their care needs they are unable to protect themselves? (If yes, safeguarding referral)	Has the person been deprived of their liberty in order to meet care or treatment needs in their best interests?	
Potential outcomes	Provision of care & support; protection from abuse or neglect; a multi-agency approach coordinated via formal duty on LA to act	Stage 2: Decisions made in the best interests of the person on their behalf Stage 3: DoLS if liberty deprived in **hospital or care home**	Stage 2: Assessment or/and treatment in **hospital** without consent

A stepped process through the Acts



The Care Act (2014) – 2 levels of referral

‘Needs assessment’ for an ‘Adult with care and support needs’

- Refer to the local authority to assess a person who appears to have needs for care and support, regardless of the level of need
- Managing and maintaining nutrition; Maintaining personal hygiene; Managing toilet needs; Being appropriately clothed; Being able to make use of the home safely; Maintaining a habitable home environment; Maintaining and developing family and other personal relationships; Accessing and engaging in work, training; Accessing services in the community; Caring for others

Section 42 (safeguarding) enquiry

‘Section 42 (Safeguarding) Enquiry’ for an ‘Adult at risk’

- A local authority is required to complete an assessment where the adult is experiencing or is at risk of abuse or neglect, including *self-neglect* and **their care and support needs are preventing them from protecting themselves**
- It ‘should establish whether any action needs to be taken to stop or prevent abuse or neglect, and if so, by whom.’
- The Act does *not* dictate the specific action to be taken or give local authorities powers to ensure care is delivered.
- For someone with alcohol dependence the response is likely to involve:
  - Multi-agency management and assertive outreach
  - Relationship building, ongoing assessment, harm reduction, motivational work, dietary approaches
  - In some instances the response will require residential rehabilitation.

Care Act - conclusions

- Where you have valid concerns around a self-neglecting person with alcohol problems, have a low threshold for making a safeguarding (Section 42) referral
- You do not need the consent of the individual to make a safeguarding referral (although you should usually inform them)
- In the first instance, the referral should hopefully lead to a coordinated multi-agency response and a structure for dealing meaningfully with the issues faced.
- Failure of a number of different agencies to make a timely safeguarding referral was a main finding in Robert's SAR

Mental Capacity Act (2005)

- Principles
- The 2-stage test
- Executive capacity
- Micro and macro capacity
- Fluctuating capacity
- Restraint
- Restriction vs Deprivation of Liberty
- Deprivation of Liberty Safeguards

MCA: Five statutory principles

Before concluding the person lacks capacity to reach a decision:

1. A person must be assumed to have capacity unless it is established that they lack capacity
    - Start with a **presumption of capacity**

2. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
    - **Support the person to make a decision** before finding they are unable to

3. A person is not to be treated as unable to make a decision merely because he makes an **unwise decision**
    - Making an unwise decision does not necessarily mean the person lacks capacity, but it might be a consequence.

After concluding the person lacks capacity to reach a decision:

4. An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in their **best interests**.

5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is **less restrictive** of the person's rights and freedoms of action.

MCA: The two-stage test

A person lacks capacity in relation to a matter if at the material **time** he is unable to make a **decision** for himself in relation to the matter ***because*** *of* **an impairment of,** or a disturbance in the functioning of, **the mind or brain**.

- Capacity is time and decision specific
- There must be a ‘causal nexus’ between the impairment and the inability to make the decision

MCA: 1st stage test: the ‘functional’ test

(1) A person is unable to make a decision for himself if he is unable to

(a) understand the information relevant to the decision,

(b) retain that information,

(c) use or weigh that information as part of the process of making the decision, or

(d) communicate his decision (whether by talking, using sign language or any other means).

(2) A person is not to be regarded as unable to understand the information relevant to a decision if he is able to understand an explanation of it given to him in a way that is appropriate to his circumstances (using simple language, visual aids or any other means).

(3) The fact that a person is able to retain the information relevant to a decision for a short period only does not prevent him from being regarded as able to make the decision.

(4)The information relevant to a decision includes information about the reasonably foreseeable consequences of—

- (a)deciding one way or another, or
- (b)failing to make the decision.

Retain the information

Can the person retain the information *for long enough to make the decision?*

“The fact that a person is able to retain the information relevant to a decision for a short period only does not prevent him from being regarded as able to make the decision.”

- Will depend on the complexity of the decision
- Memory function is a key area when assessing capacity in people with alcohol problems

Use & Weigh the information

- The Code of Practice says:
  - ‘a person with the eating disorder anorexia nervosa may understand information about the consequences of not eating. But their compulsion not to eat might be too strong for them to ignore.’
  - ‘Some people with serious brain damage might make impulsive decisions regardless of information they have been given or their understanding of it’
- Both may imply an inability to ‘Use’ information - this has relevance to the core symptom of loss of control in the diagnosis of ‘alcohol dependence’
- Difficulties using and weighing information are also closely aligned to the concepts of ‘executive capacity’ and ‘macro and micro capacity’

MCA: 2nd stage test – the ‘diagnostic’ test

Some clarifications:

- We do not need to wait for a formal diagnosis before applying the MCA, but it may help
  - Your defence in terms of the MCA is: i) Did you *reasonably* believe that P lacked capacity having taken all reasonable steps to help P decide and ii) Did you act in what you *reasonably* believed to be P’s best interests?
- Having a diagnosis might increase the likelihood of the person lacking capacity *in your judgement* (over 50% likelihood), and aid in demonstrating your ‘reasonableness’ in reaching that conclusion
- Equally, having a diagnosis may become more pertinent the greater the impact on the individual (intensity and time) of the decision you reach in their best interests
- The MCA *does* apply to people with mental impairments due to the symptoms of alcohol or drug use which is confirmed in the Code of Practice.
- The Act states ‘it does not matter whether the impairment or disturbance is permanent or temporary’.
- However, different approaches should be taken in application of the Act in those with temporary impairment as compared to those with permanent or longer-term impairments.

Executive capacity (executive functioning)

The term ‘executive capacity’ does not appear in the Mental Capacity Act (MCA), nor in the Code of Practice. However, the courts have recognised this concept and refer to it in the relevant case law (preferable legal terms are executive functioning/dysfunction; longitudinal capacity; performative capacity).

- It refers to the individual’s capacity to put a decision into effect whereas the ability to make a decision may be referred to as ‘decisional capacity’.
- Can the person ‘walk the walk’ as well as ‘talk the talk’?
- Despite its close correlation with behaviour (putting a decision into effect) we must still relate it to the inability to reach a coherent decision – Section 2(3) MCA: ‘never be based *simply* on…any aspect of their behaviour’
  - The behaviour is the ‘clue’ that the person may lack capacity rather than evidence they lack capacity

Micro and macro capacity

- Court of Protection case law has also described themes of micro- and macro-capacity:
  - just because the person can reach a decision on one element of a situation does not mean they can effectively manage the overall situation.
- It is similar to executive capacity and is tied to the concept of a chief executive overseeing multiple inputs to coordinate an output.
- An absence of macro capacity implies an inability to stand back and consider the overall or longer-term consequences of a smaller decision.
  - For example, a person who repeatedly agrees to hospital admission followed by early self-discharge against medical advice may be judged to have capacity for each small decision around admission and discharge but to lack the ability to ‘stand-back’ and consider the overall impact of each small decision.

Executive and macro/micro capacity

- Closely associated with damage to the prefrontal cortex which is found in between 30-50% of those with alcohol dependency on imaging and post-mortem studies.
- More recent fMRI brain studies also frequently find evidence of prefrontal dysfunction in people with alcohol dependency where there are no gross structural changes visible
- Assess based on both verbal explanations (communication of the decision) and on observation of **capabilities over a period of time**.
- Always consider if a person is **repeatedly** making decisions that put themselves or others at risk.
- And, in the immediate aftermath of alcohol detox, beware of the ‘pink cloud’ and of worker over-optimism before concluding capacity has returned.

Fluctuating capacity

Delirium, dementia, severe mental illness can all be associated with **fluctuating capacity**

- In cases of fluctuating capacity, the courts and NICE have advised taking a **long-term perspective** on someone's capacity rather than simply assessing the capacity at one point in time.

(Also consider taking a long-term perspective and seek information from others who know the person well if someone is always intoxicated. Just because a person is always intoxicated does *not* mean their capacity cannot be assessed.)

Restraint and restriction

The MCA Code of Practice defines restraint as:

- Use of force – or threat to use force – to make someone do something they are resisting, or
- **Restriction** of a person's **freedom of movement**, whether they are resisting or not.

For restraint to be legal within the MCA:

- The person taking action must reasonably believe that restraint is *necessary* to prevent *harm* to the person who lacks capacity, and
- The amount or type of restraint used and the amount of time it lasts must be a *proportionate response* to the likelihood and seriousness of the harm

Restraint and restriction

You may also rely on the common law **doctrine of necessity** if use of force is the only way to prevent serious, imminent harm.

- You might rely on this where there has been no time to make any assessment of capacity, for example preventing someone jumping from a bridge or running into traffic

In the community, consider involvement of police if Section 136 MHA might be applicable

- They appear to be suffering from a mental disorder and
- They appear to be in immediate need of care or control

What is deprivation of liberty?

- There is no set definition – it is case law dependent
- It may be helpful to envisage **a scale which moves from restriction of liberty to deprivation of liberty** - the difference is one of degree or intensity not one of nature or substance (ECHR)
- The Mental Capacity Act allows restraint and restrictions to be used, but only if they are in a person's best interests.
- Extra safeguards are needed if the restrictions and restraint used will amount to a deprivation of someone's liberty. These are the Deprivation of Liberty Safeguards (DoLS).
- The DoLS can only be used if the person will be deprived of their liberty in a **care home or hospital**. In other settings, the Court of Protection can authorise a deprivation of liberty.

What are the safeguards?

- A formalised assessment to see if deprivation of liberty is occurring and whether the law has been followed
- A person has someone appointed with legal powers to represent them. This is called the relevant person's representative and will often be a family member or friend – if none available then an Independent Mental Capacity Advocates (IMCA) is appointed.
- The person, their representative or IMCA have rights to challenge authorisations in the Court of Protection
- There are requirements for periodic review, notification of CQC
- Professionals acting within the terms of the DoLS are protected from civil and criminal liability

MCA Assessment Conclusions: Time

- Take your time
  - The MCA is decision and time-specific
    - A decision may change in the future which may lead to a different outcome of your assessment of capacity
  - Short acting causes of mental impairment
    - If likely to resolve in the near future without adverse consequence, then delay your assessment
  - Fluctuating capacity – take a longer-term/overall view
  - Executive capacity – consider behaviour over the longer-term
  - Consistently intoxicated – consider behaviour over the longer-term
- Memory: Can information be retained long enough to reach the decision?
  - Your assessment will depend on the complexity of the decision
- Also relevant in considering whether someone is being deprived of their liberty
  - Short periods of restriction or restraint which proportionately reduce the risk of harm are not likely to amount to a deprivation of liberty

MCA Assessment Conclusions: Diagnosis

Formal diagnosis of the mental impairment which is causal for the mental dysfunction is **not** a pre-requisite for reaching your decision around capacity

However:

- A formal diagnosis of mental disorder is likely to add weight to your assessment of the probability around the person's capacity
- It is also likely to add weight to any argument you have to make to the Court of Protection around your decision being a 'reasonable' one.
- The greater the impact of the outcome of your assessment on the individual (e.g. longer durations of deprivation of liberty, greater intrusiveness of treatment interventions) the more relevant a formal diagnosis becomes.
- Where a condition which impacts on mental capacity is likely to persist, *plan early* to seek formal diagnosis.

The Mental Health Act 1983 (rev 2007)

- The MHA 1983 focuses on the provision of assessment (Section 2) and treatment (Section 3) of a mental disorder in hospital when a person does not or cannot consent to that treatment.
- In order for a person to be detained in hospital in the absence of consent they need to be found to suffer from a mental disorder and also to pose a risk of harm to themselves (including to their health) or others. The mental disorder and associated risk needs to be of a nature or degree necessary for detention in hospital – the 'necessity test'.
- While the diagnosis of 'alcohol dependence' is a mental disorder as defined in ICD-10/11 and DSM-5, it is excluded as a mental disorder under the MHA.
- However, diagnoses which arise secondary to a primary diagnosis of alcohol dependence may qualify as a mental disorder under the MHA
- And, medical treatment can include measures to address alcohol or drug dependence if that is an appropriate part of treating the mental disorder which is the primary focus of the treatment.

Relevance of the MHA in alcohol dependence

Where the person is found to have capacity around treatment decisions but does not consent to treatment:

E.g. a person with alcohol-related depressive disorder with associated suicide risk:

- May be detainable under the MHA
- Treatments for alcohol dependence (e.g. medicated detoxification, prescription of relapse prevention medication) can then be administered under the MHA

Mental Health Act or Mental Capacity Act?

A person who is found to lack capacity to consent to treatment (whether they agree to treatment or not):

- and is being accommodated **in a hospital** for care and/or treatment for mental disorder and
- and who is likely to be deprived of their liberty

should *never* be informally admitted to hospital (whether they are content to be admitted or not)". (MHA code of practice for England, 13.52)

- **Question – which Act applies?**

Mental Health Act or Mental Capacity Act?

- E.g. a person who lacks capacity due to delirium (an organic mental disorder) related to hepatic encephalopathy secondary to alcoholic liver disease
- E.g. a person with a very severe alcohol-related depression who lacks capacity related to thought retardation or mutism

For a person who lacks capacity to reach a decision to consent to treatment in hospital:

	Receiving treatment partially or wholly for mental disorder	Not receiving treatment for mental disorder
Objects to admission (or objects to treatment partially or wholly for mental disorder)	*MHA must be used* *MCA (not DoLS) can also be used for treatment for additional physical health conditions*	*MCA + DoLS (if deprived of liberty)*
Does not object to admission (and does not object to treatment partially or wholly for mental disorder)	*MCA + DoLS (if deprived of liberty) OR MHA* *Use whichever is least restrictive*	*MCA + DoLS (if deprived of liberty)*

Any Questions?

Neuropathology of alcohol use

Alcohol is potentially toxic to multiple organs

Alcohol and the brain - neuropathology

Objectives:

- Understand three different mechanisms by which alcohol affects the brain over time
- Understand that those mechanisms express themselves variably in different brain areas
- Relate this to diagnosis
- Relate this to assessment of mental capacity

Alcohol and the brain - neuropathology

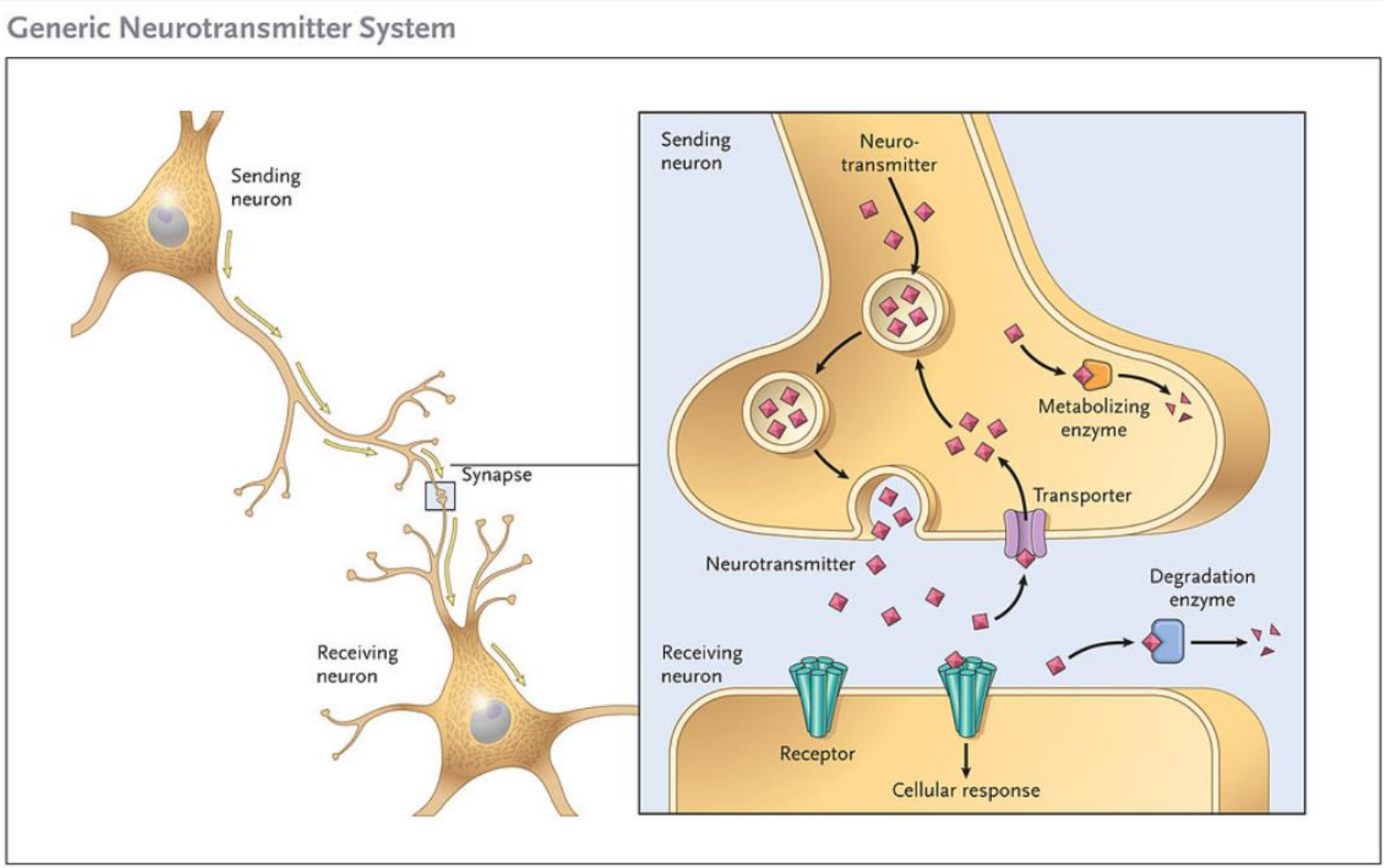
Three main ways alcohol affects the brain in time

- An **immediate** chemical effect via neurotransmitters
- With continued drinking in the **medium-term**: Changes in neurotransmitter *receptor responsiveness* to counteract the immediate chemical effect (neuroadaptation/tolerance)
- With long-term drinking: A **longer-term** toxic effect in some brain areas leading eventually to structural damage visible on brain scan in those areas

Immediate chemical effect

- The brain consists of billions of nerve cells (neurons) which communicate with each other through chemicals (neurotransmitters)
- Neurotransmitters can either excite the next neuron leading to an increased response, or depress it (inhibitory) leading to a reduced or no response
- Stimulant or depressant effects can occur at different times in different brain areas which then lead to more complex outcomes

Neurobiology: neurotransmitters

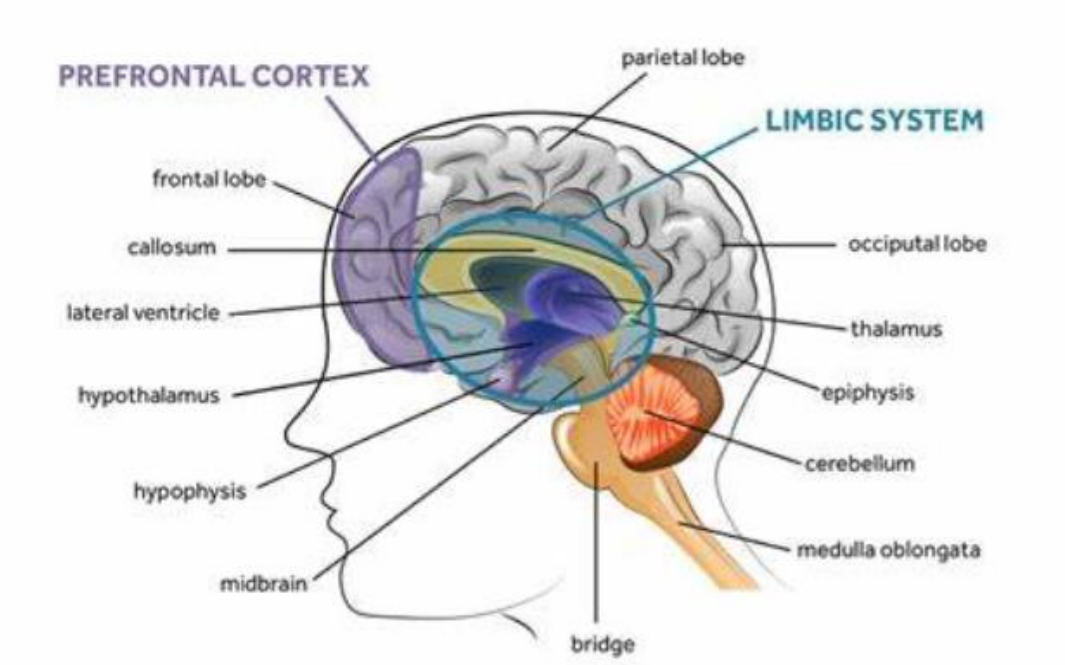


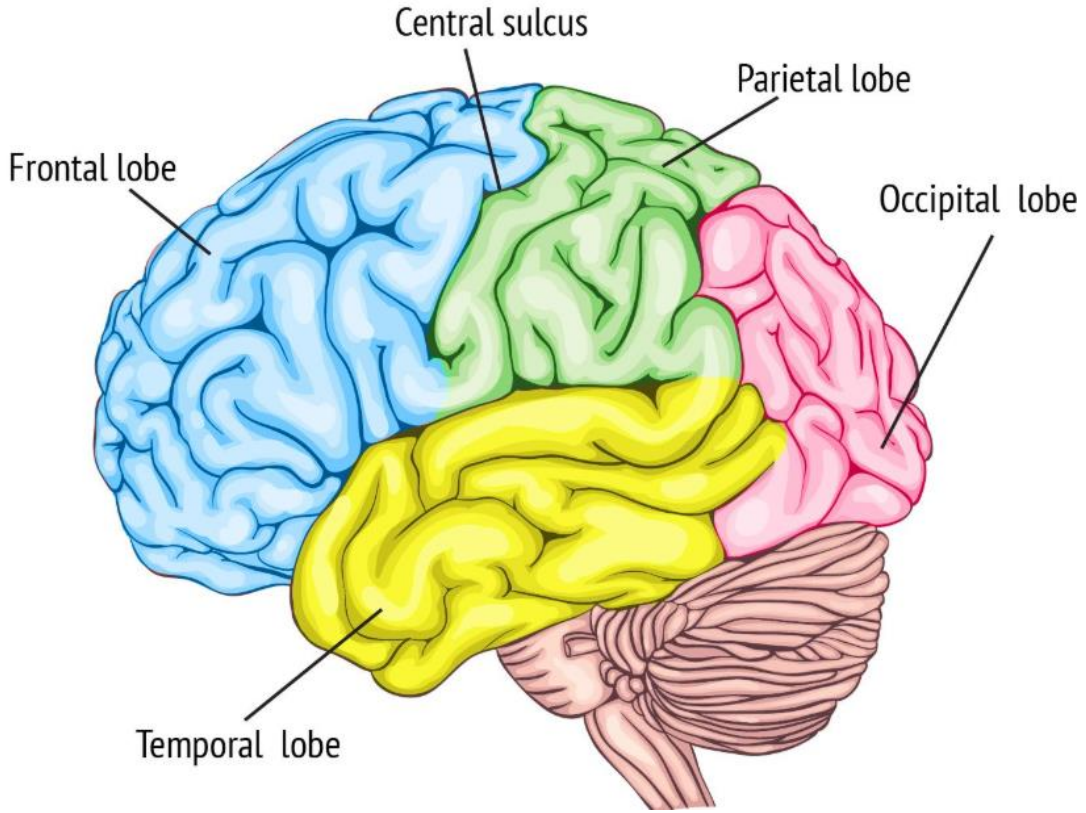
Immediate chemical effects: what and where?

- As for all addictive drugs, alcohol **stimulates** the brain's '**reward system**' through release of dopamine in the Nucleus Accumbens – this is indirectly associated with the experience of '**pleasure**' (mediated through release of endorphins and endo-cannabinoids)

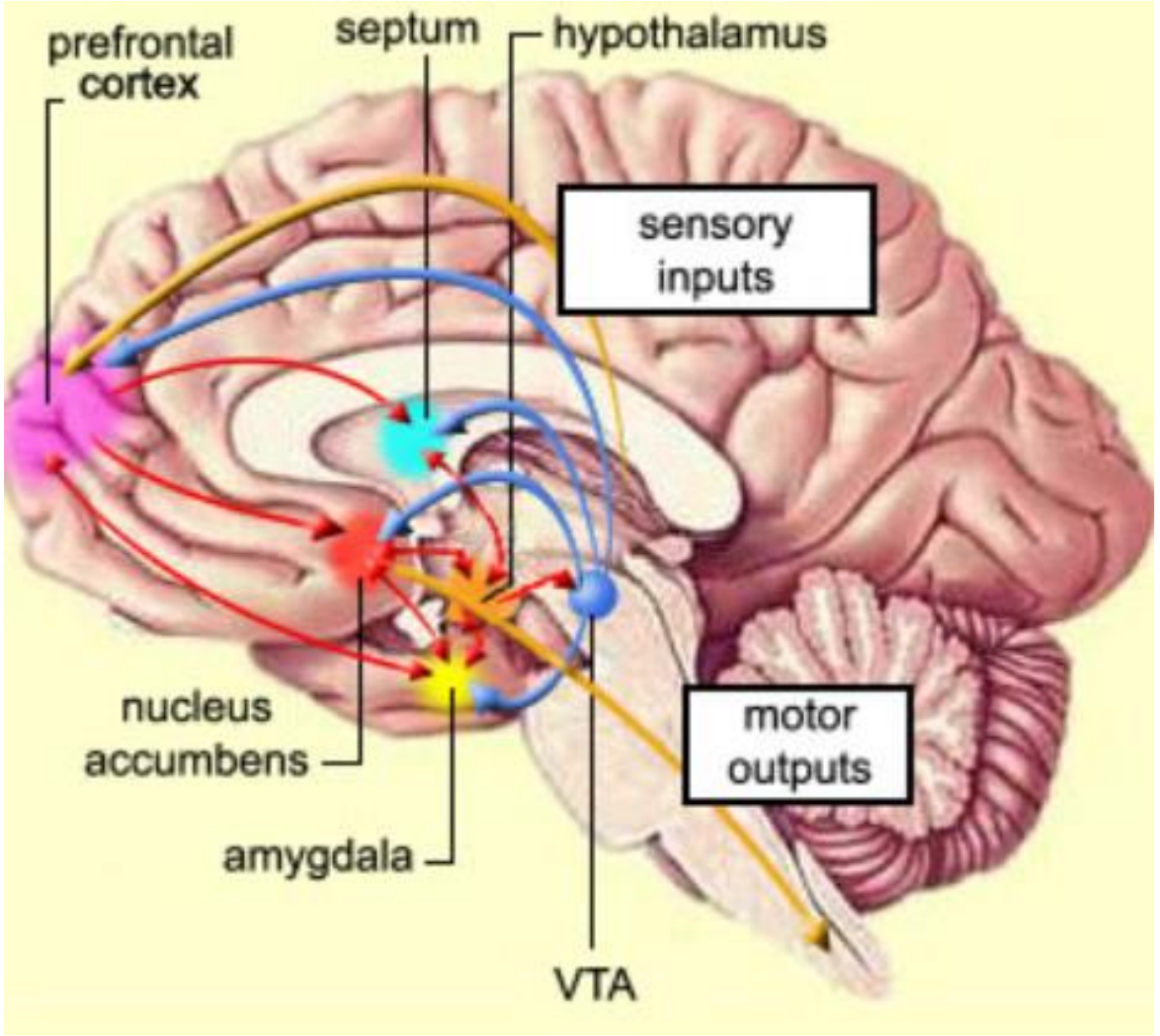
- Alcohol also causes a more overall (**global**) **inhibitory** (or depressant) effect on the brain by (indirectly) increasing the effect of GABA (inhibitory) and reducing the effect of glutamate (stimulant) – this presents as **intoxication**

NEUROANATOMY

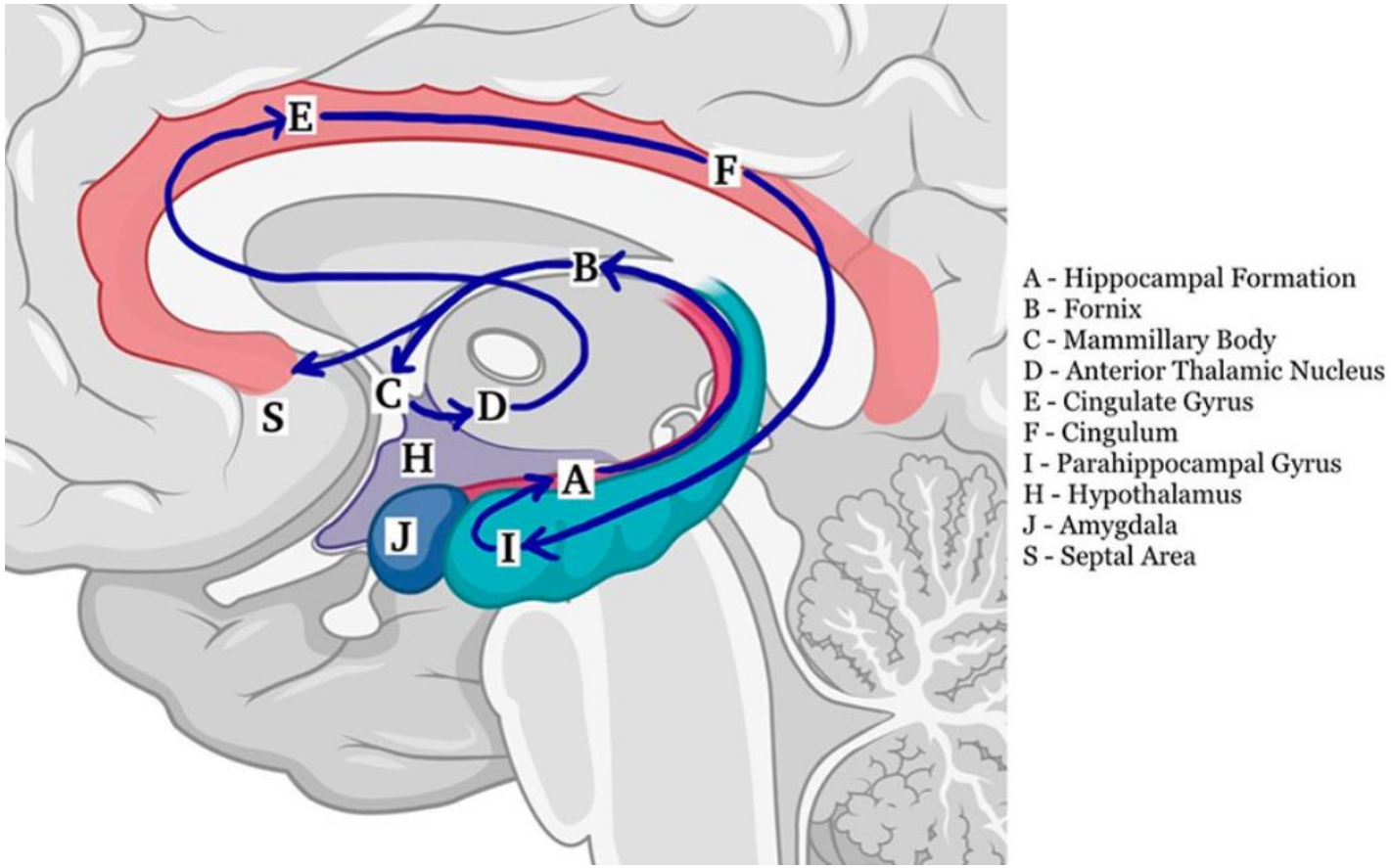




Limbic system - the Reward Circuit



Hippocampus and Papez circuit – storing new memories



Immediate Chemical Effects of Alcohol on the Brain (by Blood Alcohol Concentration)

BAC (%)	Primary Brain Region Affected	Key Effects Observed
0.02 – 0.05	Prefrontal Cortex	Reduced inhibition, impaired judgment, increased confidence
0.05 – 0.08	Cerebellum	Slurred speech, poor coordination, delayed reaction times
0.08 – 0.15	Hippocampus & Amygdala	Memory impairment (blackouts), emotional volatility, aggression
0.15 – 0.30	Basal Ganglia & Brainstem Centers	Vomiting, severe motor dysfunction, reduced gag reflex
> 0.30	Reticular Activating System	Stupor, coma, respiratory depression — medical emergency

Medium-term receptor effect: neuroadaptation; tolerance and withdrawal

- But with regular, heavy alcohol use, **over days and weeks**, the brain **adapts** to attempt to maintain overall normality (homeostasis)
- The adaptive aim is to help maintain functioning despite the brain being bathed continuously in alcohol
- It achieves this largely through changes in receptor numbers and function which have the effect of making the brain '**tolerant**' to alcohol
  - In the reward system – **reduced endorphin** receptor numbers and sensitivity leading to **less reward** from drinking a certain amount of alcohol
  - In the wider brain – **reduced GABA** receptor numbers and sensitivity and **increased glutamate** receptor numbers and sensitivity – **leading to less intoxication** caused by a certain amount of alcohol

Medium-term receptor effect: neuroadaptation; tolerance and withdrawal

But good intentions can have **unintended consequences**:

- The development of tolerance in the reward system can drive the individual to drink more and more in order to achieve the desired pleasure, as well as to counteract increased baseline activity in the amygdala associated with increased stress and dysphoria, leading to
  - **onset of addiction**
  - **toxic damage to brain areas and body organs which cannot adapt**
- Development of tolerance in the wider brain leads to the brain being in an over-excited state in the absence of alcohol leading to
  - **Withdrawal symptoms**
  - Drinking to relieve withdrawal **– toxic damage** as above

Longer-term toxic effects

Many brain areas are susceptible to toxic damage from alcohol, but **two areas are especially susceptible**:

Prefrontal cortex

- In the short-term function is reduced by immediate chemical effects, but then increasingly over time by dysfunction and eventually structural damage
- The effect is to reduce control over urges to drink coming from the limbic/reward system
- In the longer term reduced control over impulses in general.

Hippocampus

- In the short-term function is reduced by immediate chemical effects (alcoholic blackouts), but in the longer term permanent structural damage can arise:
  - If damage is local to hippocampus: Korsakoff's syndrome/amnestic syndrome
  - If damage is also widespread through brain: Alcoholic dementia

Summary of short, medium and long-term effects

Short-term: Alcohol interferes with brain chemistry to cause reward and to depress brain function

- Prefrontal cortex is suppressed early leading to disinhibition associated with intoxication, before other systems are then depressed leading to increasing sedation, slurred speech, falls, coma.

Medium-term: adaptive chemical effects (with regular use)

- Increasing **loss of control** by an underactive prefrontal cortex of impulses to drink arising from an overactive limbic/reward system which now sends craving signals and dysphoric feelings in the absence of alcohol – the key to understanding addiction neuropathology
- A global neuroadaptation effect – development of tolerance to the effects of alcohol and emergence of **withdrawal symptoms** (as for many drugs which act on the brain including antidepressants)

Medium-term: reduced function (with regular use)

- Effects on brain **cognitive function (executive and memory function in particular)** which persist well after alcohol has been removed from the brain, but full recovery will eventually occur after weeks and months of abstinence

Long-term (heavy regular use for years): **structural damage**

- Can cause irreversible cognitive dysfunction through damage to the structure of the brain – although some recovery may occur clinically and on MRI brain scan with long term abstinence

Diagnosis

What is Alcohol Use Disorder?

- Primary diagnoses
- Secondary diagnoses
- Other diagnoses

Terminology

Two diagnostic systems

- USA (APA) v WHO
- DSM-5 v ICD-11 (currently ICD-10 in clinical practice)
- Alcohol Use Disorder (USA) = Alcohol dependence + Harmful pattern of use (UK)
- We tend to mix terms up in everyday use, but for practical usage Alcohol Use Disorder (USA) is similar to Alcohol Dependence (UK)

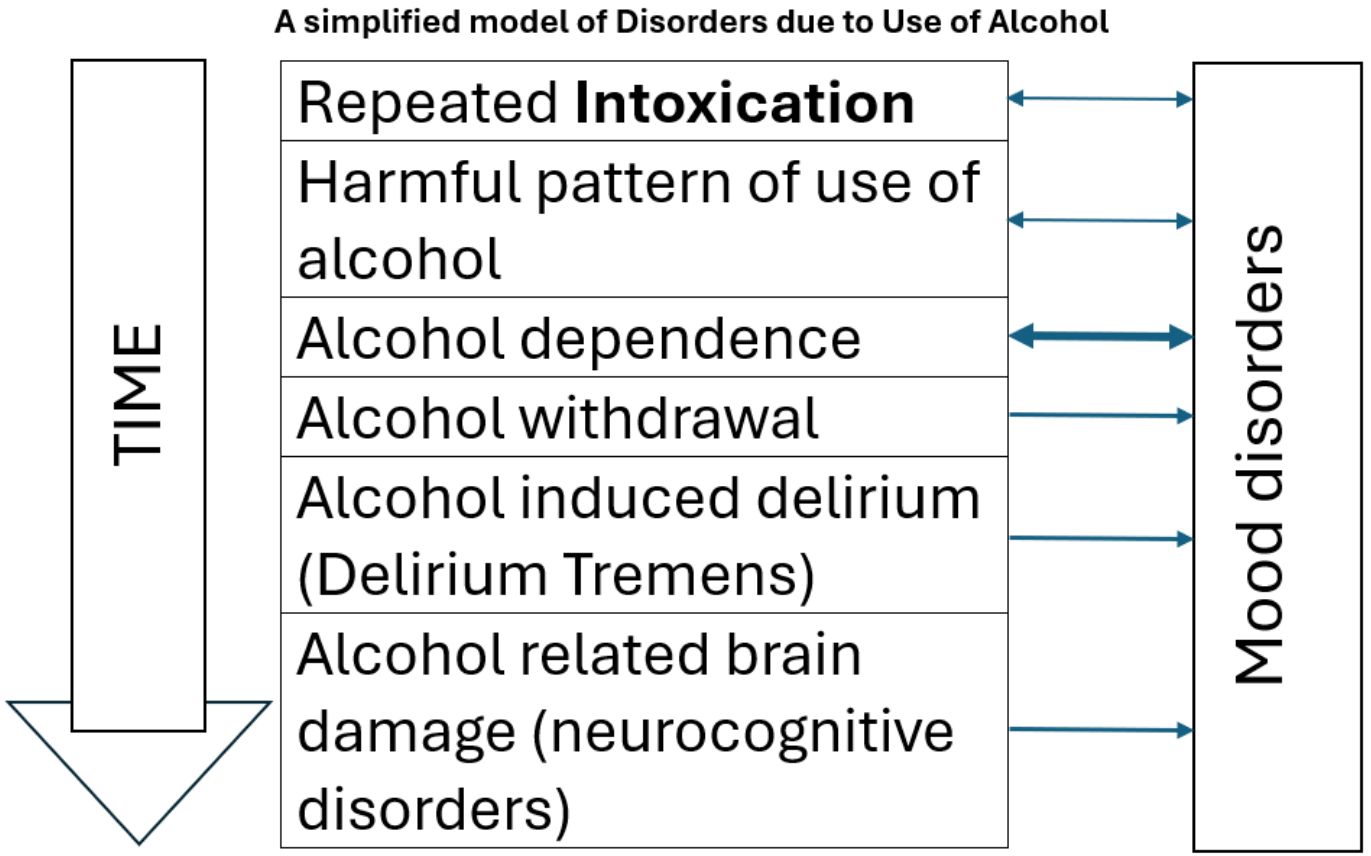
Primary and secondary diagnoses

- In the UK **the primary diagnosis** will be either alcohol dependence or harmful pattern of use of alcohol
- There are then a number of secondary diagnoses which can be coded in addition to primary diagnosis. These include
  - Alcohol intoxication
  - Alcohol withdrawal
  - Alcohol-induced mental disorders (delirium, psychosis, mood disorder, anxiety disorders)
  - Alcohol-induced neurocognitive disorders
- Both the primary diagnoses and the secondary diagnoses have direct relevance to the second-stage (diagnostic) test in the Mental Capacity Act.

Terminology in DSM-5 and ICD-11

American Psychiatric Association (APA)	**World Health Organisation (WHO)**
Diagnostic and Statistical Manual of Mental Disorder – 5th edition (DSM-5)	International Classification of Diseases – 11th revision (ICD-11)
Chapter Heading	
Alcohol-related Disorders	Disorders due to use of Alcohol
Primary diagnoses	
Alcohol Use Disorder	Alcohol Dependence
	Harmful Use of Alcohol
Secondary diagnoses	
Alcohol intoxication	Alcohol intoxication
Alcohol withdrawal	Alcohol withdrawal
	Alcohol-induced delirium
Alcohol-induced mental disorders	Alcohol-induced psychotic disorders
Alcohol-induced mental disorders	Alcohol-induced mood disorders
Alcohol-induced mental disorders	Alcohol-induced anxiety disorders
Chapter Heading	
Neurocognitive disorders	Neurocognitive disorders
Diagnoses	
Alcohol-induced delirium	
Alcohol-induced neurocognitive disorder	Amnestic disorder due to use of alcohol
Alcohol-induced neurocognitive disorder	Dementia due to use of alcohol

A simplified model of progression of diagnoses through time



Other alcohol-related diagnoses with relevance for the MCA

Common causes of delirium in alcohol dependency

- Wernicke's encephalopathy
  - Acute onset of confusion, ataxia, nystagmus (classic triad) caused by deficit in thiamine (vitamin B1)
- Head injury (typically from falls)
  - Concussion
  - Acute extradural haematoma
  - Chronic subdural haematoma
- Hepatic encephalopathy
  - Liver fails to convert ammonia to urea – ammonia absorbed into brain
- Hypoglycaemia (low blood sugar)
  - Poor nutrition
  - Metabolism of alcohol reduces capacity of new formation of glucose
- As well as alcohol intoxication, alcohol withdrawal delirium and alcohol withdrawal seizures

Alcohol-related diagnoses with relevance for the Mental Capacity Act

Alcohol-related diagnoses with relevance for Mental Capacity

Alcohol Dependence (and Harmful Pattern of use of Alcohol)

Short-lived – hours to a week or so

- **Intoxication**
- **Withdrawal**
  - **Psychosis**
  - **Seizures**
- **Hypoglycaemia**
- **Head injury**
  - **Concussion**
  - **Extradural haematoma**
- **Hepatic encephalopathy**
- **Wernicke's encephalopathy**

Longer duration

Often reversible

- **Depression**
- **Anxiety**
- **Subdural haematoma**

NOT fully reversible

- **ARBD/ARBI**
  - **Alcohol-related dementia**
  - **Korsakoff's/amnestic syndrome**

Screening for alcohol dependence

To identify problem drinking NICE suggests first use the **AUDIT** (Alcohol Use Disorders Identification Test).

Takes several minutes to administer (10 questions)

Other shorter versions available for busy clinics (e.g. AUDIT-C)

- 0-7 indicates low-risk.
- 8-15 indicates increasing risk.
- 16-19 indicates higher risk.
- 20 or more indicates possible dependence.

AUDIT

Questions	Scoring system				
	0	1	2	3	4
How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week
How many units of alcohol do you drink on a typical day when you are drinking?	0 to 2	3 to 4	5 to 6	7 to 9	10 or more
How often have you had 6 or more units if female, or 8 if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you found you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year
Has a relative or friend, doctor or health worker been concerned about your drinking or suggested that you cut it down?	No		Yes, but not in the last year		Yes, during the last year

Severity of Alcohol Dependence Questionnaire (SADQ)

If scoring 20 or more on the AUDIT, progress to the SADQ

- Ask the person to recall a typical period of heavy drinking in the last 6 months and then to respond the main questions.
- 20 questions – around 10 minutes to deliver
- Developed in the 1970s and 80s at the National Institute of Psychiatry

Cut-offs for the SADQ are

- 15 or less — mild or no dependence – unlikely to need medicated detoxification (<8 probably no dependence)
- 16 to 30 — moderate dependence – likely need for medicated detoxification
- 31 or more — severe dependence – consider in-patient/residential detoxification

SADQ subscales	Items
Physical Withdrawal	1. The day after drinking alcohol, I woke up feeling sweaty. 2. The day after drinking alcohol, my hands shook first thing in the morning. 3. The day after drinking alcohol, my whole body shook violently first thing in the morning if I didn't have a drink. 4. The day after drinking alcohol, I woke up absolutely drenched in sweat.
Affective Withdrawal	5. The day after drinking alcohol, I dread waking up in the morning. 6. The day after drinking alcohol, I was frightened of meeting people first thing in the morning. 7. The day after drinking alcohol, I felt at the edge of despair when I awoke. 8. The day after drinking alcohol, I felt very frightened when I awoke.
Withdrawal Relief Drinking	9. The day after drinking alcohol, I liked to have an alcoholic drink in the morning. 10. The day after drinking alcohol, I always gulped my first few alcoholic drinks down as quickly as possible. 11. The day after drinking alcohol, I drank more alcohol to get rid of the shakes. 12. The day after drinking alcohol, I had a very strong craving for a drink when I awoke.
Alcohol Consumption	13. I drank more than a quarter of a bottle of spirits in a day (OR 1 bottle of wine OR 7 beers). 14. I drank more than half a bottle of spirits per day (OR 2 bottles of wine OR 15 beers). 15. I drank more than one bottle of spirits per day (OR 4 bottles of wine OR 30 beers). 16. I drank more than two bottles of spirits per day (OR 8 bottles of wine OR 60 beers)
Rapidity of Reinstatement	17. I would start to sweat. 18. My hands would shake. 19. My body would shake. 20. I would be craving for a drink.

SADQ

1. The day after drinking alcohol, I woke up feeling sweaty.
ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

2. The day after drinking alcohol, my hands shook first thing in the morning.
ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

3. The day after drinking alcohol, my whole body shook violently first thing in the morning if I didn't have a drink.
ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

4. The day after drinking alcohol, I woke up absolutely drenched in sweat.
ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

5. The day after drinking alcohol, I dread waking up in the morning.
ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

6. The day after drinking alcohol, I was frightened of meeting people first thing in the morning.
ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

7. The day after drinking alcohol, I felt at the edge of despair when I awoke.
ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

8. The day after drinking alcohol, I felt very frightened when I awoke.
ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

9. The day after drinking alcohol, I liked to have an alcoholic drink in the morning.
ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

10. The day after drinking alcohol, I always gulped my first few alcoholic drinks down as quickly as possible.
ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

11. The day after drinking alcohol, I drank more alcohol to get rid of the shakes.
ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

12. The day after drinking alcohol, I had a very strong craving for a drink when I awoke.
ALMOST NEVER SOMETIMES OFTEN ALMOST ALWAYS

13. I drank more than a quarter of a bottle of spirits in a day (OR 1 bottle of wine OR 7 beers).
ALMOST NEVER SOMETIMES OFTEN ALMOST ALWAYS

14. I drank more than half a bottle of spirits per day (OR 2 bottles of wine OR 15 beers).
ALMOST NEVER SOMETIMES OFTEN ALMOST ALWAYS

15. I drank more than one bottle of spirits per day (OR 4 bottles of wine OR 30 beers).
ALMOST NEVER SOMETIMES OFTEN ALMOST ALWAYS

16. I drank more than two bottles of spirits per day (OR 8 bottles of wine OR 60 beers)
ALMOST NEVER SOMETIMES OFTEN ALMOST ALWAYS

Imagine the following situation:
1. You have been **completely off drink for a few weeks**
2. You then drink **very heavily** for **two days**

How would you feel the **morning after** those two days of drinking?

17. I would start to sweat.
NOT AT ALL SLIGHTLY MODERATELY QUITE A LOT

18. My hands would shake.
NOT AT ALL SLIGHTLY MODERATELY QUITE A LOT

19. My body would shake.
NOT AT ALL SLIGHTLY MODERATELY QUITE A LOT

20. I would be craving for a drink.
NOT AT ALL SLIGHTLY MODERATELY QUITE A LOT

Any Questions?

Part 3: Theory to Practice

Neuropathology, diagnosis and the first stage test of mental capacity

Medical versus legal concepts of capacity

Avoidance of professional sanctions

Neuropathology & the MCA functional test

UNDERSTAND THE INFORMATION

RETAIN THE INFORMATION

USE & WEIGH THE INFORMATION

COMMUNICATE THE DECISION

UNDERSTANDING

Understanding – global effects of alcohol

Global effects – i.e. over the whole brain

Acute intoxication

- Intoxication gradually reduces ability to ‘understand’ eventually leading to coma and even death via a generalised whole brain depressant effect

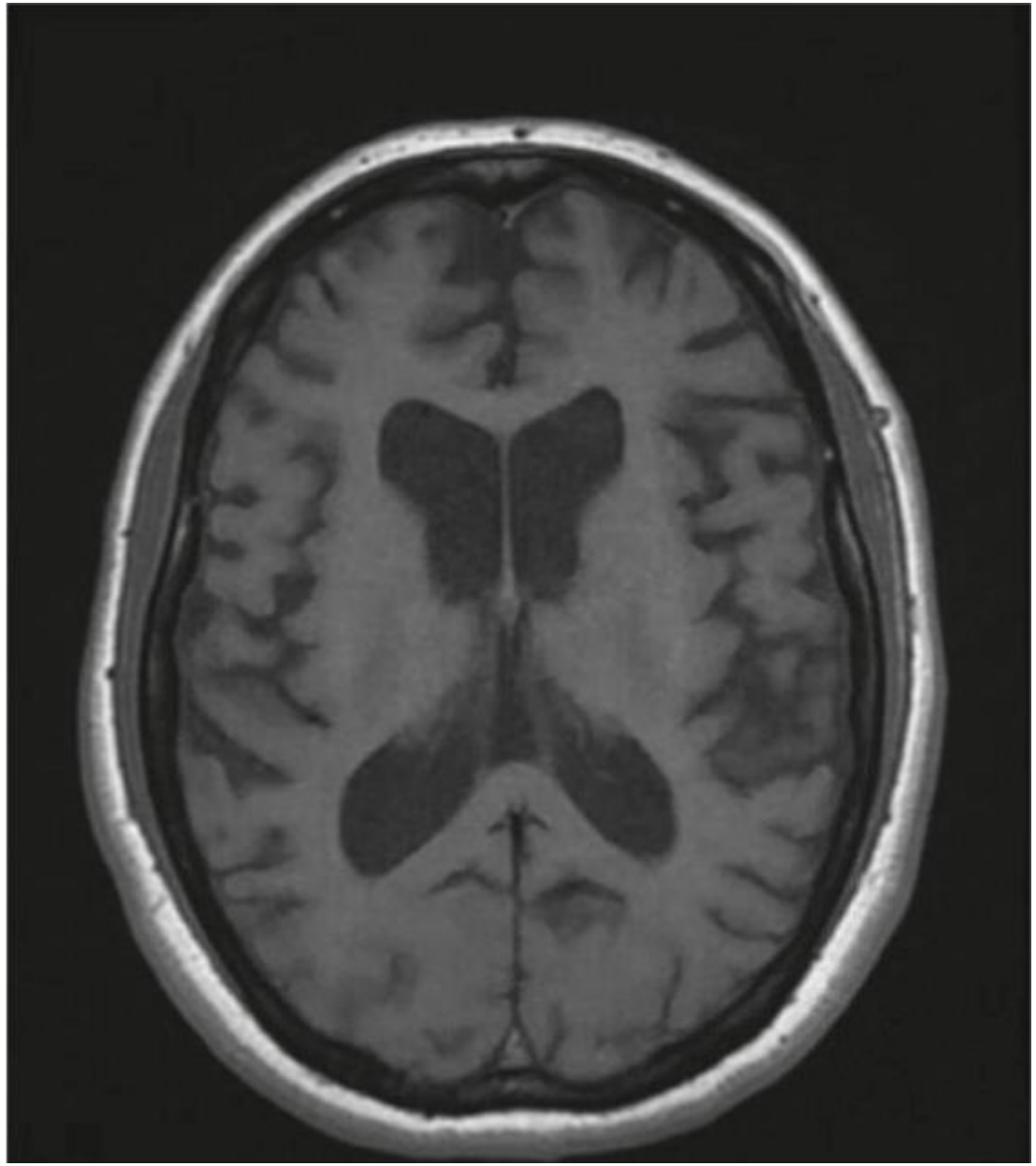
Medium-term effects

- Neuroadaptation effects, especially when causing withdrawal delirium can impact ‘understanding’.

Chronic alcohol misuse

- Prolonged heavy drinking can cause widespread cortical atrophy and white matter loss associated with reduced comprehension; even moderate regular drinking has been linked to reduced grey matter density and structural integrity (and fMRI studies have shown dysfunction in the absence of structural damage)
- This can produce a pattern of cognitive impairment akin to a dementia: a ‘global’ decline in all brain functions – alcohol-related dementia

MRI brain scan of diffuse cortical atrophy widened sulci, increased prominence of subarachnoid spaces, and ventricular enlargement



Diffuse cortical atrophy

NORMAL BRAIN

BRAIN IN ALCOHOLIC DEMENTIA

Understanding – localised effects

Acute intoxication and chronic alcohol misuse can also have more specific/localised effects on:

Prefrontal cortex (the front of the frontal lobe)

- Slowed information processing and executive dysfunction can limit the ability to comprehend complex or abstract information.

Hippocampus (within the temporal lobe)

- For more complex decisions failure to retain new information also impacts understanding (memory is one component of ‘intelligence’).

RETENTION: MEMORY

Retention of information – critical brain areas

Prefrontal cortex

- Working memory (holding and manipulating information “online” for a few seconds) and
- Retrieval of stored knowledge when reasoning.

The Papez circuit – hippocampus, mamillary bodies and thalamus

- Formation of new episodic memories (a type of long-term explicit (conscious) memory that enables individuals to recall specific personal experiences and events, including the context in which they occurred – includes associated sensory memories such as smells as well as associated emotions)

Retention – acute vs chronic effects

- **Acute intoxication** with alcohol impacts on memory mostly through **temporary hippocampal dysfunction**
  - in its most marked form known as '**alcoholic blackouts**' where memories are not laid down and preserved, although immediate memory may appear to remain intact
  - the individual will have little or no recollection of events of the previous evening
  - you might have noticed this effect when finding a drunk person repeating conversation they already held with you earlier in the evening
- **Chronic, heavy alcohol use can cause permanent damage to the hippocampus (and the connected Papez circuit).**
  - When this occurs without excessive damage to the brain elsewhere it presents as **Korsakoff's syndrome**.
  - When it occurs **together with wider damage to the brain** elsewhere (particularly in prefrontal cortex) it presents as **alcohol-related dementia**

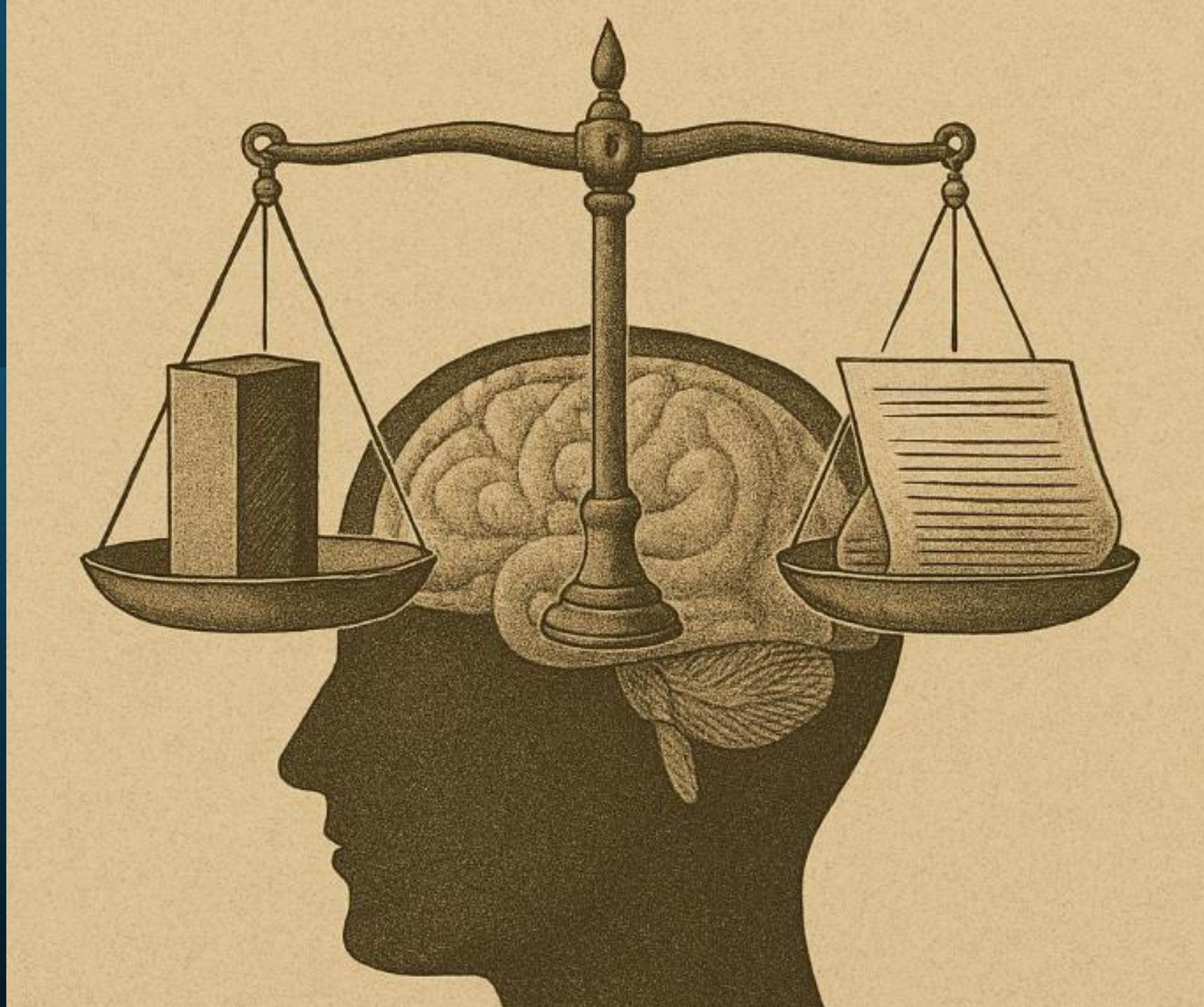
Wernicke-Korsakoff syndrome

- Commonly found at autopsy – 12.5% of those diagnosed with alcohol dependence – damage to hippocampus and Papez circuit
- Caused by lack of thiamine (vitamin B1)
- Usually starts with an acute syndrome (**Wernicke's encephalopathy**), often triggered by alcohol withdrawal (sympathetic nervous system overload uses up remaining thiamine stores).
- Characterised by confusion and disorientation, ataxia, nystagmus.
- A medical emergency which can lead to death and requires urgent treatment with IV thiamine (give thiamine before correcting glucose).
- If survived often leads to **Korsakoff's syndrome**
  - characterised by relatively intact immediate recall and absent delayed recall (after 5 minutes or so) due to anterograde amnesia (inability to store new memories)
  - associated with **confabulation** (memory gaps filled with fabricated information – not lying – individual is unaware of the fabrication).

Assessment of retention in ARBD

- May be unable to repeat back the options for treatment or forget the consequences that were explained, even within minutes
- Important in such cases to use techniques like repetition, written prompts, or memory aids – but even then, severe impairment may mean the person simply cannot hold onto the information long enough to decide
- Observe carefully for confabulation: person may give an answer that is confidently incorrect or inconsistent on repeat questioning, indicating memory gaps being filled unconsciously, thus revealing an inability to retain (despite superficially coherent conversation)

Weigh and use the information



Use and Weigh - Prefrontal cortex dysfunction

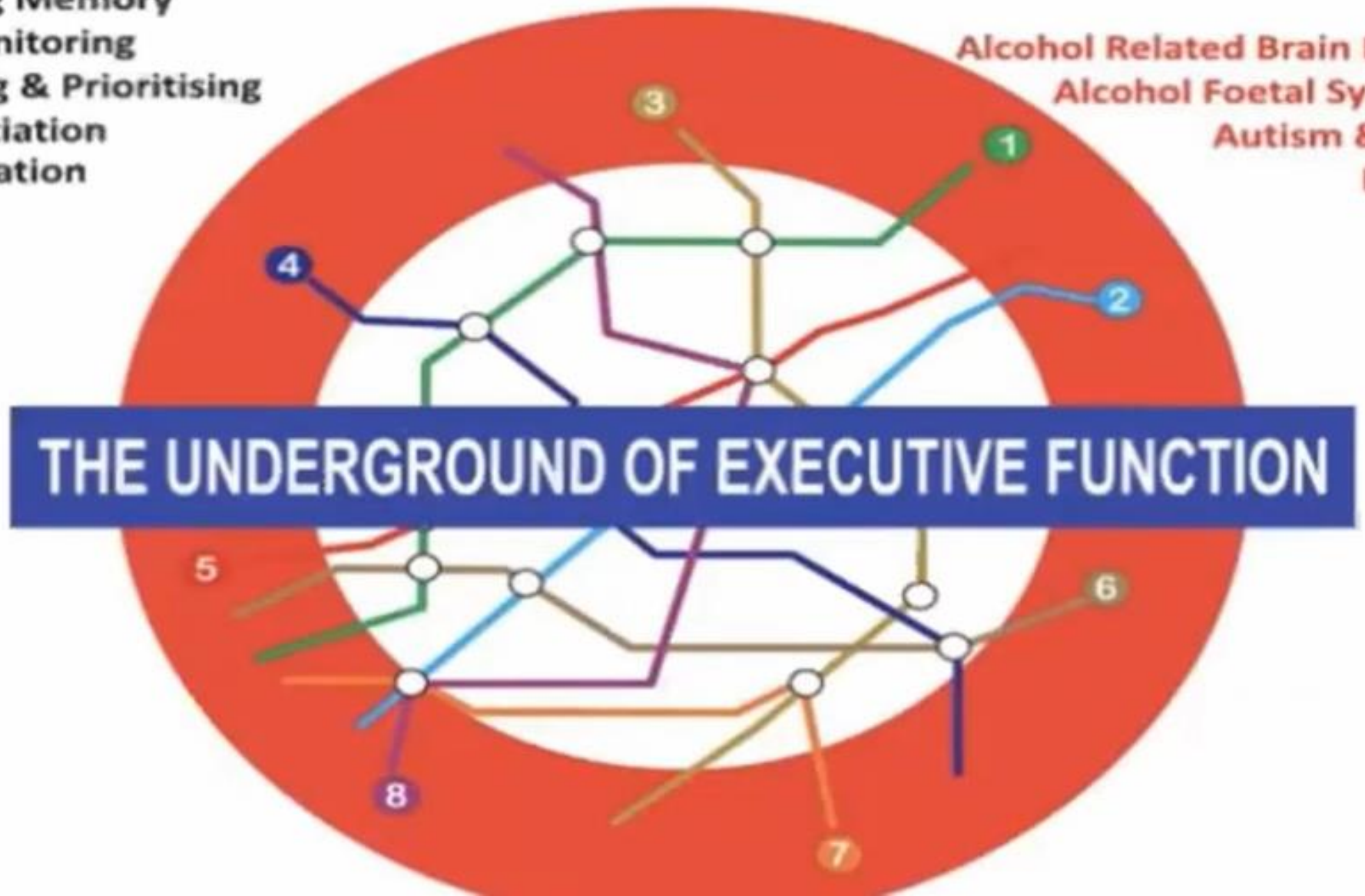
- Poor planning, inflexibility, impaired judgment, and **impulsivity**.
- Impaired risk appraisal: leaving safe housing to return to drinking on the streets
- Inability to follow through on decisions or plans
- Unrealistic optimism or denial (“I hear you say I could die, but I’m sure I won’t”)
- Failure to prioritize self-care (e.g. declining a safe housing placement despite acknowledging living on the street is dangerous)
- An understanding of options might be verbalised but the information might not be used appropriately (talk the talk but not walk the walk).

EXECUTIVE FUNCTIONING SKILLS

1. Emotional Control
2. Impulse Control
3. Flexible Thinking
4. Working Memory
5. Self-monitoring
6. Planning & Prioritising
7. Task Initiation
8. Organisation

HIDDEN DISABILITIES AND DIFFERENCES

- Acquired Brain Injury
- Traumatic Brain Injury
- Developmental Trauma
- PTSD
- Alcohol Related Brain Damage
- Alcohol Foetal Syndrome
- Autism & ADHD
- Epilepsy

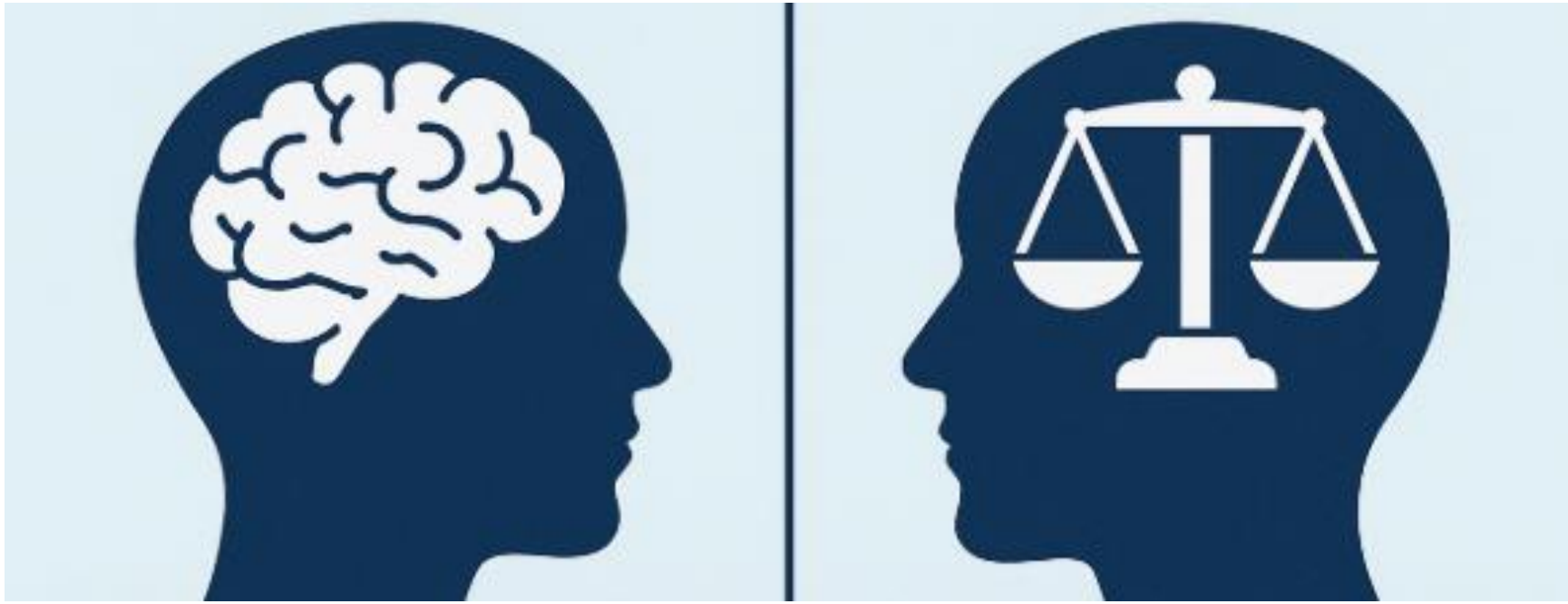


Communicate the decision

Communicate

- Basic language abilities (vocabulary, grammar, syntax) are often relatively spared in alcohol-related brain damage
- Beware of '**superficial eloquence':** A fluent, articulate patient might be assumed to have intact decision-making, when in fact they are parroting phrases or lacking true comprehension: a known pitfall in assessing capacity in ARBD cases
- ARBD may be associated with **higher-order language dysfunction**
  - May struggle with interpreting metaphors
  - May have trouble with word fluency and finding the right words under pressure

Medical vs Legal concepts of capacity



Does a diagnosis of alcohol dependence imply a loss of capacity for treatment decisions?

Argument for:

- A diagnosis of alcohol dependence meets the stage two criterion
- The core symptom of alcohol dependence is ‘loss of control of onset, duration, amount and termination of alcohol use’
- We have seen that this arises from a dysfunction of mind or brain characterised by an imbalance between the drive to use alcohol (limbic system) and the ability to control that drive (prefrontal cortex).
- So, there is a (strong) hypothesis of a causal connection between the diagnosis and the inability to use (and weigh) the information to reach a decision around whether to drink
- This inability to use and weigh information around drinking will impair decision making around treatment

Does a diagnosis of alcohol dependence imply a loss of capacity for treatment decisions?

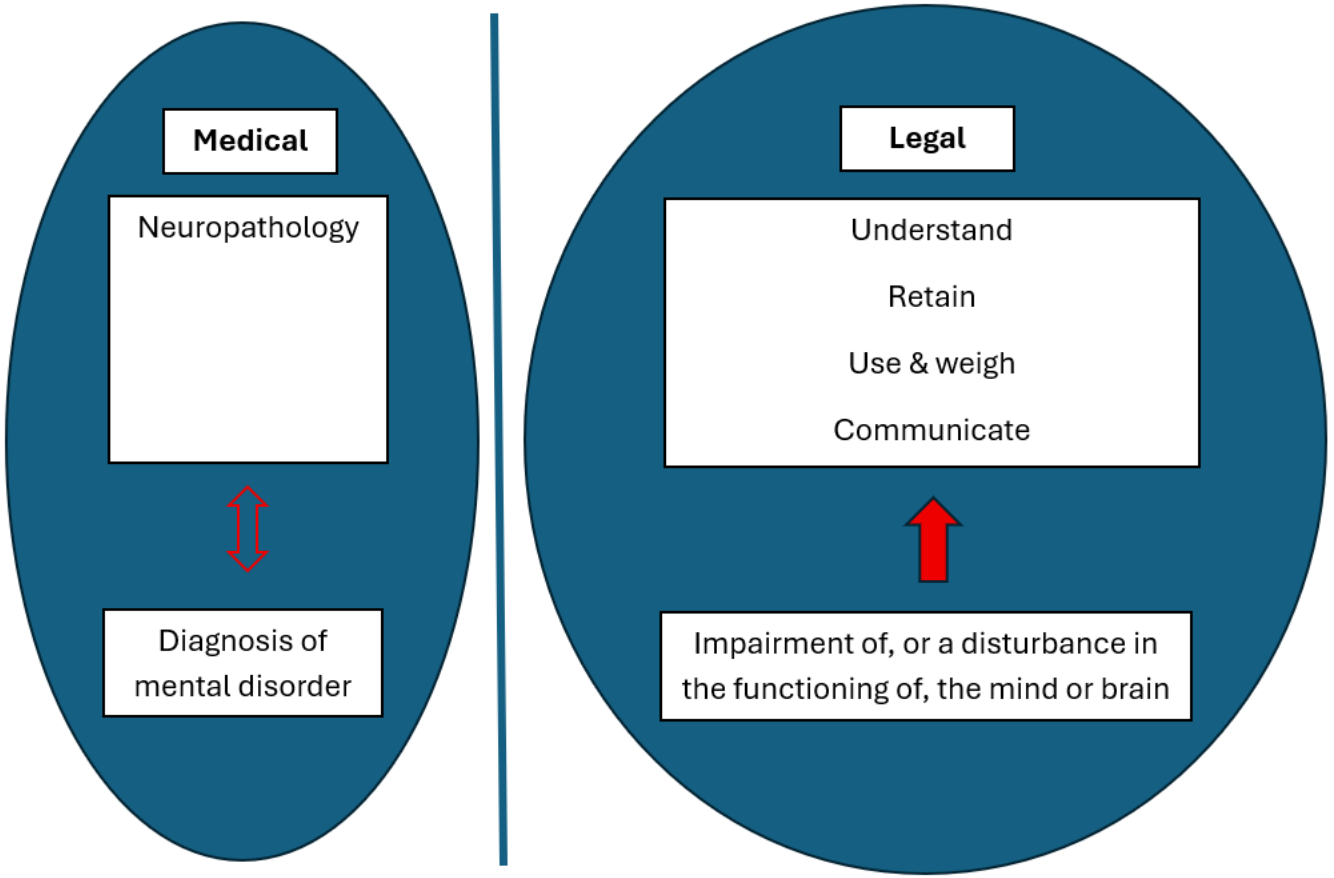
Arguments against:

- We have mixed a medical argument with a legal argument – the legal argument must be able to stand on its own; we have to look in detail at whether the person can use and weigh the information by carrying out the functional assessment, not make an assumption around this based on neuroscience
- Capacity is time and decision specific
  - The person may have lost capacity around whether to drink, but have capacity around treatment decisions
  - The person may have capacity to decide whether to drink at one time, and not at another – the amount of loss of control may vary

Does a diagnosis of alcohol dependence imply a loss of capacity for treatment decisions?

- **Answer: No – certainly not automatically**
- The medical arguments help us in a general way by improving our understanding and thus hopefully our overall judgement around capacity
- They may impact on whether or not we feel there is a greater than 50% chance of loss of capacity by causing us to look more closely for functional difficulties in weighing and using information
- If our decision is being questioned, they may aid in demonstrating that we ‘reasonably’ believed our finding around capacity

Medical v Legal



The Vice President's (Court of Protection) judgment- reported as London Borough of Tower Hamlets v PB [2020] EWCOP 34

In observations that are likely to be applicable generally to cases involving individuals with drug or alcohol dependence, the judge held that (i) the fact PB seriously overestimated his ability to keep his alcohol use under control was not enough to establish a lack of capacity; (ii) **not every addict in some degree of denial can be regarded as incapacitous**; and (iii) the requirement to be able to understand the "reasonably foreseeable consequences" of a particular decision does not mean that the relevant person must accept the professions' view that they will not be able to control their drinking.

London Borough of Tower Hamlets v PB | 39 Essex Chambers

Court of Protection case law in ARBD

Case	Impairment/issue	Background	Evidence for incapacity	Judge's determination
London Borough of Tower Hamlets v PB [2020] EWCOP 34	Capacity of PB, a 52-year-old man with ARBD and dissocial personality disorder, to make residence and care decisions	PB had a history of homelessness and recurrent hospital admissions with alcohol-related complications. At the time of the hearing, he was living in a residential care unit that placed restrictions on his access to alcohol; his wish was that these restrictions be lifted.	The expert witness argued that PB was unable to use or weigh information (most pertinently his own inability to moderate his drinking) and attributed this to both to his alcohol dependence and executive dysfunction associated with ARBD.	The judge deemed that PB had capacity to make the relevant decisions, arguing that the expert's test would have 'the alarming effect of rendering most addicts incapacitous'. He noted that PB expressed an appreciation of the consequences of drinking to excess and an aspiration to moderate his drinking.
X v A Local Authority & Anon [2014] EWCOP 29	Capacity of X, a retired lawyer with Korsakoff's syndrome, to make decisions about his care, residence and medical treatment	After a lengthy admission under the Mental Health Act, X was transferred to a care home under deprivation of liberty safeguards, which he subsequently appealed.	X's social worker, who had known him throughout his illness, expressed concern about his unrealistic expectations of the future and his ability to mask his cognitive difficulties.	The judge concluded that 'although he suffers from short term memory problems, he retains sufficient information to be able to deal with planning'. The judge was further persuaded by evidence of an independent psychiatrist (who saw X once), who emphasised that X's mental state appeared to have improved over recent months.

Unwise decision vs inability to weigh & use information: implications of Tower Hamlets v PB

- If the person can demonstrate they can weigh even if the scales appear faulty to us, then that is sufficient to continue to presume capacity for the decision ('paternalism' *not* allowed)
- If the person can demonstrate they can weigh even if *they agree* the scales are faulty, then that is also sufficient to continue to presume capacity for the decision ('persistence despite awareness of harm' allowed)
- However, if the person cannot demonstrate in response to questioning that they are weighing at all, that could possibly indicate absence of capacity for the decision – e.g. truly impulsive action without an associated thought process.

Any Questions?