Alcohol Related Brain Damage (ARBD) Barriers to care

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Clinical issues: As most ARBD sufferers have been alienated from their families and friends and are socially isolated (Jacques, 2000); they have few natural advocates. Such patients are not usually identified or brought to the attention of clinical services until significantly impaired, with presentation frequently associated with dramatic changes in behaviour (ARBIAS).

Most reviewers draw attention to the wide spread clinical ignorance related to the diagnoses of ARBD (McRae & Cox 2003). As ARBD may frequently present with frontal lobe dysfunction (Schmidt et al 2005); commonly used assessment instruments such as the Mini Mental State Examination are unlikely to identify early cases (Chiang 2002). These problems are compounded by the frequent lack of insight experienced by patients with ARBD. Memory problems are problematical in terms of the patient not being able to retain information regarding appointments, participating in alcohol treatment programmes and being unable to provide biographical histories to generic staff. The more easily identified memory problems are usually compounded by frontal lobe damage (Cummings, 1995; Goldman-Rakic, 1987; Luria, 1973) including difficulties in reasoning, synthesising information, appreciating implications of decisions and understanding the condition and implications of subsequent exposure to alcohol.

National Guidance: Service providers and commissioners are provided with very little national guidance in the provision of services for people with ARBD. This is evidenced in seminal documentation by The Department of Health, NICE and Professional bodies. In 2006 the Department of Health published ‘Models of care for Alcohol Misusers, (MoCAM 2006). This is a detailed document in which assessment and treatment advice is provided. Notably; the document refers to the need for ‘comprehensive assessment’ including cognitive and Occupational Therapy assessment of individuals. However, apart from this the document fails to address the issues of ARBD, its potential effect on insight, screening, treatment and prognosis. Subsequently, the Department of Health published guidance ‘Local Routes: Alcohol Treatment Pathways’ (DoH 2009) fails to mention cognitive damage and associated implications other than suggesting a ‘comprehensive assessment’.

Current NICE Guidelines concerning the treatment of Alcohol Misuse Disorders and Physical Complications is confined to the acute treatment of Wernicke’s encephalopathy. The guideline does not address the longer term issues of ARBD.

In two recent documents addressing alcohol related problems in terms of service provision (Royal College of Physicians 2009a) and patient information for people with alcohol related problems (Royal College of Physicians 2009b) no mention was made of ARBD. In a recent review published in the British Journal of Psychiatry, Gupta & Warner (2008) draws attention to the increasing prevalence of neurocognitive damage related to excessive alcohol ingestion. The only document that offers some guidance in the psycho-social management of ARBD is a document published by the Royal College of Physicians (2001). The document examines the impact of alcohol related problems in acute hospital settings. It draws attention to the importance of the psychiatric liaison services as having responsibility and identifies ARBD as being a potential complication. The document does draw attention to the potential of a specialised neuropsychiatry service to assess and provide specialist care for patients under the age of 65 with ARBD.

Organizational issues: The paucity of national and professional guidance is reflected in problems associated in service commissioning and provision. Despite a recent publication addressing the needs of carers working with people with ARBD (Dementia Development Services Centre 2006); rarely does a single mental health specialty take responsibility for this patient group (Price et al 1988, Lennane 1986). The lack of expertise and related services are reflected in the findings of a recently commissioned CSIP and Alzheimer’s Society study of patients (ARBD) in England and Wales (Boughy 2007). The research highlights a lack of diagnostic expertise, general ignorance within psychiatric, medical and nursing staff, no evident pathways of care and being ‘passed from
pillar to post’, stigma and lack of resources. The lack of commissioned services, the failure of Trusts to generate local pathways of care and the lack of clear professional guidance has direct implications for acute hospital trusts as failure to provide appropriate care planning results in prolonged in-patient stays.

The lack of established clinical pathways has significant implications for acute hospitals. Poopla et al (2008) reviewed 44 ARBD patients admitted into acute hospital care over a six month period and found the average length of stay in the hospital was 84.0 +/- 72.3 days and mean lost bed days was 15.9 +/- 36.6. These circumstances reflect much of the current situation in England and are associated with increased likelihood of early re-admission and increased mortality (Price et al 1988).

Patients identified through acute, generic inpatient services are likely to be very ill; often presenting with acute withdrawal or encephalopathies. Prevalence figures indicate that the majority of patients suffering from ARBD are not recognized by clinical services and have varying degrees of functionality within community settings. Most of these patients will not have been cognitively assessed but may be in contact with a variety of health providers including:

- Primary care
- A&E departments
- Alcohol treatment services
- Psychiatric services
- Acute hospital inpatient services
- Memory clinics

Up to a third of heavy alcohol users will have alcohol related post mortem brain changes. It is likely that a significant proportion of these individuals will have neurocognitive deficits, including frontal lobe damage. The cognitive deficits are likely to have a direct impact on prognosis in terms of response to alcohol treatment programs. It is likely that most alcohol treatment services do not cater for the cognitive damage experienced by a significant proportion of clients. What evidence there is suggests that appropriate cognitive assessment should be the norm in these circumstances and therapeutic programs can be appropriately adjusted (Meek, Clark, & Solana, 1989, Glass, 1991).

**Summary:** It is evident that ARBD sufferers represent a vulnerable and stigmatised group of patients. The cognitive damage frequently impairs insight and understanding of the implications of their alcohol related behaviour. They rarely have advocates and are usually socially isolated.

The lack of inter-professional consensus relating to clinical responsibility and care is reflected in little national guidance, few, if any, established clinical pathways and significant consequences for ARBD patients and service provision.
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