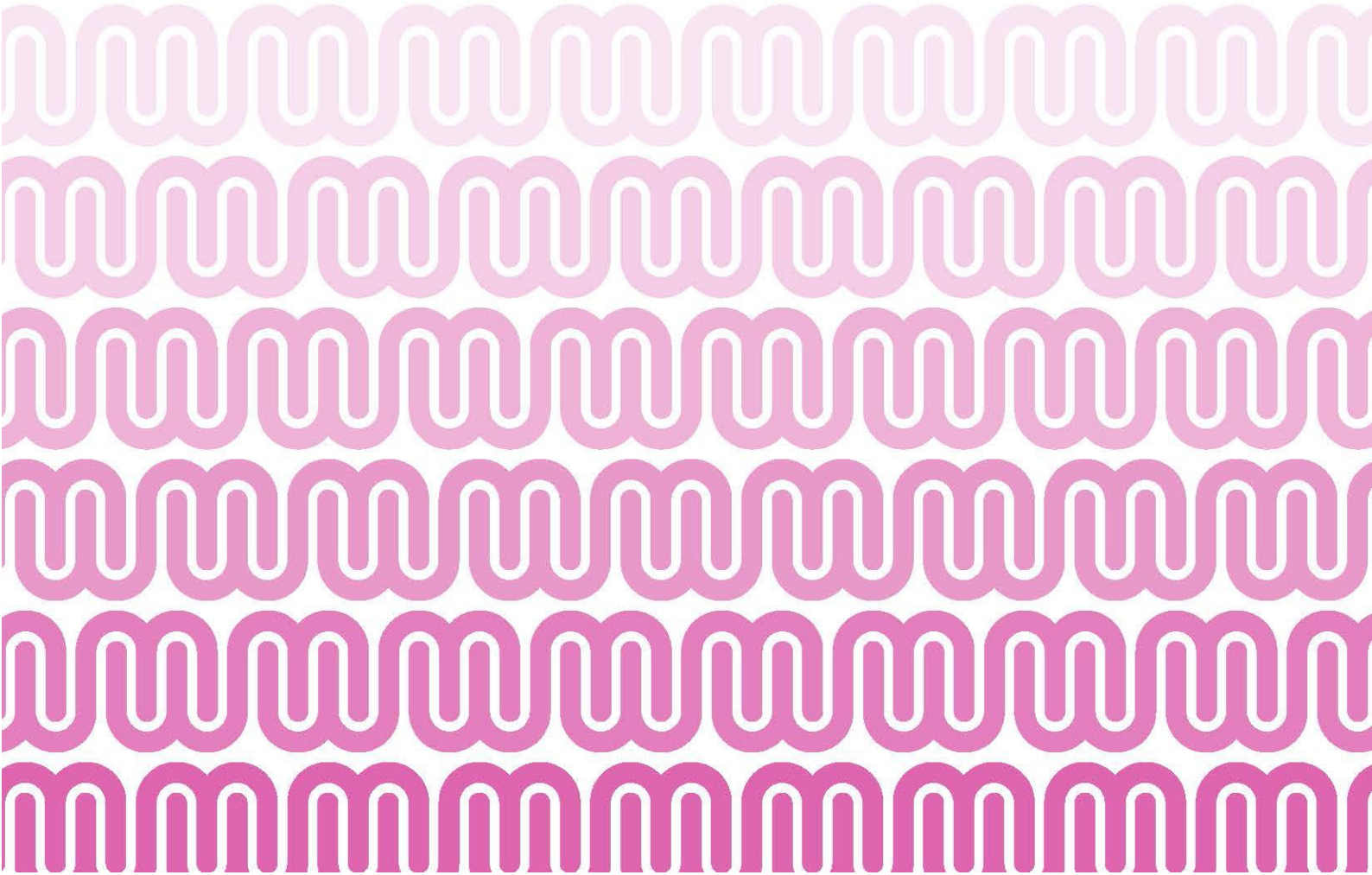
mental welfare commission for scotland

Alcohol-related brain damage (ARBD)

Good practice guide

July 2026



Our mission and purpose

Our Mission

To be a leading and independent voice in promoting a society where people with mental illness, learning disabilities, dementia and related conditions are treated fairly, have their rights respected, and have appropriate support to live the life of their choice.

Our Purpose

We protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

Our Priorities

To achieve our mission and purpose over the next three years we have identified four strategic priorities.

- To challenge and to promote change
- Focus on the most vulnerable
- Increase our impact (in the work that we do)
- Improve our efficiency and effectiveness

Our Activity

- Influencing and empowering
- Visiting individuals
- Monitoring the law
- Investigations and casework
- Information and advice

This guidance was first published in 2019. It was reviewed and updated in July 2026.

Contents

Relevant legislation

- Mental Health (Care and Treatment) (Scotland) Act 2003 (Mental Health Act)
- Adults with Incapacity (Scotland) Act 2000 (AWI Act)
- Adult Support and Protection (Scotland) Act 2007 (ASP Act)

Intended audience

This guidance is intended primarily for professionals directly involved in the assessment, treatment, care, and support of people with alcohol-related brain damage (ARBD), including approved medical practitioners, responsible medical officers, mental health officers, general practitioners, consultant psychiatrists, liaison psychiatry teams, alcohol and drug services, occupational therapists, clinical psychologists, neuropsychologists, nursing staff, Mental Health Act administrators and adult support and protection practitioners.

It will also be of interest to service managers, medical directors, directors of nursing, chief social work officers, alcohol and drug partnerships, independent advocacy organisations, and others responsible for planning, commissioning or overseeing services for people with ARBD.

Acknowledgments

We are very grateful to everyone who contributed to this guidance. Thanks in particular to Dr Roger Smyth, Dr Catriona Howes, and Deirdre Hanlon, solicitor, who were part of the drafting team and whose contributions were crucial. The Commission held two consultation events, and we are grateful for the contributions of Sheriff Fiona Reith and Dr John Higgon, consultant clinical neuropsychologist, and to everyone who attended.

First published by the Mental Welfare Commission for Scotland in 2019, this revised edition was published in 2026 and incorporates updated clinical evidence, policy developments, legislative changes, and relevant national guidance. We are very grateful to Dr Roger Smyth who kindly reviewed this updated edition.

Why we wrote this guidance

Alcohol-related brain damage (ARBD) is a condition where there are changes to the structure and function of the brain as a result of long-term, heavy alcohol use.

People with ARBD can have problems with their memory, their judgement, and their ability to live independently. These problems, often compounded by ongoing alcohol use, can make people more likely to develop social and health problems and to present to social services, their GP, or hospital. Working with individuals with ARBD can be challenging for all those involved in their assessment, care, treatment, and rehabilitation.

The brain changes and functional impairments seen in ARBD can be partially or fully reversible if the person stops using alcohol, but these will often progress with ongoing use. People with ARBD can require help managing their alcohol use as well as with their day-to-day living and their healthcare needs. Many people will accept such help voluntarily. However, some will refuse help, and in some individuals with ARBD there is so much concern about their judgement and their safety that legal measures are considered in order to maintain their health and wellbeing.

In Scotland the use of certain legal powers is restricted to those people who are considered to lack decision-making capacity for a particular decision or to have significantly impaired decision-making ability due to mental impairment.

Establishing whether a person with ARBD lacks decision-making capacity is therefore often crucial. We have heard that practitioners find it difficult to assess decision-making capacity in people with ARBD. This may be because the individual is either intoxicated or in withdrawal when they are seen, or it may be because people with ARBD can have preserved verbal abilities which can cause practitioners to underestimate their deficits.

People with ARBD can be a stigmatised group where there is a perception that they are difficult to help and a belief among some that their difficulties are the result of personal choices. A further difficulty can be balancing the rights of individuals to live as they choose, with their rights to access potential help to maximise their quality of life.

We continue to receive questions about this area through our advice service and hear about challenges and examples of good practice through our visits and engagement with services.

We have written this guidance primarily for professionals directly involved in the assessment, care, treatment and support of people with ARBD, including medical practitioners (particularly psychiatrists and GPs), social workers, mental health officers (MHOs), mental health support workers, and addictions workers. We hope it

will also be of value to managers and others responsible for planning, overseeing or improving services for people with ARBD. Although this guidance is written primarily for professionals, individuals with ARBD, their families and carers may also find it helpful in understanding available resources, legal frameworks and approaches to care and support.

The guidance considers the diagnosis of ARBD and gives an overview of treatment options, before discussing the assessment of decision-making capacity with specific reference to the problems presented by people with ARBD. It goes on to review the legal powers available in Scotland, and the use of those powers in particular settings and situations, illustrated by a variety of case examples.

Part 1: The nature and treatment of alcohol-related brain damage (ARBD)

What is ARBD?

ARBD describes a clinical syndrome due to structural and functional brain changes which occur as a result of chronic, heavy alcohol use[1]. Those affected may experience problems with memory, learning new information and everyday functioning. Both the brain changes and the functional impairments are at least partially reversible if the individual stops using alcohol but will often progress with ongoing use.

While ARBD has been increasingly recognised as a major clinical problem over the last two decades, it has long been recognised that excessive alcohol use can lead to both physical and mental impairment. Wernicke-Korsakoff Syndrome (WKS), a condition caused by thiamine deficiency that most commonly occurs in chronic alcohol use, was first described in the 1800s. It is characterised by severe difficulties with short-term memory and learning[2], as well as problems with balance and eye movements. Broader, reversible cognitive difficulties are also routinely observed in heavy alcohol users. The terms "wet brain", alcoholic dementia, and alcohol-related brain injury (ARBI) have all been used to refer to this group. ARBD is now the generally preferred term. It encompasses both situations described above as well as the damage caused by the withdrawals and recurrent head injuries often experienced by people with long-term heavy alcohol use[3]. Head injuries caused by alcohol will often affect different brain regions and have differing consequences.

Most individuals with ARBD will exhibit problems with short-term memory and recall, and changes associated with damage to the frontal lobe of the brain. These changes are characterised by impairment of executive functioning, including planning, abstract thinking, cognitive flexibility (the ability to switch between tasks or adapt to

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[1]Neither of the current major diagnostic classifications of mental disorders uses the term alcohol-related brain damage (ARBD). In ICD-11, relevant categories include dementia due to use of alcohol (6D84.0) and amnestic disorder due to use of alcohol (6D72.10). ICD-11 also classifies Wernicke-Korsakoff syndrome and Korsakoff syndrome separately, reflecting the distinction between cognitive impairment directly attributable to alcohol use and cognitive change associated with thiamine deficiency. In DSM-5-TR, alcohol-related cognitive impairment is best described within the category of substance/medication-induced major or mild neurocognitive disorder, with alcohol as the relevant substance and with clinical specification according to severity and associated features.

[2] Kopelman MD "Disorders of memory," *Brain* 125, no. 10 (2002): 2152–90.

[3] Lishman WA *Organic Psychiatry: The Psychological Consequences of Cerebral Disorder (3rd edition)* (Chichester: Blackwell Science, 1998)

changing situations), and impulse control. Confabulation is another common feature, where an individual creates false memories but without the deliberate intention to deceive. This can be as a result of the individual's need to make sense of their own situation. These memories are often bizarre but can be more plausible. Visuospatial problems are commonly observed later, while general intellect and verbal skills often remain relatively unaffected.

Prevalence of ARBD

It is believed that ARBD is often not recognised[4]. This is important as contact with general hospitals for people with ARBD often results in prolonged admissions.

Alcohol-related harm continues to place a substantial burden on health services in Scotland. In 2024/25 there were 29,430 hospital admissions for conditions wholly attributable to alcohol, with 92% occurring in general acute hospitals with the remainder in psychiatric hospital[5]. Men were 2.4 times more likely than women to be admitted for conditions wholly attributable to alcohol, and people living in the most deprived areas were seven times more likely to be admitted than those living in the least deprived areas. These figures highlight the continuing burden of alcohol-related harm on health services in Scotland.

Estimating the prevalence of ARBD is challenging. Variations in diagnostic criteria, inconsistent terminology, under-recognition of the condition and differences in service provision all contribute to uncertainty regarding its true prevalence. Recent reviews have concluded that ARBD remains substantially underdiagnosed and that existing prevalence estimates are likely to underestimate the true burden of disease[6].

Dedicated epidemiological studies in Scotland have reported prevalence estimates ranging from 0.07% to 0.14% of the population, with substantially higher rates reported in some groups at risk of harm, including people experiencing

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[4] Popoola A, Keating A, Cassidy E "Alcohol, cognitive impairment and hard to discharge acute hospital inpatients," *Irish Journal of Medical Science* 177 (2008): 141–5.

[5] Public Health Scotland. *Alcohol-related Hospital Statistics Scotland: Financial Year 2024/25*. Public Health Scotland, 2026. https://publichealthscotland.scot/media/36992/2026-01-27-arhs-summary_pra_final.pdf

[6] Quelch D, Roderique-Davies G, John B. *Alcohol-related brain damage: an umbrella term for the approaching post-COVID monsoon*. Clinical Medicine. 2023;23(6):595–602. https://pmc.ncbi.nlm.nih.gov/articles/PMC10753228/

homelessness[7]. However, these figures are likely to underestimate the true prevalence because many affected individuals do not come to specialist services or receive a formal diagnosis.

People with ARBD are often younger than people presenting with neurodegenerative dementias such as Alzheimer's disease and are more commonly male. Specialist services in Scotland have reported a mean age at referral of approximately 55 years, with around three-quarters of referrals being male[8]. ARBD is also associated with complex health and social care needs, frequent hospital attendance and prolonged admissions[9].

Making a diagnosis

The diagnosis of ARBD requires a good clinical history from the individual when not under the influence of, or withdrawing from, alcohol. The assessor should gather reliable information about the person's alcohol use over time. They should ensure that an objective test of the individual's cognition is undertaken.

Some commonly used cognitive screening instruments provide only limited assessment of executive function. We would recommend the use of either the Addenbrooke's Cognitive Examination (ACE-III) or the Montreal Cognitive Assessment (MoCA). The Mini Mental State Examination (MMSE) is less helpful in this context because it contains only limited assessment of executive functioning.

In individual cases, where available, specialist neuropsychological assessment of executive functioning can provide a more detailed understanding of cognitive strengths and deficits. This may include formal assessment using tests such as the Hayling Sentence Completion Test and the Brixton Spatial Anticipation Test. Neuropsychological assessment may also help identify preserved abilities that can be used to support rehabilitation and recovery.

Neither cognitive screening nor formal neuropsychological assessment should be interpreted in isolation. The diagnosis of ARBD, assessment of functional ability, and

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[7] Gilchrist G, Morrison DS. Prevalence of alcohol-related brain damage among homeless hostel dwellers in Glasgow. *European Journal of Public Health*. 2005;15(6):587–588. https://pubmed.ncbi.nlm.nih.gov/16162595/

[8] Smith, I. (2012) "Alcohol-Related Brain Damage in the Longer Term: Scottish Initiatives to Maximize Recovery". *Alcohol and Alcoholism* Vol. 47, No. 2, p. 84.

[9] Wilson K, Halsey A, Macpherson H, et al. The psycho-social rehabilitation of patients with alcohol-related brain damage in the community. *Alcohol and Alcoholism*. 2012;47(3):304–311. https://pubmed.ncbi.nlm.nih.gov/22278316/

evaluation of decision-making capacity should be based on a combination of clinical assessment, collateral history, cognitive testing and, wherever possible, functional assessment by the multidisciplinary team (MDT).

Preserved verbal abilities and plausible confabulation can lead clinicians to overestimate an individual's abilities. People with ARBD are often younger than those presenting with other forms of cognitive impairment and may appear physically well.

A further difficulty is that many people with ARBD have a limited social network, meaning that collateral information which might challenge confabulation or apparent competence is often unavailable. Together, these factors can result in cognition and decision-making capacity being overestimated.

To reduce this risk, an occupational therapy (OT) functional assessment should be considered. One commonly used tool is the Assessment of Motor and Process Skills (AMPS). This provides a practical assessment of an individual's abilities in activities of daily living (ADLs), giving a more comprehensive picture of functioning which can inform treatment planning and assessment of decision-making capacity.

Oslin[10] proposed criteria for the diagnosis of probable "alcohol-related dementia" that have been adapted and are commonly used clinically. These criteria include:

- Documented evidence of cognitive impairment.
- Significant alcohol use (35 standard units per week for women and 50 for men) for a period of at least 5 years.
- The period of significant alcohol use must have occurred within three years of onset of the cognitive deficits.
- The absence of a better explanation e.g. acute alcohol intoxication/withdrawal or progressive mental disorder.

In addition, the presence of a lack of co-ordination or evidence of alcohol-related damage to other organs would add weight to a clinical suspicion of ARBD.

Co-morbidity is common in this group and may complicate assessment. Some people with ARBD will have evidence of vascular or traumatic brain changes[11]. Features that may suggest significant or complicating co-morbidity include difficulties with language or word finding, prominent neurological signs, or brain

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[10] Oslin D, Atkinson R, Smith D, Hendrie H "Alcohol related dementia: Proposed clinical criteria," *International Journal of Geriatric Psychiatry* 13, no. 4 (1998): 203-212; Royal College of Psychiatrists Alcohol and brain damage in adults with reference to high-risk groups (2014)

[11] Wilson K, Halsey A, Macpherson H, et al "The psycho-social rehabilitation of patients with alcohol-related brain damage in the community," *Alcohol and Alcoholism* 47 (2012): 304–11.

imaging demonstrating vascular or traumatic brain injury. Pre-existing learning difficulties or educational disadvantage may also influence assessment.

Professionals often meet individuals with suspected ARBD whilst they are either acutely intoxicated with, or withdrawing from, alcohol. These states may be the presumed explanation for subtle changes in memory or functioning. Many will also have liver disease and associated hepatic encephalopathy. This can obscure the symptoms of ARBD and complicate the clinical picture.

Given the change in presentation over time and with alcohol status, determining the best time to assess an individual can be challenging. The person should be free from alcohol intoxication and acute withdrawal symptoms. In many cases this will mean waiting at least seven to ten days after the last drink, although the timing of assessment should be guided by the individual's clinical presentation. It may be possible to complete only cognitive screening rather than a full diagnostic assessment while the individual is in an acute setting due to pressures on hospital beds. This may mean that some individuals with a concerning cognitive screen and a planned diagnostic assessment are discharged before a full assessment can take place and subsequently resume drinking. Finding a suitable alcohol-free environment for the individual may therefore be an important consideration where a full assessment is required. Clinicians should allow sufficient time for assessment and it is often helpful to repeat cognitive testing after three to six months. ARBD remains a diagnosis of exclusion and ruling out other causes of cognitive impairment can be time-consuming.

Assessment should include consideration of supported decision-making. Before concluding that a person lacks decision-making capacity, reasonable steps should be taken to maximise their ability to understand, retain, use, and weigh information. This may include repeating information, providing information in written or visual formats, involving advocacy, and seeking collateral information from those who know the person well.

Clinical course

ARBD typically develops as a result of many years of heavy alcohol use and the early signs can be subtle. As a result, it is common for the diagnosis of ARBD to be made several years after the onset of symptoms. Early features often include difficulties with executive functioning, such as planning, organisation, judgement, cognitive flexibility, and reduced social inhibition. If heavy alcohol use continues, memory

impairment and broader cognitive and functional difficulties may develop over time[12].

Cognitive and functional impairments associated with ARBD may improve with sustained abstinence from alcohol. A lack of improvement despite sustained abstinence should prompt consideration of alternative or additional diagnoses, such as a neurodegenerative disorder, vascular cognitive impairment or traumatic brain injury.

With abstinence and appropriate support, many people with ARBD experience significant cognitive and functional improvement[13]. The extent of improvement varies considerably between individuals. Some regain sufficient skills to live independently, while others continue to require varying levels of support.

Improvement is influenced by factors including the severity and duration of alcohol use, nutritional status, co-existing physical or neurological conditions, engagement with rehabilitation, and continued abstinence. Although the greatest gains are often seen in the first few months, further improvement may continue over a much longer period[14]. Further research is needed to better understand long-term outcomes and to establish consistent definitions of recovery in ARBD.

Treatment of ARBD

The prevention of new cases of ARBD is an important goal[15]. Prevention includes early identification of harmful alcohol use, effective treatment of alcohol

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[12] Ihara H, Berrios GE, London M "Group and case study of the dysexecutive syndrome in alcoholism with-out amnesia," *Journal of Neurology, Neurosurgery and Psychiatry* 68 (2000): 731–7.

[13] Emmerson C and Smith J,. (2015) *Evidence-based profile of alcohol related brain damage in Wales*. Public Health Wales. p9.

[14] Wilson K, Halsey A, Macpherson H, Billington J, Hill S, Johnson G, Raju K, Abbott P "The psycho-social rehabilitation of patients with alcohol-related brain damage in the community" Alcohol and Alcoholism 47, no. 3 (2012): 304-311

[15] National Institute for Health and Care Excellence. *Alcohol-use disorders: diagnosis and management of physical complications (CG100).* London: NICE; 2010. Updated April 2017. https://www.nice.org.uk/guidance/cg100

Joint Formulary Committee. *British National Formulary.* London: BMJ Group and Pharmaceutical Press. Alcohol Dependence

https://bnf.nice.org.uk/treatment-summaries/alcohol-dependence/

Department of Health and Social Care. *UK Clinical Guidelines for Alcohol Treatment: People with Alcohol-Related Brain Damage.* London: Department of Health and Social Care; 2025. https://www.gov.uk/guidance/clinical-guidelines-for-alcohol-treatment

dependence, and the safe management of alcohol withdrawal. Repeated episodes of withdrawal may contribute to cognitive impairment and should be minimised where possible. Administration of prophylactic thiamine reduces the risk of developing Wernicke-Korsakoff syndrome (WKS). In suspected Wernicke's encephalopathy, parenteral thiamine should be administered promptly in accordance with current clinical guidance. Long-term heavy alcohol use is frequently associated with nutritional deficiency, impaired thiamine absorption and storage, and a range of gastrointestinal and hepatic disorders. Ongoing oral thiamine supplementation may be appropriate in some individuals at continuing risk of deficiency.

Prevention of ARBD requires both individual and population-level approaches. In Scotland, public health measures including minimum unit pricing (MUP), alongside efforts to improve access to alcohol treatment and support services, form part of a wider strategy to reduce alcohol-related harm. Evaluations of MUP have demonstrated reductions in alcohol purchases, alcohol-specific deaths and alcohol-related hospital admissions, particularly among heavier drinkers and people living in more deprived communities. Although the specific impact on ARBD is not fully known, reducing harmful alcohol consumption is likely to contribute to the prevention of future cases[16].

Early recognition and identification of ARBD may reduce morbidity and improve outcomes. Screening people referred for treatment of alcohol problems using simple cognitive assessment tools is likely to increase detection. Many individuals with ARBD present acutely to general hospitals and consideration should be given to assessing cognition in those undergoing alcohol withdrawal or detoxification. This assessment may be undertaken by liaison psychiatry services, specialist alcohol care teams or appropriately trained clinical staff.

Ongoing alcohol use in people with ARBD is likely to result in further cognitive and functional impairment. Supporting abstinence is therefore a key component of treatment. There is no established safe minimum level of alcohol consumption in this group, and even relatively small amounts of alcohol may have a disproportionate effect on thinking and memory.

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[16] Public Health Scotland. *Evaluating the Impact of Minimum Unit Pricing for Alcohol in Scotland: Final Report.* Edinburgh: Public Health Scotland; 2023. https://publichealthscotland.scot/publications/evaluating-the-impact-of-minimum-unit-pricing-for-alcohol-in-scotland-a-synthesis-of-the-evidence/Public Health Scotland. *Monitoring and Evaluating Scotland's Alcohol Strategy: Monitoring Report 2025.*Edinburgh: Public Health Scotland; 2025. https://publichealthscotland.scot/population-health/improving-scotlands-health/alcohol/alcohol-harm-data-and-monitoring/monitoring-and-evaluating-scotland-s-alcohol-strategy-mesas/

Five stages of treatment have been proposed for ARBD[17]:

1. Firstly, **medical stabilisation** is often required and is likely to occur in a general hospital. The duration will vary depending upon an individual's physical condition and co-morbidities.
2. The next phase is **psycho-social assessment** which ideally should occur in a supported, safe environment such as a specialised ARBD unit or inpatient facility. The approach is holistic and will involve doctors, psychologists, social workers, and OTs. With good community care this can take place at home. It typically requires approximately three months to complete and will emphasise abstinence, good nutrition, and establishing healthy routines. It is also important to begin to develop relationships with professionals, and to involve relatives and carers if possible[18].
3. The focus of the third phase is **therapeutic rehabilitation**. This may last up to three years. Those with ARBD are encouraged to begin gaining skills in independent living through behavioural programmes and cognitive rehabilitation. Ideally, this stage will happen in a domestic context.
4. The next stage is a period of **adaptive rehabilitation**, focusing on optimising the individual's environment in order to give them the best opportunity to gain any independence possible.
5. The final phase is **long-term maintenance and relapse prevention**. Building positive social relationships and developing structure and routine have been demonstrated to improve outcomes in this context.

This model requires specialist services which are not available in many areas of Scotland. We acknowledge that, in many instances, people with ARBD will be managed by general adult psychiatry, alcohol services, on long-stay wards, or in care homes.

In the absence of a specialised provision for ARBD, it has been found that an identified care co-ordinator can improve outcomes through regular reviews and a good therapeutic relationship[19].

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[17] Wilson K, Halsey A, Macpherson H, Billington J, Hill S, Johnson G, Raju K, Abbott P "The psycho-social rehabilitation of patients with alcohol-related brain damage in the community," (2012): 304-311

[18] Ylvisaker M, Feeney TJ *Collaborative Brain Injury Intervention: Positive Everyday Routines* (San Diego: Singular Publishing Group, 1998)

[19] MacRae, R, Cox, S *Meeting the Needs of People with Alcohol Related Brain Damage: A Literature Review on the Existing and Recommended Service Provision and Models of Care* (University of Stirling Dementia Services Development Centre: Stirling 2003)

Specialised and co-ordinated support has been shown to be effective, particularly at the second stage of treatment, but is not yet widely available across Scotland.

We are aware of a number of 'step down' units across the central belt, where adults are able to move from the acute hospital setting when they no longer require ongoing medical intervention, but are unable to return home. These services are able to provide re-enablement support while reducing the number of days spent in hospital. Support is provided by in-reach NHS staff, including psychiatry, psychology, social work, and OT.

In the later stages, securing appropriate long-term accommodation and support for people with ARBD can be challenging. Individuals with more severe ARBD may require significant levels of care and protection. Some may be able to return home with substantial support and close involvement from specialist community services. Others may require supported accommodation, residential care, or nursing care. It remains important that placements are matched as closely as possible to the individual's age, needs, abilities and rehabilitation potential. Care settings designed primarily for older people may not always be appropriate for younger adults with ARBD, and inappropriate placements can contribute to loss of independence and reduced opportunities for rehabilitation[20].

The Mental Welfare Commission's review of care and treatment for people with alcohol-related brain damage subject to welfare guardianship[21] highlighted the importance of person-centred care, access to meaningful activity, opportunities for rehabilitation and the availability of suitable accommodation and support. Where specialist accommodation is not available, smaller care settings and supported housing arrangements may offer advantages over larger institutional placements for some individuals.

Stigma

People with ARBD may experience multiple forms of stigma. Stigma associated with alcohol use can be compounded by stigma relating to cognitive impairment, mental illness, poverty, homelessness, and social exclusion. Some individuals may internalise these attitudes, which can affect self-esteem, willingness to seek help

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[20] Blansjaar BA, Takens H, Zwinderman AH "The course of alcohol amnesic disorder: a three-year follow-up study of clinical signs and social disabilities," *Acta Psychiatr Scand* 86 (1992):240–6

[21] Mental Welfare Commission for Scotland. *Care and Treatment for People with Alcohol Related Brain Damage Subject to Welfare Guardianship.* Edinburgh: Mental Welfare Commission for Scotland; 2021. https://www.mwcscot.org.uk/node/1631

and engagement with treatment and rehabilitation. Many people with ARBD become socially isolated and estranged from family and friends.

In those who continue to drink, behaviours associated with intoxication may further contribute to exclusion from services and society. Recent Scottish work has highlighted the continuing impact of stigma on people affected by alcohol and drug problems and the importance of rights-based, person-centred approaches to care[22].

Relapse to alcohol use is common in people with ARBD and can be discouraging for both individuals and those supporting them. This can contribute to pessimism among health and social care professionals and reinforce perceptions that helping people with ARBD and alcohol-related problems is difficult or unrewarding.

Professionals should recognise and challenge stigma, discrimination, and therapeutic nihilism, as these can act as barriers to assessment, treatment, rehabilitation and the provision of appropriate services.

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[22] Scottish Health Action on Alcohol Problems (SHAAP). *Stigma Around Alcohol Use Disorders in Scotland.* Edinburgh: SHAAP; 2025. https://www.shaap.org.uk/wp-content/uploads/2025/09/Stigma-Expert-Meeting-11.01.2022.pdf

Scottish Government. *Tackling the Stigma of Addiction.* Edinburgh: Scottish Government; 2021.

https://www.gov.scot/news/tackling-the-stigma-of-addiction/

Mental Welfare Commission for Scotland. *Ending Exclusion: Care and Treatment for People with Mental Ill Health and Substance Use in Scotland.* Edinburgh: Mental Welfare Commission for Scotland; 2022. https://www.mwcscot.org.uk/node/1850

Part 2: Responding to ARBD

Consideration of legal interventions

People with ARBD can be exposed to significant risks to their health, safety and wellbeing. They are at risk of poor self-care and nutrition, poor mobility, exacerbation or neglect of medical co-morbidities, and falls and traumatic injuries. Furthermore, continued alcohol use is likely to worsen cognitive and functional impairment. They may also be subject to external risks such as assault from others, domestic fires, and road traffic accidents[23]. Finally, they can be at risk of harm from both financial and physical exploitation.

Successfully preventing alcohol consumption may not only avoid harm, but also create potential for improvement of functioning, and the maximising of opportunities to gain social capital and develop new interests and relationships.

There is often a conflict between respecting the individual's apparent choices and protecting a person at risk of harm - and sometimes third parties.

In some situations, interventions may be justified under legal frameworks which apply to everyone, for example housing, environmental health, fire safety, or public protection legislation. However, where mental health or decision-making capacity law is relevant, the assessment of decision-making capacity, or the closely related concept of significantly impaired decision-making ability, is of crucial importance.

Decisions taken for people with ARBD have the potential to impact upon their human rights. Most human rights may be restricted in certain circumstances, provided that any restriction is lawful, necessary, and proportionate. Any intervention should be undertaken with the aim of protecting the individual, protecting others, or promoting the individual's health, welfare, and rights. The principles contained within Scottish legislation reflect the European Convention on Human Rights and should be considered before any action is taken. Practitioners should also have regard to the principles of participation, supported decision-making, and the least restrictive alternative when considering interventions[24].

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

[24] Mental Welfare Commission for Scotland. *Human Rights in Mental Health Services.* Edinburgh: Mental Welfare Commission for Scotland; revised edition 2021. https://www.mwcscot.org.uk/node/497

The use of compulsory legal measures for a person with ARBD will depend on the circumstances of each case. Care plans will often involve a combination of informal and formal measures, depending on the intervention required, the person's decision-making capacity and the risks identified. Compulsory measures should form part of a broader plan of care, treatment and support. Before considering compulsory intervention, practitioners should seek wherever possible to maximise the person's ability to participate in decisions affecting them. Where intervention under the AWI Act[25] or the Mental Health Act[26] is being considered, the principles of the relevant legislation must be carefully applied.

An overview of the legal options available

The following outlines the three main pieces of legislation of relevance when considering issues around the care, treatment, and welfare of people with ARBD.

All three Acts contain broadly similar statements of principle, which anyone using the legislation should apply[27].

Mental Health (Care and Treatment) (Scotland) Act 2003 (Mental Health Act)

The Mental Health Act authorises the compulsory treatment of people with mental impairment or disorder.

ARBD falls within the definition of mental disorder (the specific term used within the Mental Health Act)[28].

Dependence on, or use of, alcohol is expressly excluded from the definition of mental disorder, however in the case of most people with ARBD such dependence may exist alongside mental disorder. Where someone is misusing alcohol or has

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Mental Welfare Commission for Scotland. *Supported Decision Making: Good Practice Guide.* Edinburgh: Mental Welfare Commission for Scotland; 2024. https://www.mwcscot.org.uk/node/503

Mental Welfare Commission *Rights in Mind* (Mental Welfare Commission: Edinburgh, 2017) https://www.mwcscot.org.uk/rights-in-mind/

Scottish Human Rights Commission. *Human Rights Based Approach Toolkit.* Edinburgh: Scottish Human Rights Commission. https://www.scottishhumanrights.com/projects-and-programmes/human-rights-based-approach/

[25] https://www.mwcscot.org.uk/law-and-rights/adults-incapacity-act

[26] https://www.mwcscot.org.uk/law-and-rights/mental-health-act

[27] Adults with Incapacity (Scotland) Act 2000 s1; Mental Health (Care and Treatment) (Scotland) Act 2003 ss1-3; Adult Support and Protection (Scotland) Act 2007 ss1-2

[28] s328

alcohol dependence but has normal cognitive functioning, they will not have a mental disorder for the purposes of the Mental Health Act. An individual with cognitive impairment, acute confusion, or hallucinosis, secondary to alcohol misuse, would be considered as having a mental disorder.

Importantly the power to treat under the Mental Health Act only extends to treatment for the mental disorder, not unrelated physical conditions. However, physical conditions which are a cause or consequence of the mental disorder may be treated under the Mental Health Act. Furthermore, the range of treatment which may be authorised under the Act is very broad[29]. Treatment can mean nursing, care, psychological intervention, habilitation (including education, training in work, social, and independent living skills), and rehabilitation. The types of treatment within each of these categories is varied and it is important that practitioners are aware of the very flexible range of options for medical treatment for people with ARBD.

The Mental Health Act authorises three main types of detention in hospital:

- emergency detention (up to 72 hours),
- short-term detention (up to 28 days), and
- a compulsory treatment order (CTO) which can last initially for up to six months with further extension available. A CTO can authorise hospital or community-based treatment and can only be authorised by the Mental Health Tribunal for Scotland.

[29] s329(1)(d)

Adult Support and Protection (Scotland) Act 2007 (ASP Act)

The ASP Act is designed to protect adults at risk of harm. The Act is broad enough to cover those with decision-making capacity but who are at risk of harm, and may be useful when a person with ARBD is deemed to be at such risk.

The 'three-point test' often referred to when discussing the ASP Act is as follows[30]:

An adult is deemed to be 'at risk' if they are:

a. unable to safeguard their own well-being, property, rights or other interests,
b. are at risk of harm, and
c. because they are affected by disability, mental disorder, illness or physical or mental infirmity, are more vulnerable to being harmed than adults who are not so affected.

The risk can be because another person's conduct is causing, or is likely to cause, harm to the adult or, importantly, if the adult "is engaging (or is likely to engage) in conduct which causes (or is likely to cause) self-harm."

The ASP Act does not provide for compulsory care or treatment of an adult with ARBD. It allows for a range of interventions on behalf of an adult at risk and broadly covers three main areas;

- inquiries and investigations,
- protection orders, and
- adult protection committees.

Inquiries and investigations

If a local authority becomes aware that an adult is at risk, there is a general duty under the ASP Act to carry out inquiries and investigations. An inquiry is where the local authority needs to establish if an adult is at risk and requires any interventions. An investigation should be undertaken if the outcome of inquiries determines an adult is at risk and that the individual may need support and protection, with possible use of legislation.

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[30] Adult Support and Protection (Scotland) Act 2007, s3(1) (2)

Scottish Government. *Adult Support and Protection (Scotland) Act 2007: Code of Practice.* Edinburgh: Scottish Government; 2022. https://www.gov.scot/binaries/content/documents/govscot/publications/advice-and-guidance/2022/07/adult-support-protection-scotland-act-2007-code-practice-3/documents/adult-support-protection-scotland-act-2007-code-practice/adult-support-protection-scotland-act-2007-code-practice/govscot%3Adocument/adult-support-protection-scotland-act-2007-code-practice.pdf

Often people with ARBD will come to the attention of formal agencies as a result of an ASP referral, for example where there has been involvement with emergency services. The use of ASP multi-agency procedures offers opportunities to further investigate a person's circumstances and bring together a combined approach.

These often do not result in an application to court under the ASP Act. Often the issues may resolve informally with appropriate informal supports, monitoring of the individual being put in place, or intervention under the Mental Health Act or AWI Act.

Protection orders

The ASP Act provides for a range of protection orders to deal with situations when an adult is at risk from harm or abuse. These are short-term powers which may be used to temporarily remove a person from an unsafe situation. Generally speaking, the individual must consent to these orders, unless they are considered to be subject to undue pressure from another adult or adults. Where an individual is subject to coercion or abuse from another person, it is also possible to apply for a banning order preventing the third party from being in a specified place such as the adult's home.

Adult support and protection (ASP) committees

The ASP Act places an obligation on all local authorities to establish multi-agency ASP committees. They are responsible for monitoring and advising on adult protection procedures and practice, ensuring co-operation between agencies, and improving the skills and knowledge of those with a responsibility for the protection of adults at risk. All of these issues become important when ensuring that the complex needs and risks of people with ARBD are highlighted and monitored.

Adults with Incapacity (Scotland) Act 2000 (AWI Act)

The AWI Act provides the general legal framework with regards to adults who lack decision-making capacity in relation to their welfare, property, or finances. The Act is wide-ranging and provides for powers of attorney, guardianship and intervention orders for adults who lack decision-making capacity to make specific decisions about their welfare and/or finances[31]. It also contains provision regarding medical treatment for a person who is incapable of consenting[32]. We discuss the use of guardianship in detail later in this guidance.

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[31] https://www.mwcscot.org.uk/law-and-rights/adults-incapacity-act

[32] Mental Welfare Commission *Consent to Treatment* (Mental Welfare Commission: Edinburgh, 2025) https://www.mwcscot.org.uk/node/230

Advocacy

The Mental Health Act gives every person with a mental disorder a right of access to independent advocacy[33]. This right is not restricted to those who are subject to compulsory measures under the Act. Problems with short-term memory, recall and executive functioning are common features of ARBD, and people with ARBD may benefit from access to independent advocacy to support their engagement, participation and decision-making throughout the care and treatment process.

The AWI Act does not create an explicit right to advocacy, but recognises the importance of taking account of the adult's wishes and feelings. Advocacy can play an important role when applications for welfare guardianship or intervention orders are being considered. An advocate may assist the individual to participate in case conferences, discussions about care planning and court proceedings. Advocacy may also support ongoing participation in care reviews, legal reviews and the exercise of legal rights.

Section 6 of the ASP Act places a duty on local authorities to have regard to "the importance of the provision of appropriate services (including, in particular, independent advocacy services)". The participation of the adult, and their views and wishes, are central to ASP practice.

Independent advocacy may be particularly valuable where cognitive impairment, memory difficulties or fluctuating decision-making ability affect a person's ability to participate effectively in discussions about their care, treatment or legal status. Advocacy can help ensure that the individual's views, wishes and preferences are heard and taken into account when decisions are being made.

Scottish Government *Adults with Incapacity (Scotland) Act 2000: Code of Practice (Third Edition): For Practitioners Authorised to Carry Out Medical Treatment or Research Under Part 5 of the Act* (Scottish Government: Edinburgh, 2010) https://www2.gov.scot/Publications/2010/10/20153801/0

[33] Scottish Independent Advocacy Alliance. *Principles and Standards for Independent Advocacy.* Edinburgh: SIAA. https://www.siaa.org.uk/wp-content/uploads/2021/02/SIAA-Principles-Final-2nd-print-run-with-ISBN.pdf

Mental Welfare Commission for Scotland. *Supported Decision Making: Good Practice Guide.* Edinburgh: MWC; 2024. https://www.mwcscot.org.uk/node/503

Assessment of decision-making capacity and decision-making ability in ARBD

Best practice in undertaking a decision-making capacity assessment[34]

An assessment of an individual's decision-making capacity may be required for a variety of reasons and may take a number of forms: an initial assessment to determine whether statutory intervention is required, an assessment for the purposes of confirming incapacity to activate welfare powers under a power of attorney, or a statutory medical report to accompany a guardianship application[35].

An important consideration is the timing of the assessment. ARBD can produce significant impairments in memory, executive functioning and other cognitive abilities which may affect decision-making capacity. In people who continue to drink alcohol, these difficulties may worsen, whereas sustained abstinence may lead to cognitive and functional improvement[36]. In some individuals, this improvement may result in the recovery of decision-making capacity.

For this reason, where abstinence has been achieved and circumstances allow, a definitive assessment of decision-making capacity should take account of the potential for improvement over time. Although improvement may continue for many months, the most substantial gains are often seen during the first twelve weeks of abstinence. In many cases it will be helpful to defer a formal assessment until the individual has had an opportunity to achieve a period of sustained abstinence and stabilisation.

Assessments should not focus solely on identifying deficits. Practitioners should take reasonable steps to maximise the individual's ability to participate in decisions affecting them. This may include allowing additional time, repeating information, presenting information in different formats, involving independent advocacy, and seeking support from those who know the individual well. Supported decision-making approaches should be considered wherever possible before concluding that an individual lacks decision-making capacity.

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[34] NICE *NG108: Decision-making and Mental capacity* (2018) https://www.nice.org.uk/guidance/NG108. This relates to English law and is not specific to ARBD, but is useful for general advice on decision-making capacity assessments.

[35] Adults with Incapacity (Scotland) Act 2000 s57(3)(a)

[36] Cox S, Anderson I, McCabe L (eds) *A Fuller Life: Report of the Expert Group on Alcohol Related Brain Damage* (2004) For more general guidance on decision-making capacity, albeit in an English context, see NICE Guideline NG108 on Decision-makingand Mental Decision-making capacity: https://www.nice.org.uk/guidance/ng108

The following describes our view of an optimal three-stage assessment process, but we recognise that many assessments will take place in far from optimal settings or situations. This may relate to ongoing alcohol use, incomplete information, fluctuating cognition or a lack of access to a suitable assessment environment. If individuals continue to drink alcohol, acute intoxication may impair thinking, judgement and the assessment of decision-making capacity. Health professionals may find it difficult to assess individuals when they are not under the influence of alcohol.

The first step is detailed information gathering. This will include personal, family and social history. Particular attention should be paid to relationships and community links that have been maintained. Information gathering may be hampered by the absence of family members or a wider social network able to provide collateral information. Consideration should also be given to recent risks and adverse events. Relevant information may come from GPs, hospital records, social work records, family reports and other agencies. A detailed account of current social circumstances, finances and support arrangements will also be important. This should be supplemented by an up-to-date functional assessment from OTs, nursing staff and support staff. Functional assessments often reveal a greater degree of impairment than is apparent during interview alone. A multidisciplinary team meeting may provide a useful forum for sharing information and reaching a consensus regarding issues affecting capacity, risk and future care planning.

The second stage is the direct assessment of the individual. This may take place in the person's home, hospital or current placement. Wherever possible, however, the assessor should seek a quiet environment with minimal distractions and allow sufficient time. Information should be presented in a way that maximises the individual's ability to understand and participate in the assessment. Breaking information into smaller sections and providing written or visual information may be helpful.

A key focus of the assessment is establishing the diagnosis, including up-to-date cognitive assessment where appropriate. Incapacity cannot be inferred from any particular cognitive test score, but cognitive testing may provide useful information regarding the nature and severity of any impairment. The process of undertaking cognitive assessment may itself provide valuable information about information processing, memory, cognitive flexibility, and decision-making. The individual's views regarding alcohol use, including willingness to consider abstinence, are also important. While a refusal to stop drinking does not in itself demonstrate incapacity, many people with ARBD have limited insight into their difficulties and associated risks. This may affect both engagement with services and participation in assessment.

Applying the legal criteria to people with ARBD

Assessment of decision-making capacity for an intervention under the AWI Act must be in line with the test in statute[37]. Practitioners making an assessment of decision-making capacity for a person with ARBD should consider whether the individual:

1. has a general understanding of the decision required, the information relevant to the decision, and an understanding and belief that the decision and information are relevant to them at the current time,
2. has an adequate knowledge of the risks and benefits associated with the decision, is able to retain this knowledge, and use and weigh it in coming to a decision,
3. is aware of alternatives and the consequences of acting and not acting,
4. is not under undue external influence, and is aware of their right to refuse any choice or intervention, and
5. how their current choices and actions align with their previously expressed views and their family, social, and cultural background.

Decision-making capacity should be assessed in the context of *the particular decisions that require to be made*. It is contrary to the spirit of the AWI Act to assess decision-making capacity in a general sense.

People with ARBD can often initially present as having a greater degree of decision-making capacity than they actually have, due to preserved verbal skills and a good social façade. Particular consideration should be given to factors seen in people with ARBD:

Acting and making decisions

In some people with ARBD the impairment may be so severe that they do not even realise there is a decision to be made. Many potential decisions relate to addressing risk. The person with ARBD may have no insight as to their deficits or fail to appreciate or remember information they have been told about risk.

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[37] Section 1(6) AWI Act. An adult has incapacity in relation to a decision if they are incapable of:

- Acting; or
- Making decisions; or
- Communicating decisions; or
- Understanding decisions; or
- Retaining the memory of decisions

by reason of mental disorder or inability to communicate that can't be rectified.

Frontal lobe damage can mean that the person being assessed may be unable to act to safeguard their own interests e.g. gatekeeping their own tenancy, buying and eating nutritious food, looking after their own personal care, keeping away from others whose intention is to exploit them.

Communication

This is often apparently unimpaired. Compared to other dementing conditions, people with ARBD often have preserved verbal abilities[38] and may exhibit confabulation. This can result in an ability to give plausible, but false, explanations and answers to questions.

Retain memory of decisions

Poor memory, particularly working memory, is a feature of most ARBD cases. In relation to decision-making capacity decisions, the issue to be decided is whether they can they retain information pertinent to the decision long enough to use it. Poor memory can also lead to an underestimation of risk, due to the inability to retain information about those risks or appreciate recent deterioration in function.

Understanding

The issue of whether the person with ARBD is able to understand the information sufficiently to make a decision can be the most difficult of all. It is possible for different practitioners, making the same observations and using the same information, to come to a different view. The issues for consideration are whether the person is able to believe the information about their deficits, appreciate its personal relevance to them, and use and weigh the information, particularly as the situation changes or deteriorates due to a cognitive rigidity. The interviewer should explore the contrast between the person's understanding of their situation and the risks, and the objective account gathered above.

Assessments of decision-making capacity in ARBD should not be made on one occasion only. Given the possibility of fluctuating cognition and decision-making capacity, regularly reviewing this decision at roughly six-monthly intervals is recommended.

Completing court papers in guardianship applications

In the completion of a statutory medical report to accompany a guardianship application the doctor must specify the mental disorder in terms of the meaning specified in s328 of the Mental Health Act. This will generally state 'alcohol-related

[38] Bates ME, Barry D, Bowden SC "Neurocognitive impairment associated with alcohol use disorders: implications for treatment," *Exp Clin Psychopharmacology* 10 (2002):193-212.

brain damage', with or without additional diagnoses. In the medical opinion, the practitioner should set out:

- the results of their assessment, and in particular how the identified medical condition affects the individual's decision-making capacity,
- the likely duration of the incapacity, the extent to which they have been able to communicate with the individual, and
- the extent of consultations with other people with knowledge of the individual.

Where the doctor is asked to indicate the likely duration of the incapacity, this can be difficult, as dramatic improvements are possible in the early stages of abstinence. It may be appropriate to bear in mind that, with appropriate care, there is the potential for gradual improvement, with the extent and timescales of possible improvement in line with the timescales suggested above.

Significantly impaired decision-making (SIDMA)

In order to detain or compulsorily treat an adult under the civil provisions of the Mental Health Act, it is necessary that the adult has, or is likely to have SIDMA[39]. The code of practice for the Act explains[40] that the factors which may establish that a person has SIDMA are similar to those which are relevant to incapacity. However, the intention is that the test is less binary in nature and can be applied more flexibly[41].

The time available for an assessment of SIDMA is likely to be short, so not all of the features of best practice described in relation to a decision-making capacity assessment may be practicable, but they are still relevant so far as they can be achieved.

Interventions while decision-making capacity is maintained

Case study 1: John

John is 66. He is a retired professional who lives alone and has no family contact. The Scottish Fire and Rescue Service has made several ASP referrals following small accidental fires in his home. The conditions in the house are described as squalid. John was intoxicated and unsteady on his feet each time the fire service responded.

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[39] For Compulsory Treatment Orders see Mental Health (Care and Treatment) (Scotland) Act 2003 s64(5) (d)

[40] Scottish Government, *Mental Health (Care and Treatment) (Scotland) Act 2003 Code of Practice Vol 2* (Scottish Government: Edinburgh, 2005): 22-27

[41] For a discussion of the nature of SIDMA see Mental Welfare Commission *'Significantly impaired decision-making ability; general guidance'* (2025) https://www.mwcscot.org.uk/node/2485

Social work has visited, but John refuses all offers of intervention. Neighbours and a local councillor have complained that something should be done.

Two ASP case conferences are convened within a brief period.

Initially, John is assessed not to meet the three-point test for an adult at risk of harm because there is insufficient evidence that he is affected by a disability, mental disorder, illness, or physical or mental infirmity that places him at greater risk of harm than other adults.

At the second conference, a removal order is considered in order to gain access to the house for cleaning. John refuses access, stating that he has valuable possessions throughout the property. He puts his views forward clearly at the conference and is considered to have decision-making capacity. He does not consent to the removal order.

Both addiction services and the community mental health team feel unable to work with John while he continues to drink. Following another incident at home and a further referral from his GP to addiction services, a support worker is allocated jointly with social work services. The support worker visits John regularly at home to build a relationship, encourage him to accept minimal support and help maintain his home at an acceptable standard.

In addition, staff are able to monitor John's nutritional intake and develop a clearer understanding of his overall needs. On days when he is unwilling or unable to prepare meals, he will accept simple food or drinks, allowing staff to maintain some nutritional intake and monitor his wellbeing. Support staff are also keen to ensure that his home environment is safe and that fire risks are reduced.

It is agreed that both the three-point test and John's decision-making capacity will be kept under regular review, and that the effectiveness and tolerability of the planned interventions will be monitored.

Learning points and best practice

- Building a fuller assessment: Many individuals such as John will strongly oppose intervention from services, insist on continuing to drink and have little or no support. In situations such as this, minimal contact, primarily focused on welfare monitoring, can contribute to a fuller assessment over time. Regular brief contact may allow support staff to identify subtle changes in physical health, mental health, and functioning, helping professionals determine when intervention may become necessary.
- Individuals with alcohol problems can sometimes present well and articulate their views clearly, even when still drinking heavily. This may mask significant cognitive difficulties. Assessment should take place over time, involve a

holistic approach and draw upon information from a range of professionals and agencies wherever possible.

- Consideration should be given to the number and frequency of ASP referrals relating to an individual. Even where a person is not initially considered to meet the three-point test, repeated referrals within a relatively short period should prompt consideration of a case conference and a co-ordinated multi-agency response.
- Nutrition plays an important role. Deficiencies, particularly of thiamine, may occur in people whose alcohol consumption replaces normal dietary intake. Maintaining adequate nutrition and considering appropriate vitamin supplementation can be important aspects of care planning. Responsibility for monitoring and supporting nutrition should be clearly identified.
- Some addiction services may find it difficult to engage people who continue to drink heavily or who do not recognise the impact of alcohol on their health and wellbeing. Many people with ARBD have limited insight into their difficulties and may repeatedly decline support. This can create challenges in accessing services that depend upon active engagement. However, local authorities and NHS services should ensure that appropriate support remains available for people whose cognitive impairment arising from ARBD significantly affects their ability to engage voluntarily with treatment and support.
- Even where an individual meets the three-point test under the ASP Act, formal intervention may not be indicated. In this case the removal order cannot proceed because John does not consent and there is no evidence of undue pressure. However, the duty to inquire and investigate under the Act, and to bring agencies together, can support the development of a co-ordinated plan which may improve safety and provide the basis for later intervention if required.
- Some people have very limited contact with health and social care services and, if owner-occupiers, may also have little contact with housing services. Organisations such as the Scottish Fire and Rescue Service can play an important role in identifying adults who may be at risk of harm and bringing concerns to the attention of statutory agencies.[42]

[42] Discussed further in Care Inspectorate and HMICS *Joint Inspection of Adult Support and Protection* (2018) http://www.careinspectorate.com/images/documents/4453/Review%20of%20adult%20support%20and%20protection%20report%20(April%202018).pdf

Interventions where decision-making capacity is more uncertain

Case study 2: Lisa

Lisa is 40 years old and lives in a flat rented from the local authority. She has been drinking on a regular basis for the last five years but is still in employment. She has two children of primary school age. Lisa has an adult social worker who has been trying to get her engaged with addiction services. Lisa is often under the influence of alcohol when the social worker visits but has refused all offers of support. The situation deteriorates over time and the children are placed with foster carers. Lisa also loses her job. Her mood is low and the house is becoming more and more unkempt.

Environmental health and housing become involved due to the poor condition of the flat and are considering taking action to evict her from the tenancy. The social worker feels that Lisa's cognitive abilities are impaired.

A multidisciplinary case conference is called by social work under the ASP Act. Given her diagnosis of depression, coupled with her alcohol dependence, the local authority feel that Lisa meets the three-point test and is at risk of emotional and financial harm. An ASP protection plan is drawn up.

The plan includes the following:

- Social work services arrange for the flat to be cleared of debris and cleaned. The cost of this is met by social work, as Lisa is in debt and has limited funds.
- A specialist mental health homecare team is allocated to support Lisa, by visiting on a regular basis and building up a relationship with her. At the same time staff are monitoring her well-being and her safety at home.
- The GP is identified to assess her decision-making capacity in relation to welfare decision-making with the aim of this being kept under review by the same GP and consideration given to reassessment by specialist services. At this point, the GP concludes that Lisa retains decision-making capacity.

Lisa continues to drink to excess and is often found on the floor when home care workers go in. Lisa agrees to a key safe, as long as workers from the mental health team knock and wait to be asked to come in. They agree with Lisa that they will only use the key safe if they are unable to gain entry. Over time, Lisa gets to know the team members and does not object when they clean up around her. She remains passive most of the time but is also very angry and upset at times that her children were removed. However, she does not keep to contact arrangements, despite support from social work to help her to do this. Her alcohol intake does not reduce.

Learning points and best practice

- This case study highlights the dilemmas around intervening with individuals who are drinking heavily but have yet to be diagnosed with ARBD. Often there will be poor engagement with services and all offers of support are refused. Common issues identified by social work staff at this point will be a deterioration in physical health, and a steady decline in household maintenance. The former can lead to brief hospital admissions, involving GPs and hospitals, while the latter can result in numerous house cleans and attract the attention of housing services. Both health and housing authorities can struggle to make inroads into these situations, and it is social work services that require to co-ordinate the multi-agency response.
- Assessment of decision-making capacity: in this instance this is undertaken by GP, but not all practitioners are confident in this area and it may be worth being clear with the local GP about what level of assessment is required. There can be a reluctance for community mental health teams to take on a role if an individual is not known to their service. It is our opinion that decision-making capacity assessments are within the responsibilities of the GP or an approved medical practitioner (AMP) based in the community mental health team, although they should consider when a more specialist assessment should be initiated. This can be frustrating for staff concerned particularly if decision-making capacity is viewed to be fluctuating. It is important to keep this under review.
- The use of the Mental Health Act or the AWI Act in a case such as this may be appropriate and professionals should understand and reflect collectively on the legislative options, although, as here, it may often be concluded either that the statutory tests are not met or the use of compulsory interventions is not justified. At times, a limited and consistent care plan may be the best that can be achieved.

Using the Mental Health Act in urgent situations

Case study 3: Tadeusz

Tadeusz is a 55-year-old man with a long history of alcohol dependence. He has previously worked with alcohol services but is not currently in follow-up and is drinking six litres of strong cider a day. He lives in a homeless hostel and has little contact with his family. He regularly has admissions to hospital in relation to falls and liver disease.

There has been concern from staff that Tadeusz's memory is worse and that he is not functioning as well as he did. However, until now it has been felt that he has the decision-making capacity to make his own welfare decisions and has not been suffering from a mental impairment, other than alcohol dependence.

Tadeusz has another fall and his GP visits him at home. He is prescribed opiate painkillers for his injuries. Tadeusz is not able to get out for a few days, and the hostel staff refuse to buy him cider. Two days later, they contact the GP again with concerns that Tadeusz seems agitated, more confused, and is uncharacteristically aggressive. His GP visits and finds him disorientated, unsteady on his feet, and with a cut to his forehead.

The GP recommends admission for Tadeusz to investigate his confusion and head injury, but he refuses to accept this voluntarily. Given the suspicion of a mental disorder in addition to dependence, Tadeusz's impaired decision-making, and the significant risks to his health and well-being the GP detains him under an emergency detention certificate (EDC).

Tadeusz is brought to the emergency department and has a brain scan, which does not reveal any significant abnormalities. It is thought he may be suffering from delirium tremens, WKS, or hepatic encephalopathy precipitated by the opiates. He requires treatment for his alcohol withdrawals, and thiamine. The EDC authorises his detention in hospital, and an AMP and MHO review is arranged for the following morning.

Overnight, Tadeusz becomes very behaviourally disturbed and ultimately breaks a sink and assaults a nurse. He appears very frightened and is "seeing things". A senior doctor decides that urgent treatment is required and that this can be authorised by s243 of the Mental Health Act. Tadeusz receives diazepam and quickly becomes much more settled.

The following morning, the AMP and MHO agree to convert the EDC to a short-term detention certificate (STDC) and, after a further three days in hospital, Tadeusz appears more settled. An Addenbrooke's Cognitive Examination ACE-III is performed and he scores 84 out of 100, suggesting mild cognitive impairment. On further discussion, Tadeusz's decision-making is improved, he is felt to have regained decision-making ability, and the STDC is revoked. He is discharged with reiterated advice about support from alcohol services.

Learning points and best practice

- An EDC authorises a person to be held in hospital for up to 72 hours while their condition is being assessed, provided the conditions of the Mental Health Act are met. There must be a reasonable suspicion of a mental disorder. New or additional mental health conditions, such as delirium or ARBD, can authorise detention in individuals who are alcohol dependent.
- Even in cases where an individual has been deemed to have decision-making capacity, the situation can change rapidly, especially if there are concurrent physical ill-health or withdrawal symptoms.

- Crisis admissions should primarily be for the safe management of the emergency situation. However, they can allow for short periods of assessment of cognition and functioning without the influence of alcohol.
- An EDC does not authorise the giving of medical treatment without consent. Urgent general medical treatment may be administered to a person subject to an EDC under s243 of the Mental Health Act[43].
- Provided the conditions are met in terms of the Act, an STDC can be used as authority to remove a person with ARBD to hospital, transfer the person from a general hospital to a psychiatric hospital, detain the person for up to 28 days, and give the person medical treatment in terms of part 16 of the Act. An STDC may be appropriate in the case of acute withdrawal and allow further assessment.
- Ideally, people might leave from a short period of detention with a more comprehensive discharge plan. We recognise this is often not the case.

Longer-term interventions

Using the AWI Act

A welfare guardianship order may be sought when a person is deemed incapable of making decisions about their welfare and finances. It is an important piece of legislation in planning and managing the future needs of individuals with ARBD and can confer a range of powers on an appointed welfare guardian.

A guardianship order should be part of a wider plan for the care and treatment of the person and will in many cases be a tool to underpin the care plan.

What powers should be sought?

With the exception of a few limited prohibitions[44] the AWI Act has a wide scope, conferring powers to deal with matters in relation to the adult's property, financial affairs, and/or personal welfare. The powers sought should be based on the needs and strengths of the individual and should be personalised. They should not necessarily be limited to those that might be immediately required. Any powers that might be deemed necessary for the duration of the guardianship order should be included, provided this can be evidenced and supported by the principles of the Act.

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[43] Where it is necessary as a matter of urgency, treatment can be given for the purposes of saving the detained person's life, preventing serious deterioration in their condition, alleviating serious suffering on the part of the individual and preventing the person from behaving violently or being a danger to self or others. See Scottish Government, *Mental Health (Care and Treatment) (Scotland) Act 2003 Code of Practice Vol 1* (Scottish Government: Edinburgh, 2005): Ch 10 paras 81-87

[44] Adults with Incapacity (Scotland) Act 2000 s64(2)

Some general powers, for example to determine where the individual should live, are commonly sought. Where ongoing alcohol misuse is an issue, it is often appropriate to seek some specifically tailored powers. We believe this needs to be better understood. We looked at powers relating to welfare guardianship orders relating to ARBD for a six-month period and found that less than half featured targeted powers that aimed to address drinking or problem behaviours associated with this.

The following specific powers might be useful:

- to consent, or withhold consent, to the consumption of alcohol on behalf of the adult,
- to restrict the adult's access and consumption of alcohol, and to take any necessary steps to prevent the adult consuming alcohol,
- to make decisions about, or to consent or withhold consent on, the adult's participation in cultural, social, or recreational activities,
- to decide who shall accompany the adult on cultural, social, or recreational activities,
- to decide with whom the adult can consort,
- to search the adult's accommodation for the purposes of finding and confiscating alcohol, or
- to consent, withhold consent, or make decisions about any person having access to or contact with the adult.

It is important when considering powers that the necessary care and support to implement the powers are available. Authority can be delegated, for example to care staff, and it is important that the care providers are aware of these powers, their legal authority, and how they can implement these powers.

We do not cover financial guardianship in this guidance. Where the individual's only resources are social security benefits, these may be appropriately managed under Department of Work and Pensions (DWP) appointeeship. If the individual has other funds, financial guardianship, a financial power of attorney, or management of the funds under part 3 or 4 of the AWI Act may be appropriate. For further guidance, see the Commission's publication *Money Matters*[45], and the website of the Office of the Public Guardian (Scotland)[46].

Who should act as welfare guardian?

If it has been determined that a guardianship order is appropriate, the question of who should be appointed requires careful and early consideration. The AWI Act

[45] https://www.mwcscot.org.uk/node/502

[46] http://www.publicguardian-scotland.gov.uk/

allows any person claiming an interest in the property, financial affairs, or welfare of an incapable adult to seek appointment as guardian, either on their own or jointly.

The local authority is under a duty to apply where no application has been made, or is likely to be made, where an individual is incapable and there is no other appropriate way to safeguard or promote the individual's property, financial affairs, or personal welfare[47].

It is important to ascertain quickly if there is someone both suitable and willing to seek appointment as guardian, failing which the local authority should take steps to promptly progress an application[48].

Where a suitable private individual is willing to apply to be welfare guardian, they need to be aware that, even with legal aid, there may be residual costs at the outset. They also need to be aware that if they were to be appointed, this may bring them into conflict with the individual. Will they be in a position to exercise and, where necessary, enforce the powers that they have been given? Is the prospective guardian in a position to instruct a solicitor, and engage with the legal process without delay?

While the AWI Act prohibits a local authority from seeking appointment as financial guardian, the authority may submit the application and propose an independent financial guardian be appointed, for example a local solicitor.

The Court process

The Sheriff Court deals with all guardianship applications under the AWI Act. Following the necessary statutory reports, the application may be subject to further delays due to notification periods, court time, or the appointment of a safeguarder[49].

Interim orders for guardianship can be sought in cases where powers are needed urgently[50]. However, a full summary application with the accompanying statutory reports will still be required. Therefore, where urgent intervention is required, consideration of the Mental Health Act and ASP Act may be necessary.

Non-compliance with a guardianship order

Welfare guardians are entitled to apply to the sheriff for an order ordaining the individual to comply with the decision that they have made on the adult's behalf, in terms of the powers that have been granted to them. A warrant can also be sought

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[47] Adults with Incapacity (Scotland) Act 2000 Section 57(2)(b)

[48] Section 57(1)

[49] Section 3(4)

[50] Section57(5)

to order a third party, such as a relative or carer, to implement a guardian's decision, in the event that they are not complying with a decision of a guardian in terms of the powers.[51]

If an adult fails to comply with a decision as to their place of residence, the sheriff can grant a warrant authorising a police officer to enter premises where the adult is and remove them to such a place as the guardian directs. The AWI Act only makes specific provision for a warrant authorising a police intervention when the failure to comply relates to the individual's place of residence.[52]

In the case of a person with ARBD, if all other options are exhausted, a warrant may be useful as a last resort when conveying them to new place of residence in the event of refusal to go, with all other options being exhausted, or returning them to that place in the event that the adult absconds.

Any application to the sheriff seeking such a warrant would be a last resort and would require to demonstrate that it complies with the general principles of the Act. It would be for the guardian to demonstrate that the granting of the warrant would be the only means of achieving the proposed benefit to the adult, and that other means have been exhausted.

The sheriff has the power to dispense with the requirement for notice to the adult of such proceedings in cases of extreme urgency and high risk.[53]

Case study 4a: Iain

Iain is a 58-year-old man, with a long history of alcohol dependence which began after he left the army. He separated from his wife some years ago as a result of his drinking. He lives alone in a housing association tenancy and has had very little contact with social or health services.

Iain is admitted to hospital following a serious physical assault, during which he sustained a head injury and a fractured arm. He requires treatment for alcohol withdrawal and is given i/v thiamine. Unfortunately, he remains very confused, is determined to self-discharge, and is unaware of the risks he would pose to himself if he left the hospital. He is placed on an STDC under the Mental Health Act. Psychiatry is able to conduct a thorough assessment of his cognition, and it is confirmed Iain has ARBD and ultimately meets the criteria for further detention under a CTO.

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[51] Section 70

[52] Section 70(1)(b)

[53] Section 70(4A)

It is clear that his decision-making ability is severely impaired. Iain's MHO completes a social circumstances report. They discover that Iain has been allowing acquaintances to use his flat as a place to drink, and it is likely they have also been financially exploiting him. The ward physiotherapist and OT assess Iain and report significant concerns about his risk of falls and his functioning. Care in his own home is no longer an option.

Iain remains in hospital, but the orthopaedic team feel he is "medically fit" for discharge and there is some pressure to find a placement for Iain. Staff on the ward feel frustrated with his inappropriate placement, and Iain is very restricted in terms of his activities. He is now homeless and will require a great deal of support due to his ongoing cognitive impairment. Iain is more settled in terms of his behaviour as he has become accustomed to the environment and his responsible medical officer (RMO) is able to revoke the CTO as it is no longer necessary.

Fortunately, a local ARBD unit has recently been set up, where people with ARBD can be transferred for treatment and rehabilitation. Iain is assessed by this service and accepted. Following transfer there, Iain settles in well. He engages in the group activities and enjoys the company of the other residents. He is gradually encouraged and supported to do more for himself, including washing and shopping. He is assessed by the specialist OT and psychologist.

Iain's cognition is slow to improve, particularly his short-term memory. Despite stating he would like to remain abstinent, this is variable, and support staff have observed him in the alcohol aisle at the supermarket when on supervised passes. He does not fully understand and believe the role of alcohol in ARBD. The decision to proceed to welfare guardianship for Iain is discussed at an AWI case conference, attended by psychiatry, the unit nurse manager, the OT, physiotherapy, and the MHO. Those who attend comment on Iain's decision-making capacity and discuss his current support needs. Iain and an advocacy worker also attend and Iain's wishes to be discharged are recorded.

At the case conference there is a discussion of the powers, how they are to be used, and how they would be linked into a care plan. The powers under consideration relate to the areas where Iain lacks decision-making capacity but also promote the use and development of his residual skills. Iain is opposed to the welfare guardianship order and does not recognise that he has an issue with alcohol. He feels that he can safeguard his own welfare, and that he should be allowed to return home. He does not agree with plans for him to move to a supported residential setting.

Learning points and best practice

- It is important that key staff who are able to contribute specific information in relation to decision-making capacity, behaviours, and future care planning attend the case conference. If attendance is difficult, then written statements or reports should be provided in advance.
- The presence of an individual with ARBD on a general hospital ward can be challenging, and there is often pressure on social work staff to relieve bed space. This is understandable, but it is important for ward staff to understand the condition and the process required to authorise a safe and legal discharge. A person with ARBD and complex care needs should receive a full assessment and care plan which provides for those needs to be met in the community, upon discharge.
- There are very few specialised ARBD units available. However, where present, such units are able to provide specialised rehabilitation for people with ARBD, as well as expertise in terms of the assessment of decision-making capacity in this cohort.
- Some powers may be delegated to residential care staff. These may be difficult to implement. Staff must feel confident that they have the legal authority to act. This is often not conveyed, and at times knowledge of powers is limited. These discussions and decisions should be recorded. We recommend a copy of the order and the delegation of powers is kept with an individual's care plan in a care setting.
- Powers under guardianship may be used to prevent the individual from consorting with people who may exploit or abuse them. An alternative approach is to consider a banning order under the ASP Act.[54]
- Although welfare guardianship is normally the preferred option for long-term management of someone who lacks decision-making capacity, a community-based compulsory treatment order (CCTO) under the Mental Health Act may also be considered, as a way to ensure structure and support continues to be provided. Under a CCTO, the individual can be required to reside at a specified place, attend specified places to receive treatment or services, and to allow professionals or care providers to visit the individual.

[54] Adult Support and Protection (Scotland) Act 2007, sections 19-34. This can bar someone from being in a specified place, such as the home of an adult at risk. Further information is in *Adult Support and Protection (Scotland) Act 2007 Code of Practice* (Scottish Government: Edinburgh 2008) Ch 11 https://www2.gov.scot/Publications/2009/01/30112831/13

Maintaining support during recovery

Case study 4b: Iain

Iain is now in a residential setting, and has been abstinent from alcohol, is eating well, and taking part in some activities. This is assisted by the powers contained in the welfare guardianship order, and the provision of good care and support. After eight months he appears to have regained some elements of decision-making capacity. Iain complains of being bored in his current setting and frequently talks about his past home. The social worker is aware that Iain may no longer meet the grounds for all of the powers contained within the current welfare guardianship order, and that his decision-making capacity should be reassessed. The MHO/social worker is required to advise Iain of his rights, which includes the right to challenge the guardianship on the basis that he may no longer be incapable of making some welfare decisions.

Iain, although well looked after, is miserable, and has begun to refuse to engage with activities at the care home. He is frustrated at not being able to resume his past social life but has no insight that this led to his diagnosis of ARBD. His social worker organises a review of his decision-making capacity by his local mental health team.

Learning points and best practice

- It is important that a thorough reassessment of care needs, care deficits, and decision-making capacity takes place, which takes into consideration supporting information from care staff. For example, are they able to evidence from Iain's behaviours that he is actively seeking alcohol? What are his current views on alcohol, and his understanding of its likely effects on him? If an individual does not have the decision-making capacity to understand the consequences of drinking again, this aspect of decision-making may need to be tested before revoking the powers completely.
- The medical assessment needs to clearly address the legal criteria of incapacity but should also be set in context of Iain's history of misuse of alcohol and what has brought him to his current position. Some individuals can present as articulate, well presented, and can superficially present with decision-making capacity at the point of assessment. It is important that the assessment is undertaken by an AMP and preferably someone with experience in this area.
- Even if professionals are confident that an individual would continue to benefit from structured care and abstinence, a guardianship order can only be maintained in the long term if the conditions continue to be met, including that the individual lacks decision-making capacity in relation to some decisions. Unlike the Mental Health Act, the AWI Act does not specifically provide that there is a responsibility to revoke the order immediately if

someone regains decision-making capacity. It is reasonable to consider if this could be a transient and short-lived recovery. The powers could continue to be used for a period, pending a fuller assessment and consideration of available options.

- Ultimately, if there is evidence of a sustained regaining of decision-making capacity, the local authority should consider revoking the order[55]. Iain should also be advised of his ability to seek a recall of the order[56]. He should be assisted by legal support and advocacy.
- A decision by the local authority to revoke a welfare guardianship order should, if possible, be made following a multi-agency case conference where a consensus agreement is reached. Likewise, if after a period in the community Iain's care plan is not effective, then a discussion about the future use of guardianship should be held within this forum. Best practice would suggest that Iain's return to the community could be tested from the security of the care placement. It is essential for the MDT to recognise aftercare planning as their continued responsibility.
- If an individual dislikes the constraints of a care setting this needs to be taken seriously, even if there is good reason to believe it is keeping them safe. This reflects the principles of the AWI Act, and the requirement under the United Nations Convention of the Rights of People with Disabilities to respect the "rights, will and preference" of disabled persons. Adults with ARBD might reasonably be miserable in some of the care settings in which they are placed. They should be entitled to a care setting which reflects their age and interests, just like anyone else. In considering ongoing compulsion, it is important to consider if this will be breaching someone's human rights by imposing a way of life which may be intolerable to them. The answer should not be to abandon this group to their fate, but to develop more appropriate services.
- If it is established that decision-making capacity is recovered, professionals may ultimately have to accept that people with decision-making capacity are entitled to resume a self-destructive lifestyle. But services should do all they can to plan appropriately before ending an order, put in supports, and consider ongoing ASP issues. As discussed in part 9, vulnerability may be a

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[55] Under s73 of the AWI Act, the local authority may recall guardianship if the grounds are no longer met. Under s73A, if the guardian is the Chief Social Work Officer, other interested parties may object and the matter would then be referred to the sheriff.

[56] The adult can ask the local authority to recall the order under s73, or apply to the sheriff under s71. A form to apply to the local authority can be downloaded at https://www2.gov.scot/Topics/Justice/law/awi/forms/Local-Authorities/newformawi12word

component of incapacity if it can be established that a person is at severe risk of exploitation by others, and lacks the executive function to protect themselves.

Summary: Key learning points

1. ARBD is a mental impairment, with a significant disease burden, and NHS boards and local authorities have a responsibility to provide appropriate supports, including measures directed at prevention and early intervention.
2. There are examples of excellent practice which should be used as a basis for the development of ARBD services nationally.
3. Many people with ARBD will initially present to generic services (A&E, police, housing, GPs), and there should be clear pathways to access appropriate assessment and care planning. This will potentially save money and reduce demands on frontline services.
4. Building trust and a therapeutic relationship, and long-term multidisciplinary interventions, are crucial.
5. There are effective treatments for ARBD, and legal interventions can often help to ensure these treatments can be delivered, and the chances of long-term recovery maximised - whether short term interventions in a crisis using the ASP Act or the Mental Health Act, or longer term measures under the AWI Act.
6. For interventions under incapacity and mental health law decision-making capacity, incapacity, and SIDMA, are fundamental. There are particular challenges in carrying out decision-making capacity assessments with ARBD, so assessments should be carefully planned and carried out by specialists wherever possible.
7. The powers needed to support someone with ARBD may not be the same as for other individuals, and services should make creative and individualised use of the range of powers available under welfare guardianship.
8. ARBD presents complex ethical issues around human rights and respecting autonomy while keeping people safe, and careful multidisciplinary planning is extremely important.

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