

Supporting people with Korsakoff's Syndrome

Arbennig has supported people with Korsakoff's syndrome between November 2002 and May 2010. Listed below is a follow up analysis post discharge, which loosely supports the recovery outcome of Korsakoff's

Path after Discharge	Percentage
Unknown	4%
Hospital—Mental Health	15%
Hospital—Physical Health	4%
Residential or Home Support	48%
Died	29%

Sam's Story—Background

Sam was admitted to the Arbennig Unit from her home, after confirmation of Korsakoff's Syndrome, and a thorough assessment confirmed abstinence for six weeks. She presented with poor physical and mental condition, was non communicative, and very difficult to motivate. An appointee had been nominated to look after finances, otherwise Sam's legal status was informal.

Baseline assessments suggested that Sam had at one time managed a household and a job, and we were fortunate to have some involvement of the family. Psychiatric, functional, and cognitive assessments were repeated periodically, as "ability to do adequate assessments was impeded by a lack of background information" Macrae and Cox (2003).

Staff understood that Sam's rehabilitation would not be quick, and needed to be provided in a safe, predictable, and structured environment.

Using the Arbennig Support Model—Case Study

abstinence—Sam was offered the services of local statutory agencies i.e. AA and CAIS, but preferred to work with staff. Arbennig use the Stages of Change Model Prochaska & DiClemente (1982), with additional work on relapse prevention as outlined by G Martlett (2008). There were some lapses, however Sam worked with staff to get back on track by identifying triggers and implementing coping strategies

daily living skill—when Sam felt safe in her environment and had built trust in staff, work commenced on personal and household tasks, including cooking, managing finance, and attending appointments. A structured routine was implemented, and in time fewer prompts from staff were required

improvements in health—medication was reviewed with GP to ensure appropriate vitamin supplements were prescribed. A weekly menu was devised to take account of likes and dislikes, which was high in Vitamin B1. Sam met with our visiting consultant psychiatrist monthly to discuss issues affecting / effecting her mental health.

meaningful activities—through time building professional relationships and 1-1 sessions, Sam was supported with walking, knitting, baking, shopping, cinema and bingo. By using activities familiar and enjoyed by Sam, staff were able to assess other areas of her life i.e. socialisation, financial procedures, and implicit memory

family, friends, and professional involvement—on admission, a complete life history was sketchy. Trust had to be built with the family as there were indicators of financial abuse. Sam also had young children with whom contact with was appropriate. Rebuilding relations with the family was very structured, starting with weekly telephone calls. Eventually relationships were improved, and before leaving the Arbennig Unit Sam was able to stay in the family home for weekends and significant occasions.

everyday memory functioning—initially Sam was reluctant to interact with staff, but was able to navigate around the service with environmental prompts, and memory aids. When Sam started to recognise that memory could be regained, her motivation to learn was improved, and she developed her own strategies for success

Sam left the Arbennig Unit after two years and moved into a supported living setting closer to her family. Reports are that Sam is able to put her rehabilitation into context of her new environment, and has remained abstinent.