# Alcohol-Related Cognitive Impairment: Prevalence, Impact, and Service Implications

East Sussex County Council

Public Health

Monday, 02 February 2026

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## Contents

# Definitions

| Term | Description |
|---|---|
| **6-CIT** | Six-Item Cognitive Impairment Test – brief cognitive screening tool. |
| **ACE-III** | Addenbrooke's Cognitive Examination III – detailed cognitive screening assessment. |
| **ACT** | Alcohol Care Team – hospital-based team providing care for patients with alcohol-related problems. |
| **ARBD** | Alcohol-Related Brain Damage – cognitive impairment caused by long-term heavy alcohol use. |
| **ARBI** | Alcohol-Related Brain Injury – injury to the brain associated with alcohol use, sometimes used interchangeably with ARBD. |
| **ARD** | Alcohol-Related Dementia – dementia caused or exacerbated by alcohol use. |
| **CGL** | Change Grow Live – UK-based substance misuse treatment and recovery organisation. |
| **HES** | Hospital Episode Statistics – administrative data on hospital admissions, outpatient appointments, and A&E attendances in England. |
| **KS** | Korsakoff's Syndrome – chronic memory disorder, typically following untreated Wernicke's Encephalopathy. |
| **MCN** | Multiple Compound Needs – co-occurring social, health, or economic disadvantages. |
| **MMSE** | Mini-Mental State Examination – commonly used cognitive assessment tool. |
| **MoCA** | Montreal Cognitive Assessment – cognitive screening tool sensitive to mild impairments. |
| **PHOF** | Public Health Outcomes Framework – tool to measure public health outcomes in England. |
| **PWYLL** | Potential Working Years of Life Lost – measure of premature mortality impact on workforce. |

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| **SID** | Sussex Integrated Data – linked health and social care data for Sussex. |
| **SMR** | Standardized Mortality Ratio – ratio of observed to expected deaths in a population. |
| **SPFT** | Sussex Partnership Foundation Trust – mental health and learning disability NHS trust in Sussex. |
| **UK** | United Kingdom – country comprising England, Scotland, Wales, and Northern Ireland. |
| **WE** | Wernicke's Encephalopathy – acute neurological condition caused by thiamine deficiency; can progress to WKS if untreated. |
| **WKS** | Wernicke-Korsakoff Syndrome – severe neurological disorder due to thiamine deficiency, often associated with alcohol dependence. |
| **ARCI** | Alcohol Related Cognitive Impairment |

# Purpose of Review

This evidence review synthesises local and national datasets, service intelligence, and case-based learning to illuminate the scale of need, the extent of under-detection, and the consequences of delayed or inaccessible diagnosis and support. It also identifies the structural and pathway-related barriers that contribute to unmet need, including fragmented access to assessment and inconsistency in recording and referral routes. Taken together, these findings provide a robust foundation for defining strategic opportunities for earlier identification, integrated care pathways, and coordinated multi-agency responses to reduce harm and improve outcomes for people living with alcohol-related cognitive impairment in East Sussex.

1. **Review of Local Needs Assessment:** Examined the Multiple Compound Health Needs Assessment to identify data and insights relevant to cognitive impairment and Alcohol-Related Brain Damage, extracting all pertinent aspects.
2. **National Data Review:** Explored available national datasets and publications to understand the broader prevalence and context of ARBD and cognitive impairment.
3. **Benchmarking with Other Local Authorities:** Investigated approaches and data from peer local authorities to identify potential benchmarks.
4. **Hospital Data Analysis:** Accessed local hospital data via the Hospital Episode Statistics database to identify patterns and prevalence of ARBD-related admissions.
5. **Primary Care Data Review:** Examined the Sussex Integrated Dataset for relevant primary care information, including GP records, to understand ARBD and cognitive impairment at the community level.
6. **Public Health Outcomes Framework Review:** Checked PHOF indicators for any relevant metrics on alcohol related brain damage, cognitive impairment, and related health outcomes.
7. **Local Service Data Collection:** Engaged with local services, including the Alcohol Care Team, Sussex Partnership NHS Foundation Trust, and Change Grow Live, to gather relevant service-level data if possible.
8. **Case Studies:** Requested anonymised case studies from ACT and CGL to illustrate real-life experiences, highlight the complexity of support needs, and demonstrate how cognitive impairment and ARBD impact both individuals and service provision.

# Literature Review: Alcohol-Related Cognitive Impairment and Alcohol-Related Brain Damage

## Introduction

Alcohol-Related Brain Damage (ARBD), increasingly understood within the broader concept of Alcohol-Related Cognitive Impairment (ARCI), refers to a spectrum of cognitive and neurological impairments resulting from prolonged heavy alcohol consumption. These impairments arise through a combination of alcohol neurotoxicity, thiamine deficiency, malnutrition, repeated withdrawal episodes, and associated physical and mental health conditions[1, 2].

ARCI encompasses a range of clinical presentations, including Wernicke's encephalopathy (WE), Korsakoff's syndrome (KS), alcohol-related dementia, alcohol-induced cerebellar degeneration, and peripheral neuropathy. Importantly, ARBD is not a single diagnostic entity within ICD-10, and cases are therefore recorded across multiple diagnostic codes. This contributes to under-recognition within routine datasets and limits accurate assessment of prevalence and service need[3].

This review synthesises national and international evidence on prevalence, clinical characteristics, outcomes, system impacts, and service responses to ARCI, with a focus on implications for identification, diagnosis and care pathways.

## Prevalence and Population Impact

Estimates suggest that approximately 0.5% of the UK population experience alcohol-related brain changes, with prevalence increasing substantially among people with heavy or dependent drinking patterns[4]. Among very heavy drinkers, ARCI prevalence has been estimated at 30–35%, highlighting the strong dose–response relationship between alcohol exposure and cognitive harm.

ARCI represents a significant proportion of dementia diagnoses. Evidence indicates that 10–24% of all dementia cases may be alcohol-related, rising to 12–12.5% among people with young-onset dementia (<65 years)[5, 6]. This has implications for

[1] Thomson AD, Guerrini I, Bell D, Drummond C, Duka T, Field M, Kopelman M, Lingford-Hughes A, Smith I, Wilson K, Marshall EJ. Alcohol-related brain damage: report from a Medical Council on Alcohol Symposium, June 2010. Alcohol Alcohol. 2012 Mar-Apr;47(2):84-91. doi: 10.1093/alcalc/ags009. Epub 2012 Feb 16. PMID: 22343345.
[2] Royal College of Psychiatrists. (2014). *Alcohol and brain damage in adults: With reference to high-risk groups* (College Report CR185). Royal College of Psychiatrists. Retrieved from https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr185.pdf?sfvrsn=66534d91_2
[3] Ward R, Roderique-Davies G, Hughes H, Heirene R, Newstead S, John B. Alcohol-related brain damage: A mixed-method evaluation of an online awareness-raising programme for frontline care and support practitioners. Drug Alcohol Rev. 2023 Jan;42(1):46-58. doi: 10.1111/dar.13545. Epub 2022 Sep 12. PMID: 36097437; PMCID: PMC10087889.
[4] Schölin, L., Rhynas, S., Holloway, A., & Jepson, R. (2019). *Dual diagnosis, double stigma: A rapid review of experiences of living with alcohol-related brain damage (ARBD)*. Alcohol Change UK / The University of Edinburgh. Retrieved from https://s3.eu-west-2.amazonaws.com/sr-acuk-craft/documents/Dual-diagnosis-double-stigma-a-rapid-review-of-experiences-of-living-with-alcohol-related-brain-damage-Final-Report.pdf
[5] Alzheimer's Society. (2021). *Alcohol-related brain damage (ARBD)*. Alzheimer's Society. Retrieved from https://www.alzheimers.org.uk/about-dementia/types-dementia/alcohol-related-brain-damage-arbd
[6] Dementia UK. (n.d.). *Alcohol-related brain damage*. Dementia UK. Retrieved from https://www.dementiauk.org/information-and-support/types-of-dementia/alcohol-related-brain-damage/

working-age populations and long-term dependency on health and social care services.

International registry data reinforce the scale of the issue. A nationwide Finnish study reported incidence rates of 2.4 per 100,000 for Wernicke–Korsakoff syndrome and 5 per 100,000 for alcohol-related dementia, alongside extremely high crude mortality rates[7]. Population-based studies in Scotland and Wales similarly suggest prevalence ranging from 0.07% to 0.14%, with acknowledged underestimation due to diagnostic and recording limitations[8, 9].

## Clinical Characteristics and Course

ARCI is characterised by impairments across multiple cognitive domains, including memory, attention, executive functioning, visuospatial skills and social cognition (Smith et al., 2025; Ramey, 2018). These impairments significantly affect functional ability, including treatment engagement, adherence, independent living and service navigation.

Wernicke's encephalopathy represents an acute neurological emergency associated with thiamine deficiency. Although potentially reversible, WE is widely underdiagnosed; post-mortem studies suggest that only 5–20% of cases are identified during life[10]. Untreated WE carries a 10–20% mortality risk, and approximately 75–85% of survivors develop Korsakoff's syndrome, which is associated with persistent memory impairment and functional decline.

ARCI is considered non-progressive if abstinence is achieved and maintained. Recovery trajectories vary, with evidence suggesting that approximately 25% of individuals experience substantial or complete recovery, 50% partial improvement, and 25% minimal or no recovery, often requiring long-term care[11]. Most cognitive recovery occurs within the first three months of abstinence, with further improvement possible over 1–2 years.

## Mortality, Morbidity and Health System Impact

ARCI is associated with significantly elevated mortality and morbidity. The Finnish register study reported standardised mortality ratios exceeding five times that of the general population for both Wernicke–Korsakoff syndrome and alcohol-related dementia. Even where treatment is initiated, individuals experience high rates of hospital admission, prolonged length of stay, and repeated readmissions.

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[7] Palm A, Vataja R, Talaslahti T, et al. Incidence and mortality of alcohol-related dementia and Wernicke-Korsakoff syndrome: a nationwide register study. *Int J Geriatr Psychiatry*. 2022; 1-9. https://doi.org/10.1002/gps.5775

[8] Quelch D, Roderique-Davies G, John B. Alcohol-related brain damage: an umbrella (term) for the approaching post-COVID monsoon. Future Healthc J. 2023 Nov;10(3):313-320. doi: 10.7861/fhj.2023-0022. PMID: 38162212; PMCID: PMC10753228.

[9] Welsh Government. (2021). *Substance misuse treatment framework: Prevention, diagnosis, treatment and support for alcohol-related brain damage* (WG43872). Cardiff: Welsh Government. Retrieved from https://www.gov.wales/sites/default/files/publications/2021-11/substance-misuse-treatment-framework-prevention-diagnosis-treatment-and-support-for-alcohol-related-brain-damage.pdf

[10] Isenberg-Grzeda E, Chabon B, Nicolson SE. Prescribing thiamine to inpatients with alcohol use disorders: how well are we doing? J Addict Med. 2014 Jan-Feb;8(1):1-5. doi: 10.1097/01.ADM.0000435320.72857.c8. PMID: 24343128.

[11] Royal College of Psychiatrists. (2014). *Alcohol and brain damage in adults: With reference to high-risk groups* (College Report CR185). Royal College of Psychiatrists. Retrieved from https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr185.pdf?sfvrsn=66534d91_4

Evidence from Northern Ireland indicates substantial system costs associated with ARCI. One analysis estimated annual hospital costs approaching £1 million for 105 patients, driven largely by delayed discharges and lack of appropriate post-acute pathways[12]. Similar findings are reported across UK and international settings, with ARCI frequently contributing to bed blocking, repeated crisis presentations and long-term dependency.

## ARCI, Multiple Disadvantage and Service Engagement

ARCI disproportionately affects individuals experiencing severe and multiple disadvantage, including homelessness, substance dependence, mental ill health and criminal justice involvement[13]. Studies in homeless populations report ARCI prevalence of up to 21%, with broader cognitive impairment affecting over 80% of individuals in some settings[14].

Cognitive impairment is also prevalent across substance use treatment populations more broadly. Evidence suggests that 60–70% of individuals in substance use treatment exhibit moderate to severe cognitive deficits, particularly in executive functioning and working memory[15]. These impairments are associated with poorer engagement, reduced retention, and weaker outcomes, reinforcing cycles of relapse and crisis-driven care.

## Diagnosis, Pathways and Workforce Capability

Across the literature, ARCI is consistently described as underdiagnosed and poorly integrated within care pathways. Barriers include fragmented referral routes, inconsistent use of diagnostic criteria, limited access to neuropsychological assessment, and insufficient workforce training[16].

Many rehabilitation and residential services require a minimum level of cognitive functioning and capacity to engage in structured programmes, rendering them inaccessible to individuals with more advanced impairment[17]. This contributes to a structural gap in which individuals with the highest levels of need are least able to access appropriate care.

Training and awareness interventions have demonstrated effectiveness. A mixed-methods evaluation of an online ARCI training programme reported significant

[12] Craig, D. V. (2018). *Alcohol-related brain damage in Northern Ireland: Treatment, not just care* (College Report CR212, Apr 2018). Royal College of Psychiatrists. Retrieved from https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/college-reports/2018-college-reports/alcohol-related-brain-damage-in-northern-ireland-cr212-apr-2018

[13] Fisher, G. (2015). *The Complexity of Severe and Multiple Disadvantage*. Lankelly Chase Foundation. Retrieved from https://lankellychase.org.uk/wp-content/uploads/2015/09/SMD-and-Complexity.pdf

[14] Gilchrist G, Morrison DS. Prevalence of alcohol related brain damage among homeless hostel dwellers in Glasgow. Eur J Public Health. 2005 Dec;15(6):587-8. doi: 10.1093/eurpub/cki036. Epub 2005 Sep 14. PMID: 16162595.

[15] Bruijnen CJWH, Dijkstra BAG, Walvoort SJW, Markus W, VanDerNagel JEL, Kessels RPC, DE Jong CAJ. Prevalence of cognitive impairment in patients with substance use disorder. Drug Alcohol Rev. 2019 May;38(4):435-442. doi: 10.1111/dar.12922. Epub 2019 Mar 27. PMID: 30916448; PMCID: PMC6593747.

[16] Quelch, Darren & Davies, Nyle & John, Bev & Taylor, Rachel & Fishleigh, Lucy & Bowers, Dan & Lewis, Julia & Gwyn, Sue & Bevan, Janet & Ward, Rebecca & Thorkildsen, Elin & Cassley, Harriet & Roderique-Davies, Gareth. (2025). Outcomes from a National Consensus Event Targeting Service Development Strategies for Alcohol Related Brain Damage. Alcoholism Treatment Quarterly. 44. 1-14. 10.1080/07347324.2025.2579313.

[17] Wade DT. Selection criteria for rehabilitation services. Clin Rehabil. 2003 Mar;17(2):115-8. doi: 10.1191/0269215503cr591ed. PMID: 12625650.

improvements in staff confidence, recognition and practice, sustained over time. National guidance consistently recommends integrated, multi-agency pathways, embedding ARCI expertise within existing services rather than creating parallel systems[18].

## Models of Practice and Service Responses

Evidence from the UK and internationally demonstrates that specialist, integrated ARCI services can improve outcomes. Case studies from Scotland, Kent and Devon highlight reductions in hospital bed days, improvements in cognitive functioning and greater stability when multidisciplinary approaches are employed [19, 20].

Effective models typically include early identification, nutritional and thiamine supplementation, abstinence or alcohol management support, occupational therapy, and coordinated discharge planning. Innovations such as recovery passports and named care coordinators have been shown to improve continuity and service engagement[21].

## Multiple Compound Needs Review

### Multiple Compound Needs Health Needs Assessment

The East Sussex Multiple Compound Needs (MCN) Health Needs Assessment draws on national and local evidence to characterise complexity and associated health risks. In the Changing Futures national evaluation (April 2023) involving 1,250 participants, 85% reported lifetime substance misuse and 92% reported mental health issues, highlighting the high prevalence of co-occurring needs that may intersect with cognitive impairment.

People experiencing Multiple Compound Needs (MCN) often face overlapping challenges, including homelessness, substance dependence, offending behaviour and mental ill health. These experiences are frequently underpinned by trauma, poverty and social isolation, and are associated with poorer health outcomes and increased risk of premature mortality[22]. Within this population, alcohol dependence is common. Sustained heavy drinking, combined with poor nutrition, repeated detoxification, head injury and limited access to health care, significantly increases the risk of cognitive impairment[23].

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[18] UK Government. (2023). *Draft UK clinical guidelines for alcohol treatment: Specific settings and populations* (Consultation). Department of Health and Social Care / Office for Health Improvement and Disparities. Retrieved from https://www.gov.uk/government/consultations/uk-clinical-guidelines-for-alcohol-treatment/uk-clinical-guidelines-for-alcohol-treatment-specific-settings-and-populations

[19] Care Inspectorate (Scotland). (2024). *Inspection report: Penumbra Supported Accommodation (ARBD) Care Home* (Service No. CS2006130024). Care Inspectorate. Retrieved from https://www.careinspectorate.com/berengCareservices/html/reports/getPdfBlob.php?id=318723

[20] A.D. Thomson, I. Guerrini, D. Bell, C. Drummond, T. Duka, M. Field, M. Kopelman, A. Lingford-Hughes, I. Smith, K. Wilson, E.J. Marshall, Alcohol-Related Brain Damage: Report from a Medical Council on Alcohol Symposium, June 2010, *Alcohol and Alcoholism*, Volume 47, Issue 2, March/April 2012, Pages 84–91, https://doi.org/10.1093/alcalc/ags009

[21] Glasgow City Health and Social Care Partnership (HSCP). (2023). *Alcohol Related Brain Damage Recovery Passport*. Glasgow City HSCP. Retrieved from https://glasgowcity.hscp.scot/news/alcohol-related-brain-damage-recovery-passport

[22] East Sussex Joint Strategic Needs Assessment. *Multiple compound needs health needs assessment*. 2025. Available from: https://www.eastsussexjsna.org.uk/resources/multiple-compound-needs-health-needs-assessment/

[23] Bramley G, Fitzpatrick S, Edwards J, Ford D, Johnsen S, Sosenko F, et al. *Hard Edges: Mapping Severe and Multiple Disadvantage in England*. London: Lankelly Chase Foundation; 2015. Available from: https://lankellychase.org.uk/wp-content/uploads/2015/07/Hard-Edges-Mapping-SMD-2015.pdf

Cognitive impairment is increasingly recognised as both a cause and a consequence of MCN. Impairments in memory, concentration and executive functioning can reduce an individual's ability to engage with services, maintain stable housing, adhere to treatment plans, or manage daily living tasks. In turn, chaotic lifestyles, continued substance use, repeated withdrawal episodes, nutritional deficiencies and exposure to trauma further exacerbate cognitive decline. This interaction creates a reinforcing cycle in which cognitive impairment both contributes to, and is worsened by, social and health inequalities[24, 25, 26].

The evaluation also found that 83% had experienced three or more disadvantages and 62% had experienced four or more, indicating a level of cumulative adversity associated with poorer outcomes and heightened vulnerability to substance-related harm. Locally, service data from East Sussex providers (including Change Grow Live) contributed to a linked dataset identifying individuals where substance misuse is recorded as a primary need, supporting estimation of prevalence and characteristics of people who may be at risk of alcohol-related cognitive impairment.

Among individuals experiencing four MCNs, substance misuse was the most common need, suggesting a strong association between higher complexity and substance-related harm. The assessment further reports that people with MCN experience poor health outcomes, including avoidable deaths, and identifies key barriers to accessing support, such as difficulty navigating fragmented systems, limited trauma-informed practice, and capacity constraints in specialist services, which may contribute to delayed identification and support for conditions such as alcohol-related cognitive impairment.

The report notes evidence from the Fulfilling Lives programme indicating that service users can cost the public sector £28,800 per person per year, largely driven by crisis use (including emergency healthcare), reinforcing the case for more integrated provision and earlier identification of need.

Within this broader landscape, Alcohol-Related Brain Damage (ARBD) represents a spectrum of acquired brain injury associated with prolonged alcohol use and thiamine deficiency. Presentation ranges from subtle cognitive changes to more severe conditions such as Wernicke–Korsakoff syndrome. Evidence suggests that many individuals within the MCN cohort display symptoms consistent with ARBD; however, diagnosis is frequently missed or delayed. Contributing factors include fragmented service engagement, inconsistent recording within health systems, limited workforce awareness, and diagnostic pathways that are poorly aligned to the realities of alcohol dependence[27, 28].

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[24] Public Health England. *Better care for people with co-occurring mental health and alcohol/drug use conditions: a guide for commissioners and service providers*. London: Public Health England; 2017. Available from: https://assets.publishing.service.gov.uk/media/5a75b781ed915d6faf2b5276/Co-occurring_mental_health_and_alcohol_drug_use_conditions.pdf

[25] Ramey T. Cognitive impairment in substance use disorders. *Addiction Science & Clinical Practice*. 2018;13(1):1. Available from: https://pmc.ncbi.nlm.nih.gov/articles/PMC6599555/

[26] Erga AH. Patients with cognitive deficits and substance use disorders: a clinical population in need of focused attention. *Front Psychiatry*. 2023;14:10613487. Available from: https://pmc.ncbi.nlm.nih.gov/articles/PMC10613487/

[27] Isenberg-Grzeda E, Kutner HE, Nicolson SE. Wernicke-Korsakoff syndrome: under-recognized and under-treated. *Psychosomatics*. 2012;53(6):507–16. Available from: https://pubmed.ncbi.nlm.nih.gov/23157990/

[28] Royal College of Psychiatrists. *Alcohol-related brain damage in Northern Ireland: treatment not just care*. College Report CR212. London: Royal College of Psychiatrists; 2018. Available from: https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr2121829213d17e3461785bcb073c1529334.pdf

The relationship between MCN and alcohol-related cognitive impairment is mutually reinforcing. Individuals experiencing MCN are at heightened risk of developing cognitive impairment due to prolonged alcohol use, poor nutrition, repeated detoxification and barriers to accessing care, including stigma and service fragmentation. Cognitive impairment, in turn, undermines recovery by reducing an individual's ability to sustain abstinence or reduced drinking, manage accommodation, engage with support services, or navigate complex systems. This deepens disadvantage and increases the likelihood of repeated crisis presentations, hospital admissions and homelessness. This cycle highlights the need for coordinated, multi-agency approaches that integrate substance use treatment, healthcare, social care and housing, with a focus on early identification and effective support for cognitive impairment.[29].

To better reflect the spectrum of harm and reduce diagnostic silos, the preferred terminology moving forward is Alcohol-Related Cognitive Impairment (ARCI), encompassing both ARBD and broader alcohol-associated cognitive decline.

# Economic Evidence

Most economic evidence comes from broader studies of alcohol use disorder (AUD) and alcohol-related cognitive impairment rather than ARBD specifically.

Available evidence suggests that individuals with alcohol-related cognitive impairment have higher healthcare utilisation and costs prior to assessment and diagnosis. A Norwegian cohort study examining healthcare use before and after specialist cognitive assessment reported median annual healthcare costs of approximately €2,226 in the year prior to assessment, with substantial variation between individuals. Participants with AUD incurred around 50% higher healthcare costs than those without AUD (median €3,286 compared with €2,190), indicating increased use of healthcare services prior to recognition of cognitive impairment. This pattern is consistent with wider literature showing that people with alcohol-related cognitive challenges often experience fragmented care, repeated crisis presentations, and frequent use of emergency and acute services.

Following assessment and diagnostic recognition, the same study found that the difference in healthcare costs between individuals with and without AUD became negligible. This suggests that identification of cognitive impairment and access to appropriate post-diagnostic care may reduce excess healthcare utilisation, likely through improved care coordination, more appropriate service responses, and reduced reliance on crisis-led care. This finding aligns with evidence from alcohol harm and dementia-related literature, which indicates that early identification and structured support can reduce unplanned admissions, emergency department attendances, and avoidable hospital stays.

However, the current evidence base has significant limitations. There are no UK-specific cost-of-illness studies focused solely on ARBD or ARCI, and most studies report median costs, which may underestimate the financial impact of individuals with complex needs

[29] Schölin L, Rhynas S, Holloway A, Jepson R. Dual diagnosis, double stigma: a rapid review of experiences of living with alcohol-related brain damage. Alcohol Change UK; 2019 Jul 31. Available from: https://s3.eu-west-2.amazonaws.com/sr-acuk-craft/documents/Dual-diagnosis-double-stigma-a-rapid-review-of-experiences-of-living-with-alcohol-related-brain-damage-Final-Report.pdf

who experience repeated hospital admissions, prolonged lengths of stay, delayed discharges, or safeguarding involvement. ARBD is also frequently under-coded or misclassified as alcohol dependence alone, limiting the ability of routine data to capture true prevalence and associated costs. In addition, wider system costs related to housing instability, social care involvement, and delayed discharge are often excluded from healthcare-focused analyses.

Overall, the literature indicates that alcohol-related cognitive impairment is associated with increased healthcare costs prior to diagnosis, but that these excess costs may reduce following assessment and appropriate care. While published estimates suggest annual healthcare costs in the low thousands of euros for managed cases, real-world experience and broader alcohol harm evidence indicate that unrecognised or unmanaged ARBD can drive substantially higher costs through repeated crisis presentations and inefficient use of acute services. This supports the case for earlier identification, improved diagnostic coding, and targeted interventions to reduce avoidable healthcare utilisation.

# Local Context

Local intelligence from the East Sussex Multiple Compound Needs Assessment (2025), while not explicitly diagnosing cognitive impairment, strongly supports the association between MCN, alcohol dependence and likely ARCI. The assessment identifies a cohort with high levels of alcohol dependence, poor mental health and unstable housing, with concentrations of need in Hastings and Eastbourne. These areas also experience the highest rates of alcohol-specific mortality and alcohol-related hospital admissions, indicating long-term, high-risk drinking patterns that increase susceptibility to cognitive impairment.

Frontline intelligence from the Alcohol Care Team (ACT) and Change Grow Live (CGL) further evidences this issue. Clinicians and practitioners report frequent presentations of individuals with memory loss, disorientation and impaired executive functioning, often without a formal diagnosis of ARCI. Many of these individuals experience repeated hospital admissions, difficulties adhering to care plans, and challenges securing or sustaining accommodation. Patterns consistent with findings from the MCN Needs Assessment.

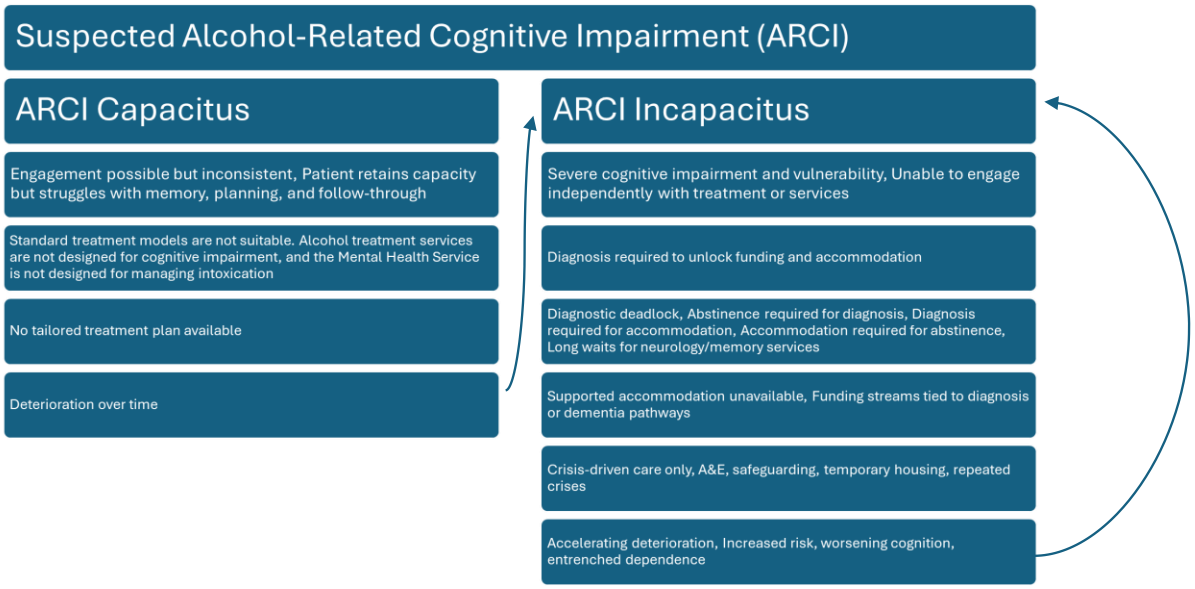
Hospital Episode Statistics (HES) and local treatment data suggest significant under-recording of ARCI, with relatively few coded diagnoses despite a clinical picture indicating a substantially higher underlying prevalence.

# The Gap

There is a group of individuals living with Alcohol-Related Cognitive Impairment (ARCI) for whom current diagnostic and support pathways are inaccessible or ineffective. This group sits at the intersection of alcohol dependence, cognitive decline and multiple compound needs, and experiences persistently poor outcomes despite repeated contact with health and social care services.

## Current System for People with ARCI

Present Pathway that has been observed:




Formal diagnosis of ARCI typically requires referral to Memory Clinics or Neurology services. However, access to these pathways is constrained by several structural limitations:

- Memory Clinics are unable to undertake assessments where an individual is intoxicated at the time of appointment.
- General Practitioners are not able to diagnose ARCI within primary care.
- Neurology referrals often involve waiting times of up to three years, during which time individuals may experience significant cognitive and functional deterioration.

A central barrier across these pathways is the requirement for abstinence at the point of assessment. For individuals who are alcohol-dependent, achieving and sustaining abstinence without appropriate support is extremely challenging. This is further compounded by the widespread availability of alcohol and the absence of consistent alcohol policies within supported accommodation. While many settings operate clear restrictions in relation to illicit substances, there is no equivalent, standardised approach to alcohol, enabling continued access and use.

## Differentiation within the ARCI Population

It is important to recognise that ARCI does not present uniformly, and that barriers to diagnosis and support vary by severity.

For individuals with emerging or mild-moderate cognitive impairment, stabilisation or abstinence at the time of assessment can often be achieved through existing specialist alcohol treatment services, including community-based provision

delivered by Change Grow Live (CGL). For this group, engagement with cognitive assessment and onward support may be feasible without specialist accommodation, and current pathways may be sufficient.

However, there exists a smaller but highly vulnerable cohort whose cognitive impairment has progressed to a level where memory, executive functioning and decision-making capacity are significantly compromised. In this group, the expectation of abstinence at the point of assessment becomes unrealistic without a higher level of structured support. Cognitive impairment itself undermines the ability to plan, self-regulate, adhere to detoxification regimes, or sustain abstinence for long enough to access diagnostic services.

This cohort is disproportionately affected by repeated hospital admissions, failed discharges, homelessness and disengagement from services. Fluctuating or declining mental capacity further complicates engagement with standard treatment models and increases the likelihood of crisis-driven care.

## Dependence on Diagnosis-Led Support

For individuals with advanced ARCI, access to diagnosis and effective care is structurally dependent on specialist support and accommodation capable of providing stability, nutritional support and either managed alcohol or abstinence-focused environments. Yet access to such provision frequently relies on the presence of a confirmed diagnosis and the diagnosis confirms the funding stream.

This creates a **systemic catch-22** where individuals cannot access the environments required to achieve abstinence without a diagnosis but cannot obtain a diagnosis without achieving abstinence.

This gap affects a small but high-impact population whose needs cannot be met through existing community-based alcohol treatment services alone.

## Limitations of Residential Rehabilitation

It is also important to note that this cohort is not typically able to access residential rehabilitation services. Most rehabilitation settings require a minimum level of cognitive functioning, insight and capacity to engage in structured therapeutic programmes. For individuals with advanced ARCI, these thresholds are often unattainable until a degree of cognitive and physical recovery has already occurred, further narrowing available pathways and reinforcing exclusion from care.

## Abstinence as Treatment

Abstinence from alcohol is the primary intervention for improving cognitive function in ARCI. Evidence indicates that, with sustained abstinence, nutritional support and appropriate care, cognitive functioning can stabilise and partially recover.

However, for individuals with advanced cognitive impairment, the deficits caused by ARCI, particularly impaired memory, reduced executive functioning and

diminished capacity, significantly limit the ability to achieve and maintain abstinence independently.

In these cases, abstinence is not simply a treatment goal but a treatment outcome that depends on the availability of the right environment and support.

For this cohort, achieving abstinence often requires specialist accommodation and integrated care, rather than standard community-based treatment alone. Without this, individuals remain trapped in a cycle of continued alcohol use, cognitive deterioration and repeated crisis presentations, despite abstinence being the key therapeutic intervention.

## Implications for the System

This systemic gap leaves individuals without appropriate assessment, treatment or care and places sustained pressure on treatment and recovery services, which are forced to manage deterioration rather than enable recovery for this cohort.

The data gathered through this project will provide robust evidence of unmet need and the structural barriers embedded within the current system. This evidence will be used to demonstrate the necessity for system change, including:

- Earlier identification of alcohol-related cognitive impairment
- Alternative and pragmatic diagnostic approaches
- Workforce development and training
- The development of appropriate supported accommodation pathways for people living with ARCI

Collectively, these changes are essential to breaking cycles of repeated crisis, improving outcomes for individuals with Multiple Compound Needs, and enabling more stable recovery and independent living.

## Coding and Recording of Alcohol-Related Cognitive Impairment

ARCI is not recognised as a single diagnostic category within ICD-10. As a result, individuals living with alcohol-related cognitive impairment are recorded across a range of diagnostic codes that reflect specific clinical presentations rather than the underlying, alcohol-related aetiology. This fragmentation limits the visibility of ARCI within routine datasets and contributes to significant under-identification at both local and national levels.

To address this limitation, an agreed proxy definition of Alcohol-Related Cognitive Impairment (ARCI) has been applied for the purposes of this analysis. This definition draws together the relevant ICD-10 codes that collectively capture alcohol-related cognitive and neurological harm within Hospital Episode Statistics (HES) and Sussex Integrated Dataset (SID). These codes reflect conditions commonly associated with prolonged alcohol use and thiamine deficiency and are consistent with clinical descriptions of ARCI and ARBD.

ICD-10 codes identified within HES include:

- E51.2 – Wernicke's encephalopathy
- F10.6 – Alcohol amnesic syndrome
- F10.7 – Alcohol-related residual and late-onset psychotic disorder
- G31.2 – Degeneration of nervous system due to alcohol (including cerebellar atrophy)
- G62.1 – Alcoholic polyneuropathy

ICD-10 codes identified within SID include:

- E512 – Wernicke's disease
- F106 – Korsakoff's psychosis
- F107 – Dementia associated with alcoholism
- G312 – Alcohol-induced cerebellar ataxia
- G621 – Chronic alcoholic brain syndrome

The necessity to use multiple ICD-10 codes as proxies highlights a key data and system challenge. ARCI is likely to be substantially under-recorded, as cognitive impairment may be coded under acute presentations, mental health diagnoses, or alcohol dependence alone, without capturing the associated neurological harm. This limits the ability to quantify prevalence, track pathways, and plan services effectively.

Improving recognition, recording and consistent use of ARCI-related codes, alongside workforce training and clearer diagnostic pathways, will be essential to strengthening local intelligence and ensuring that individuals with alcohol-related cognitive impairment are identified earlier and supported more appropriately across the system.

## Drug and Alcohol Specialist Service versus ARBD specific service findings

Evidence from local service intelligence and frontline practice indicates that the challenge is not a lack of existing drug and alcohol treatment provision, but a mismatch between current service models and the needs of a small cohort of individuals with more advanced Alcohol-Related Cognitive Impairment (ARCI). Community-based alcohol treatment services are effective for the majority of people with alcohol dependence, including those with emerging or mild-moderate cognitive impairment, and remain a critical component of the local system.

The primary gap identified relates to workforce awareness, confidence and capability in recognising alcohol-related cognitive impairment. While cognitive

difficulties are frequently observed in practice, they are not consistently identified, recorded or escalated as a distinct clinical concern. Upskilling the workforce in ARCI awareness, screening and functional recognition would support earlier identification and more appropriate referral, reducing reliance on crisis-driven responses.

A further gap relates to clarity of diagnostic referral pathways. Current routes to diagnosis are complex, fragmented and poorly aligned to the needs of people with alcohol dependence, resulting in delays or missed diagnoses. Clear, pragmatic referral pathways, supported by shared understanding across health, social care and substance use services, are required to ensure timely assessment and to define clinical responsibility at each stage.

Finally, where community-based treatment is insufficient, particularly for individuals with advanced cognitive impairment, there is a lack of clarity around commissioning and funding responsibility for enhanced support, including specialist supported accommodation. The absence of defined pathways creates uncertainty over who holds responsibility for funding and coordinating care, contributing to service drift and unmet need. Addressing this requires system-level agreement on thresholds, responsibilities and funding mechanisms, rather than changes to existing drug and alcohol services themselves.

# Hospital Episode Statistics Data

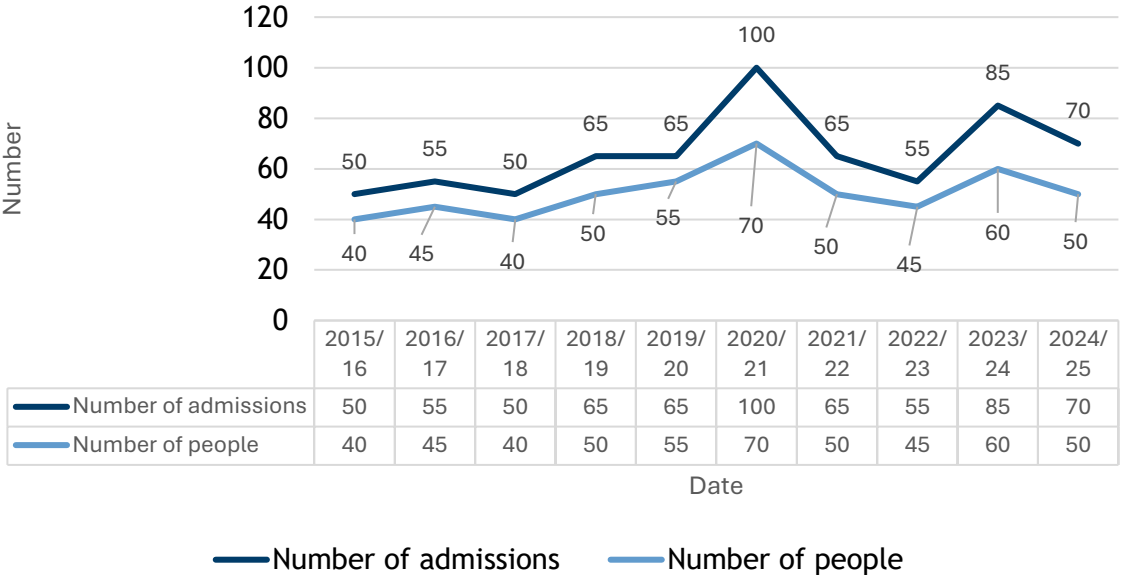
Hospital Episode Statistics (HES) is a national administrative dataset that records all NHS hospital admissions in England. In this analysis, HES inpatient data were used to examine hospital activity related to alcohol-related cognitive impairment (ARCI) among residents of East Sussex, providing insight into acute presentations and demand on hospital services.

Hospital admissions for ARCI were defined as first finished admission episodes among patients resident in East Sussex with any recorded mention of an ARCI-related diagnosis. Diagnoses were identified using the following ICD-10 codes: E51.2, F10.6, F10.7, G31.2, and G62.1. Admissions occurring at any point during the ten-year period from 2015/16 to 2024/25 were included.

In line with HES data governance requirements, all sub-national counts of admissions and patients were rounded to the nearest five and counts between one and seven were suppressed. Proportions were calculated using rounded counts, while directly age-standardised rates were calculated using unrounded counts to ensure statistical accuracy.

Hospital admission episodes do not represent unique individuals; the same person may have multiple admissions within or across years, meaning admission counts may exceed the number of people affected. All data was sourced from Hospital Episode Statistics, NHS England, and accessed by East Sussex Public Health.

Number of hospital admissions, East Sussex, 2015/16 to 2024/25



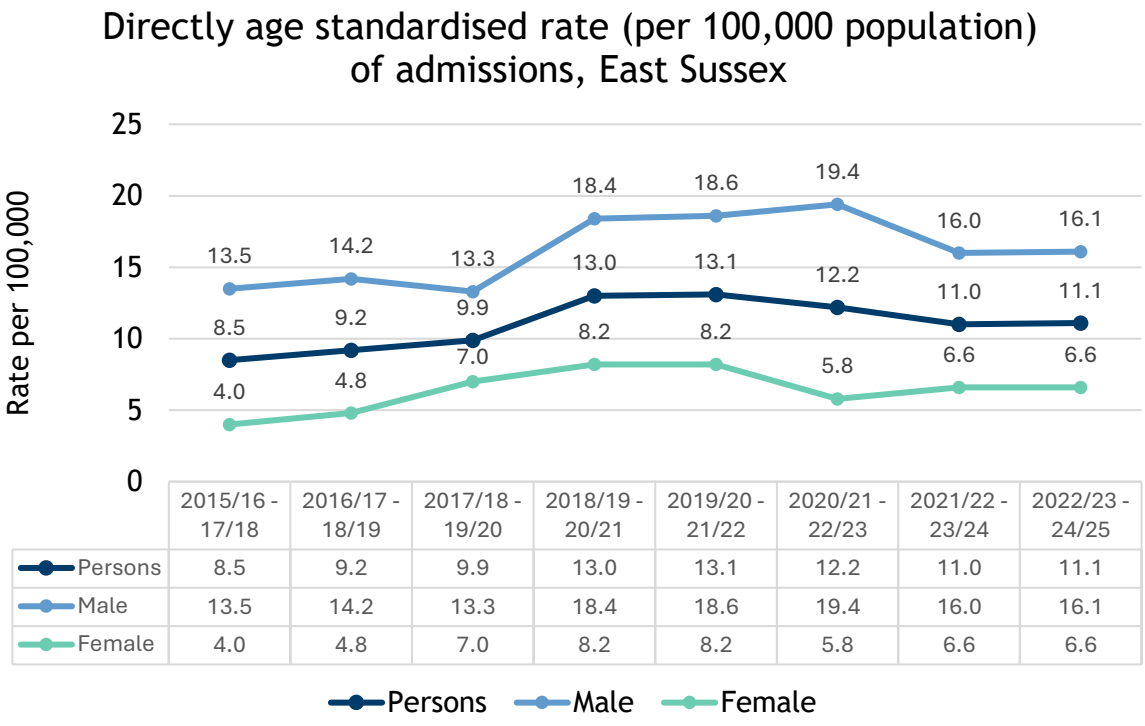

| | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21 | 2021/22 | 2022/23 | 2023/24 | 2024/25 |
|---|---|---|---|---|---|---|---|---|---|---|
| Number of admissions | 50 | 55 | 50 | 65 | 65 | 100 | 65 | 55 | 85 | 70 |
| Number of people | 40 | 45 | 40 | 50 | 55 | 70 | 50 | 45 | 60 | 50 |

In the past 10 years, there were 660 hospital admissions with a mention of ARCI (in any diagnostic field) in East Sussex. There was a yearly average of 66 admissions and on average, 50 patients were admitted each year with ARBD.

| | Number of admissions | | |
|---|---|---|---|
| Year | Males | Females | Total |
| **2015/16** | 35 | 10 | 50 |
| **2016/17** | 40 | 10 | 55 |
| **2017/18** | 35 | 15 | 50 |
| **2018/19** | 45 | 20 | 65 |
| **2019/20** | 35 | 30 | 65 |
| **2020/21** | 75 | 25 | 100 |
| **2021/22** | 45 | 20 | 65 |
| **2022/23** | 45 | 10 | 55 |
| **2023/24** | 50 | 35 | 85 |
| **2024/25** | 50 | 20 | 70 |
| **Total** | 460 | 200 | 660 |

| | Number of people | | |
|---|---|---|---|
| Year | Males | Females | Total |
| 2015/16 | 25 | 10 | 40 |
| 2016/17 | 35 | 10 | 45 |
| 2017/18 | 30 | 15 | 40 |
| 2018/19 | 35 | 15 | 50 |
| 2019/20 | 25 | 30 | 55 |
| 2020/21 | 50 | 15 | 70 |
| 2021/22 | 35 | 15 | 50 |
| 2022/23 | 35 | 10 | 45 |
| 2023/24 | 35 | 25 | 60 |
| 2024/25 | 40 | 10 | 50 |
| Total | 340 | 160 | 505 |

Across, the 10-year period, 70% of admissions were males. The average age of ARBD admissions was 61.4 years (females = 62.3 years Males = 61 years).




## Readmissions, 2015/16 to 2024/25

Number of ARCI (any mention) admissions per patient 2015/16 to 2024/25

| Number of admissions | Number of patients | Percentage of patients |
|---|---|---|
| **1 admission** | 265 | 68% |
| **2 admissions** | 65 | 17% |
| **3 admissions** | 30 | 8% |
| **4 admissions** | 10 | 3% |
| **5 or more admissions** | 20 | 5% |

| | | |
|---|---|---|
| **Total** | 390 | 100% |

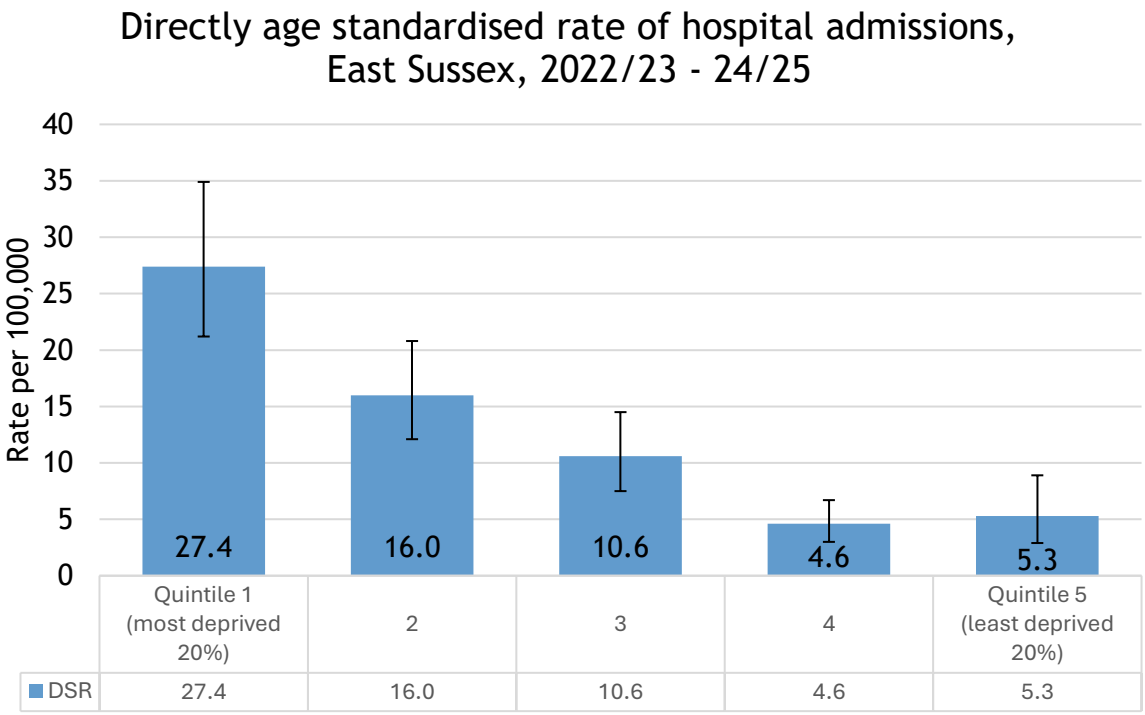
## Types of admission

The majority of the 660 ARCI admissions were emergency admissions (87%, 575 admissions). The site with the most admissions was the Conquest Hospital in Hastings (310 admissions, 47%).

| Trust | Number of admissions | Percentage of Admissions |
|---|---|---|
| **Conquest** | 310 | 47% |
| **EDGH** | 210 | 32% |
| **Total** | 660 | |

## 7.2 Deprivation

Directly age standardised rate of hospital admissions for ARBD (any mention) in East Sussex by national Index of Multiple Deprivation (2025) quintiles.



# Sussex Integrated Data

Sussex Integrated Data (SID) is a locally linked, person-level dataset that brings together health and care records across Sussex, including primary care, secondary care, and community services. SID was used in this analysis to identify unique individual residents in East Sussex with a recorded diagnosis sitting under the umbrella term of alcohol-related cognitive impairment, providing a broader view of diagnosed prevalence beyond hospital admissions.

ARCI cases were identified using ICD-10-aligned diagnostic codes recorded within SID: E512 (Wernicke's disease), F106 (Korsakoff's psychosis), F107 (Dementia associated with alcoholism), G312 (Alcohol-induced cerebellar ataxia), and G621 (Chronic alcoholic brain syndrome). Any individual with a recorded diagnosis at any point within the period analysed was included (2015/16 to 2024/25).

Counts derived from SID represent people rather than admission episodes, allowing identification of individuals who may not appear in hospital data. Data was accessed and analysed by East Sussex Public Health in line with local information governance requirements.

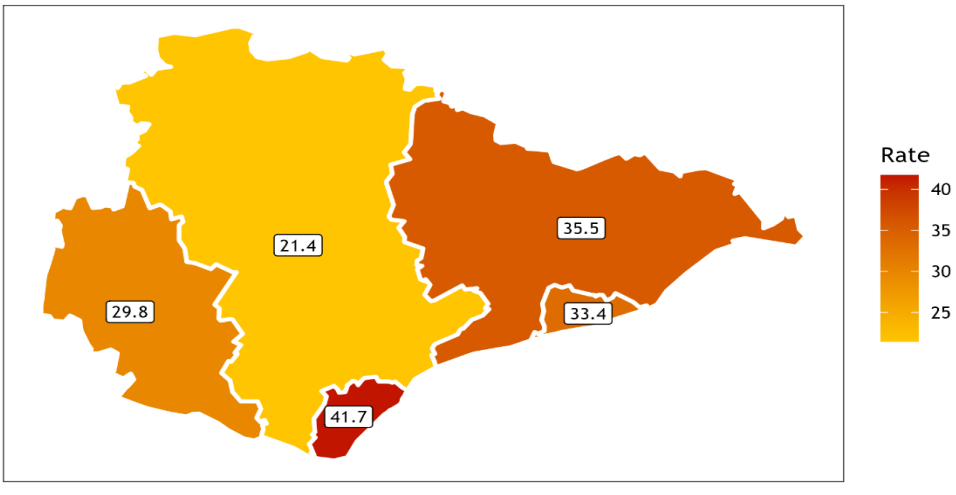
## ARCI by location

Rates of alcohol-related cognitive brain damage vary across East Sussex, with clear differences between local authority areas. Higher rates are concentrated in more urban parts of the county, while lower rates are observed in more rural districts. This geographic pattern suggests that alcohol-related cognitive harm is shaped by place and local context, rather than being evenly distributed across the county.

In the below figures, "Persons" represents the age-standardised rate for the total population, calculated using all recorded cases and the combined population. It is included to show the overall burden of alcohol-related cognitive impairment, rather than an average of male and female rates.

Alcohol-Related Cognitive Impairment in East Sussex, Persons,

by Lower Tier Local Authority - Rate per 100,000
Resident/Registered Population




Source: SID

Examining age-standardised rates by sex adds important nuance to the geographic picture, Examining age-standardised rates by sex provides important insight into how alcohol-related cognitive impairment is distributed across local authority areas.

Across all local authority areas, rates are substantially higher among males than females, indicating a consistent male predominance. As a result, male prevalence contributes disproportionately to the overall population rate and drives much of the variation observed between areas.

However, the geographic distribution of recorded prevalence does not fully align with expected deprivation patterns. In particular, Eastbourne records higher male and overall rates than Hastings, despite Hastings having higher levels of deprivation; a similar pattern is also observed among females.

This suggests that recorded prevalence reflects not only underlying need, but also variation in identification, diagnostic pathways, engagement with services, and local population characteristics.

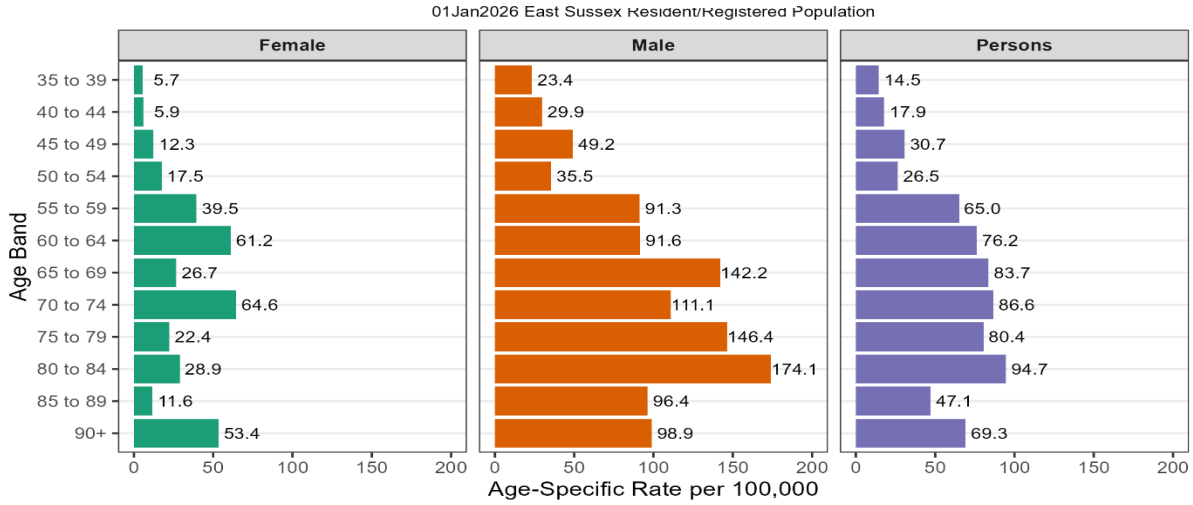
Alcohol-Related Cognitive Impairment in East Sussex, by LTLA


* n < 10 - cannot be calculated
Any res/reg patient ever having had a diagnosis

## ARCI by Age and Sex

Age-specific rates of alcohol-related cognitive impairment show that harm is evident from mid-adulthood, with recorded prevalence present from as early as ages 35–39 for both males and females. Rates increase through the 40s followed by a more pronounced increase from the mid-50s onwards. Rates peak in the 80–84 age group before declining in the oldest age bands, likely reflecting increased mortality and survivorship effects at older ages rather than a true reduction in underlying risk. Overall, the pattern reflects the cumulative impact of long-term alcohol-related harm across the life course.

Alcohol-Related Cognitive Impairment in East Sussex by Age-Specific Rates




Source: SID
Any res/reg patient ever having had a diagnosis

# Public Health Outcomes Framework Data

Fingertips | Department of Health and Social Care

The alcohol-specific hospital admissions (narrow definition) indicator from Public Health Fingertips is the most appropriate proxy for the ICD-10 codes associated with (ARBD, such as E51.2 (Wernicke's encephalopathy), F10.6 (Alcohol amnesic syndrome), F10.7 (Alcohol-related residual and late-onset psychotic disorder), G31.2 (Degeneration of nervous system due to alcohol), and G62.1 (Alcoholic polyneuropathy). This is because the indicator includes conditions that are wholly attributable to alcohol, which covers these neurological and psychiatric conditions. While Fingertips does not report each ICD-10 code individually, the alcohol-specific definition encompasses these codes, making it the closest available population-level measure for ARBD-related harm via this Database.

We are not including under-18s data because the neurological and psychiatric conditions associated with ARBD (e.g., Wernicke's encephalopathy, alcoholic polyneuropathy) typically develop after prolonged, heavy alcohol use, which is unlikely to occur in younger age groups.

| Code | Description |
|---|---|
| E24.4 | Alcohol-induced pseudo-Cushing's syndrome |
| E51.2 | Wernicke's encephalopathy |
| F10 | Mental and behavioural disorders due to alcohol (includes F10.6, F10.7) |
| G31.2 | Degeneration of nervous system due to alcohol |
| G62.1 | Alcoholic polyneuropathy |
| G72.1 | Alcoholic myopathy |
| I42.6 | Alcoholic cardiomyopathy |
| K29.2 | Alcoholic gastritis |
| K70 | Alcoholic liver disease |

| | |
|---|---|
| K85.2 | Alcohol-induced acute pancreatitis |
| K86.0 | Alcohol-induced chronic pancreatitis |
| Q86.0 | Foetal alcohol syndrome |
| R78.0 | Excess alcohol blood levels |
| T51.* | Toxic effects of alcohol (ethanol, methanol, unspecified) |
| X45, X65, Y15 | Poisoning by and exposure to alcohol (accidental, intentional, undetermined) |
| Y90, Y91 | Evidence of alcohol involvement |

(*Some codes apply to hospital admissions but not mortality measures.)

Of the measure available on Public Health Fingertips, we identified four potentially relevant indicators.

1. Admission episodes for alcohol-specific conditions (persons) (2023/24)
2. Admission episodes for mental and behavioural disorders due to alcohol (narrow) (persons) (2023/24)
3. Admission episodes for alcohol liver disease (broad) (persons) (2023/24)
4. The proportion of clients entering alcohol treatment identified as having a mental health treatment need, who were receiving treatment for their mental health (2023/24)

## Admission episodes for alcohol-specific conditions (persons) (2023/24)

Within East Sussex, there is significant variation in alcohol-specific hospital admission rates. Hastings have rates that are significantly worse than the England average, indicating a high burden of alcohol specific harm. Eastbourne, Lewes and Rother are similar to the national average, while Wealden performs significantly better, suggesting comparatively lower levels of harm. Although most districts show a decreasing trend, Eastbourne and Hastings remain priority areas for targeted interventions.

Better 95% | Similar | Worse 95% | Not compared

Recent trends: – Could not be calculated | → No significant change | ↑ Increasing & getting worse | ↑ Increasing & getting better | ↓ Decreasing & getting worse | ↓ Decreasing & getting better

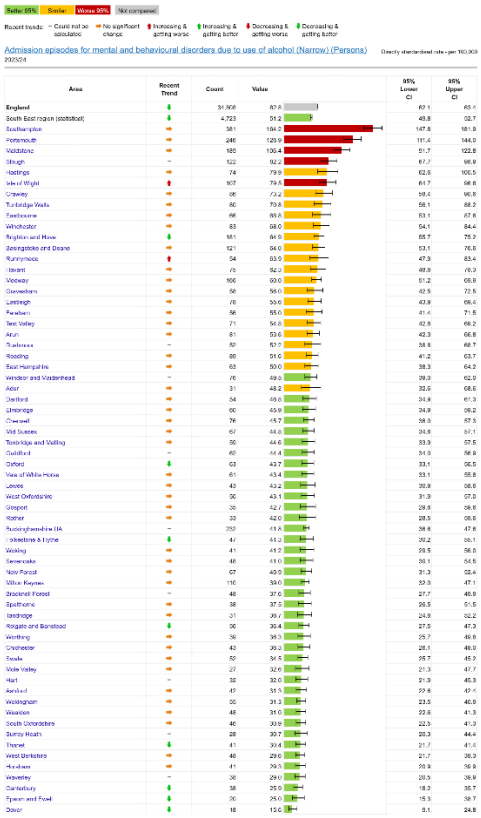
Admission episodes for alcohol-specific conditions (Persons) 2023/24

Directly standardised rate - per 100,000

| Area | Recent Trend | Count | Value | 95% Lower CI | 95% Upper CI |
|---|---|---|---|---|---|
| England | → | 339,916 | 612 | 610 | 614 |
| South East region (statistical) | ↓ | 48,649 | 521 | 516 | 526 |
| Southampton | ↓ | 3,645 | 1,713 | 1,657 | 1,770 |
| Portsmouth | ↓ | 1,727 | 932 | 888 | 978 |
| Eastleigh | ↓ | 1,087 | 778 | 733 | 826 |
| New Forest | ↓ | 1,547 | 756 | 717 | 797 |
| Hastings | → | 696 | 754 | 699 | 813 |
| Spelthorne | ↑ | 730 | 719 | 667 | 773 |
| Gravesham | ↑ | 706 | 700 | 649 | 753 |
| Test Valley | ↓ | 968 | 696 | 653 | 742 |
| Winchester | → | 889 | 677 | 633 | 723 |
| Runnymede | ↑ | 566 | 676 | 621 | 735 |
| Gosport | ↓ | 546 | 650 | 596 | 708 |
| Basingstoke and Deane | ↑ | 1,185 | 638 | 602 | 675 |
| Dartford | ↑ | 650 | 633 | 585 | 685 |
| Isle of Wight | → | 944 | 628 | 586 | 671 |
| Crawley | → | 647 | 618 | 570 | 668 |
| Maidstone | → | 1,088 | 611 | 575 | 648 |
| Rushmoor | – | 586 | 609 | 560 | 661 |
| Woking | ↑ | 565 | 584 | 537 | 635 |
| Arun | ↓ | 1,035 | 582 | 546 | 620 |
| Slough | – | 777 | 580 | 538 | 625 |
| Brighton and Hove | → | 1,518 | 579 | 549 | 609 |
| Eastbourne | → | 583 | 567 | 521 | 615 |
| Guildford | – | 768 | 561 | 522 | 602 |
| Oxford | ↓ | 685 | 524 | 484 | 566 |
| Tunbridge Wells | ↑ | 594 | 522 | 480 | 566 |
| Havant | ↓ | 682 | 522 | 482 | 563 |
| East Hampshire | → | 704 | 509 | 471 | 549 |
| Chichester | ↓ | 708 | 504 | 467 | 544 |
| Windsor and Maidenhead | – | 765 | 499 | 464 | 536 |
| Adur | → | 340 | 499 | 446 | 555 |
| Elmbridge | → | 675 | 495 | 458 | 534 |
| Worthing | → | 564 | 489 | 449 | 531 |
| Surrey Heath | – | 452 | 486 | 442 | 533 |
| Fareham | ↓ | 585 | 481 | 442 | 523 |
| Cherwell | → | 759 | 469 | 436 | 503 |
| Tonbridge and Malling | → | 600 | 454 | 419 | 492 |
| Thanet | ↓ | 656 | 448 | 414 | 485 |
| Reading | ↓ | 672 | 446 | 412 | 482 |
| Rother | → | 427 | 443 | 400 | 490 |
| Lewes | → | 479 | 437 | 398 | 479 |
| Buckinghamshire UA | – | 2,379 | 428 | 411 | 446 |
| Sevenoaks | ↑ | 523 | 425 | 389 | 464 |
| Wealden | → | 758 | 415 | 385 | 446 |
| West Oxfordshire | → | 502 | 410 | 374 | 447 |
| Folkestone & Hythe | ↓ | 477 | 407 | 371 | 446 |
| Mid Sussex | → | 636 | 404 | 373 | 437 |
| Dover | → | 511 | 403 | 368 | 440 |
| Medway | → | 1,085 | 401 | 377 | 425 |
| Vale of White Horse | → | 569 | 397 | 364 | 431 |
| Bracknell Forest | – | 472 | 393 | 358 | 430 |
| Reigate and Banstead | ↓ | 583 | 391 | 360 | 424 |
| South Oxfordshire | → | 583 | 382 | 351 | 414 |
| Tandridge | → | 348 | 381 | 342 | 424 |
| Waverley | – | 511 | 380 | 348 | 415 |
| Canterbury | ↓ | 584 | 380 | 350 | 413 |
| Milton Keynes | ↓ | 984 | 365 | 342 | 389 |
| Mole Valley | ↓ | 334 | 357 | 319 | 398 |
| Swale | → | 531 | 351 | 322 | 383 |
| Hart | – | 358 | 349 | 314 | 387 |
| Horsham | → | 513 | 334 | 305 | 364 |
| West Berkshire | → | 549 | 333 | 306 | 363 |
| Ashford | → | 427 | 317 | 288 | 349 |
| Epsom and Ewell | ↓ | 200 | 259 | 224 | 298 |
| Wokingham | ↓ | 442 | 255 | 232 | 281 |

## Admission episodes for mental and behavioural disorders due to the use of alcohol (Narrow) (Persons) (2023/24)

Admission rates for mental and behavioural disorders due to alcohol (narrow definition) show East Sussex districts performing differently across the county. Hastings and have the highest rates locally, with Hastings significantly above the England average and Eastbourne similar to the national level. Lewes, Rother, and Wealden are all significantly better than the England average, indicating lower levels of alcohol-related psychiatric harm. Most districts show no significant recent trend, suggesting stable patterns over time. Hastings remains a clear outlier and priority for targeted mental health and alcohol interventions.

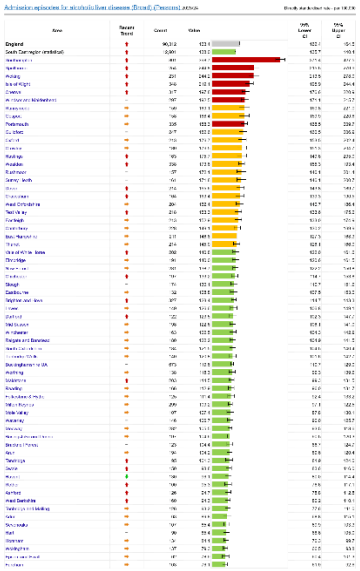


## Admission episodes for alcoholic liver disease (Broad) (Persons) (2023/24)

People with conditions recorded under ICD-10 codes associated with ARBD (such as Wernicke's encephalopathy, alcoholic polyneuropathy, and alcohol-related psychotic disorders) are more likely to develop alcoholic liver disease because both share the same underlying cause: prolonged, heavy alcohol consumption. Chronic alcohol use affects multiple organ systems simultaneously, so neurological damage and liver disease often co-occur in individuals with long-term harmful drinking patterns.

Although alcoholic liver disease is not a direct measure of ARBD, it serves as a useful proxy for the level of chronic alcohol harm in a population. High rates of alcoholic liver disease admissions indicate sustained heavy drinking patterns, which are strongly associated with the development of ARBD-related conditions

Admission rates for alcoholic liver disease (broad definition) in East Sussex districts show a mixed picture. Eastbourne and Hastings are similar to the England average indicating a substantial burden of liver-related harm. Lewes and Rother are slightly better, while Wealden performs significantly better than the national average. Most districts show no significant recent trend. The data reinforces that Eastbourne and Hastings remain priority areas for reducing alcohol-related harm, particularly liver disease.



# The proportion of clients entering alcohol treatment identified as having a mental health treatment need, who were receiving treatment for their mental health (2023/24)

In 2023/24, 85.4% of clients entering alcohol treatment in East Sussex who had a mental health need were receiving treatment for their mental health. This is slightly above both the Southeast regional average (82.5%) and the England average (83.4%). East Sussex falls within the “similar” (yellow) band, meaning its performance is not significantly different from the regional average.

Better 95% | Similar | Worse 95% | Not compared

Recent trends: – Could not be calculated | ➡ No significant change | ⬆ Increasing & getting worse | ⬆ Increasing & getting better | ⬇ Decreasing & getting worse | ⬇ Decreasing & getting better

The proportion of clients entering alcohol treatment identified as having a mental health treatment need, who were receiving treatment for their mental health, 2023/24 — Proportion - %

| Area | Recent Trend | Count | Value | 95% Lower CI | 95% Upper CI |
|---|---|---|---|---|---|
| **England** | – | 38,971 | 83.4 | 83.1 | 83.8 |
| South East region (statistical) | – | 5,064 | 82.5 | 81.5 | 83.4 |
| Portsmouth | – | 92 | 48.9 | 41.9 | 56.0 |
| Brighton and Hove | – | 191 | 70.7 | 65.1 | 75.8 |
| Medway | – | 118 | 70.7 | 63.4 | 77.0 |
| Wokingham | – | 62 | 71.3 | 61.0 | 79.7 |
| Isle of Wight | – | 125 | 74.4 | 67.3 | 80.4 |
| Southampton | – | 174 | 78.0 | 72.1 | 83.0 |
| Kent | – | 800 | 78.9 | 76.3 | 81.3 |
| Windsor and Maidenhead | – | 84 | 80.0 | 71.4 | 86.5 |
| Slough | – | 65 | 80.2 | 70.3 | 87.5 |
| Buckinghamshire UA | – | 304 | 81.5 | 77.2 | 85.1 |
| West Berkshire | – | 62 | 81.6 | 71.4 | 88.7 |
| Milton Keynes | – | 121 | 82.3 | 75.3 | 87.6 |
| Bracknell Forest | – | 44 | 83.0 | 70.8 | 90.8 |
| West Sussex | – | 462 | 84.9 | 81.7 | 87.7 |
| East Sussex | – | 346 | 85.4 | 81.7 | 88.5 |
| Hampshire | – | 550 | 86.3 | 83.5 | 88.8 |
| Surrey | – | 942 | 89.7 | 87.7 | 91.4 |
| Reading | – | 102 | 90.3 | 83.4 | 94.5 |
| Oxfordshire | – | 420 | 95.5 | 93.1 | 97.0 |

## East Sussex Services Data

In October 2025, East Sussex County Council reached out to service providers in East Sussex, to build an understanding of what data already exists about ARBD in a local context. Responses were received from the following services: East Sussex Memory Clinics, Sussex Partnership NHS Foundation Trust, East Sussex Healthcare NHS Trust, Change Grow Live and Drug and Alcohol Related Deaths.

These services could not provide any data relating to ARBD, for a number of reasons:

- Data on ARBD is not recorded.
- There is not a formal pathway for ARBD, and therefore data relating to it is not collected.
- CGL complete a cognitive screening which is not integrated or reliable so cannot be used for an ARBD diagnosis. Once referred to a GP there is no follow up pathway for a person with suspected ARBD.
- Active intoxication is an exclusion for assessment at East Sussex Memory Clinics.

However, following service mapping from the 3rd of November 2025, CGL will record 6CIT for all clients. A tracker has been put in place to monitor all those scoring over 8. If a client reaches a score over 10, CGL complete a MOCA and assessment for Wernicke's risk: get IM thiamine prescribed if required. GP to be informed and a repeat 6CIT/MOCA to be undertaken at post detox so a review 2 weeks after alcohol detox occurs.

## Case Studies

Case Study 1:

| | |
|---|---|
| Background | • Age bracket: 25-34<br>• Substance Use: Up to 300 units of alcohol/week; crack cocaine use; cannabis; benzodiazepines (non-prescribed).<br>• Presenting Issues: Severe alcohol dependency (~300 units/week), epilepsy, suspected neurodivergence (ASD/ADHD), acquired brain injury (frontal lobe), and complex trauma history.<br>• Diagnosis: MRI confirmed frontal lobe trauma and cerebellar damage (Aug 2024), consistent with ARBD and possible Korsakoff's Syndrome.<br>• Mental Health: PTSD, suicidal ideation, hallucinations, cognitive decline, suspected ARBD. |
| Clinical Indicators of ARBD | • Cognitive Impairment:<br>o Memory loss, poor executive functioning, disinhibition.<br>o 6CIT score: 10 (mild impairment); AQ10 and ASD screening completed.<br>o MCA concluded lack of capacity regarding alcohol use and care decisions.<br>• Neurological Findings:<br>o MRI: Bilateral frontal cortical/subcortical encephalomalacia, gliosis, cerebellar atrophy.<br>o Neurologist (Dr Ali) confirmed ARBD and advised abstinence and structured risk assessment.<br>• Behavioural Presentation:<br>o Repeated hospital admissions for seizures and intoxication.<br>o Aggression, inappropriate public behaviour, and self-neglect.<br>o Frequent absconding from placements and hospital. |
| Hospital Liaison and Clinical Pathway | • Detox Attempts:<br>o Declined by Bridge House and Birchwood due to forensic history. |

| | |
|---|---|
| | ○ Conquest Hospital provided unplanned inpatient detox (Aug 2024); Librium-based protocol.<br>○ Acamprosate initiated post-detox, adherence inconsistent.<br>• Hospital Coordination:<br>○ Alcohol Care Team led inpatient management.<br>○ Safeguarding Nurses coordinated risk reviews.<br>○ MHLT were involved for psychiatric assessment; DOLS applied and later revoked.<br>• Post-Detox Planning:<br>○ MDT agreed on structured discharge with neuropsychiatric follow-up.<br>○ Referral for executive functioning assessment (CGL-funded).<br>Fibroscan scheduled to assess liver damage. |
| Safeguarding and Risk Management | • Safeguarding Status: Persistent concerns flagged under Section 42 (self-neglect).<br>• Community Protection Warning (CPW): Issued to restrict public intoxication and aggression.<br>• Risk Factors:<br>○ Vulnerability to exploitation.<br>○ Assaults on staff and emergency workers.<br>○ Incontinence, poor hygiene, and refusal of medication. |
| Multi-Agency Coordination | • Key Stakeholders:<br>○ CGL<br>○ Social Care<br>○ Healthcare: ESHT (Alcohol Care Team, Neurology, Safeguarding), SPFT (Psychiatry)<br>○ Probation<br>• Meetings & Forums:<br>○ COSUMH, MDTs, safeguarding panels, clinical reviews.<br>○ Coordinated planning for detox, rehab, and neurodiversity assessment. |

| | |
|---|---|
| Housing Instability | • Multiple placements in 18 months: Little Acorns → Kingswood NH → The Hurst.<br>• Frequent absconding, non-compliance, and behavioural issues.<br>• Concerns raised about care quality and safeguarding at The Hurst.<br>• Awaiting placement at Elizabeth House or High View. |
| Outcomes and Next Steps | • Rehab: Kenward Trust admission (Nov 2024); self-discharged after 9 days.<br>• Placement: Accepted by Elizabeth House (Upstreet Project); awaiting bed.<br>• Legal: Court dates pending; forensic history complicates care planning.<br>• Clinical: Awaiting neuropsychiatric assessment and autism diagnosis.<br>• Monitoring: Continued hospital liaison, safeguarding oversight, and structured engagement via STAR Recovery Service. |
| Conclusion | This case illustrates the clinical complexity of ARBD, the importance of hospital-based detox, and the critical role of multi-agency coordination in managing high-risk individuals with overlapping neuropsychiatric, forensic, and safeguarding needs. |

Case Study 2:

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| Background | • Age bracket: 55 - 64<br>• Presenting Issues: Severe alcohol dependency and potential EUPD. Client B characterised by street drinking, and putting themselves in highly vulnerable situations, necessitating the public calling ambulances.<br>• Diagnosis: Executive Function Assessment completed, and the patient was found to have capacity.<br>• Client B has had 47 presentations to ED in 2025.<br>• Client B lives in a care home, where they were dispensed alcohol in an attempt to modify their drinking. We worked |

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| | closely with the Care Home and CGL, both of whom tried everything in their disposal. |
| Clinical Indicators of ARBD | • Cognitive Impairment:<br>o Variable. There are issues in correctly conducting assessments for ARBD and there is no current pathway, but it was suspected that Client B had ARBD due to their presentation. However, after having a detox, Client B appeared to have capacity.<br>o Assessed Client B for a referral to neuropsychiatry assessment.<br>o Client B was put on a DOLS for the duration of one of their detoxes, but this was relinquished when Client B was deemed to have capacity, whereupon they immediately discharged.<br>• Neurological Findings:<br>o 5 x CT head due to concerns of head injury following a fall. My understanding is that they did not reveal abnormalities.<br>• Behavioural Presentation:<br>o Repeated hospital admissions for intoxication.<br>o Presented with sunburn and poor personal hygiene - self-neglect.<br>o They would take discharge against medical advice as soon as they could. |
| Safeguarding and Risk Management | • Safeguarding Status:<br>o Persistent concerns flagged under Section 42 (self-neglect).<br>• Risk Factors:<br>o Vulnerability to exploitation.<br>o Theft of alcohol.<br>o Aspirating whilst intoxicated. |
| Multi-Agency Coordination | • Key Stakeholders:<br>o CGL<br>o Social Care Healthcare: ESHT (Alcohol Care Team, Safeguarding) and SPFT (Psychiatry)<br>o Arden House<br>• Meetings & Forums:<br>o MDTs, safeguarding panels and clinical reviews. |

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| Outcomes and Next Steps | • Patient Outcomes:<br>  ○ Client B would like to re-engage with CGL to manage his alcohol use.<br>  ○ Client B would like to access counselling.<br>  ○ Client B would like to get back into volunteering.<br>  ○ Client B would like to keep the current alcohol plan at Arden in place as a backup.<br>  ○ Client B would like to attend some groups at Thrift House, possibly including acupuncture.<br>• Outcomes and Next Steps:<br>  ○ Monitoring: Continued hospital liaison, safeguarding oversight, and structured engagement via STAR Recovery Service.<br>  ○ Patient has not attended ED since a safeguarding meeting held in 2025. |
| Conclusion | This case illustrates the importance of joint working across the borough, with careful planning and jointly agreed outcomes.<br>It also highlights the borough's need for an adequately resourced care pathway specifically for ARBD. |

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