

Alcohol Health Needs Assessment

NHS Lothian

May 2024

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Executive Summary

Alcohol deaths are rising across the UK with Scotland recording the highest number. In Lothian, the age standardised mortality rate for alcohol specific deaths is lower than Scotland, however the rates are currently higher than rates of drug related deaths. In Lothian, 35% of males and 20% of females drink alcohol above recommended limits. These figures are higher than any other health board area in Scotland.

Each premature death is a tragedy, for the individual as well as for their family, friends and wider community. From a public health perspective, it is important that we use available intelligence about patterns of alcohol death and the wider harm to individuals, families and communities, to inform action. It is however important that we focus that action as 'upstream' as possible, with a particular focus on the actions that are likely to reduce deaths and harm from a range of causes, such as by addressing poverty and inequality, and ensuring that people have access to the building blocks of health that will enable them to avoid isolation and loneliness.

In relation to harm and death caused by alcohol, the majority of which are a result of chronic alcohol use, the World Health Organisation is clear that action to reduce alcohol harm should focus on reducing the availability, affordability and acceptability of alcohol. Within Lothian, the public health team is working to influence local Licensing Board policies on the availability of alcohol, as well as advocating for continued and further national action on pricing and advertising in order to influence affordability and acceptability. Local Alcohol and Drug Partnerships are also working to improve access to treatment for excess alcohol use.

There is a significant relationship between deaths caused by alcohol and the experience of multiple disadvantage. We must therefore continue to tackle the underlying causes and structural determinants of health that will help reduce inequalities that ultimately impact on the rates of death by alcohol.

For alcohol deaths, we will collate and analyse data on local and national trends on an annual basis to help inform the focus of our work. Public Health Teams will continue to work with our four Community Planning Partnerships to reduce levels of poverty and increase access to employment and health and wellbeing-promoting environments across Lothian, to reduce the unfair differences in people's life circumstances. In addition, we will continue working with local Alcohol and Drug Partnerships and health service colleagues to help inform service responses.

We need to address the adverse health and social consequences for individuals, families, communities and wider society from harmful alcohol consumption. This needs assessment provides background information to support the further policy and service delivery development within Lothian at an individual and population level.

We have listed in the next section of this report, recommendations that have been identified during this health needs assessment, which we hope can be considered by colleagues and services, in our joint efforts to reduce the harm caused by alcohol.

Recommendations		Recommendation Owner
The Alcohol Environment		
1	Continue work to address availability, affordability and acceptability, with a focus on influencing policy and decisions of local authority Licensing Boards	NHS Lothian – Public Health
Alcohol Related Behaviours		
2a	Use information on alcohol consumption and harms in children and young people to inform the work of local authority Children’s Partnerships.	NHS Lothian – Public Health
2b	Improve support for children affected by parental substance use, including raising awareness with relevant professionals who have contact with children and families.	ADPs
2c	Improve staff awareness that poor mental health and high levels of existing alcohol consumption are risk factors for future harmful levels of alcohol consumption and ensure adequate supports are available for mental health.	ADPs
Alcohol Harms		
3a	Review and improve pathways of support for those who frequently attend A&E, taking account of recommendations from the Glasgow Frequent Attenders Study.	ADPs
3b	Review and improve provision of alcohol liaison and post-discharge pathways, taking account of recommendations from the SHAAP Report.	ADPs
Fetal Alcohol Spectrum Disorder (FASD)		
4a	Raise primary care staff awareness of FASD, including importance of recording.	ADPs
4b	Use information on FASD to inform actions in the Women’s Health Plan and Children’s Services Plans, including raising staff awareness and ensuring FASD is considered within neurodevelopmental pathways.	NHS Lothian – Public Health
4c	Review and improve pathways of support between substance use services and sexual and reproductive health services.	ADPs
Alcohol Related Liver Disease (ARLD)		
5	Review and improve pathways between hepatology and recovery services/primary care, taking account of ARLD Quality Standards	ADPs
Alcohol Related Brain Damage (ARBD)		
6	Raise staff awareness of ARBD, including appropriate referral pathways, ensuring information is included as part of online and in person training.	ADPs
Alcohol Services and Pathways		
7a	Implement recommendations from national review of ABIs, when available.	ADPs
7b	Review and improve pathways of outreach, taking account of recommendations from Glasgow PCANOS work.	ADPs
7c	Review and improve pathways from substance use services into wider holistic care, including housing and income maximisation.	ADPs

7d	Call for improved national evidence / guidance on alcohol harm reduction.	NHS Lothian – Public Health
Pharmacological Treatments		
8	Exploring prescribing data in more detail to identify areas of good practice as well as potential gaps and inform service requirements.	NHS Lothian – Public Health
Data and Intelligence		
9a	Improve data collection and recording of protected characteristics within substance use services.	ADPs
9b	Make use of PHS Alcohol Data Dashboard to inform future decisions.	ADPs NHS Lothian – Public Health
9c	Further investigate the pathways and uptake of referrals from alcohol related A&E attendances to wider services.	NHS Lothian – Public Health
9d	Further investigate the incremental reduction for alcohol related hospital admissions over the past three years.	NHS Lothian – Public Health
Oversight of Recommendations		
10	Review progress against Alcohol Harms Needs Assessment Recommendations 6-monthly, via Lothian Alcohol Harm Reduction Group and / or Drug and Alcohol Harms Partnership Group.	NHS Lothian – Public Health

Introduction and Policy Context

The current Scottish Government framework for alcohol harm is the [Alcohol Framework 2018: Preventing Harm](#). This document sets out the national prevention aims on alcohol activities that will reduce consumption and minimise alcohol-related harm arising in the first place, with keys aims of reducing health inequalities and protecting children and young people.

The framework's overarching commitment is:

- Put the voices of children and young people at the heart of developing preventative measures on alcohol.

The rest of the framework actions are grouped under the following themes:

- Reducing consumption: affordability and sales
- Reducing consumption: availability and licensing
- Positive attitudes, positive choices: attractiveness – marketing and advertising
- Positive attitudes, positive choices: education, awareness raising and behaviour change
- Supporting families and communities: Foetal Alcohol Spectrum Disorder – prevention, diagnosis and support
- Supporting families and communities: positive alternatives and safer communities
- Supporting families and communities: preventing alcohol-related violence and crime

The framework endorses and aligns with the World Health Organisation's best buys to reducing the harmful use of alcohol by tackling affordability, availability and attractiveness.¹ The framework aligns with the Public Health Priorities for Scotland, where one of the current priorities (public health priority 4) is a 'Scotland where we reduce the use of and harm from alcohol, tobacco and other drugs.'²

[Rights, Respect and Recovery](#) is Scotland's alcohol and drug treatment strategy* to improve health by preventing and reducing alcohol and drug use, harm and related death. The strategy's vision is that individuals, families and communities:

- have the **right** to health and life - free from the harms of alcohol and drugs
- are treated with dignity and **respect**
- are fully supported within communities to find their own type of **recovery**.

**Note that in terms of drug harm, the Rights, Respect and Recovery strategy has been superseded by the National Mission on Drug Deaths: Plan 2022-2026, however the elements of the strategy that refer to alcohol treatment still apply.*

¹ <https://apps.who.int/iris/bitstream/handle/10665/259232/WHO-NMH-NVI-17.9-eng.pdf>

² <https://www.gov.scot/publications/scotlands-public-health-priorities/>



Local alcohol and drug partnerships (ADPs) are responsible in Scotland for commissioning and developing local strategies for tackling problem alcohol and drug use and promoting recovery, based on an assessment of local needs. The Scottish Governments [Partnership Delivery Framework to Reduce the Use of and Harm from Alcohol and Drugs](#) outlines the shared ambition across Local Government and Scottish Government that local areas (ADPs) have the following in place:

- A strategy and clear plans to achieve local outcomes to reduce the use of and harms from alcohol and drugs.
- Transparent financial arrangements
- Clear arrangements for quality assurance and quality improvement
- Effective governance and oversight of delivery

In Lothian, three ADPs cover the City of Edinburgh, West Lothian and jointly Mid and East Lothian. ADP strategies are currently being refreshed for 2024-2027 related to reducing the use of, and harm from, alcohol and drugs. Ongoing information sharing and learning occurs across Lothian supported by the ADPs and other relevant local services, such as via the Lothian Drug and Alcohol Harm Partnership Group.

Background

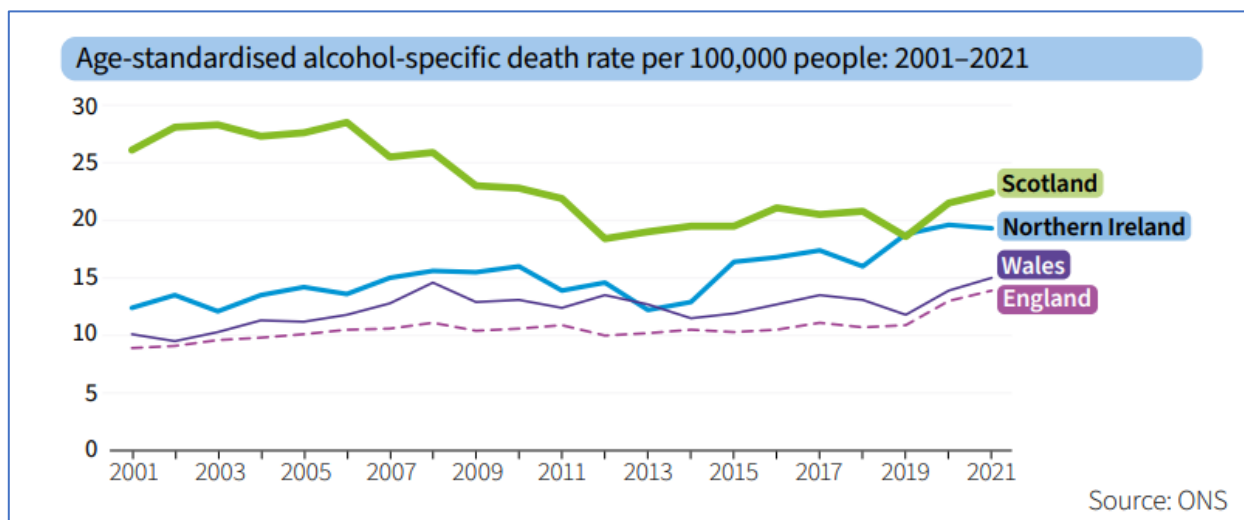
A significant number of people live more difficult lives, have poorer health and die younger than they should. We know the things that people need to be healthy: a nurturing, safe, and secure childhood, enough money, a decent home, a stable job, a good education and a sense of control and belonging.³ Health inequalities are a consequence of unfair differences in people's living conditions and life experiences. According to a recent report by The Health Foundation,⁴ the persistence of health inequalities in Scotland over the past decade is related to three underlying factors:

1. The accumulation of severe and multiple disadvantage.
2. A lack of improvement in living standards.
3. Austerity has left public services in a fragile state and reduced provision for supporting healthier lives.

Specific areas of concern identified in the report included:

- Prevalence of drug-related deaths in Scotland
- Health and experiences of infants and children in their early years
- Health and socioeconomic outcomes of young and middle-aged men.
 - Suicide, alcohol and drugs are leading causes of death for men aged 15–44 years old, accounting for two-thirds of absolute inequalities in total mortality at that age. This age group also accounts for two-thirds of absolute inequalities in total mortality, related to a higher likelihood of experiencing multiple disadvantage.

Alcohol deaths are rising across the UK. Deaths are highest in Scotland, despite the estimated number of lives saved by the introduction of minimum unit pricing (MUP).⁵ In Lothian, 35% of males and 20% of females drink alcohol above recommended limits. These figures are higher than any other health board area in Scotland.⁶



In Lothian, rates of alcohol specific deaths are currently higher than rates of drug related deaths. The age standardised mortality rate for alcohol specific deaths in Lothian is 19.1 per 100,000 (2018–2022

³ DPH Report - [NHS-Lothian-Public-Health-Annual-Report-2022-final.pdf \(nhslothian.scot\)](https://www.nhs.uk/publications/nhs-lothian-public-health-annual-report-2022-final.pdf)

⁴ <https://www.health.org.uk/publications/leave-no-one-behind>

⁵ [Policy briefing: alcohol \(publichealthscotland.scot\)](https://www.publichealthscotland.scot/policy-briefing/alcohol)

⁶ [ScotPHO profiles \(shinyapps.io\)](https://shinyapps.io/scotpho/)

rolling average), which is lower than Scotland (21.2 per 100,000), most likely due to the lower levels of deprivation. The most deprived areas in Lothian have the highest deaths, with an 82% higher alcohol specific death rate than Lothian as a whole.⁷

Alcohol Focus Scotland provided a recent reminder that ‘While deaths are the most extreme form of alcohol harm, these are likely to be accompanied by increases in other harms such as alcohol-related diseases, accidents, violence, unemployment, family and relationship breakdown, domestic abuse, child neglect and fetal alcohol spectrum disorder.’⁸

We need to address the adverse health and social consequences for individuals, families, communities and wider society from harmful alcohol consumption. This needs assessment provides background information to support further policy and service delivery development within Lothian at an individual and population level.

⁷ [ScotPHO profiles \(shinyapps.io\)](https://shinyapps.io/ScotPHO_profiles/)

⁸ Briefing - Emergency response required to prevent deaths from alcohol. September 2023 AFS

Method

To ensure this needs assessment comprehensively addressed the issue of alcohol harm in Lothian whilst being feasible for a small team, elements from epidemiological, comparative and consultative needs assessments were adopted.

To understand the epidemiology of alcohol harms, local and national data that is publicly available was used. This included information on alcohol provision, consumption and health and social harms, as well as specialist service activity data. National data was used to allow for a comparison between Lothian and the rest of Scotland. Data is also presented at a local authority level where available.

Data was extracted from systems and databased during 2023 and the report published in 2024. The report contains the most up to date data that was available at the time of extracting. We wish to specially thank colleagues within the Lothian Analytical Team for assisting us.

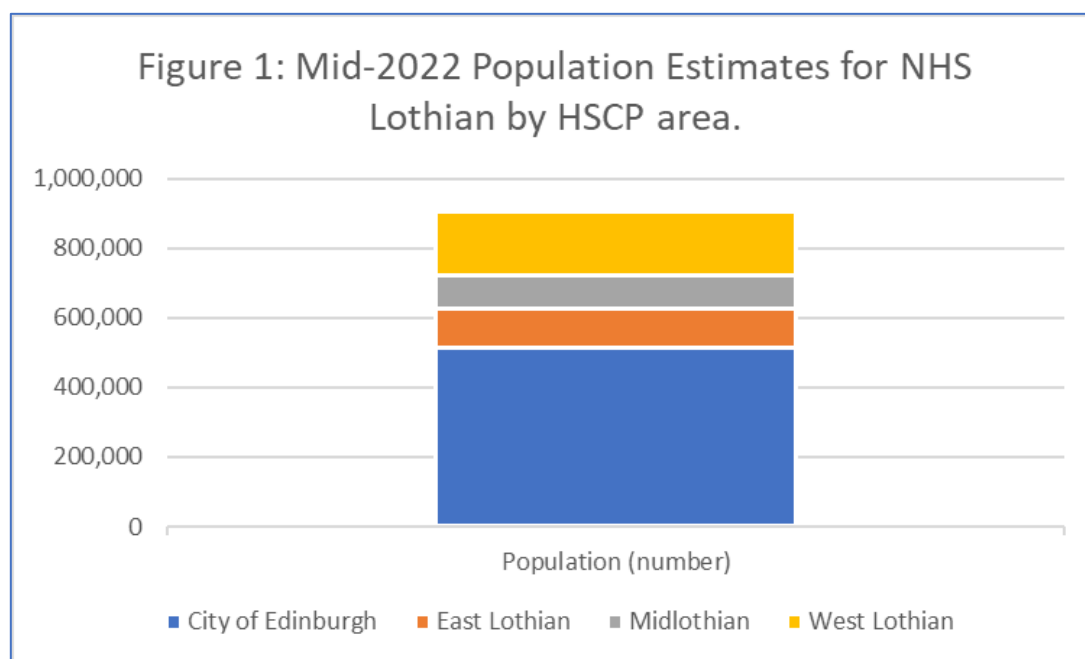
To give a greater understanding of the available services for alcohol related health conditions, some informal qualitative discussions were held with stakeholders. These were identified by sending a request out through the Lothian Alcohol Harms Reduction Group (LAHRG) as well as identifying key individuals from other parts of the service. This needs assessment did not seek to evaluate service user experience or satisfaction with current services. However, in parallel to this needs assessment, the local ADPs were developing new three year strategies, which included service user involvement. Stakeholders that were involved were sourced from a variety of NHS and third sector organisations and from across inpatient and outpatient services. We wish to thank all stakeholders who kindly spoke with us during this process.

As part of the data request for this health needs assessment, GP read codes for alcohol were requested. This resulted in a list of approximately 200 read codes and therefore it was not possible to extract meaningful information to explore or analyse.

Data on protected characteristics (other than age and gender) was not readily available in the data that was used, and we recognise the need for improved local and national data collection and linkage to allow us to understand if we are meeting the needs of different groups equitably.

Local Profiles and Demographics

NHS Lothian is the second largest of the fourteen territorial health boards in Scotland.⁹ Since 2002, it has experienced the largest amount of growth of any health board, with the population having increased by approximately 136,500 people. NHS Lothian covers four local health and social care partnerships (HSCP): City of Edinburgh, East Lothian, Midlothian and West Lothian. Together they cover a population of 906,190 people according to 2022 mid-year estimates, approximately 13.7% of Scotland's total population, as shown in Figure 1.

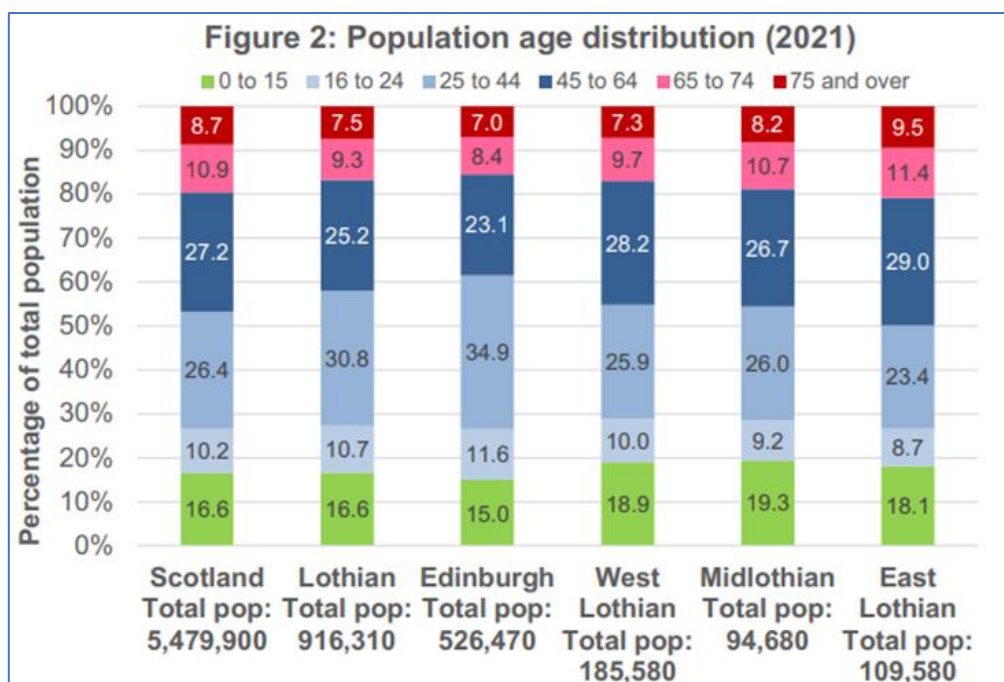


The four local authority areas contain three Alcohol and Drug Partnerships (ADPs): Edinburgh (EADP), West Lothian (WLADP) and a combination of Midlothian and East Lothian (MELDAP).

Compared to Scotland, Lothian has a relatively similar proportion of under-16s in their population, but a relatively higher proportion of those in the working age categories of 16-64 years old (Figure 2). This is thought to be related to the large working-age population in and around the City of Edinburgh. Of the four areas, East Lothian has the highest proportion of those aged 65 and over. However, this is very similar to the Scotland level proportion of 65 and overs – 20.9% compared to Scotland's 19.6%.¹⁰

⁹ [ScotPHO profiles \(shinyapps.io\)](https://shinyapps.io/scotpho/)

¹⁰ DPH Report - [NHS-Lothian-Public-Health-Annual-Report-2022-final.pdf \(nhslothian.scot\)](https://nhs.uk/lothian/public-health/annual-report-2022-final.pdf)



With regards to deprivation, using the Scottish Index of Multiple Deprivation (SIMD), Lothian experiences proportionally fewer areas in the 20% most deprived areas of Scotland compared to the rest of the country. 11% of Lothian's population, just over 100,000 people, live in data zones amongst the 20% most deprived in the country. The greatest number of these people live in the City of Edinburgh, but the area with the highest proportion of people from the most deprived data zones is West Lothian (Table 1).

	SIMD 1 (Most Deprived 20% data zones)	SIMD 2	SIMD 3	SIMD 4	SIMD 5 (Least Deprived 20% data zones)
Edinburgh	11.8	14.3	14.3	17.5	42.0
East Lothian	4.8	28.1	22.3	25.5	19.3
Midlothian	7.5	32.8	23.9	21.4	14.4
West Lothian	14.3	27.8	18.9	20.6	18.4
Lothian	11.0	20.6	17.2	19.5	31.7

Table 1: SIMD 2020 datazones by population share in Lothian (2021)

Within NHS Lothian HSCP areas, the healthy life expectancy for men and women varies. For women, healthy life expectancy in Scotland has been decreasing slightly year on year since 2015. Trends in Lothian HSCP areas are more variable, likely due to the smaller numbers involved and any population fluctuations. Generally, City of Edinburgh has the highest healthy life expectancy, followed by East Lothian, then Midlothian, all above the national average. West Lothian has the

lowest female healthy life expectancy of the four areas, and it has been consistently slightly lower than the national average (Figure 3).¹¹

For men, trends in healthy life expectancy have been relatively more stable. Similarly to women, men in the City of Edinburgh and East Lothian have the highest healthy life expectancy and this was consistently higher than the Scottish average. The healthy life expectancy trends for men in Midlothian and West Lothian tend to match the national averages for men (Figure 4).¹²

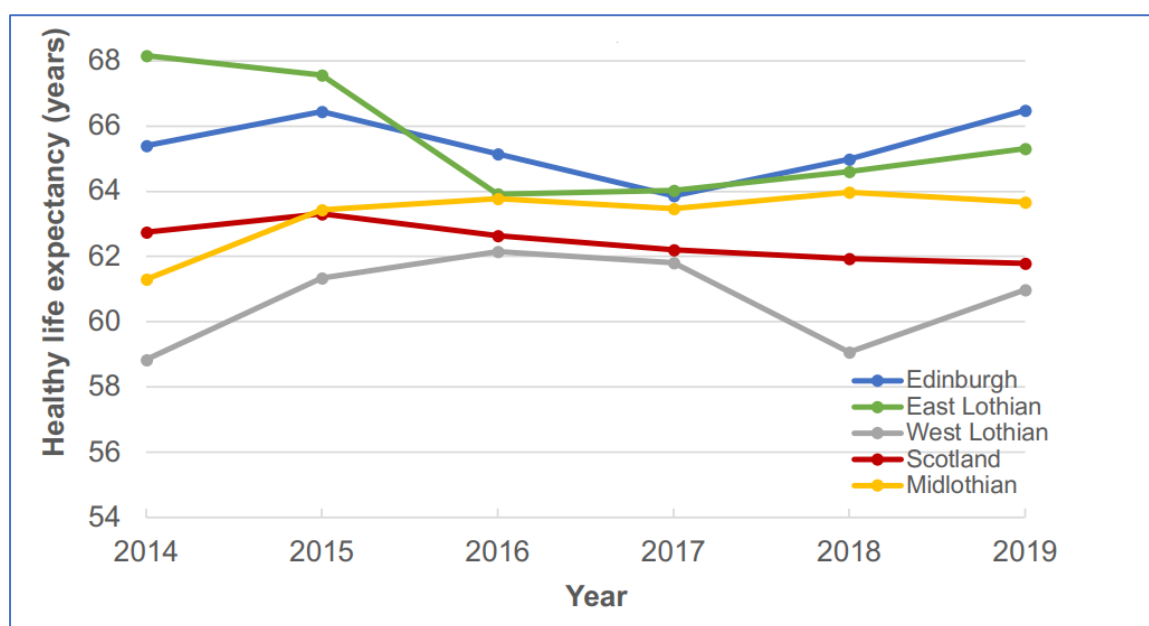


Figure 3: Female healthy Life Expectancy at Birth (2014-2019)

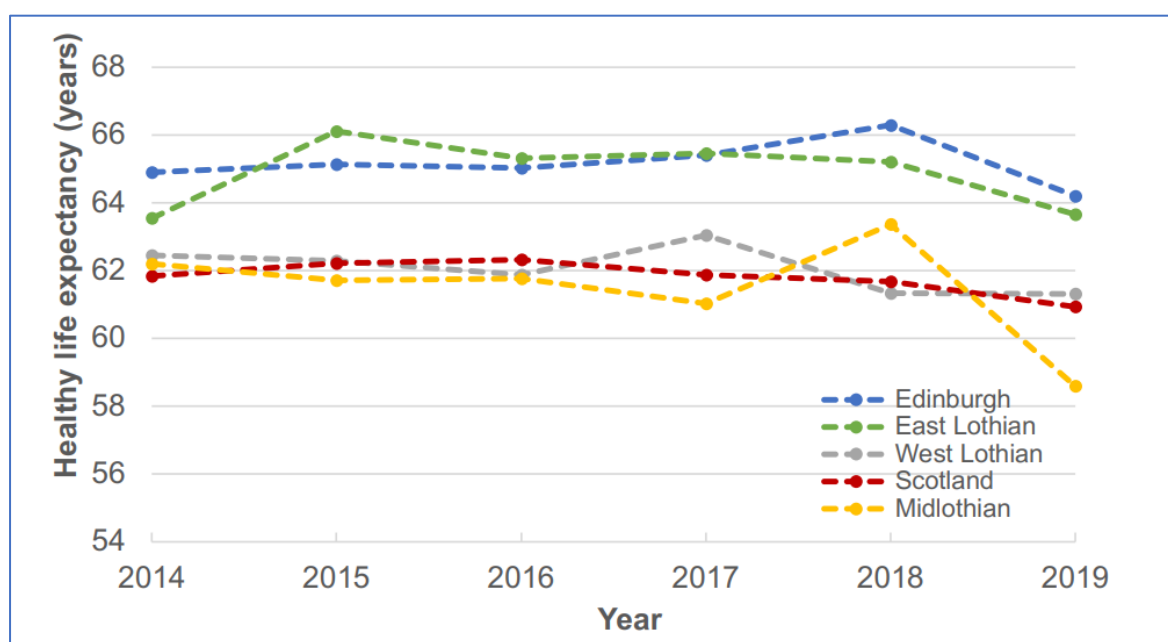


Figure 4: Male Healthy Life Expectancy at Birth (2014-2019)

¹¹ DPH Report - [NHS-Lothian-Public-Health-Annual-Report-2022-final.pdf](https://www.nhs.uk/publications/nhs-lothian-public-health-annual-report-2022-final.pdf) (nhsllothian.scot)

¹² DPH Report - [NHS-Lothian-Public-Health-Annual-Report-2022-final.pdf](https://www.nhs.uk/publications/nhs-lothian-public-health-annual-report-2022-final.pdf) (nhsllothian.scot)

Alcohol Provision

There has been good evidence for over a decade that increased alcohol outlet density is associated with harms to health.¹³ Overprovision of alcohol creates harm by directly increasing opportunities for purchases, and influences the perceived normality of alcohol consumption, including the exposure to children and young people. Overprovision also makes it more difficult for people to recover from alcohol dependence.¹⁴ Specifically within Scotland, researchers at the University of Edinburgh have found that alcohol related mortality and morbidity are significantly higher in neighbourhoods with a greater density of alcohol outlets.¹⁵ This relationship was particularly striking for off sales outlet density.

The Centre for Research on Environment Society and Health (CRESH) is a virtual centre joining scientists from the Universities of Edinburgh and Glasgow. Their research is focused on exploring how physical and social environments can influence population health, for better and for worse. This newly available CRESH data provides further evidence of the links between alcohol availability and harm in Scotland. Information was gathered on alcohol outlets, health harms and crime rates within neighbourhoods across the whole of Scotland. Below is a summary of the data relating to alcohol density for all retailers, on sale retailers and off sale retailers.¹⁶

	All Sales		On Sales		Off Sales	
	2020	2023	2020	2023	2020	2023
City of Edinburgh	4.0	4.4	3.2	3.3	0.8	1.0
East Lothian	2.6	3.3	1.8	2.4	0.8	0.9
Midlothian	2.2	2.6	1.4	1.4	0.7	0.8
West Lothian	2.0	2.5	1.2	1.5	0.8	1.0
Lothian	3.2	3.7	2.4	2.7	0.8	1.0
Number of outlets per 1,000 persons						

Table 2: Alcohol Density – Outlets Per 1,000 Persons

The table above shows the increase across all sales from 2020 to 2023 and for all local authority areas. The same data is shown visually for the four council areas in Lothian.

¹³ Campbell C, Hahn R, Elder R et al. The effectiveness of limiting alcohol outlet density as a means of reducing excessive alcohol consumption and alcohol-related harms. American Journal of Preventive Medicine 2009; 37(6):556–569.

¹⁴ <https://pubmed.ncbi.nlm.nih.gov/28886441/>

¹⁵ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4415114/#:~:text=An%20IQR%20increase%20in%20off,%2C%2015%25%20higher%20mortality>

¹⁶ <https://creshmap.com/>

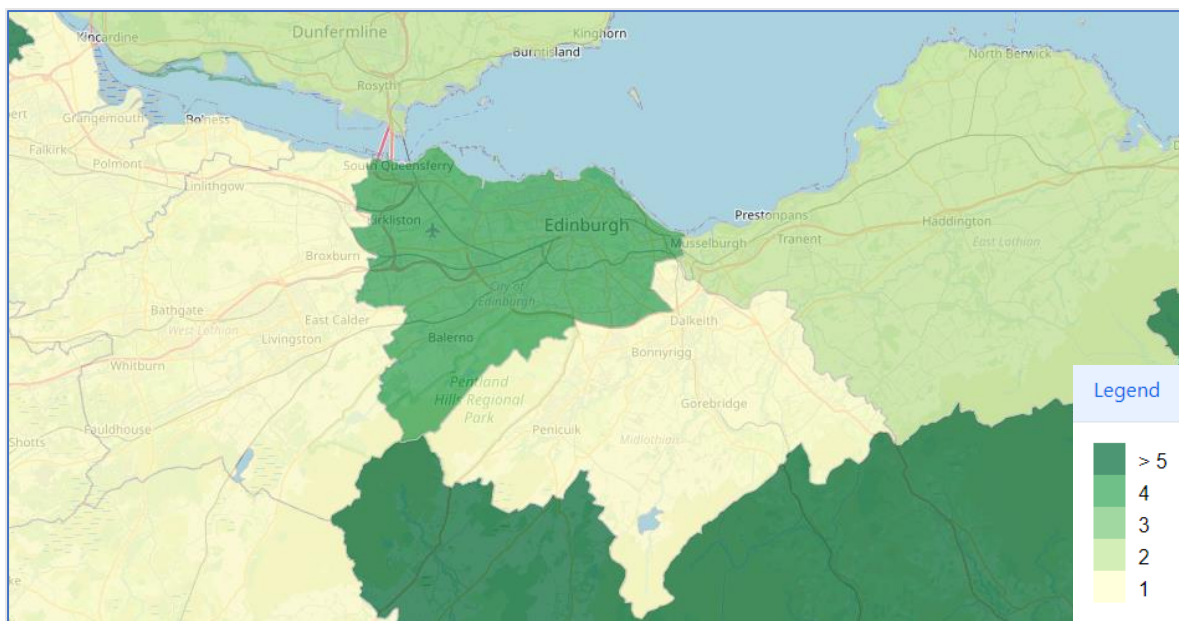


Figure 5 - CRESH Map of Alcohol Retailer Density (all sales)

The purpose of the licensing system in Scotland is to regulate the retail provision of alcohol in such a way as to mitigate the risks of harm to individuals and society from its use. The remit of a Licensing Board is to decide whether any proposed further expansion in the supply of alcohol, through additional licensed premises, capacity or hours is compatible and consistent with the licensing objectives and the wider public interest.¹⁷ Further work should continue and expand to continue highlighting to the Licensing Boards about alcohol related harm and the relationship with alcohol density, promoting the use of overprovision areas to help protect public health.

In addition to the availability of alcohol and its impact on health, research highlights the impact of alcohol availability in terms of the effects of exposure to alcohol outlets on children, especially in low-income areas. Although the long-term health impacts affect mostly adults, the foundations of harmful health behaviours are often established in childhood. A Scottish study showed that the proportion of children exposed to alcohol outlets did not differ by area deprivation. However, the proportion of time children were exposed to alcohol outlets showed stark inequalities. Children living in the most deprived areas were almost five times more likely to be exposed to off sales alcohol outlets than children in the least deprived areas and almost three times more likely to be exposed to on sales alcohol outlets, because those living in the more deprived areas spend more time in these local areas. Children in deprived areas experienced 31% of their exposure to off sales outlets within 500 m of their homes compared to 7% for children from less deprived areas.¹⁸ As children have little control over what they are exposed to, we should advocate and support policies that reduce inequities in alcohol availability, to ensure that all children have the opportunity to lead healthy lives.

Work to reduce exposure to alcohol should continue and seek further opportunities to expand, which would compliments the national policy drivers on the acceptability of alcohol such as alcohol advertising.

¹⁷ <https://www.alcohol-focus-scotland.org.uk/media/263089/AFS-Resource-Section-4.pdf>

¹⁸ [Inequalities in children's exposure to alcohol outlets in Scotland: a GPS study - Enlighten Publications \(gla.ac.uk\)](https://www.enlightenpublications.org.uk/publications/inequalities-in-childrens-exposure-to-alcohol-outlets-in-scotland-a-gps-study)

Price and Affordability

In 2020, alcohol sold in the UK was 73% more affordable than it was in 1987.¹⁹ In 2021, there was enough alcohol sold in Scotland for every adult to drink 18.1 units of alcohol a week.²⁰ The World Health Organisation states that the strongest evidence for reducing alcohol consumption and alcohol related harm is to implement alcohol pricing policies. 'Price increases reduce the harms caused by alcohol. Policies that increase alcohol prices delay the initiation of alcohol use, slow young people's progression towards consuming larger amounts, and reduce heavy episodic use of alcohol among them.'²¹

Minimum unit pricing (MUP) was introduced by the Scottish Government in May 2018, which sets the minimum price that a unit of alcohol can be sold for in Scotland – currently set at 50 pence per unit (ppu) and will increase to 65p from the end of September 2024. The aim of the MUP policy is 'to reduce health harms caused by alcohol consumption. It aims to reduce both the consumption of alcohol at population level and, in particular among those who drink at hazardous and harmful levels.'²²

An evaluation conducted by Public Health Scotland shows that MUP is effective at reducing alcohol consumption and harm. The evaluation concluded that:²³

- MUP reduced alcohol consumption by 3% in the three years after implementation.
- People who bought the most alcohol before MUP reduced their purchasing the most.
- MUP reduced deaths directly caused by alcohol consumption by an estimated 13.4%, equivalent to 156 fewer deaths per year.
- MUP reduced hospital admissions by an estimated 4.1%, equivalent to 411 fewer hospital admissions per year.
- Reductions were greatest for men and those living in the most deprived areas, helping to address alcohol related health inequalities.
- There was no clear evidence of substantial negative impacts on the alcoholic drinks industry.

NHS Lothian fully supports the continuation of alcohol MUP and further work locally should continue to advocate this national policy driver, including incremental increasing of MUP in line with inflation and the introduction of a public health levy, especially to target the positive impact of those who drink at hazardous and harmful levels, which are particularly high across Lothian.

¹⁹ [Availability, affordability and consumption - ScotPHO](#)

²⁰ [Executive Summary - Alcohol - minimum unit pricing - continuation and future pricing: interim business and regulatory impact assessment - gov.scot \(www.gov.scot\)](#)

²¹ [SAFER - Pricing policies on alcohol \(who.int\)](#)

²² [Executive Summary - Alcohol - minimum unit pricing - continuation and future pricing: interim business and regulatory impact assessment - gov.scot \(www.gov.scot\)](#)

²³ [Evaluating the impact of minimum unit pricing for alcohol in Scotland: Final report \(publichealthscotland.scot\)](#)

Alcohol Consumption - Adults

Data on alcohol consumption tends to be self-reported through national surveys such as the Scottish Health Survey, therefore the usual caveats that you would apply to self-reported data, especially underreporting, also apply here.

Definitions used to describe different types of drinking habits:²⁴

- **Harmful drinking** (high-risk drinking) - A pattern of alcohol consumption that is causing mental or physical damage. Consumption (units per week): Drinking 35 units a week or more for women. Drinking 50 units a week or more for men.
- **Hazardous drinking** (increasing risk drinking) - A pattern of alcohol consumption that increases someone's risk of harm. Some would limit this definition to the physical or mental health consequences (as in harmful use). Others would include the social consequences. The term is currently used by the World Health Organisation to describe this pattern of alcohol consumption. It is not a diagnostic term. Consumption (units per week): Drinking more than 14 units a week, but less than 35 units a week for women. Drinking more than 14 units a week, but less than 50 units for men.
- **Binge drinking** - A heavy drinking session in which someone drinks a lot of alcohol in a short period of time raising their risk of harm on that occasion.
- **Moderate drinking** – consumption of up to and including 14 units per week.²⁵

Considering alcohol consumption in Scotland as a whole, in 2021 approximately 17% of the population (17% of women and 15% of men) reported being non-drinkers, 60% of the population (67% of women and 54% of men) reported drinking amounts that would class them as moderate drinkers, and 24% of the population (16% of women and 31% of men) reported drinking amounts that would class them as being harmful or hazardous drinkers.²⁶ When comparing NHS Lothian to Scotland, 14% of NHS Lothian residents reported being non-drinkers, 58% of residents reported drinking amounts that would class them as moderate drinkers and 28% reported drinking amounts that would class them as being harmful or hazardous drinkers – only this third figure is considered a statistically significant difference.

Looking at HSCP areas within Lothian, there is a significant difference in how each area contributes to these figures. This is demonstrated in Table 3 which highlights that the City of Edinburgh has higher proportions of harmful and hazardous drinkers and lower proportions of non-drinkers than the other HSCPs in Lothian.

Table 3 Self-reported alcohol consumption 2021

HSCP AREA	NON-DRINKERS	MODERATE DRINKERS	HARMFUL OR HAZARDOUS DRINKERS
CITY OF EDINBURGH	13%	61%	32%
EAST LOTHIAN	14%	56%	25%
MIDLOTHIAN	16%	62%	22%
WEST LOTHIAN	18%	61%	21%
LOTHIAN	14%	58%	28%
SCOTLAND	17%	60%	24%

Statistically significantly lower than national average

Statistically significantly higher than national average

²⁴ <https://www.nice.org.uk/guidance/ph24/chapter/4-Glossary>

²⁵ [Scottish Health Survey \(shinyapps.io\)](https://shinyapps.io/scottish-health-survey/)

²⁶ [Scottish Health Survey \(shinyapps.io\)](https://shinyapps.io/scottish-health-survey/)

The City of Edinburgh also has higher proportions of harmful and hazardous drinkers than the Scottish average: the only local authority area to be significantly higher than Scotland.²⁷

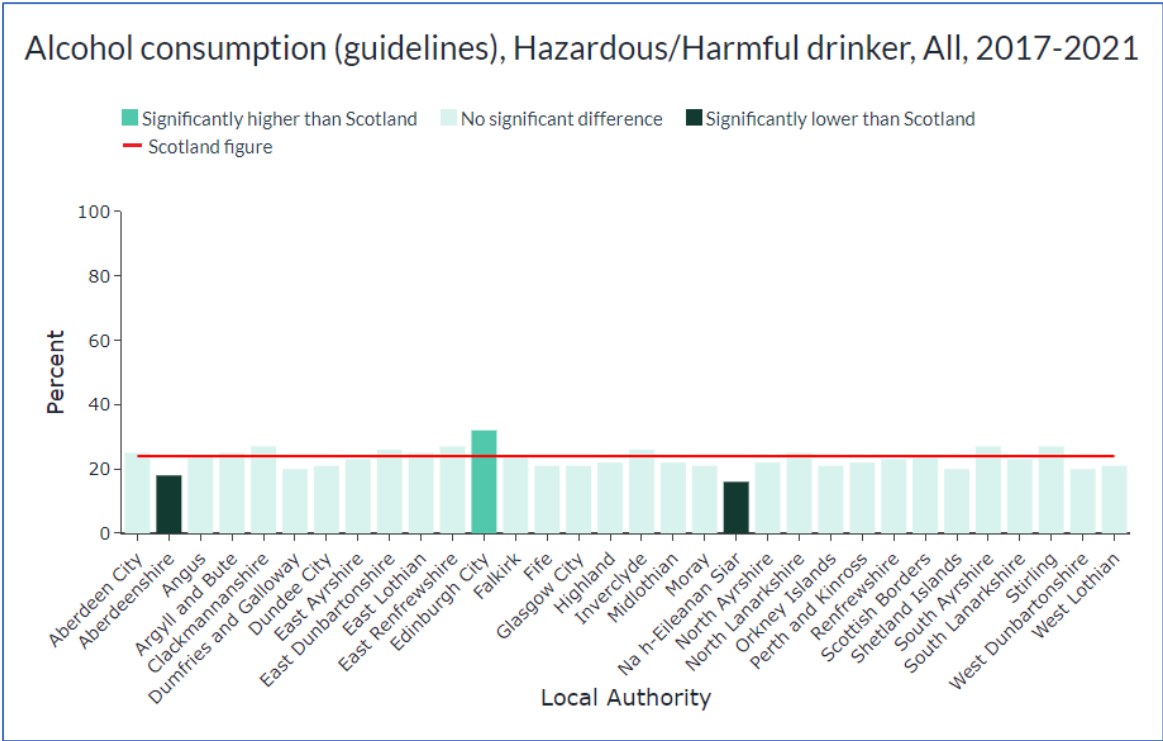


Figure 6: Self-reported hazardous/harmful alcohol consumption figures, Scotland, 2017-2021

The mean weekly unit consumption of alcohol in Scotland in 2021 was 12.1, the average for men was 14.8 and the average for women was 8, and these figures have been gradually declining since 2008. In Lothian the mean weekly unit consumption for alcohol was 13.2 in 2021 (this is not a statistically significant difference to the national average). When examining local authority areas, the City of Edinburgh has statistically significantly higher than the Scottish average mean weekly unit consumption at 14.3. There was no significant difference between mean weekly unit consumption in East Lothian, Midlothian, and West Lothian (11.4, 11.6, and 11.8 units respectively) and the Scottish average consumption.

²⁷ [Scottish Health Survey \(shinyapps.io\)](https://shinyapps.io/scottish-health-survey/)

Alcohol Consumption – Young People

The Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) provides a broad-based approach to the monitoring of substance use, including alcohol, among young people in Scotland.²⁸ The most recent data published from this survey is 2018.

Key trend data from Scotland indicates that:²⁹

- Just over a third (36%) of 13 year old pupils and 71% of 15 year olds have ever had an alcoholic drink.
- The proportion that had drunk alcohol in the 7 days prior to completing the survey was: 6% of 13 year olds and 20% of 15 year olds.
- Between 2015 and 2018, there has been an increase in the proportion of boys who had drunk in the last week: from 4% to 7% among 13 year olds and from 16% to 20% among 15 year olds. There was also an increase among 13 year old girls, from 4% in 2015 to 6% in 2018. Among 15 year old girls there has been no statistically significant change.
- Just over half of 13 year olds (53%) and around two-thirds of 15 year olds (70%) who had ever had alcohol, had been drunk at least once.
- The mean age that 15 year olds first had a drink was 13.3 years.
- The most common drinking location among both 13 and 15 year olds was at their own home.
- Among 13 year olds, around half (52%) of those who had ever had a drink had experienced one (or more) negative effect as a result of drinking alcohol in the last year, compared with over half of 15 year olds (63%).
- Among both age groups, the most common negative consequence was doing something they regretted or vomiting.

The SALSUS data is also provided for certain council and health board areas, depending on participation levels, as summarised below in Tables 4, 5, and 6.³⁰

Key for table below:

Statistically significant (more favourable in comparison to Scotland)

Statistically significant (less favourable in comparison to Scotland)

Less than 50 pupils (small sample)

Table 4: Alcohol Use – prevalence and attitudes

Edinburgh	East Lothian	Mid Lothian	West Lothian	Lothian	Statement
29%	42%	49%	36%	33%	of 13 year olds reported they had ever had an alcoholic drink
66%	73%	75%	65%	69%	of 15 year olds reported they had ever had an alcoholic drink
4%	3%	6%	6%	5%	of 13 year olds said they had drunk alcohol in the week prior to the survey
16%	19%	18%	16%	18%	of 15 year olds said they had drunk alcohol in the week prior to the survey

²⁸ [Availability, affordability and consumption - ScotPHO](#)

²⁹ [Scottish Schools Adolescent Lifestyle and Substance Use Survey \(SALSUS\): alcohol report 2018 - gov.scot \(www.gov.scot\)](#)

³⁰ [Supporting documents - Scottish Schools Adolescent Lifestyle and Substance Use Survey \(SALSUS\): national overview 2018 - gov.scot \(www.gov.scot\)](#)

57%	53%	55%	47%	51%	of 13 year olds thought it was 'ok' for someone their age to 'try drinking alcohol to see what it's like'
84%	81%	76%	74%	80%	of 15 year olds thought it was 'ok' for someone their age to 'try drinking alcohol to see what it's like'

Table 5: Alcohol Use – drinking to excess

Edinburgh	East Lothian	Mid Lothian	West Lothian	Lothian	Statement
56%	51%	58%	45%	50%	of 13 year olds reported that they had never been drunk
31%	36%	36%	29%	30%	of 15 year olds reported that they had never been drunk
44%	49%	42%	55%	50%	of 13 year olds said they had ever been drunk
69%	64%	64%	71%	70%	of 15 year olds said they had ever been drunk
6%	9%	5%	11%	9%	of 13 year olds said they had been drunk more than 10 times
24%	19%	21%	25%	25%	of 15 year olds said they had been drunk more than 10 times

Table 6: Alcohol Use – availability

Edinburgh	East Lothian	Mid Lothian	West Lothian	Lothian	Statement
6%	3%	3%	6%	7%	of 13 year olds reported that they had managed to buy alcohol
16%	9%	14%	11%	13%	of 15 year olds reported that they had managed to buy alcohol
1%	2%	-	2%	2%	of 13 year olds said they had tried to buy alcohol but were refused
2%	1%	1%	2%	2%	of 15 year olds said they had tried to buy alcohol but were refused
93%	95%	97%	92%	91%	of 13 year olds said they had not/never tried to buy alcohol
82%	90%	85%	87%	85%	of 15 year olds said they had not/never tried to buy alcohol

More recent data is available from the Scottish Government's Health and Wellbeing Census 2021-22 in Scotland, which aggregated the results from the 16 local authorities that collected data. However, the collated data was not weighted to population totals and therefore may not be as accurate a representation of young people's alcohol consumption. The survey indicates that:³¹

³¹ [Health and Wellbeing Census Scotland 2021- 2022 - gov.scot \(www.gov.scot\)](https://www.gov.scot/publications/health-and-wellbeing-census-2021-22/pages/10.aspx)

- 7.4% of S2 (age 13 years old) and S4 (age 15 years old) pupils said they usually drank alcohol about once a week or more (breakdown in table 7).
- The prevalence of usually drinking alcohol at least once a week is higher for S4 pupils than for S2 pupils.
- More boys report drinking more than once per week, where more girls report drinking about once per week (table 8).
- The percentage of pupils drinking once a week or more doesn't follow a clear deprivation trend (table 9).

Table 7: Percentage of pupils that drink alcohol at least once a week, by pupil stage

	S2	S4	Total
More than once a week	1.2%	3.2%	2.0%
About once a week	2.3%	9.6%	5.4%

Table 8: Percentage of pupils that drink alcohol at least once a week, by pupil sex

	Female	Male	Total
More than once a week	1.8%	2.3%	2.0%
About once a week	6.0%	4.8%	5.4%

Table 9: Percentage of pupils that drink alcohol at least once a week, by deprivation

	SIMD 1 (most deprived)	SIMD 2	SIMD 3	SIMD 4	SIMD 5 (least deprived)	Not Known	Total
More than once a week	1.9%	2.6%	2.1%	2.0%	1.7%	2.3%	2.0%
About once a week	4.6%	5.2%	6.1%	5.9%	5.3%	2.3%	5.4%

Self-reported alcohol consumption in young people, in this survey, increases between the stages of S2 and S4. Further monitoring of these trends should happen as the data collection is refined to ensure we have accurate data related to young people and alcohol consumption. Further thought should be given to the best age group to implement any alcohol social norm work for the greatest level of influence.

Alcohol Consumption – Impacts of COVID-19 Pandemic

Studies commissioned by the Monitoring and Evaluating Scotland's Alcohol Strategy (MESAS) programme looked at alcohol sales and self-reporting consumption within the UK to investigate the impacts of COVID-19 in relation to alcohol consumption during early lockdown. The studies indicate that:³²

- Overall, there was a 6% reduction in total alcohol sales in Scotland, as increases in off trade sales did not fully replace the loss of on trade sales.
- Most self-reported alcohol consumption measures also reduced accordingly, although statistically significant reductions could only be reported for England.
- There was evidence of alcohol consumption shifting to later in the evening in both Scotland and England. In Scotland, individual population sub-group analyses indicated that later consumption was evident in those aged 55 years and above; women; two-adult households; households with no children; and those that consumed alcohol on a weekly basis.
- There were increases in solitary alcohol consumption in both countries, but to a larger extent in Scotland. There were notable increases in the absolute number of occasions involving drinking alone for population sub-groups including single adult households; households with three or more adults; and those in full-time education.

A more recent study published by PHS in March 2023 summarised evidence on the impact of COVID-19 on alcohol consumption harm across the UK. The summary points include:³³

- Overall, alcohol consumption decreased in Scotland and England following the start of the COVID-19 pandemic. However, changes in drinking behaviour were polarised, with some increasing their alcohol consumption and others decreasing. This was associated with drinking behaviour before the pandemic: those who increased their alcohol consumption tended to drink more before the pandemic, and those who decreased consumption tended to drink less.
- In England, some evidence of an increase in high-risk drinking was seen following the start of the COVID-19 pandemic, although some studies found no effect. Evidence of this in Scotland is mixed, partly because of there being less Scottish-specific data available.
- Increased drinking was associated with increased psychological distress and factors related to changes in work and social circumstances.
- Women and adults in households with children may have been most likely to increase their alcohol consumption over the pandemic, although some evidence was mixed.
- Evidence was mixed around the relationship between consumption changes and socioeconomic status.
- Younger people were more likely than older people to change how much they drank, either by increasing or decreasing the amount or frequency.
- In Scotland, referrals to alcohol treatment services fell following the start of the pandemic.
- Alcohol related hospital admissions decreased in Scotland and England over the COVID-19 pandemic.
- Alcohol specific deaths increased in Scotland and England over the COVID-19 pandemic.

³² [Alcohol sales and consumption in Scotland during the early stages of COVID-19 pandemic – briefing paper \(publichealthscotland.scot\)](https://publichealthscotland.scot)

³³ [The impact of the COVID-19 pandemic on alcohol consumption and harm in Scotland and England: An evidence summary \(publichealthscotland.scot\)](https://publichealthscotland.scot)

The study highlighted two key considerations:

- Polarised nature of changes in alcohol consumption - the fact that those who were the heaviest drinkers before the pandemic were more likely to increase their alcohol consumption. This indicates where support could be targeted now.
- The link between poorer mental health and increased alcohol consumption - indicates the importance of supporting people's psychological wellbeing to lower their risk of increased alcohol consumption and alcohol related harms.

Further consideration should therefore be given to targeting high risk drinkers and the link between mental health and alcohol consumption.

Alcohol Related Harm – Health Harm

Consumption of alcohol can result in a wide range of health problems. Some may occur after drinking over a relatively short period, such as acute intoxication (drunkenness) or poisoning (toxic effect). Others develop more gradually, such as damage to the liver and brain.

Figure 7 below illustrates how alcohol use is one of the leading local causes of ill health in men.³⁴ For males, in 2019, alcohol use accounted for 1,826 Years Lived with a Disability (YLD) in Lothian compared to 645 years for YLD for females.

Note: YLD = years of life with disability.³⁵

Leading causes of ill health (YLD) in NHS Lothian - 2019

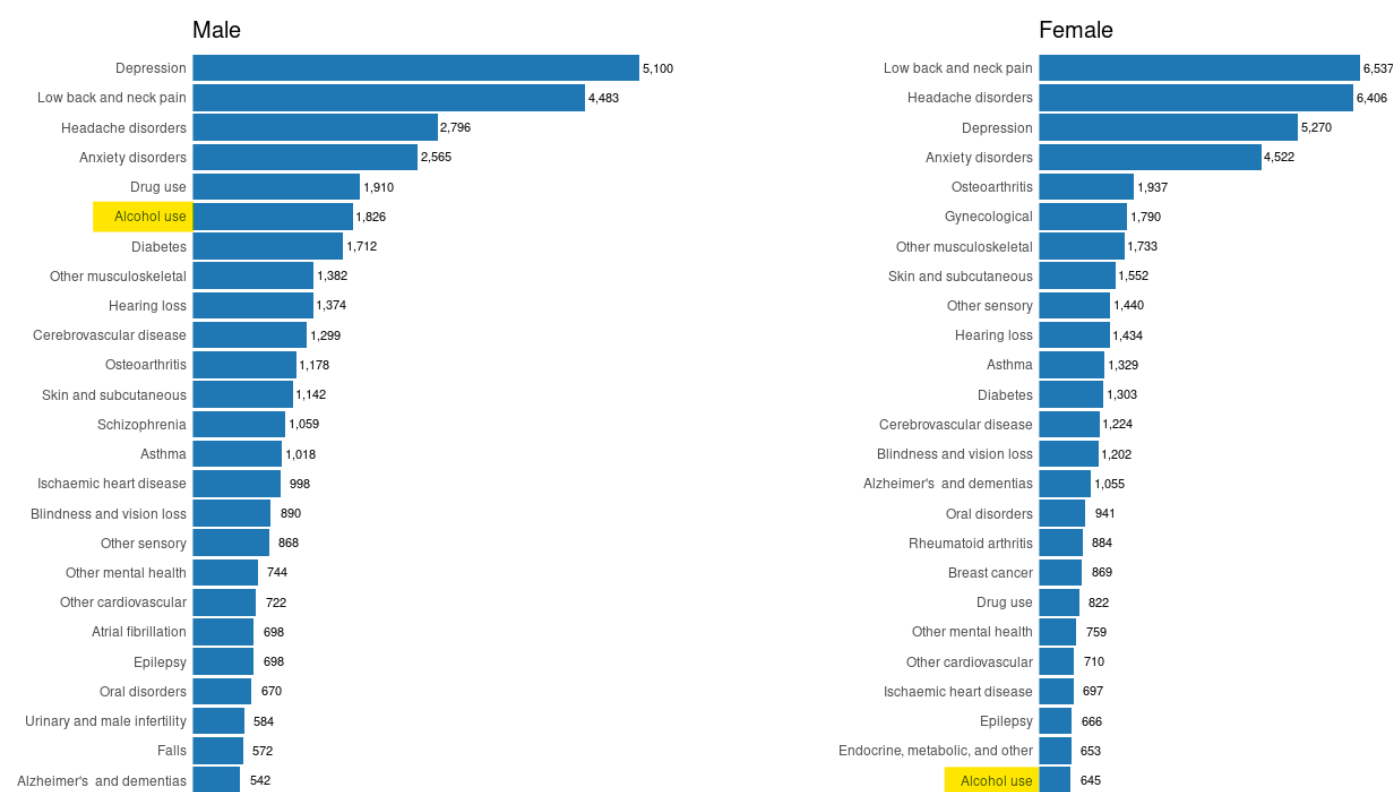


Figure 7: Leading causes of ill health (measured in years of life with disability) in NHS Lothian, by sex, 2019

³⁴ [Scottish Burden of Disease \(shinyapps.io\)](https://shinyapps.io/scottish-burden-of-disease/)

³⁵ [https://www.healthscotland.scot/health-inequalities/impact-of-ill-health/burden-of-disease-overview#:~:text=Burden%20of%20Disease%20is%20measured,years%20of%20life%20with%20disability\).](https://www.healthscotland.scot/health-inequalities/impact-of-ill-health/burden-of-disease-overview#:~:text=Burden%20of%20Disease%20is%20measured,years%20of%20life%20with%20disability).)

Alcohol Related Harm – Health Harm (Hospital Stays)

Alcohol related hospital statistics are used to illustrate levels of health harm attributable to alcohol. They include estimates of the number of inpatient and day case hospitalisations and are based on counts where alcohol related conditions are diagnosed during the hospital stay.

Note - Attendances at Accident and Emergency that do not result in an admission to hospital are not included in hospital stay data. Individuals may have more than one stay in hospital during a year, therefore the number of people admitted will be less than the total number of stays.

In 2022/23, there were 31,206 alcohol related hospital admissions (stays) in Scotland. The majority of alcohol related hospital admissions (92%) were treated in general acute hospitals (28,800) with the remaining 8% of admissions (2,406) occurring in psychiatric hospitals.³⁶

- In 2022/23, the European age-sex standardised rate (EASR) of alcohol related hospital admissions to general acute hospitals in Scotland was 532.1 per 100,000 population and was 13% lower than the rate in 2021/22 (610.7 per 100,000). The rate during 2019/20 was 681 per 100,000. The COVID-19 pandemic and measures put in place are likely to have contributed to the decrease since 2019/20 and may still affect rates in the following years.
- In 2022/23, men were 2.3 times more likely than women to be admitted to general acute hospitals for alcohol related conditions (750 compared to 315 per 100,000 population).
- In 2022/23, people in the most deprived areas were seven times more likely to be admitted to general acute hospitals for an alcohol related condition than those in the least deprived areas (1322.8 compared to 180.1 per 100,000 population).

The EASRs for alcohol related hospital stay in Lothian for 2022/23 is listed below.

- Combined stays (acute and psychiatric): 416.6 per 100,000 population.
- All patients: 288.5 per 100,000 population.
- New patients: 135.5 per 100,000 population.

The trends for the above indicators are illustrated in Figure 8 below, showing EASR for alcohol related hospital stays until 2021/22. Although data is available for 2022/23, this is not available in the dashboard graphic form.

Note definitions:

Patient

Patient rates refer to the number of unique individuals treated within the financial year. Patients are counted only once in the financial year in which they have an alcohol related stay, even though the same patient may be admitted to hospital several times in a year.

New Patient

New patients are defined as patients who have not been previously admitted to hospital with an alcohol diagnosis within the last 10 years. If a patient has several alcohol related stays over a number of years, this patient will be counted only in the year of the first alcohol related hospital stay.

³⁶ <https://scotland.shinyapps.io/phs-health-achd/>

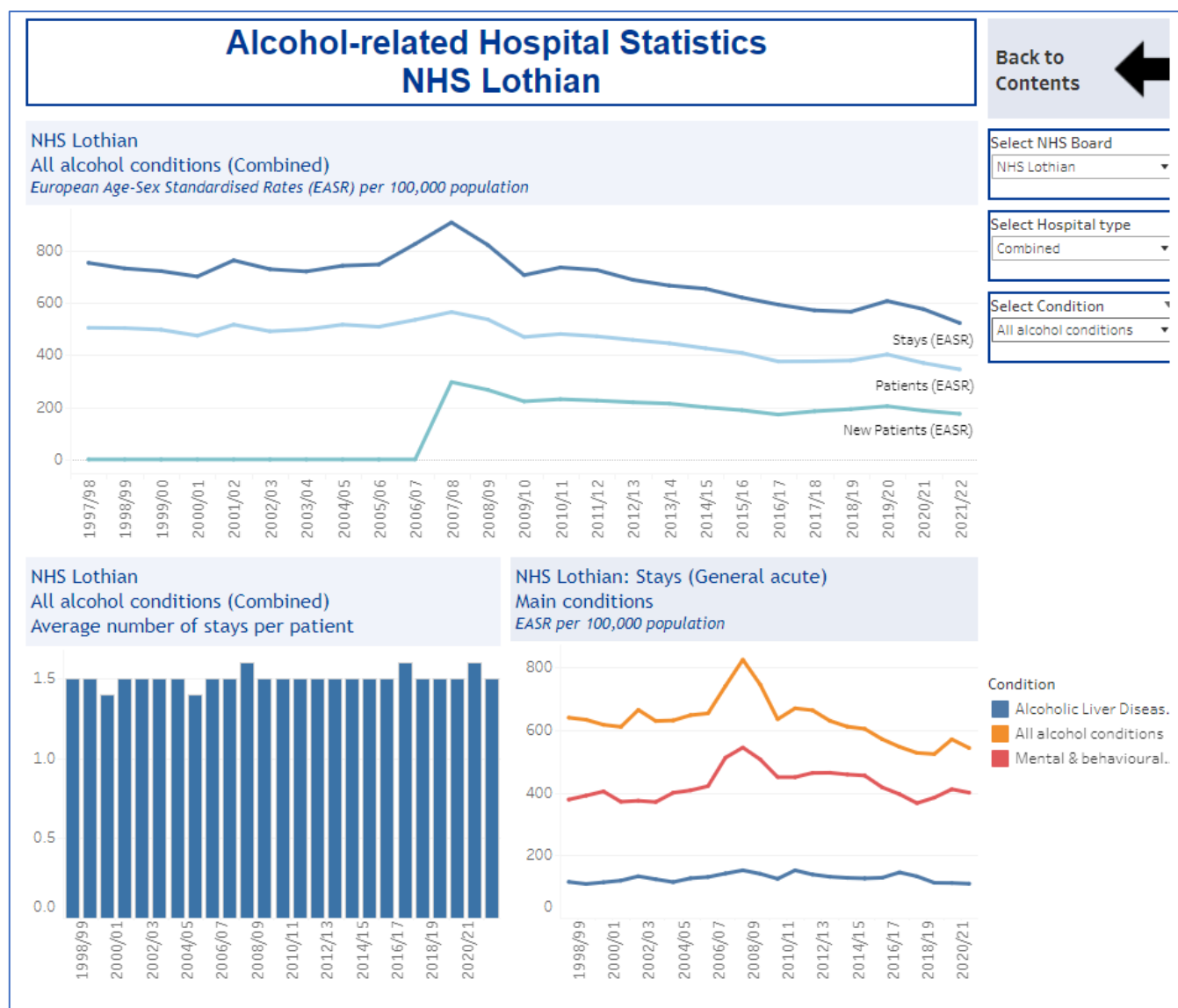


Figure 8: Alcohol related hospital stay data, NHS Lothian, 2021/22

At a local authority level, the European age-sex standardised rate of alcohol related hospital stays for 2022/23, 2021/22 and 2020/21 were:^{37 38}

Table 10: Alcohol Related Hospital stays (combined) 2022-23 EASR per 100,000 population	City of Edinburgh	West Lothian	East Lothian	Midlothian	Scotland
Alcohol Related Hospital stays (combined) 2022-23 EASR per 100,000 population	429.7	472.3	382.4	339.8	576.9
Hospital stays (combined) 2021-22 EASR per 100,000 population	549.2	542.6	474.0	435.6	650.3
Hospital stays (combined) 2020-21 EASR per 100,000 population	602.4	640.3	481.1	507.2	653.2

³⁷ <https://publichealthscotland.scot/publications/alcohol-related-hospital-statistics/alcohol-related-hospital-statistics-scotland-financial-year-2021-to-2022/>

³⁸ <https://scotland.shinyapps.io/phs-health-achd/>

All Lothian rates are below the Scotland rate each year, perhaps linked to the lower than Scottish average levels of deprivation. The City of Edinburgh has the highest alcohol related hospital stays, which could be related to the statistically significantly higher rates (than Scotland) of hazardous and harmful drinking, mean weekly alcohol unit consumption and alcohol provision.

All rates incrementally reduced over the past three years, which could be investigated further considering alcohol related deaths continue to increase. The COVID-19 pandemic would have impacted on earlier annual rates and may continue to affect rates associated with service delivery. The decrease in rates per local authority follows a similar pattern to the decreasing Scottish rate.

European Age-sex Standardised Rate per 100,000 population of stays admitted to general acute and psychiatric hospitals combined

Note that the current selected condition is: all alcohol conditions

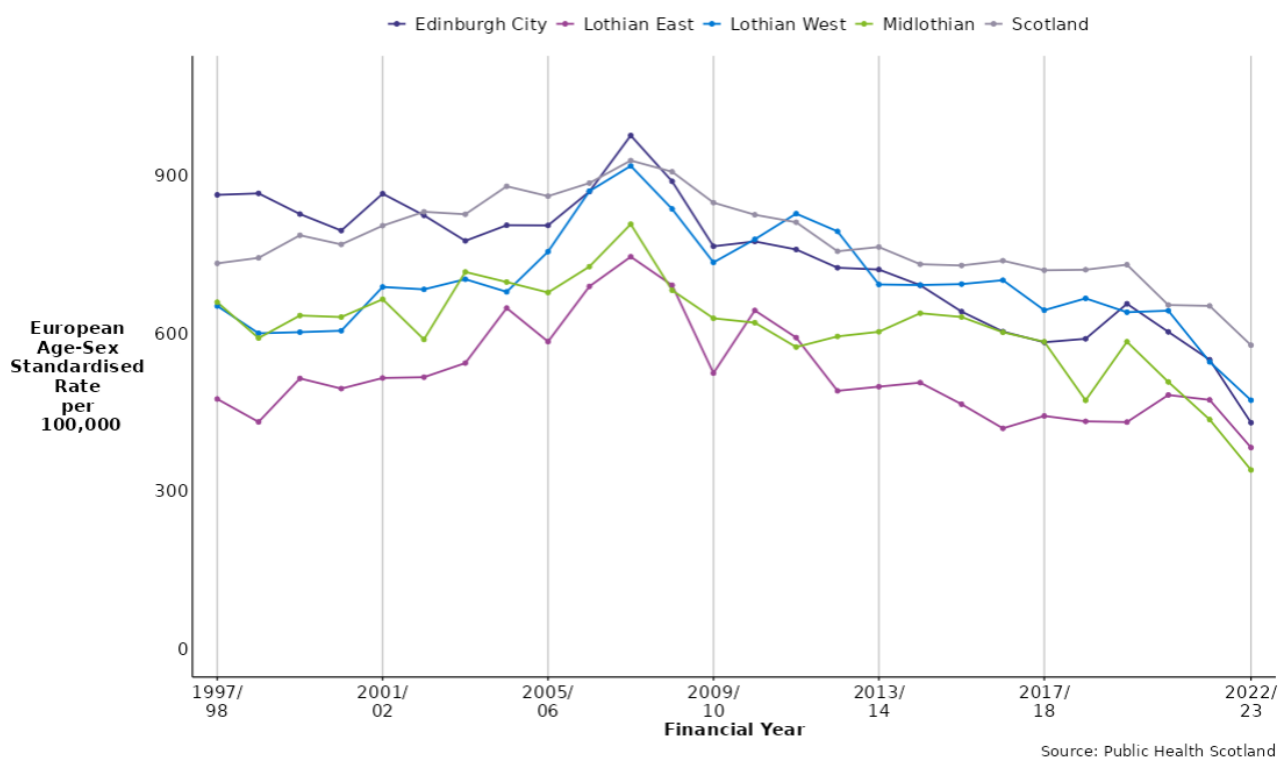


Figure 9 Hospital Stays, EASR Per 100,000 Population

There is an inequalities gradient for alcohol related hospital stays in Scotland, shown by Figure 10, where stays are considerably higher for SIMD decile 1 compared to 10. It is expected that Lothian would follow a similar trend to the national trend.

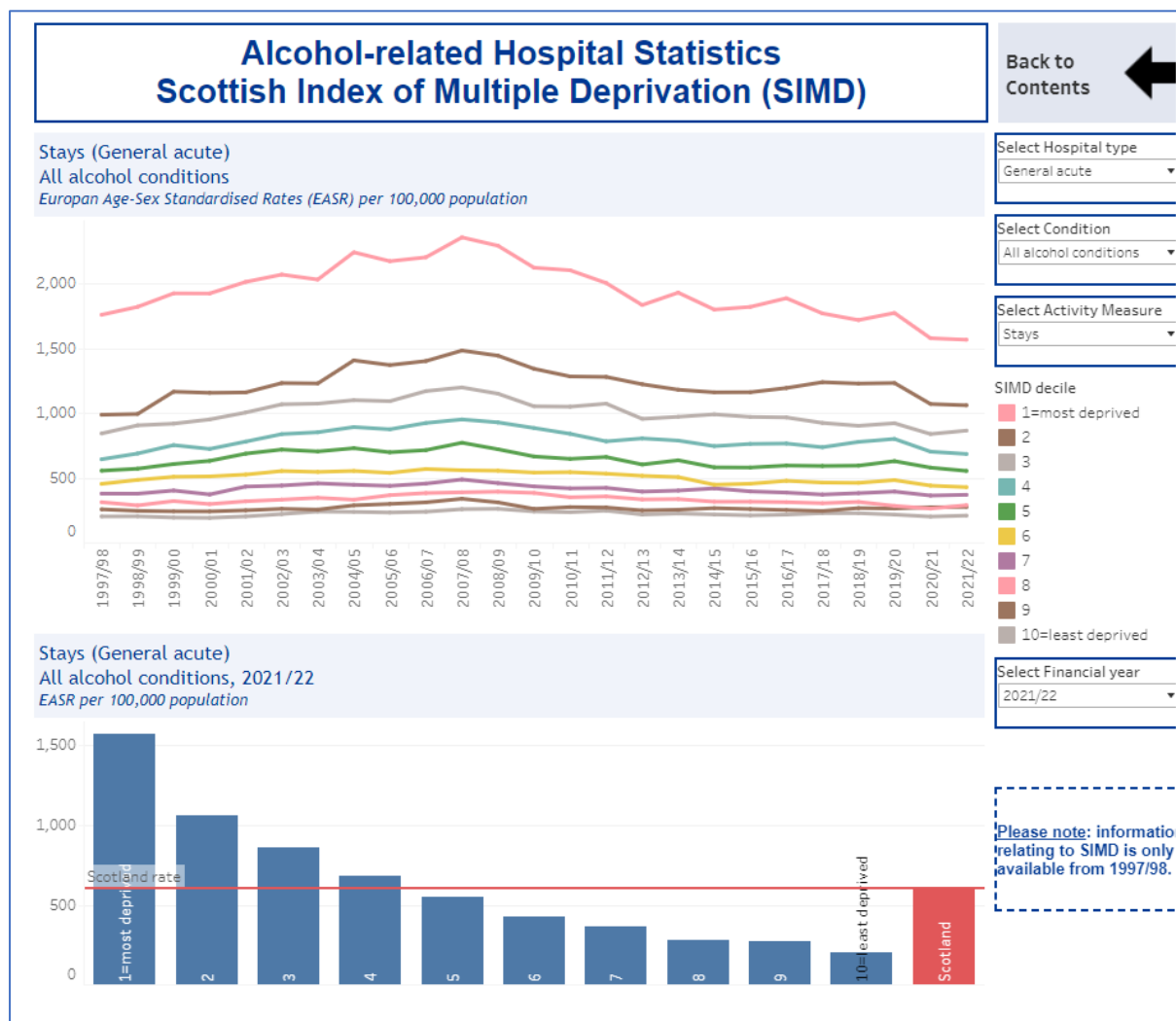


Figure 10: Alcohol related hospital stays in general acute hospitals in Scotland, by SIMD decile, 2021/22

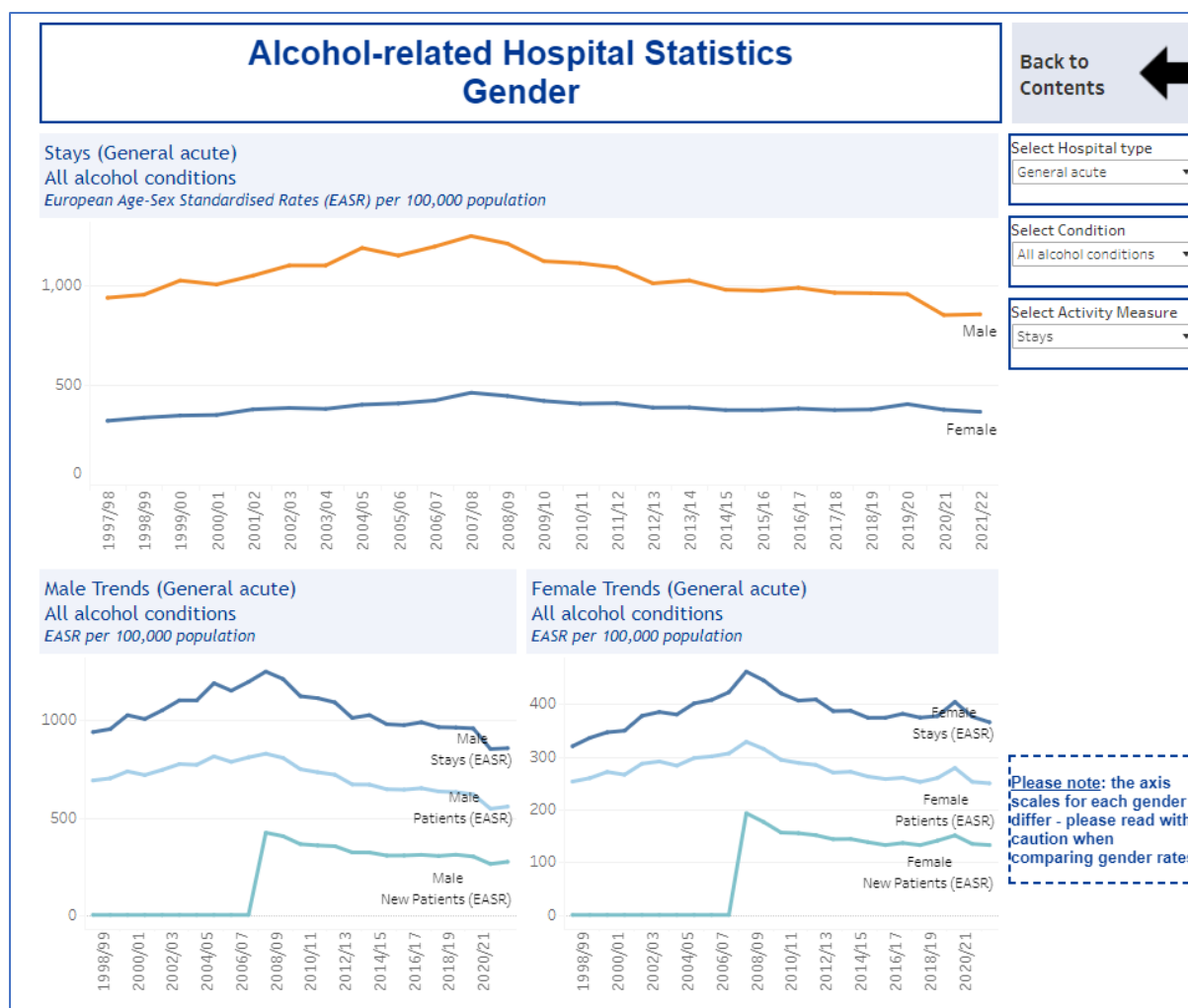


Figure 11: Alcohol related hospital stays in general acute hospitals in Scotland, by gender, 2021/22

The rate of alcohol related stays for Scotland is more than double for males compared to females. The highest rates of stays occur in the 45-54 years and 55-64 years age categories for both males and females (Figure 11 and Figure 12).

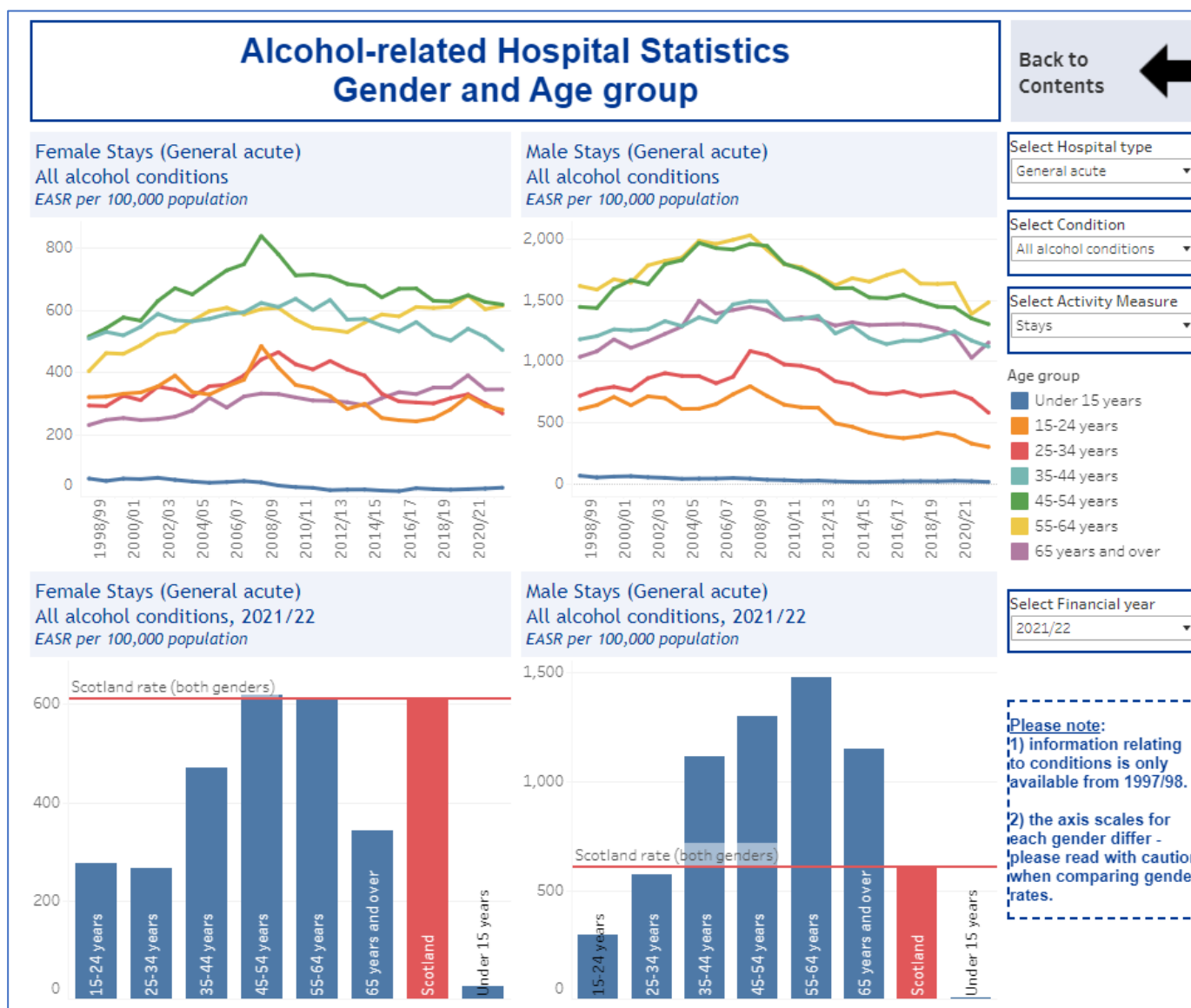


Figure 12: Alcohol related hospital stays in general acute hospitals in Scotland, by gender and age, 1998/99 to 2020/21

Although the data above shows a trend of decreasing hospital stays over time, it is important to note the high rates in comparison to the rest of the UK and Europe. There also remains stark inequalities related to alcohol harm, which should be the focus of interventions.

Data on the unique number of patients discharged per year by diagnosis groups illustrates the spread of alcohol related conditions responded to, with the largest proportion as mental and behaviour disorders due to the use of alcohol (MBD). Figure 13 shows that the unique patients discharged per year as decreasing recently. This may be due to the changes in admissions, and therefore discharges, related procedural changes due to COVID-19.

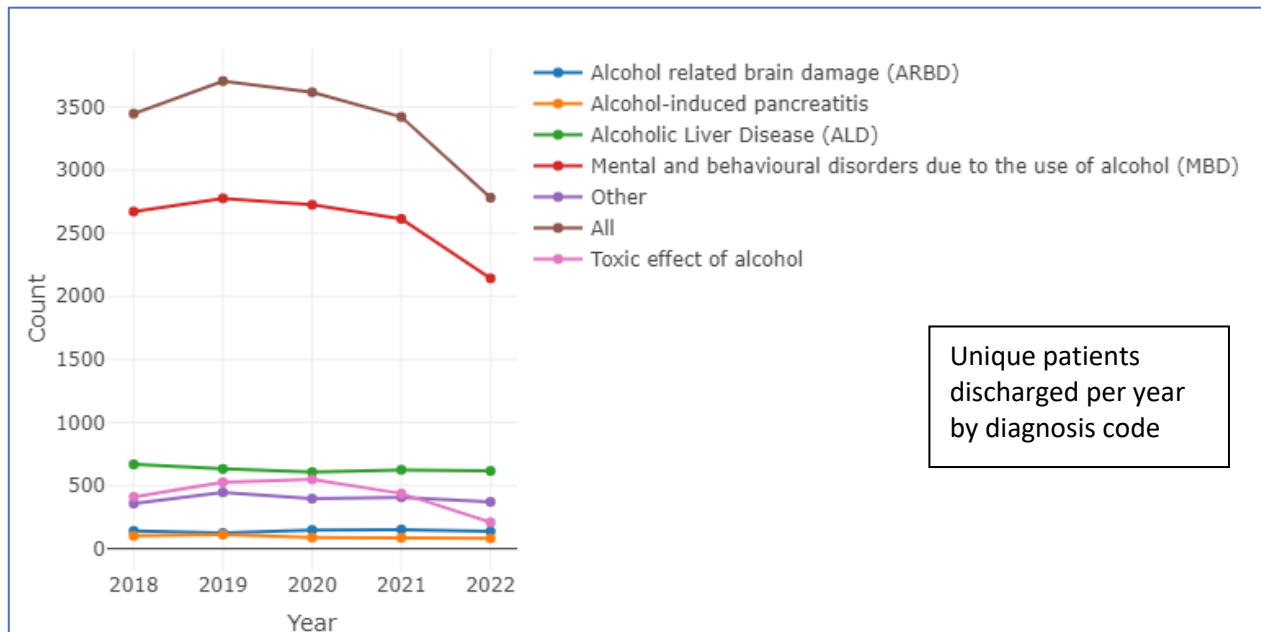


Figure 13: Trends in alcohol related diagnoses on discharge from NHS Lothian, 2018-2022

Alcohol Related Harm – Health Harm (A&E Data)

Data from NHS Lothian shows that in 2022 there were 1681 unique patients that attended Lothian accident and emergency departments. The majority of attendances were attributable to alcohol intoxication, as shown in Figure 14.

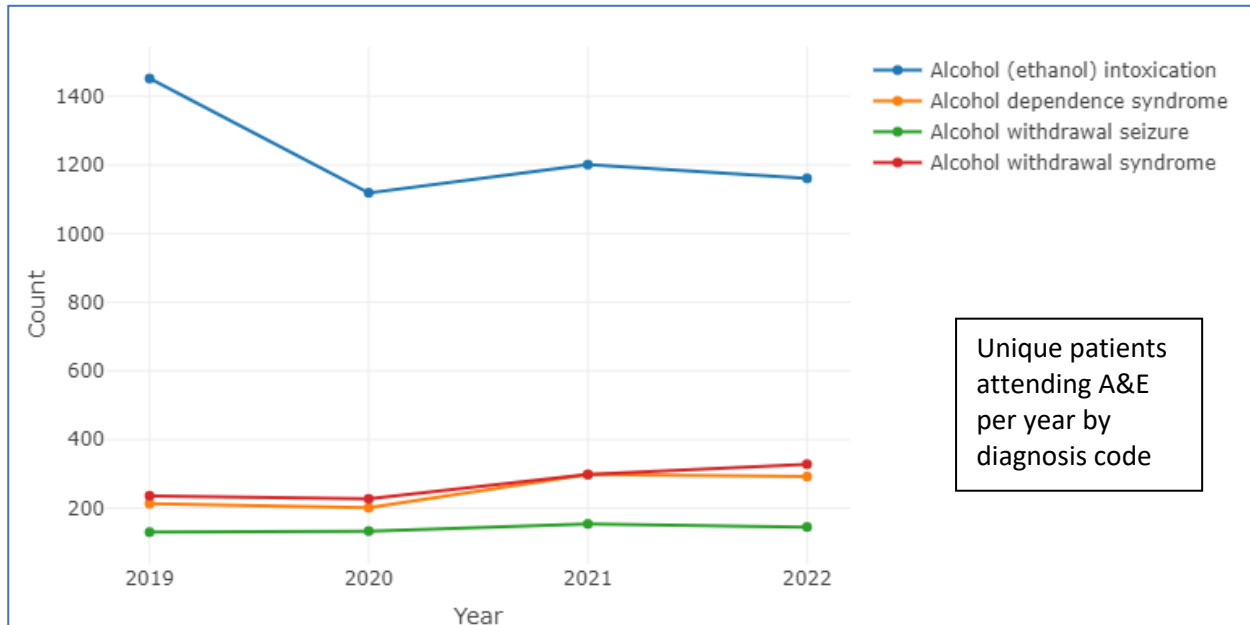


Figure 14: Alcohol related attendances at A&E, NHS Lothian, 2019-2022

More males attended the accident and emergency departments compared to females. For males, the highest number of attendees were in the 65 year+ category followed by 40-44 years and then 50-54 years.

For females, the highest attendees were in the 16-19 years and 20-24 years age categories.

This data is consistent with an in-depth study completed in Glasgow looking at alcohol frequent attendance at the Royal Alexandra Hospital in 2023 where there was a marked gender difference in the focus of attendance.³⁹ The data and patient interviews showed that males presented as suffering the physical effects of chronic alcohol misuse and females presented as drinking in the context of crisis, using alcohol to cope with mental health issues.

Together with the gender differences, other key findings from the study are listed below and it would be interesting to explore if these findings were relatable to patients and services in Lothian:

- Women have very different experiences and needs to those of men.
- The link between mental health and trauma and alcohol consumption and problems.
- A lack of joined-up approach between mental health and alcohol services, meaning that people seeking help often fall into the cracks between services.
- The importance of family support and recovery communities.
- A lack of service signposting for patients.
- How difficult it can be for people to make changes and/or seek help for their alcohol problems.
- Barriers to accessing and maintaining treatment.

³⁹ <https://shaap.org.uk/downloads/reports/518-a-qualitative-study-of-the-views-of-alcohol-frequent-attenders-at-royal-alexandra-hospital-renfrewshire.html>

For local authority level, the unique patients attending accident and emergency departments per year (EH postcodes only) is shown in Figure 15. [For 2022, unique patients were: City of Edinburgh 796; West Lothian 351; East Lothian 135; and Midlothian 123]

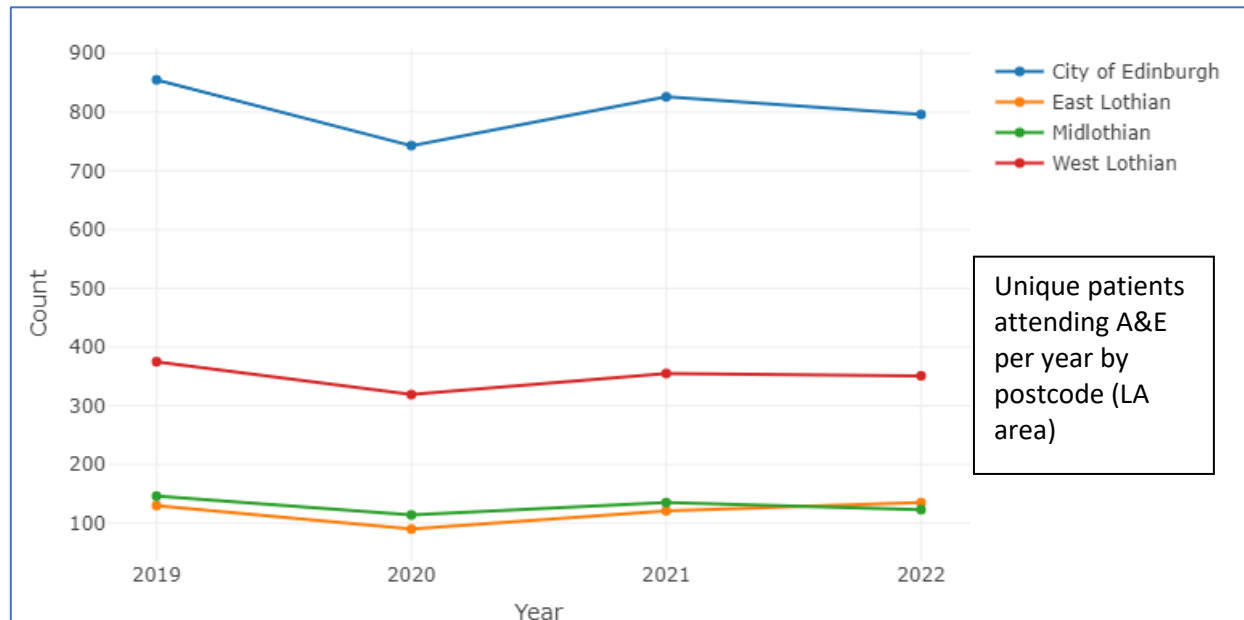


Figure 15: Alcohol related A&E attendances in NHS Lothian, by HSCP area, 2019-2022

Alcohol Related Harm – Social Harm

‘While deaths are the most extreme form of alcohol harm, these are likely to be accompanied by increases in other harms such as ... accidents, violence, unemployment, family and relationship breakdown, domestic abuse, child neglect and fetal alcohol spectrum disorder.’⁴⁰

Excessive alcohol consumption can have extensive consequences for individuals, family, communities and the economy. The impact of this excessive consumption of alcohol was previously estimated to cost Scotland £3.6 billion each year, equivalent to an average of £900 for every adult in Scotland. This includes:⁴¹

Health services	£268m
Social care	£231m
Crime	£727m
Productive capacity	£866m

A breakdown of the costs for each Lothian local authority is available in Appendix 1 - 5.

There has been good evidence for over a decade that increased alcohol outlet density is associated with harms to health and society.⁴² Work looking at the association between alcohol outlet density and alcohol related harm was completed in 2018 by Alcohol Focus Scotland and the Centre for Research on Environment, Society and Health (CRESH).⁴³ Findings included:

- Crime rates in the neighbourhoods with the most alcohol outlets were 4.2 times higher than in neighbourhoods with the least (in City of Edinburgh).
- The link between alcohol outlet availability and harm was found even when other possible explanatory factors, such as age, sex, urban/rural status and levels of income deprivation, had been considered.

The crime rate includes recorded crimes of violence, sexual offences, domestic housebreaking, vandalism, drugs offences, and common assault per 10,000 people.⁴⁴

Data from the national monitoring and evaluation of Scotland’s alcohol strategy (MESAS) concluded that alcohol use is a likely contributory factor in many crimes.⁴⁵

- Between 2010/11 and 2020/21, alcohol was a factor in 74% of homicides where the drug or alcohol status of the accused was known (57% of cases). In 2020/21, 76% of people accused of homicide were recorded as being under the influence of alcohol or under the influence of alcohol and drugs at the time of the offence, where the status of the accused was known (69% of cases).

⁴⁰ Briefing - Emergency response required to prevent deaths from alcohol. September 2023 AFS

⁴¹ [The Societal Cost of Alcohol Misuse in Scotland for 2007 \(stir.ac.uk\)](https://www.stir.ac.uk/research/2007/07/the-societal-cost-of-alcohol-misuse-in-scotland-for-2007)

⁴² Campbell C, Hahn R, Elder R et al. The effectiveness of limiting alcohol outlet density as a means of reducing excessive alcohol consumption and alcohol-related harms. American Journal of Preventive Medicine 2009; 37(6):556–569.

⁴³ <https://www.alcohol-focus-scotland.org.uk/media/310734/alcohol-outlet-availability-and-harm-in-city-of-edinburgh.pdf>

⁴⁴ Data from Scottish Index of Multiple Deprivation 2020

⁴⁵ [Monitoring and Evaluating Scotland's Alcohol Strategy \(MESAS\), 2022 \(publichealthscotland.scot\)](https://publichealthscotland.scot/research/2022/01/monitoring-and-evaluating-scotland-s-alcohol-strategy-mesas-2022/)

- In 2019/20, of those respondents to the Scottish Crime and Justice Survey who report being the victim of violent crime, and could say anything about the offender, almost half (44%) thought the offender was under the influence of alcohol.
- In 2019, 40% of prisoners reported being under the influence of alcohol at the time of their arrest; this has fluctuated between 39% and 50% since 2005. About one fifth (19%) of prisoners also reported that drinking affected their ability to hold down a job and one third (33%) reported that it affected their relationship with their family.

Table 11 below reports crude rates of crime per 10,000 population for each alcohol related indicator and provides a summary profile for each local authority area. ⁴⁶

Table 11: Alcohol Related Indicator (crude rate per 10,000 population)	City of Edinburgh	East Lothian	Midlothian	West Lothian	Scotland
Common Assault (2021/22)	117.2	77.84	89.78	113.32	106.4
Attempted murder/common Assault (2021/22)	5.68	2.92	5.6	8.08	6.97
Vandalism (2021/22)	75.43	62.06	66.54	73.71	70.08
Breach of the Peace (2020/21)	80.6	69.9	82.8	83.7	90.92
Driving Under the Influence (2021/22)	9.59	11.5	12.99	13.53	14.18
<i>Statistically significantly worse than Scotland</i>					
<i>Statistically significantly better than Scotland</i>					

The Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) collects information on the adverse effects of alcohol experienced by young people in Scotland. The latest available data from SALSUS are from 2018/19, therefore predates the COVID-19 pandemic.

- Between 2002 and 2010, the proportion of both 13-year-olds and 15-year-olds who reported experiencing negative effects from drinking alcohol was relatively stable. Between 2010 and 2018 the proportion rose for both age groups.⁴⁷

Early teenage binge drinking can also lead to bullying, lower levels of mental wellbeing and difficulties at school. ⁴⁸

Alcohol related hospital admissions for children aged under 15 years have increased after a sustained period of decrease.

Rates of alcohol related stays in general acute hospitals for children aged under 15 years in Scotland fell from a peak of 59.7 per 100,000 population in 1997/98 to a low of 14.9 per 100,000 in 2014/15; by 2020/21 this had risen to 21.0 per 100,000 population.

Data from social work statistics show that during 2021-22, parental substance use was cited as a concern in 1,364 case conferences of children on the child protection register in Scotland.

⁴⁶ [ScotPHO profiles \(shinyapps.io\)](https://shinyapps.io/scotpho/)

⁴⁷ [Scottish Schools Adolescent Lifestyle and Substance Use Survey \(SALSUS\) - gov.scot \(www.gov.scot\)](https://www.gov.scot/publications/scotpho-reports/pages/12.aspx)

⁴⁸ [Policy briefing: alcohol \(publichealthscotland.scot\)](https://publichealthscotland.scot/publications/policy-briefing-alcohol/)

Specifically, 27% of the cases involved alcohol and 24% involved both alcohol and drugs, as illustrated in Figure 16.⁴⁹

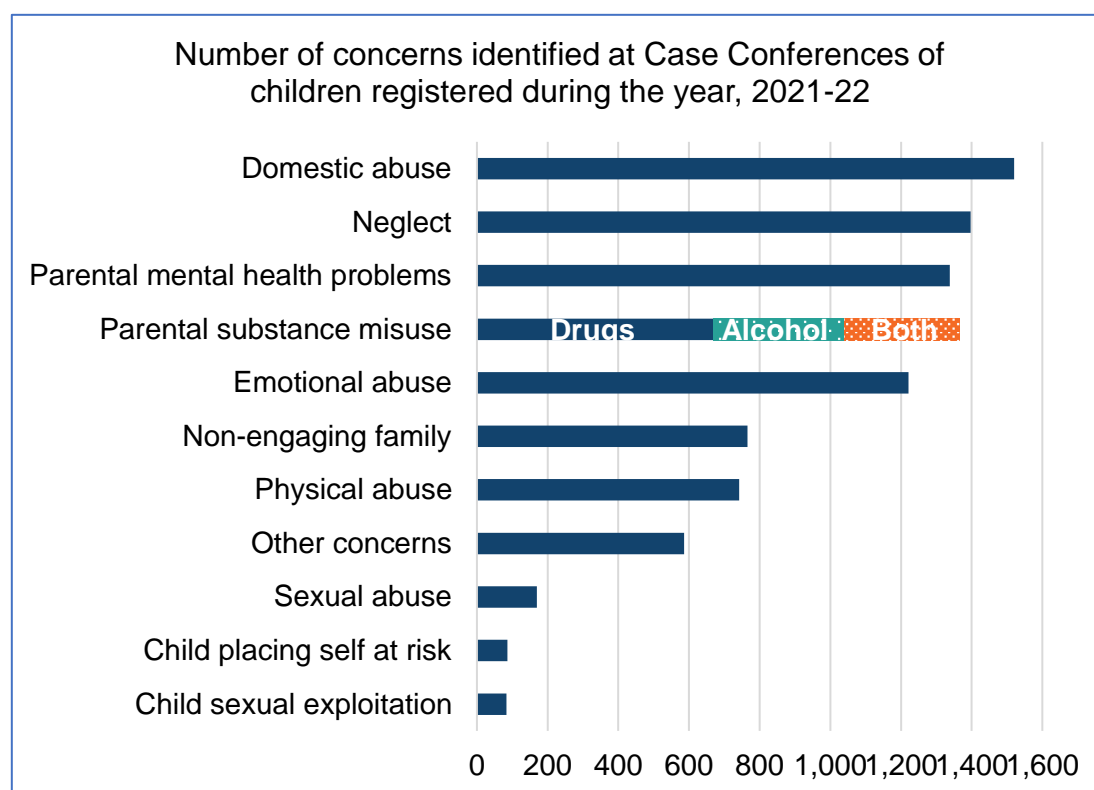


Figure 16: Number of concerns noted at case conferences of children registered on the Child Protection Register during 2021/22, Scotland

At a local authority level, the rate for West Lothian seems particularly high in comparison to the rest of Lothian and Scotland. Further work could commence to investigate the reasons and if there are any differences in the gender split compared to the rest of Lothian or Scotland. Further preventive work could perhaps be identified using a whole family wellbeing model.

	Child protection concern identified relating to parental alcohol use Crude rate per 10,000 population (July 2021 snapshot) ⁵⁰	
City of Edinburgh	0.91	Statistically significantly better than Scotland
West Lothian	7.83	Statistically significantly worse than Scotland
Midlothian	1.97	Not statistically significantly different to Scotland
East Lothian	1.8	Statistically significantly better than Scotland
Lothian	2.77	Statistically significantly better than Scotland
Scotland	4.89	

Table 12: Rates of child protection concerns regarding parental alcohol use per 10,000 population, by HSCP area, Lothian total, and Scotland, July 2021

⁴⁹ [Children's Social Work Statistics 2021-22 - Publication Tables.xlsx \(live.com\)](#)

⁵⁰ [ScotPHO profiles \(shinyapps.io\)](#)

The above data mostly provides a generalised picture of the social harm of alcohol related to alcohol for children and young people, rather than specific Lothian or local authority rates. Key data points that would be worth investigating further could be the rising rate of alcohol related hospitalisation for young people and the large proportion of child protection cases that involve parental substance use. This could include earlier identification of an adult with substance use with a child in the family, using a whole family wellbeing model.

This aligns with the recommendation from the Report of the Commission on Alcohol Harm, where 'all professionals who have regular contact with children and families must have a core competency to intervene and provide support in cases where alcohol harm is evident. Professionals who have contact with children and families, including teachers, must have the competency to enable them to make interventions around alcohol and to signpost family members to receive help.'⁵¹

⁵¹ [Its-Everywhere-Commission-on-Alcohol-Harm-final-report.pdf \(ahauk.org\)](#)

Alcohol Specific Deaths – National Profile

There were 1,276 alcohol specific deaths registered in Scotland in 2022, an increase of 2% (31 deaths) on 2021. The rate of mortality for alcohol specific deaths was 22.9 deaths per 100,000 people in 2022, similar to the rate of 22.3 per 100,000 people in 2021. This measure takes into account the size and age-structure of the population.⁵²

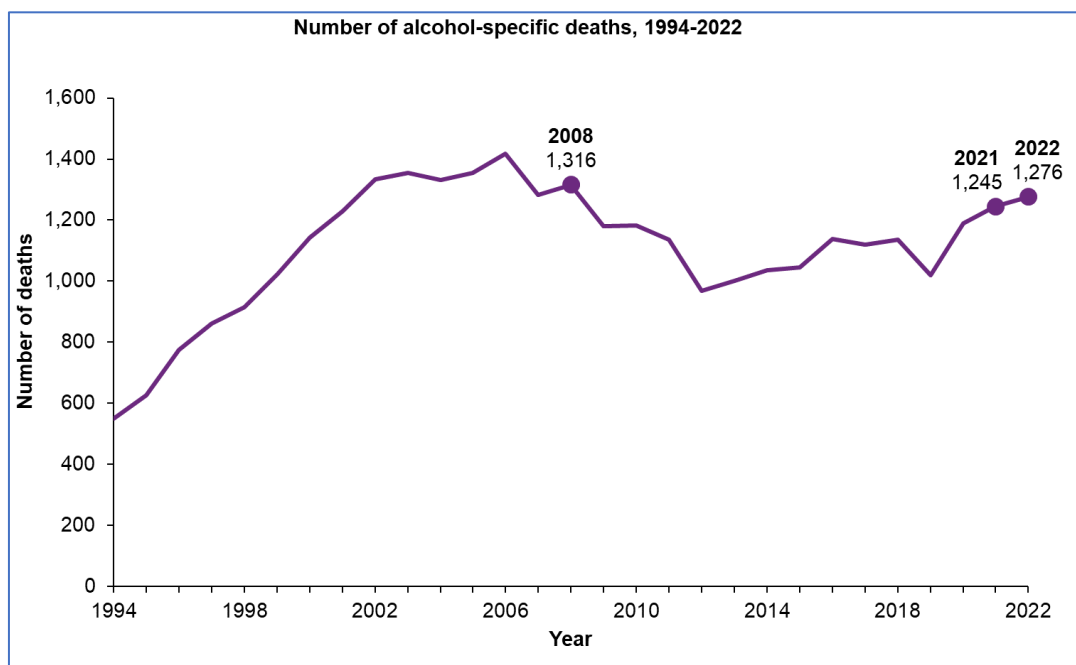


Figure 17: Number of alcohol related deaths per year, in Scotland, 1994-2022

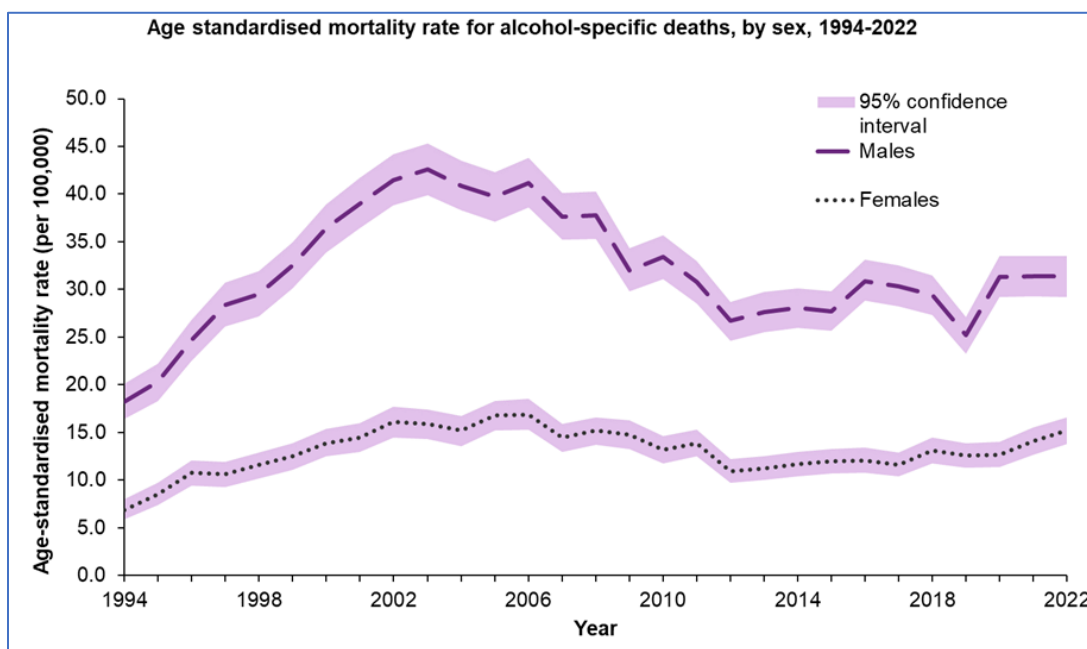


Figure 18: Age standardised mortality rates (per 100000) for alcohol-specific deaths, by sex, in Scotland, 1994-2022

⁵² <https://www.nrscotland.gov.uk/files//statistics/alcohol-deaths/2022/alcohol-specific-deaths-22-report.pdf>

Female deaths increased by 31 to 440 deaths in 2022, with the number of alcohol specific male deaths unchanged from 2021. Male deaths continue to account for around two thirds of alcohol specific deaths (Figure 18).

Alcohol specific deaths were 4.3 times as high in the most deprived areas of Scotland compared to the least deprived areas in 2022 (Figure 19). This compares to a ratio of 1.8 times for all causes of death. The gap between alcohol specific mortality rates in the most and least deprived areas has narrowed over time. However, alcohol specific deaths continue to be more common in more deprived areas.

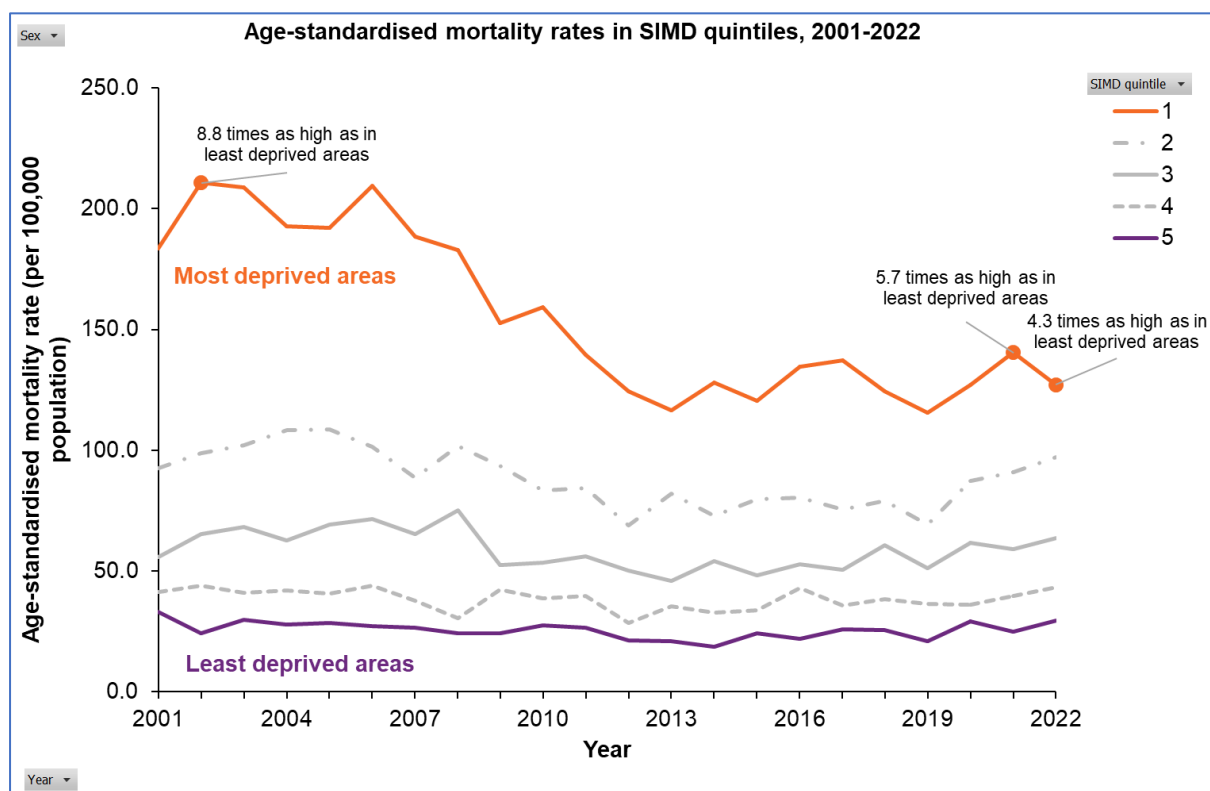


Figure 19: Age-standardised mortality rates (per 100000 population) by SIMD quintile, in Scotland, 2001-2022

Mortality rates for the age groups 45-64 and 65-74 are the highest. Since the conditions that contribute to alcohol specific deaths are predominantly chronic, this would be the expected age pattern. For the oldest age group (age 75+) the rate of alcohol specific mortality has generally increased since 2006, but the rate is still about half of the two highest age groups. For age 25-44, the rate of mortality has generally fallen since 2006. In 2022, the average age at death for females from an alcohol specific cause was 58.7 years and for males it was 60.0 years (Figure 20).

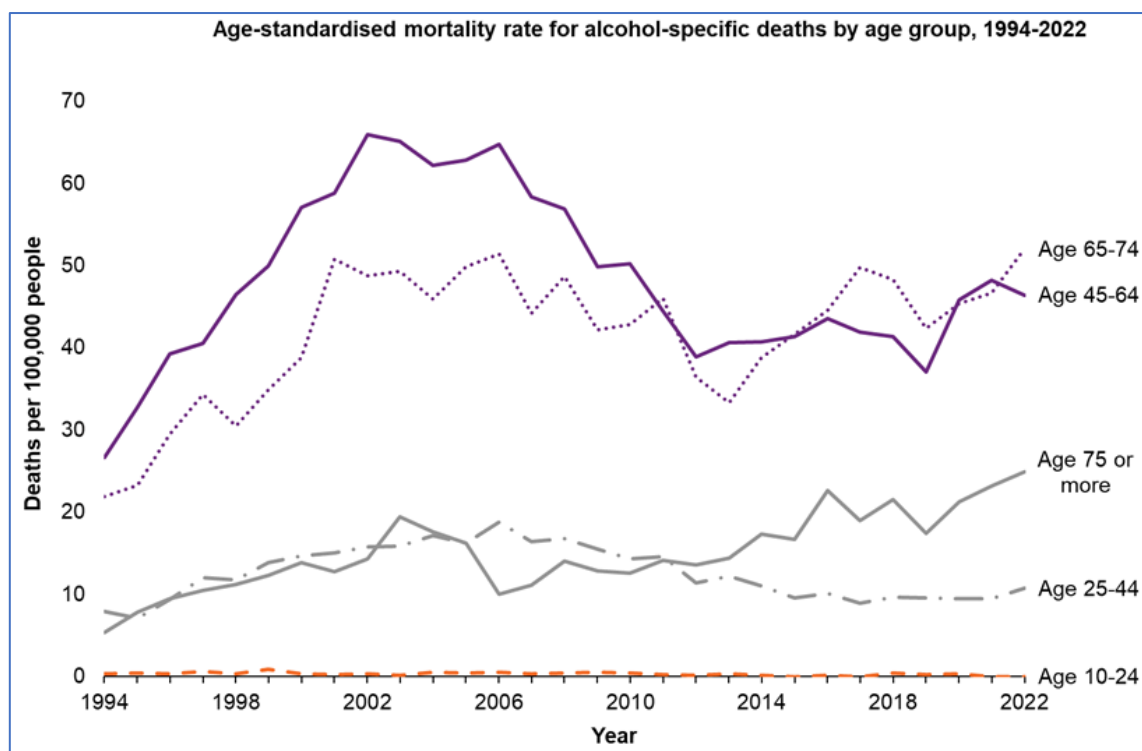


Figure 20: Age-standardised mortality rate (deaths per 100000 people) for alcohol specific deaths by age group, in Scotland, 1994-2022

In 2022, alcohol specific deaths were 1.6 times as likely to be in large urban areas compared to remote rural areas (Figure 21).

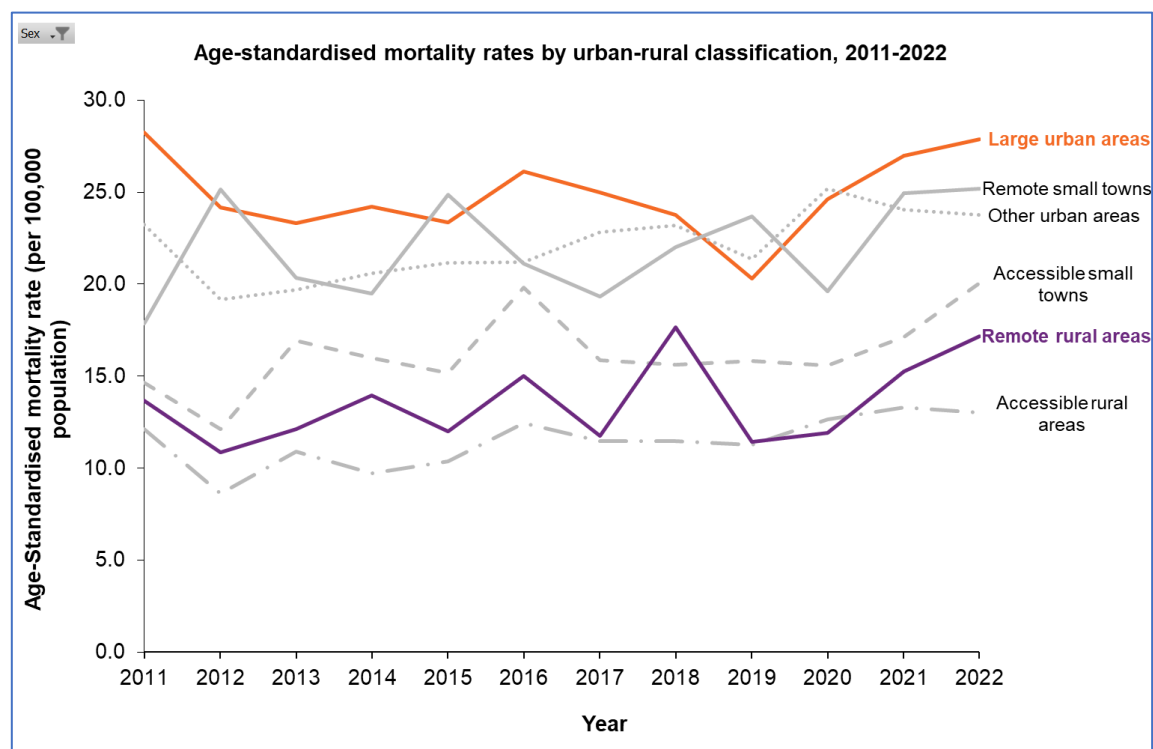


Figure 21: Age-standardised mortality rate (per 100000 population) by urban-rural classification, in Scotland, 2011-2022

Alcohol specific deaths in Scotland by primary underlying causes of death in 2022 are shown in Figure 22. Alcoholic liver disease (all categories) accounts for 61% of all deaths, with cirrhosis of the liver being the highest sub-category. Mental and behaviour disorders due to alcohol (all categories) accounts for 31% of all deaths.

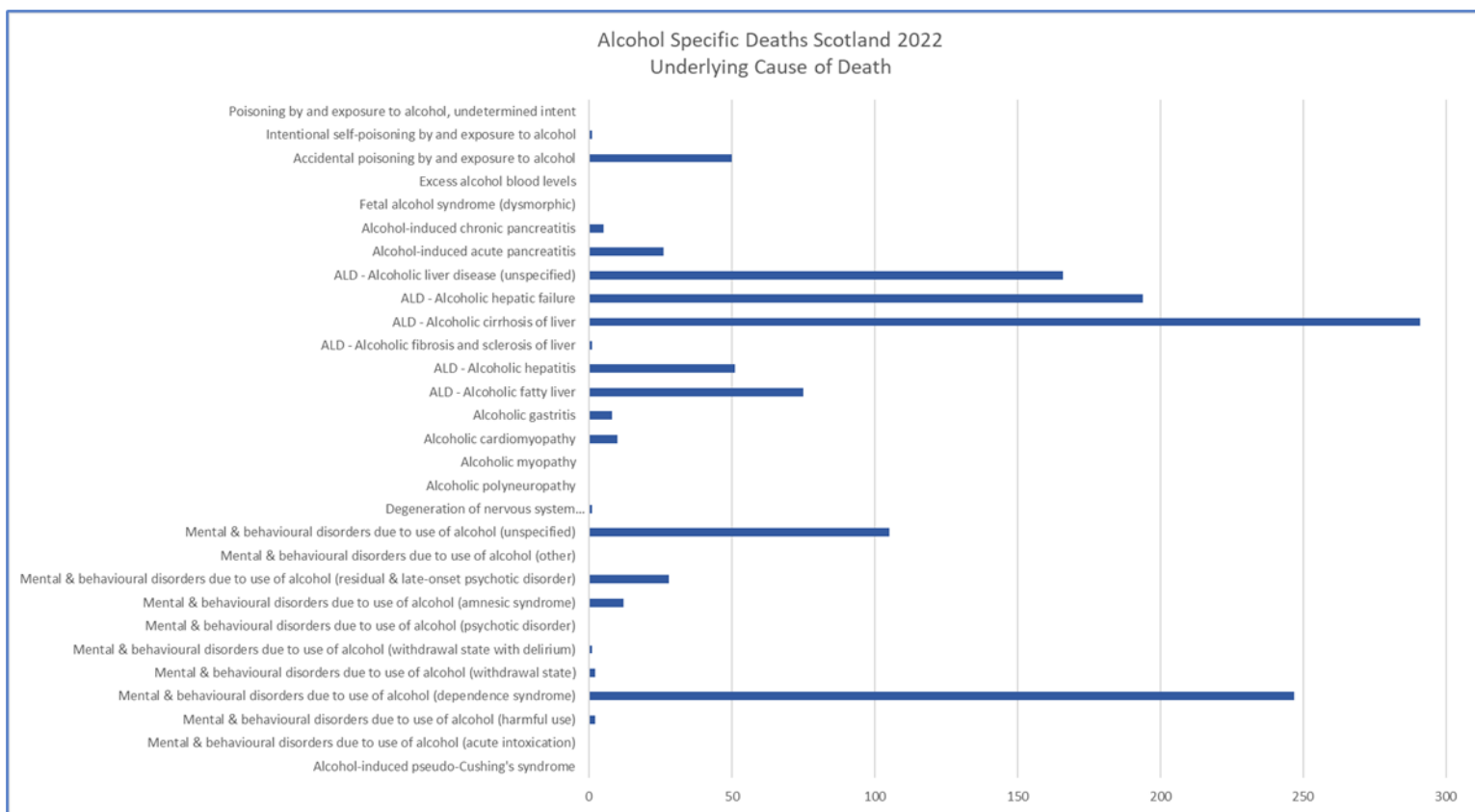


Figure 22: Number of alcohol specific deaths in Scotland, by underlying causes 2022

The above data relates to alcohol specific deaths only, which are deaths that are known to be direct consequences of alcohol use. These figures for alcohol specific deaths do not include all deaths which may be caused by alcohol - for example, they do not include deaths:⁵³

- as a result of road accidents, falls, fires, suicide or violence involving people who had been drinking; or
- from some medical conditions which are considered partly attributable to alcohol, such as certain forms of cancers, cardiovascular disease or stroke.

⁵³ [Alcohol-specific deaths, Methodology \(nrsotland.gov.uk\)](https://nrsotland.gov.uk)

Alcohol Specific Deaths – Lothian Profile

Five-year averages are used to provide a more robust picture of mortality at council and health board level. Annual data can fluctuate, and numbers are small, so it's important to focus on the longer-term trend rather than changes year to year. The age standardised mortality rate for Lothian (19.1 per 100,000) is slightly lower than the Scotland average (21.2 per 100,000), most likely due to the lower levels of deprivation in Lothian, compared to the overall Scotland average (Figure 23).

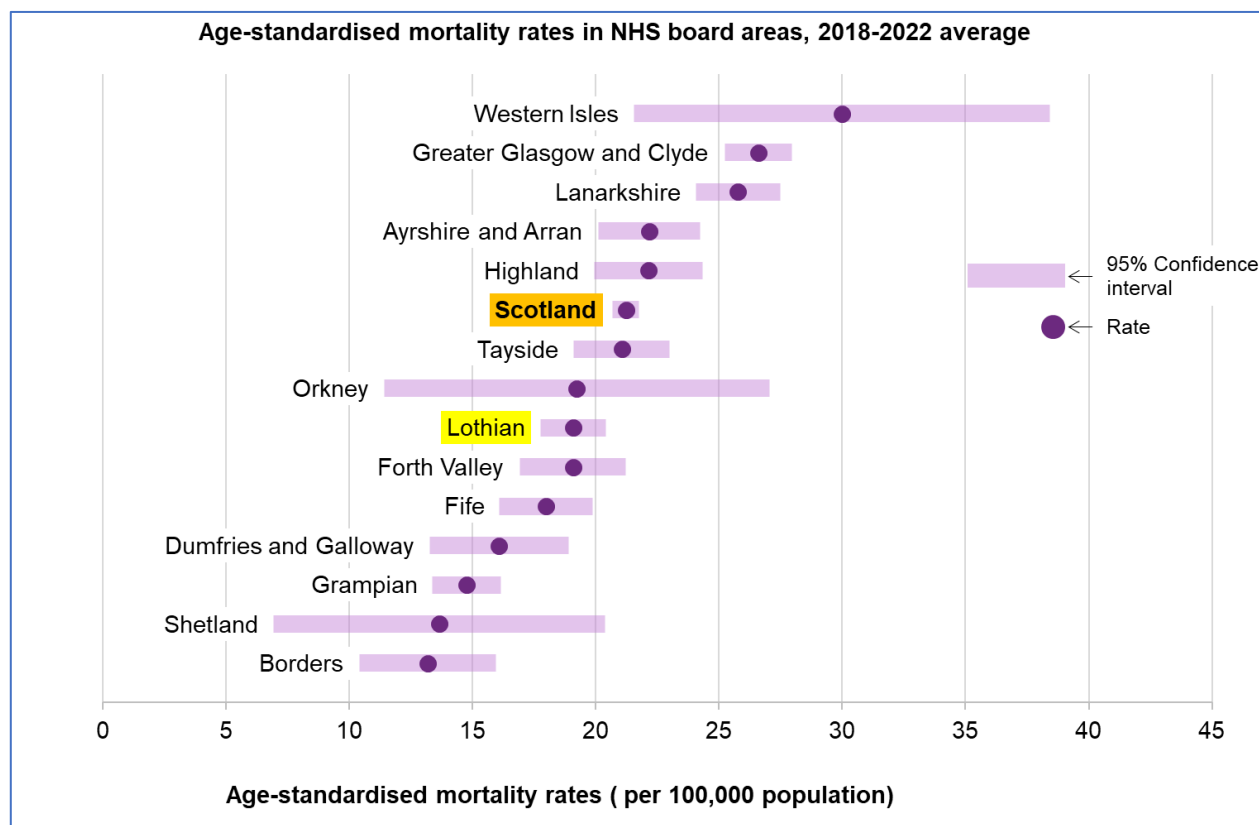


Figure 23: Age-standardised mortality rate (per 100,000 population) rates in NHS Board areas, 2018-2022 average

Alcohol specific deaths by deprivation groups is shown for Lothian in Figure 24.

Note – latest data on deprivation and age for Lothian and local council areas only runs until 2021 from SCOTPHO

The most deprived areas in Lothian have the highest deaths, similar to the national pattern of inequality, as illustrated below. Over time, the inequality gap has reduced. However, the most deprived areas have 82% higher death rates than Lothian as a whole. Deaths across NHS Lothian would be 52% lower if the levels of the least deprived areas were experienced across the whole population.⁵⁴

⁵⁴ https://scotland.shinyapps.io/ScotPHO_profiles_tool/_w_0a26df73/#tab-5254-5

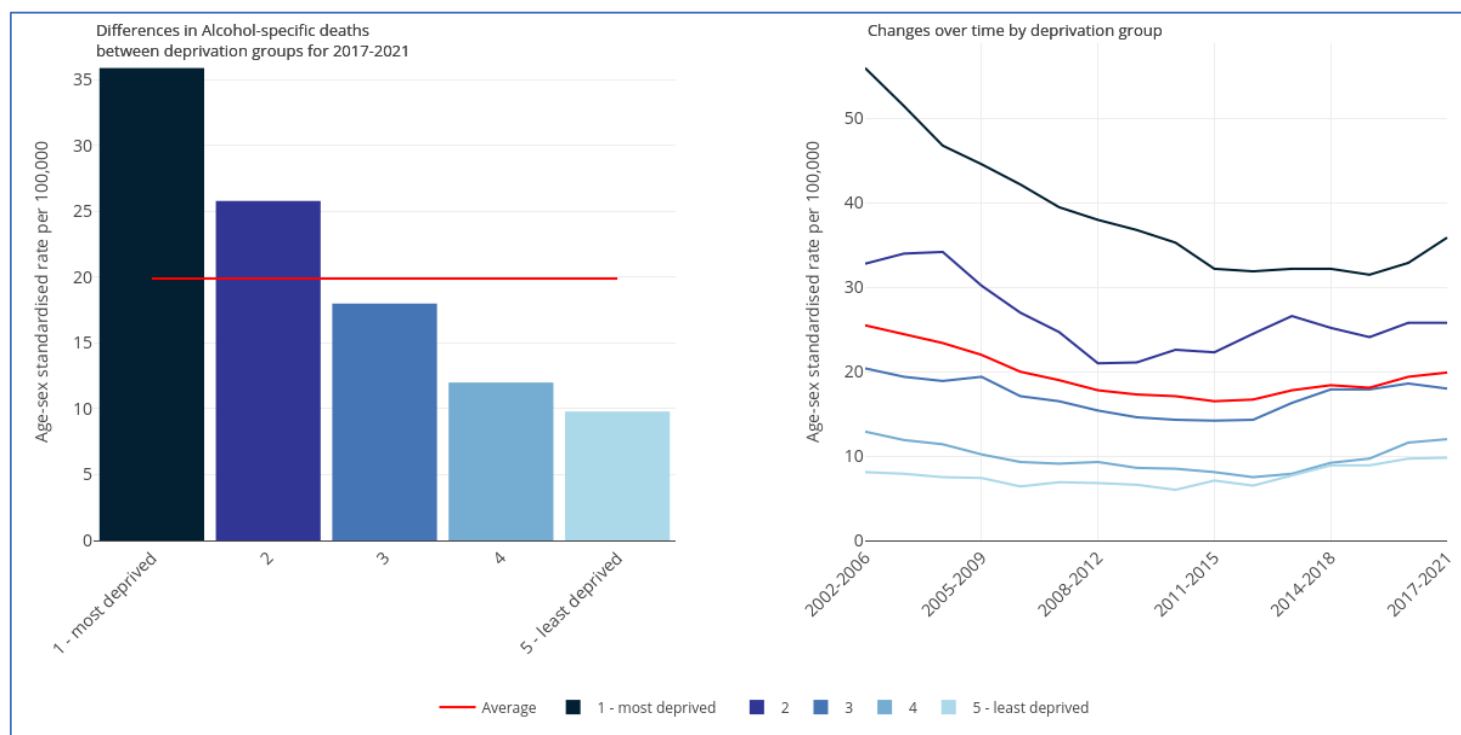


Figure 24: Differences in age-sex standardised alcohol specific deaths by deprivation quintile for 2017-2021 and changes in age-sex standardised mortality rate over time from 2002-06 to 2017-21 by deprivation quintile in Lothian

Alcohol Specific Deaths – Local Authority Profile

The chart below (figure 25) illustrates the age standardised mortality rates for the City of Edinburgh, East Lothian, Midlothian and West Lothian compared to other council areas and Scotland. All four local authority areas in Lothian have lower alcohol mortality rates than the Scotland average, but only the rate for East Lothian is statistically significantly different. The lower rates are likely to be due to the relatively lower levels of deprivation in Lothian compared to other areas of Scotland.

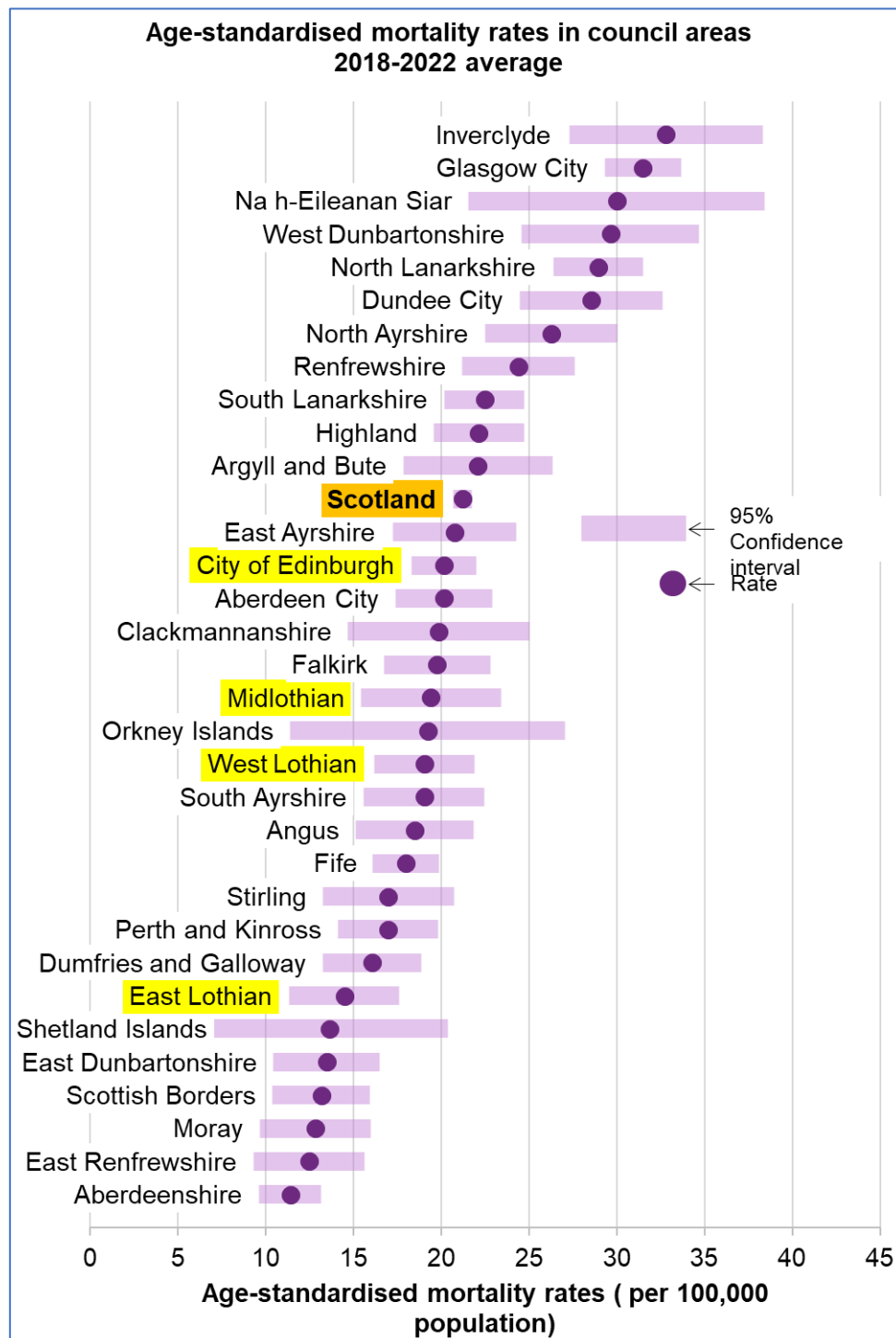


Figure 25: Average (2018-2022) age-standardised mortality rates in Scottish council areas

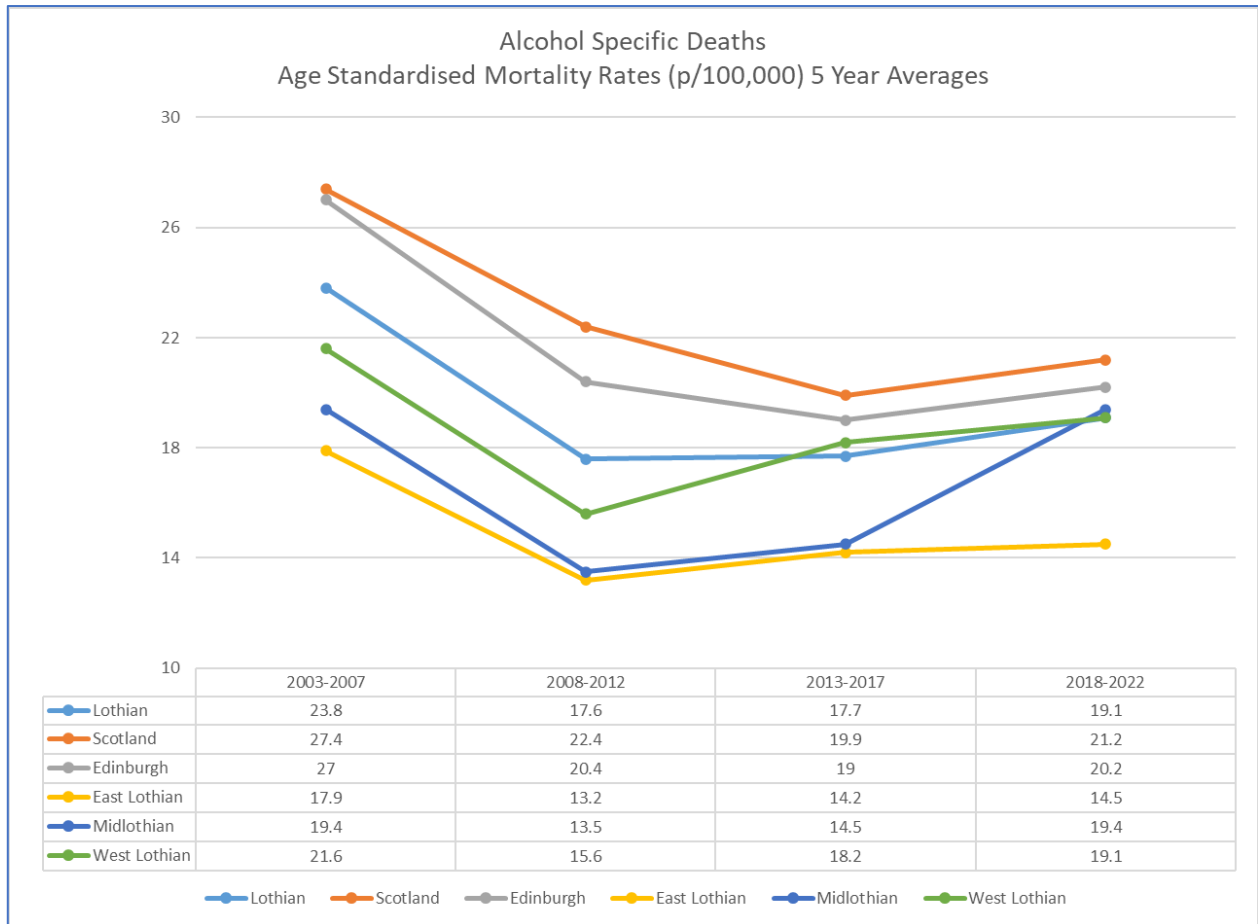


Figure 26: 5-year rolling average alcohol-specific, age-standardised mortality rates for NHS Lothian HSCP areas and Scotland.

The mortality rates can be viewed over time in 5 year rolling averages (figure 26), showing initially a large drop, followed by a small increase over the past 5 years. This shows a similar trend to the Scottish rates over time.

Alcohol specific deaths by deprivation groups is shown in Figure 26 for the local council areas.⁵⁵

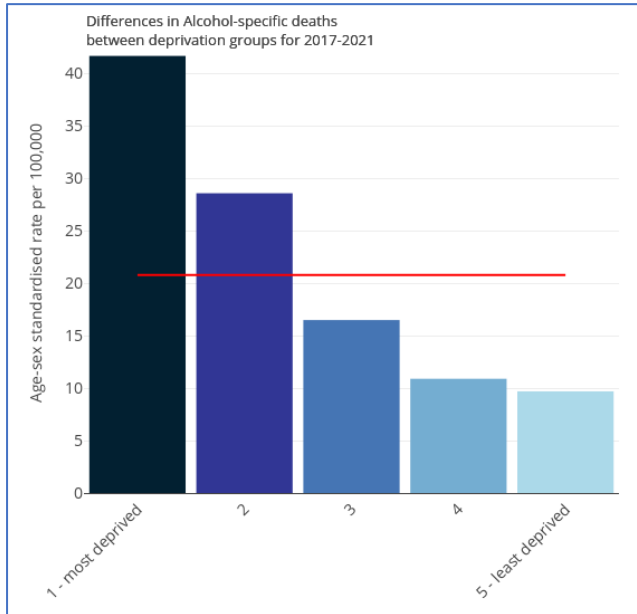
Note – latest data on deprivation and age for Lothian and local council areas only runs until 2021 from SCOTPHO.

Data specific to local council areas indicate that:

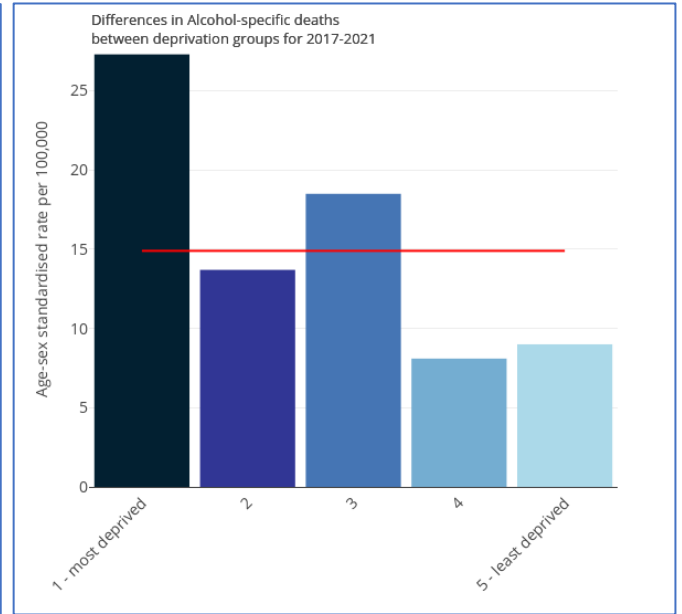
- City of Edinburgh – the most deprived areas have a 98% higher death rate than the City of Edinburgh as a whole. Deaths across the city would be 55% lower if the levels of the least deprived areas were experienced across the whole population.
- East Lothian – the most deprived areas have a 71% higher death rate than the East Lothian as a whole. Deaths across the city would be 41% lower if the levels of the least deprived areas were experienced across the whole population.
- Midlothian – the most deprived areas have a 34% higher death rate than Midlothian as a whole. Deaths across the city would be 32% lower if the levels of the least deprived areas were experienced across the whole population.

⁵⁵ https://scotland.shinyapps.io/ScotPHO_profiles_tool/_w_0a26df73/#tab-5254-5

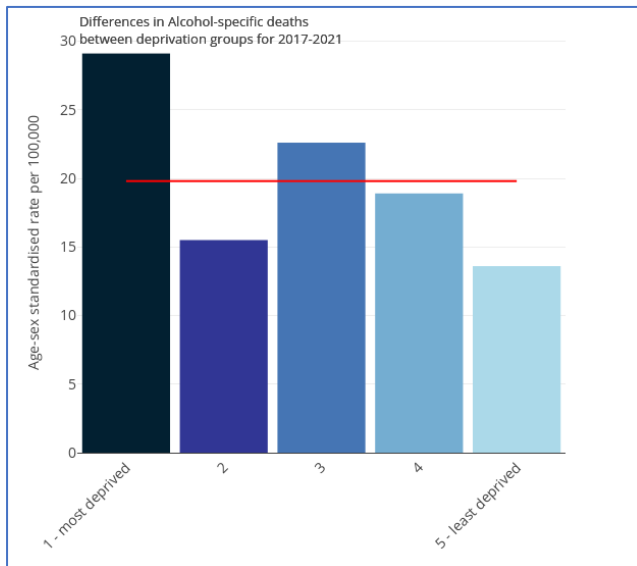
- West Lothian – the most deprived areas have a 75% higher death rate than West Lothian as a whole. Deaths across the city would be 60% lower if the levels of the least deprived areas were experienced across the whole population.



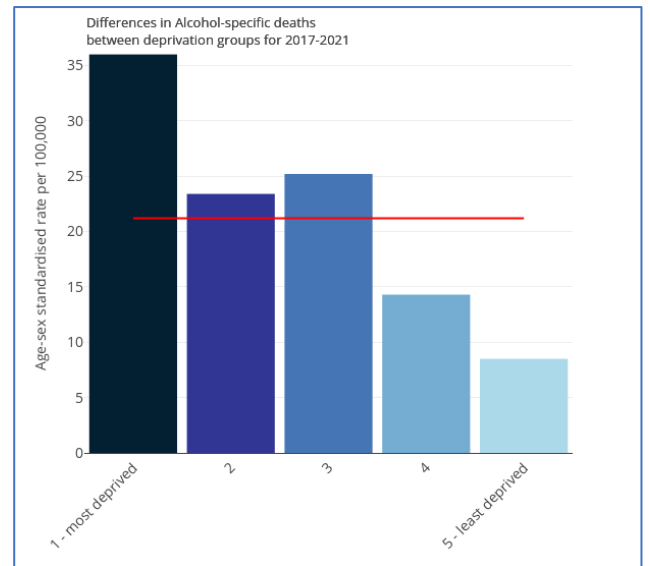
City of Edinburgh



East Lothian



Midlothian



West Lothian

Figure 27: Differences in age-sex standardised alcohol specific death rates for 2017-2021 by HSCP area and deprivation quintile

Alcohol specific deaths by gender are shown in figure 28 and 29 for the local council areas in Lothian and in comparison to Lothian and Scotland. Alcohol specific deaths in males are higher than in females for all the local authority areas in Lothian. The decrease in alcohol specific deaths between

2002 and 2012, followed by a slight increase between 2012 and 2020 is mirrored in both sexes across most of the local authorities.

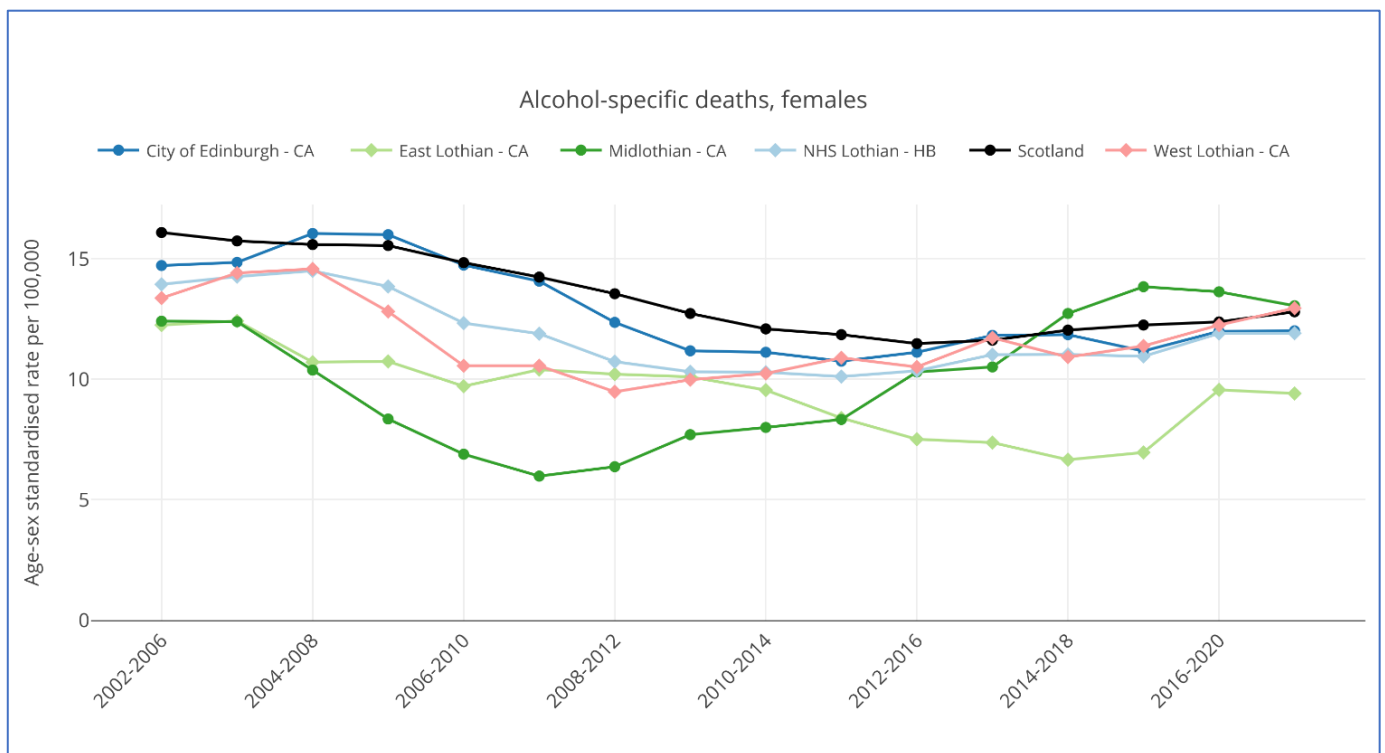


Figure 28: Alcohol-specific deaths in females (age-standardised), 5 year rolling average, per HSCP area, health board and Scotland, from 2002-2020

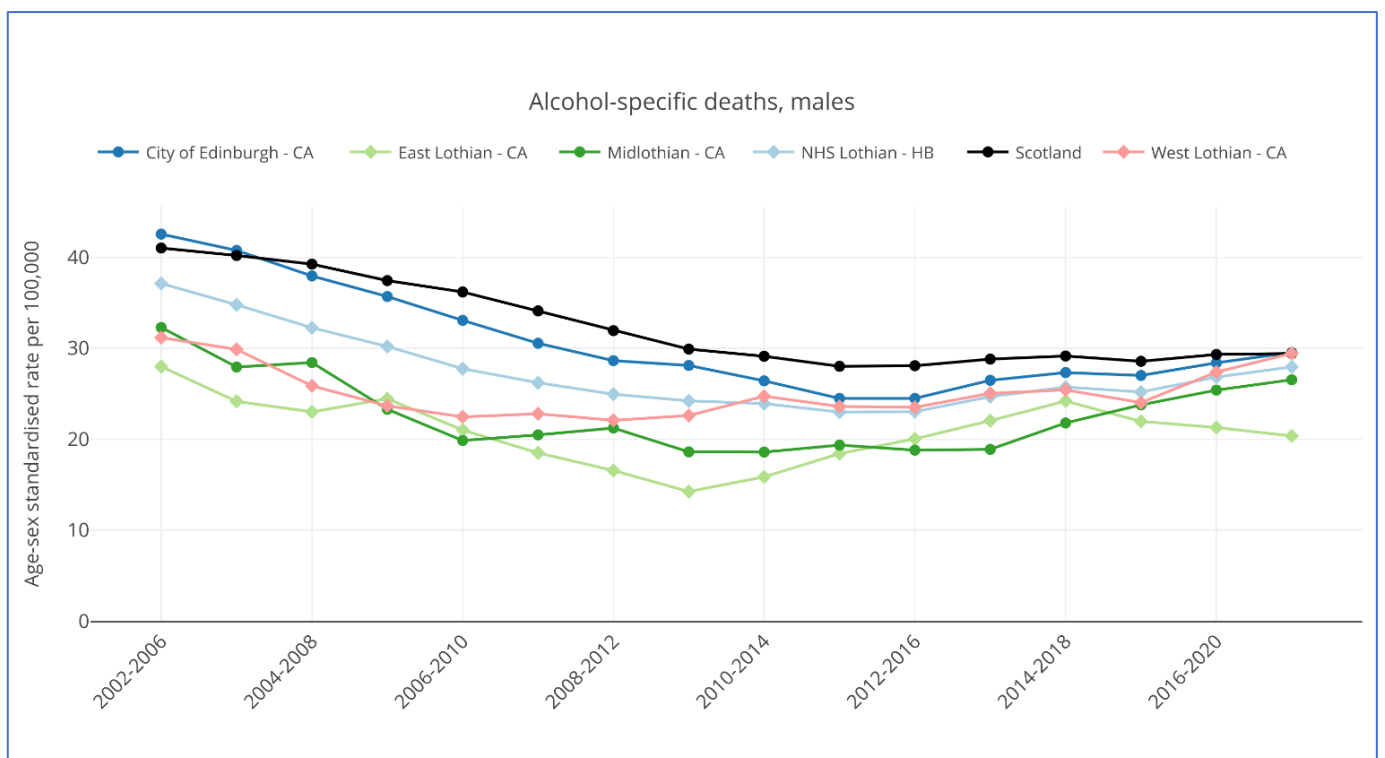


Figure 29: Alcohol-specific deaths in males (age-standardised), 5 year rolling average, per HSCP area, health board, and Scotland, from 2002-2020

Fetal Alcohol Spectrum Disorder

Fetal Alcohol Spectrum Disorder (FASD) is an overarching term describing a range of effects that can occur following prenatal alcohol exposure (PAE) of the fetus. These effects can include neurocognitive and behavioural disabilities together with structural abnormalities. The impact of this on affected children may result in a number of wellbeing needs including physical, growth and neurobehavioral problems, affecting everyday life, limiting independence, and resulting in permanent lifelong developmental disabilities.⁵⁶

Recent national guidelines for children and young people exposed prenatally to alcohol, published by SIGN in 2019, estimated the prevalence of FASD in the UK to be 32.4 per 1,000.⁵⁷ Data for Lothian and Scotland is lacking. SIGN notes that in Scotland many fewer children than predicted by international studies are identified, which suggests that there is a failure to identify and support these children.

FASD recorded in NHS Lothian Primary Care for 2012- 2022 shows 75 cases from a total of 98,850 live births.⁵⁸ FASD is not a notifiable condition that GPs are required to report on and currently GPs are encouraged to record however as it is not mandatory, this may be a contributory factor to low incidence reporting. Underreporting may contribute to lack of services as the needs are not fully understood.

Clinical experience and published evidence suggest reasons for low incidence reporting includes:

- Failure to consider PAE.
- Lack of standardised diagnostic approach and training in its use.
- Lack of expertise/confidence or reluctance in making diagnosis.
- Polysubstance abuse in mothers which overshadows FASD.

Appropriate identification and referral of affected children into services, supports the affected child and family and prevents secondary disabilities. This also allows for opportunity to identify risks for future pregnancies for that birth mother and may serve as a motivator to abstain from alcohol. As FASD is a lifelong condition continuing beyond childhood, adults with FASD (undiagnosed or not) may display symptoms which could continue a cycle of FASD due to impaired brain function that results in lack of impulse control, inability to learn from consequences, and continuing to drink alcohol through pregnancy. Therefore, it is important to consider beyond childhood in the detection of FASD and support and strategies on offer.

Promoting abstinence from alcohol during pregnancy, as recommended by UK Chief Medical Officers,⁵⁹ is the key primary prevention strategy for development of FASD. In Scotland, alcohol consumption in women of childbearing age is common and is recognised as a significant public health issue.⁶⁰ While surveys show a pattern of decline in self-reported alcohol consumption in Scotland, most women still drink some alcohol. This proportion has decreased from 87% in 2003 to 82% in 2017 with the abstinence rate among women aged 16–34 years being 18%, falling to 13% in 35–44 year olds. Women in the least deprived areas are most likely to drink and those in most

⁵⁶ [Fetal Alcohol Spectrum Disorder \(FASD\) Diagnostic Pathway - To improve the identification and diagnosis of affected children \(scot.nhs.uk\)](https://www.sign.ac.uk/media/1092/sign156.pdf)

⁵⁷ [sign156.pdf](https://www.sign.ac.uk/media/1092/sign156.pdf)

⁵⁸ [Births Time Series Data | National Records of Scotland \(nrscotland.gov.uk\)](https://www.nrscotland.gov.uk/births-time-series-data)

⁵⁹ [Lower-risk drinking guidelines: factsheet - gov.scot \(www.gov.scot\)](https://www.gov.scot/resources/consultation-papers/plain-language/lower-risk-drinking-guidelines-factsheet)

⁶⁰ <https://www.sign.ac.uk/media/1092/sign156.pdf>

deprived areas are least likely to drink at all, but those living in deprivation who do drink are more likely to drink heavily.⁶¹

Studies looking at alcohol consumption in pregnancy have shown the UK to have comparatively high rates in comparison to other countries, placing the UK 4th highest of all countries considered in 2017 (41% drinking during pregnancy).^{62, 63} Limitations around self-reporting and inconsistent data on drinking patterns were noted. A UK cohort study suggested a higher proportion (79% drinking in the first trimester, declining thereafter).⁶⁴

Policy in Scotland has been to adopt whole population approaches to reduce general consumption, recognising that consumption in women reflects overall consumption patterns.⁶⁵

A health needs assessment on fetal alcohol spectrum disorder completed in England in 2021 highlighted the need to further focus on:⁶⁶

- a lack of robust prevalence estimates in England
- the importance of multi-sector working to support individuals through the life course
- better training and awareness for health professionals
- better organisation of services to improve accessibility
- a need to develop innovative approaches to support those living with the condition

Much of these needs are reflected in the SIGN guidance, which highlights the following as areas of focus that could be explored locally to gauge practice and identify areas for improvement.

- Identification of risk factors for development FASD – clear recording of alcohol consumption in woman in planning pregnancy, antenatal or post-partum period. Focus should be on ensuring this is done in a non-stigmatising way with clear messaging on abstinence.
- Identification of children affected by PAE and assessment for FASD. Current reporting would suggest a low referral rate; however, more robust data is required to understand this.
- Implementation and access to a neurodevelopmental pathway that allows referral from multi-sector professionals beyond solely healthcare i.e., social work, education.
- Consequences of FASD can mean that affected people are more likely to be seen in the justice system or have educational needs. Therefore, a wider access or entry point for referral neurodevelopmental services beyond reliance on GP, could allow for improved detection and importantly support for affected people. This would be combined with raising the profile and understanding of FASD across all sectors.

⁶¹ Bardsley D, Dean L, Dougall I, Feng, Qingyang, Gray L, Karikoski M, et al. The Scottish Health Survey. Edinburgh: National Statistics. The Scottish Government; 2017. (Volume 1). Available from <https://www.gov.scot/publications/scottish-health-survey-2017-volume-1-mainreport/>

⁶² O’Keeffe LM, Kearney PM, McCarthy FP, et al. Prevalence and predictors of alcohol use during pregnancy: findings from international multicentre cohort studies. *BMJ open*. 2015;5(7)

⁶³ Popova S, Lange S, Probst C, et al. Estimation of national, regional, and global prevalence of alcohol use during pregnancy and fetal alcohol syndrome: a systematic review and meta-analysis. *The Lancet Global Health*. 2017;5(3)

⁶⁴ [Fetal alcohol spectrum disorder: health needs assessment - GOV.UK \(www.gov.uk\)](#)

⁶⁵ Changing Scotland’s Relationship with Alcohol: A Framework for Action. Edinburgh: The Scottish Government; 2009.

⁶⁶ [Fetal alcohol spectrum disorder: health needs assessment - GOV.UK \(www.gov.uk\)](#)

- Management and follow up – reduce risk of loss to follow up by ensuring information follows child as they move through life.

As well as promotion of messaging around both alcohol abstinence during pregnancy and risks of alcohol for those planning pregnancy, development of support for preventing pregnancy in at risk women should also be considered. This may include strengthening links with sexual and reproductive health services and those working in substance misuse or other relevant settings to ensure women have good access to contraception and contraceptive advice.

This would be consistent with the three broad categories of FASD prevention:⁶⁷

- Primary prevention – broad population efforts designed to raise awareness about the risks of alcohol-exposed pregnancies.
- Secondary prevention – targeted screening, counselling and interventions with women seen as being in, or at risk of, alcohol-exposed pregnancies.
- Tertiary prevention – highly targeted work with the aim of minimising the likelihood of another pregnancy resulting in FASD

⁶⁷ [Prevention6.pdf \(scot.nhs.uk\)](#)

Alcohol Related Liver Disease

Alcohol related Liver Disease (ARLD), also known as Alcoholic Liver Disease (ALD) comprises of a range of liver diseases that have resulted due to excess alcohol consumption. In response to excessive alcohol consumption, the liver can become fatty. This can progress to further damage with the occurrence of inflammation and with ongoing alcohol consumption further progresses to fibrosis and ultimately to cirrhosis which is the final and irreversible stage. This progression however is generally asymptomatic and diagnosis of ARLD is often made at a late stage commonly during a hospital admission.^{68 69} There is potential for reversal or cessation of damage to the liver, dependent on staging of damage and if patients are able to abstain from further alcohol consumption. As previously discussed, data for Scotland for alcohol specific deaths, shows alcoholic liver disease to be the most common, with cirrhosis the most frequent subcategory.

In Scotland in 2022/23, there were 6,492 alcohol related hospital admissions (stays) due to alcoholic liver disease (ALD). The majority of ALD stays were males (4,350) compared to females (2,142).⁷⁰

- In 2022/23, the European age-sex standardised rate of ALD related hospital stays to general acute hospitals was 119.2 per 100,000 population and which was 5% lower than the rate in 2021/22 (126.4 per 100,000).
- The highest proportion of stays was for 'ALD – Cirrhosis' (EASR rate of 68 per 100,000) followed by ALD – Unspecified (EASR rate of 32.4 per 100,000). An assumption has been made that diagnosis coding has improved over time as the unspecified category has decreased.
- The highest proportion of stays were for the 55-64 years age category (EASR rate of 265.9 per 100,000) followed by the over 65 years category (EASR rate of 203.7 per 100,000) and by the 45-54 years category (EASR rate of 190.8 per 100,000). As cirrhosis is a progressive liver disease that develops over many years, it is expected that higher admissions would be seen in older age groups.

For Lothian during 2022/23:

- The European age-sex standardised rate of ALD (main condition) stays in general acute hospitals was 90.9 per 100,000 population. This is lower than the Scotland rate and may be influenced by lower levels of deprivation in Lothian compared to other board areas in Scotland.

The trends for the above indicators are illustrated in Figure 30 below, showing European age-sex standardised rate until 2021/22. Although data is available for 2022/23, this is not available in the dashboard graphic form, as shown below.

⁶⁸ [Identification of liver disease: why and how \(bmj.com\)](#)

⁶⁹ [Alcohol-Related Liver Disease Is Rarely Detected at Early Stages Compared With Liver Diseases of Other Etiologies Worldwide - Clinical Gastroenterology and Hepatology \(cghjournal.org\)](#)

⁷⁰ [Dashboard - Alcohol related hospital statistics - Scotland financial year 2021 to 2022 - Alcohol related hospital statistics - Publications - Public Health Scotland](#)

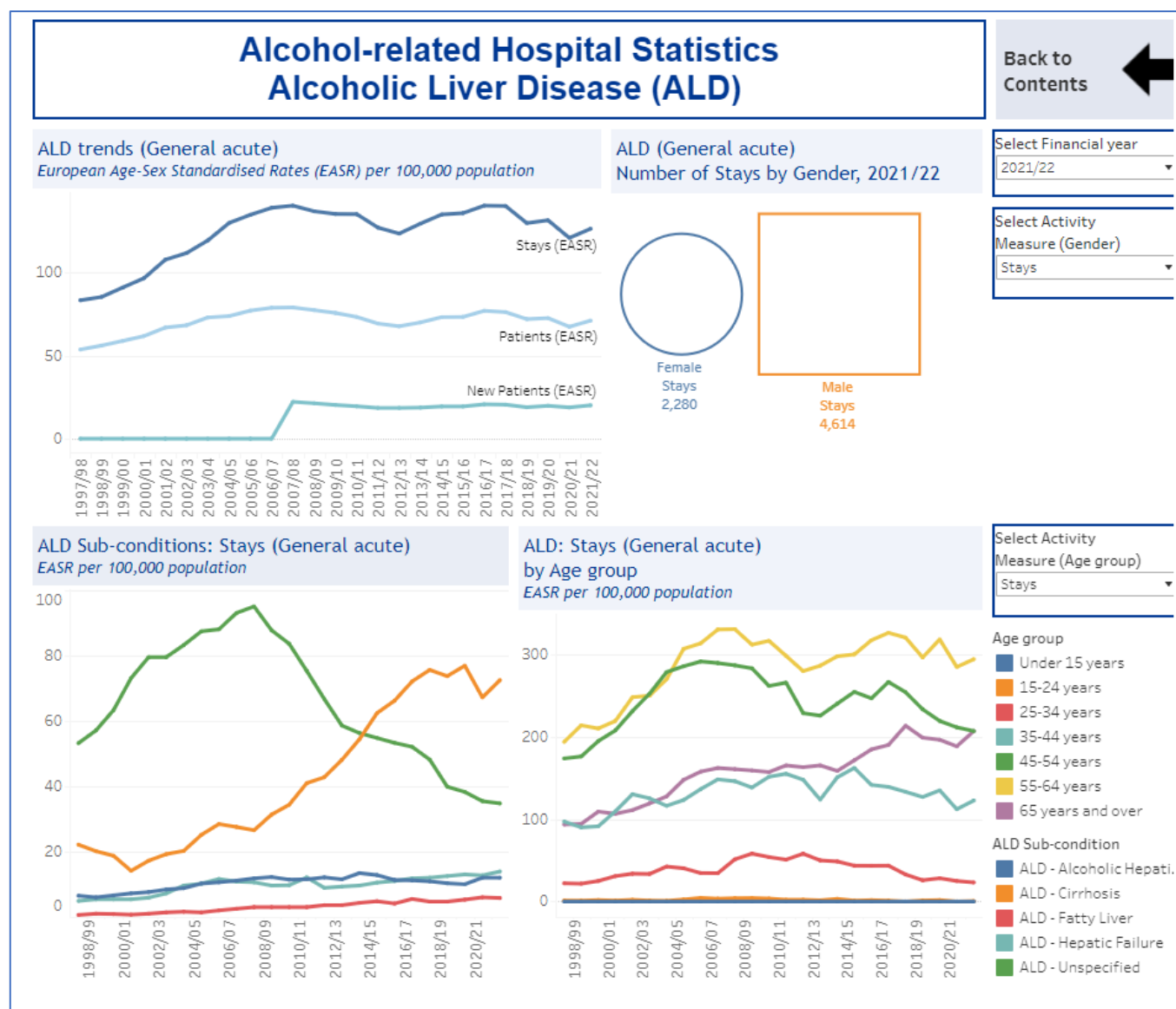


Figure 30 ALD Hospital Statistics

Earlier identification and diagnosis of ARLD can allow appropriate interventions to be put in place to monitor and where possible, prevent disease progression. Identifying the appropriate cohort of patients who require referral and management can be challenging as blood tests used in isolation to monitor liver function, liver function tests (LFTs), are non-specific and not all patients with abnormal results will need referral or input from hospital-based specialist liver services.

Other modalities such as Fibroscan® (a type of imaging to measure liver stiffness) in combination with blood tests and patient history can help to identify and triage those patients at risk and requiring input of specialist liver services. Fibroscan® is not available in the primary care setting (in the context of ARLD) and currently is available to secondary care based specialists only. It may be of benefit to explore innovative strategies to improve identification of patients at risk of ARLD in the community setting. Strategies to improve understanding of measurements of fibrosis within primary care to aid earlier referral may help to improve longer term outcomes.

A set of quality standards for the management of alcohol related liver disease was produced by the British Association for the Study of the Liver and British Society of Gastroenterology ARLD special interest group to support best practice.⁷¹ These highlighted areas of best practice could be used to benchmark current services and identify areas for development.

As the main strategy to reduce progression of ARLD is requirement for reduction or ideally abstinence from alcohol, there is a requirement to ensure patients are linked to services to support them to do this. This will include specialist addictions services but there is also a need to provide opportunity to identify other factors which may support patients in reduction of alcohol such as income maximisation or housing for example. Further exploration of linkages between these services would be beneficial to understand where they could be strengthened.

⁷¹ [Quality standards for the management of alcohol-related liver disease: consensus recommendations from the British Association for the Study of the Liver and British Society of Gastroenterology ARLD special interest group | BMJ Open Gastroenterology](#)

Alcohol Related Brain Damage

Alcohol Related Brain Damage (ARBD) describes a clinical syndrome due to structural and functional brain changes which occur as a result of chronic, heavy alcohol use.⁷² The resulting cognitive impairment affects people's memory, attention and ability to think, plan and carry out their intentions and consequently, it can be hard for people with ARBD to engage with the very services they need to in order to improve with their health and wellbeing. Both the brain changes and functional impairments are at least partially reversible if the person stops drinking alcohol but will progress if alcohol consumption continues. It is thought that ARBD is not always recognised and therefore underdiagnosed.

In Scotland, prevalence of ARBD is estimated at 1.5% of the general population and in 30% of dependant alcohol drinkers. National data has shown the mean age of patients referred into specialist ARBD services is 55 years and 75% of patients are male.⁷³ Data from PHS shows that in Lothian there has been an increasing number of people treated for ARBD, with most recent data from financial year 2020/21, showing 88 patients, accounting for 20% of the national total.⁷⁴

It is estimated that among people with alcohol dependence, up to one in three have ARBD.⁷⁵ A study with homeless individuals living in hostels in Glasgow, where hazardous drinking is highly prevalent, established that 21% had ARBD; most of whom were male and in their early 50s.⁷⁶

Service provision in NHS Lothian for people with ARBD is provided via an inpatient unit known as Penumbra Milestone. This is a comparatively unique service within Scotland and is a collaborative initiative delivered in partnership with NHS Lothian, City of Edinburgh Council and Penumbra (third sector agency). Penumbra Milestone is a 10 bedded residential unit which offers a 12-week rehabilitative programme provided by a multidisciplinary team allowing time for continued supported physical and mental recovery and abstinence, optimise nutritional intake including thiamine, as well as planning for discharge to community. Occasionally some patients will require longer admission, usually relating to issues with onward suitable care/accommodation.

The majority of admissions come direct from acute hospital wards within NHS Lothian once patients are medically stable and having completed detoxification and occasionally as a planned admission following inpatient detoxification admission at the Ritson unit. There are no direct admissions from community, as Penumbra Milestone does not have facilities to provide detoxification. Patients should be resident in NHS Lothian (or out of board area by prior arrangement). Following completion of the residential programme, patients are linked to aftercare including occupational therapy and third sector agencies of CARDS (Community Alcohol Related Damage Support, provided by RowanAlba) and Penumbra. Patients may also be linked into ongoing recovery services via Drug and Alcohol services.

Data for Lothian, collated from the ARBD Unit from January 2017 to June 2023 shows that:

- Annual admission is on average 32 patients.
- The majority of patients are male (69%)
- The average age at time of admission is 58 years.

⁷² [arbd_gpg.pdf \(mwcscot.org.uk\)](#)

⁷³ [arbd_gpg.pdf \(mwcscot.org.uk\)](#)

⁷⁴ Alcohol Related Brain Damage Unit – NHS Lothian. Annual Report on ARBD Unit Activity for 2020/21

⁷⁵ [Care and treatment for people with alcohol-related brain damage: a matter of human rights \(shaap.org.uk\)](#)

⁷⁶ [Prevalence of alcohol related brain damage among homeless hostel dwellers in Glasgow | European Journal of Public Health | Oxford Academic \(oup.com\)](#)

- The majority of patients are from the City of Edinburgh. Numbers from each local authority area in Lothian appears to be decreasing, with the exception of Midlothian, which is increasing. Further detail can be seen in figure 31.

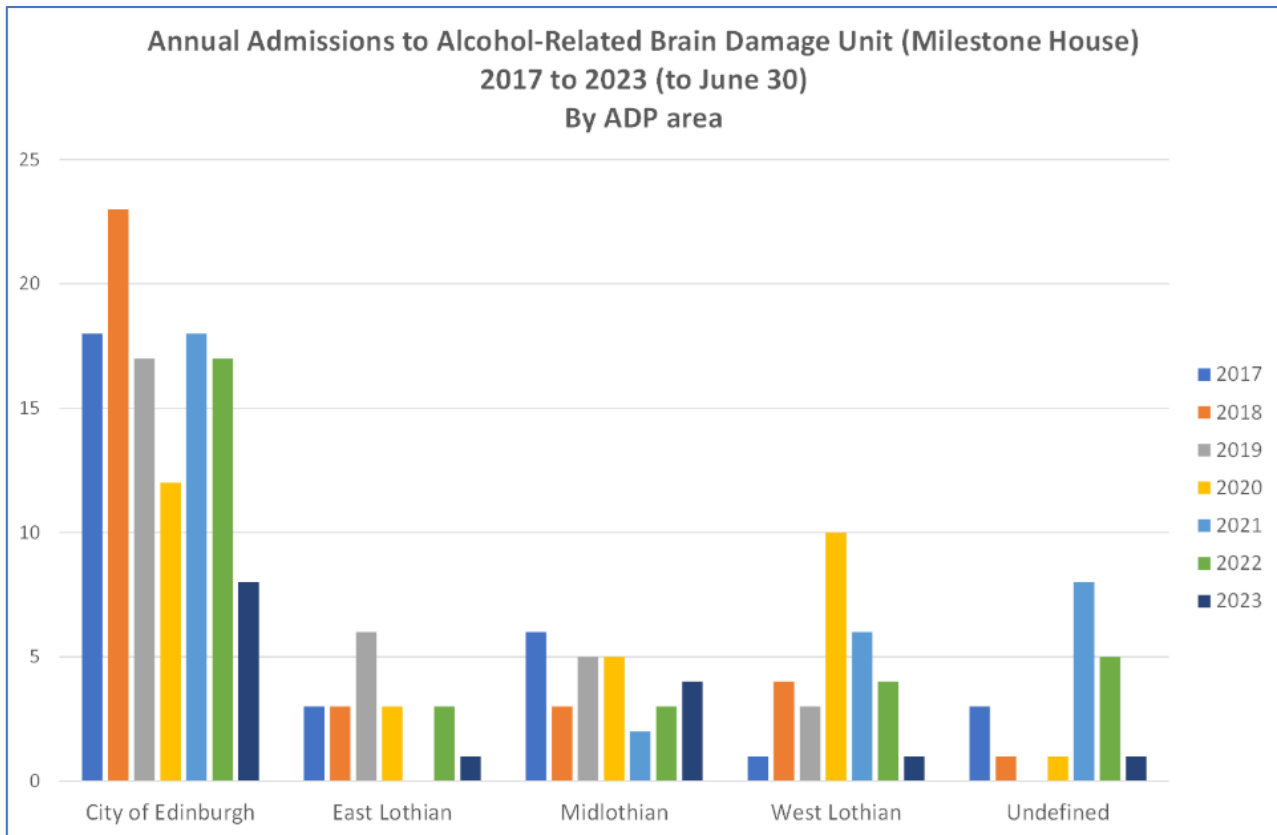


Figure 31 Annual Admissions to Milestone House

The admission numbers reflect the capacity of Penumbra Milestone. There may be occasions when a patient is identified during an inpatient admission as being suitable for Penumbra Milestone, but there are no available beds at that time within the discharge window. It is acknowledged that due to the condition of ARBD, there is a likelihood of readmission into acute services in the future and it may be possible at that point to transfer to Penumbra Milestone, dependent on bed availability at that time.

Outcome data examined from March 2019 until March 2021, demonstrated the following:

- Reduction in A&E attendance by 35%.
- Reduction in inpatient bed use of 85%. Based on this data, it is anticipated that 899 bed days were (are) released by this service.
- Cognition scores (measured using ACE III), improved from average by 11%.

Improved cognition enables patients to be able to engage with services that can support ongoing recovery and other health needs.

In addition, funding was received by the ARBD service to design and implement a training resource which is aimed at health care professionals as well as third sector. The aim of this is to upskill and raise awareness of ARBD, particularly around improving understanding of issues such as non-engagement in patients with ARBD.

Alcohol Use Screening and Alcohol Brief Interventions

A number of tools are available to assess level of alcohol consumption. This process is often termed alcohol use screening, but these are not part of screening programmes as defined by UK National Screening Committee.

Alcohol screening assesses an individual's alcohol consumption and level of health risks from alcohol. Those with consumption levels that would indicate increased risks (hazardous and harmful drinking) can be provided with an alcohol brief intervention (ABI). An ABI is a short, structured conversation about alcohol consumption which seeks to motivate and support the individual to think about and/or plan a change in their drinking behaviour in order to reduce their consumption and/or their risk of harm.⁷⁷ People who are identified as having harmful level of alcohol consumption may also require referral to specialist addiction services, together with those identified as alcohol dependent (where ABI is not appropriate intervention).

There are a number of alcohol use screening tools that are validated and in use including FAST, AUDIT-C and CAGE. Within primary care in NHS Lothian the 'Rethink your Drink' self-assessment tool is the only one where risk scores are recorded centrally. From April 2021 to December 2023, an average of 38% of GP practices in NHS Lothian undertook screening using the Rethink Your Drink tool. The range of scores can be seen in table 13 below. A score of 5 or above indicates increased risk level of alcohol consumption and would provide an indication for an ABI to be delivered.

Number of patients (n= 4094*)	Risk category	
828 (20.2%)	Red (score 9+)	Higher risk levels; likely to cause serious alcohol related illness
925 (22.6%)	Amber (score 5-8)	Increasing risk levels; could cause serious health implications longer term
2218 (54.2%)	Green (score 0-4)	Low risk; less likely to develop alcohol related illness in future
123 (3%)	Score not recorded	

*Duplicate patients removed

Table 13 No. Patients and Scores for Rethink Your Drink Assessment

Delivery of ABIs has been monitored for a number of years as part of Scottish Government Local Delivery Plan and data has been published annually until 2019/2020. Nationally, the ABI programme is currently being reviewed. Outcomes of the national review will be considered within Lothian in terms of future planning.

The latest published data from PHS on delivered ABI is from 2019/2020 (figure 32) and shows that Lothian exceeded the target set within the local delivery plan by 22.3%. The majority of Lothian ABIs were conducted within primary care by GP or nurse (58.5%), followed by wider settings (31.2%), accident and emergency departments (7.8%) and antenatal (2.6%).⁷⁸ Data is not currently collected on the impact of ABI conversations.

⁷⁷ [1 \(nhslothian.scot\)](https://www.nhs.uk/lothian-scot/1)

⁷⁸ [Alcohol Brief Interventions Dashboard - Alcohol brief interventions - 2019/20 - Alcohol brief interventions - Publications - Public Health Scotland](#)

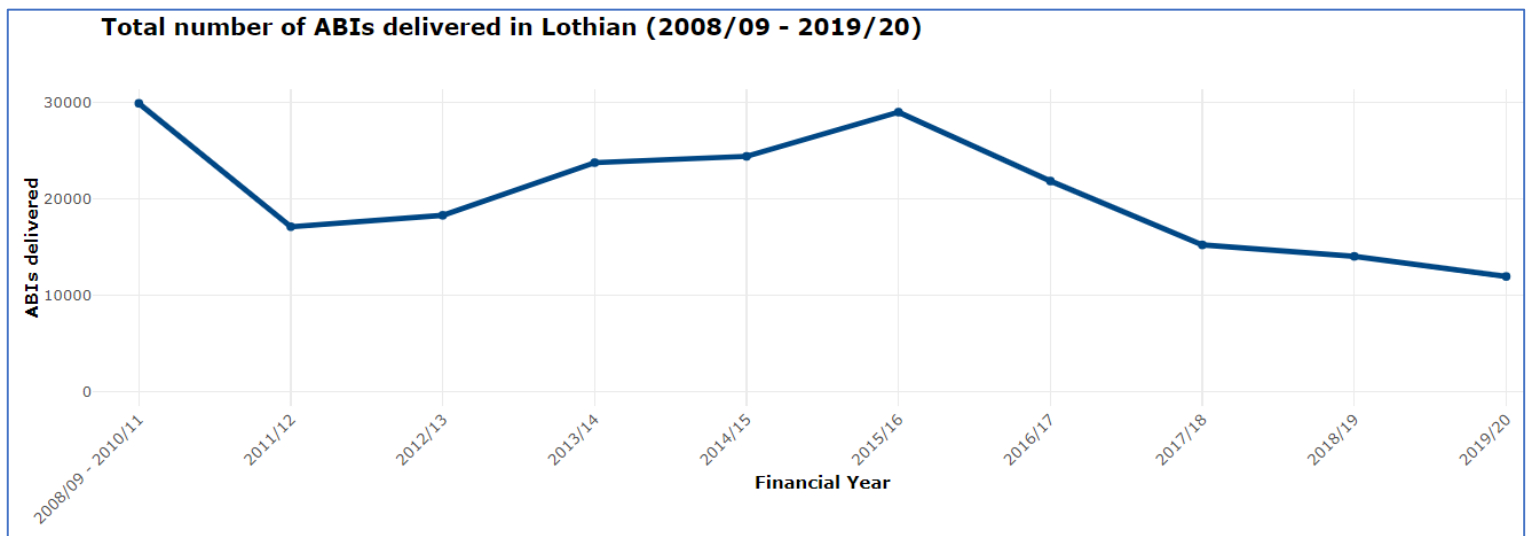


Figure 32 No. ABIs Delivered in Lothian

Locally, more recent data on GP delivery of ABI has been recorded relating to a locally enhanced service agreement and can be seen as follows in figure 33. It is noted that this may under record the number of ABI delivered by GP. The effect of the pandemic is also recognised in delivery and recording.

**Recorded Alcohol Brief Interventions ("9k1A") by Lothian GP practices
April 2019 to December 2023**

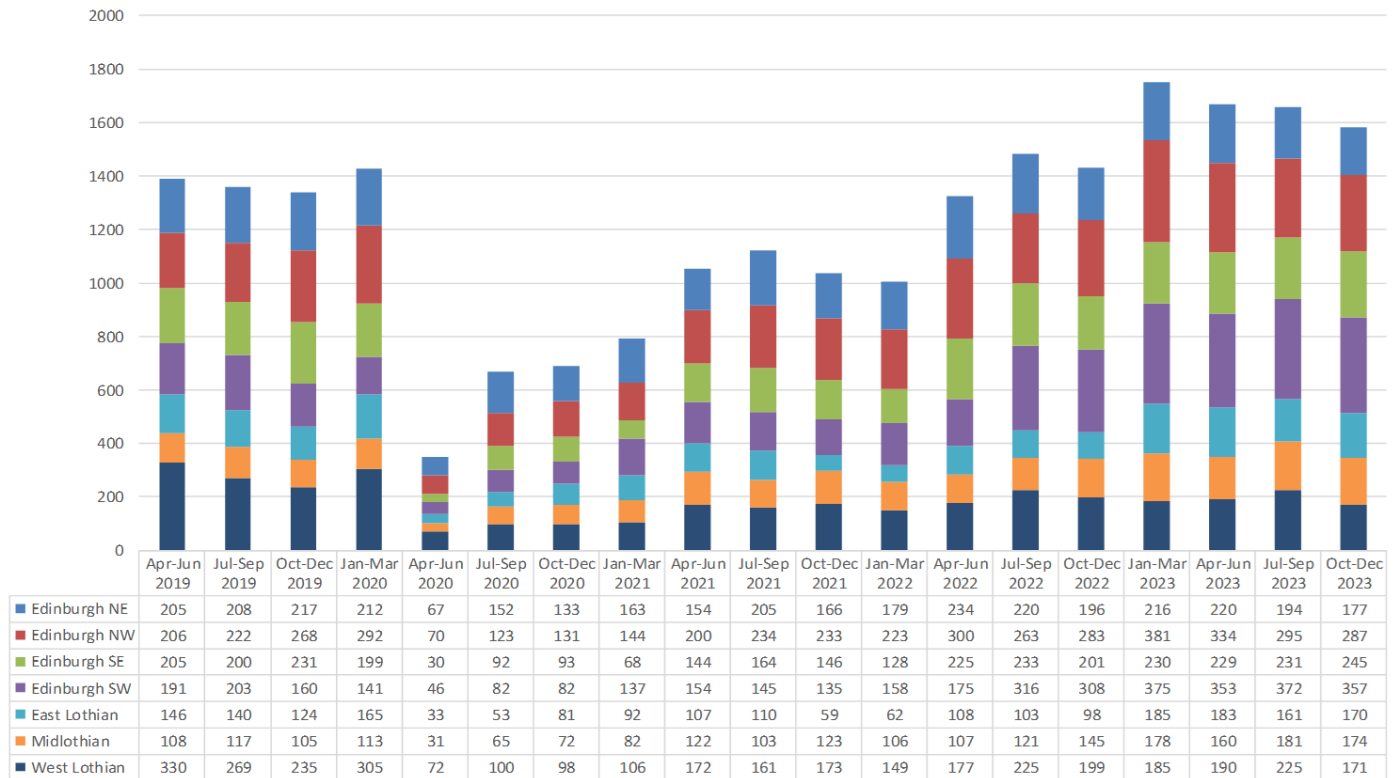


Figure 33 ABIs Delivered by Lothian GP Practices

At present there is no data available to demonstrate number of patients receiving ABI as direct result of screening score, nor if referred into services (or if alcohol consumption reduces) following identification of increased risk of alcohol intake after assessment with one of these tools.

Alcohol Support Services

Services to support people with problematic alcohol use are provided via a number of agencies, dependent on the needs of the individual. This can range from professional and social specialist services to third sector organisations/charities and lived experience support. These specialist treatment services are coordinated through Alcohol and Drug Partnerships (ADP), which provide services via co-located or integrated substance use teams. A summary chart of the key services is below (figure 34). In Lothian they are geographically arranged as follows:

- Edinburgh Alcohol and Drug Partnership (services referred to as recovery hubs)
- West Lothian Alcohol and Drug Partnership
- Midlothian and East Lothian Drug and Alcohol Partnership

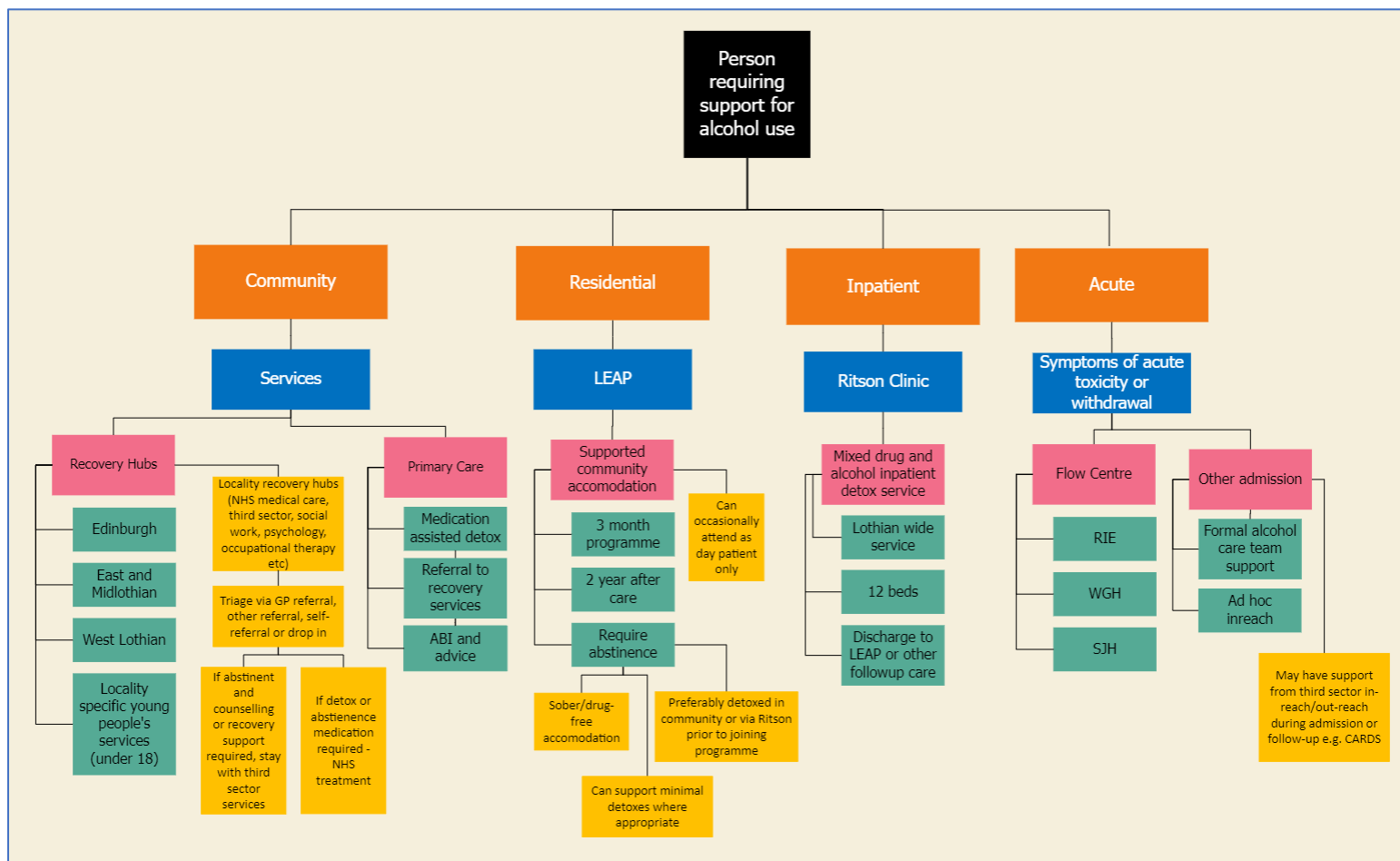


Figure 34 Key Lothian Alcohol Use Services

In order to access community based services, patients can self-refer, attend drop-in sessions, or can be referred by several services including health (i.e. GP, ED, other secondary or primary care), criminal justice, social work, third sector, employer or education to their local integrated service/recovery hub. Here, their needs will be assessed, usually by a third sector organisation, who will identify what support is required.

Those exhibiting symptoms of acute toxicity or withdrawal are not suitable for community support and will be referred to local hospital services. Those requiring a detoxification (detox) that is not deemed safe in the community, for example due to physical health issues or mental health concerns, can be referred to the Ritson Clinic at the Royal Edinburgh Hospital for an inpatient detox. People who require detox or medication to support abstinence in the community will be managed by NHS services within the integrated services/hubs.

Those requiring counselling and recovery support, who are already abstinent, can be managed within the third sector recovery services in the community. The Lothian and Edinburgh Abstinence Programme, or LEAP, is a community based residential rehabilitation programme for people in whom regular community recovery support has not been successful. Recovery hubs can also refer people to this service. The aim of most alcohol treatment services for people with alcohol dependence is abstinence.

Outside of integrated services/recovery hubs, other third sector organisations act independently to support people in recovery from alcohol. This includes counselling services, befriending services, peer support groups and other rehabilitation activities. These organisations and their support can be accessed instead of, or as well as, the services offered by the integrated services/recovery hubs. Service users are encouraged to engage in meaningful activities in the community to support their own recovery.

As part of the data request for this health needs assessment, GP read codes for alcohol were requested. This resulted in a list of approximately 200 read codes and therefore it was not possible to extract meaningful information about the number of patients with problematic alcohol use who are supported in primary care at this time.

Treatment services report activity data to PHS using the Drug and Alcohol Information System (DAISy) and prior to 2021, its predecessor the Drug and Alcohol Treatment Waiting Times database. It should be noted that implementation of a new system introduced changes which require to be considered when interpreting and making comparisons over time.

Analysis of data published by Alcohol Focus Scotland (AFS) in July 2023, reported that nationally, access to specialist alcohol treatment declined by 40% over the last 10 years. This decline predates any impact of the pandemic on service provision as prior to the COVID-19 pandemic, where they found a decline of 30% in the number of people accessing treatment. AFS also noted that alcohol deaths are at their highest level since 2008.⁷⁹

In the quarter ending September 2023 in NHS Lothian, there were 1635 community referrals for substance use, of which 785 were for alcohol and 214 for co-dependency (i.e. alcohol and drugs), as illustrated below in figure 35.⁸⁰

⁷⁹ [Newly published figures reveal 40% drop in alcohol treatment in Scotland over 10 years \(alcohol-focus-scotland.org.uk\)](https://www.alcohol-focus-scotland.org.uk)

⁸⁰ [Dashboard - National drug and alcohol treatment waiting times - 1 April 2023 to 30 June 2023 - National drug and alcohol treatment waiting times - Publications - Public Health Scotland](#)

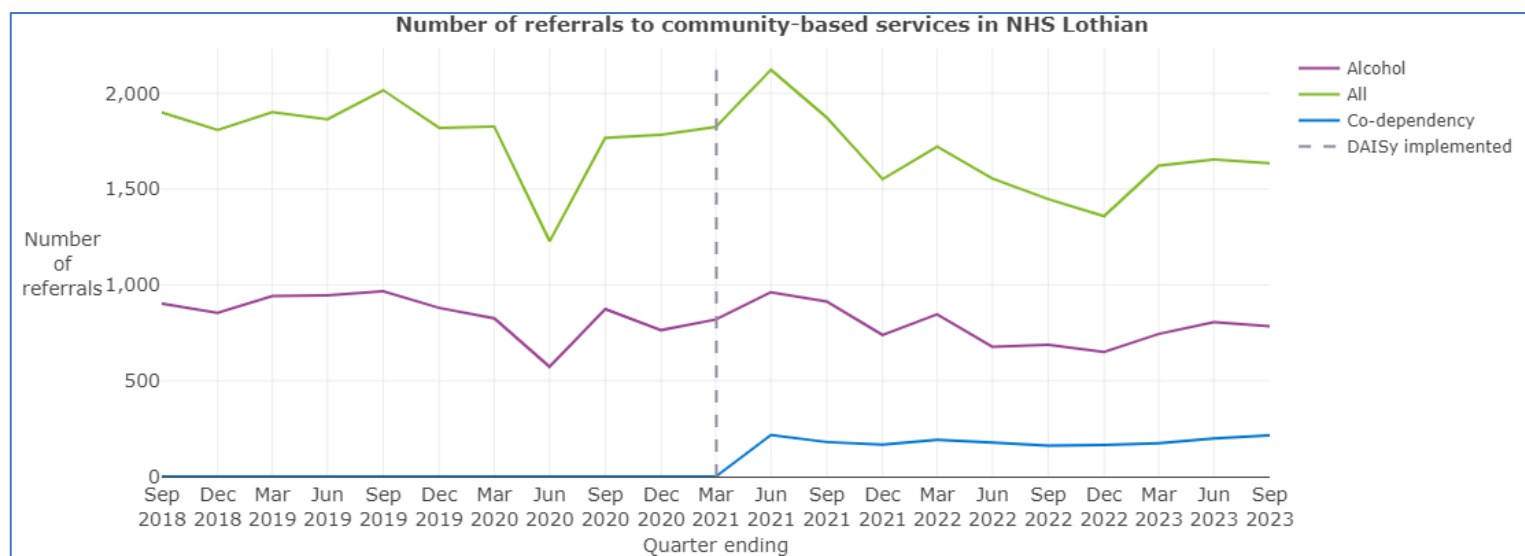


Figure 35 Referrals to Community Based Services

Scottish Government has set a standard that 90% of people referred for problematic alcohol or drug use should wait no longer than three weeks for specialist treatment. PHS data for Lothian can be seen in figure 36 below.

The waiting time for 'all substance' referrals in Lothian for September 2023 was 83.2%, slightly lower than the target of 90%. Referrals for co-dependency was 86.5%, slightly lower than the national target of 90%. Alcohol specific referrals were 79%, again below the 90% target.⁸¹ Lothian has not met the standard (for all services) as reported for each quarter from April 2021 (when reporting with DAISy system commenced) to September 2023.

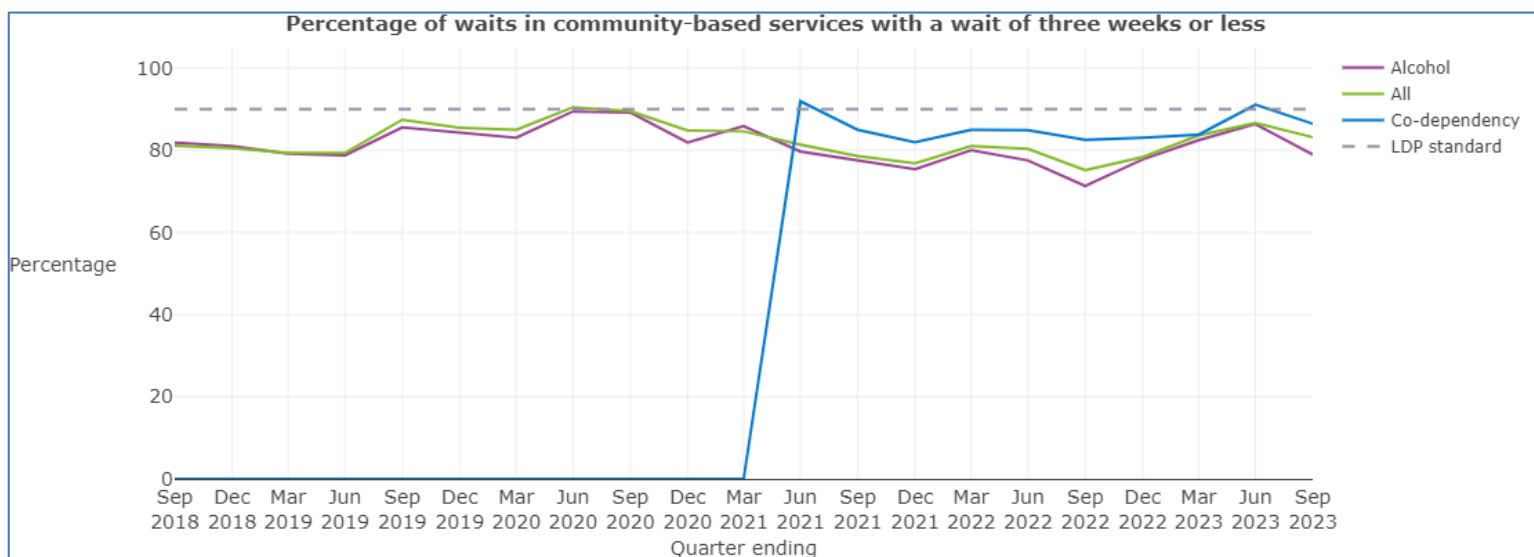


Figure 36 Community Based Referrals With 3 Weeks Wait or Less

⁸¹ [Dashboard - National drug and alcohol treatment waiting times - 1 April 2023 to 30 June 2023 - National drug and alcohol treatment waiting times - Publications - Public Health Scotland](#)

In autumn of 2023, PHS published a new interactive dashboard that provides data on treatment types, setting and discharge, in addition to referral and waiting time data. PHS have noted intention to work closely with ADPs and other stakeholders to ensure data capture and outputs are user friendly. At this early stage, not all data for NHS Lothian services is included but as this becomes embedded this has potential to be a valuable resource.⁸²

It is noted that these community-based services require patient to engage with services that can be external to an individual's usual/familiar routine which could result in increased likelihood of disengagement. A model from Glasgow, Primary Care Alcohol Nurse Outreach Team (PCANOS) demonstrated successful engagement and targeted communities at high risk of alcohol harms. These were based in deep end GP practices, which experience high levels of deprivation. Specialist addiction nurses worked with GP practices to identify and engage with patients with alcohol problems who had not previously engaged with specialist services. This model took care to the patient, rather than expecting the patient to attend an additional service, potentially in unfamiliar location. This collaborative piece of work was found to provide a person-centred care to improve engagement in this cohort.⁸³

Alcohol detoxification (detox)

Alcohol detoxification is one element of a treatment plan and can be undertaken in a community setting provided the patient's clinical condition allows. Data for community alcohol detox provided by specialist addictions service from January 2017 to June 2023 (half year) shows that:

- On average 140 patients per year received at least one detoxification, as shown in figure 37.
- The majority of patients received one detoxification (80%) followed by 2 detoxifications (16%), as shown in figure 38.

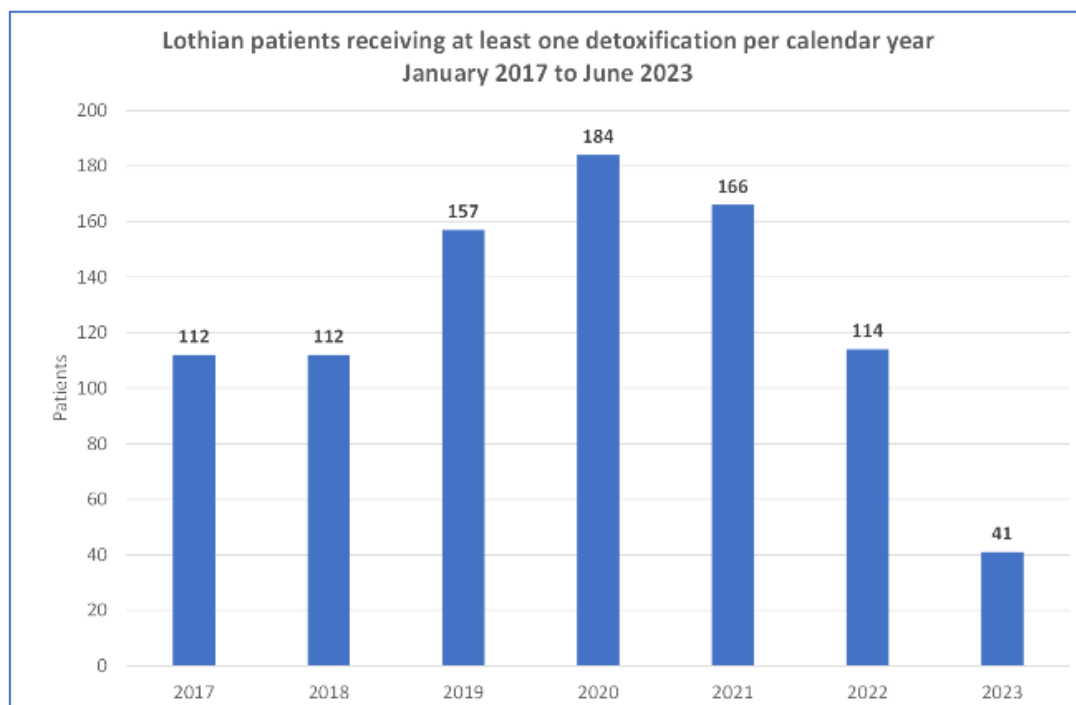


Figure 37 No. Patients Receiving At least One Detox Per Year

⁸² [Dashboard - National drug and alcohol treatment waiting times - 1 July 2023 to 30 September 2023 - National drug and alcohol treatment waiting times - Publications - Public Health Scotland](#)

⁸³ [405.html \(shaap.org.uk\)](#)

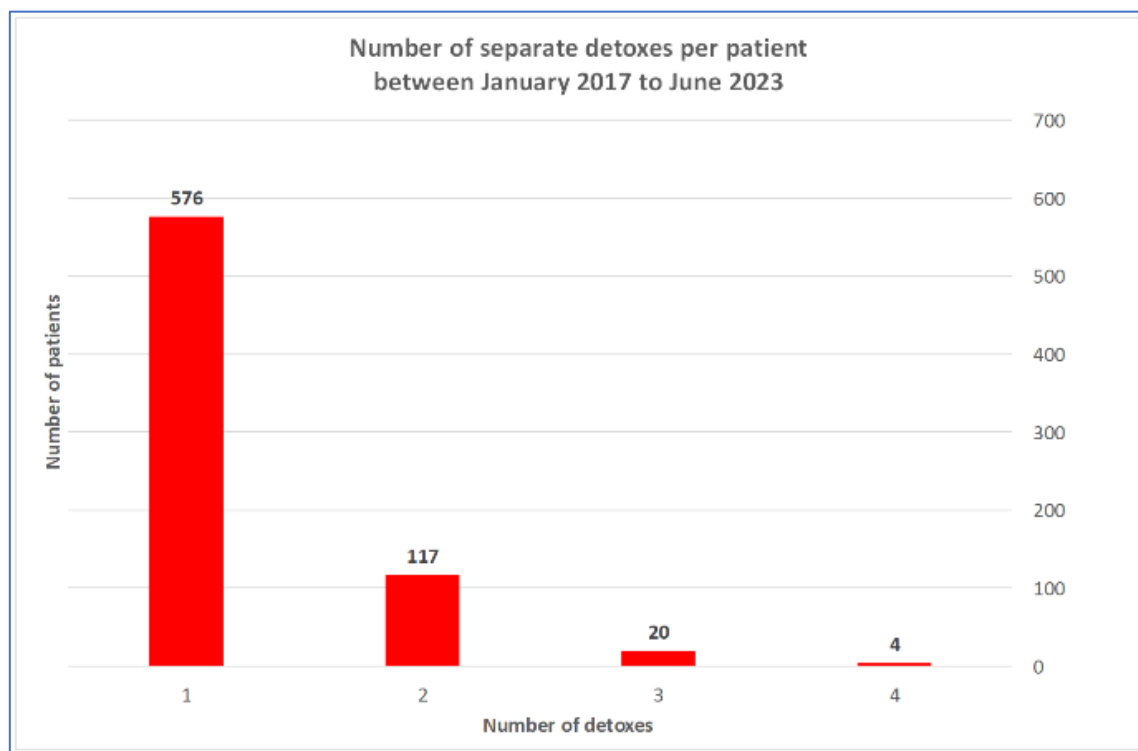


Figure 38 No. Detoxes Per Patient

Detoxification can also be undertaken by GPs, but current practice would encourage patients to be directed to specialist addictions service for this.

The Ritson Clinic is the NHS Lothian inpatient detoxification ward based in the Royal Edinburgh Hospital. The ward is for people for whom it is clinically unsafe to undertake detoxification in a community setting, including for physical or mental health reasons. The service is overseen by consultant psychiatrists and patients can be referred from a number of sources including GPs, although more commonly by specialist addictions services.

Data from the Ritson Clinic for alcohol detoxification collated between January 2017 to June 2023 illustrates that:

- An average of 67 detox starts occurred per quarter (over the past year). The COVID-19 pandemic led to an initial repurposing, then reconfiguration of inpatient beds which has influenced capacity.
- The majority of patients are from the City of Edinburgh (66%), followed by West Lothian (15%), Midlothian (10%) and East Lothian (7%), as shown in figure 39.
- The average length of detox stay is 12 days.
- The majority of patients are male (67.7%).

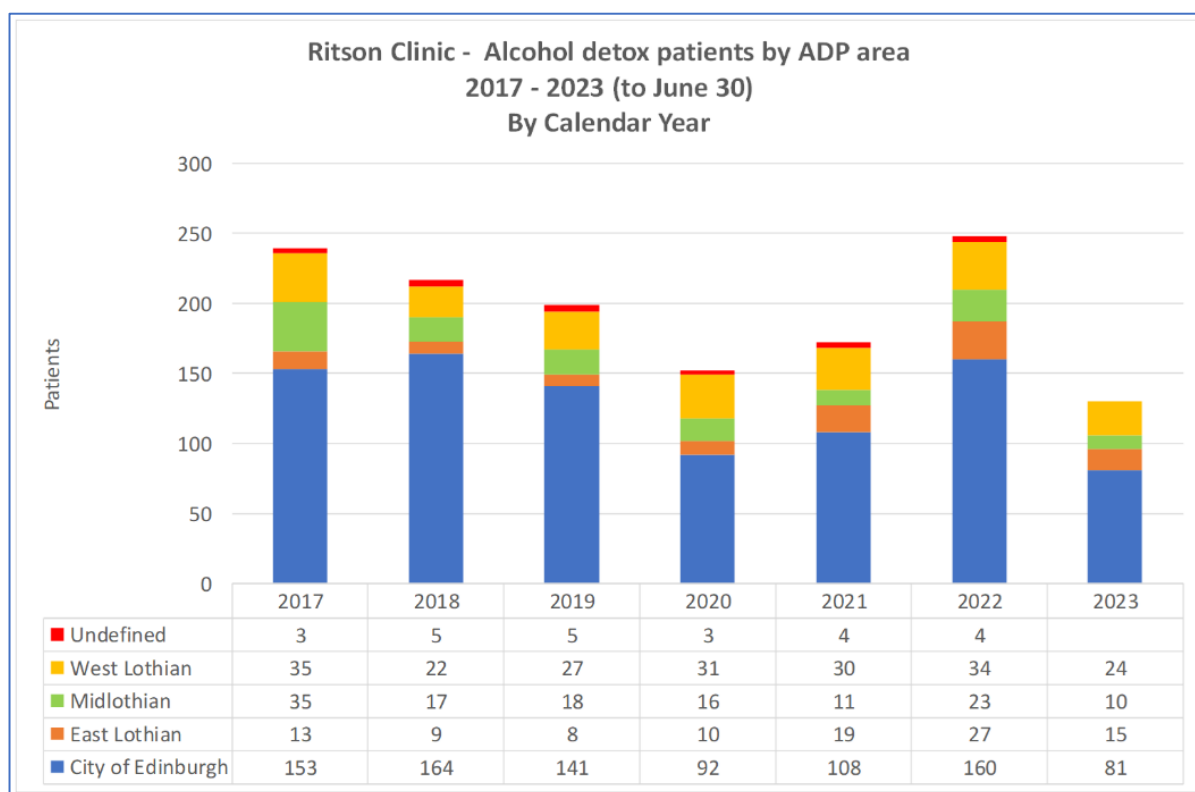


Figure 39 Alcohol Detox Patients By ADP Area

Residential rehabilitation programme

Lothian & Edinburgh Abstinence Programme (LEAP) is a treatment and rehabilitation programme for those dependent on alcohol and other drugs (including opiates, stimulants, cannabis, tranquillisers etc.) and usually lasts 3 months or longer. It is suitable for those who want to achieve a substance-free recovery.⁸⁴

LEAP is an NHS service delivered in partnership with City of Edinburgh Council, the Cyrenians (third sector agency), Access to Industry and the Social Work Residential Rehab Team (RRT).

LEAP offers information sessions, assessment, pre-rehab group sessions, admission for residential rehab and aftercare for up to two years. The service offers detox to patients from opioids, alcohol, benzodiazepines, and stimulants – either in-house or through an admission to the Ritson Clinic.

The team includes two GPs with specialist interest in addictions, a therapy team which includes CBT therapists, a psychiatrist, an occupational therapist, a pharmacist, a psychologist, a peer support coordinator, peer supporters, and a team of administrators. LEAP also has a dedicated dental service. Access to housing support, education, training, and employability is also available.

⁸⁴<http://intranet.lothian.scot.nhs.uk/Directory/pcft/PCFT%20GoodPracticeGuidance/Documents/PCFT%20Brief%2010%20November%202022.pdf>

LEAP and the Ritson clinic can now treat more people and can coordinate detox and the whole treatment episode. The multidisciplinary team at LEAP allows treatment for more complex individuals.

LEAP can now offer treatment for up to 28 (up from 20) individuals at a time in a programme lasting at least three months. Aftercare provision has also been increased. The referral pathway is illustrated below in figure 40.⁸⁵

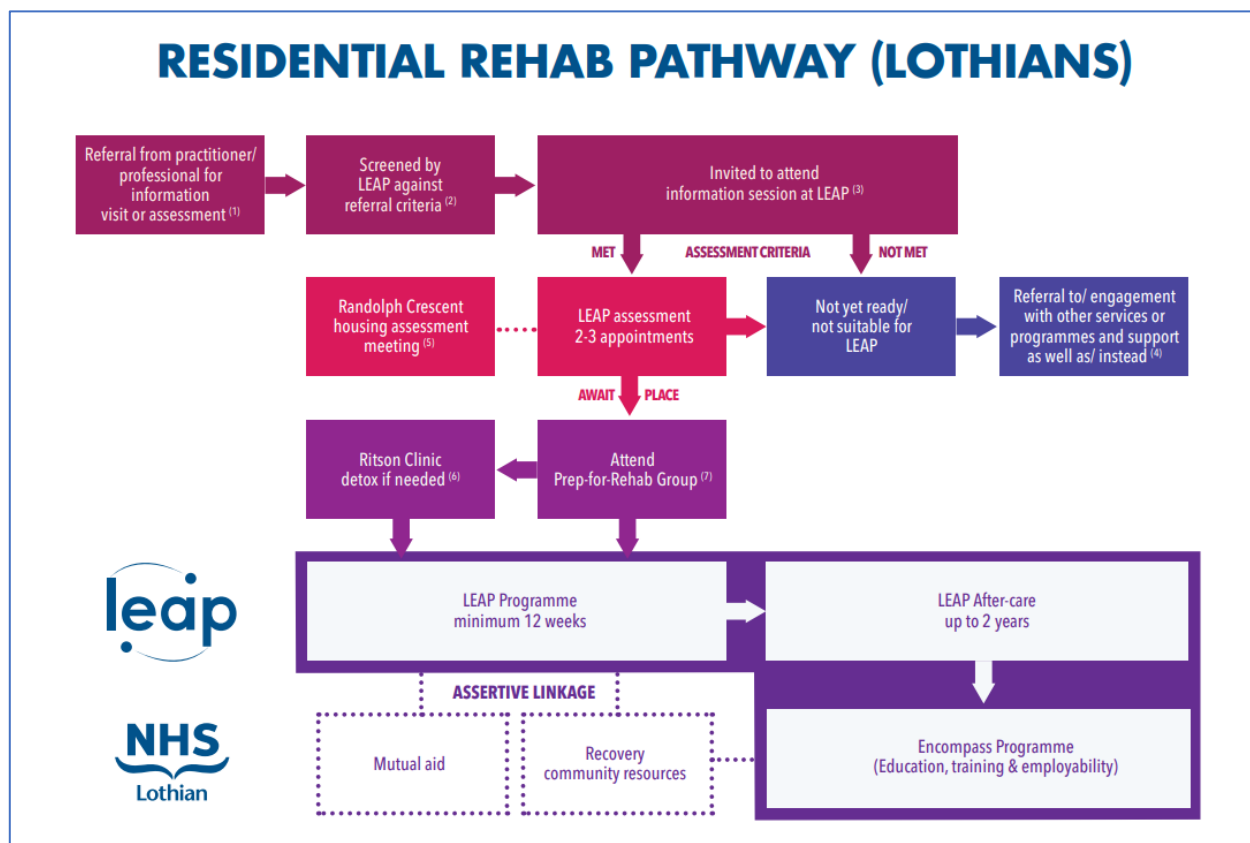


Figure 40 Residential Rehab Pathway for Lothian

Data for the LEAP service, January 2017 to June 2023, illustrates that for alcohol and co-dependency:

- Admissions to LEAP have increased over the past 5 years. Over the last year, admissions average 24 per quarter.
- Patients are predominately from Edinburgh (61%), followed by West Lothian (17%), Midlothian (12%) and East Lothian (10%), as shown in figure 41.
- More males are admitted than females. Over the past 3 years, 61% patients were males, 39% female.
- The majority of patients (63%) graduate from (i.e. complete) the LEAP programme. For patients who do not complete, the most common categorisation is discharged against medical advice (DAMA) (32%), as shown in figure 42.

⁸⁵ <https://services.nhslothian.scot/leap/wp-content/uploads/sites/57/2022/08/leapLothiansPathway.pdf>

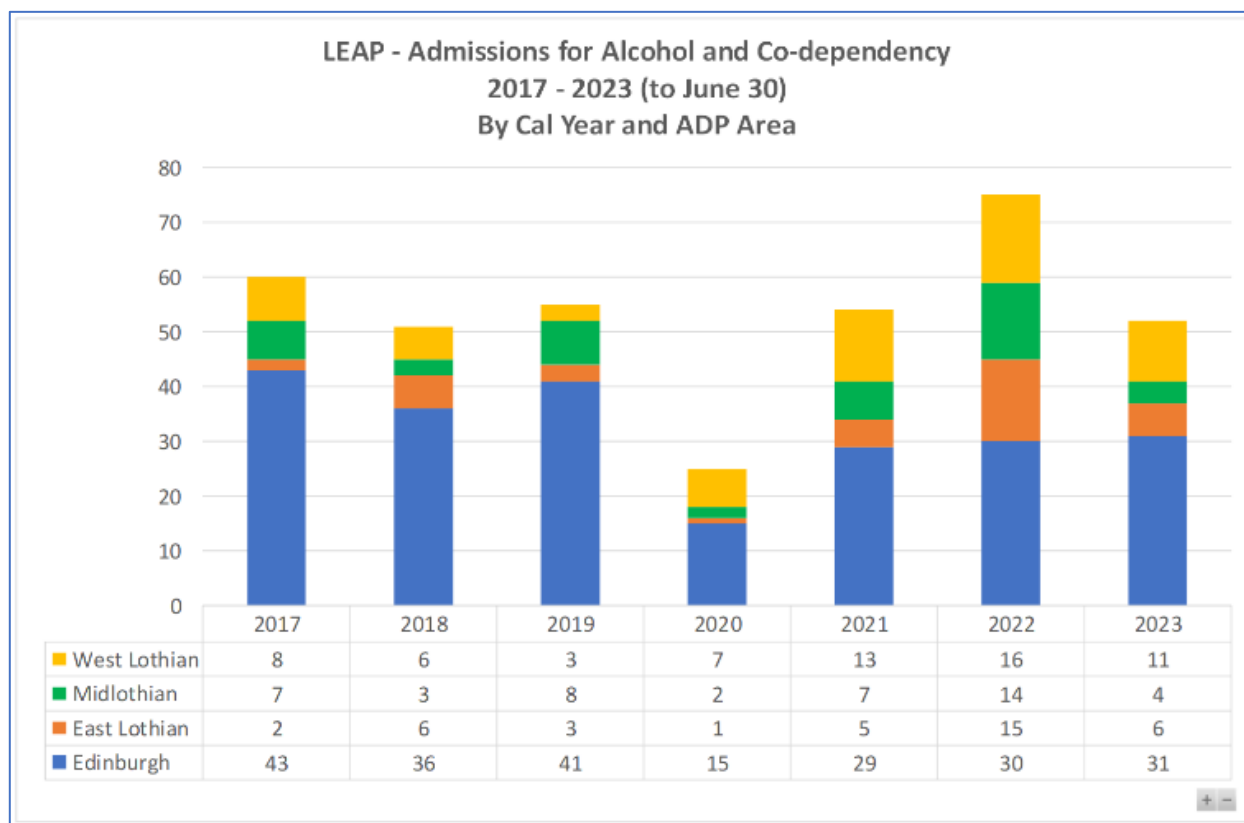


Figure 41 LEAP Admissions by ADP Area

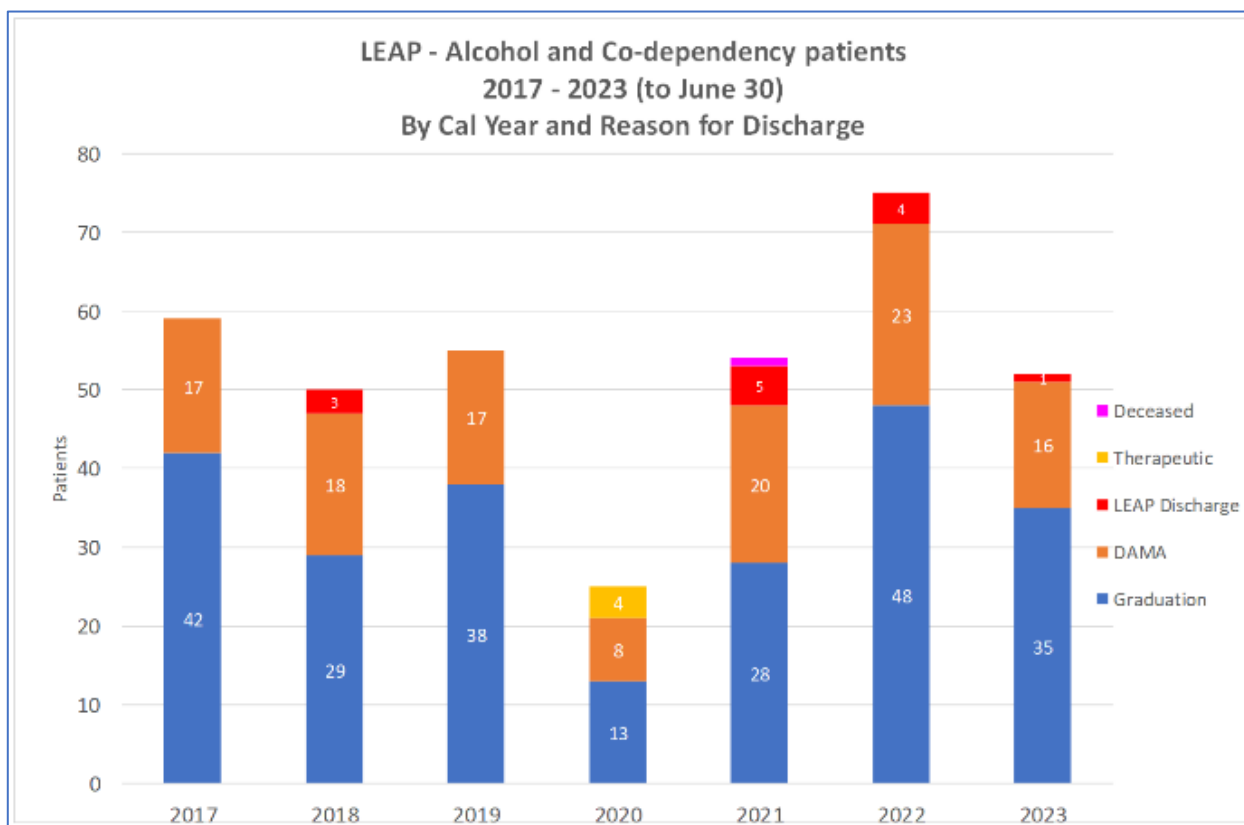


Figure 42 LEAP Patients - Reason for Discharge

A recent review of alcohol services in Scotland's acute hospitals was commissioned by the Scottish Health Action on Alcohol Problems (SHAAP) with a particular focus on ARLD, to identify areas for improvement.⁸⁶

The survey was designed to establish the level of provision and gaps in hospital-based alcohol services, categorised under four tiers, as illustrated in table 14 below.

Tier 1: A hospital with a formally designated Alcohol Care Team [ACT].			
Tier 2: A hospital with an established service specifically targeting problem drinkers which has not been formally designated an Alcohol Care Team.			
Tier 3: A hospital with a limited/occasional/ intermittent/ad hoc service for problem drinkers.			
Tier 4: A hospital with no service specifically for problem drinkers.			
Tier category	% of total responses	Number	Hospitals
We have a formally designated Alcohol Care Team [ACT].	15%	3	<ul style="list-style-type: none"> • Ninewells • <u>Royal Infirmary of Edinburgh</u> • University Hospital Ayr
We have an established service specifically targeting problem drinkers which has not been formally designated as an ACT.	30%	6	<ul style="list-style-type: none"> • Aberdeen Royal Infirmary • Forth Valley Royal Hospital • Glasgow Royal Infirmary • <u>St. John's Hospital</u> • University Hospital Hairmyres • Victoria Hospital
We have a limited/occasional/ intermittent/ad hoc service for problem drinkers.	40%	8	<ul style="list-style-type: none"> • Borders General Hospital • Caithness General Hospital • Dumfries & Galloway Royal Hospital • Lorn and Islands Hospital • Mackinnon Memorial Hospital • Raigmore Hospital • The Balfour • <u>Western General Hospital</u>
We have no service specifically for problem drinkers.	15%	3	<ul style="list-style-type: none"> • Belford Hospital • Dr. Gray's Hospital • Perth Royal Infirmary

Table 14 Summary of Hospital Based Alcohol Services

⁸⁶ <https://www.shaap.org.uk/downloads/565-review-of-alcohol-services-in-scotland-s-acute-hospitals/viewdocument/565.html>

The survey results from qualitative interviews indicated the below high-level key findings (across Scottish acute hospitals) in table 15.

Disparity in screening and management of harmful, hazardous, and dependent alcohol use	a) The reported practices for screening for, referral and management of AUD in both patients in general and in those with ArLD varied widely.
	b) The variety in approaches observed, points towards a lack of standardisation across the country and even within Health Boards.
Inconsistent follow-up	a) Inconsistencies were identified in post-discharge follow-up practices, especially regarding specialist nurses' engagement.
Reliance upon community-based alcohol services	a) A reliance upon community-based alcohol services for post-discharge management was noted but not necessarily with clear patient pathways into these services.
Challenges unveiled	a) Qualitative insights from survey responses revealed staffing shortages and infrastructure issues.

Table 15 Key High-level Findings

- The survey found diversity in the management and treatment of Alcohol Use Disorder (AUD) across Scotland's acute hospitals, which may be due to variations in resource, hospital priorities, regional prevalence of AUD and differing perspectives on the best approaches to care.
- There was inconsistency in post-discharge follow-up, with an absence of follow-up from specialist nurses in most hospitals.
- The heavy reliance upon community-based alcohol services, whilst beneficial for supporting people and their health once back at home/in a community setting, also underscores a potential gap in hospital-based post-care services. Depending on the robustness and efficacy of these community services and how well integrated they are with hospital services, this could either be a positive approach to care or a potential pitfall.

The survey also highlighted the following consistent messages shown in table 16:

Consistent or frequent messages		
Emergency Departments (ED or A&E)	Issue	Inconsistencies in policy development and practice in ED regarding alcohol-related provision.
	Variation	Inconsistencies are notably visible between larger hospitals with more developed alcohol service provision (e.g., Aberdeen and Edinburgh Royal Infirmarys) and other hospitals.
	Interventions	Consideration for universal alcohol-use screening for all ED patients was observed as a potential best practice.
Psychiatry	Disparity	Notable differences in service provision between hospitals with addiction psychiatry specialists and those reliant on general liaison psychiatry.
	Specialist need	Highlight the value and need for specialist and liaison psychiatry services for alcohol.
	Challenges	Care for patients with Alcohol Related Brain Damage (ARBD) and interconnectedness with psychiatric interventions and alcohol were noted.
Provision and practice disparities	Fragmentation	Practices are often reliant upon specific individuals rather than a systematic approach, leading to variances in provision from hospital to hospital.
	Nomenclature	Variation in local terminologies and acronyms impacts uniform understanding and documentation.
	Inconsistencies	There appears to be a lack of consistency at regional and hospital levels regarding specific alcohol provisions, such as fibro-scanning and care for people with ARBD.
Staff support	Importance of supervision	Instances were noted where lead consultants provided pivotal support and supervision.
	Peer networking	Different forums and groups facilitated peer support and knowledge exchange, though accessibility and awareness of these forums varied, with staff in smaller, more remote, hospital settings being the least likely to be involved in such networking. At the same time these staff would potentially benefit most from such networking.
Struggle for prioritisation	Competing demands	Alcohol care provision is often in competition with other medical and procedural demands, hindering focused attention and prioritisation.
	Policy struggle	Alcohol care in hospitals has to compete at a policy level with a whole range of other considerations, with ArLD often finding itself lower down the priority list.

Table 16 Consistent Messages from Study

Overall, the findings expose:

- Gaps in policies and practices across various hospitals.
- The fragmentation in alcohol related healthcare provision and disparities in quality and accessibility.
- The value in developing a unified approach, possibly through a toolkit and other guidance, aimed at standardising and enhancing alcohol-related care.

Although this report focuses on differences between Scottish hospitals, it would be worth reviewing the key messages and issues highlighted in respect of services delivered in Lothian.

Pharmacological Treatments

Prescribing for alcohol use disorder is supported in Lothian through the [East Regional Formulary](#) which reflects evidence based guidance, including [NICE Clinical Guideline Alcohol-use disorders](#): diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence (CG 115). Consultation on a [UK-wide clinical guideline](#) recently closed (December 2023) and publication of this is awaited. The specialist service in [NHS Lothian produces a guideline](#) which again reflects the evidence base. Although this is produced by and for the specialist service, it is accessible to primary care. Out with an acute medical emergency setting, prescribing would usually be led and initiated via specialist addictions services.

Medicines used within the context of alcohol use disorder fall into three categories although there may be overlap between these in an individual patient at any one time.

- Acute alcohol withdrawal and detoxification: benzodiazepines, namely chlordiazepoxide, diazepam and occasionally oxazepam. Diazepam in particular has many indications beyond alcohol withdrawal and detoxification. Depending on the clinical circumstances of the individual patient, detoxification may be undertaken in community settings or inpatient setting and may require urgent admission to acute medical settings. In general, chlordiazepoxide is preferred in community services and specialist addictions service inpatients, however, diazepam is preferred in acute medical services, particularly for management of acute withdrawal.
- Prevention of relapse to alcohol dependence: acamprosate, disulfiram, naltrexone, nalmefene and baclofen. Note naltrexone and baclofen have other indications and prescribing is not solely confined for use in alcohol dependence. In general, these medicines would be initiated by specialist addiction services, but may be continued in longer term by GP services.
- Prevention of Wernicke-Korsakoff syndrome and associated alcohol related brain damage: People with a harmful or dependent drinking pattern are at risk of developing Wernicke's encephalopathy due to thiamine deficiency. Therefore, thiamine should be offered to those at risk of developing or with suspected Wernicke's encephalopathy. This may be given by injection during acute withdrawal or detox episode and longer term (usually 6 months) orally in patients with certain risk factors. This may be initiated during an acute/unplanned admission or as part of planned medically assisted detoxification. Thiamine is also known as Vitamin B1 and has a broader indication as vitamin supplementation for a number of indications, therefore its use is not specific to patients with alcohol use disorder.

Pharmacological treatments are only part of a strategy to support or maintain abstinence and should be part of a package that includes psychological support. A treatment package that includes medicines may be introduced depending on the extent of alcohol dependence as well as according to response to psychological support.

Therefore as a treatment package will vary in terms of medicines use and due to the wide ranging indications of some of the medicines used within this context, there are some limitations in using prescribing data to assess alcohol treatment provision.

However review of local prescribing data provides some insight. As previously described, with the establishment of recovery hubs, patients requiring support are directed towards these for review and subsequent prescribing, which may include detoxification. Therefore the decline in GP

prescribing activity of chlordiazepoxide as seen below, is not unexpected. It also recognised that other medicines may also be used for this indication, namely diazepam and rarely oxazepam and due to their wide indications, this data has not been interrogated. In addition, chlordiazepoxide was subject to shortage autumn 2022 which may have affected prescribing volumes.

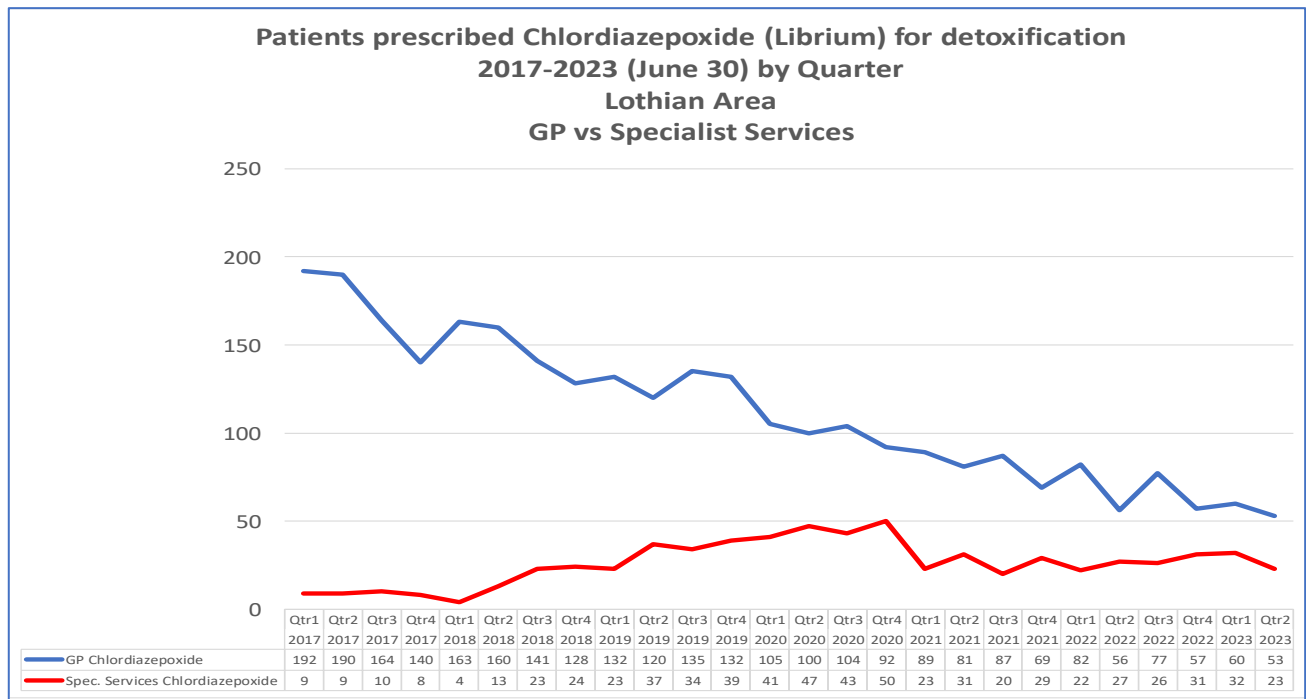


Figure 43 Patients Prescribed Chlordiazepoxide for Detoxification

Further examination by geographical area, shows that, towards end 2020- 2022, there was minimal prescribing within Mid and East ADP. This reflects use of alternative supply routes used by the service which are not picked up by this reporting system.

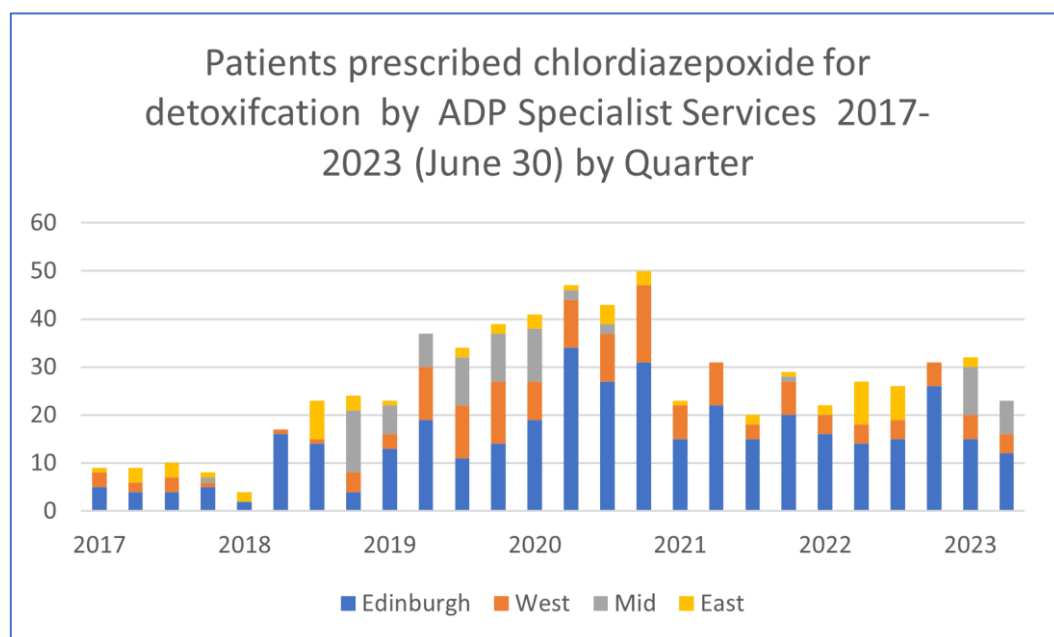


Figure 44 Patients Prescribed Chlordiazepoxide by Specialist Services – by locality

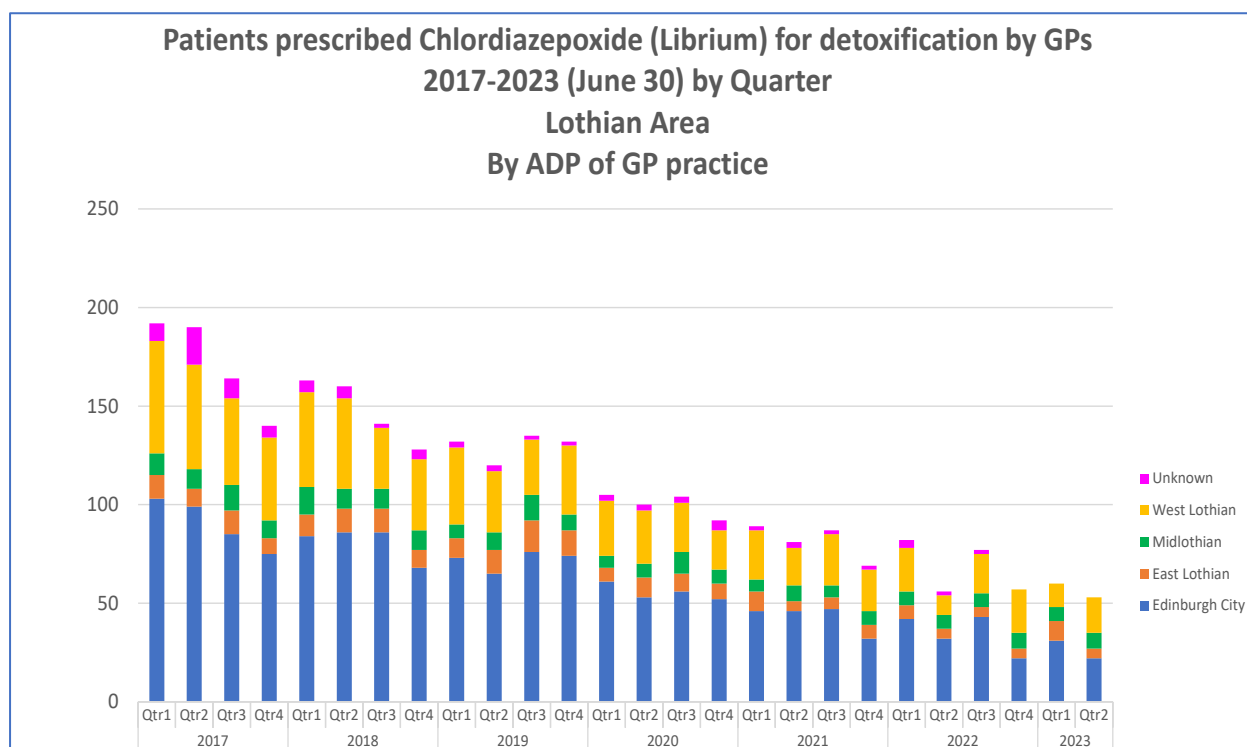


Figure 45 Patients Prescribed Chlordiazepoxide by GP Practices – by locality

Prescribing activity for medicines to prevent relapse is shown in the figures below. As noted previously, these medicines in general are initiated by specialist services and prescribing may be transferred to GP.

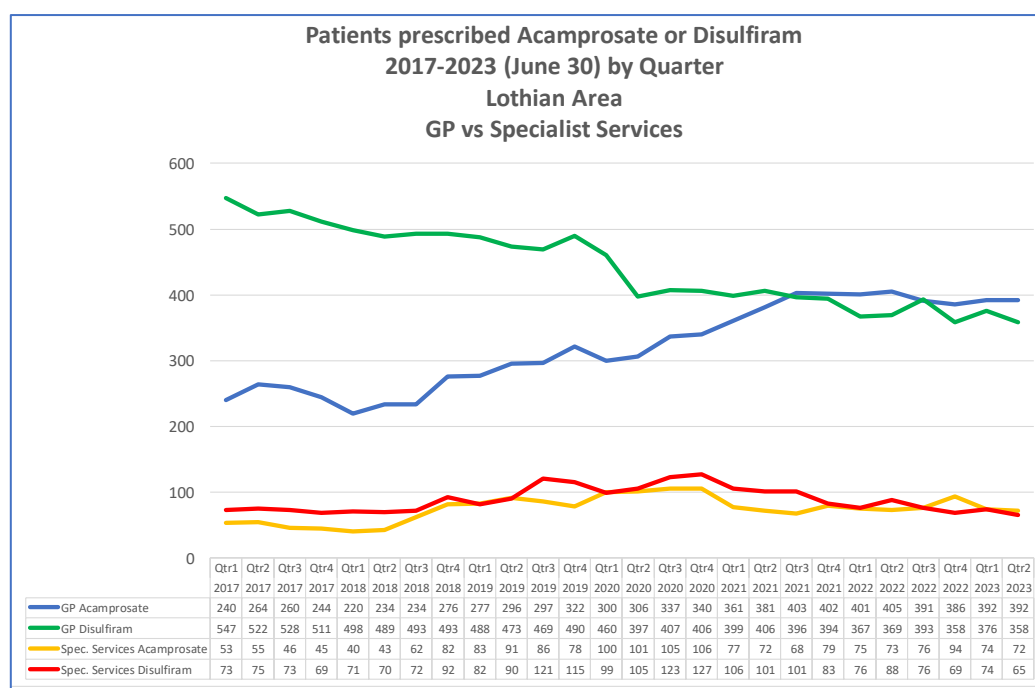


Figure 46 Patients Prescribed acamprosate or disulfiram by GP vs Specialist Services - Lothian

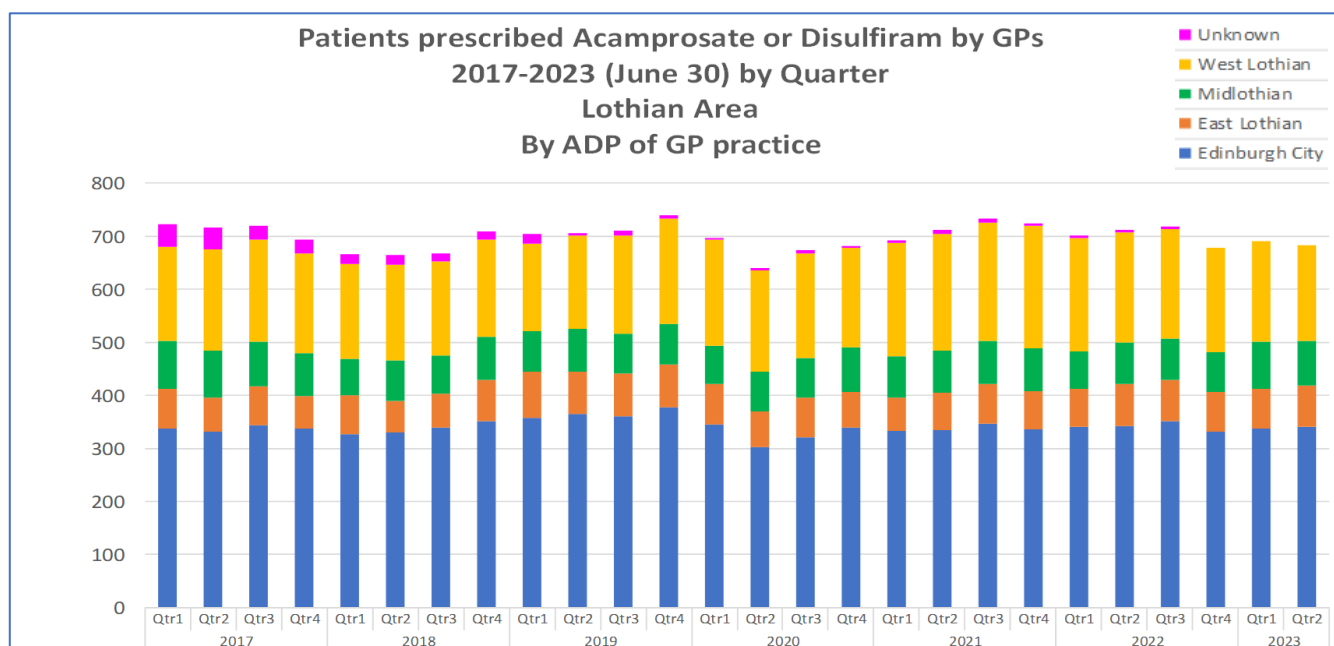


Figure 47 Patients Prescribed acamprosate or disulfiram by GP by ADP area

National comparative data is available for acamprosate and disulfiram from ScotPHO.⁸⁷

Figure 50 below shows that prescribing rates of these medicines increased 2019/20 in comparison to 2009/10 in Scotland, however the rates within Lothian have fallen.

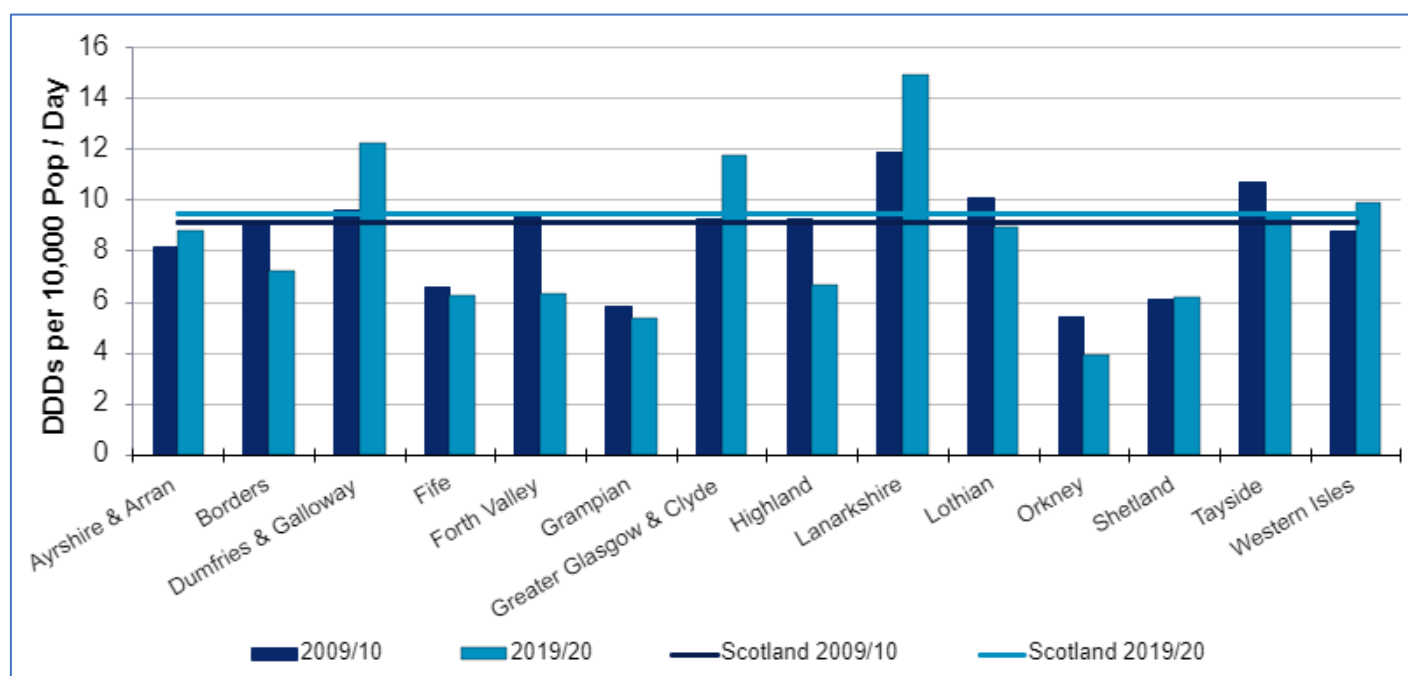


Figure 48 Drugs for Alcohol Dependence – Defined Daily Doses s per 10,000 Population (aged 16+) per Day

⁸⁷ [Treatment for alcohol misuse - ScotPHO](#)

Stakeholder Discussions

To add richness to the available data on alcohol related harms, a number of discussions were held with key stakeholders from a variety of services. This included those in primary and secondary care NHS addiction services, as well as colleagues from third sector organisations that provide support to those who engage in harmful or hazardous drinking.

Regarding capacity of services, both voluntary and NHS services felt they were working at or near maximum capacity for their services. Many reported that demand was continuing to increase or was staying static when they would usually see seasonal variation. Most reported there had been an increase in demand immediately during and after the COVID-19 pandemic, which overall appeared to be reverting to close to pre-pandemic levels. However, there was a feeling that the demand is “infinite” and if more funding, staff and resources could be provided, there would always be more people wanting to use the service. Inpatient services like the Ritson noted that their bed provision was decreased during the height of COVID-19 and has not been returned to pre-pandemic levels. Due to a lack of inpatient beds, but ongoing demand for detoxification, this has resulted in increased demand for community and semi-supported detoxes. Some services, including LEAP, have been able to increase the number of people they can support at any one time to accommodate. However, this expansion does not meet all expressed need for supported detoxes.

Referrals to recovery hubs were felt to most often be self-referrals and drop-ins. A smaller number of referrals came directly from Thrive.⁸⁸ This reflects expected referral patterns, which support individuals accessing services directly, and discourages GPs from trying to manage community detoxification alone. When considering the demographics of patients presenting to services, some voluntary services felt that they had seen an increase in younger people presenting, especially those using alcohol to cope with the stress of lockdown, and its effects on relationships and employment. Other services did not feel they had seen a change in demographics. Generally, services are attended by more males than females, although counselling services felt their split was less pronounced, perhaps because women are more willing to seek psychological help than men, due to societal norms and stigma. Most services reported that people they see tend to be in physical crisis, often presenting very unwell, or only being referred to services following a hospital admission for alcohol related illness.

Most services have returned to being able to offer face to face support. There has been some difficulty across the voluntary and primary care services regaining access to certain community venues. This means people may have to travel further to reach hubs for support. There were also some concerns over the rising cost of living, and how this affects voluntary services ability to maintain in person service availability due to the rising costs of renting and maintaining the physical spaces required to deliver their services. One service is no longer keeping their office open on a Friday to reduce costs, due to part time staff not working that day, so less staff working overall, and the cost of keeping the building open on a Friday therefore not being cost effective. Rising costs may also have an effect on service users, both in terms of the stress this adds to an individual's circumstance, or the costs associated with attending services or rehabilitation activities.

A common observation from discussions with all services was the separated way of working. Most psychological services offered by the NHS are commissioned from third sector organisations and do not follow the same harm-reduction principles as drug use services, usually requiring service users to be abstinent from alcohol before they can engage in some of the services on offer. Therefore, people may be required to undertake a community based detox, with or without medication

⁸⁸ [Thrive – strategy for improving mental health and wellbeing in Edinburgh, led by Edinburgh HSCP.](#)

support, prior to attending psychological support services, rather than being able to access this support during their detox. With regards to standard configurations of support services, there is minimal space for people who are interested in reducing their alcohol intake or managing other harms relating to alcohol in their life, but for whom it is not realistic or practical to stop drinking at that time, or possibly ever. Most practitioners felt there was benefits to be gained in wrap around support, where an individual has access to psychological services and recovery groups through all stages of their detox, and potentially mixed support groups including those at different stages of the abstinence process but they didn't feel this was currently offered by the services they were familiar with. Services also reported the increasing incidence of co-dependency, specifically those using alcohol and cocaine together. This can prove more difficult to manage than a single substance dependency and often the drug use is addressed first, or at least separately, due to the setup of addiction services, which often separate out drug and alcohol treatment and support. It may be that a review of the evidence on the treatment of alcohol use disorders is required to ensure that the services commissioned for Lothian are in-line with best practice, whether this is a harm reduction approach or otherwise.

A final theme that was noted was around assertive in-and outreach. Alcohol liaison nurses are not available at all hospital sites and cannot always manage to see all of those who are referred to them prior to discharge. Even when this is possible, they may only be able to signpost patients and require patients to self-follow up once discharged. There was also some discussion around people who have gone through a hospital-based detox for whatever reason, but then are not referred on to follow-up services for their harmful or hazardous drinking. There is limited capacity to follow these patients up by any service, especially if the person themselves doesn't get in touch with services. There is potentially more support required for these individuals but due to lack of resources there is minimal capacity for ongoing support in recovery. This has also been reflected in a recent report from SHAAP *A review of alcohol services in Scotland's acute hospitals*.⁸⁹ The report noted a reliance on community-based services for patients identified during inpatient admission and potential gap and likelihood for loss to follow up. Improved integration between the interface of secondary and primary care together with exploration of equitable provision of alcohol care teams across all acute hospital sites could help to promote opportunities for secondary prevention with regard to alcohol use.

⁸⁹ <https://www.shaap.org.uk/downloads/565-review-of-alcohol-services-in-scotland-s-acute-hospitals/viewdocument/565.html>

Discussion

Each premature death is a tragedy, for the individual as well as for their family, friends and wider community. From a public health perspective, it is important that we use available intelligence about patterns of alcohol death and the wider harm to individuals, families and communities, to inform action. It is however important that we focus that action as 'upstream' as possible, with a particular focus on the actions that are likely to reduce deaths and harm from a range of causes, such as by addressing poverty and inequality, and ensuring that people have access to the building blocks of health that will enable them to avoid isolation and loneliness.

In relation to harm and death caused by alcohol, the majority of which are a result of chronic alcohol use, the World Health Organisation is clear that action to reduce alcohol harm should focus on reducing the availability, affordability and acceptability of alcohol. Within Lothian, the public health team is working to influence local Licensing Board policies on the availability of alcohol, as well as advocating for continued and further national action on pricing and advertising in order to influence affordability and acceptability. Local Alcohol and Drug Partnerships are also working to improve access to treatment for excess alcohol use.

There is a significant relationship between deaths caused by alcohol and the experience of multiple disadvantage. We must therefore continue to tackle the underlying causes and structural determinants of health that will help reduce inequalities that ultimately impact on the rates of death by alcohol.

In Lothian, rates of alcohol specific deaths are currently higher than rates of drug related deaths, however receive far less attention in terms of media and targeted interventions, perhaps due to the social acceptance of drinking.

For alcohol deaths, we will collate and analyse data on local and national trends on an annual basis to help inform the focus of our work. Public Health Teams will continue to work with our four Community Planning Partnerships to reduce levels of poverty and increase access to employment and health and wellbeing-promoting environments across Lothian, to reduce the unfair differences in people's life circumstances. In addition, we will continue working with local Alcohol and Drug Partnerships and health colleagues to help inform service responses.

We need to address the adverse health and social consequences for individuals, families, communities and wider society from harmful alcohol consumption. This needs assessment provides background information to support the further policy and service delivery development within Lothian at an individual and population level.

We have listed in the next section of this report, recommendations that have been identified during this health needs assessment, which we hope can be considered by colleagues and services, in our joint efforts to reduce the harm caused by alcohol.

Recommendations

Recommendations have been suggested throughout this report that can be summarised under the following headings.

The Alcohol Environment

The availability, affordability and acceptability of alcohol all create an environment where alcohol is embedded as the norm. To impact on the alcohol environment, action can be taken at a national policy level as well as a local level, including:

- Availability – work should continue around engaging with local authority licensing boards to highlight the impact of alcohol availability and population harm. Especially the impact of availability of alcohol on hazardous and harmful drinkers which is particularly high in Lothian. This would include boards having a greater regard for public health concerns in relation to licencing applications and particularly in overprovision areas.
- Affordability – work should continue locally to engage on and support the national policy driver on the price of alcohol – minimum unit pricing (MUP). The continuation of MUP and the incremental increasing of price (with inflation) will reduce health harms caused by alcohol consumption, in particular among those who drink at hazardous and harmful level. Again, hazardous and harmful drinking is particularly high in Lothian.
- Acceptability - work should continue locally to engage on and support the national policy driver on the acceptability of alcohol such as alcohol advertising.

Recommendations		Recommendation Owner
1	Continue work to address availability, affordability and acceptability, with a focus on influencing policy and decisions of local authority Licensing Boards	NHS Lothian – Public Health

Alcohol Related Behaviours

To impact on alcohol related behaviours, consideration could be given to the areas for intervention with young people, harmful and hazardous drinking, hospital attendance and hospital admissions, including:

- Self reported alcohol consumption in young people increases at the age of 15. Further thought should be given to the best age group to implement any alcohol social norm work for the greatest level of influence.
- Investigating the rising rate of alcohol related hospitalisation for young people and what can be done to prevent these.
- Investigate the large proportion of child protection cases that involve parental substance use and if any earlier identification of an adult with substance use and a child in the family, using a whole family wellbeing model. All professionals who have regular contact with children and families should provide support in cases where alcohol harm is evident. Likewise, professionals that have contact with adults (females and males), should identify if there is a child in the family and offer holistic family support.
- Child protection cases involving parental substance use. The rate for West Lothian seems particularly high in comparison to the rest of Lothian and Scotland. Further work should commence to investigate the reasons and if there are any differences in the gender split compared to the rest of Lothian or Scotland. Further preventive work should be identified using a whole family wellbeing model.

- Further consideration must be given to targeting high risk drinkers (harmful and hazardous levels) which is significantly higher in Lothian than the Scottish average.
- Further consideration should be given to the link between mental health and alcohol consumption.

Recommendations		Recommendation Owner
2a	Use information on alcohol consumption and harms in children and young people to inform the work of local authority Children's Partnerships.	NHS Lothian – Public Health
2b	Improve support for children affected by parental substance use, including raising awareness with relevant professionals who have contact with children and families.	ADPs
2c	Improve staff awareness that poor mental health and high levels of existing alcohol consumption are risk factors for future harmful levels of alcohol consumption and ensure adequate supports are available for mental health.	ADPs

Alcohol Harms

To impact the highest level of alcohol harm, further consideration should be given to alcohol related hospital frequent attenders and alcohol specific conditions such as Fetal Alcohol Spectrum Disorder (FASD), Alcohol related Liver Disease (ARLD) and Alcohol Related Brain Damage (ARBD), including:

- Investigate further hospital frequent attendance in Lothian in relation to the gender difference on presentation and appropriate gender referral pathways on discharge (males presented as suffering the physical effects of chronic alcohol misuse and females presented as drinking in the context of crisis, using alcohol to cope with mental health issues).
- Consider the main findings from the Glasgow frequent attenders study for any learning and implementation in Lothian, such as:
 - Women have very different experiences and needs to those of men.
 - The link between mental health and trauma and alcohol consumption and problems.
 - A lack of joined-up approach between mental health and alcohol services, meaning that people seeking help often fall into the cracks between services.
 - The importance of family support and recovery communities.
 - A lack of service signposting for patients.
 - How difficult it can be for people to make changes and/or seek help for their alcohol problems.
 - Barriers to accessing and maintaining treatment.
- Investigate potential gaps in alcohol care teams (aka alcohol liaison service - ALS) for inpatients where alcohol use is identified as a concern. This could include gaps in existing service at some sites to expand availability as well as sites where this service is limited/not currently in place.
- In addition to the above recommendation, review the key findings from the SHAAP report⁹⁰ in terms of alcohol services in acute hospitals, and apply any relevant learning within Lothian.

⁹⁰ <https://www.shaap.org.uk/downloads/565-review-of-alcohol-services-in-scotland-s-acute-hospitals/viewdocument/565.html>

- Investigate pathways/options for patients that attend hospital based detox that are not routinely followed up or referred to services to support their harmful or hazardous drinking.
- Investigate further the incremental reduction for alcohol related hospital admissions over the past three years, especially in comparison to increase alcohol related deaths.

Recommendations		Recommendation Owner
3a	Review and improve pathways of support for those who frequently attend A&E, taking account of recommendations from the Glasgow Frequent Attenders Study.	ADPs
3b	Review and improve provision of alcohol liaison and post-discharge pathways, taking account of recommendations from the SHAAP Report.	ADPs

Fetal Alcohol Spectrum Disorder (FASD)

- Investigate profile and knowledge of FASD with all services who may come into contact with affected children and adults.
- For these services, highlight available FASD [training resources, including a TURAS module \(NHS\)](#), [information for social workers](#) and [online training for GPs](#).
- Investigate provision of neurodevelopmental pathway and access to this across multi sector agencies (i.e. healthcare, education, social work, justice, third sector- all agencies working with children and families).
- Improve messaging and support for abstinence during pregnancy, including clear recording of alcohol consumption (and maternal alcohol history).
- Investigate existing links between recovery hubs/integrated services to sexual & reproductive health services to optimise access to contraception for women.

Recommendations		Recommendation Owner
4a	Raise primary care staff awareness of FASD, including importance of recording.	ADPs
4b	Use information on FASD to inform actions in the Women's Health Plan and Children's Services Plans, including raising staff awareness and ensuring FASD is considered within neurodevelopmental pathways.	NHS Lothian – Public Health
4c	Review and improve pathways of support between substance use services and sexual and reproductive health services.	ADPs

Alcohol Related Liver Disease (ARLD)

- Investigate opportunities for earlier identification of ARLD in community settings and impact this may have on slowing disease progression.
- Reduction/abstinence is key to preventing disease progression where ARLD is identified. Further exploration of links from hepatology to recovery services, including holistic care, that can contribute to successful recovery journey such as streamlined access to income maximisation, housing, mental health etc.

- Investigate the use of the British Association for the Study of the Liver and British Society of Gastroenterology ARLD special interest group's quality standards⁹¹ for benchmarking services in Lothian and identifying areas for improvement.

Recommendations		Recommendation Owner
5	Review and improve pathways between hepatology and recovery services/primary care, taking account of ARLD Quality Standards	ADPs

Alcohol Related Brain Damage (ARBD)

- Raise profile of benefit of ARBD unit in reducing A&E and inpatient admissions, noting bed days saved.
- Linking to above investigation of frequent attenders to explore factors that may affect onward referral and care at ARBD unit.
- Investigate strategies to raise awareness of ARBD with healthcare professionals and third sector agencies where appropriate.

Recommendations		Recommendation Owner
6	Raise staff awareness of ARBD, including appropriate referral pathways, ensuring information is included as part of online and in person training.	ADPs

Alcohol Services and Pathways

People with alcohol dependency need timely and high quality treatment. Further consideration should be given to understanding the current pathways and understanding links to holistic care such as housing, income and mental health which can support the person in their recovery, including:

- Implementing the outcomes of national review of the ABI programme (expected soon). This may include extending the principles beyond alcohol to support good conversations across all settings (such as make every conversation count).
- Further investigate best practice models, such as the Primary Care Alcohol Nurse Outreach Service (PCANOS),⁹² which could improve and strengthen engagement between services and service users, and if suitable for implementing in Lothian.
- Review of the evidence base for the treatment of alcohol use disorders to ensure that the services commissioned for Lothian are in-line with best practice, whether this is a harm reduction approach or otherwise.
- Ensure all substance use services are linked into current pathways to support patients on the cost of living (such as income maximisation).
- Further investigate patient demographics to see if there has been an increase in young people attending services, especially linked to the use of alcohol as a coping mechanism for stress/mental health issues.

⁹¹ [Quality standards for the management of alcohol-related liver disease: consensus recommendations from the British Association for the Study of the Liver and British Society of Gastroenterology ARLD special interest group | BMJ Open Gastroenterology](#)

⁹² <https://www.shaap.org.uk/downloads/405-alcohol-management-deep-end-2022/viewdocument/405.html>

Recommendations		Recommendation Owner
7a	Implement recommendations from national review of ABIs, when available.	ADPs
7b	Review and improve pathways of outreach, taking account of recommendations from Glasgow PCANOS work.	ADPs
7c	Review and improve pathways from substance use services into wider holistic care, including housing and income maximisation.	ADPs
7d	Call for improved national evidence / guidance on alcohol harm reduction.	NHS Lothian – Public Health

Pharmacological Treatments

Prescribing for alcohol treatment should continue to reflect evidence based guidance.

- Further consideration should be given to exploring prescribing data in more detail to identify areas of good practice as well as potential gaps and inform service requirements.

Recommendations		Recommendation Owner
8	Exploring prescribing data in more detail to identify areas of good practice as well as potential gaps and inform service requirements.	NHS Lothian – Public Health

Data and Intelligence

- Further explore the referral rate for any alcohol related attendance or admission and what holistic services are offered, including uptake rates into services.
- Data on protected characteristics (other than age and gender) is limited and we recognise that there needs to be improved data collection in order for us to understand if we are meeting the needs of different groups equitably.
- Utilise PHS dashboard data as it becomes more comprehensive for Lothian services.

Recommendations		Recommendation Owner
9a	Improve data collection and recording of protected characteristics within substance use services.	ADPs
9b	Make use of PHS Alcohol Data Dashboard to inform future decisions.	ADPs NHS Lothian – Public Health
9c	Further investigate the pathways and uptake of referrals from alcohol related A&E attendances to wider services.	NHS Lothian – Public Health
9d	Further investigate the incremental reduction for alcohol related hospital admissions over the past three years.	NHS Lothian – Public Health

Oversight of Recommendations

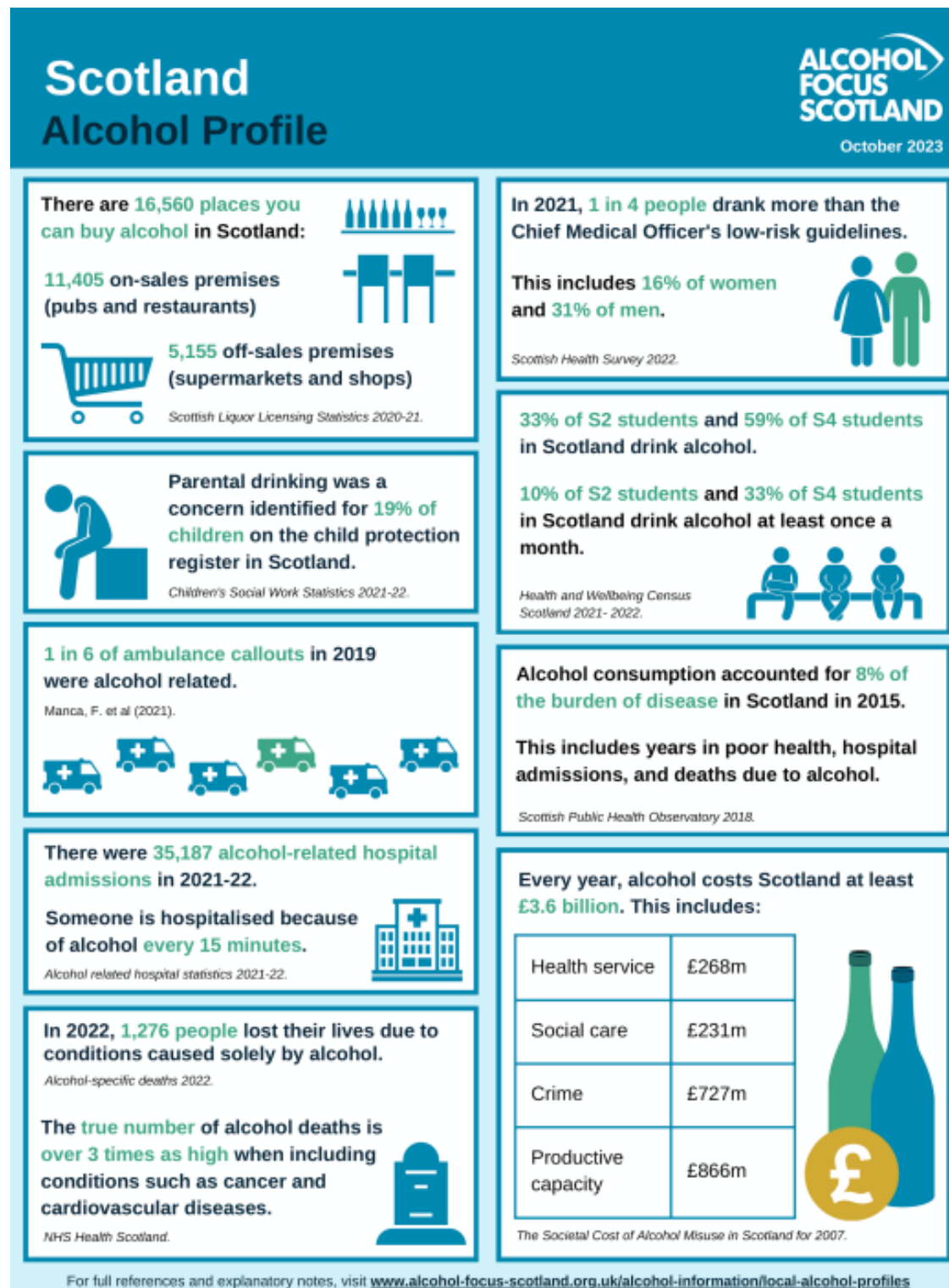
To ensure that the above recommendations are considered by the appropriate services /organisations and where possible implemented, the progress made should be tracked and reviewed by an appropriate partnership group, such as the Lothian Alcohol Harm Reduction Group (LAHRG) and / or the Lothian Drug and Alcohol Harms Partnership Group (DAHPG) on a bi-annual basis.

Recommendations		Recommendation Owner
10	Review progress against Alcohol Harms Needs Assessment Recommendations 6-monthly, via Lothian Alcohol Harm Reduction Group and / or Drug and Alcohol Harms Partnership Group.	NHS Lothian – Public Health

Appendix 1 – Scotland Alcohol Profile

From Alcohol Focus Scotland

Scotland Alcohol Profile - Oct 2023 (alcohol-focus-scotland.org.uk)



For full references and explanatory notes, visit www.alcohol-focus-scotland.org.uk/alcohol-information/local-alcohol-profiles

Appendix 2 – City of Edinburgh Alcohol Profile

From Alcohol Focus Scotland.

<https://www.alcohol-focus-scotland.org.uk/media/440398/edinburgh-lap-oct-2023.pdf>



Appendix 3 – East Lothian Alcohol Profile

From Alcohol Focus Scotland.

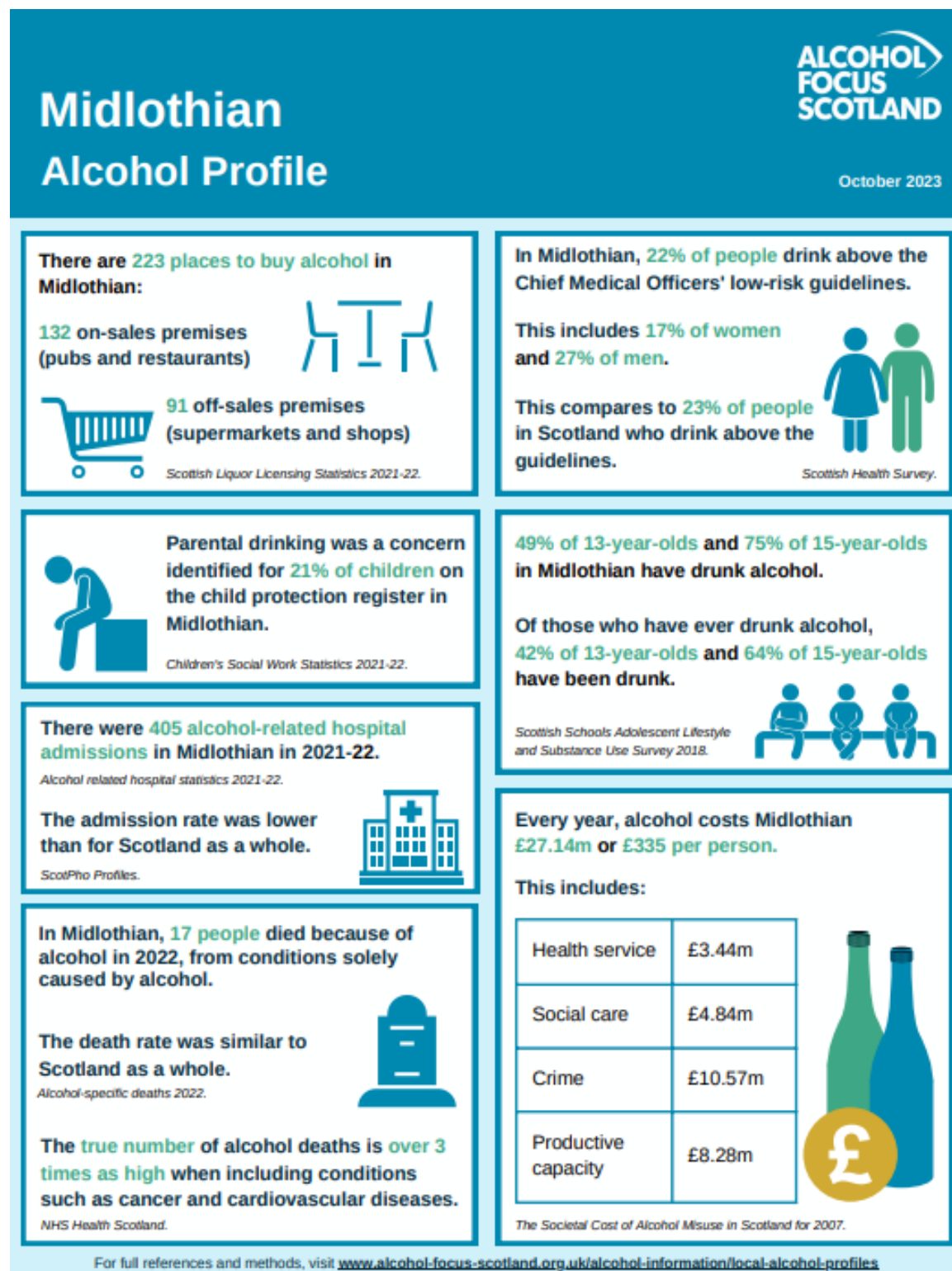
<https://www.alcohol-focus-scotland.org.uk/media/440396/east-lothian-lap-oct-2023.pdf>



Appendix 4 – Midlothian Alcohol Profile

From Alcohol Focus Scotland.

[Midlothian LAP Sept 2023 \(alcohol-focus-scotland.org.uk\)](http://alcohol-focus-scotland.org.uk)



Appendix 5 – West Lothian Alcohol Profile

From Alcohol Focus Scotland.

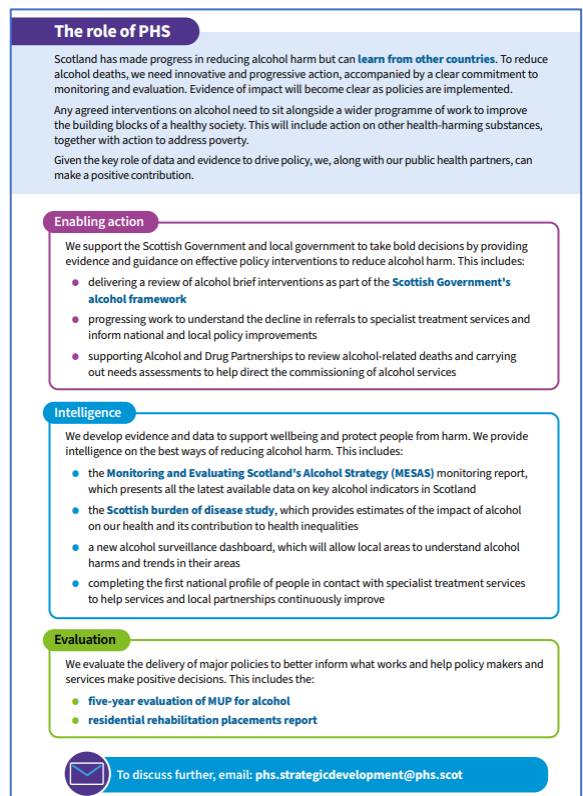
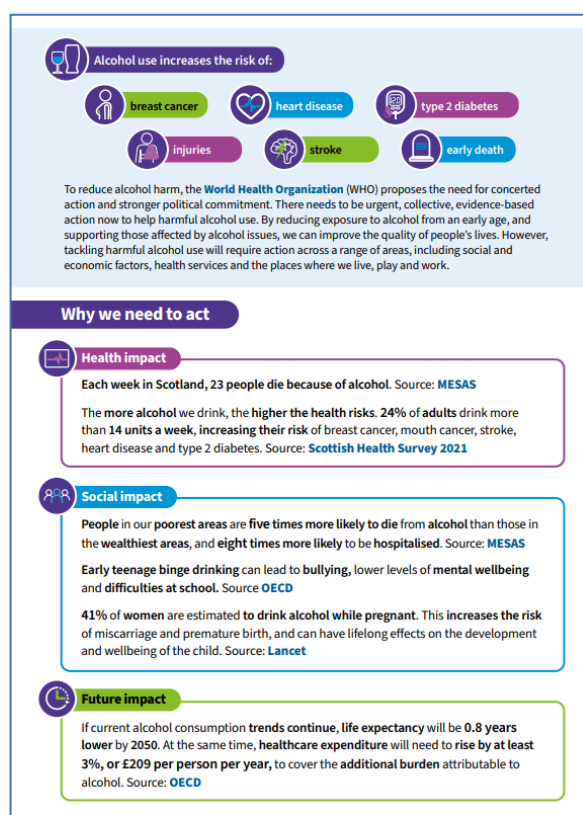
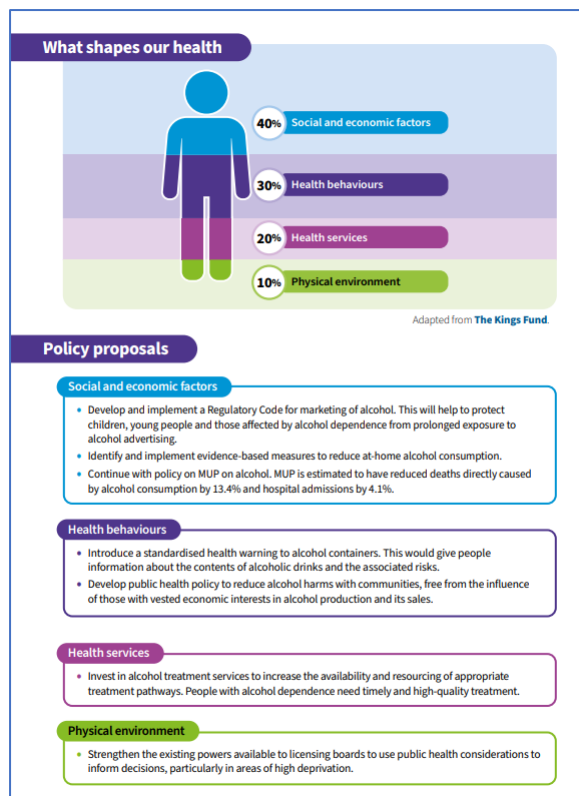
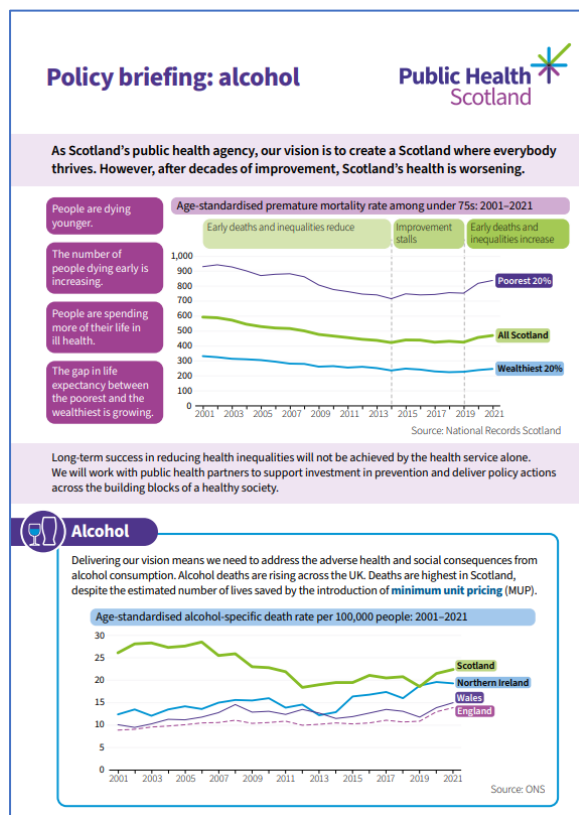
[West Lothian LAP Sept 2023 \(alcohol-focus-scotland.org.uk\)](http://West Lothian LAP Sept 2023 (alcohol-focus-scotland.org.uk))



For full references and methods, visit www.alcohol-focus-scotland.org.uk/alcohol-information/local-alcohol-profiles

Appendix 6 – Alcohol Policy Briefing

PHS Policy Briefing on Alcohol [Policy briefing: alcohol \(publichealthscotland.scot\)](https://publichealthscotland.scot/policy-briefing-alcohol)



Appendix 7 – Glossary

Term	Definition
Alcohol attributable death <i>[note out with remit of this HNA]</i>	Alcohol attributable deaths, also known as alcohol related deaths, include deaths from any cause that can be attributed to alcohol. This includes alcohol specific causes (those that can only be caused by alcohol), such as alcoholic liver disease. Also included are those which are made more likely by alcohol, but also occur in people who do not drink, such as heart disease or various types of cancer.
Alcohol dependence	A cluster of behavioural, cognitive and physiological factors that typically include a strong desire to drink alcohol and difficulties in controlling its use. Someone who is alcohol-dependent may persist in drinking, despite harmful consequences. They will also give alcohol a higher priority than other activities and obligations. ⁹³
Alcohol Related Brain Damage (ARBD)	Alcohol Related Brain Damage (ARBD) describes a clinical syndrome due to structural and functional brain changes which occur as a result of chronic, heavy alcohol use. ⁹⁴
Alcohol related harm	Physical or mental harm caused either entirely or partly by alcohol. If it is entirely as a result of alcohol, it is known as alcohol specific. If it is only partly caused by alcohol it is described as alcohol-attributable. ⁹⁵
Alcohol Related Liver Disease (ARLD or ALD)	Alcohol related Liver Disease (ARLD), also known as Alcoholic Liver Disease (ALD) comprises of a range of liver diseases that have resulted due to excess alcohol consumption.
Alcohol specific death	Alcohol specific deaths only include those health conditions where each death is a direct consequence of alcohol (that is, wholly attributable causes such as alcoholic liver disease). It does not include all deaths that can be attributed to alcohol.
Alcohol Use Disorders (AUD)	Alcohol-use disorders cover a range of conditions, including: ⁹⁶ <ul style="list-style-type: none"> • hazardous drinking (a pattern of alcohol consumption that increases someone's risk of harm) • harmful drinking (a pattern of alcohol consumption that is causing mental or physical damage) • alcohol dependence (behavioural, cognitive and physiological factors that typically include a strong desire to drink alcohol and difficulties in controlling its use) • acute alcohol withdrawal (the physical and psychological symptoms that people can experience when they suddenly reduce the amount of alcohol they drink if they have previously been drinking excessively for prolonged periods of time).
Binge drinking	A heavy drinking session in which someone drinks a lot of alcohol in a short period of time raising their risk of harm on that occasion.

⁹³ <https://www.nice.org.uk/guidance/ph24/chapter/glossary#alcohol-dependence>

⁹⁴ [ard_gpg.pdf \(mwscot.org.uk\)](https://www.mwscot.org.uk/ard_gpg.pdf)

⁹⁵ <https://www.nice.org.uk/guidance/ph24/chapter/4-Glossary>

⁹⁶ <https://www.nice.org.uk/guidance/qs11/chapter/Quality-statement-2-Community-support-networks-and-self-help-groups#definitions-of-terms-used-in-this-quality-statement-2>

Brief Intervention	Structured brief advice comprises a 5-minute to 15-minute session of structured advice aimed at helping someone reduce their alcohol consumption or to stop drinking alcohol. ⁹⁷
Fetal Alcohol Spectrum Disorder (FASD)	Fetal Alcohol Spectrum Disorder (FASD) is an overarching term describing a range of effects that can occur following prenatal alcohol exposure (PAE) of the fetus. These effects can include neurocognitive and behavioural disabilities together with structural abnormalities.
Harmful drinking	High risk drinking Consumption: 35 units/week in women, 50 units/week in men
Hazardous drinking	Increases risk of harm Consumption: More than 14 units a week, but less than 35 units a week for women. Drinking more than 14 units a week, but less than 50 units for men.
ICD Codes	Clinical terms coded with ICD are the main basis for health recording and statistics on disease in primary, secondary and tertiary care, as well as on cause of death certificates. ⁹⁸

⁹⁷ <https://www.nice.org.uk/guidance/gs11/chapter/Quality-statement-1-Use-of-validated-alcohol-questionnaires#definitions-of-terms-used-in-this-quality-statement>

⁹⁸ <https://www.who.int/standards/classifications/classification-of-diseases#:~:text=Clinical%20terms%20coded%20with%20ICD,safety%2C%20and%20health%20services%20research.>