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A national survey of assertive outreach treatment services for people who frequently attend hospital due to alcohol related reasons in England

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Abstract

Aims: To characterise England's alcohol assertive outreach treatment (AAOT) services for people who frequently attend hospital due to alcohol related reasons according to their concordance with six core AAOT components.

Methods: A cross-sectional national survey using structured telephone interviews with health professionals examining 6 essential AAOT components. High-level AAOT services were those that delivered 5 or more components, mid-level 3 to 4 components, low-level AAOT services 2 or less.

Results: The analysis included 37 services that were classified according to their concordance with the 6 AAOT components. Six were identified as high-level AAOT services, 13 as mid-level AAOT services and 18 as low-level services. Extended support covering housing, mental and physical health over and above alcohol consumption was the most commonly delivered AAOT component provided. Having a multidisciplinary team was the least observed component, delivered in 33% high-level AAOT services and in 15% mid-level AAOT services. None of the low-level AAOT services had a multidisciplinary team.

Conclusions: Access to AAOT services developed to support high-cost and high-needs frequent hospital attenders varies across the nation. Further research, service evaluation and AAOT implementation should focus on essential AAOT components rather than self-defined labels of AAOT.

Short summary: The study investigated alcohol assertive outreach treatment (AAOT) services in England. The study found variability in service provision across AAOT services when measured against six essential AAOT components. Improvement of AAOT in England's hospitals should focus on the implementation of essential AAOT components.

Introduction

Alcohol related hospital admissions in England have more than doubled since the period of 2003/04 to reach over 1.1mn in 2015/16. Of these, more than a quarter (307,250) were for conditions wholly attributable to alcohol (National Statistics, 2017). The cost of alcohol related harm to the UK National Health Service (NHS) is estimated to be £2.7bn annually; £1.8bn of which resulted from hospital inpatient admissions (Health and Social Care Information Centre, 2015). Reducing the costs and harms of alcohol consumption in England therefore remains a key target for practice and policy (Strategy Unit, 2004; Department of Health, 2007; HM Government, 2012).

People with chronic conditions attributable to alcohol place a disproportionate burden on emergency departments (EDs) and inpatient services (Phillips *et al*., 2016). Many people who frequently attend hospital for alcohol related reasons have complex needs, including many years of alcohol dependence, mental and physical health problems, unemployment, dependence on state benefits, unstable housing or homelessness, social isolation and criminal justice involvement (Neale *et al*., 2017). A further challenge is that many of the people within this group do not engage well with conventionally delivered community drug and alcohol services (Passetti *et al*., 2008; Drummond *et al*., 2005).

Assertive outreach treatment is a model of community service provision originally developed in the 1970s to support people with severe mental illnesses (Stein and Test, 1980). It aims to support patients in the community over long periods and focuses on health care, material resources (accommodation, clothing and food), and coping skills. It aims to involve patients in managing their treatment

(Stein and Test, 1980).There is evidence for its efficacy compared to usual community care (Bond *et al*., 2001; Mueser *et al*., 1998; Marshall and Lockwood, 1998).

Assertive outreach treatment services have also been developed to work specifically with people who are alcohol dependent and people who frequently attend hospital due to alcohol related problems. For these AAOT services, Drummond *et al*. (2017) developed an AAOT intervention manual with input from experts in provision of assertive outreach treatment, proposing nine AAOT components: a low patient caseload; a multidisciplinary team; regular contact including in the community; persistent attempts at contact; focus on health and social care; flexibility toward patients' goals; openness; an ethos of 'going the extra mile' for patients; and extended care. Pilot studies have indicated that AAOT is a feasible approach for people who are dependent on alcohol and can enhance treatment engagement (Passetti *et al*., 2008; Drummond *et al*., 2017). An assertive outreach team was established at Salford Royal Hospital in 2011 to reduce alcohol related admissions, in which Hughes *et al*. (2013) conducted an evaluation of a cohort of 54 patients engaged with the team comparing outcomes in the 3-month period prior and after intervention and found significant reductions in hospital admissions, ED attendances, the patient's alcohol use and service costs. There is currently limited information about the number of AAOT services in England and their operational characteristics.

The aim of this study was to investigate AAOT services for people who frequently attend hospital with alcohol related problems in England by classifying services according to AAOT components defined by Drummond *et al*.(2017). Data were collected from telephone interviews with service practitioners across England.

Methods

The study was carried out between December 2015 and June 2016. Structured telephone interviews were conducted with ED consultants (n = 5), nurses (n = 19), other clinicians (n = 11) and service managers (n = 2) working in EDs or in separate but integrated services within the community. Minor injury units, children's hospitals and specialist trauma centres were excluded.

The study was a service review of current care and as such did not require ethical permission.

Setting

AAOT services were based (i) in hospitals working closely with other staff and supporting patients as they are discharged (delivered by alcohol care teams or health professionals with the specific role of working with people who frequently attend hospital for alcohol-related reasons); and (ii) in the community with the aim of enhancing community support, and doing 'in-reach' hospital work.

Recruitment

EDs were identified from the Third National Emergency Department Survey of Alcohol Identification and Intervention Activity (Patton and Green, 2017). At the time of data collection for the current survey, data were not available for six departments. Out of the remaining 141 EDs, those that offered services which aimed to reduce frequent alcohol-related attendances and/or offered AAOT were contacted (*n* = 73). An additional three services fulfilling the inclusion criteria were identified through the interview process, resulting in a sample of 76 eligible services.

Services were contacted by e-mail with follow-up after two weeks. For services that did not respond to e-mails, or did not share contact details, telephone numbers were sought. When follow-up e-mails and telephone calls were

unsuccessful alternative appropriate points of contact (e.g. alcohol liaison service) were identified. As a final option an electronic version of the questionnaire was offered, although no clinicians completed the survey in this manner. Whilst all initial contacts were based in hospitals, sometimes staff from external community AAOT services completed the survey.

This study measured concordance to the six components essential to AAOT (Drummond *et al*., 2017):

1) A maximum caseload of between 10 and 20 patients per practitioner.
2) Input from a multidisciplinary team in form of input from at least three different professions including nurses, medical and psychology or community support and drug workers.
3) Regular contact between patient and practitioner (at least once a week).
4) At least 50% of contacts occurring outside of the service settings, either in patients' homes or local community settings.
5) A focus on both health and social care needs, including accommodation, finance, leisure, occupation, and physical and mental health.
6) Extended care provided for a prolonged period of 12 months.

An attempt was made to measure assertive engagement by the number of methods used to engage clients in addition to routine appointments, such as home visits, peer mentoring approaches, text messages and e-mails. However, this item produced a very high non-response rate and the component was excluded from the criteria for classification. Future studies should identify a quantifiable measure of assertive engagement as this is a core component of AAOT.

A maximum caseload of 10 patients per practitioner has been used in assertive outreach treatment for people with severe mental illness (Teague *et al*., 1998; Bond *et al*., 2001). However, for clients with less debilitating conditions a caseload of 20 to 1 may be appropriate (Bond *et al*., 2001; Ryan *et al*., 1997). Drummond *et al*. (2017) used a caseload of 15 to 1 in an AAOT model developed for alcohol dependent clients. In this study, a maximum caseload of between 10 to 20 patients per practitioner was used.

Service classification

Services were classified according to concordance with six AAOT components (Wright *et al*., 2003; McHugo *et al*., 1999): (i) high-level AAOT services (≥5 AAOT components), (ii) mid-level AAOT services (3-4 AAOT components) or (iii) low-level AAOT services (≤2 AAOT components).

Data collection and analysis

A questionnaire was developed covering location of services, staff and AAOT components. Interviews were carried out over the telephone. In total, 47 out of 55 telephone interviews were audio recorded. Reasons for interviews not being recorded included staff not giving consent and failure of the recording device.

Data were recorded in an electronic spreadsheet, imported into SPSS and analysed using SPSS version 24. Data were collapsed into binary variables where appropriate to determine the presence of each of the six AAOT components in each service.

Results

A total of 76 services meeting inclusion criteria for the study were approached during the recruitment period. Of these, a staff member from 55 services (72%) took part in

an interview. No services refused to take part in the study. However, after a minimum of five attempts to contact a member of staff and the recruitment period lapsing no further attempts were made. Out of these 55 services, 18 services (12%) could not be classified according to the AAOT criteria as data were missing and so were excluded, leaving a total of 37 services (49%) in the final analysis.

Service location

Out of the 37 services included in the analysis, ten were located in North West England, eight in Greater London, six in Yorkshire and the Humber, five in South West England, three in East of England, two from North East England, two from South East England, one from West Midlands. No services from East Midlands were included in the analysis.

Concordance with AAOT components

Six services were identified as high-level AAOT services (16%), in that they delivered five or more components, 13 were mid-level (35%) delivering three to four AAOT components. Eighteen services were classified as low-level AAOT services (49%), delivering two or less of the AAOT components. One low-level AAOT service did not deliver any of the AAOT components.

AAOT components

Extended support beyond that directly relating to alcohol was the most commonly delivered AAOT component, present in all services but one. This may include support with housing, mental health problems, physical health problems, getting involved in activities, other drug misuse, referral to a community service, accompanying clients to appointments and a housing worker holding a clinic within their service. Having a multidisciplinary team was the least observed AAOT

component and ranged from 33% in high-level AAOT services to 15% in mid-level AAOT services. None of the low-level AAOT services had a multidisciplinary team.

A quarter of the services delivered most of their appointments within the community, with all the high-level AAOT services having this component compared to 23% of mid-level AAOT services and only one (6%) low-level AAOT service. All high-level AAOT services provided at least weekly contact and support for a period of 12 months with patients as did the majority of the mid-level AAOT services (77%), in contrast only one low-level AAOT service (6%) provided at least weekly contact and no low-level AAOT services offered support for a period of 12 months.

All high-level AAOT services had a caseload of between 10 to 20 patients per practitioner. However, only one (6%) low-level AAOT services had a maximum caseload of no more than 20 patients. About a fifth of the mid-level AAOT services (23%) had a maximum caseload of 20 patients per practitioner.

Amongst the mid-level AAOT services, the most common AAOT components delivered were having a focus on both health and social needs (100%), contact once a week (77%) and extended care provided for a prolonged period of a year (77%).

Staff

Most services included nurses (100% of high-level AAOT services, 92% of mid-level AAOT services and 83% of low-level AAOT services) and staff from other backgrounds, such as community support and drug workers (83% of high-level AAOT services, 54% of mid-level AAOT services and 28% of low-level AAOT services). Some services included medical staff (33% of high-level AAOT services, 15% mid-level AAOT services and 17% of low-level AAOT services). Social workers

were rarer and only identified in high (100%) and mid-level (15%) AAOT services. Psychology staff were only present in one of the high-level AAOT services.

Discussion

This is the first study to classify England's AAOT services for people who frequently attend hospitals for alcohol related reasons according to their concordance with six essential AAOT components. In a survey of alcohol care in England's hospitals, 21 hospitals reported providing assertive outreach for high impact users with frequent hospital attendance, but did not account for which AAOT components were delivered (Public Health England, 2014). Using defined criteria to classify AAOT services according to the number of AAOT components has underlined the variability of AAOT for alcohol dependent drinkers across England.

Having a multidisciplinary team was the least observed AAOT component in the study, which also found a low prevalence of social workers and psychology staff. A national survey of assertive community treatment services in England found that a third of services had no input from a psychiatrist, half had no psychologist and the majority had no specialist in substance misuse (Ghosh and Killaspy, 2010). Burns and colleagues (2007) undertook a meta-regression and found that a lack of team-working explained variation in the outcome of hospital use between trials of intensive case management. Further attention in clinical practice and research on availability of a multidisciplinary team in AAOT services and patient outcomes is warranted.

Almost all the classified AAOT services offered extended support to their clients with a focus on both health and social care needs, including accommodation and finance. This compares favourably to previous studies of AAOT models for patients with severe mental illness where support to address both health needs and

community living skills was also an essential component (Stein and Test, 1980; Burns *et al*., 2000; McHugo *et al*., 1999).

Home visits and community care provision can increase the likelihood of treatment completion (Gilbert, 1998) and reduce time in hospitals which is costly, stigmatising and disliked by patients (Burns *et al*., 2007). However, this study found that the number of AAOT services in England that are able to support high need alcohol dependent clients in the community is limited. This may have been related to patient caseloads in mid and low-level AAOT services, where only few had restricted the maximum caseload to 20 patients per practitioner, indicating that the higher the ratio of patients per practitioner, the more difficult it becomes to see patients outside services.

For England, the National Institute for Health and Care Excellence (NICE) recommends assertive outreach models for people who have moderate to severe alcohol dependence and who otherwise would find it difficult to engage in specialised alcohol treatment (National Collaborating Centre for Mental Health, 2011; National Institute for Health and Care Excellence, 2011). However, at this early stage of AAOT implementation in the UK, local policy and commissioning vary. Although six high-level AAOT services delivered almost all the six essential AAOT components, eighteen low-level AAOT services provided very few AAOT components. None of these offered long-term support for up to a year with input from a multidisciplinary team. Assertive outreach treatment is emerging as a model of community care for people with severe mental illness, but has been only gradually adopted by alcohol care teams in England's hospitals. In the absence of central guidelines, implementation of AAOT depends on local stakeholders, local health systems and funding. This may explain the current variation in AAOT recorded in our study.

We recommend further research to investigate the efficacy of AAOT delivered in alcohol dependent populations and evaluate the outcomes of AAOT in real-life scenarios, encouraged by studies for the severely mentally ill that show that high fidelity assertive community treatment models results in better outcomes (Bond *et al*., 2001).

Limitations

The main limitation of the study is the non-response rate of 51% eligible services. Non-responses were high in East Midlands (no responses) and West Midlands (20%).

The study is limited by missing values in the data. On first contact with participating EDs, we aimed to identify the most appropriate staff member to complete the survey. In some cases, two members of staff were interviewed to complete the survey and characterise services. However, the data collected relied on the knowledge of staff and information could have been missed or inaccurately reported, e.g. by new staff. If respondents were unable to provide sufficient details or the interviewer was not confident in their answers data was reported as missing.

A further limitation of the study was the screening process used to identify potential participating EDs. Only services who responded to the initial survey of alcohol interventions in EDs (Patton and Green, 2017) and who reported providing an alcohol assertive outreach and/or specific support for people who frequently attend the department due to alcohol related problems were approached. EDs that did not complete the initial survey, or did not respond positively to the screening questions, but may have provided AAOT, could have been missed. Moreover, the sampling strategy focussed on services within or known to EDs, and thus other

services working within the community but not known to the ED could also have been missed. However, AAOT services were asked if they were aware of similar services, and as a result three additional services were included.

Conflicts of interests

None declared.

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References

Bond GR, Drake RE, Mueser KT, *et al*. (2001) Assertive community treatment for people with severe mental illness. *Dis Manage Health Outcomes* **9**:141–159.

Burns T, Fiander M, Kent A, *et al*. (2000) Effects of case-load size on the process of care of patients with severe psychotic illness. *Br J Psychiatry* **177**:427–433.

Burns T, Catty J, Dash M, *et al*. (2007) Use of intensive case management to reduce

time in hospital in people with severe mental illness: systematic review and meta-regression. *BMJ* **335**:336–336.

Department of Health. (2007) *Safe. Sensible. Social. The next steps in the National Alcohol Strategy*. London: Department of Health.

Drummond C, Oyefeso A, Phillips T, *et al*. (2005) *Alcohol Needs Assessment Research Project (ANARP): The 2004 national alcohol needs assessment for England*. London: Department of Health.

Drummond C, Gilburt H, Burns T, *et al*. (2017) Assertive community treatment for people with alcohol dependence: A pilot randomized controlled trial. *Alcohol Alcohol* **52**:234–241.

Ghosh R, Killaspy H. (2010) A national survey of assertive community treatment services in England. *JMH* **19**:500–508.

Gilbert FS. (1998) The effect of type of aftercare follow-up on treatment outcome among alcoholics. *J Stud Alcohol* **49**:149–159.

HM Government. (2012) *The Government's Alcohol Strategy*. London: Home Office.

Hughes NR, Houghton N, Nadeem H, *et al*. (2013) Salford alcohol assertive outreach team: a new model for reducing alcohol-related admissions. *Frontline Gastroenterol* **4**:130–134.

Marshall M, Lockwood A. (1998) Assertive community treatment for people with severe mental disorders. *Cochrane Database Syst Rev* DOI: 10.1002/14651858.CD001089.

McHugo GJ, Drake RE, Teague GB. (1999) Fidelity to assertive community treatment and client outcomes in the New Hampshire dual disorders study.

Psychiatr Serv **50**:818–824.

Mueser KT, Bond GR, Drake RE, *et al*. (1998) Models of community care for severe mental illness: a review of research on case management. *Schizophr Bull* **24**:37–74.

National Collaborating Centre for Mental Health. (2011) *Alcohol-use disorders: Diagnosis, assessment and management of harmful drinking and alcohol dependence*. London: The British Psychological Society and The Royal College of Psychiatrists.

National Institute for Health and Care Excellence. (2011) *Alcohol dependence and harmful alcohol use quality standard*. London: National Institute for Health and Care Excellence.

National Statistics. (2017) *Statistics on Alcohol, England 2017*. London: NHS Digital.

Neale J, Parkman T, Day E, *et al*. (2017) Socio-demographic characteristics and stereotyping of people who frequently attend accident and emergency departments for alcohol-related reasons: Qualitative study. *Drugs Educ Prev Pol* **24**:67–74.

Passetti, F, Jones G, Chawla K, *et al*. (2008) Pilot study of assertive community treatment methods to engage alcohol-dependent individuals. *Alcohol Alcohol* **43**:451–455.

Patton R, Green G. (2017) Alcohol identification and intervention in English emergency departments. *Emergency Medical Journal.*

Phillips TS, Coulton S, Drummond C. (2016) Using hospital episode statistics to identify the burden of alcohol related conditions on emergency departments in England. *Alcohol Clin Exp Res* **40**:47A.

Public Health England. (2014) *Alcohol care in England's hospitals. An opportunity not to be wasted*. London: Public Health England.

Ryan CS, Sherman PS, Bogart LM. (1997) Patterns of services and consumer outcome in an intensive case management program. *J Consult Clin Psychol* **65**:485–493.

Stein LI, Test MA. (1980) Alternative to mental hospital treatment: I. Conceptual model, treatment program, and clinical evaluation. *Arch Gen Psychiatry* **37**:392–397.

Strategy Unit. (2004) *Alcohol Harm Reduction Strategy for England*. London: Cabinet Office.

Teague GB, Bond GR, Drake RE. (1998) Program fidelity in assertive community treatment: development and use of a measure. *Am J Orthopsychiatr* **68**:216–232.