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

Stephanie Fincham-Campbell[1], Andreas Kimergård[1], Amy Wolstenholme[1], Ros Blackwood[1], Robert Patton[2], Jacklyn Dunne[1], Paolo Deluca[1], and Colin Drummond[1]

[1] Addictions Department, National Addiction Centre, Institute of Psychiatry, Psychology and Neuroscience, King's College London, London, UK
[2] School of Psychology, University of Surrey, Guildford, UK

Background

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). Assertive outreach treatment services have recently been developed to work specifically with people who are alcohol dependent and people who frequently attend hospital due to alcohol related problems.

There is currently limited information about the number of AAOT services in England and their operational characteristics.

Aims

The aim was to classify and characterise alcohol assertive outreach treatment (AAOT) services for patients in emergency departments (EDs) in England according to their concordance with six core AAOT components

Alcohol Assertive Outreach Treatment (AAOT)

- Low patient caseload
- Multidisciplinary team
- Regular contact in the community
- Persistent attempts at contact
- Focus on health and social care
- Flexibility towards patient's goals
- Openness
- Ethos of 'going the extra mile' for patients
- Extended care

Reference: Drummond et al (2017)

Methods

A cross-sectional national survey using structured telephone interviews with health professionals based in EDs or separate, but hospital supporting community services in England. Six essential AAOT components were used for classification. High-level AAOT services were those that delivered five or more components; mid-level AAOT services delivered three to four components; and low-level AAOT services delivered two or less.

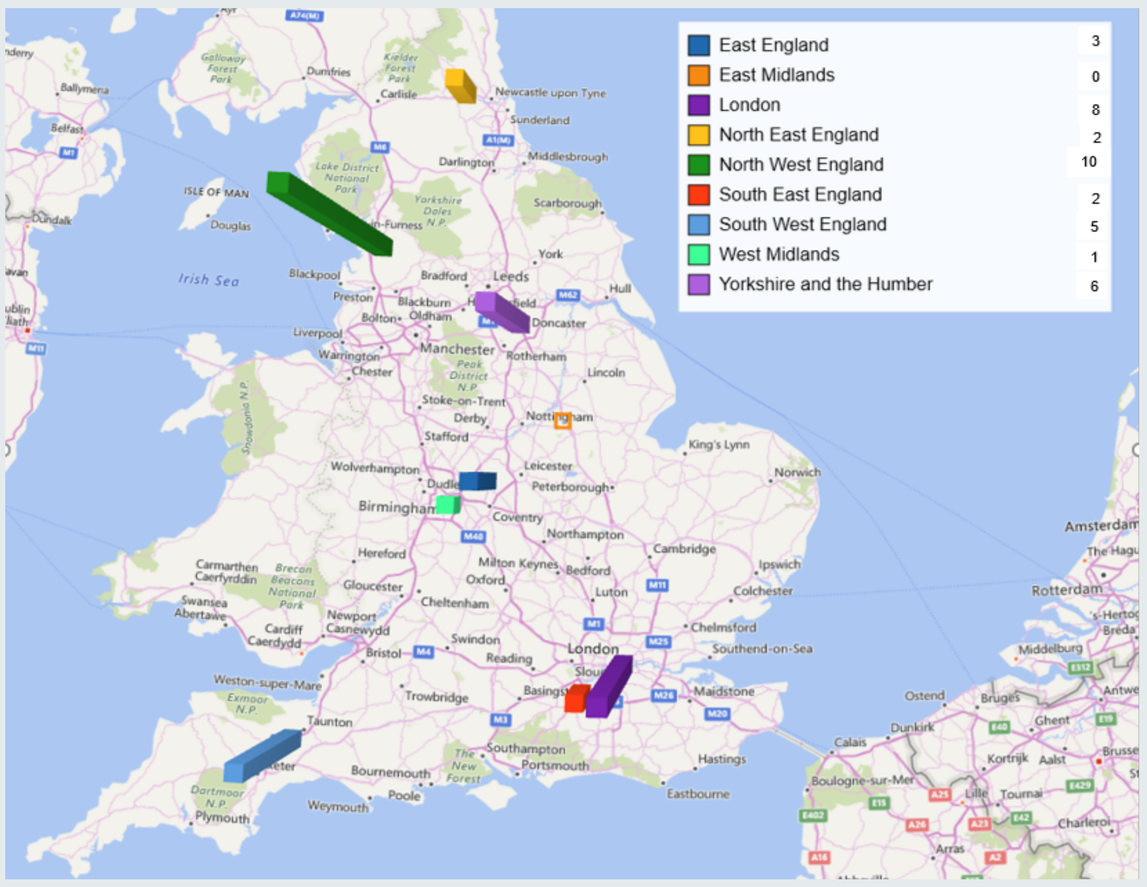
Results

The analysis included 37 services that were classified according to their concordance with six AAOT components. ***Six were identified as high-level AAOT services, thirteen as mid-level AAOT services and eighteen 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 in all services but one. 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 to reduce hospital admissions varies greatly nationally. Further research, service evaluation and AAOT implementation should focus on essential AAOT components opposed to self-defined labels of AAOT.

AAOT components	High-level AAOT services	Mid-level AAOT services	Low-level AAOT services
A caseload of between 10 and 20 patients per AAOT practitioner	100%	23%	6%
Input from a multidisciplinary team	33%	15%	0%
Regular contact (at least once a week)	100%	77%	6%
50% of contacts occurring outside of the service settings	100%	23%	6%
A focus on both health and social care needs	100%	100%	94%
Extended care provided for a prolonged period of 12 months	100%	77%	0%



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Conflict of interest declaration
None

Correspondence: Stephanie Fincham-Campbell, PhD student, National Addiction Centre, PO48, Institute of Psychiatry, Psychology & Neuroscience, Addiction Sciences Building, 4 Windsor Walk, Denmark Hill, London, SE5 8BB stephanie.fincham-campbell@kcl.ac.uk