



Frequent attenders to accident and emergency departments: a qualitative study of individuals who repeatedly present with alcohol-related health conditions

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Key findings

- People who frequently attend Accident and Emergency (A&E) departments for alcohol-related reasons tend to experience alcohol dependence associated with multiple and complex needs, but also report diverse patterns of drinking and other substance use, and varied health and social problems.
- Although A&E staff are generally sympathetic to the needs of people with complex drinking and related problems, they do not have the resources or training to provide the kind of personalised support that people who frequently attend A&E for alcohol-related reasons often need.
- Assertive outreach - a treatment model that offers intensive, individualised, caseworker support for patients in the community - seems to offer good potential for helping people who frequently attend A&E for alcohol-related reasons.

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Background

People who frequently attend A&E departments for alcohol-related reasons place a disproportionate burden on hospital bed usage (Mandelberg et al., 2000). Members of this patient population are most commonly referred to as 'alcohol frequent attenders', but they have also been described as 'frequent flyers' and 'change resistant drinkers' (Herring et al., 2011; Ward & Holmes, 2014). Local UK data indicate that people who frequently attend A&E for alcohol-related reasons experience high levels of comorbidity, social disadvantage and exclusion, but beyond this there is very little information about them (Moriarty et al., 2010; British Society for Gastroenterology and the Royal Bolton Hospital NHS Foundation Trust, 2011). The central aim of this study was to provide detailed insights into the characteristics, views and experiences of individuals who repeatedly present to A&E with alcohol-related health conditions in order to optimise the development, implementation and evaluation of interventions for them.

Methods

Interviews were conducted with 30 individuals who had attended A&E ten or more times within the last year or five or more times within the last three months for an alcohol-related condition. Individuals were identified to the study team by alcohol liaison nurses and specialist alcohol workers from A&E departments located in six hospitals across London, UK. Interviews were undertaken using a semi-structured topic guide, lasted 60-120 minutes, and took place in non-hospital settings, such as participants' homes, hostels, GP surgeries or cafés. Interviews were audio-recorded, transcribed verbatim, and then coded and systematically analysed line by line. All participants gave written consent to be interviewed and none was intoxicated at interview.

Focus groups were also undertaken with 44 A&E staff who worked in six hospitals across England. Three hospitals had a specialist service for alcohol frequent attenders and three hospitals did not. No hospital was in London. Each focus

group began with a short presentation by the research team on key findings from the one-to-one patient interviews, and focus group members were then asked to discuss the findings with particular reference to their own hospital setting and day-to-day practice. The focus groups were also audio recorded, transcribed verbatim, coded and analysed line-by-line. Staff included alcohol liaison nurses, A&E nurses, A&E consultants, registrars, consultant gastroenterologists, psychiatrists, clinical support workers, generic healthcare workers, A&E managers, receptionists, and a porter.

Findings

Patient interviewees included 18 males and 12 females, age range 20-68 years (mean 48 years). Nineteen described themselves as White British; 4 as Asian British; 3 as Mixed Race British; 3 as German; and 1 as Somalian. As a group, they reported high levels of mental and physical ill health, unemployment, dependence on state benefits, housing problems and social isolation. These problems were often interconnected and mutually reinforcing. At an individual level, the extent and nature of their health and social problems were very varied, with some reporting good health and positive social support.

Hospital record data indicated that the mean number of A&E attendances per individual interviewed in the last 12 months was 24 (range = 10-84), with a mean of 5 hospital admissions (range = 0-17). However, A&E staff believed that hospital monitoring systems failed to record many alcohol-related attendances (e.g. because patients gave no or a false name or did not disclose alcohol use or because data were not fully or accurately entered by hospital staff). Thus, actual attendances and admissions were likely to be higher.

Most interviewees reported many years of heavy drinking and the types of drink consumed included beer, strong cider, spirits, and wine. Almost all interviewees drank daily. The main reasons interviewees gave for drinking were dependence and to self-medicate for physical or mental health problems, although boredom and loneliness were also discussed. None said they drank for pleasure.

A&E staff concurred with the drinking patterns and high levels of smoking reported by the interviewees, but believed that co-existing drug use was greater amongst this patient population in their own hospitals.

Patient interviewees reported histories of transient engagement with addiction services and Alcoholics Anonymous and almost no contact with broader health and social care services. Most interviewees stated that the professional support available was not sufficient or appropriate for them and service providers lacked knowledge of their needs. Although some interviewees said that they had received excellent care from their GPs, most felt that GPs were unsupportive and lacked empathy, and knowledge of addiction and treatment options.

A&E staff felt that people who frequently attend A&E for alcohol-related reasons do not use specialist addiction services because of long waiting times, poor assessment processes and the need to attend services when they are not feeling motivated. Some A&E staff also reported that they were personally unable to refer patients to others for support as they had no knowledge of suitable local services.

Patient interviewees' reasons for attending A&E included: being intoxicated, being in pain because of withdrawal symptoms, having an injury from intoxication, or self-harming after drinking. Most were brought to A&E by ambulance, with members of the public, family, friends and the interviewee themselves variously calling out the emergency services. The hospital attended was nearly always the one closest to where the interviewee was when the ambulance was called (usually their home).

Interviewees reported that A&E staff rarely gave them advice on their drinking, and only one said that she had received a care plan from a hospital. Interviewees' views of the support provided by hospital staff ranged from excellent

(empathetic, caring, supportive) to very poor. The main criticism of A&E departments related to the process of discharge, with many interviewees complaining that they were forced to leave very early in the morning without money or clean clothes and with no way of getting home.

Most A&E staff felt that the intensive and 'high-paced' environment of A&E was not the right place to attempt to address complex drinking problems and associated social problems with patients. Indeed, doing so could 'open up a can of worms', for which A&E staff were not resourced to respond. Although none of the hospitals had a discharge protocol, all staff explained that they allowed patients to wait in the reception or waiting room until the first bus if they were discharged early in the morning. They also often gave patients clean clothing or washed soiled clothes for them.

A&E staff were reluctant to provide transport on discharge in case this encouraged patients to return unnecessarily. Despite this, they sometimes handed out bus fares. A&E staff believed that patients repeatedly came back to A&E departments because they are always open, warm, familiar, and safe, and because A&E staff provide free hot drinks and sandwiches, tend to be friendly, and treat people with care and empathy.

Patient interviewees reported little desire for any help in addressing their drinking or other drug use. Instead, most explained that they wanted assistance with their mental health issues, particularly one-to-one counselling. Others expressed a desire for support with more practical and social problems, such as housing needs, benefit issues, and finding opportunities to work or volunteer.

Although A&E staff gave many examples of how they had tried to help patients, they recognised the limits of their roles and resources. Equally, they emphasised that this patient population is very difficult to motivate, engage, and treat, and no single model of care can possibly work for everyone.

A&E staff felt that the best method of identifying patients who frequently attend A&E for alcohol-related reasons would be via a computer-based system that recorded the number and frequency of A&E attendances for each patient. Staff reported that the best way of engaging and retaining patients in treatment would be via a multi-disciplinary team, with specialist workers, who provided an individualised package of care and visited patients in the community as soon as possible after discharge.

A&E staff felt that assertive outreach was a potentially valuable treatment model for this patient population. However, they expressed concerns that clients would become dependent on assertive outreach case workers; were worried about the level of emotional and practical demands that might be placed on assertive outreach caseworkers; and anticipated high rates of assertive outreach caseworker turnover.

Implications

Patients who frequently find themselves in A&E for alcohol-related reasons need to be open about their drinking with A&E staff, otherwise staff cannot help them. However, patients also need to remember that A&E departments are not the best places to have detailed discussions about drinking. Staff in A&E departments will treat physical health problems but then discharge patients. They do not tend to provide transport home.

People who frequently attend A&E for alcohol-related reasons collectively experience multiple and complex needs, but individually report diverse patterns of drinking and other substance use, and varied health and social problems.

Flexible person-centred systems are therefore needed to support this patient population. Additionally, care should be taken not to stereotype or stigmatise them based on generalised assumptions about their needs.

Identification of people who frequently attend A&E because of alcohol is likely to be achieved best via electronic



records of A&E attendances. However, current hospital recording processes underestimate the demands people who frequently attend A&E place on hospital time and resources. Recording processes should therefore be reviewed in order to ensure that the most accurate information is captured.

A&E staff should try to build and sustain close working relationships with relevant local partners, particularly specialist addiction services. Representatives of local specialist addiction services should be invited to any relevant hospital-based multi-disciplinary team meetings, such as 'frequent attender' meetings. A&E staff also need up-to-date information on local addiction services to assist with referral and care co-ordination.

Assertive outreach - a treatment model that offers intensive, individualised, caseworker support for patients in the community - seems to offer good potential for helping people who frequently attend A&E for alcohol-related reasons. Ideally, assertive outreach workers would be based within, or work closely with, multi-disciplinary teams of professionals.

Hospital discharge offers an important window of opportunity to intervene in the life of a patient who frequently attends A&E for alcohol-related reasons. It would be an ideal time for an alcohol liaison nurse or alcohol assertive outreach worker to step in with offers of practical support for a range of broader health and social problems, as well as referral to addiction services.

Assertive outreach workers should work with patients on relapse prevention plans and crisis plans before crises occur and develop a protocol or guidance on 'tapering off' support to ensure that any future transition to life without assertive outreach is manageable.

The demands of the assertive outreach caseworker role are likely to be intensive. Caseworkers will therefore need regular unhurried supervision with a senior colleague. They should also receive guidance on setting boundaries that enable them to stay safe and prevent them from feeling overwhelmed.

Further Information

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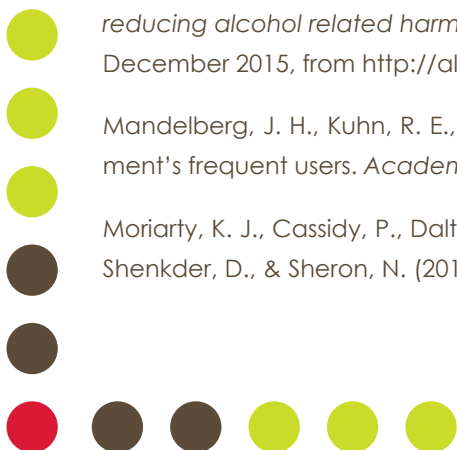
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