

**Final Report**

**High Impact Complex Drinkers Pilot 2016**

**Surrey County Council  
Public Health**

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## 1. Introduction

Alcohol related risk, in all forms, places a significant burden on a range of public services, but in every locality there will be a group of more complex drinkers, whose alcohol use and associated lifestyle contributes to a pattern of more frequent contact with a range of frontline services. They are often characterised by the complexity of the needs, multi- morbidity and exclusion from society. This is a highly diverse service user group whose social circumstance ranges from being housed to being homeless or having temporary accommodation, involved in the criminal justice system, commonly experiencing mental health problems, facing financial difficulties and lacking in social capital or support networks.

In addition they often fail to engage, or maintain engagement, in core services, both substance misuse specific and wider health and social care services. The complexity of these health and social care needs often act as a barrier to engagement, for example the organisation of appointments with no fixed abode or stable contact information can become problematic. High impact complex drinkers service use is commonly crisis driven. Accessing and engaging in treatment requires a level of motivation and some minor client stability; alcohol Treatment in Surrey is delivered in line with NICE Guidance CG 115<sup>1</sup>, however High Impact Complex Drinkers (HICD) are characterised by crisis driven service engagement. Often for those with these complex needs this threshold of engagement is beyond their level of motivation, clients are frequently socially excluded and can become isolated from services, which may then classify them as 'treatment resistant', 'intentionally homeless' or 'hard to engage'.

There is emerging evidence which demonstrates that through an outreach approach and improved pathways this client group can be engaged and supported to reduce alcohol consumption and improve quality of life, thus reducing the impact on public services<sup>2</sup>. This evidence suggests that these clients respond best to an assertive approach (taking the service to the client), which is not time limited, and accepts that change may be more gradual and faltering. A fully integrated response is required, involving a number of services working to shared goals and sharing information. Often, health and social needs addressed either in parallel or before the client can effectively access

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<sup>1</sup> CG 115 Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence <https://www.nice.org.uk/guidance/cg115>

<sup>2</sup> Alcohol Concern (2014) Working with Change resistant drinkers: The project manual.

and sustain substance misuse treatment. Evidence suggests that tenancy stability and better health can be a foundation from which reduction in alcohol use or abstinence can be contemplated<sup>2</sup>.

### 1.1 Rational – National Blue Light Project

In 2014 Surrey County Council partnered in the National Blue Light project delivered by Alcohol Concern. The Blue Light Project aims to develop alternative approaches to care pathways for treatment resistant drinkers<sup>3</sup>. The project provided a better local understanding of the number of potential clients who could benefit from an alternative approach and the potential costs to services. These estimates are based on Public Health England Estimates that 94% of dependent drinkers (Surrey n = 21,671) and 85% of those drinking at higher risk levels (Surrey n= 35,505) do not currently engage with treatment services. Estimates are based on service specific national estimates or the evidence then adjusted to Surrey's population and level of need. For instance, evidence shows that 27% of respondents with mental disorder, had an AUDIT score of 8 or more (increasing risk or higher) including 14% who were classified as alcohol dependent<sup>3</sup>. The table identifies over 2000 clients, however, due to the nature of these clients, it is highly likely that estimates will double count clients as they are known to more than one service. However, even an estimate of 15-20% of these estimates would still present a level of need of between 300-400 clients.

**Table 1: Estimates for Surrey based on Blue Light Modeling**

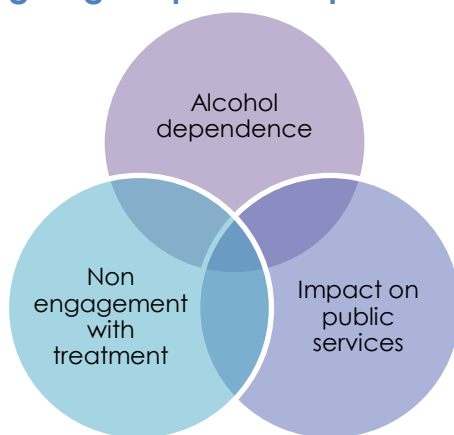
Service area	Cost of <i>Blue Light</i> clients	Estimated numbers
Primary Care	Unknown	194
<b>Emergency department</b>	<b>£2,329,752</b>	<b>194</b>
Hospital	£334,749	194
Ambulance	<b>£2,153,190</b>	
Alcohol services	£1,369,429	
Mental health services	£699,958	116
<b>Police</b>	<b>£5,767,473</b>	<b>91</b>
Probation	£4,613,979	142
Anti-social behaviour services	£700,641	52
<b>Adult social services</b>	<b>£5,810,195</b>	<b>259</b>
<b>Children and families services</b>	<b>£5,036,414</b>	<b>414</b>
Housing and homelessness services	£11,129,942	41

<sup>3</sup> Alcohol Concern (2014) *The Blue Light: Treatment Resistant Drinkers* project: Defining and quantifying the impact of this client group

Fire service call outs	£725,249	
Fire service false alarms	£48,532	
MAPPA		18
MARAC		<b>207</b>
Street Drinkers		155
Total	<b>£55,664,693</b>	

A breakdown of how these figures were calculated in “**The Blue Light: Treatment Resistant Drinkers project: Defining and quantifying the impact of this client group**” available on request.

## 1.2. Defining “High Impact Complex Drinkers” (HICD)



**Figure 1: Defining High Impact Complex Drinkers**

Specifically defining “the client” can be difficult due to the wide range of needs; however each client must include three criteria shown in Figure 1. Within each criterion there will be eligibility criteria. Broadly a high impact complex drinker can be defined as:

- Community based
- Problematic and/or dependent alcohol use
- Often with complex issues neglect, mental health, homelessness
- Non engagement or failure to maintain engagement with substance misuse treatment services
- Frequent/repeat use of emergency services – Police, A&E/hospital, Fire and Ambulance.

The eligibility criteria used in the local pilot can be found in Appendix A.

## 2. Evidence of what works

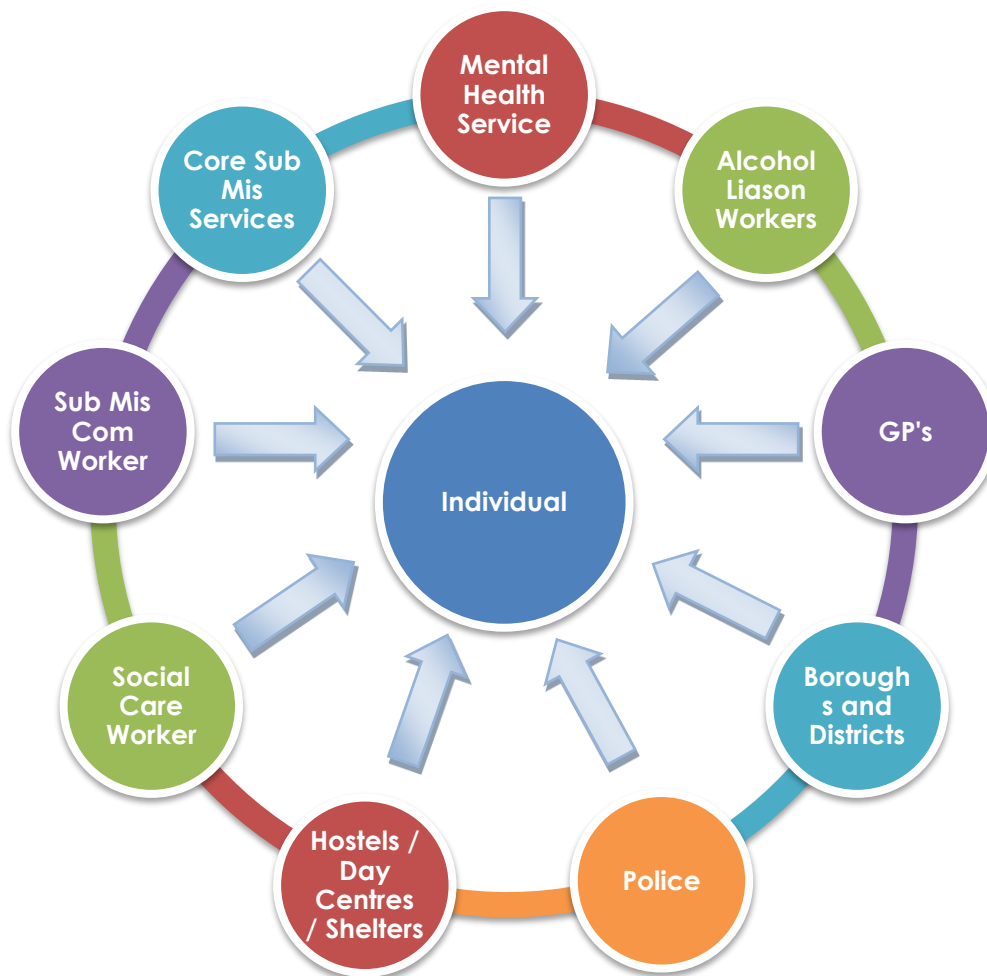
### 2.1 National Blue Light model.

The Blue Light Project was developed by Alcohol Concern and local partnerships; supported by Public Health England, to develop best practice to assertively engage and sustain medium to long term change with those who are considered to be change or treatment resistant<sup>3</sup>. Assertive outreach underpins the Blue Light Project, however, there is a much larger emphasis placed on the role of the partnership between agencies working that an individual may come into contact with. Another major difference between the Blue Light Model, assertive outreach and core services, is the emphasis on continued and prolonged support, without time limitations and encouraging the use of peer mentors and recovery. Rather than the individual touching on a range of different services all responding in isolation, the model looks to engage services to joint case manage the client (See Figure 2).

The core aims of the Blue Light project are to develop responses that require minimal investment by:

- Using existing resources more effectively.
- Achieving the greatest impact by bringing organisations together and refocusing what they do.
- Building bridges with partners like the police, housing and social care.

This approach places emphasis on a joint response with the addition of a substance misuse specialist rather than only placing new assertive outreach workers in to a community. There is the risk that just placing an assertive outreach worker into the system they become the new 'end point' for the client, rather than looking for a joint solution which addresses a number of different client needs. Services that have the most engagement with the client should remain the consistent key worker but understand that the substance misuse workers have the flexibility to support and respond in a more tailored way than the 'core' service.



**Figure 2: Application of Blue Light Model to Surrey Services**

Since the inception of the Blue Light Project a number of Local Authorities have built local models for delivery. Nottinghamshire invested between £160,000 and £180,000 to support the delivery of a Multi-Disciplinary Team (MDT) being delivered from hospital. The MDT includes ambulance, emergency department (ED), social care and the police. The core aims of the team are to build a relationship, stabilise and reduce harm, develop care planned interventions and engage in recovery where possible<sup>4</sup>. The service delivers a care package which is driven by the client's needs which maybe a combination of services and support, rather than use of a specific service with set structures or systems. In an evaluation by Nottinghamshire the service has shown to have saved £360,000 in healthcare costs which exceeds the cost of providing the service and does not include wider savings (i.e. criminal justice)<sup>4</sup>.

Lincolnshire focused their delivery through Community Incident Action Groups (CIAG's) as an already functional MDT. Findings suggest that after five months

<sup>4</sup> Project Evaluation: Nottinghamshire Alcohol Related Long Term Condition Team.  
<http://ranzetta.typepad.com/files/the-nottinghamshire-alcohol-related-long-term-condition-team.pdf>

of operation there has been a 30% reduction in police incidents relating to those Blue Light clients who are now being targeted through this approach<sup>5</sup>. Sandwell and Medway also focused their service to reducing contact with the criminal justice system, but are too early into delivery to be able to measure financial return in investment or impact on services yet.

## 2.2 Other areas and approaches

Salford also delivered an outreach element from a MDT, this has been enabled through their NHS England Quality and Productivity targets. The alcohol outreach service cost £300,000 per annum and included a multidisciplinary team with a medical, psychiatric, substance misuse, psychology nursing and social work specialists. The team worked with the top 30 frequent attendees with the highest number of alcohol related admissions, these were case managed in a community setting, every six months this cohort was refreshed<sup>6</sup>. In the report by Hughes *et al*, (2013) 54 patients were case managed, results showed reductions in admissions from 151 pre three month intervention to 50 post intervention, and emergency attendances fell from 360 in three months to 146 following the intervention. A recent published report on the service shows that in the second year of the service savings of £606,675 were achieved.

The South East London Health Innovation Network is also piloting this approach to target specifically Alcohol Related Frequent Attendees with a MDT approach. Whilst the primary focus is on reducing healthcare costs, patients identified to support include those with temporary accommodation, unemployment, mental health problems, financial difficulties, relationship difficulties and are often thought to be 'beyond help'<sup>7</sup>. The South East London Health Innovation Network (HIN) anticipate similar healthcare savings to those of Salford. In addition they highlight the potential savings to the criminal justice system via the UKATT and STEPWISE Clinical trials<sup>7</sup>. Based on these trials the HIN estimate that NHS costs represent 16%-50% of the identified costs before someone enters treatment, whilst the criminal justice costs are estimated to be 25-50% of the overall pre-treatment costs<sup>8,9</sup>.

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<sup>5</sup> Ward (2016) Tackling high impact drinkers in STP Plans.

<sup>6</sup> Hughes *et al.*, (2013) Salford alcohol assertive outreach team: a new model for reducing alcohol-related admissions <http://fg.bmj.com/content/early/2013/01/22/flgastro-2012-100260.full.pdf>

<sup>7</sup> Alcohol Related Frequent Attenders to Secondary Care: a briefing Report. South London HIN (2015) [http://www.hin-southlondon.org/system/resources/resources/000/000/096/original/Report\\_-\\_Alcohol\\_-\\_FINAL\\_VERSION\\_16pgs\\_160315.pdf](http://www.hin-southlondon.org/system/resources/resources/000/000/096/original/Report_-_Alcohol_-_FINAL_VERSION_16pgs_160315.pdf)

<sup>8</sup> Godfrey *et al.* (2005) Cost effectiveness of treatment for alcohol problems: findings of the UK Alcohol Treatment Trial (UKATT). *BMJ*, 331 (7516), 544-548.

<sup>9</sup> Drummond *et al.* (2009) Cost effectiveness of a stepped care intervention for alcohol use disorders in primary care. *Brit J Psychiat*, 195, 448-456.



### 3. Surrey Pilot

#### 3.1 Case for Change

The High Impact Complex Drinkers (HICD) Pilot ran between March 2015 and April 2016, across the boroughs of Woking, Waverly and Guildford. The pilot was titled High Impact Complex Drinkers, to maintain focus on those with alcohol as their sole or primary substance use and recognised as severely complex. These boroughs were selected as they offered access to a critical mass of services within the town centers which could be drawn on to work and support the project.

An initial review of the Royal Surrey County Hospital data to identify the case for change showed:

- 22 adults who attended A&E four or more times in 2014/15 where alcohol was identified as a contributory factor.
- Attendances ranged from 4-47 with an average of 12.5 attendances.
- 15 (68%) were admitted on at least one occasion.
- The average time spent by alcohol related frequent attendees was 3.3 hours.

A review of admissions data for the Guildford and Waverley CCG catchment area identified:

- 25 adults were admitted to hospital on 4 or more times in 2014/15 where alcohol was consistently coded as a factor in admission.
- The total number of admissions attributed to these patients was 192, an average of 8 per patient.
- 37% of those admitted were discharged in less than a day
- A further 21% admitted for one night.
- For the 42% who stayed for more than one night the average length of stay was 8 days

#### 3.2 Approach

Two community workers were employed through Surrey and Borders Partnership Trust. These workers were able to work with clients without time limited and or thresholds that impact on future engagement. The core functions of these workers were:

- To provide assertive alcohol outreach for those who find it difficult to engage with substance misuse treatment services and to support their access to a variety of support networks or services
- To plan and organise activities with service users according to their care plan and liaison with other key worker

The community workers core skills are centered on motivational interviewing rather than clinical treatment. For the pilot these workers worked with a specific pre-determined group made up of the primary night/day shelters, core substance misuse treatment services and an Alcohol Liaison Nurse from the Royal Surrey County Hospital, to develop joint care plans for the clients. The group met on a 6 week basis to review cases and discuss the pilot developments. The meetings included learning from best practice cases where services have worked well together and highlighting difficulties and barriers where things were not working so well.

### 3.3 Results

The pilot service received 24 referrals over the course of the year, though the bulk of referrals came in the later part of the year, highlighting the need to ensure the infrastructure is in place to enable partnership working. This might include a lead organisation which facilitates / develops this approach before the appointment of the outreach workers.

A total of 14 clients were supported as part of the project, of these clients the following outcomes have been reported:

- 93% (actual 13) were offered key-working, of which;
  - the number of weeks engagement ranged from 3 weeks minimum to 56 weeks maximum with 62% (actual 8) engaged more than 12 and 38% (5 actual) engaged for less than 12 weeks

By the end of the HICD Pilot Project of the 13 clients;

- 69% (actual 9) were **successfully transferred** to the core i-access service for on-going support.
- As a result of continued engagement in treatment there was a **significant reduction in drinking days** with 46% reporting daily drinking compared to 93% at the start of the project
- **Psychological health**, 64.3% (actual 9) showed **improved** scores
- **Physical health scores** 57.1% (actual 8) showed **improved** scores

### 3.4 Cost Analysis

Royal Surrey County Hospital provided anonymous data which shows client visits for nine clients which were referred to the HICD pilot by Alcohol Liaison Nurses. Using this data a very basic cost analysis has been carried out using the following costs:

**Table 2: Costs used for HICD cost analysis.**

<b>Item</b>	<b>Cost</b>	<b>Reference</b>
<b>Ambulance call out and transfer</b>	£239	SECAMB
<b>Unplanned Admission</b>	£2344	Blue Light Nottinghamshire Evaluation
<b>Average cost of a frequent attendee</b>	£1500	Blue Light Manual
<b>Emergency department attendance and assessment from a consultant</b>	£130	PSSRU
<b>Inpatients detox</b>	£142	PSSRU
<b>Bed Day</b>	£341	PSSRU

Data was provided from January 2015 to June 2016, all referrals were received in either September or October 2015.

The cost analysis shows an expected 1:4 (£) return on investment; case workers working with a rolling caseload of 36 clients across a 12 month period. Therefore a further investments of £75,000 HICD investment in Surrey is expected to reduce health costs from £612,125 to £303,151. This cost projection is based from a HICD patient tracking exercise and a series of modelling assumptions conducted in partnership with the RSCH Alcohol Liaison Nurse these included ambulance call outs and transfers, attendance at A&E, admissions, bed days and unplanned non specialist detoxification but did not include other further medical interventions delivered, which were administered for the presented issue requiring medical attention following the individual presenting at A&E. The pilot was unable to track the impact on the criminal justice and community safety however, evidence suggests that savings to the criminal justice system would be between 50% and 100% to those of the Health care system.

The assumptions used to develop this cost analysis are as follows:

- All HICD clients are seen by a consultant on arrival rather than triage.
- Clients generally arrive by ambulance, it is estimated that this happens in at least 80% of cases, though a calculation for 50% has also been included.

- A cost of £239 was provided by SECAMB for the cost of a visit and transfer of patients for analysis in the Public Health Falls Needs Assessment, this report assumes the same cost.
- Royal Surrey County Hospital have changed their pathways to ensure that detoxes are not automatically carried out. Where stabilization can effectively support the client instead, this is the preferred option, reducing health risks associated to detoxing. Therefore, these calculations use the assumption that detoxing is most likely to occur after
  - a stay of 3 or more nights  
**and**
  - Only for 10% of those clients and associated nights

**Table 3: Costs for all clients across 18 months**

<b>Visits Jan 2015 – June 2016</b>		
Attendance and consultant assessment	296	£38,480.00
<b>Ambulance Call outs</b>		
If 80% Ambulance call outs and transfer	236.8	£56,595.20
If 50% Ambulance call outs and transfer	148	£35,372.00
<b>Admissions</b>		
If at average cost of a frequent attendee	50	£75,000.00
If unplanned admission	50	£117,200.00
<b>Bed Days</b>		
Bed Days	193	£65,813.00
<b>Detox</b>		
Total more than 3 nights	136	
If 10% in receipt of detox after 3 days	13.6	£1931.20
If 20% in receipt of detox after 3 days	27.2	£3862.40
<b>TOTAL COSTS</b>		
<b>Maximum</b>		<b>£281,757.60</b>
<b>Minimum</b>		<b>£216,403.20</b>

When looking at the average number of attendances, admissions and bed days, this cost analysis also showed:

- Average number of **attendances** for all clients across 18 months was 33. For pre and post intervention this reduced from 29 to 21 per client respectively.
- Average number of **admissions** for all clients across 18 months was 5. For pre and post intervention this reduced from 5 to 2 per client respectively.

- Average number of **bed days** per stay across the 18 months was 5 nights. When this is looked at pre and post intervention this reduces from 5 nights to 2 nights.

### 3.5 Operational recommendations from the Pilot

Based on feedback from the MDT which participated in the Surrey Pilot the following recommendations have been developed for future HICD service delivery.

- Training provided to all partner agencies in relation to the wider alcohol related needs and the link with recovery.
- Training/awareness raising provided to substance misuse services on partner services
- Better balance between Tier 2 complex needs and Tier 3 complex needs to understand the interplay and cross over between the two services
- Clear multi-agency project plan/pathways from development to evaluation with data from all services to accurately measure impact
- Identification of lead professional to:
  - Co-ordinate treatment,
  - Facilitate joint care plans,
  - Organise and facilitate MDT meetings,
  - Organise and facilitate partnership meetings
  - Information sharing virtual platform
- Clearly defined and integrated role of partnership agencies
- Commitment to attend partnership meetings, MDT meetings and adhere to joint care plans from partner organisation
- Ongoing evaluation of outcomes
- Joint Care plans should be administered by facilitating agency and adhered to by all in the MDT
- Improved joint risk management
- Developed exit/referral pathways including transition to core treatment services

## 4. Options for future service delivery

### 4.1 Vision and recommendations

The vision for High Impact Complex Drinkers is to develop an integrated treatment response that offers measurable benefits to individual service users and the services they come into contact with. Such a service should be holistic and client centered, working with the client to address barriers to change and

as foundation for engaging in core services. The service development should be underpinned by the following principles:

- Recognition that HICD's present a challenge to range of services, and as such the most effective response is one where agencies align their input to individual clients within a single integrated care plan.
- A named case coordinator which in most cases will be the agency with which the service has first and / or most contact with.
- A rapid response to assessment and engagement reflecting the crisis led help seeking behaviour of this service user group.
- A sustained (rather than time limited) approach to client engagement reflecting the often slow and faltering pace of change.
- The project also recognises that there is a need for an integrated approach to assessment and care planning which requires robust information sharing protocol and tool, the project will aim to understand the barriers to developing such a protocol and tool and how this might be overcome in the future.

#### 4.2 Matrix work

There are a number of other complex needs or priority services which are currently being delivered in Surrey, the HICD service should link with these services to improve partnership working and where possible contribute to the joint care plan for these clients, thus improving outcomes. Other services / projects include:

- Policing teams
- High Intensity Mental Health Users Project
- Homelessness alliance (specifically contributing to the recommendations of the 2016 Homelessness Audit)
- Transforming Women's Justice

#### 4.3 Proposal: 2 Year Extensive Evaluation Project

- Two year project which sits alongside the aforementioned complex needs services
- Either continues work Guildford, Waverly or Woking **and**
  - Follows same model of 2 workers **and**
  - Placed in a current provider which has the potential to decrease management costs
- **OR** expands into North (Spelthorne), East (Reigate and Banstead) and South West (Guildford, Waverly and Woking) **and**

- Increases to 4 workers, 1 per area and one 'floating community worker' to support based on need **and**
- Placed within a current provider to reduce costs for additional supervision, facilities and infrastructure
- Working with a case load of between 15-20
- Links into the I access core services to ensure ease of access to transfer into services once engaged
- Operationally increases work with JAG's and CIAG's
- Increases work with primary care to identify those who are having frequent visits to GP's
- Strategically increases work with community safety boards
- Includes a data linking exercise where a third party pseudo anonymise data for analysis or improved information sharing protocol
- Re-assesses thresholds to consider allowing those with dual use, but primary alcohol dependence
- Improved prioritised referral pathway; clients will only able to access the service if they meet the High Impact Complex Drinkers Criteria and have been referred by:
  - Alcohol Liaison Nurses
  - Substance misuse treatment services
  - CIAG
  - Policing teams
  - High Intensity Users Pilot (Mental health).
  - Adult Safeguarding Board
  - Homelessness support services.

#### 4.3.1 Evaluation and outcomes:

Services will be expected to present the client for consideration at either the CIAG or alternative MDT meeting to enable the HICD community workers to engage with them. Part of this will require the lead service (the service with the most contact) to present how many times the client has had a repeated effect on their services, the other partners will then carry out the same for their services to measure impact across all services. This should then be measured again at 3 months, 6 months, 12 months and 18 month periods.

Service outcomes could include:

- Number of clients engaged from CIAG's
- Number of clients engaged from Police Teams
- Number of clients engaged from ALN's

- Number of clients engaged through high intensity mental health users project

Treatment indicators could include:

- quality of life scores
- mental wellbeing scores
- physical wellbeing scores
- drinking days
- units consumed
- Time taken to transfer to Tier 3 service
- Time maintained in Tier 3 service

Criminal Justice Outcomes:

- Reduction in police call outs (Residential)
- Reduction in Police call outs (Hospital)
- Reduction in Police call outs (Town Centers)
- Reduction in Detentions and custody stays
- Reduction in S136's
- Reduction in Missing persons call outs

Healthcare Outcomes:

- Reduction Hospital Bed days
- Reduction Ambulance call outs
- Reduction Number of detoxes administered
- Reduction Dual Diagnosis clients identified and appropriately supported
- Improved access to Social Care support



## Acknowledgments

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## Appendix A

i.	An alcohol problem
	Have an enduring pattern of problem drinking, dating back at least ten years & Score 20+ on AUDIT or Be classified as dependent on SADQ (16-30 = moderate dependence/30 is severe dependence range is 0-60) or Have other markers of dependence on alcohol (e.g. blood or breath alcohol levels or biomarkers such as liver function test scores)
ii.	A pattern of not engaging with or benefiting from alcohol treatment
	Clients will: Have been subject to alcohol Identification and Brief Advice (IBA) & Have been referred to services, usually on more than two occasions, and have not attended, attended and then disengaged or remained engaged but not changed.
iii.	A burden on public services
	Clients will either directly, or via the burden they place on others e.g. their family, be placing a burden on the following services: Health Social care including adults involved with children's services Criminal Justice / ASB / Domestic violence Services Emergency services (999) Housing and homelessness agencies  The burden will be mainly due to: multiple use of individual services but in a few cases may be due to placing an exceptional burden on these services in other ways.
	Exception 1 – level of risk
	An exception category will be required. For example, a person may meet the first two criteria (dependence and non-engagement) but the burden on public services is due to a single exceptional risk.

## Markers of Impact placed on broader services

Health	Marker	Indicative level at which the person can be seen as a significant burden
Emergency Department	► Attendances per annum <sup>i</sup>	12 attendances per annum <sup>ii</sup>
Hospital	► Admissions per year. <sup>iii</sup>	3 or more admissions per annum <sup>iv</sup>
Primary care	► Appointments /call outs per year ► PARR (Patient at Risk of Readmission) score <sup>v</sup>	12+ appointments per year <sup>vi</sup> See the referenced report for PARR scoring <sup>vii</sup>  Minimum of 3-4 other agencies involved.

	▶ Number of agencies involved	
Ambulance and Fire service	▶ Call outs per month <sup>viii</sup>	10+ call outs per month <sup>ix x</sup>
Crime		
Police	▶ Repeated arrests /reoffending rate	3 arrests or Fixed Penalty Notices in a 3 month period <sup>xi</sup>
Probation	▶ Non-compliance with order including further offending	All clients who meet the first two elements of the definition and are non-compliant <sup>xii</sup>
MAPPA	▶ All alcohol related Category 2 & 3 MAPPA clients	All clients who meet the first two elements of the definition alcohol related Category 2 & 3 MAPPA clients <sup>xiii</sup>
Domestic violence/MARAC		
Repeat abuse	▶ Incidents per annum ▶ Alcohol related MARAC clients	All clients who meet the first two elements of the definition and are high risk cases on the DASH risk assessment. <sup>xiv</sup>
Social care		
Adult services	▶ Level of risk plus either ▶ Multiple referral or ▶ Number of agencies involved <sup>xv</sup>	All clients who meet the first two elements of the definition and meet two or more of the criteria opposite <sup>xvi</sup>
Adults involved with Children and Families services	▶ Level of risk plus either ▶ Multiple referral or ▶ Number of agencies involved <sup>xvii</sup>	All clients who meet the first two elements of the definition and meet two or more of the criteria opposite <sup>xviii</sup>
Housing and homelessness services	▶ Failed tenancies ▶ Excessive rent arrears ▶ Repeated abuse of accommodation or ASB	▶ 3 failed tenancies in 5 years <sup>xix</sup> ▶ 3+ complaints or referrals for ASB per year <sup>xx</sup>
Anti-social behaviour	▶ Complaints or referrals about ASB per year ▶ Length of time case is worked by ASB team	▶ 3+ complaints or referrals per year (NB The new Anti-Social Behaviour legislation identifies 3 incidents in 6 months as a trigger for a more serious response). <sup>xxi xxii</sup> ▶ 1 year plus involved with ASB team <sup>xxiii</sup>

Street drinkers	▶The number of street drinkers in area <sup>xxiv</sup>	All regular street drinkers <sup>xxv</sup>
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- i Marker used in most hospital alcohol liaison teams
  - ii Queens Medical Centre Nottingham
  - iii Public health outcomes framework
  - iv Research in hospitals in SW London and Wigan
  - v Combined predictive model- Final report – NHS December 2006
  - vi Research into GP practices in Wandsworth
  - vii Combined predictive model- Final report – NHS December 2006
  - viii Marker used in ambulance services
  - ix Information from West Midlands Ambulance Service
  - x [http://www.londonambulance.nhs.uk/health\\_professionals/caring\\_for\\_frequent\\_callers/patient\\_referral\\_review\\_and\\_c.aspx](http://www.londonambulance.nhs.uk/health_professionals/caring_for_frequent_callers/patient_referral_review_and_c.aspx)
  - xi Ward M. – Review of alcohol related arrests in Wandsworth 2010 – NHS Wandsworth - 2011
  - xii Discussion with London Probation Trust and other Probation Trusts in England
  - xiii It is assumed that all alcohol related MAPPA clients fall into this category because of the risk involved and this definition includes all MAPPA clients except for those who are accused of child sex offences.
  - xiv Discussions with *Blue Light* partners 2014
  - xv Discussion with social services in NE England
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