
**FREQUENT ATTENDERS TO ACCIDENT AND EMERGENCY DEPARTMENTS: A QUALITATIVE
STUDY OF INDIVIDUALS WHO REPEATEDLY PRESENT WITH ALCOHOL-RELATED HEALTH
CONDITIONS**

SUMMARY FINDINGS AND IMPLICATIONS FOR A&E DEPARTMENTS AND STAFF

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BACKGROUND

Alcohol continues to pose major economic and health problems in the UK (Rehm et al., 2012). From an economic perspective, in 2012/3, problematic drinking was estimated to cost the NHS £2.7 billion annually, £720 million of which was the result of A&E admissions. From a health perspective, in 2012/3, there were an estimated 1,008,850 hospital admissions where the primary or secondary cause was an alcohol-related disease, injury or condition. This is more than twice as many as in 2002/3 (Health and Social Care Information Centre, 2013). It is estimated that 35% of all Accident and Emergency (A&E) attendances are alcohol-related, with 13-20% of these becoming hospital inpatient admissions (Bayley et al., 2012). Alcohol-related conditions account for an estimated 4% of all hospital bed days, with the majority of these (66%) attributable to just 17% of patients (NHS Evidence, 2011). This indicates that a sub population of people with alcohol problems, most commonly known as 'alcohol frequent attenders' (AFAs), is placing a disproportionate burden on emergency departments (Mandelberg et al., 2000). Increasingly, services are being developed to help the AFA population, but in an *ad hoc* way and without research to underpin their design or to ensure their effectiveness.

STUDY METHODS

The study aim 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.*

Specific objectives were to increase understanding of:

1. The demographic characteristics and social circumstances of alcohol frequent attenders (AFAs), including their support needs and recovery resources
2. AFAs' patterns of A&E attendance and inpatient admissions
3. The drinking and other drug-taking patterns of AFAs
4. AFAs' exposure to, use of, and attitudes towards alcohol services and alcohol-related interventions (including barriers and facilitators to engagement)
5. AFAs' and A&E staff views on an assertive outreach (AO) intervention for dependent drinkers recently developed by the research team
6. AFAs' experiences and use of other addiction and broader health and social care services
7. AFAs' reasons for, and views and experiences of, their attendance at A&E departments
8. Types of treatment and support most desired by AFAs

9. Optimal methods for engaging and retaining AFAs in treatment

Semi-structured interviews were conducted with 30 AFAs¹ in community settings in London (see Table 1). Focus groups were also undertaken with 44 A&E staff in six hospitals across England (3 hospitals had a specialist service for AFAs and 3 hospitals did not). The 44 staff all had regular contact with AFAs as part of their daily work and included alcohol liaison nurses, A&E nurses, A&E consultants, consultant gastroenterologists, healthcare professionals, psychiatrists, registrars, A&E managers, clinical support workers, receptionists and a porter.

Table 1: AFA characteristics (n=30)

<i>Gender</i>	
Male	18
Female	12
<i>Age (years)</i>	
Mean (range)	47.9 (20-68)
<i>Ethnicity</i>	
White British	19
Asian (British)	4
Mixed race (British)	3
European	3
Other	1
<i>Housing</i>	
Local authority/housing association	8
Homeless	6
Hostel, YMCA sheltered housing	5
Owner occupied	4
Private renting	3
Living with friends/family	3
Medical centre	1
<i>Education</i>	
None	9
GCSE	12
A-levels	5
University degree	3
PhD	1
<i>Prison (ever)</i>	
Yes	6
No	24
<i>Employed (current)</i>	
Yes	2
No	28
<i>Types of drink consumed most frequently (current)²</i>	
Beer	13
Cider	10
Spirits	6
Wine	1
<i>Drug Use</i>	
Actively using	1
Historical dependence	9
Never consumed	20
<i>Smoker (current)</i>	
Yes	22
No	8

¹ Defined as, "any patient aged 16 or over who attends any A&E department 10 or more times within a year or 5 or more times within a 3-month period for an alcohol-related condition" (ISD Scotland, 2011).

² In practice, most AFAs consumed multiple types of drinks.

SUMMARY FINDINGS

1. The demographic characteristics and social circumstances of AFAs, including their support needs and recovery resources

The self-reported demographic and social circumstances of the 30 AFAs interviewed in London were diverse (see Table 1). When A&E staff participating in the focus groups across England reflected on the demographic characteristics of AFAs attending their own hospitals, they noted a number of differences. For example, A&E staff in two hospitals described older AFAs as well as a younger cohort (in their late teens/early 20s) with higher levels of co-existing drug use. A&E staff in four hospitals reported an almost exclusively white British population of AFAs, whilst those in the other two hospitals believed that they saw more Asian AFAs. Additionally, staff in four hospitals felt that the AFAs attending their hospitals probably had lower levels of education.

2. AFAs' patterns of A&E attendance and inpatient admissions

According to hospital records, the mean number of A&E attendances per AFA 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 noted that hospital records under-report A&E attendances by AFAs for a number of reasons: i. AFAs often give no name or a false name on presentation; ii. individuals who present multiple times on one day may only be recorded once on the system; iii. alcohol is often omitted from A&E records if it is not the primary presenting complaint (e.g. alcohol may not be recorded in the case of a head injury caused by an alcohol-related fall); iv. individuals often delay presenting at A&E with alcohol-related injuries until after intoxication has worn off meaning that alcohol is not detectable; v. AFAs do not always receive the correct code upon presentation because of administrative errors, often related to time pressures and the increasing workloads of A&E staff; and vi. individuals who repeatedly present to A&E but are not known as being AFAs are missed because of the lack of alcohol screening.

3. The drinking and other drug-taking patterns of AFAs

The drinking and drug taking patterns of the 30 AFAs interviewed was diverse (see Table 1). Of the 30 AFAs, 29 reported many years of heavy drinking and the types of drink currently consumed included beer or strong cider (typically 'Super Skol' or 'K cider'), spirits (including vodka, whiskey and Sambuca) and wine (red and/or white wine). Almost all AFAs drank daily, although one said that she only drank four times a week and another described weekend binge drinking. Several individuals explained that they drank in the morning and continued throughout the day, whereas others started in the afternoon and then carried on into the evening. The main reasons AFAs gave for drinking were dependence and to self-medicate for physical or mental health problems, although boredom and loneliness were also discussed.

Findings from the focus groups with A&E staff broadly supported the types and patterns of drinking and high levels of smoking reported by the interviewed AFAs. However, most A&E staff believed that co-existing drug use was greater amongst AFAs in their own hospitals. For example, staff from one hospital reported high levels of illicit prescription drug use, cannabis use and heroin injecting; staff from another hospital described problems with prescribed drugs; staff from a third hospital discussed co-abuse of recreational drugs such as MDMA, cocaine and mephedrone; and staff in a fourth hospital spoke of escalating cocaine use amongst their AFAs. Staff from the remaining two hospitals suggested that their AFAs tended just to drink.

4. AFAs' exposure to, use of, and attitudes towards alcohol services and alcohol-related interventions (including barriers and facilitators to engagement)

AFAs reported histories of transient and sporadic engagement with addiction services, including community drug and alcohol teams, detoxification units, residential rehabilitation services, and self-help groups (almost exclusively Alcohol Anonymous). Most AFAs were critical of these services based on their own past negative experiences and a perception that the support available was not sufficient or appropriate for them and service providers lacked knowledge of their needs. Although some AFAs said that they had received excellent advice and care from their GPs, most felt that GPs were unsupportive and lacked empathy and knowledge of addiction and treatment options. A&E staff broadly concurred with the view that AFAs did not tend to use, or want to use, specialist addiction services, noting that long waiting times, poor assessment processes and the need for AFAs to attend services when they were not motivated seemed to hamper AFA engagement.

5. AFAs' and A&E staff views on an assertive outreach (AO) intervention for dependent drinkers recently developed by the research team

None of the AFAs had heard of assertive outreach. In contrast, a number of A&E staff had heard of assertive outreach and described similar services (offering intensive personalised outreach support) that they had encountered over the years.

Overall, A&E staff felt that assertive outreach was potentially valuable. In particular, they liked the single caseworker arrangement as they felt that this could encourage rapport and meaningful interactions with AFAs. They also liked the fact that the model was both reactive and proactive in addressing goals set by AFAs themselves. Other identified strengths related to the tailored individual approach, the intense and persistent nature of the support offered, and the extended period of engagement (one year). Despite this, A&E staff expressed some reservations and suggested ways that assertive outreach might be improved. These included developing pre-emptive relapse prevention plans and crisis plans when AFAs were well; having quantifiable goals set by AFAs to help measure their progress; ensuring there is a tapering off plan as assertive outreach comes to an end; and providing increased support for caseworkers to prevent them experiencing stress and burnout. Particular concerns were raised about the level of emotional and practical demands that might be placed on caseworkers, high rates of caseworker turnover, the provision of support when caseworkers are not at work, and the fact that the model will not work for everyone.

6. AFAs' experiences and use of other addiction and broader health and social care services

Most of the AFAs interviewed were not engaging with broader health and social care services. Three women reported contact with social services, but did not describe these interactions positively. The focus group data provided no additional insights into the use of more generic services, primarily because A&E staff said that they did not ask AFAs about their use of this type of support. A&E staff did, however, report that broader health and social care services have an important role to play in delivering interventions for AFAs given the multi-faceted nature of addiction and AFAs' complex support needs. A&E staff in two hospitals also pointed out that they had no real knowledge of the relevant services available to AFAs in their respective areas, so did not know where to refer people.

7. AFAs' reasons for, and views and experiences of, their attendance at A&E departments

When AFAs were asked why they attended A&E, their reasons were almost always directly linked to their drinking, and included being intoxicated, experiencing painful withdrawal symptoms, a physical trauma

resulting from intoxication (e.g. falling over) or self-harming after drinking. Most were brought to A&E by ambulance, with members of the public, family, friends and the AFA themselves variously calling out the emergency services. The hospital attended was nearly always the one closest to where the AFA was when the ambulance was called (usually their home). AFAs' views of the support provided by hospital staff ranged from excellent (empathetic, caring, supportive) to very poor. The greatest criticism of A&E departments related to the process of discharge, with many AFAs complaining that they were forced to leave very early in the morning without money or clean clothes and with no way of getting home. AFAs reported that A&E staff rarely gave them advice on their drinking, and only one said that she had received a care plan.

Findings from the staff focus groups were consistent with the AFAs' accounts of why they went to A&E, how they got to A&E, and which hospital they attended. In terms of the lack of advice and care plans given to AFAs, staff at five of the six hospitals reported that the intensive, often 'high-paced', environment of A&E was not the right place to engage AFAs about any broader social problems and perceived needs. Indeed, doing so could 'open up a can of worms', for which A&E staff were not resourced to respond. Staff from only one hospital explained that they provided a care pathway to AFAs, subsequently following them up with a phone call in the community.

Differences between AFA and A&E staff accounts of discharge processes also emerged. Although none of the hospitals had a discharge protocol, A&E staff from all six hospitals explained that AFAs would be allowed to wait in the reception or waiting room until the first bus if they were discharged early in the morning. AFAs were also often given clean clothing or had their clothes washed, if they arrived in soiled clothes. Whilst none of the hospitals provided transport on discharge, staff from one hospital explained that they regularly gave AFAs bus fares. Moreover, the reason for not providing transport home was a considered decision to deter AFAs from returning. A&E staff believed that AFAs 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 AFAs with care and empathy.

8. Types of treatment and support most desired by AFAs

AFAs 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. Again, A&E staff found it difficult to comment on the wider practical or social support desired or needed by AFAs as they tended (often consciously) not to discuss these topics with them in the A&E setting.

9. Optimal methods for engaging and retaining AFAs in treatment

A&E staff felt that the best method of identifying AFAs 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 AFAs in treatment would be via a multi-disciplinary team, with specialist workers, who provided an individualised package of care and visited AFAs in the community as soon as possible after they had left hospital. Although A&E staff gave many examples of how they had tried to help AFAs, they recognised the limits of their roles and resources. Equally, they emphasised that AFAs are a very difficult population to motivate, engage, and treat, and no single model of care can possibly work for everyone.

IMPLICATIONS FOR A&E DEPARTMENTS AND STAFF

1. Findings confirm the very complex needs of AFAs and highlight the many difficulties of supporting this population within A&E settings.
2. Current hospital recording processes underestimate the demands AFA attendances place on A&E time and resources. Recording processes should be reviewed in order to ensure that the most accurate information is captured. Electronic A&E records with an automated flagging system are likely to offer the best method of identifying AFAs.
3. An appropriate method of screening is needed to identify individuals who are 'at risk' of becoming AFAs (a quasi early warning system that might route individuals into more appropriate forms of support and care).
4. Where specialist services (such as alcohol liaison nurses or assertive outreach workers) cannot be provided within A&E, 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 multi-disciplinary team meetings, such as frequent attendee meetings.
5. A&E staff need rapid access to up-to-date information on local addiction services to assist with referral and care co-ordination. Links to relevant websites, including local and national helpfinder webpages, could be bookmarked on A&E computers and relevant service leaflets could be displayed on notice boards.
6. Although AFAs will often be unwilling to address their alcohol problems within A&E departments, A&E staff should provide a few minutes of support to offer advice and information (plus referral) to relevant services whenever possible.
7. A&E departments should develop care pathways for AFAs. Where care pathways exist, they should be explained carefully and clearly to AFAs.
8. Protocols for discharging AFAs from A&E (and hospital more generally) need to be developed.
9. Discharge offers an important window of opportunity to intervene in the life of an AFA. 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 issues, as well as referral to addiction services.
10. A&E staff may appreciate team discussions and guidelines on when it is/ is not appropriate to provide food and drink, wash clothes or donate clothing, give bus fares or arrange transport home, and allow people to wait in reception or waiting areas until daylight. Open discussions within A&E teams may encourage a consistent approach within and across hospitals (whilst still supporting the dignity and self-respect of AFAs).

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