



Outreach to Chronic Problem Drinkers: The service user view

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1. Introduction

For the last three years Nottinghamshire Healthcare has been running the Alcohol Long Term Conditions (LTC) team. This service operates an outreach focused approach to chronic problem drinkers who are placing a significant burden on the community.

The service was positively evaluated by Alcohol Concern in 2015 and flagged as a model of national good practice with chronic problem drinkers. In particular, the evaluation identified how the team understood and applied the assertive outreach model. It is available at:

www.alcoholconcern.org.uk/publications/

- The aim of this report is to understand outreach from the service users' viewpoint.

It asks the simple question: *what do those on the receiving end of outreach find useful?* It is hoped that this will help the development of outreach teams nationally.

2. Methodology

This was a small, qualitative study. The researcher interviewed eight people who had been clients of the Nottinghamshire Healthcare LTC team. They were interviewed both as a group and as individuals using a semi-structured interview format. The initial draft of the report was shared with the interviewees for comment and discussion prior to publication of this final version.

A detailed picture of the clients worked with can be found in the initial evaluation report. The users interviewed were all people who had experienced chronic alcohol problems and had been seen as change resistant at many points in the past. The age range was 37-66. Half were male and half female, they were all white British and resident in the Nottinghamshire area. They all had significant histories of alcohol related harm:

- ◇ *It is only my story – without their help I would be dead – when I was first in contact I was 6 stone, I couldn't walk and went into a coma. I died three times in a coma.*
- ◇ *I was told I would die if I didn't stop drinking.*
- ◇ *I have been drinking for 30 years.*
- ◇ *I wanted to stop but was very confused about it.*

They are also usually people who had tried other services.

In structuring this report we have tried to allow the framework to emerge from the users' feedback rather than imposing a previously established set of headings. Nonetheless, any organisation of the material will introduce author bias. The structure was checked with the interviewees to ensure that they were happy with the approach. The gender and names of workers and interviewees have been deliberately withheld.

3. The funding of the research

The research was undertaken by Alcohol Concern, the national charity on alcohol misuse. It was funded by Nottinghamshire Healthcare NHS Foundation Trust itself. However, the Trust did not have editorial control over the final report.

4. The user perspective

4.1 Overall view of the team

The aim of this report is to understand what works when undertaking outreach, rather than to praise the LTC team. Nonetheless, it is worth recording that the views on the team were uniformly positive. This underlines how much the users value the outreach approach.

- ◇ *I can't praise them enough actually.*
- ◇ *They were a really useful part of stopping me drinking.*
- ◇ *I don't know what I would do without them.*
- ◇ *Doing their job in that way has kept me alcohol free.*
- ◇ *The team are the best. They are fantastic at what they do. They are the SAS of the alcohol world. My life is unbelievable now – I wouldn't believe it two and a half years ago – I was waiting for death.*
- ◇ *They are absolutely brilliant. They look after all of us. They do a brilliant job.*
- ◇ *It was lovely that someone was there. I'd be dead if they weren't there.*

One of the interview questions asked about negative aspects of the service. None of the interviewees identified any problems other than the need for the team to have more resources.

Five out of the eight interviewees emphasised the quality of the service by comparing it, unprompted, with other services:

- ◇ *I have had a few bad experiences, my doctor referred me to counselling – the person who made contact wanted to do it over the phone. It was the personal contact that was important.*
- ◇ *When I first came out of hospital, I was referred to (local alcohol service) and they were quite difficult to access geographically and I had to sit waiting with another client.*
- ◇ *It's a different service from others that are available. It is less judgemental than services with a massive caseload. It is a gentler more encouraging way of doing things.*
- ◇ *The only thing I can say – I went to the GP and asked if I could stop, the GP said no and I saw a worker. The local worker really screwed up the detox and I became quite unwell it was then that the team began to sort it out and got me into hospital. They had to resus me in the hospital.*
- ◇ *The waits were too long for other services.*

4.2 Overall approach

The interviews began with an open question about what the clients liked about the service's approach. One single quotation summarised the responses:

- ◇ *I think it was their attitude. It was so non-judgemental and I felt that I was there to be helped without being told what to do. No platitudes about we are here to help, it was obvious they wanted to help. It comes out naturally. You want to tell them. They are compassionate without being patronising. A strong belief in their job and it comes through. It is about respect. That's the key word.*

Other comments included:

- ◇ *The worker is very caring and very lovely.*
- ◇ *They are not just doing their job. Vocation, passion, they do care, it is a job but it is something they want to do. They are achieving something.*

- ◇ *They are much less judgemental. They preached a lot less. You are not part of a conveyor belt.*
- ◇ *Treating me as an individual. I am a 4th generation alcoholic. You don't know what else to do. You think drink is the only way. I was just like a little kid. I didn't know what to say and do. It is like being re-born. You don't have to think about not having a drink to get there. You are not pressured to talk. They ask what you want and expect.*

4.3 Entry into the service

In general, the clients entered the service via a hospital or other medical referral. Again this is not particularly revealing about outreach - it is more a function of the team's focus on long term conditions. Often the starting point was supporting someone through a detox. One person met the team through another client.

- ◇ *I stopped shortly after meeting them– I was on my way to stopping – they made suggestions about counting how much, and how to reduce it.*
- ◇ *The detox was in hospital and they visited me and took me there and stayed me with for a while. And visited me again in the hospital.*
- ◇ *They did a detox in the city hospital – I was rushed in there but had to have an operation on a hernia so I didn't complete but after the operation I never drank again.*

4.4 Home visits

The interviewees independently identified a number of aspects of the team which they felt were valuable without prompts by the researcher. The first of these is home visits.

- ◇ *They came to the house. They asked what I wanted to do: I live up the road from the Trent and we would go for a walk and a coffee. It is about what you want to do. It is all so personal.*
- ◇ *Ease of access. One lady was on her sofa and couldn't leave there and the nurses were able to visit her.*
- ◇ *They offered home visits. The worker would take me out for a coffee – was there for whatever I wanted to do – we mainly stayed in and had a natter. It wasn't counselling - it wasn't strict – it was more like friends you could get things off your chest and talk to you and advise you with things.*
- ◇ *The beauty is that they come to you. That makes a big difference.*
- ◇ *It does make a difference that they come to your house. I do live alone. For some people it is really important. Not waiting outside an office for an appointment.*
- ◇ *Most of the time the worker comes to the house.*
- ◇ *Really working in the community i.e. on my sofa. Other services have courses and groups etc. It is lovely to have someone to come and talk to. There is nowhere else to go.*

4.5 Time and availability

A second feature of the service that was felt to be valuable was the team's ability to give time to people and not be rushing to leave them. This appears to be taken as a marker of caring, of showing interest in someone. It also allows a group who may find it difficult to express themselves the space to say what they want or need to say.

- ◇ *They used to come for a couple of hours at a time.*
- ◇ *I completely got enough time – the worker is here for an hour or more. I could sit and talk to the worker for hours and hours.*

- ◇ *They allocate a lot of time – one hour per patient. At first every week they came out to see me. I would have preferred more time. They are sympathetic, stick with you and give you time.*
- ◇ *You get a good deal of time from them: no looking at the watch and slipping off.*
- ◇ *That is another good thing it has never been rushed. There is no set time – like half an hour – they stay as long as needed.*
- ◇ *The importance of time. They give you plenty of time. They book you for an hour – they are not clock watching. They always explain if they have to go somewhere...They are not looking at their watches all the time.*

The comments on time pressure also extended to the whole intervention. Interviewees did not feel rushed into making a change.

- ◇ *They don't rush you. They don't expect you to get better quickly. They are patient, which the doctors aren't. They understand you may relapse.*
- ◇ *You are welcome: no pressure.*

The interviewees expressed a similarly positive view of the related theme of the workers' availability to them.

- ◇ *The fact that I can ring and contact my nurse when I need to and the flexibility on when I am seen is a real positive.*
- ◇ *They are in the background but they are always there.*
- ◇ *If you have a problem, you can ring them. It's nice to have the support – they are there at the end of the phone.*

4.6 Expertise on physical conditions

An aspect of the team that was particularly valued was their knowledge about the physical effects of alcohol. This again was not an aspect that had been specifically considered by the researchers and was commented on unprompted which suggests its importance. It also challenges stereotypes that drinkers do not care about their health. It highlights a benefit of having a team consisting of nurses.

- ◇ *The first thing is to look at physical condition and only then is the drinking discussed.*
- ◇ *They know about the consequences.*
- ◇ *It was nice to be with someone who knew about the physical effects.*
- ◇ *They tell you what you are doing to your body. They do that technical stuff and how to deal with it.*
- ◇ *They look at your physical health at the same time which felt like a double service. I was worried about my health.*
- ◇ *The LTC team look after you both physically and psychologically. In most services it is separated.*
- ◇ *They put the medical side in lay person's terms. They don't try to impress you.*
- ◇ *Their knowledge is really detailed. Other workers blag it. If they don't know they find out for you.*

4.7 Positive feedback

Another unprompted comment about the service was the use of positive feedback to clients:

- ◇ *It was not so much what they said – they gave me positive comments about how I was doing.*

- ◇ *They make you feel more confident. They are not telling you off. They say things like: "You are not a bad lad" "Anyone can fall into that trap"*
- ◇ *They do confidence building. You feel you are rubbish – the bottom of the pile. They help you build your confidence. They talk about the things that you have done, your jobs and family.*

4.8 Friendly

Alongside the positive feedback, the interviewees also identified the friendliness of the workers.

- ◇ *It was about their personality: a friendly personality. It is someone you can turn to: a friend. Someone you can relate to and talk to. People respond by connecting to someone. You need to build a connection.*
- ◇ *I was able to tell them everything and I really believed in their confidentiality. Everything feels easy. That is what is good: I trust her.*
- ◇ *I think initially it was that you were not on your own. This is not just a job they care.*
- ◇ *They gave me a feeling of not being alone. There are other people out there. I feel safe with them.*
- ◇ *They are there like a support at the back of you.*
- ◇ *They are not friends but are nice people to be with.*
- ◇ *They gave me hope. It made me feel like I had a friend. The service is a lifeline. Like your best mate.*
- ◇ *I was shown comfort. They are bothered and show genuine care and passion. They are helping to save your life. They want to help.*

4.9 Alcohol

Three of the interviewees mentioned that the workers did not focus on alcohol in the way that they had expected or experienced in other services.

- ◇ *At first it was general chat. Drink was not the main thing. It is not straight in with the drinking.*
- ◇ *We talk about different things; it is not all alcohol focused.*
- ◇ *There is no pressure not to drink. They don't seem to be interested in the drink.*

4.10 The content of the intervention

The interviews asked an open question about what the team did in sessions with clients:

- ◇ *They are getting information out of you without any pressure.*
- ◇ *The team make you look at yourself and keep looking at yourself.*
- ◇ *They drip feed suggestions.*
- ◇ *I lost a son a year and a half ago. The worker has been so good. They talk to me, help me to get everything and talk to me about my son.*
- ◇ *Regaining confidence – that doesn't come back easily – you have so many knock backs. I have had a slip this year – but I told the team about it – but as they say it is just for today. It has been 19 months and I have been drinking for 30 years.*
- ◇ *They are encouraging activity, exercise and diet.*
- ◇ *When you see how the nurses design a response which is very specific to you. That is absolutely brilliant.*
- ◇ *The worker comes round and asks "How are you?" and "How are you feeling?"*

- ◇ *They did a very good explanation of what was on offer.*
- ◇ *There is a gap to fill in your life. All of a sudden you are not drinking and it is hard to relate to people: even close friends and family. That is the reason people start drinking.*

4.11 Going out

One of the benefits of a process that combines sufficient time and a focus on the client's needs was that staff had time to go out with people:

- ◇ *We go out for a coffee or something like that.*
- ◇ *They encourage me to get out more. I can't do big physical things, but I can go to the library. I try and get out; when you are on your own a small acorn can grow into a big forest in 10 minutes. I have lost lots of friends recently but I can handle it now.*
- ◇ *They have discussed relaxing things to do e.g. visit gardens*
- ◇ *Get out of the room...They show you other things you can do with your life.*
- ◇ *They are on about doing different things. They encourage me to get out. When I get low I go for a walk.*
- ◇ *I was encouraged to explore interests, to try things, e.g. going for a cup of coffee.*

For some there was practical help as well:

- ◇ *They concentrated on practical things. I had a stroke and my memory was poor so they helped me with practical things. They got me out of the house.*
- ◇ *They helped me with benefits and housing to make me safe. If I had any letters they would sort them out and help me to sort them out. They are always available to offer help.*
- ◇ *The team is helping me with a welfare benefit claims. They are taking me to a place where we can get help and look at my welfare rights.*

The team has set up a support group for clients of the service. This meets in a room in a local library every four weeks. This was valued by the participants:

- ◇ *The first meeting it was difficult, I had only just stopped drinking, I didn't know anyone. I have met friends through the group meeting. Now I really want to go to the meetings – once per month.*
- ◇ *The meetings have got me out of the house and they have been very useful as a result. You feel embarrassed about being an alcoholic – being in a group has helped with that.*
- ◇ *The meeting at the library has helped. I have been involved about a year and a half.*

4.12 Family

The research questions specifically asked about the involvement of family members. This was not an issue for two of the interviewees who had no family, but for the others work on the family was important:

- ◇ *To begin with they talked about the family.*
- ◇ *The family are involved – the worker has spoken to the family and knows them all – that is very helpful.*
- ◇ *They have been in touch with my uncle. One of the reasons I started drinking was due to bereavement. Lost job. Lost self-respect. All I wanted to do was drink to forget it.*
- ◇ *CRUSE demand 6-month abstinence before they work with you.*
- ◇ *Yes – they were involved. Yes, it was useful – mainly my daughter – my husband is not very good with illness.*

- ◇ *The worker suggested that the family can talk to the team if they wanted: that was helpful.*
- ◇ *They suggest ways of getting back with family. My family wouldn't have anything to do with me. You have to atone. The worker agreed to talk to my family members.*

4.13 Paperwork

Specific questions were asked about paperwork and whether it had encumbered the process. The message was clear that workers did not allow paperwork to be a problem.

- ◇ *You never see paperwork, they are talking to you and only you.*
- ◇ *A bit of paperwork but it didn't get in the way.*
- ◇ *The only paperwork was the care plan which is not a lengthy document. I think that is different from other services.*
- ◇ *No nothing to fill in, and nothing that I can remember.*
- ◇ *At the first session the worker did not want to go into too much detail.*
- ◇ *Not really nothing to tax your brain – no forms.*
- ◇ *Not at all.*
- ◇ *The worker got some forms out but we just talked so much that we didn't do it. It took five weeks to do the care plan. It is tailor-made to the individual.*

4.14 Negative attitudes from professionals

The initial group consultation and the interviews highlighted how often problem drinkers experience negative attitudes from other professionals such as doctors or emergency services.

- ◇ *It is very non-judgemental. People do feel judged in hospitals and elsewhere. Some of the nurses on wards make you feel you have brought this on yourself and are unsympathetic.*
- ◇ *You do find doctors and staff who are really unpleasant: one doctor made me feel it was self-inflicted and I didn't want to bother.*
- ◇ *I have experienced negative stuff from A&E – from a nurse who was a bit abrupt, which upset me a bit. It didn't seem very caring – you are costing us millions, I was in a bad place at the time and I didn't want to know.*
- ◇ *I didn't experience any problems with the doctors and the dietitian.*
- ◇ *People who go to A&E and other services are not treated well.*
- ◇ *I have had doctors who are very rude to me.*
- ◇ *Doctors, even now, are judgemental. Even the consultant at the hospital made me feel "that big". The ambulance driver, treated me like something you wouldn't put your foot in. I was being talked to like a piece of shit.*
- ◇ *They are good with the doctors. They put points to the medics that I couldn't do. It was the first time that I had come across that. When you first go into the hospital the staff don't want to know you. You are a hindrance.*

As a result, one of the valued features of the team was that they were willing to take people to appointments and act as client advocates:

- ◇ *The fact that the worker offers to go to appointments in the hospital etc. is great. The worker has been with me to a couple of hospital appointments...I am living off savings at the moment.*
- ◇ *The worker used to come out every two weeks. The worker used to take me to the hospital. It would have been hard to do it without.*

- ◇ *My friend had to go to hospital for a barrage of tests, the worker always took him and came to see him at his house and the hospital.*
- ◇ *The worker came for my PIP assessment and to enrol me at the recovery college. They were both quite stressful. It was useful to have someone.*
- ◇ *The worker comes to other appointments with me e.g. the doctor and helps me to explain things.*
- ◇ *They accompanied me to doctor's appointments – every single one - I was down for a liver transplant – they have been with me for every single appointment. They are brilliant.*
- ◇ *The worker took me to see the consultant and the dietitian.*
- ◇ *They help with hospital appointments. They will come to see the consultant with me... They have supported hospital transport systems.*
- ◇ *I felt really embarrassed about being an alcoholic. They help with practical things like going to the hospital. Consultants and GP surgeries fob you off.*

4.15 Endings

The questions finally focused on how the intervention ends. The response varied with how long the client had already been engaged. However, the longer term clients show that workers are planning for endings. The group meeting offers a framework for lower level support.

- ◇ *The sessions have now got shorter with me and they are spending more time with people who need it. I have a friend I support – he won't go to groups but I support him because of the experience I have had.*
- ◇ *The worker suggested I did the peer support workers course that helped me and got me through a lapse – it was short lapse. The worker went off sick so the end happened naturally.*
- ◇ *I have now gone to monthly appointments but this has been my choice. There is the option of voluntary work to support the work and sell it to other people. The worker is sending me on to a peer support course. I am now applying for jobs. But I was told to be careful and not rush into things. But the worker gave me encouragement to do it; but also warned me about the risk of rejection.*
- ◇ *The ending was just a bit of a mix up due to the worker going off sick and the worker in the office believing I did not want any more visits.*
- ◇ *Don't know if they have succeeded there will be big tests coming along.*
- ◇ *At the beginning they came a lot. They have been good at judging when you need to see them. But now they ask when you want to see them. But I am worried they will discharge me. It is nice to know someone is there for you.*
- ◇ *You get to the point eventually where you realise how far you have come and how much you can do without alcohol. Nothing is worth drinking.*

5. Summary: Outreach - the service user view on what works

The original evaluation of the LTC team highlighted twelve features which the staff believed were the core of successful outreach.

Assertive	Passionate
Focused on building a relationship	Available to clients
Flexible	Being open
Holistic	Multi-agency
Persistent	Overcoming barriers
Consistent	Using a team approach

Other documents have also set out the required features of the approach. The *assertive community treatment for alcohol and drug users* pilot and the *American National health care for the homeless council* have both published lists of the features of assertive outreach (see appendix for references). The table below compares the three lists and identifies how they differ.

This is a very crude comparison. In the appendix the lists have been numbered so that readers can see which element was matched to the LTC list. The fact that one list is missing a feature in the LTC list does not mean that it was seen as unimportant by the other services but that it was not explicit in the list. However, the list does identify the features which are most commonly seen as important.

	Notts	ACTAD	NHCHC
Assertive	•	4	4
Focused on relationship	•		2
Flexible	•	6/8	6
Holistic	•	5	10
Persistent	•	9	12/13
Consistent	•	3	
Passionate	•		
Available to clients	•		9
Being open	•	7	8
Multi-agency	•	2	
Overcoming barriers	•		3/11
Using a team approach	•	2	

The other two lists also had features which were missing from the LTC list:

- A focus on health and mental health (ACTAD)
- Small caseloads (ACTAD)
- A non-threatening approach (NHCHC)
- A comprehensive assessment (NHCHC).

These lists can be compared with the client interviews. The list of positive features is similar but not identical. The following were important to the interviewees:

- A service which offers home visits (*assertive*)
- Offering the client time and availability (*focused on building a relationship, available to*

Both of these were contrasted with other services which were giving short appointments and rushing clients through.

Allied to this is the client perception that the work was:

- Not all about alcohol, it focused on other aspects of the person's life (*holistic, open and flexible*)

This is only possible when staff have time to build a relationship.

Clients valued support in engaging with other services (*multi-agency & overcoming barriers*) and support with:

- Making appointments; &
- Meeting with other professionals.

This was particularly important because of the stark messages about the negative attitudes that many clients had received from professionals.

The worker's' attitude was greatly valued including:

- Being non-judgemental
- Being passionate about their role
- Not telling clients what to do
- Giving positive feedback
- Being friendly
- Encouraging and supporting activity.

All of these are clearly flagged up in the lists of features identified above. However, the clients also identified three benefits which were not flagged up in the LTC workers' list:

- Not placing too great an emphasis on paperwork;
- Expertise in physical effects;
- A family focus.

It is clear from speaking to staff that client paperwork is completed, but this is not allowed to impede the care process. The clients appeared to emphasise the LTC approach in comparison to other services where paperwork has to be completed before relationship building can begin.

The ACTAD list highlighted the importance of identifying physical (and mental) health issues. The LTC team members are all nurses so it is interesting that the staff overlooked this theme. However, having access to physical health advice was clearly of importance to the clients.

The role of the family was not identified in any of the lists of the features of outreach. However, from the client viewpoint, engaging family members into the process or rebuilding family relationships was of value.

In combination the professional and client views allow the development of checklist that can be used by both commissioners and service providers when specifying, designing or evaluating an outreach service.

What works in outreach to problem drinkers: a checklist	
Is the service:	✓
* <i>Assertive by offering home visits and meeting people in the community?</i>	
* <i>Focussing on building a relationship with each client?</i>	
* <i>Persistent in its efforts to build a relationship?</i>	
* <i>Consistent in its efforts to build a relationship?</i>	
* <i>Offering sufficient time and flexibility to build a relationship?</i>	
* <i>Ensuring that paperwork happens but does not impede engagement and a client focus?</i>	
* <i>Focused on more than just alcohol – does it support the whole person?</i>	
* <i>Flexible in what it targets?</i>	
* <i>Supporting clients to engage with other services and helping them to overcome any barriers?</i>	
* <i>Building a multi-agency approach to each client?</i>	
* <i>Able to offer access to expertise on the physical impact on alcohol?</i>	
* <i>Able to help people build relationships with their families?</i>	
* <i>Encouraging and supporting activity beyond the home?</i>	
* <i>Ensuring caseload size does not impede engagement?</i>	
Are staff:	✓
* <i>Demonstrating passion about their work?</i>	
* <i>Non-judgemental in their approach?</i>	
* <i>Using a friendly approach to clients?</i>	
* <i>Giving positive feedback?</i>	
* <i>Working as a team?</i>	

Appendix 1 – Alternative descriptions of assertive outreach

The ACTAD (assertive community treatment for alcohol and drug users) pilot described the ACT intervention as comprising:

1	Maximum caseload of 15 ACT patients per practitioner
2	Input from a multidisciplinary team (including psychiatrists, substance misuse specialists)
3	Regular contact (minimum of once a week; 50% of contacts outside of the service settings, either in the patients' home or neighbourhood; short frequent contacts rather
4	Assertive engagement - persistent and repeated attempts to contact, emphasis on maintaining contact and building relationships
5	Focus on both health and social care needs - including accommodation, leisure, occupation, and physical and mental health
6	Flexibility - practitioners should work flexibly with patients' goals even when these are peripheral to the addiction.
7	Openness - practitioners are explicit about their goals both in care planning and in visits.
8	Going out of your way - stepping outside of professional roles and going the extra mile for patients.
9	Extended care - provided for a prolonged period of 1 year.

The American *National health care for the homeless council* divides outreach into four stages:

1	Approach activities - observation and introduction;
2	Companionship activities - sharing a little of the journey with another, standing or sitting with them;
3	Partnership activities - introducing the person to others who can help or assist;
4	Mutuality activities - recognising that the relationship has come to fruition and thus is brought to closure.

The same guide goes on to describe the key features of outreach:

5	Bringing services to clients rather than waiting for them to come to the services;
6	Allowing for flexible and varied times for client contact including non-scheduled contacts;
7	A non-threatening approach;
8	Flexibility in the range of services offered and the manner in which they are provided;
9	Responding quickly to an individual's perceived needs;
10	Conducting an assessment of the individual's comprehensive holistic needs and tailoring services to meet them;
11	Providing engagement services for clients who are reluctant or suspicious to receive help;
12	Patience in motivating clients to accept treatment;
13	Repeated contact over extended periods of time.

References

- (1) Kraybill K. - Outreach to people experiencing homelessness - 2002
- (2) ACTAD -- <http://trialsjournal.biomedcentral.com/articles/10.1186/1745-6215-13-19>