# ‘Falling Through the Cracks’ – The Role of Assertive Alcohol Outreach Teams in Treating Co-morbid Mental Health Problems in People with Addictions.

E. N. Smith, E. Finch, C. Drummond.

South London and Maudsley NHS Foundation Trust, London & King’s College London, UK.

## ABSTRACT

**Aims and hypothesis:** Input from Assertive Alcohol Outreach Teams (AAOTs) reduces the ‘burden’ on already overstretched community mental health teams (CMHTs).

**Background:** AAOTs are specialist addictions services. This project focuses on an AAOT based in the London borough of Southwark, which engages with people in the local community with severe alcohol and illicit substance misuse problems.

**Methods:** The full caseload of the Southwark-based AAOT was reviewed, including mental health records, general practitioner notes, medical and surgical notes and hospital discharge summaries. Information was recorded regarding psychiatric comorbidity, including mental health diagnoses and psychiatric inpatient admissions. Patients were assessed to determine whether they met criteria to be open to a CMHT.

**Results:** Significant psychiatric comorbidity was found in our caseload. We found many patients (85% of the caseload) met official criteria for acceptance by CMHTs. The most common comorbid diagnoses were anxiety and depression. One fifth of patients had a previous psychiatric inpatient admission under Section of the Mental Health Act.

**Conclusions:** The vast majority of patients on the AAOT caseload have severe mental health problems **in addition to** addictions.

## INTRODUCTION AND METHODS

Previous research has shown that input from AAOTs reduces emergency department attendances and medical hospital admissions.[1&2] This project examined the impact of AAOT input on reducing the ‘burden’ on CMHTs.

The whole of the caseload (n=39) at the time of this study (March 2020) was assessed. All patients were successfully engaged with the AAOT intervention, which included frequent regular contact in the patients’ homes or local communities, and multidisciplinary integrated mental health and addiction treatment. Data were extracted onto a standardized form including; diagnoses and details of previous hospital admissions and whether hospital admissions were informal or under the Mental Health Act.

We considered patients eligible for acceptance by community mental health teams if there was clear evidence of complex or serious mental health problems (in addition to addictions).

## RESULTS

The AAOT caseload was made up of 39 patients, 74% male and 26% female. The mean age was 52 years old with an age range from 26 years to 75 years. Full results breakdown illustrated in Figure 1.

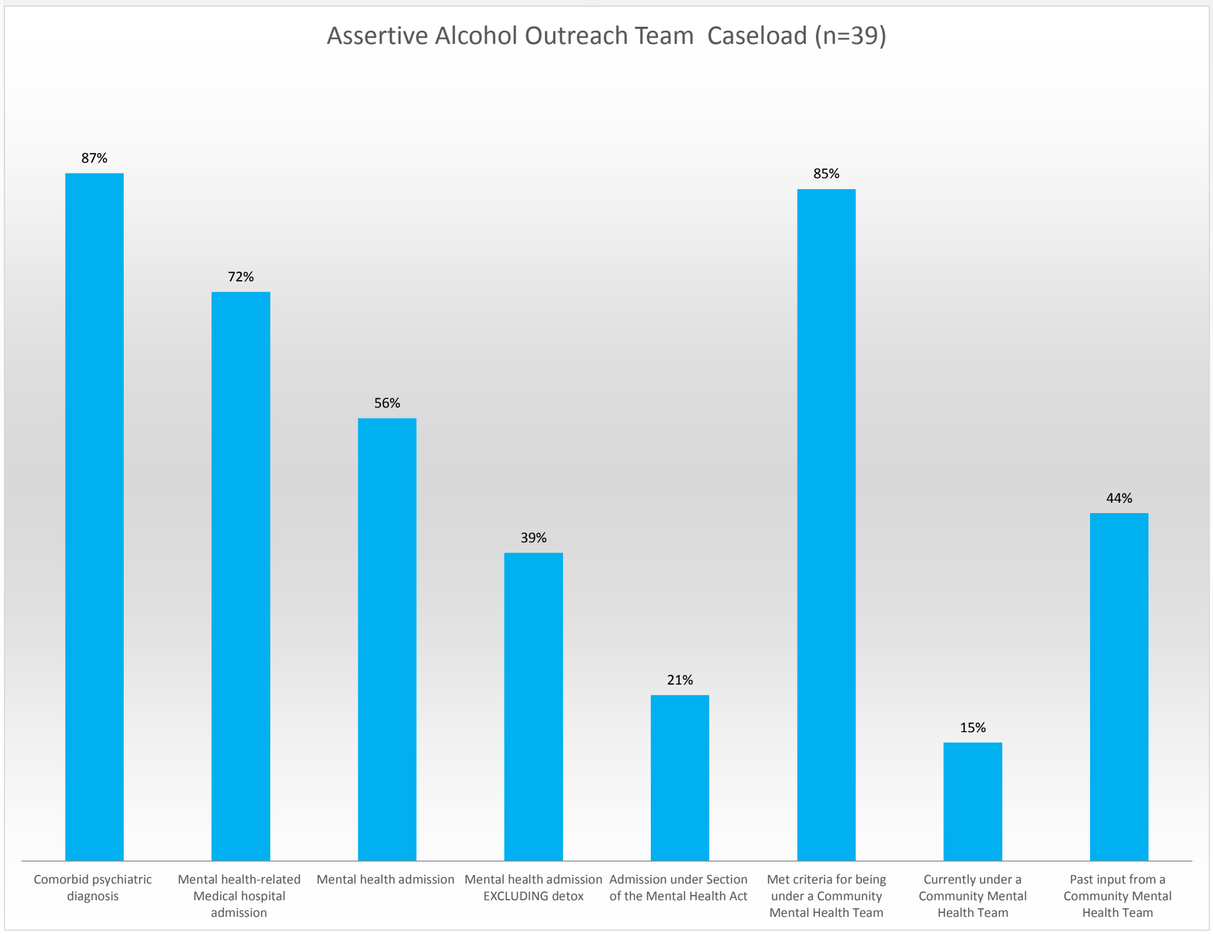


**Figure 1 – Results Summary**

## RESULTS – Continued

Eighty-five percent of patients on the caseload met the criteria for being under the care of a CMHT. Only 15% of patients were under the care of a CMHT. Forty-four percent of patients had previously been under the care of CMHTs, but many had been discharged for reasons most commonly seen as non-engagement with CMHTs. Many had been referred to and rejected by CMHTs due to high levels of drug and/or alcohol use.

Eighty-seven percent of patients had at least one comorbid psychiatric diagnosis. Co-morbid diagnoses included depression), anxiety disorders, personality disorders (most commonly emotionally-unstable personality disorder), schizophrenia and schizoaffective disorder, as well as neuropsychiatric disorders and one pervasive developmental disorder.

Seventy-two percent of patients had had at least one emergency department or medical hospital admission due to mental health-related problems, for example, suicide attempts and deliberate self-harm.

Thirty-nine percent had previous admissions to mental health wards, excluding planned admissions for alcohol detox (56% had previous admissions if detox admissions are included).

Twenty-one percent of patients has previously been admitted to hospital under Section of Mental Health Act.

Comorbid diagnoses most commonly seen were anxiety and depression (often diagnosed together and stated on GP summaries), illustrated in Figure 2.

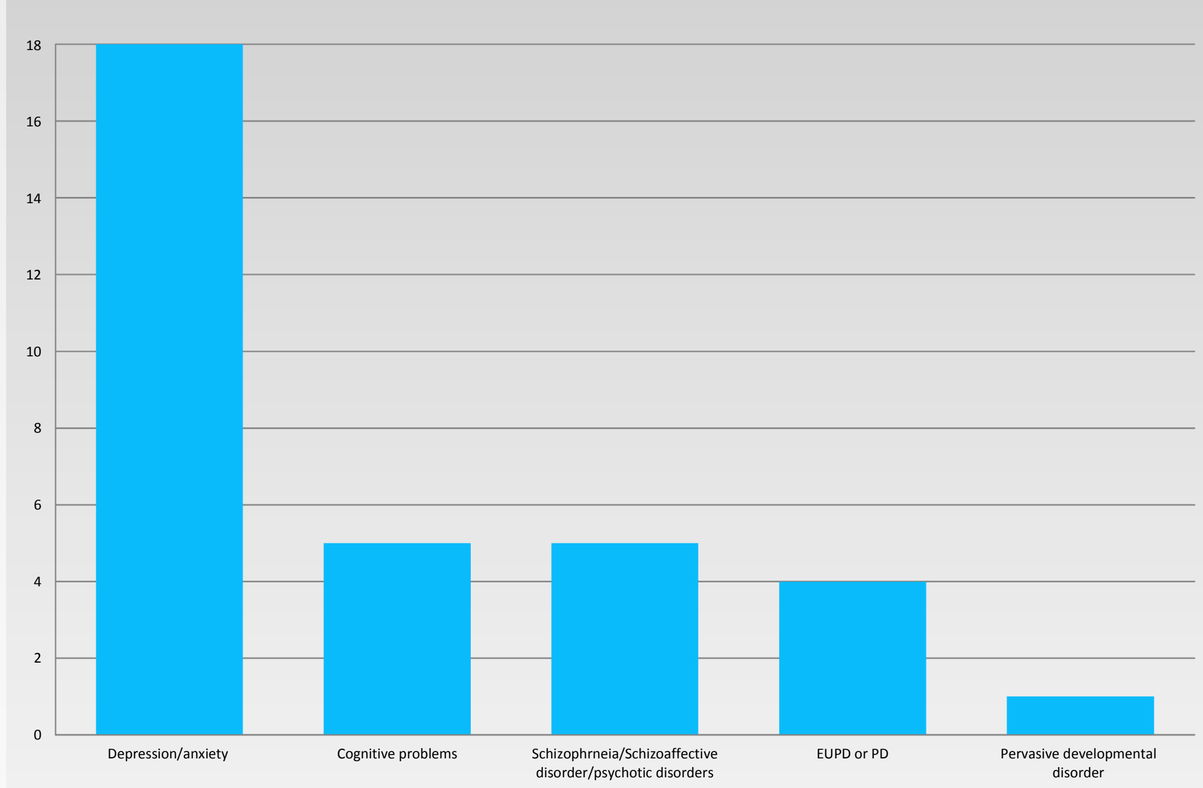


**Figure 2 – Breakdown of Comorbid Psychiatric Diagnoses**

## CONCLUSIONS

The patients on the AAOT case load are complex and often have a history of disengagement from standard mental health services. Formal diagnosis and treatment of comorbid mental health problems is challenging in the presence of protracted drug and alcohol misuse.

AAOT input appears to address a serious ‘gap’ in supporting patients with complex mental health needs who are often ineligible for CMHT input or disengage from CMHT support.

## REFERENCES

1. Hughes NR, Houghton N, Nadeem H*, et al.* Salford alcohol assertive outreach team: a new model for reducing alcohol-related admissions. Frontline Gastroenterology 2013;4:130-134.

2. Drummond, C., Gilburt, H., Burns, T., et al. Assertive community treatment for people with alcohol dependence: a pilot randomised controlled trial. Alcohol and Alcoholism, 2013; doi: 10.1093/alcalc/agw091

**Conflicts of Interests:** None declared.

**Author contact:** elizabeth.smith@slam.nhs.uk

THE MAUDSLEY TRAINING PROGRAMME