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The Mental Health Implementation Network: Integrated care protocols for mental, physical and substance use issues

Project 3: The evaluation of the implementation of Alcohol Assertive Outreach Treatment (AAOT)

NIHR ARC National Priorities Programme: Mental Health Implementation Network (MHIN)

Housekeeping

All delegates **will be muted** throughout the event

Please use the **Q&A function for questions**

The event **will be recorded.**

Please **enable captions** if you need them

For any technical issues, please contact **Michele Harris-Tafri (michele.harris-tafri@kcl.ac.uk)**

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Inclusivity

- To ensure an inclusive environment where open discussions can take place, please:
  - avoid acronyms where possible
  - be respectful and allow room for constructive challenge
- After the event
  - share the information you receive, but do not reveal the identity of who said it without their consent

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Alcohol Assertive Outreach Treatment: Scene setting

Amy Wolstenholme, Health Services Researcher, KCL

NIHR ARC National Priorities Programme: Mental Health Implementation Network (MHIN)

NIHR | Applied Research Collaboration South London

KING'S College LONDON

Assertive outreach treatment for people who attend hospital frequently for alcohol-related reasons

Amy Wolstenholme

National Addiction Centre

Institute of Psychiatry, Psychology and Neuroscience

King's College London

MHIN Project 3 Dissemination Event, March 2024

South London and Maudsley NHS

NHS Foundation Trust

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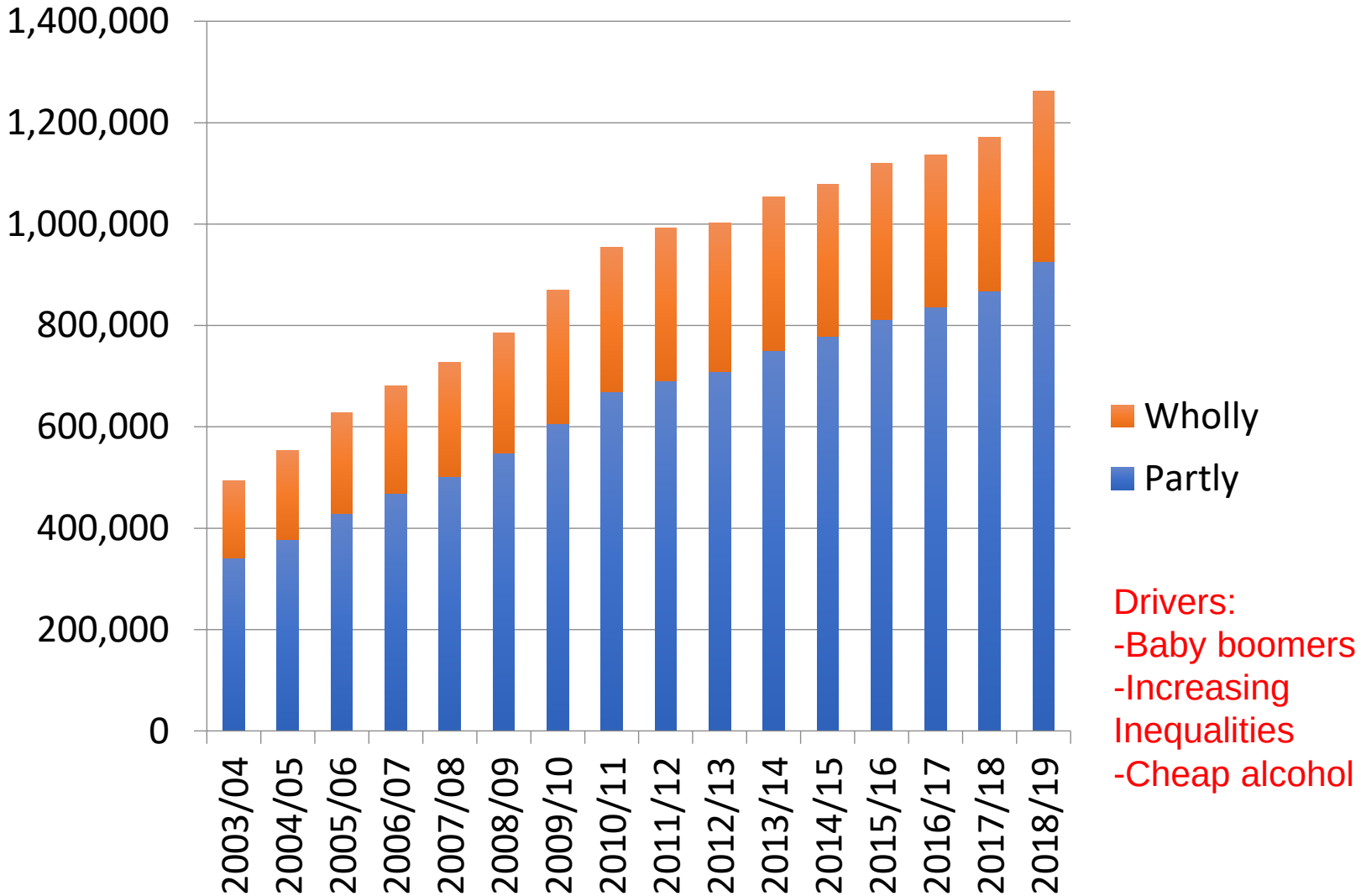
This presentation will cover:-

- Background of Alcohol Assertive Outreach Treatment (AAOT)
- Evidence of effectiveness and cost-effectiveness
- What patients think of AAOT

Context

- Harm: third leading cause of disability in Europe
- Prevalence of alcohol dependence in England 1.6 million people
- 7,556 deaths wholly caused by alcohol in 2021
- Recent fall (22%) in those with alcohol dependence accessing alcohol treatment
- Estimates between 6% and 20% of in-need population accessing treatment
- Health and Social Care Act 2012 + cuts to public health budgets
- Rising hospital admissions – more than doubled since 2003
- Alcohol costs NHS in England £3.5 bn per year
- Wider societal costs £21 bn

Alcohol related hospital admissions England 2003-2019



Drivers:
-Baby boomers
-Increasing Inequalities
-Cheap alcohol

People who attend hospital frequently for alcohol-related reasons – an overview

- Heterogeneous group
- Complex needs: alcohol dependence PLUS multiple, unmet physical/mental health and social care needs
- Rarely access community addiction services; high attendance acute hospital care
- Care and support accessed = high cost and low impact (short-term, simplistic vs. long-term, for complex needs)
- Poor outcomes
- Feel stigmatised and socially excluded
- Alcohol-related frequent (hospital) attenders (ARFA), “high-need, high-cost” (US literature)
- In two South London boroughs, 9% of people with alcohol dependence accounted for 59% of alcohol admissions
- Equated to 1.4 million bed days per year = £848 million

AUD and associated complex needs?

- Mental ill health
  - High level of anxiety and depression
  - But also undiagnosed SMI such as schizophrenia
- Learning difficulties physical or mental
  - Low educational attainment, gaps in system, poor employment record
  - Self-care
  - Local authority accommodation (of the poorest standard)
  - Vulnerability
- Physical ill health
  - Injury
  - Unplanned detoxification – high risk to patient and long-term health
  - Liver damage and cirrhosis
  - Alcohol-related brain injury (ARBI)
- Social support needs
  - Housing insecurity, benefit deficit, loss of (positive) social support network - vulnerability

Alcohol Assertive Outreach Treatment

- Originally designed for people with severe mental illness
- Building on case management for deinstitutionalisation
- ***"Assertive Community Treatment" (ACT)*** (Stein and Test, 1980)
  - Respond to material needs, coping skills, perseverance, freedom from pathological relationships, and support and education
- ***"Intensive case management" (ICM)*** (Burns 1999; Killaspy et al., 2006)
  - Caveat re: negative results in UK mental health setting?
- Adapted for people with alcohol dependence:-
  - Passetti et al., 2008 (engagement into treatment)
  - Hughes et al., 2013 (reducing hospital attendance)
  - Drummond et al., 2017 (engagement into community treatment)

What is Alcohol Assertive Outreach Treatment?

- Small keyworker caseloads ≤15
- Multidisciplinary team
- Frequent contact (e.g. weekly)
- >50% contacts in the community / home-based
- Holistic care – focus on health and social care needs
- Extended contact e.g. 12 months
- Persistent, assertive engagement
- Working across traditional professional boundaries
- Patient-led agenda
- Engagement with families, carers and professionals
- Advocacy
- Supporting patients to attend addiction and health services
- Volunteers provided practical help and support
- Survey of AOT for alcohol in hospitals n = 37. Six high, 13 mid, 18 low. Extended support common but MDT working not (Fincham-Campbell et al., 2017)

Blackwood *et al. BMC Public Health* (2020) 20:332
https://doi.org/10.1186/s12889-020-8437-y

BMC Public Health

STUDY PROTOCOL Open Access

Assertive outreach treatment versus care as usual for the treatment of high-need, high-cost alcohol related frequent attenders: study protocol for a randomised controlled trial

R. Blackwood[1*], A. Wolstenholme[1], A. Kimergård[1], S. Fincham-Campbell[1], Z. Khadjesari[1], S. Coulton[2], S. Byford[3], P. Deluca[1], S. Jennings[1], E. Currell[1], J. Dunne[1], J. O'Toole[4], J. Winnington[5], E. Finch[5] and C. Drummond[1]

Abstract

Background: Alcohol-related hospital admissions have doubled in the last ten years to > 1.2 m per year in England. High-need, high-cost (HNHC) alcohol-related frequent attenders (ARFA) are a relatively small subgroup of patients, having multiple admissions or attendances from alcohol during a short time period. This trial aims to test the effectiveness of an assertive outreach treatment (AOT) approach in improving clinical outcomes for ARFA, and reducing resource use in the acute setting.

Methods: One hundred and sixty ARFA patients will be recruited and following baseline assessment, randomly assigned to AOT plus care as usual (CAU) or CAU alone in equal numbers. Baseline assessment includes alcohol

AAOT clinical trial

- Adapt the Assertive Outreach Treatment model previously used in severe mental illness (Drummond et al., 2017)
- Compared with standard care – simple referral, no proactive follow-up
- Identified patients through hospital e-health records
- Inclusion criteria: combination of A&E attendance AND/OR acute care admission, within one month/year, PLUS diagnosis of alcohol dependence
- Multidisciplinary team based at Maudsley Trust (SLaM) – nurses, keyworkers, consultant psychiatrist and volunteers
- Partnership working with hospital and community teams
- Recruited 174 patients into a trial of AAOT versus Care as Usual, 87 per treatment group **(n=174, n=87 in each arm).**
- Funded by Guy's and St. Thomas' Foundation Trust Charity and NIHR CLAHRC (collaboration for leadership in applied health research and care)

Shows graphically error plot for PDA at baseline, month 6 and month 12. Plot shows median, IQR, min and max values.

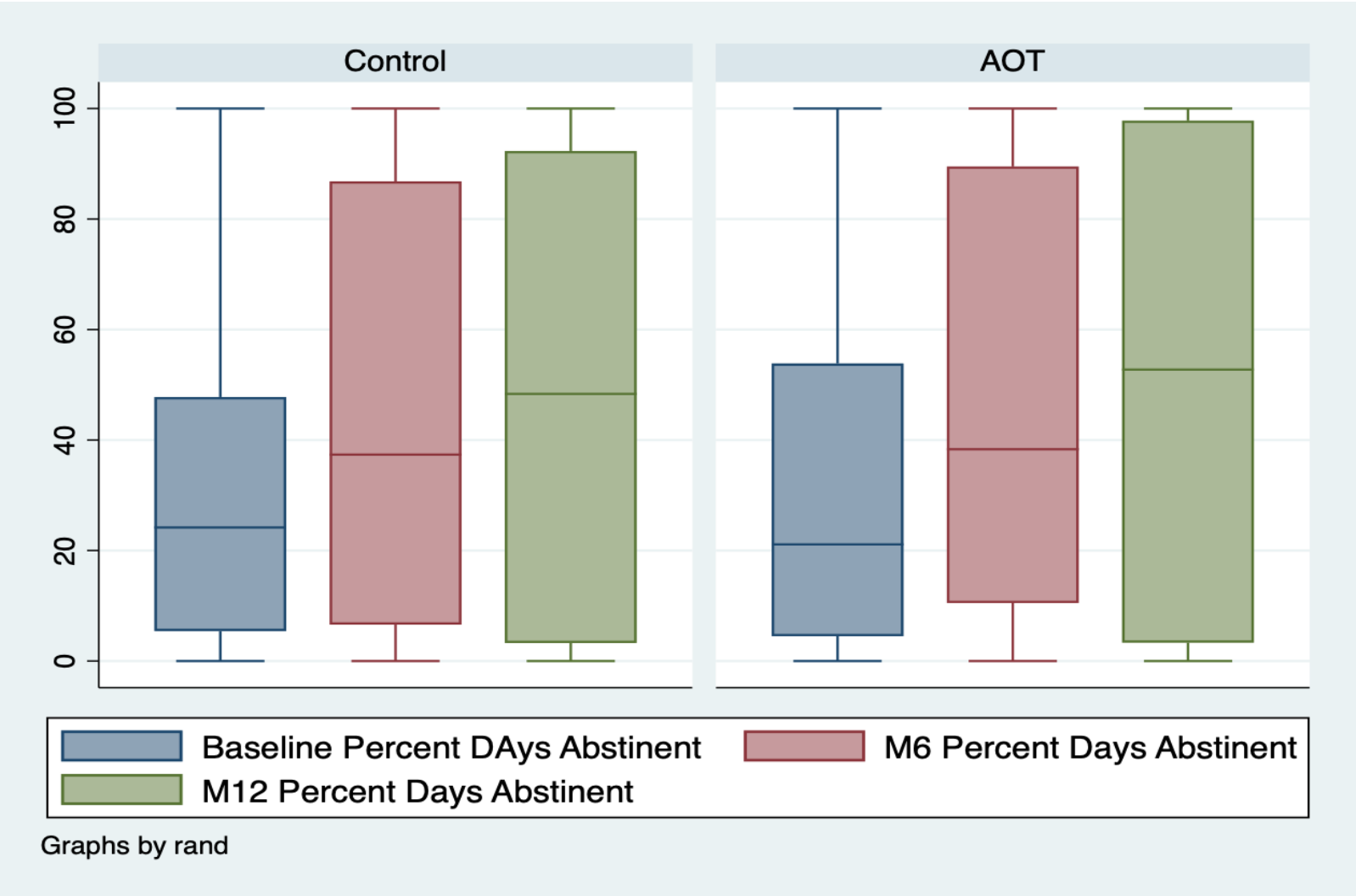


FIGURE 5: Scatterplot on a cost-effectiveness plane of differences in costs vs. differences in QALYs (complete case sensitivity analysis)

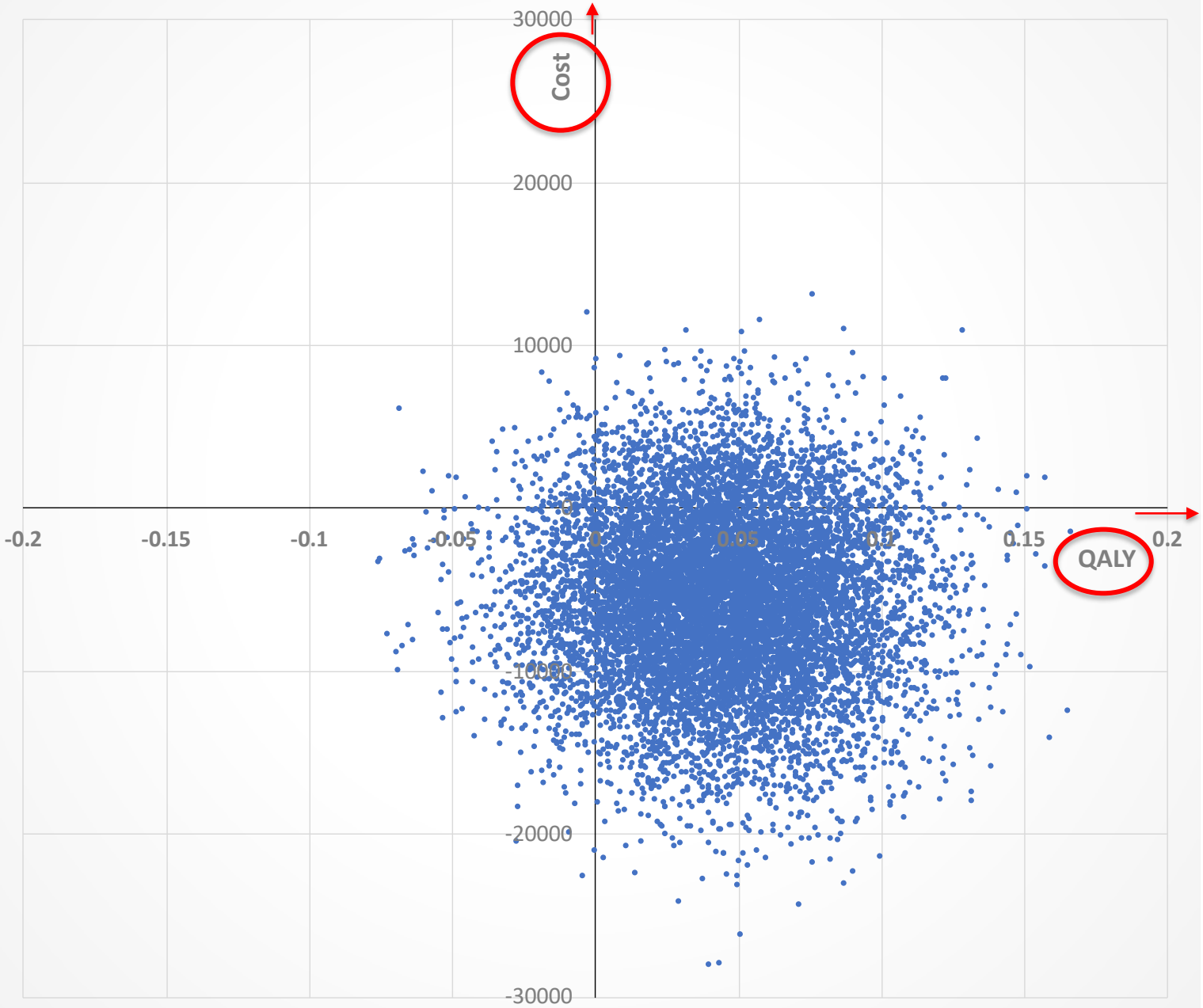
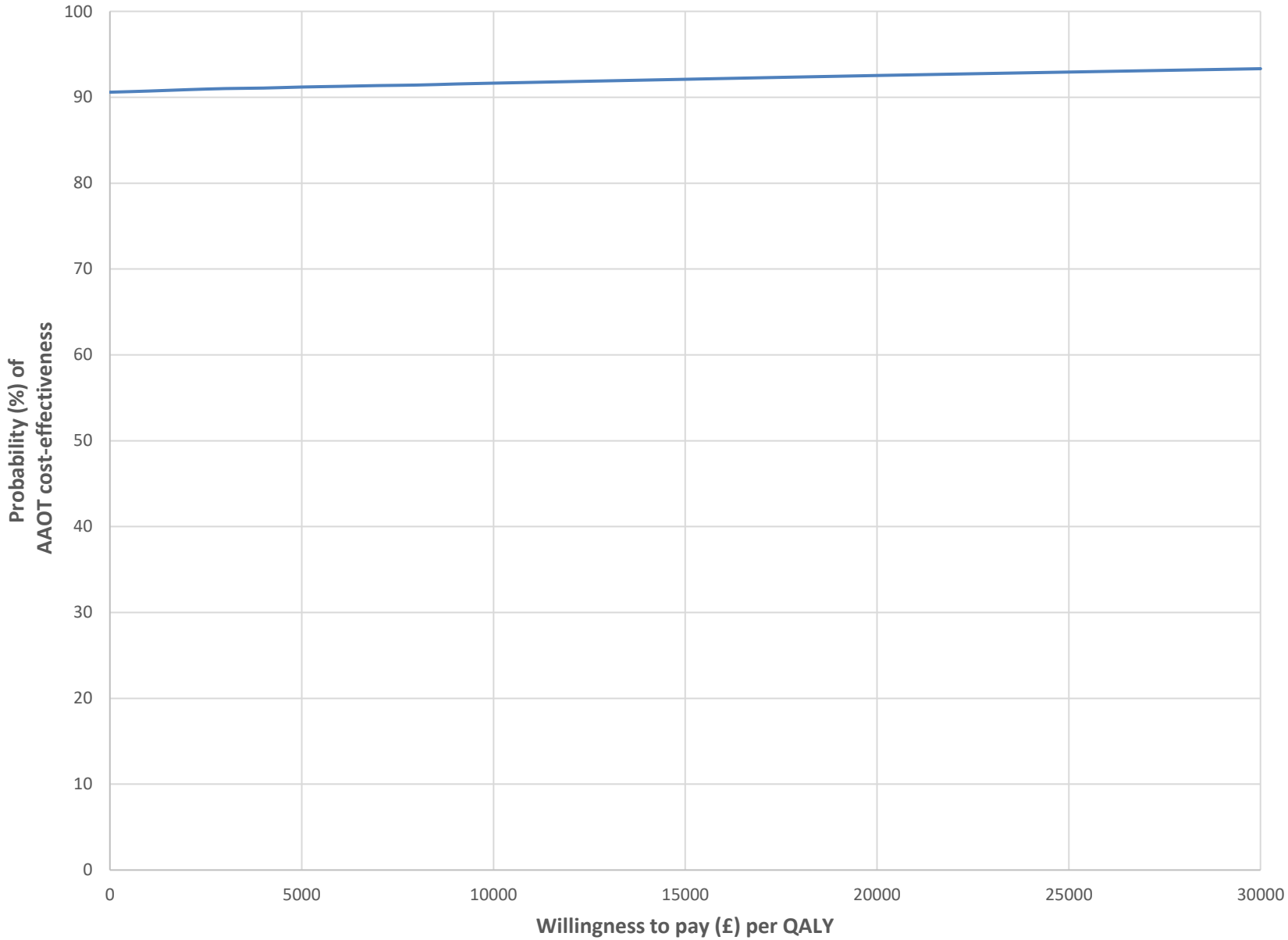


FIGURE 7: Cost-effectiveness accptability curve (primary analysis) showing the probability that AAOT is cost-effective compared with usual care for different values a decision-maker might be willing to pay per QALY

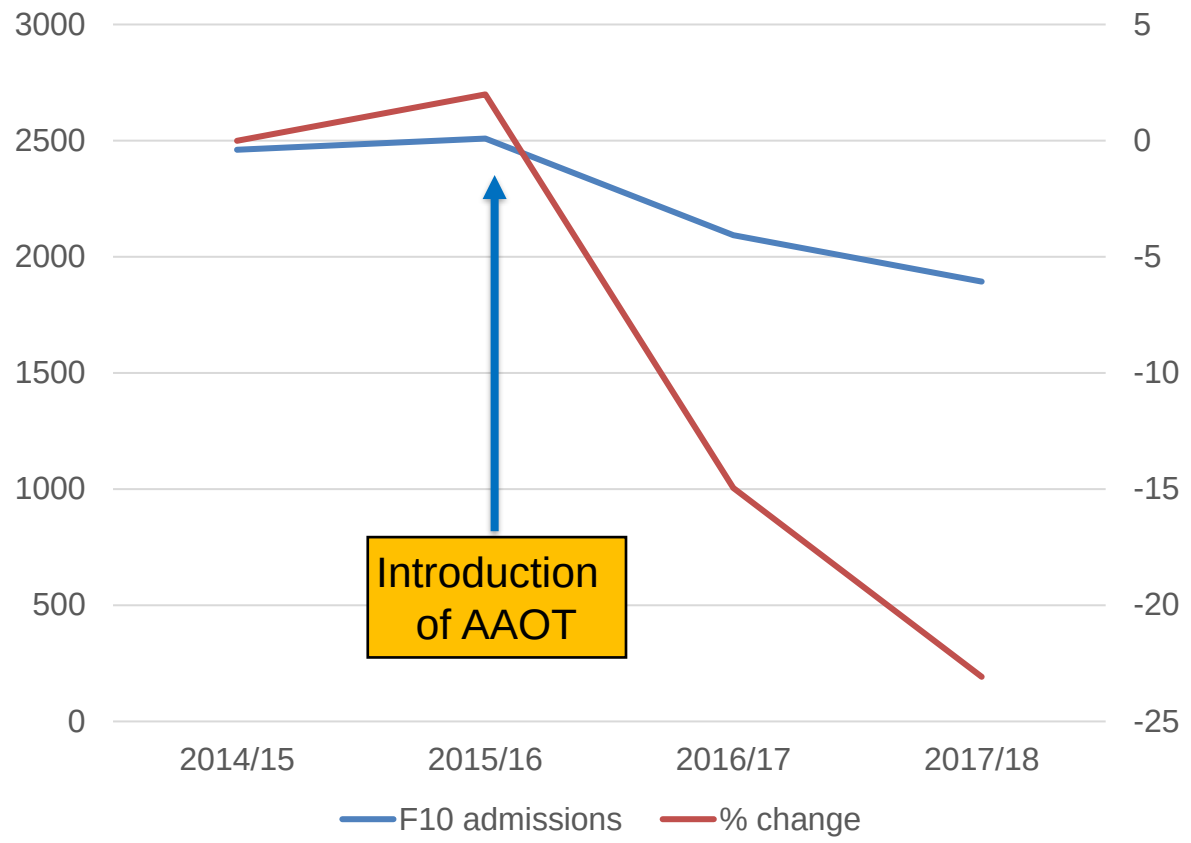


Participant resource use

- Hospital inpatient care high before and after trial (both arms)
- Spread across a wide variety of hospital specialities
- After 12 months, those receiving AAOT had lower inpatient resource use than for those in standard care
- Other differences:
  - A&E attendance and ambulance use were less for those receiving AAOT than for those in standard care
  - Community services were less for those receiving AAOT (specialist alcohol treatment was not higher for those receiving AAOT)
  - Criminal justice involvement was lower for those receiving AAOT

Impact at whole hospital level

Change in alcohol admissions via Emergency Department in King's College Hospital targeting 87 alcohol-related frequent attenders



What patients reported

- 29 patients interviewed
- Participants described large amount of unmet need before trial
- Most participants described multimorbidity: -
  - over half had a mixture of mental and physical health conditions
  - nine had physical health conditions only
  - four had mental health conditions only
- Very few had accessed community alcohol treatment services before the trial
- Those receiving AAOT reported changes in the way they engaged with services
- Very few of those receiving standard care reported any changes
- Most feedback on AAOT very positive

Positive experiences of AAOT intervention

- Cohort of 18 patients receiving AAOT
- “Interpersonal” aspects of support
  - Therapeutic style
  - Relationship with keyworker
  - Keyworker qualities
- “Practical” aspects of support
  - Flexible format of engagement and support
  - Broad focus on all needs (patient-centred approach)
  - Care coordination and navigation
- Negative experiences included too sudden / ill-timed end to support and one bad match between keyworker and patient

In summary

- AAOT is cost-effective
- Driven by small improvements in outcomes combined with a reduction in inpatient use
- Reasons for cost-effectiveness:
  - felt supported across a variety of needs
  - felt adequately supported with their alcohol problems by their AAOT keyworker
  - felt respected and listened to
  - were better informed about their own health, drinking and services
  - were more engaged in playing an active role in their health care
  - greatly valued the therapeutic relationship with their keyworker

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With thanks to:–

Professor Sarah Byford, King's College London
Professor Colin Drummond, King's College London
Professor Joanne Neale, King's College London
AAOT trial participants
AAOT team

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An overview of the Mental Health Implementation Network

Colin Drummond, Professor of Addiction Psychiatry, KCL

NIHR ARC National Priorities Programme: Mental Health Implementation Network (MHIN)

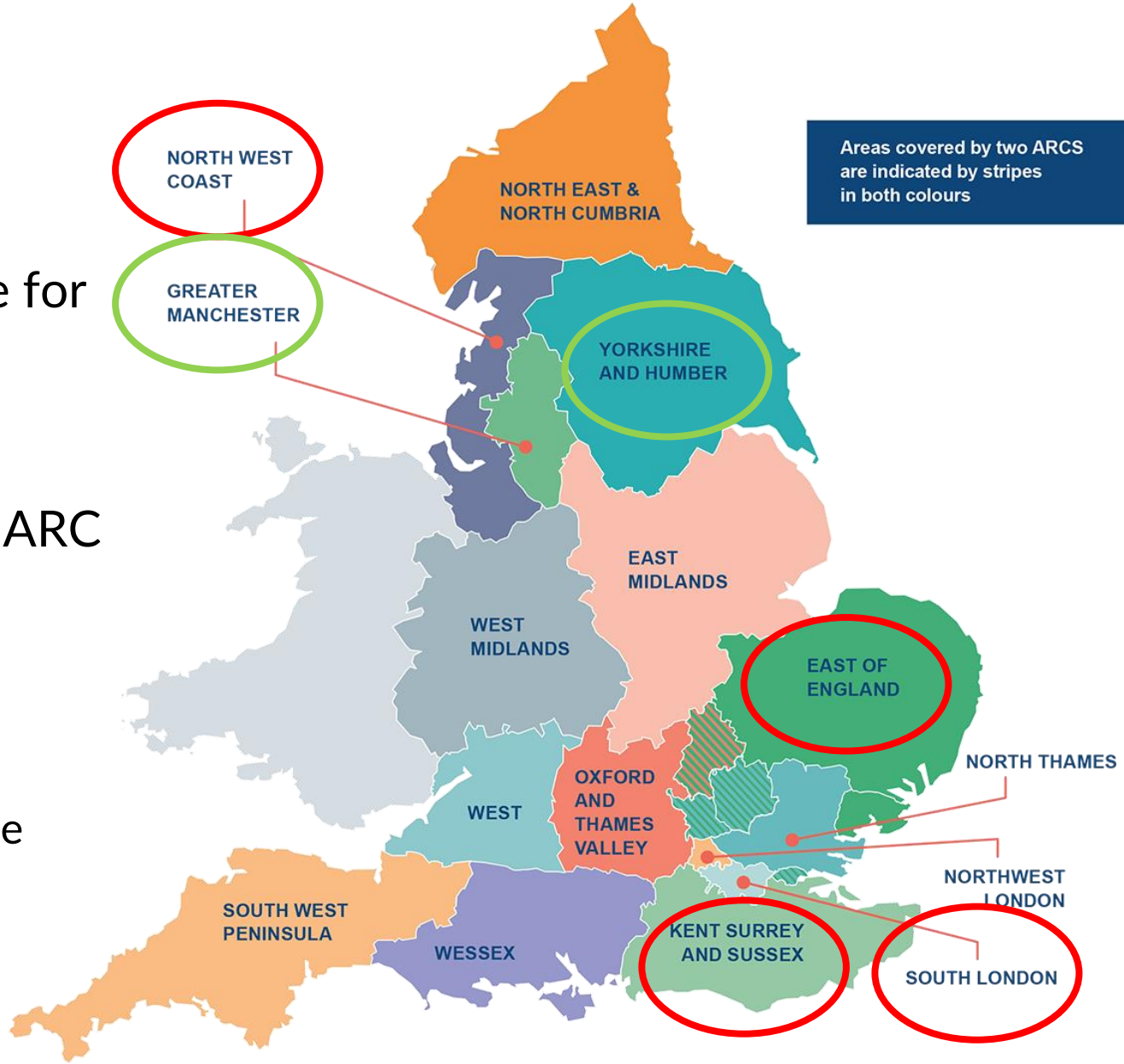
NIHR ARC National Priority Areas

- Children's health and maternity
- Prevention, including Behavioural Risk Factors
- Health and care inequalities
- Mental health, including children and young people's mental health
- Multimorbidity
- Adult social care and social work
- Healthy ageing, including dementia and frailty

*ARC = Applied Research Collaboration: a NIHR-funded regional collaboration between universities, health and social care providers, commissioners, charities, and local authorities

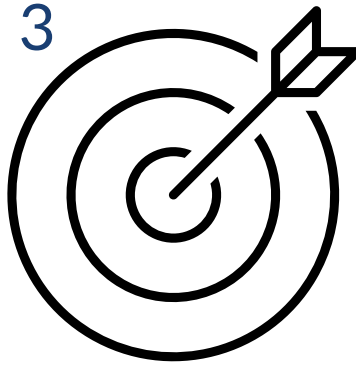
What is the MHIN?

- Commissioned by the National Institute for Health and Care Research
- Jointly led by the Applied Research Collaboration (ARC) South London and ARC East of England
- Problems being addressed:
  - Care gap in mental health
  - Slow translation from evidence to practice
  - Uneven implementation
  - Underserved populations and conditions



What is the aim of the MHIN?

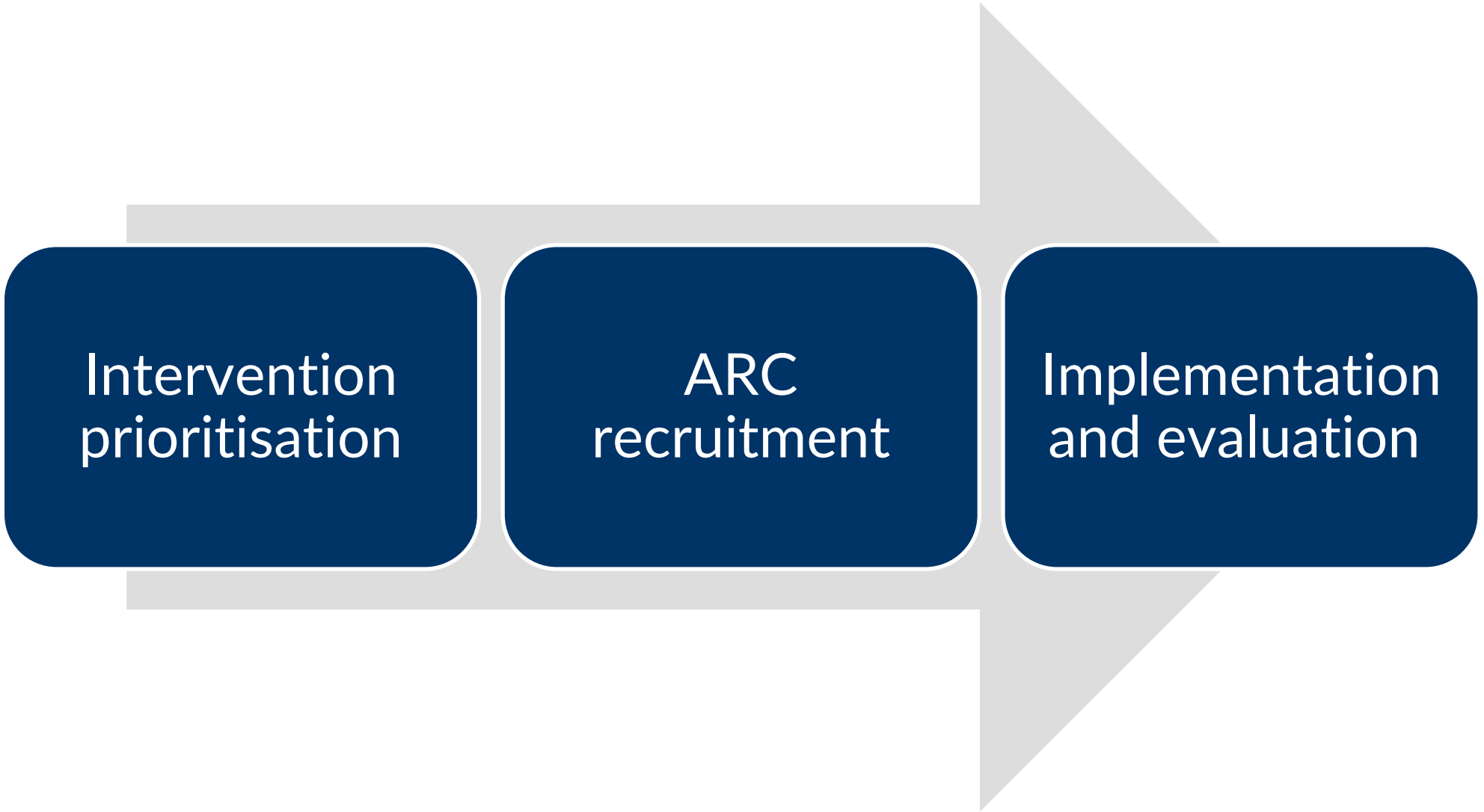
- To **catalyse and evaluate** the implementation of high-impact, evidence-based mental health interventions **supra-regionally** or **nationally** within 3 years



MHIN Objectives:

- To convene a **multidisciplinary consortium** of key stakeholders ✓
- To identify and **prioritise service areas** that require improvement ✓
- To identify **evidence-based solutions** ✓
- To identify and agree **implementation methods** that are realistic ✓
- To conduct an **evaluation** of the implementation activity ✓
- To conduct an evaluation of the MHIN as a priority network programme ✓

How has the MHIN progressed these aims?



Initial long list of priority topics for implementation

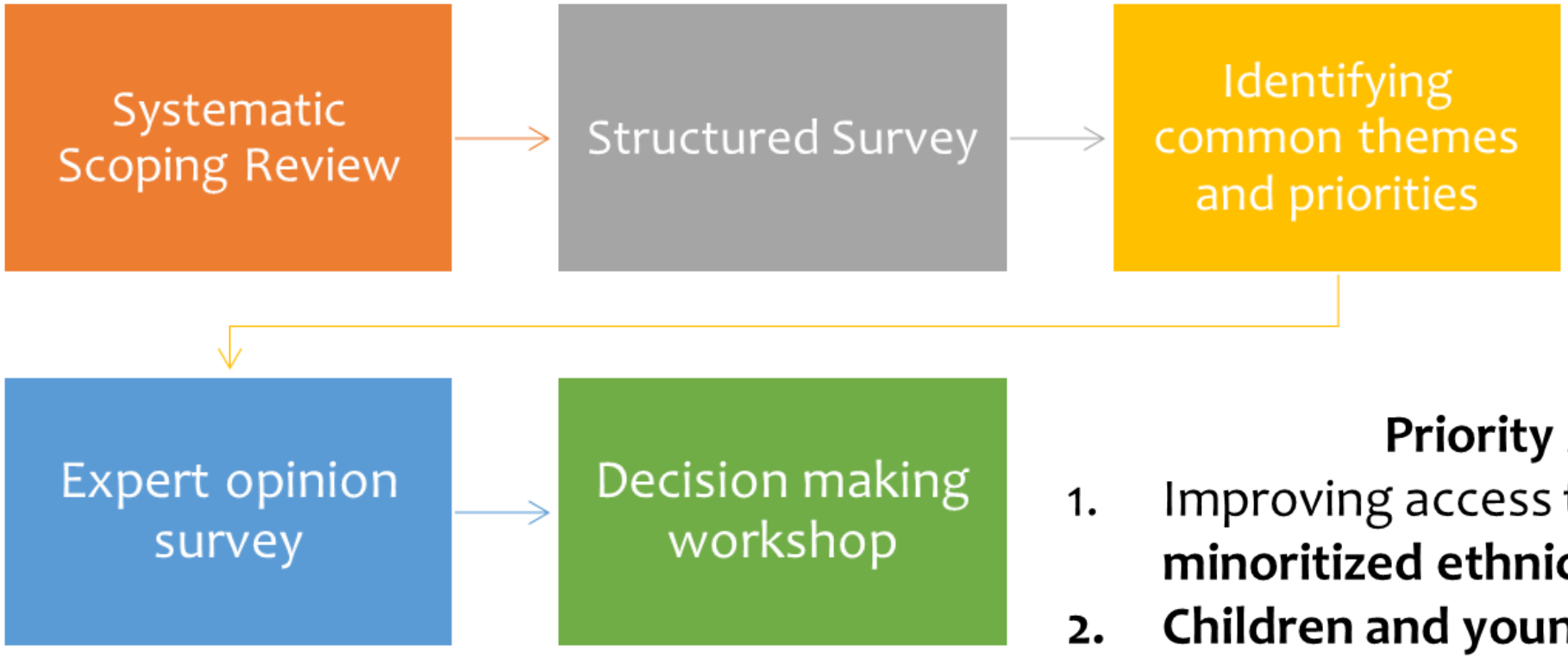
- Children and young people
  - Parent-led digital CBT for children with anxiety
  - IAPT-style services for children and adolescents
  - Self harm in adolescents
  - Crisis resolution teams in autism
  - Manage adverse events during childhood
  - Prevention strategies for head banging esp. in children and adolescents
- Perinatal mental health
  - Implementing guidelines to improve perinatal MH care for mothers, their partners and children
  - Increase awareness of risks around pregnancy and childbirth in SMI
- Comorbidities
  - Inpatients with physical comorbidity
  - Physical health checks in SMI
  - Access to MH care in LT physical illness
  - Integrated care in comorbid substance misuse, including alcohol
- Severe Mental Illness
  - Psychosis risk prediction tools
  - Implementing guidelines for bipolar disorder
  - Prevent burden on caregivers in SMI
  - Support to find and retain employment
- Suicide prevention
  - Optimising & reducing access to medicines
- Inequalities
  - Improving access to MH care for ethnic minority groups
  - Provision of talking therapies in languages other than English
  - Suicide and self harm prevention for women of South Asian origin
  - Increase professionals training in and awareness of MH needs in LGBTQ+ communities
- Peer support
  - Implementation of peer support systems across MH services

Prioritising the interventions

Criteria
• Local need addressed • Adoption appetite within local systems • Delivered improved outcomes • Has clearly defined core components • Cost effective and provides economic benefits • Implemented/commissioned in the real world • Patients involved in the intervention's design and development
• Intervention providers/commissioners receptive to implementation • Intervention can be piloted and then scaled up • Resources required to scale up are proportionate to impact expected • Intervention requires major/complex changes to the services/ pathways/ systems

Figure 1

Prioritisation: Priority Area Selection



Priority Areas:

1. Improving access to MH services for **minoritized ethnic communities**
2. **Children and young people's mental**
3. Integrated care protocols for **substance use issues, mental and physical health**

MHIN Projects and ARC partners

Project	MH Focus	Intervention	Implementing ARCs
1	Improving access to mental health services for minority ethnic communities	Patient and Care Race Equality Framework	• Yorkshire & Humber • Greater Manchester
2	Children and young people's mental health	Parent-led Cognitive Behavioural Therapy	• East of England • North West Coast
3	Integrated protocols for substance use, mental and physical health problems	Alcohol Assertive Outreach Treatment	• Yorkshire & Humber • Greater Manchester

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AAOT in Greater Manchester

Dr Stephen Kaar, Honorary Senior Lecturer and Consultant Psychiatrist, University of Manchester and Greater Manchester Mental Health NHS Foundation Trust

NIHR ARC National Priorities Programme: Mental Health Implementation Network (MHIN)

VALOR- A mixed methods evaluation of the implementation of Alcohol Assertive Outreach Treatment (AAOT) in Greater Manchester (Salford and Bolton)

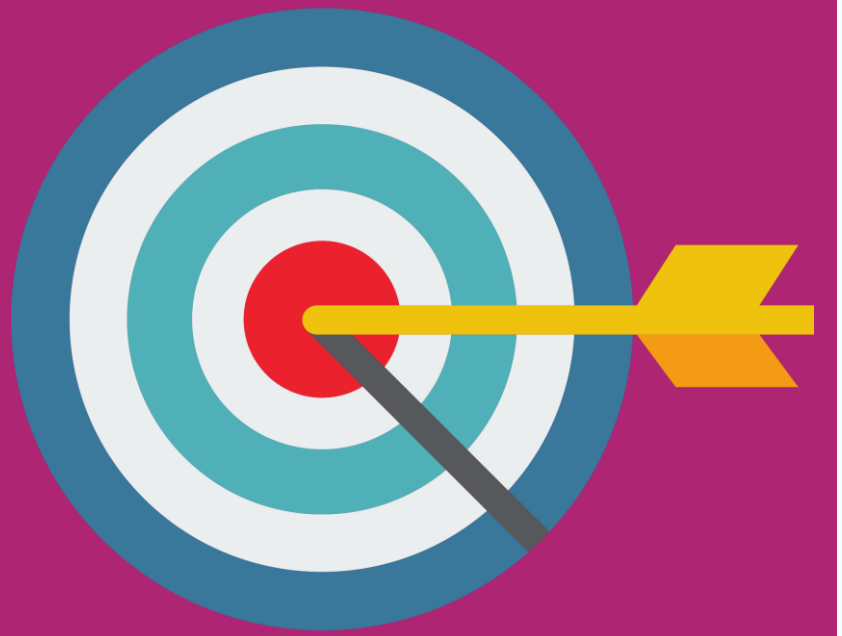
Dr Stephen Kaar
Consultant Addictions Psychiatrist, GMMH
Honorary Senior Lecturer, Manchester University

FUNDED BY NIHR | National Institute for Health and Care Research

Outline

- Overview of AAOT services under study
- Quantitative service evaluation
- Qualitative study
- Next steps

VALOR Project Aims



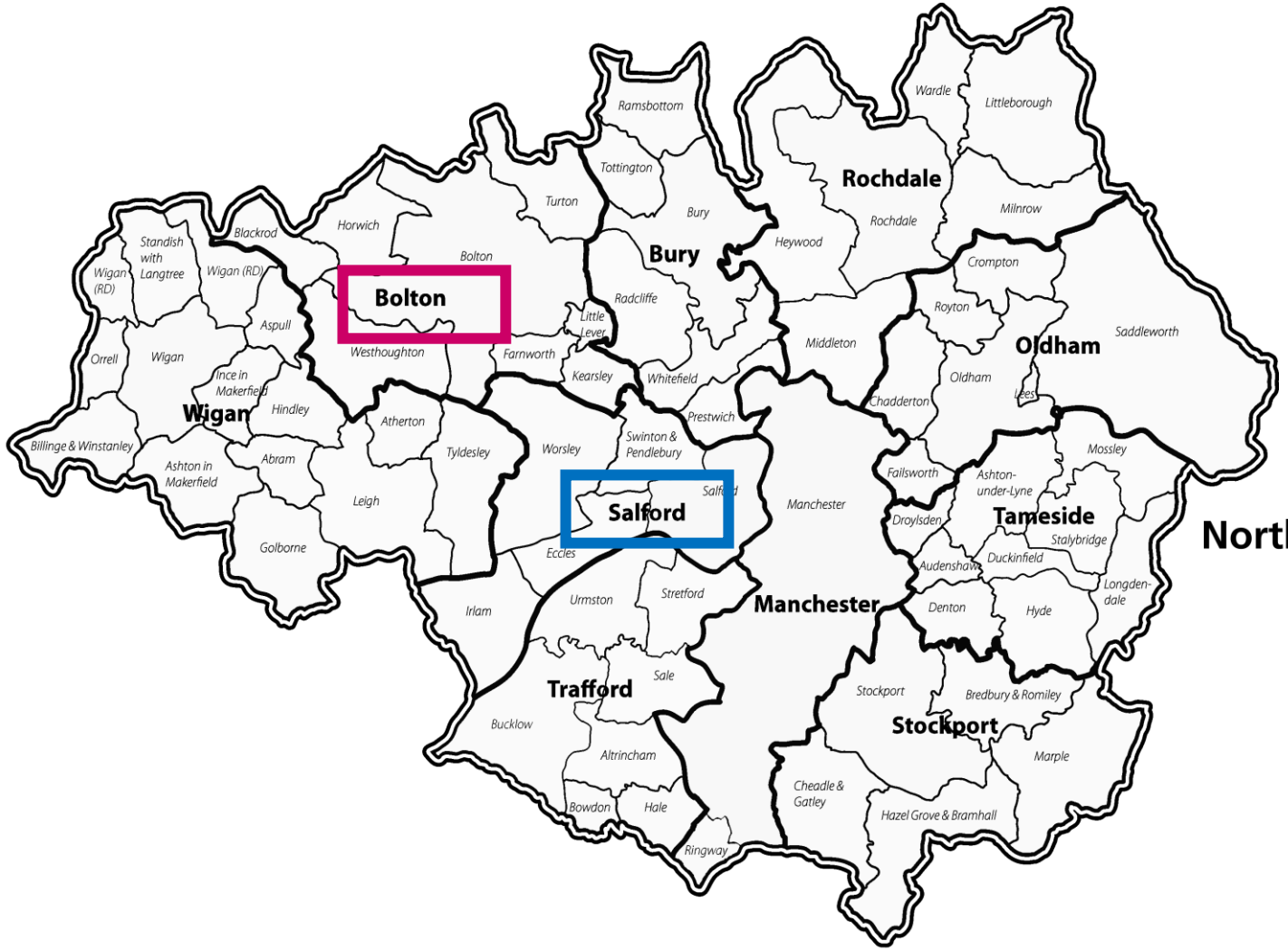
Project Aims:

1. Composition of AAOT and fidelity to the model
2. Service user informed outcome measures
3. Role of co-morbid mental health conditions
4. Health economic impact
5. Sustainability of AAOT in GM/NW
6. Disseminate best practice around implementation and clinical service development

VALOR study sites: Alcohol assertive outreach teams in Salford and Bolton

NHS
Greater Manchester Mental Health
NHS Foundation Trust

Achieve
Bolton, Salford and Trafford
Drug and Alcohol Recovery Service



The BigLife group

NHS
Northern Care Alliance
NHS Group

The Big Life Team

HISMT

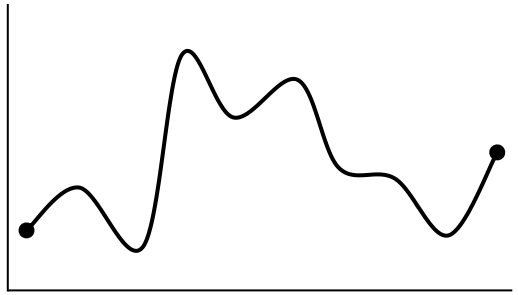
AAOT Service models

	Alcohol Assertive Outreach Model	HISMT	Big Life Assertive Outreach
Type	N/A	NHS	3rd Sector
Est.	N/A	2011	2018
Staff title	Keyworker	Recovery co-ordinator/AO Worker	Assertive Outreach Worker
Approach	Long-term case management (up to 12 months)	Long-term case management (up to 12 months)	Short-term case management (on average 2-3 months)
Objective	Recovery/Harm minimisation	Reduction in unnecessary hospital admissions	Engagement with structured care SM team
Substance	Alcohol	Mainly alcohol but occasionally opiates	All substances
Caseload	10-20	10-15	25
NDTMS	N/A	Yes	No
Contacts setting	At least 50% of contacts outside clinical settings	Service user's home	Service user's home

Mixed-methods study design

1. Quantitative service evaluation
    - Retrospective analysis of routinely collected clinical data
    - GMMH plus Bolton and Salford Royal Hospitals
2. Qualitative research study
    - Prospective study using semi-structured interviews and framework analysis

Quantitative Service Evaluation



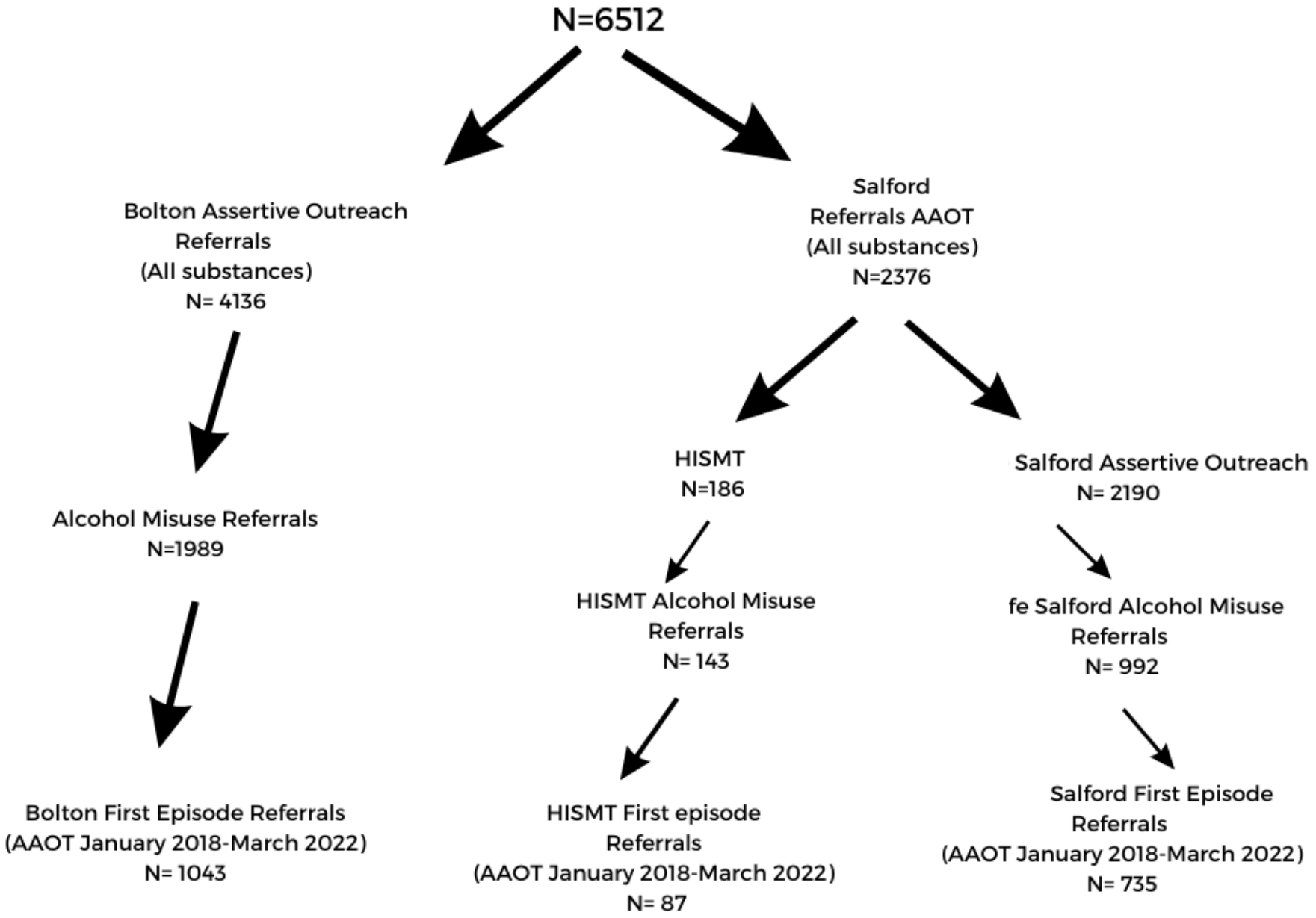
Primary aim: Explore clinical and demographic characteristics of AAOT population, measure levels of engagement with the AAOT service, measure change in acute hospital, mental health and standard substance misuse service utilization before and after AAOT.

Secondary aims: between service comparison, between site comparison.

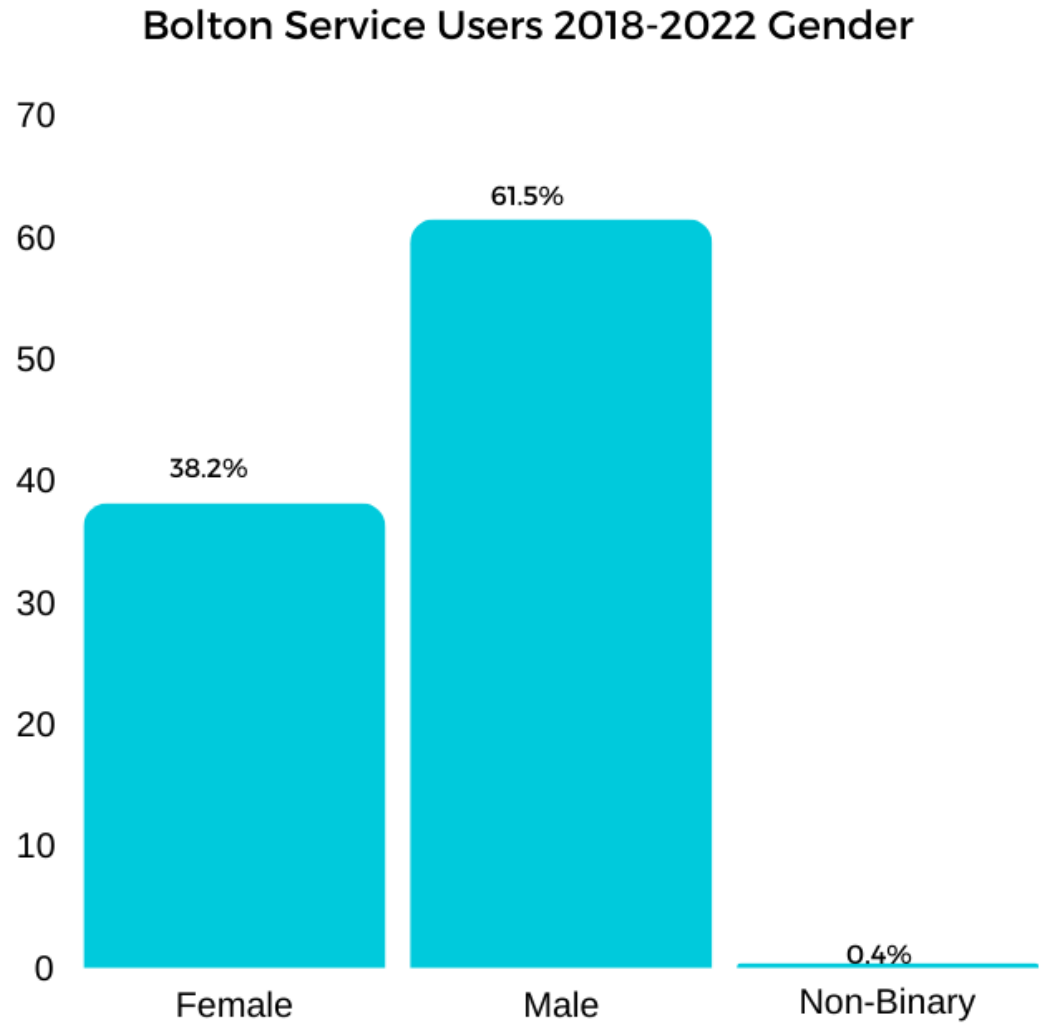
Methods: compare anonymised, aggregated clinical data from people 12 months before and 12 months after AAOT involvement.

Data collected from patients enrolled between 1st Jan 2018 and 31st March 2022 by Business Intelligence in GMMH and Acute Hospital NHS trusts.

Quantitative Service Evaluation Sample



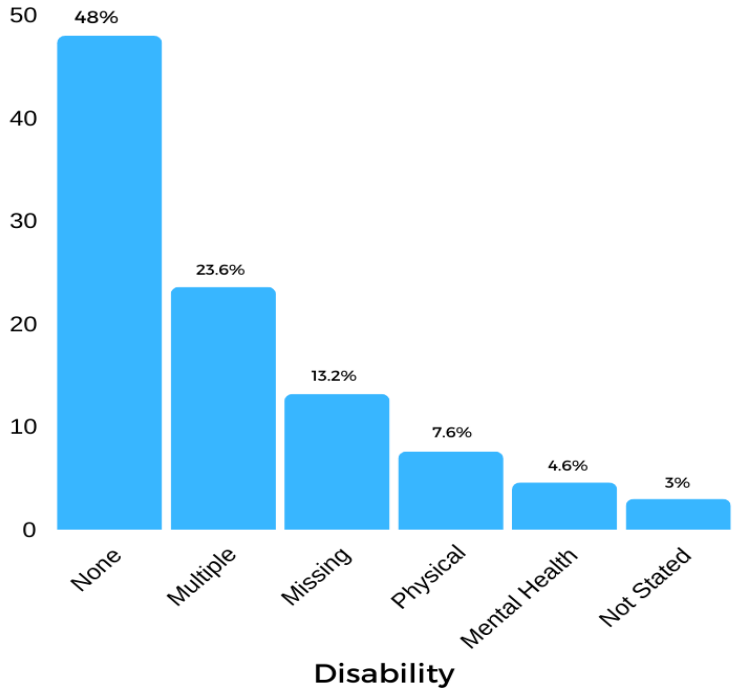
Service evaluation: Bolton sample age and gender

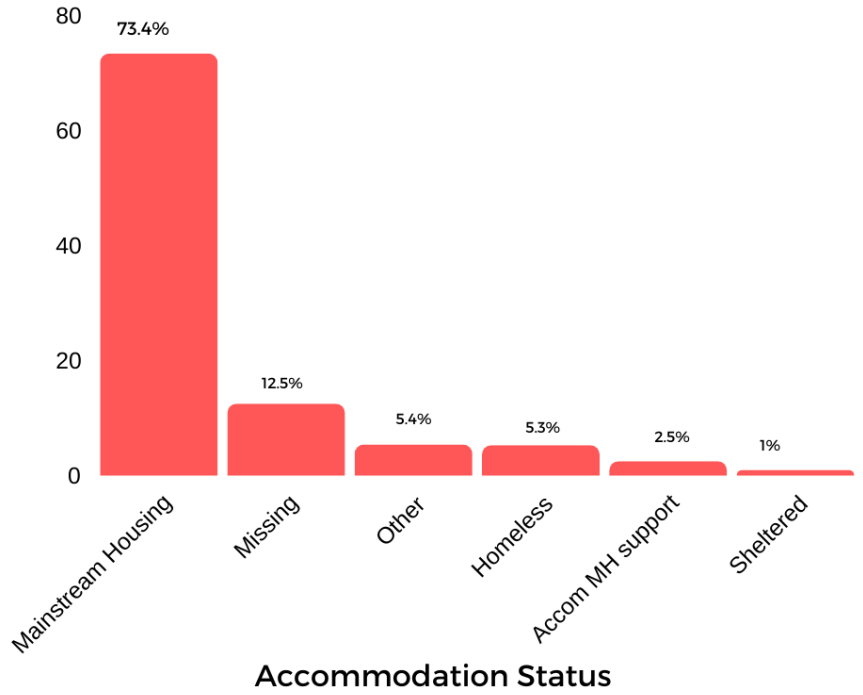


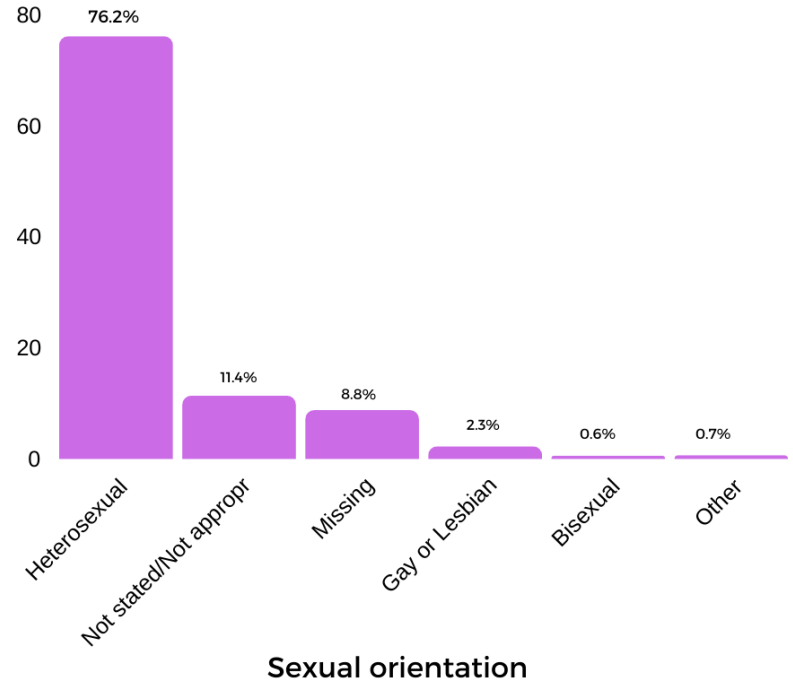
Age

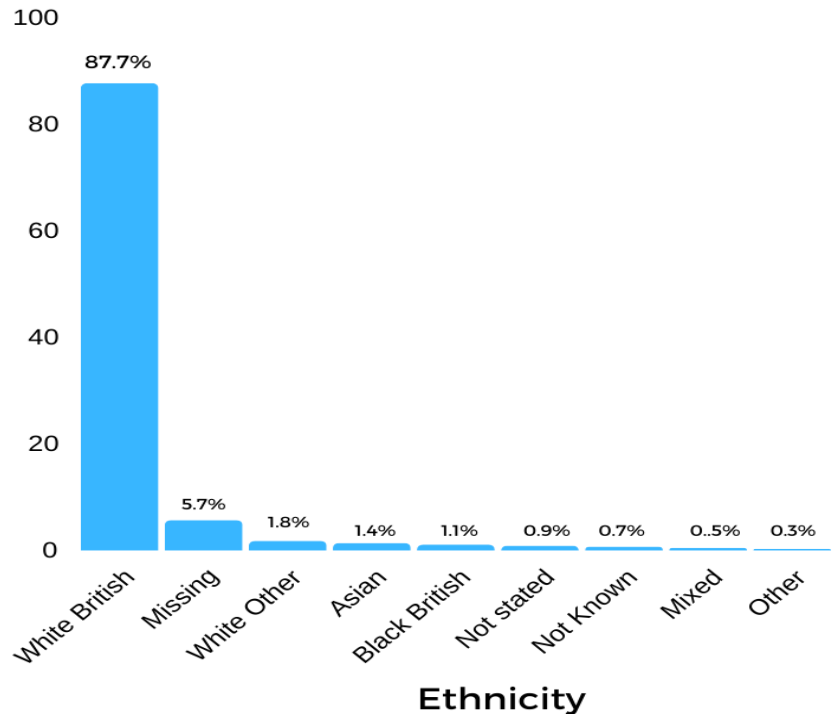
N	**1043**
Mean	47.49
Median	48
Std. Deviation	12.830
Range	69
Minimum	18
Maximum	87

Bolton AAOT demographics





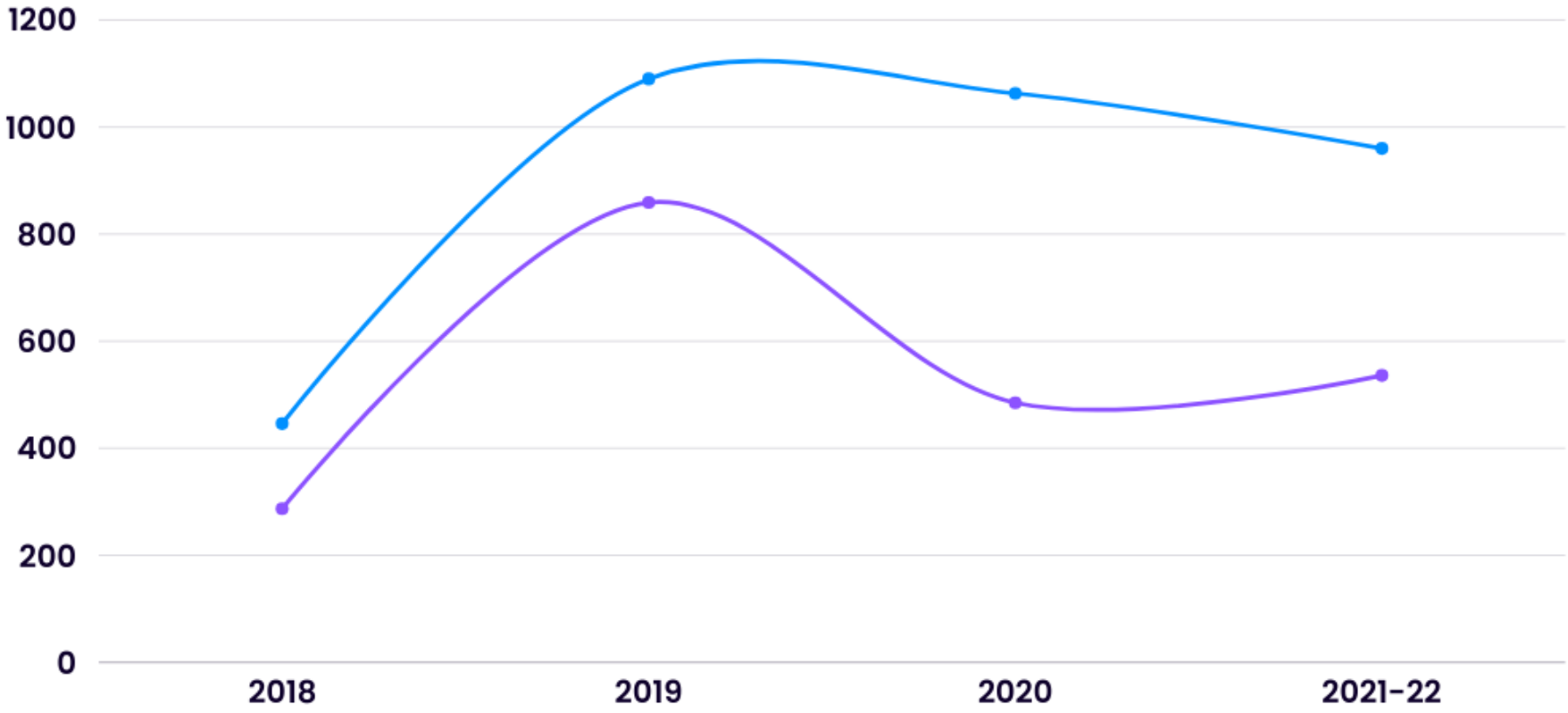




Bolton AAOT – mean length of first treatment episode

N	**1038**
Mean	61.91 days
Median	49
Std. Deviation	53.517
Range	69
Minimum	0
Maximum	296

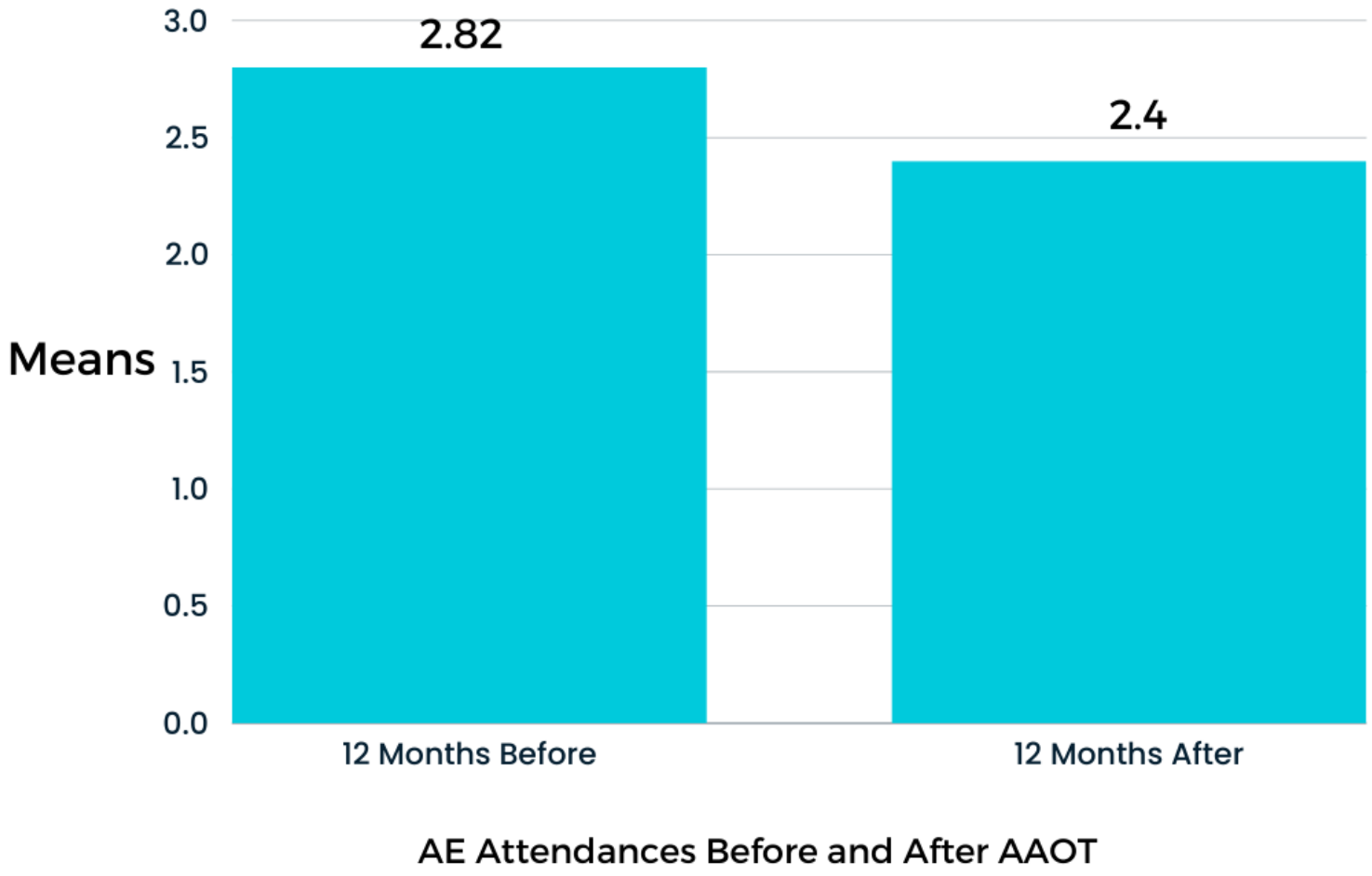
Bolton AAOT: Contacts with structured addictions care



Number of Contacts with Structured Substance Misuse Team Before and After AAOT for Service Users Referred Between January 2018 and March 2022

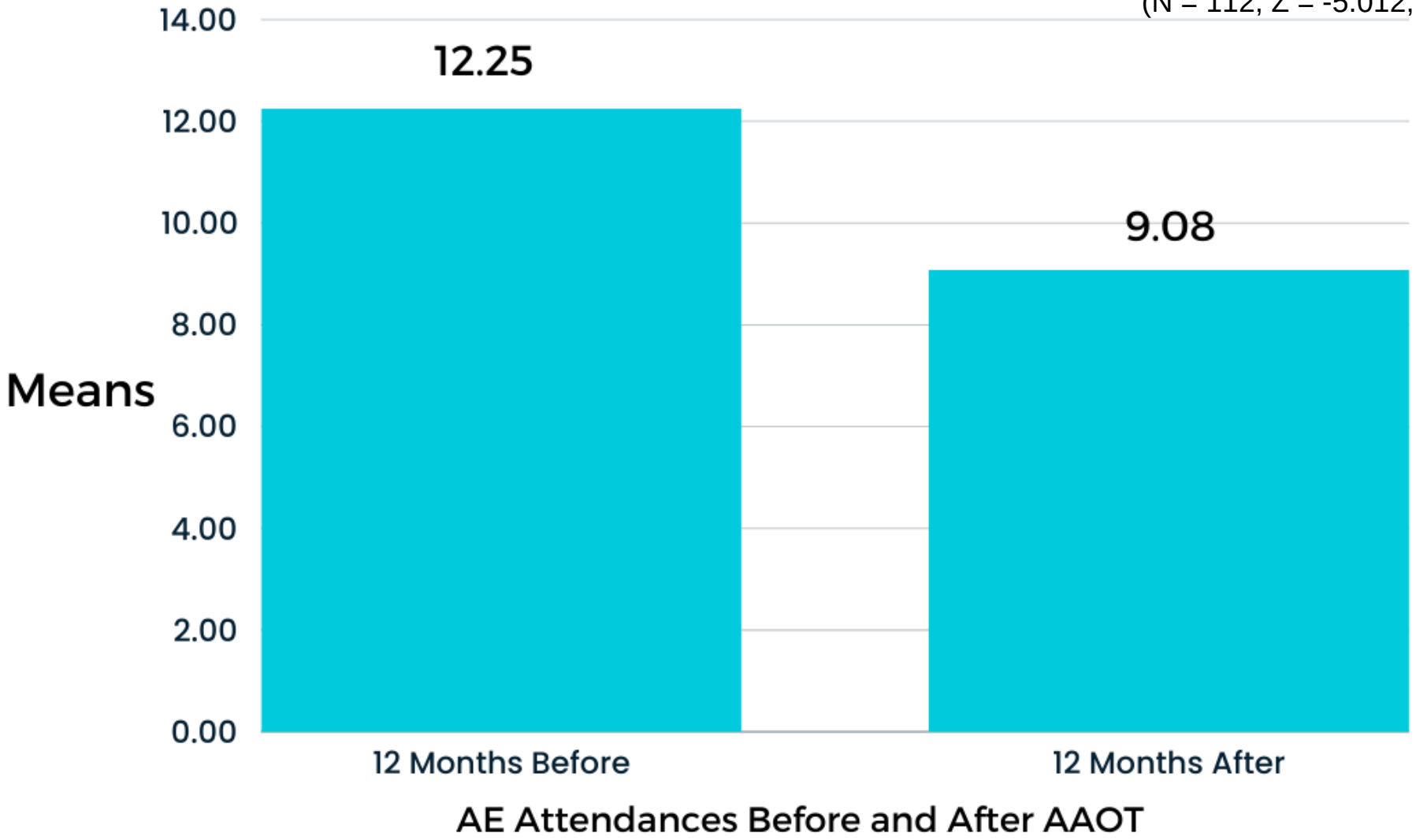
A&E Attendances 12 Months Before-After

(N = 1038, Z = -7.531, p < .001, two-tailed)



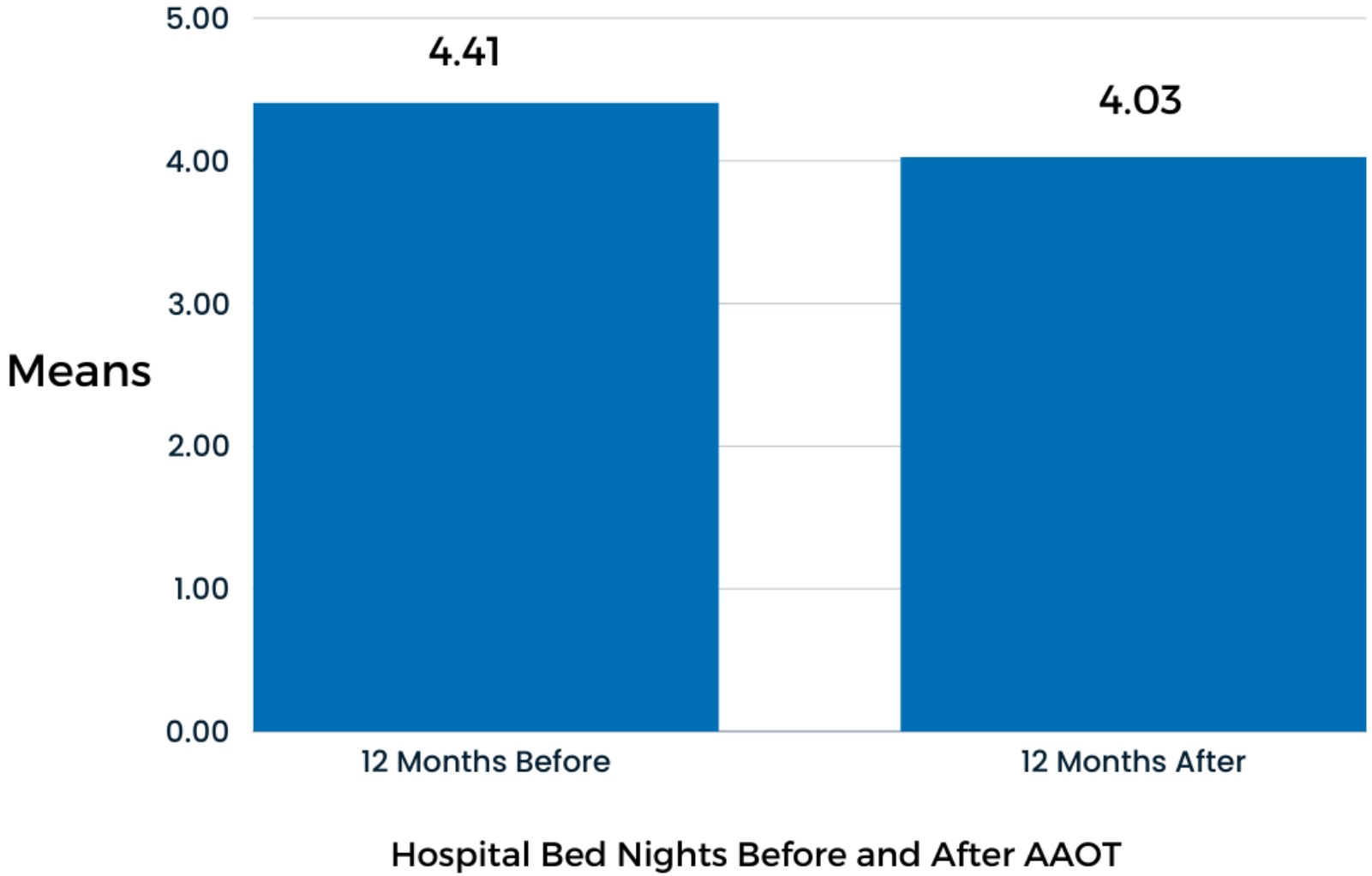
A&E Attendances of Frequent Attenders - more than 5 times/year (n = 112)

(N = 112, Z = -5.012, p < .001, two-tailed)



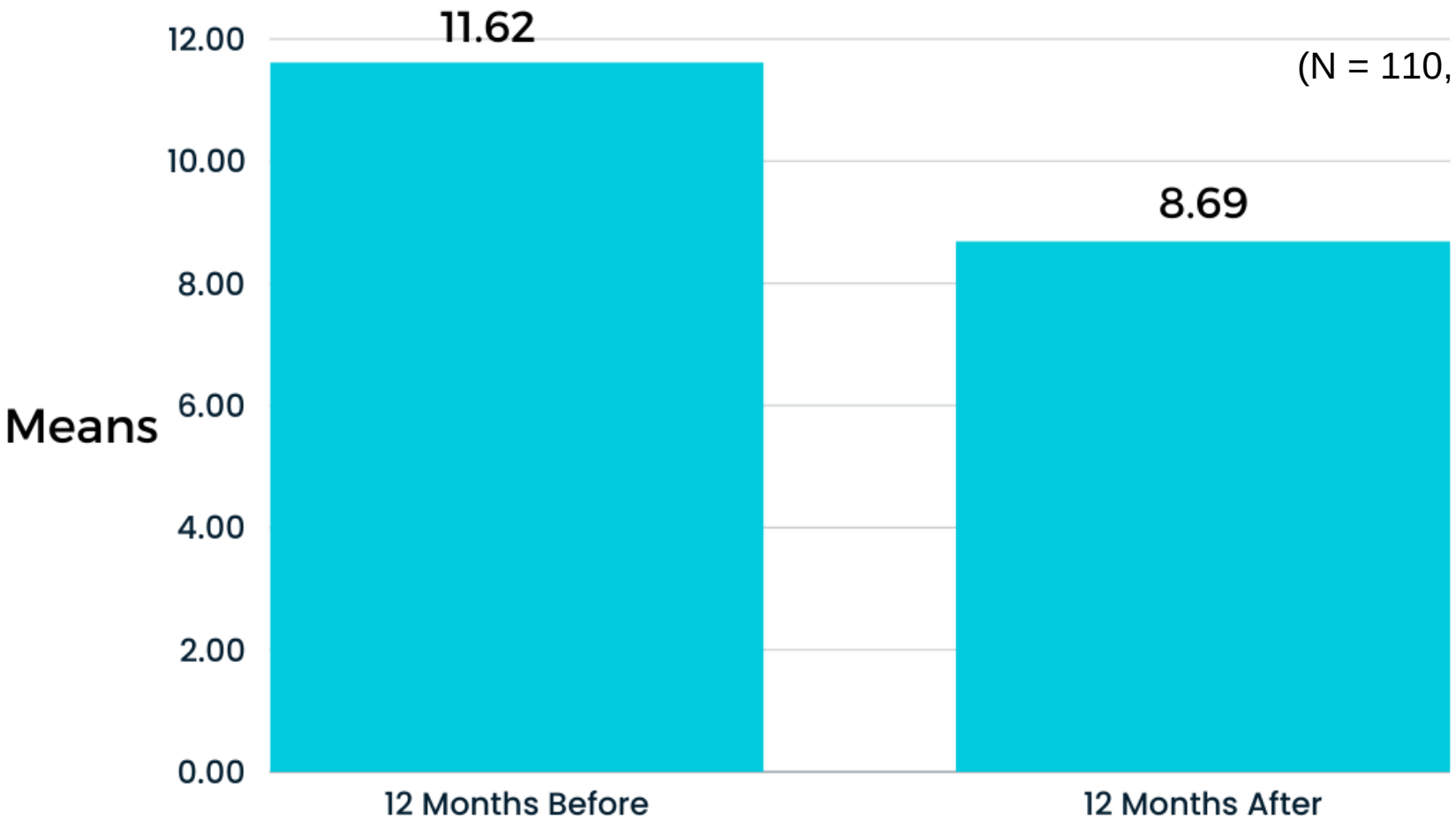
Hospital Bed Nights

(N = 1038, Z = -3.351, p < .001, two-tailed)



Hospital Bed Nights Before and After AAOT

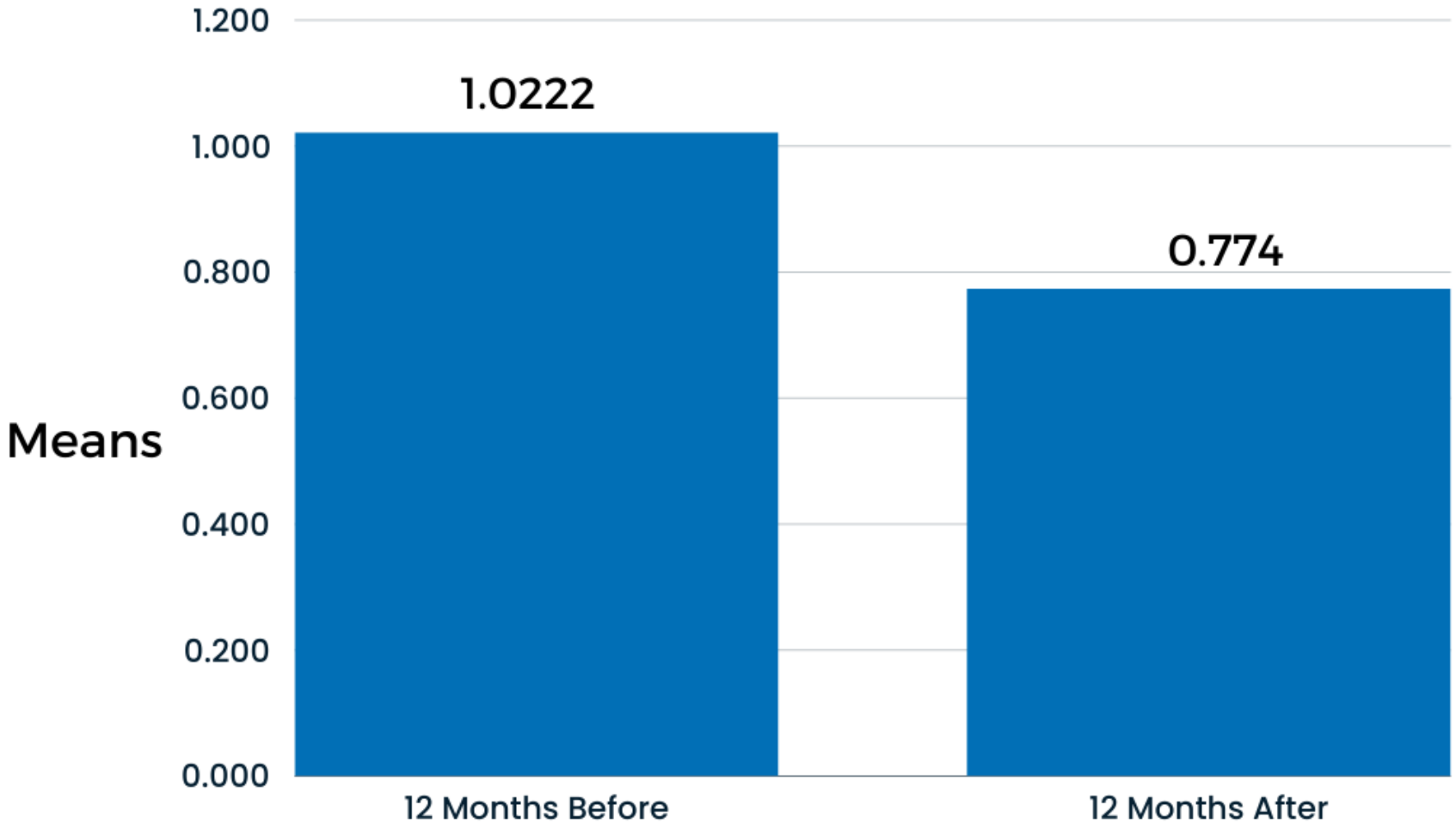
Bed nights of Frequent A+E Attenders



(N = 110, Z = -2.429, p < 0.05, two-taile

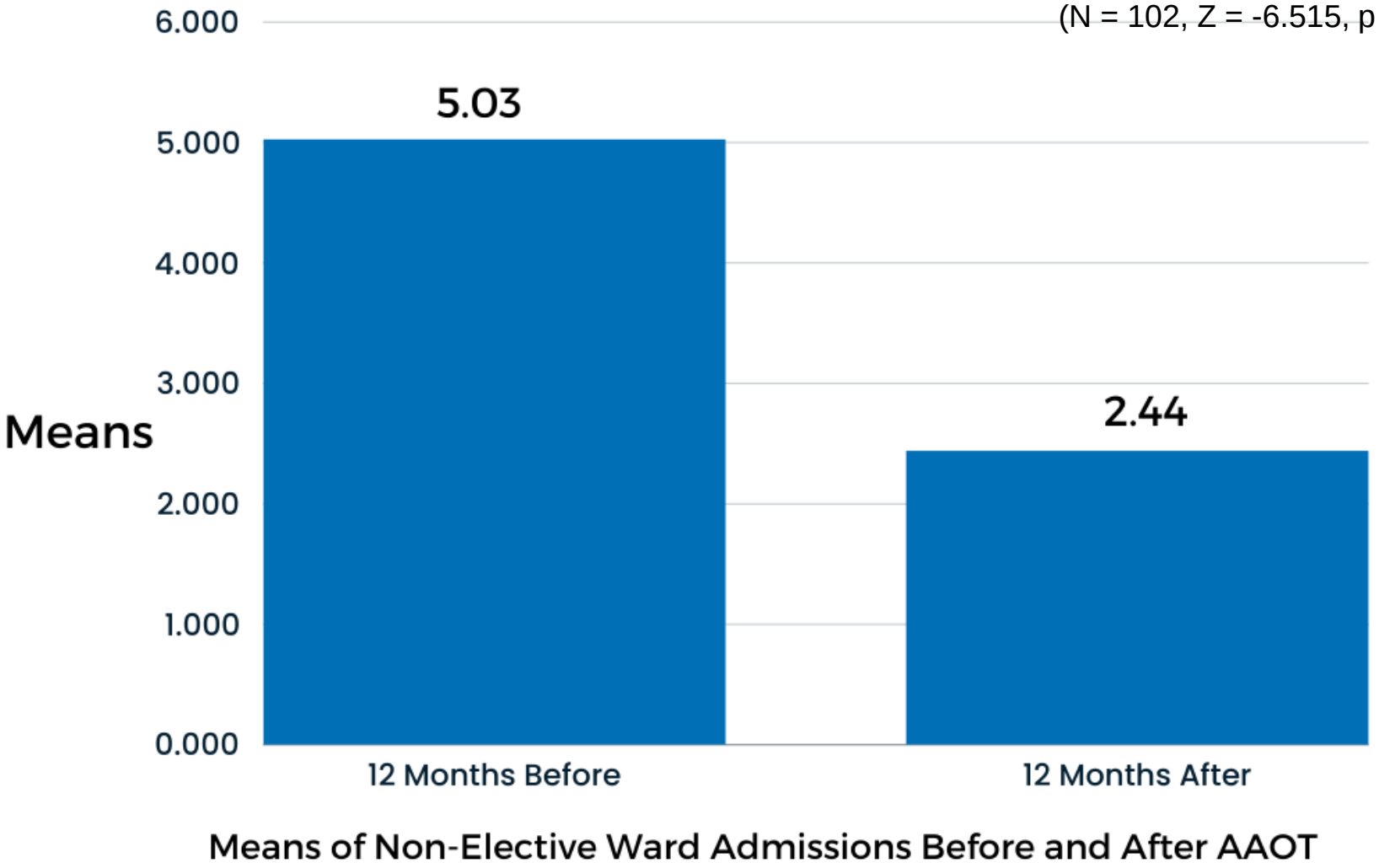
Ward admissions

(N=1038, Z = -6.240, p < .001, two-tailed)



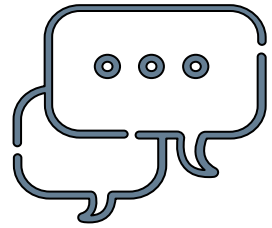
Unplanned ward admissions in people with more than 3 ward admissions/year

(N = 102, Z = -6.515, p < .001, two-tailed)



Means of Non-Elective Ward Admissions Before and After AAOT

Preliminary results: Qualitative study



- Semi-structured interviews with 58 participants
  - 18 AAOT service users; 20 AAOT staff; 20 stakeholders;
  - Research activity: December 2023 - March 2024
- Combined deductive and inductive approach taken
  - Use of Consolidated Framework for Implementation Research (CFIR) and Proctors Taxonomy
  - Themes added where data did not fit within CFIR or Proctors Taxonomy (e.g. outcomes or changes for service users)

Proctor's Taxonomy of Implementation Outcomes

- Acceptability
- Adoption
- Appropriateness
- Feasibility
- Fidelity
- Implementation Cost
- Penetration
- Sustainability

Adm Policy Ment Health (2011) 38:65–76
DOI 10.1007/s10488-010-0319-7

ORIGINAL PAPER

Outcomes for Implementation Research: Conceptual Distinctions, Measurement Challenges, and Research Agenda

Enola Proctor · Hiie Silmere · Ramesh Raghavan · Peter Hovmand · Greg Aarons · Alicia Bunger · Richard Griffey · Melissa Hensley

Published online: 19 October 2010

Abstract An unresolved issue in the field of implementation research is how to conceptualize and evaluate successful implementation. This paper advances the concept of "implementation outcomes" distinct from service system and clinical treatment outcomes. This paper proposes a heuristic, working "taxonomy" of eight conceptually distinct implementation outcomes—acceptability, adoption, appropriateness, feasibility, fidelity, implementation cost, penetration, and sustainability—along with their nominal definitions. We propose a two-pronged agenda for research on implementation outcomes. Conceptualizing and measuring implementation outcomes will advance understanding of implementation processes, enhance efficiency in implementation research, and pave the way for studies of the comparative effectiveness of implementation strategies.

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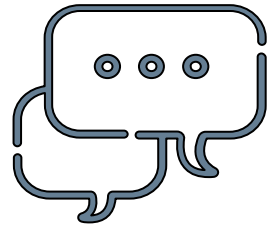
Keywords Implementation · Outcomes · Evaluation · Research methods

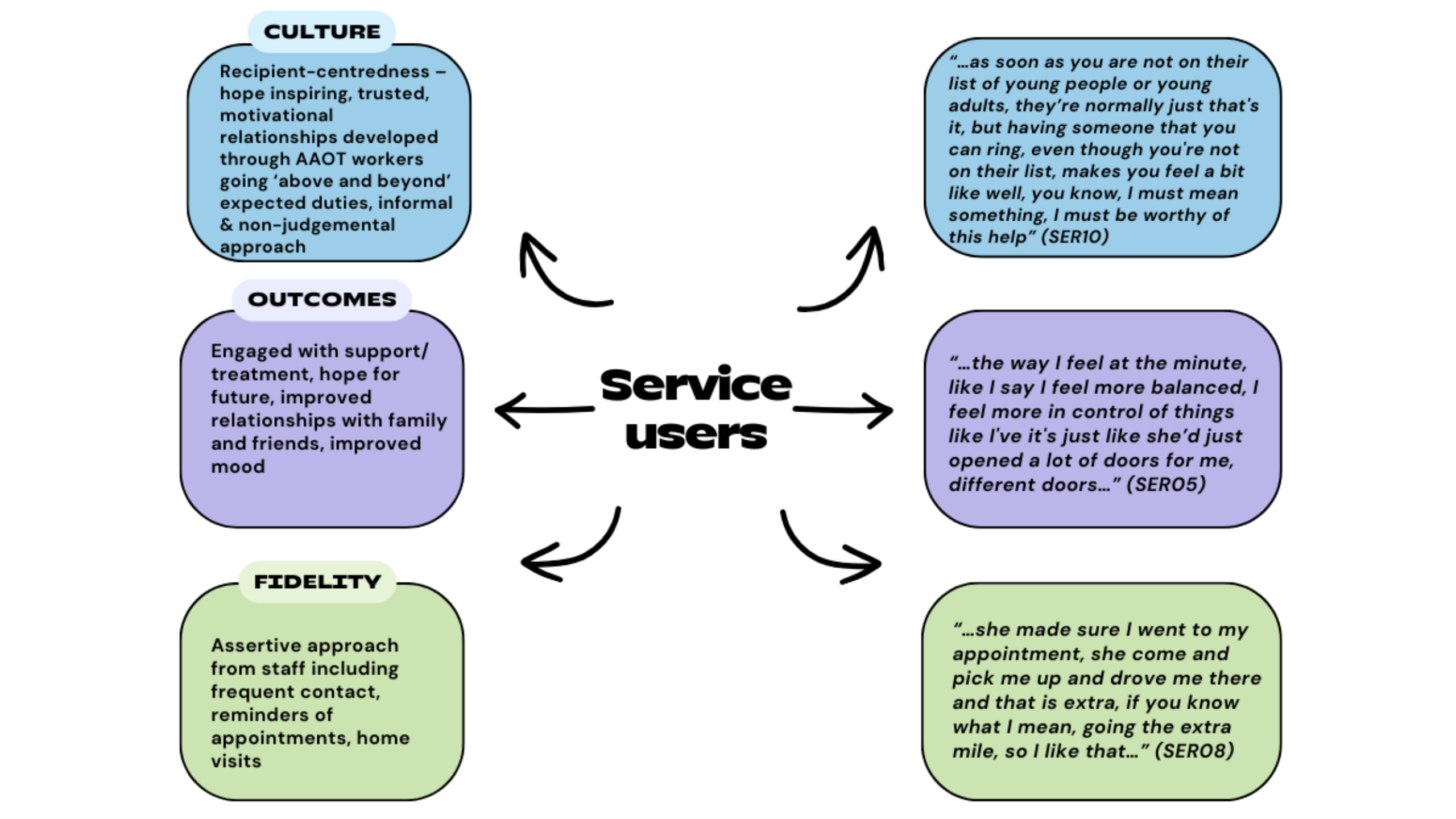
Background

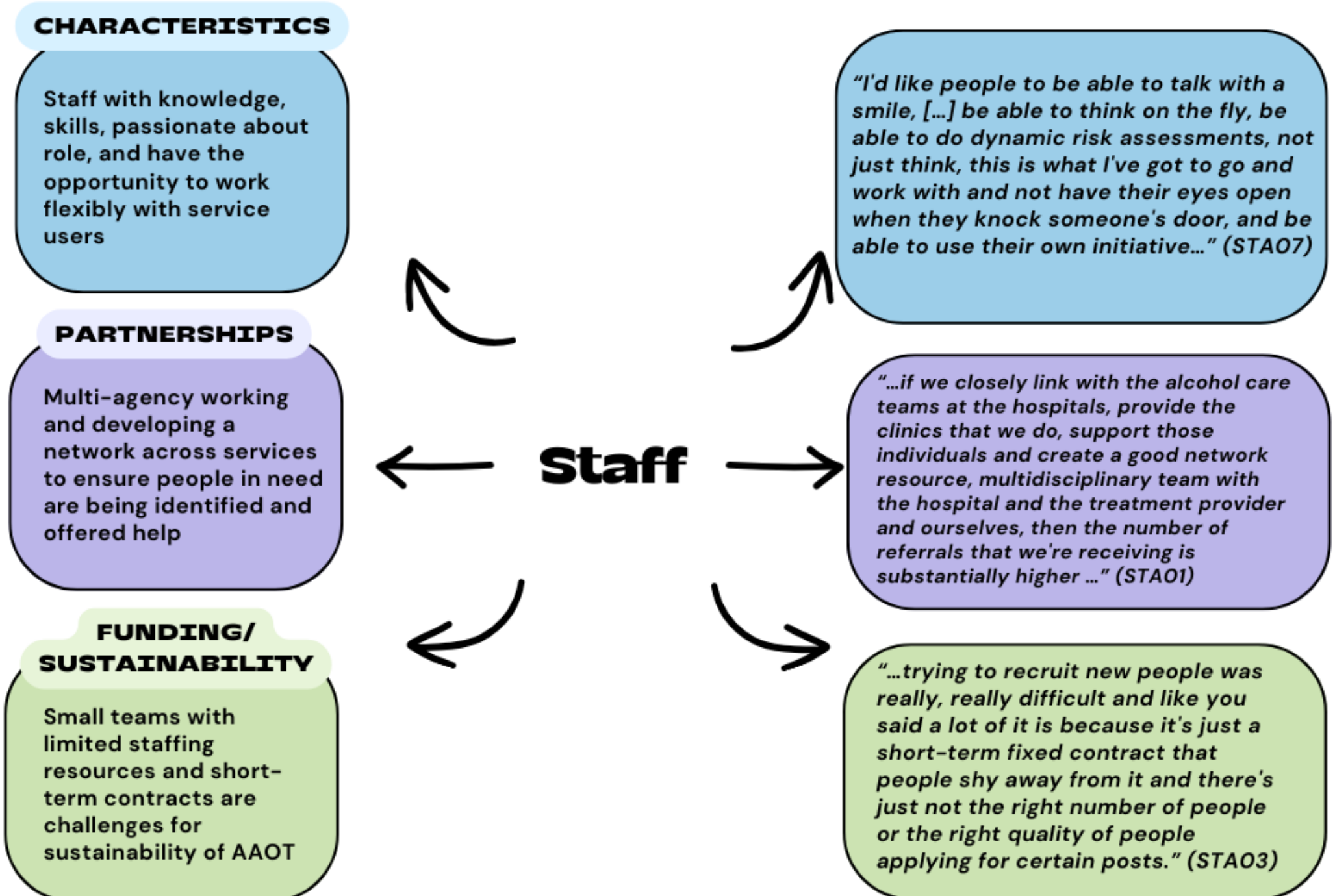
A critical yet unresolved issue in the field of implementation science is how to conceptualize and evaluate success. Studies of implementation use widely varying approaches to measure how well a new mental health treatment, program, or service is implemented. Some infer implementation success by measuring clinical outcomes at the client or patient level while other studies measure the actual targets of the implementation, quantifying for example the desired provider behaviors associated with delivering the newly implemented treatment. While some studies of implementation strategies assess outcomes in terms of improvement in process of care, Grimshaw et al. (2006) report that meta-analyses of their effectiveness has been thwarted by lack of detailed information about outcomes, use of widely varying constructs, reliance on dichotomous rather than continuous measures, and unit of analysis errors.

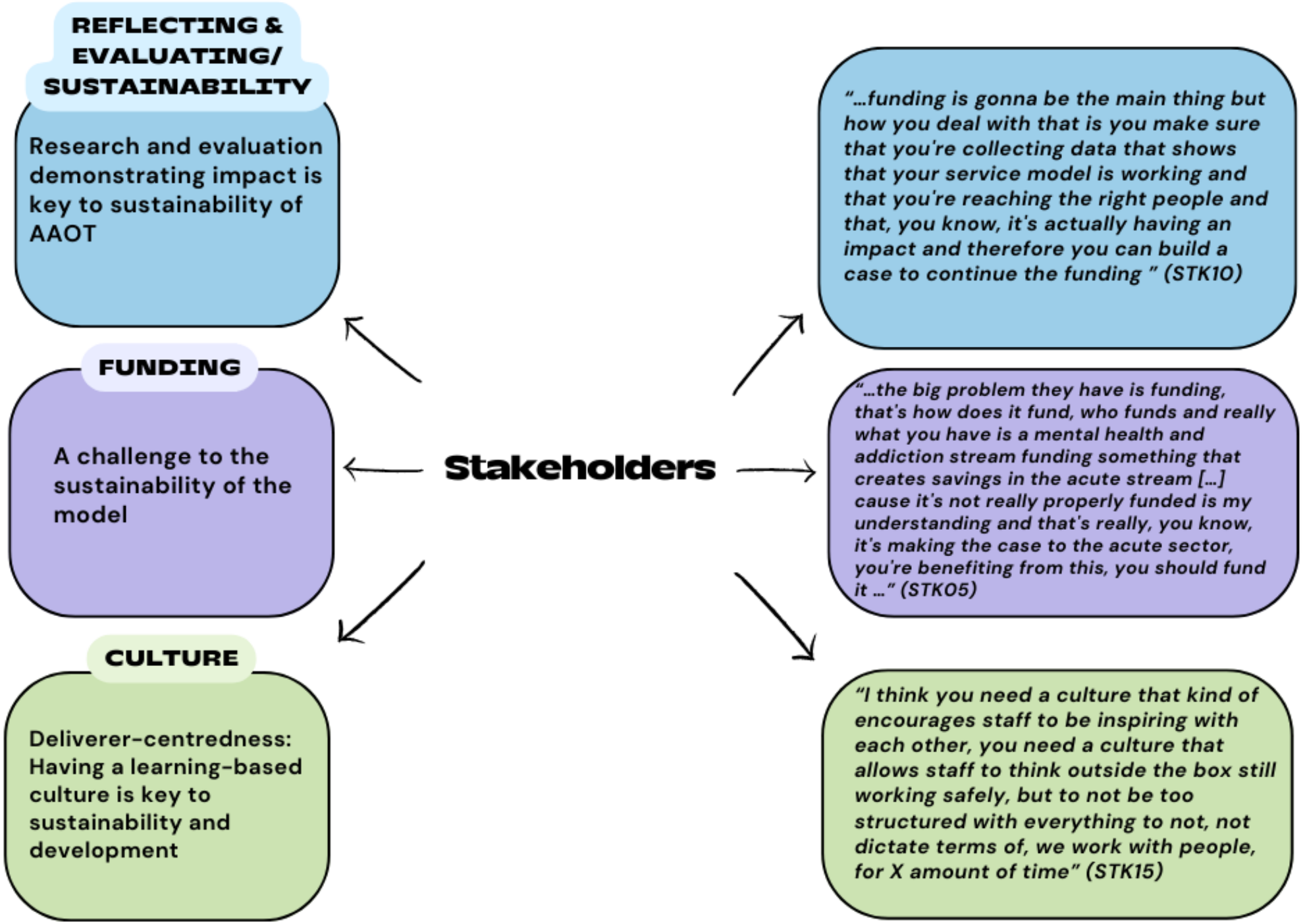
Preliminary results: Qualitative data



PARTICIPANT GROUP	THEMES
Service Users	• Culture • Outcomes • Fidelity
Staff	• Characteristics • Partnerships • Funding / Sustainability
Stakeholders	• Reflecting & Evaluating/ Sustainability • Funding • Culture


CULTURE
Recipient-centredness – hope inspiring, trusted, motivational relationships developed through AAOT workers going 'above and beyond' expected duties, informal & non-judgemental approach
"...as soon as you are not on their list of young people or young adults, they're normally just that's it, but having someone that you can ring, even though you're not on their list, makes you feel a bit like well, you know, I must mean something, I must be worthy of this help" (SER10)
OUTCOMES
Engaged with support/ treatment, hope for future, improved relationships with family and friends, improved mood
Service users
"...the way I feel at the minute, like I say I feel more balanced, I feel more in control of things like I've it's just like she'd just opened a lot of doors for me, different doors..." (SER05)
FIDELITY
Assertive approach from staff including frequent contact, reminders of appointments, home visits
"...she made sure I went to my appointment, she come and pick me up and drove me there and that is extra, if you know what I mean, going the extra mile, so I like that..." (SER08)


CHARACTERISTICS
Staff with knowledge, skills, passionate about role, and have the opportunity to work flexibly with service users
PARTNERSHIPS
Multi-agency working and developing a network across services to ensure people in need are being identified and offered help
FUNDING/ SUSTAINABILITY
Small teams with limited staffing resources and short-term contracts are challenges for sustainability of AAOT
Staff
"I'd like people to be able to talk with a smile, [...] be able to think on the fly, be able to do dynamic risk assessments, not just think, this is what I've got to go and work with and not have their eyes open when they knock someone's door, and be able to use their own initiative..." (STA07)
"...if we closely link with the alcohol care teams at the hospitals, provide the clinics that we do, support those individuals and create a good network resource, multidisciplinary team with the hospital and the treatment provider and ourselves, then the number of referrals that we're receiving is substantially higher ..." (STA01)
"...trying to recruit new people was really, really difficult and like you said a lot of it is because it's just a short-term fixed contract that people shy away from it and there's just not the right number of people or the right quality of people applying for certain posts." (STA03)


REFLECTING & EVALUATING/ SUSTAINABILITY
Research and evaluation demonstrating impact is key to sustainability of AAOT
FUNDING
A challenge to the sustainability of the model
CULTURE
Deliverer-centredness: Having a learning-based culture is key to sustainability and development
Stakeholders
"...funding is gonna be the main thing but how you deal with that is you make sure that you're collecting data that shows that your service model is working and that you're reaching the right people and that, you know, it's actually having an impact and therefore you can build a case to continue the funding " (STK10)
"...the big problem they have is funding, that's how does it fund, who funds and really what you have is a mental health and addiction stream funding something that creates savings in the acute stream [...] cause it's not really properly funded is my understanding and that's really, you know, it's making the case to the acute sector, you're benefiting from this, you should fund it ..." (STK05)
"I think you need a culture that kind of encourages staff to be inspiring with each other, you need a culture that allows staff to think outside the box still working safely, but to not be too structured with everything to not, not dictate terms of, we work with people, for X amount of time" (STK15)

Valor Future Aims:

Finalise analysis

Expand local reach e.g. adding other alcohol assertive outreach teams in Greater Manchester

Expand reach of MHIN North West AAOT evaluation e.g., addition of Liverpool and Cheshire sites

Dissemination project via North West AAOT event on 21st March with commissioners

Disseminate project amongst implementation science networks in NW

Continue to support Communities of Practice with infrastructure support from HISMT

Work with Bolton commissioner in GM to sustain AAOT work

Work on national policy and commissioning guidance with central MHIN team in KCL

Continue to support Communities of Practice with infrastructure support from HISMT

Continue collaboration with Hull and London

Acknowledgements

Nikolaos Mylonas, Laura Scoles and Aansha Priyam, GMMH Addictions Research Team

Mental Health Implementation Network Project 3 Teams in Hulls and London

Professor Karina Lovell - University of Manchester
Dr Tracey Myton - Consultant Addictions Psychiatrist, Bolton Achieve, GMMH
Julie Carey - Clinical Lead, High Impact Substance Misuse Team (HISMT)
Denise Holcroft - Team Manager, Big Life Group Assertive Outreach Team (Salford & Bolton)
Stephen Blood - PPI Lead, GMMH Addictions Research Team

Ruth Brown - Team Manager, Alcohol Care Team, Salford Royal Hospital
Sandra Kite - Performance Manager, GMMH
Caroline Butterworth - Senior Information Analyst, GMMH
Susan Dobson - Research Initiation & Delivery Manager GMMH
Carmel Thomas - Senior Clinical Studies Officer, R&I, GMMH
Bolton Royal Hospital Business Intelligence
Catherine Marlor – R&I Administrator, GMMH

FUNDED BY
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Thanks !

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AAOT in Yorkshire & Humber

Professor Tom Phillips, Professor of Nursing in Addictions,
University of Hull

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Collaborative Alcohol Care in Hull (CoACH)
AAOT Practice and Research
Yorkshire & Humber ARC

Principal Investigator: Prof Thomas Phillips

Dr Philippa Case, Research Fellow
Laura Hermann, Research Assistant
Prof Judith Cohen, Hull Health Trials Unit

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Hull City Council

NHS Hull University Teaching Hospitals NHS Trust

NHS Humber Teaching NHS Foundation Trust

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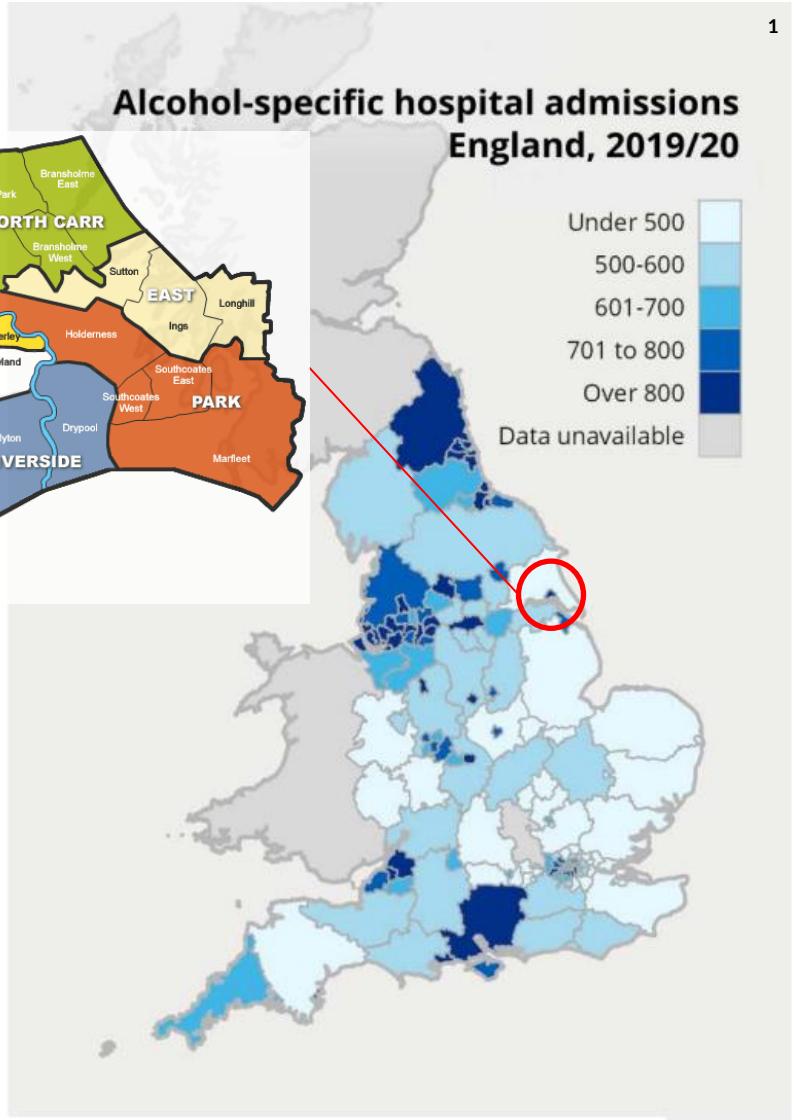
AAOT in Yorkshire & Humber
The local picture

The prevalence of alcohol dependence within the city of Hull

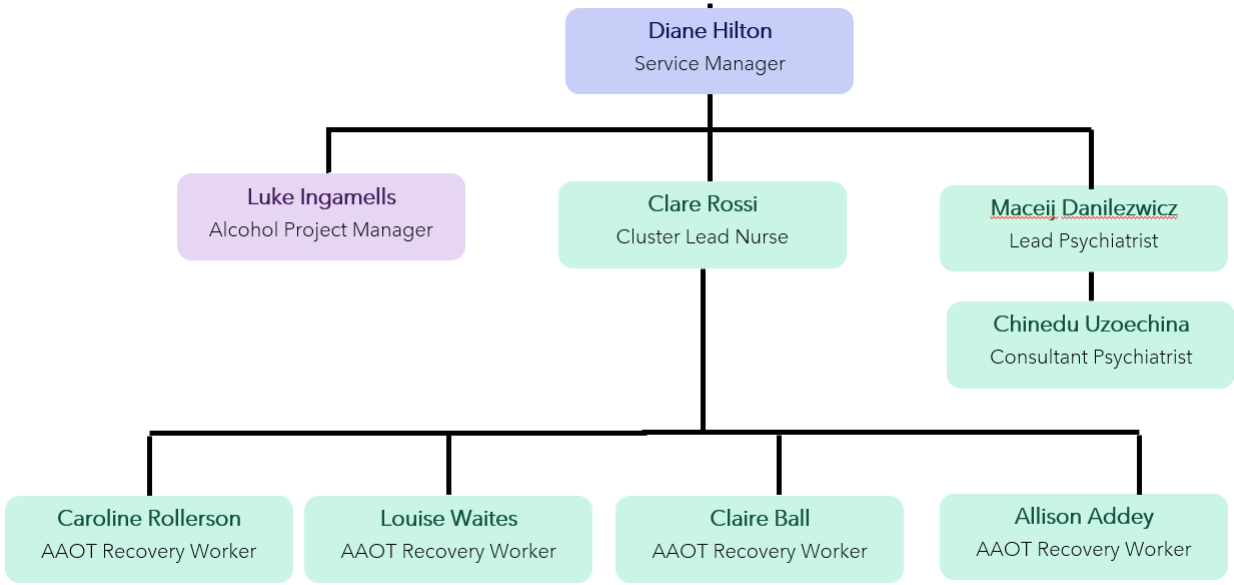
- Estimated rate of alcohol dependence per hundred of the adult population[2]:
  - England: 1.37
  - Hull: 2.38
- Alcohol-related admissions per 100,000[3]:
  - England: 1,734
  - Hull: 1,995



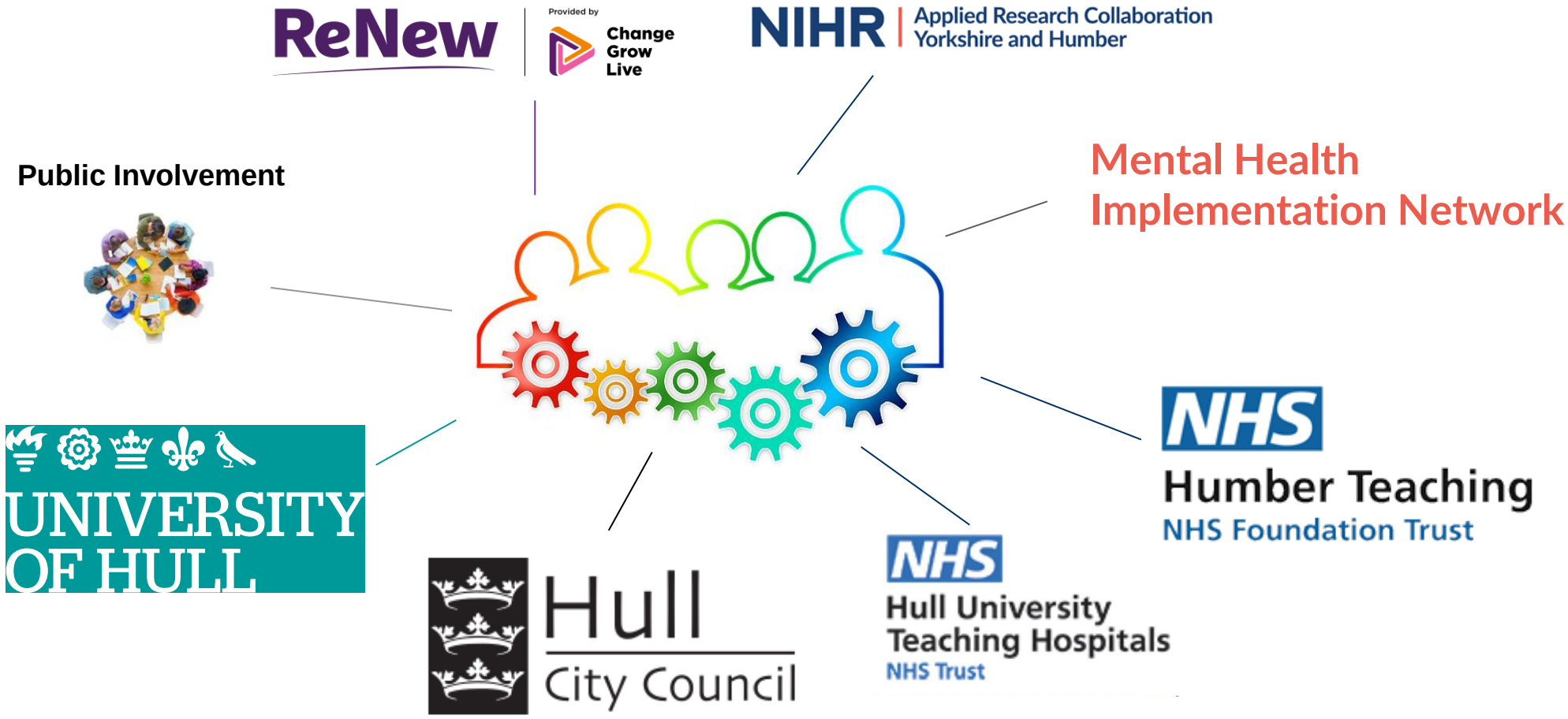
[1]Taken from House of Commons Library, 2021: https://researchbriefings.files.parliament.uk/documents/CBP-7626/CBP-7626.pdf based on data from PHE Local Alcohol Profiles
[2] Public Health England, 2021. Estimates of the number of adults in England with an alcohol dependency potentially in need of specialist treatment (2018/19): https://www.gov.uk/government/publications/alcohol-dependence-prevalence-in-england
[3] Local Alcohol Profiles for England Statistical Tables for England (Broad measure alcohol-related admissions), 2019/20. https://fingertips.phe.org.uk/profile/local-alcohol-profiles/supporting-information/admissions2

The implementation of AAOT in Hull

- Hull City Council has significantly invested in the AAOT for the first 2 years
- Service opened in July 2023
- Inclusion: repeat attendances at hospital, not engaged with services, alcohol dependence.
- Currently 40 service users on the caseload
- Staffing
- Partnership working



The implementation of AAOT in Hull



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Collaborative Alcohol Care in Hull (CoACH): A multi-method evaluation of the Hull Alcohol Assertive Outreach Treatment Service

Clinical audit

To examine the characteristics of the service users and assess the impact of the service on clinical measures and hospital admissions and attendances

Qualitative evaluation

To explore the acceptability, feasibility, and impact of implementing AAOT and fidelity to the high-quality model of AAOT

NIHR ARC National Priorities Programme: Mental Health Implementation Network (MHIN)

CoACH: Clinical Audit

Stage 1: Using routinely collected data from all service users seen by the service in months 1-6

Objectives and measures

1. To determine the characteristics of service users using data routinely collected by the service, identifying the complexity of needs presented at initial assessment.
   - ❑ Demographics of services user, living circumstances, social support, alcohol use disorder identification and severity, alcohol-related problems, common mental disorders, service use and treatment outcomes profile.
2. Identify recorded changes in alcohol and drug use, consequences of alcohol use, social support, and hospital service use recorded at the three-month and six-month review.
   - ❑Treatment outcomes profile, alcohol problems, social support, emergency department attendance, hospital admissions, occupied bed days.

CoACH: Qualitative Evaluation

Method

Sample and data collection

Service user interviews (n=10-12)

Staff focus group and interviews (n=6)

Stakeholder interviews (n=6-8)

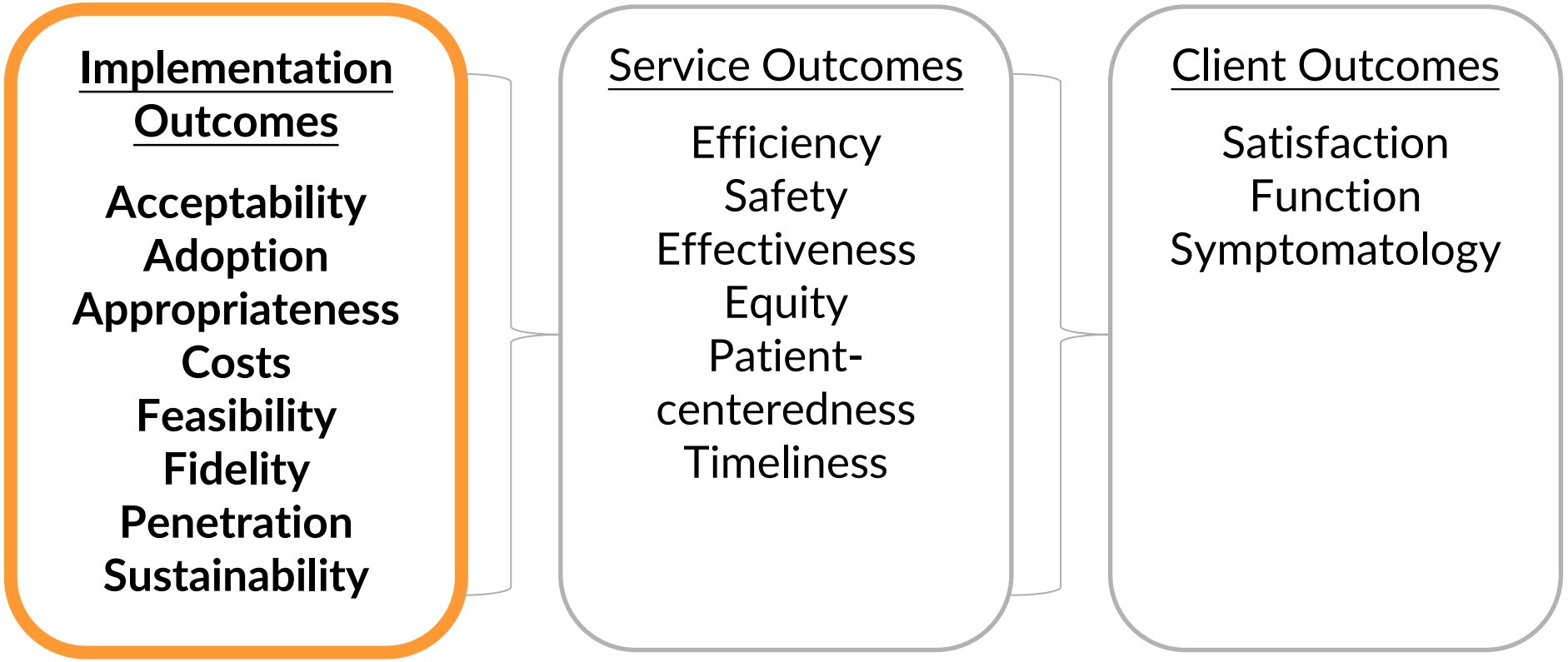
Analysis

Framework approach (Ritchie & Spencer, 2002): familiarisation, identifying a thematic framework, charting, mapping and interpretation

Ritchie J, Spencer L. The Qualitative Researcher's Companion. 2002. Thousand Oaks Thousand Oaks, California: SAGE Publications, Inc. Available from: https://methods.sagepub.com/book/the-qualitative-researchers-companion.

CoACH: Qualitative Evaluation

Outcomes for implementation research (Proctor et al., 2011)



Proctor E, Silmere H, Raghavan R, Hovmand P, Aarons G, Bunger A, Griffey R, Hensley M. Outcomes for implementation research: conceptual distinctions, measurement challenges, and research agenda. Adm Policy Ment Health. 2011 Mar;38(2):65-76. doi: 10.1007/s10488-010-0319-7. PMID: 20957426; PMCID: PMC3068522.

CoACH: AAOT Clinical Service

Hull Alcohol Assertive Outreach Team

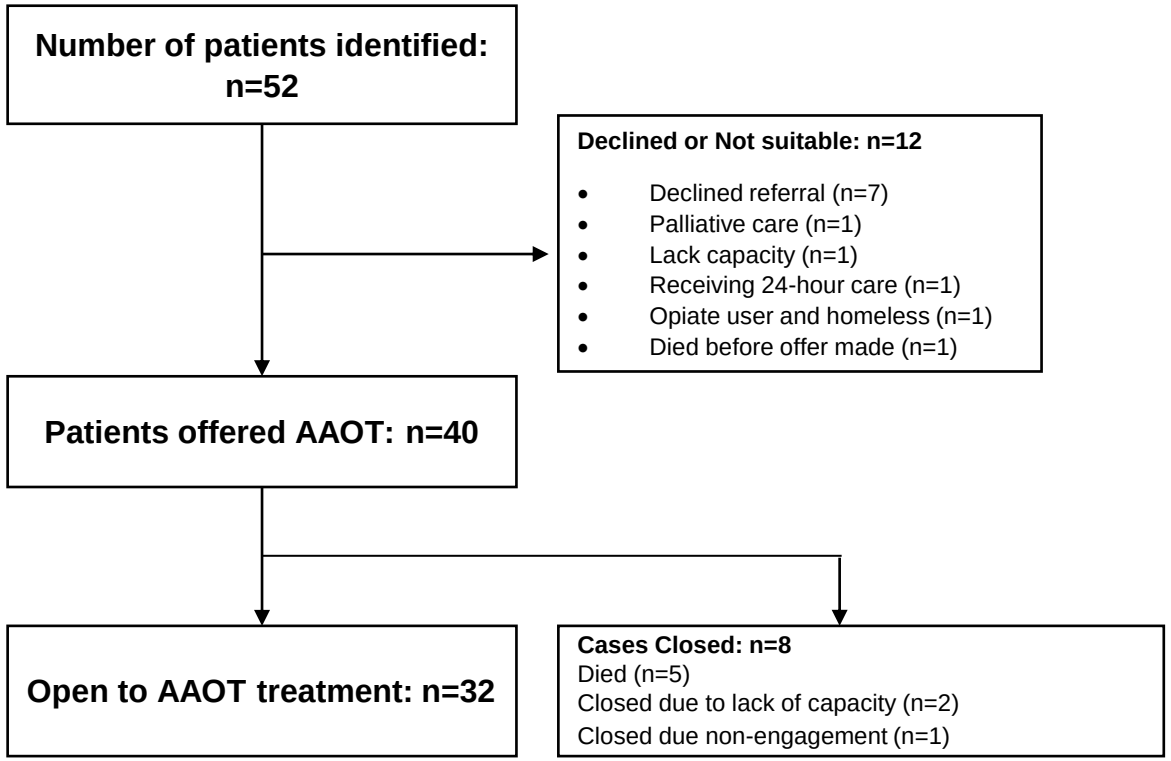
- Commissioned Nov 2022; Operational July 2023
- Extended alcohol treatment system – links with Alcohol Care Team
- Embedded within ReNEW, CGL-Hull Alcohol Services
- Leadership: Manager, Psychiatrist and Clinical Nurse Specialist, Clinical Psychologist
- 4 Practitioners – Social Care with Addictions Experience
- Adopted criteria from King's College Model (Max 60 individuals)
- Current 40 on caseload

CoACH: Evaluation

Alcohol Research Team, University of Hull

- Integrated measures into service – electronic care record
- Data Collection for Clinical Audit and Review Clinical Records commencing Dec 2023
- RA embedded into Team and MDTs – Reflections of implementation
- Qualitative Research Interviews
- Presentation of preliminary data

Patient enrolment in the AAOT service: Clinical audit



- Data available on those completing 3-month follow-up (N=36)
- 12 individuals have reached 6-month follow-up
- Presentation will include data on 36 service user

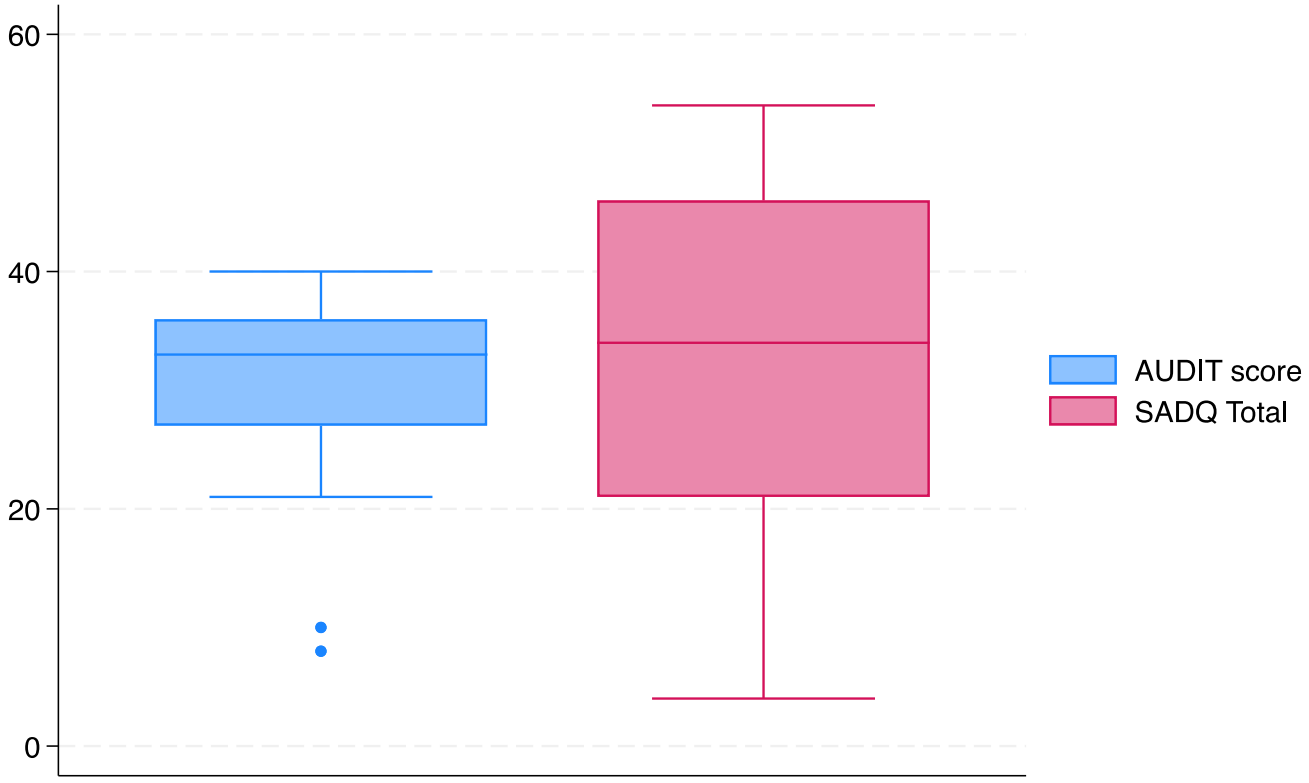
	AAOT Trial (Drummond et al; n=87)	Hull AAOT Pilot (n=36)
Mean Age (SD)	52.6 (9.8)	54.2 (12.0)
Male	53 (61%)	21 (58.3%)
Ethnicity		
White	68 (78.2%)	34 (94.4%)
Black	12 (13.8%)	1 (2.8%)
Asian	2 (2.3%)	-
Other	5 (5.8%)	1 (2.8%)
Relationship Status		
Never married	53 (60.9%)	16 (44.4%)
With Partner	2 (2.3%)	2 (5.6%)
Married	9 (10.3%)	4 (11.1%)
Separated	4 (4.6%)	1 (2.8%)
Divorced	13 (14.9%)	5 (13.9%)
Widowed	5 (5.8%)	1 (2.8%)
Missing	-	7 (19.4%)

	AAOT Trial (Drummond et al; n=87)	Hull AAOT Pilot (n=36)
Accommodation		
Owner Occupier	11 (12.6%)	5 (13.9%)
Rented	66 (75.9%)	18 (50.0%)
Other	10 (11.5%)	5 (13.9%)
Missing	-	8 (22.2%)
Alcohol Measures		
Percent days abstinent (SD)	29.1 (28.1) Over 90 days	35.9 (34.4) Over 28 days
DDD (units) (SD)	-	26.9 (15.7)
SADQ (SD)	27.8 (16.7)	32.2 (14.5)
APQ (SD)	11.6 (5.5)	14.2 (4.4)
Sexuality		
Heterosexual	-	33 (91.7%
Not known	-	1 (2.8%)
Not stated	-	2 (5.6%)

Important People Inventory – Person #1

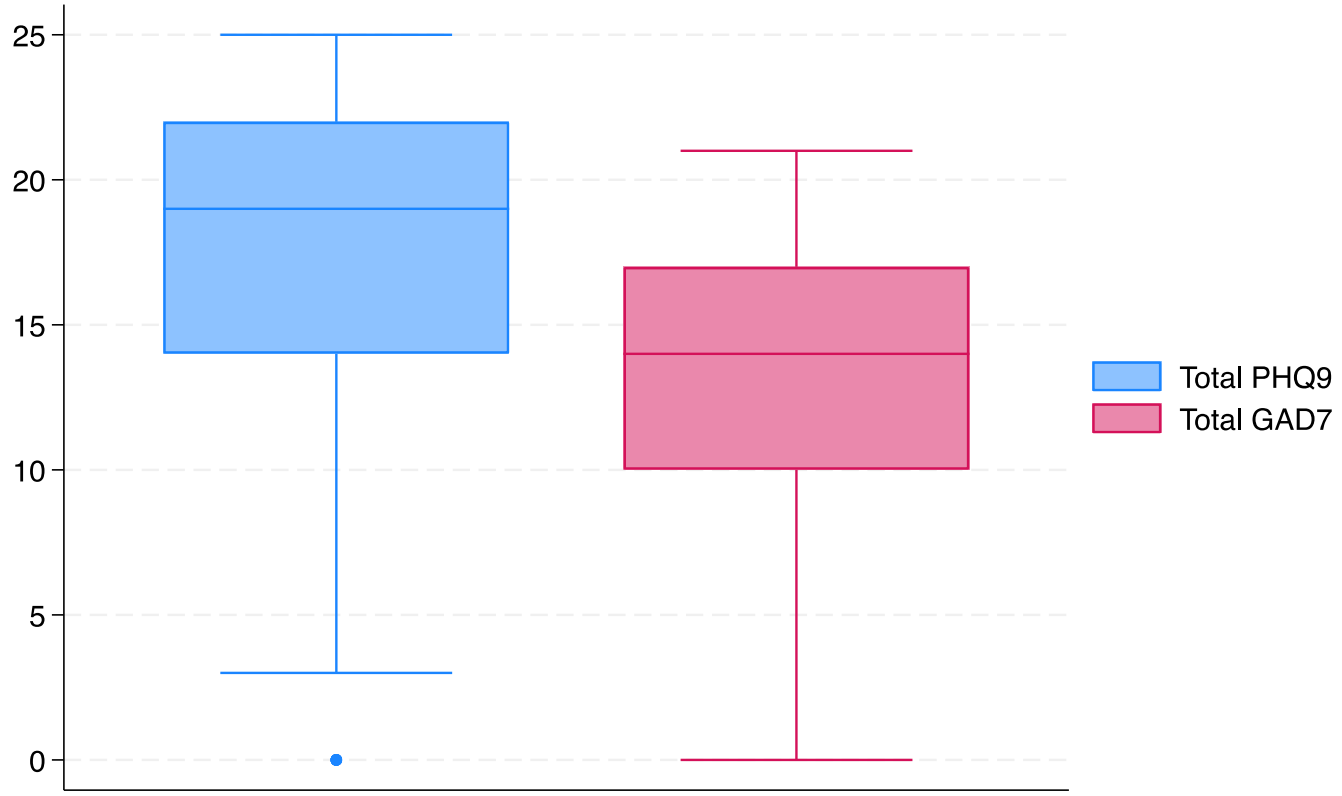
- 60% = Other relative, friend, significant other
- Level of contact in last 4 months: 46% daily, 32% once or twice a week
- How important: 68%, extremely; 14%, important
- Drinking status: 4% in recovery; 27% abstainer; 55% drinker
- Reacted to drinking:
  - Left them 5%
  - Did not accept 29%
  - Neutral 24%
  - Accepted 29%
- Entering treatment: >90% supported or strong supported entering treatment

Baseline Alcohol Severity



Severity of SADQ		
Severity	**Score**	**Number (%)**
Mild	4-14	5 (13.9%)
Moderate	15-30	12 (33.3%)
Severe	31-60	19 (52.8%)

Baseline Common Mental Health Disorder (Median & Mean PHQ9 & GAD7)



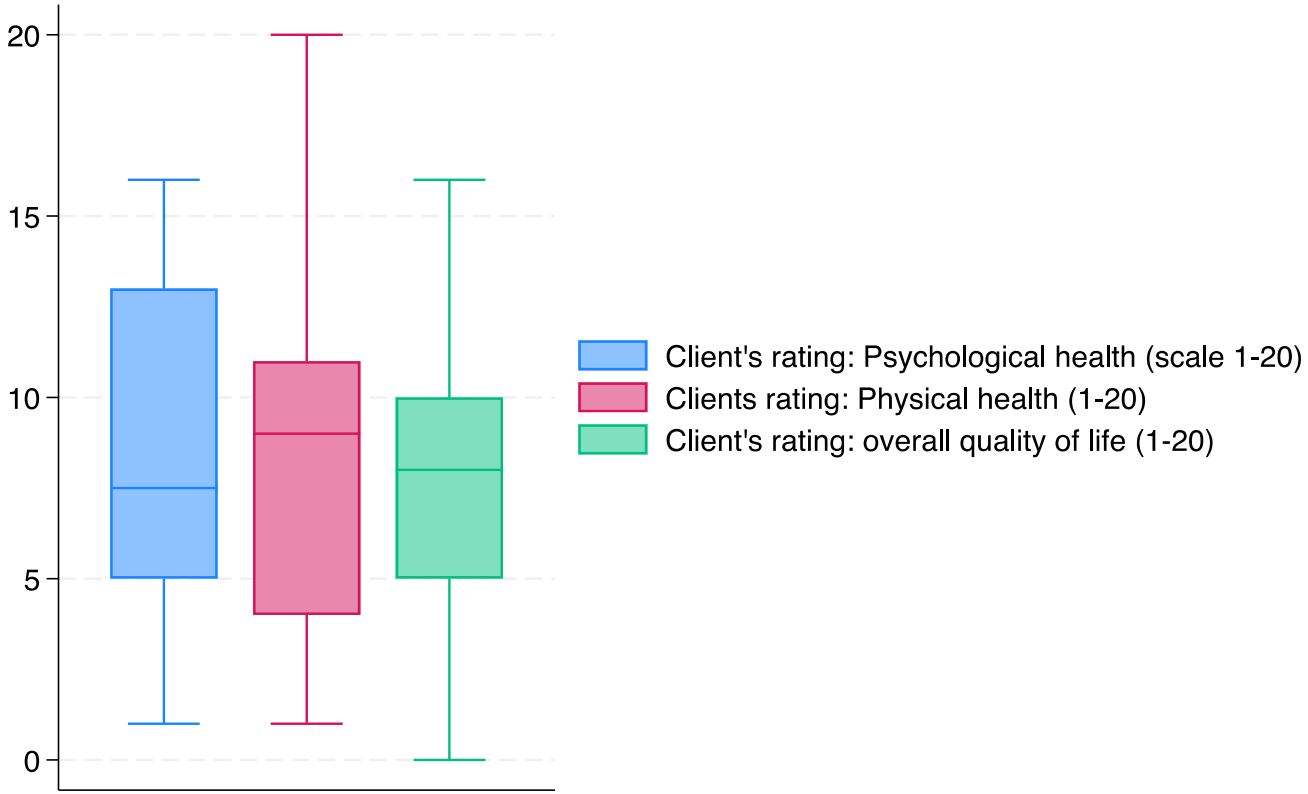
Median	IQR
19	14 - 22
Mean	**Std Dev.**
16.7	7.4

Severity: 0-4 none, 5-9 mild, 10-14 moderate, 15-19 moderately severe, 20-27 severe.

Median	IQR
14	10 - 17
Mean	**Std Dev.**
13.1	5.7

Scores of 5, 10, and 15 are taken as the cut-off points for mild, moderate and severe anxiety

Health and Functioning (Source TOP)



Psychological

- Anxiety, depression, problem emotions and feelings
- Poor (0) to good (20)

Physical

- Extent of physical symptoms and bothered by illness
- Poor (0) to good (20)

Overall

- Able to enjoy life, gets on with family and partner, etc
- Poor (0) to good (20)

Estimating hospital use costs

- ED attendance costs @ £167/ attendance derived from Phillips et al. (2019)[1]
- Occupied bed day costs @ £630/day derived from Phillips et al. (2021)[2]
- Costs then adjusted to 2023-24 prices using the HM Treasury GDP Deflator[3]
- Cost data on occupied bed days and ED attendances at 3-,6- and 12-months prior to admission.

[1]Phillips, T., Coulton, S., & Drummond, C. (2019). Burden of alcohol disorders on emergency department attendances and hospital admissions in England. *Alcohol and Alcoholism*, *54*(5), 516-524.

[2]Phillips, T., Huang, C., Roberts, E., & Drummond, C. (2021). Specialist alcohol inpatient treatment admissions and non-specialist hospital admissions for alcohol withdrawal in England: an inverse relationship. Alcohol and Alcoholism, 56(1), 28-33.

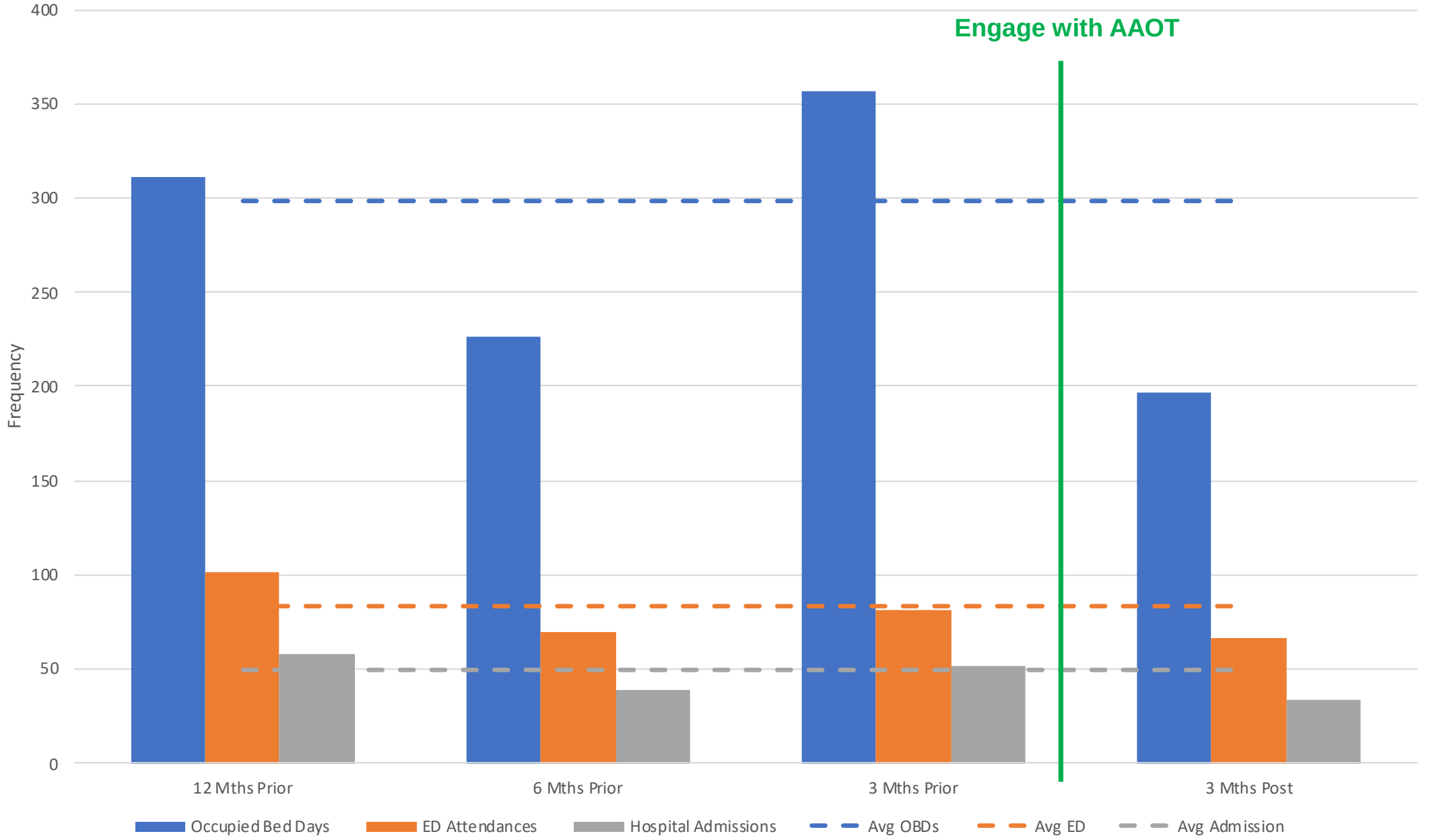
[3]https://www.gov.uk/government/collections/gdp-deflators-at-market-prices-and-money-gdp

Overall hospital service use (n=36)

	Mean for 12 months prior to AAOT	Totals for 12 months prior to AAOT
Admissions	4.1 (SD 2.4)	149
Occupied Bed Days	24.8 (SD 16.4)	894
ED Attendances	7 (SD 5.4)	252
Estimated Costs	£16,806 (SD £10,260)	£605,006

- Previous baseline analysis of hospital data identified
- 100 patients with high need may account for 2,407 admissions
- Cost estimated to be £1.5million
- Reducing hospital use through AAOT may result in 50% reduction in cost

Hospital Service Use by Individuals (n=36) Engaged with AAOT Hull. Quarterly Activity 12 months before and 3 months after engagement



HIN)

Reflections: Service Users

- All present with complex needs and competing priorities
- Involvement of numerous agencies, or very few
- Health concerns limit community engagement for many
- Unrealistic to avoid all admissions/ED attendances
- Need to address service user priorities (practical issues)
- Work towards addressing alcohol issues
- Highly value the staff and the regular frequent support

Reflections: Practitioners

- IMPRESSIVE!
- Time required to embed new ways of working – New ethos/direction
- Passionate and compassionate staff - above and beyond the call of duty
- Staff well-being essential (risk, patient deaths)
- Need to maintain CPD and peer support (CoP)
- Rapport and therapeutic milieu priority – not measures

Reflections: Service

- Brand new service and model for CGL – steep learning curve
- Time required to embed new ways of working – New ethos/direction
- Significant adaptions to:
  - MDT working
  - Multi-agency working – new relationships
  - Research governance for the evaluation
  - Referral pathways – inclusion and exclusion criteria
  - Managing expectations of referral agencies
  - Closer working relationship with alcohol care team, mental health, etc.
  - New guidelines and staff support

Achievements

- Civic University: Effective Knowledge Exchange
  - Strategic planning of alcohol & drug services
  - Supporting research-informed commissioning

- Greater Collaborations:
  - University of Hull and Y&H ARC Multi-morbidity Theme
  - Alcohol services more visible to ICB & Commissioners
  - Facilitating partnerships Acute, MH & Specialist Services
  - Engagement of services Manchester, Hull & London
  - Improving engagement of lived experiences

- New Opportunities:
  - **Clinical needs being met**
  - Clinical priorities & service developments
  - Research themes and projects (CoACH-2) - Dr Case
  - Hull Impact & Knowledge Exchange (HIKE)
  - Increasing the profile of Addiction & MH Research

CoACH@hull.ac.uk

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Overall evaluation of the MHIN: Project-wide evaluation

Dr Shalini Ahuja, Lecturer and MHIN Evaluation Co-Lead, KCL
Dr Blossom Fernandes, MHIN Research Fellow, LSHTM

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MHIN Programme Evaluation Update

Blossom Fernandes, Amy Allard-Dunbar, Annette Boaz & Shalini Ahuja

NIHR ARC National Priorities Programme: Mental Health Implementation Network (MHIN)

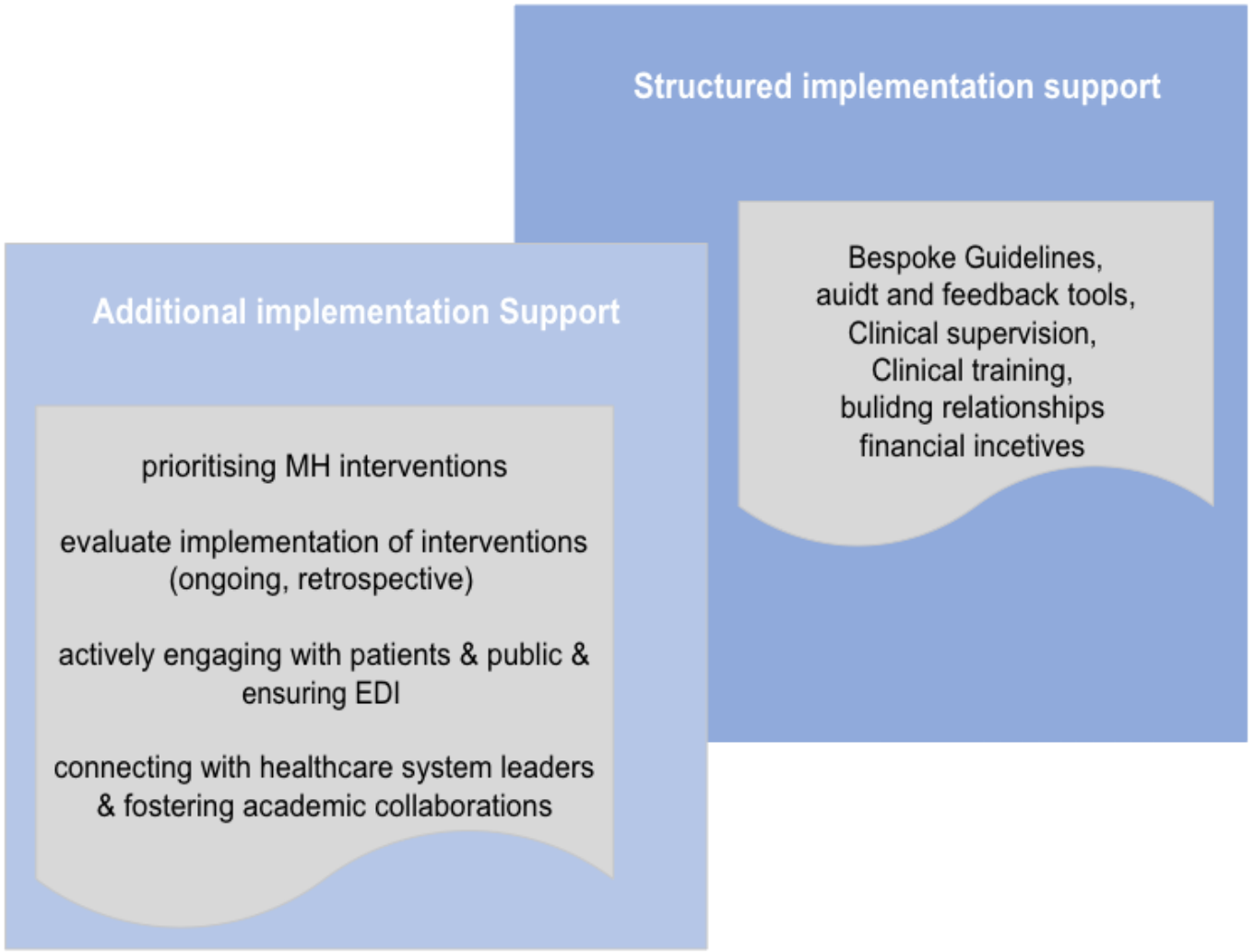
Workstream 5 – Evaluation Aims

1. Conduct programme wide evaluation of MHIN– focusing on the relationship between prioritisation and implementation, support provided by network including implication for sustainability and spread.

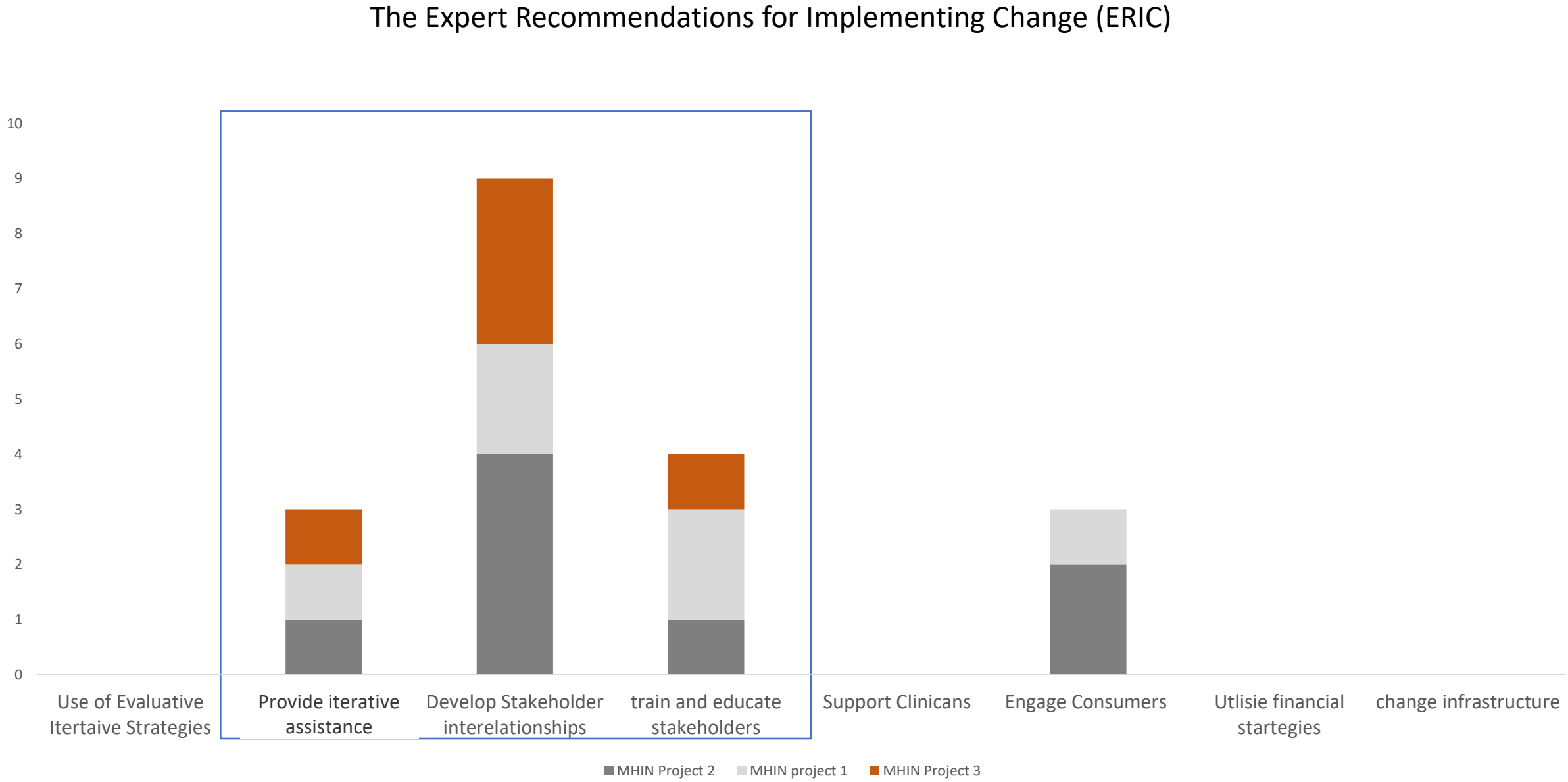
2. Offer evaluation support to MHIN sites in the delivery of mental health interventions of MHIN.

Ethical approval for this work obtained from LSHTM in 2022

Unpacking Implementation Support



MHIN (meta) implementation strategies (ERIC) by project



Evaluation methods

Design

1. Multistage mixed method study
2. Process evaluation to understand implementation as per **MRC framework** (Moore et al., 2015) to complement local evaluations.

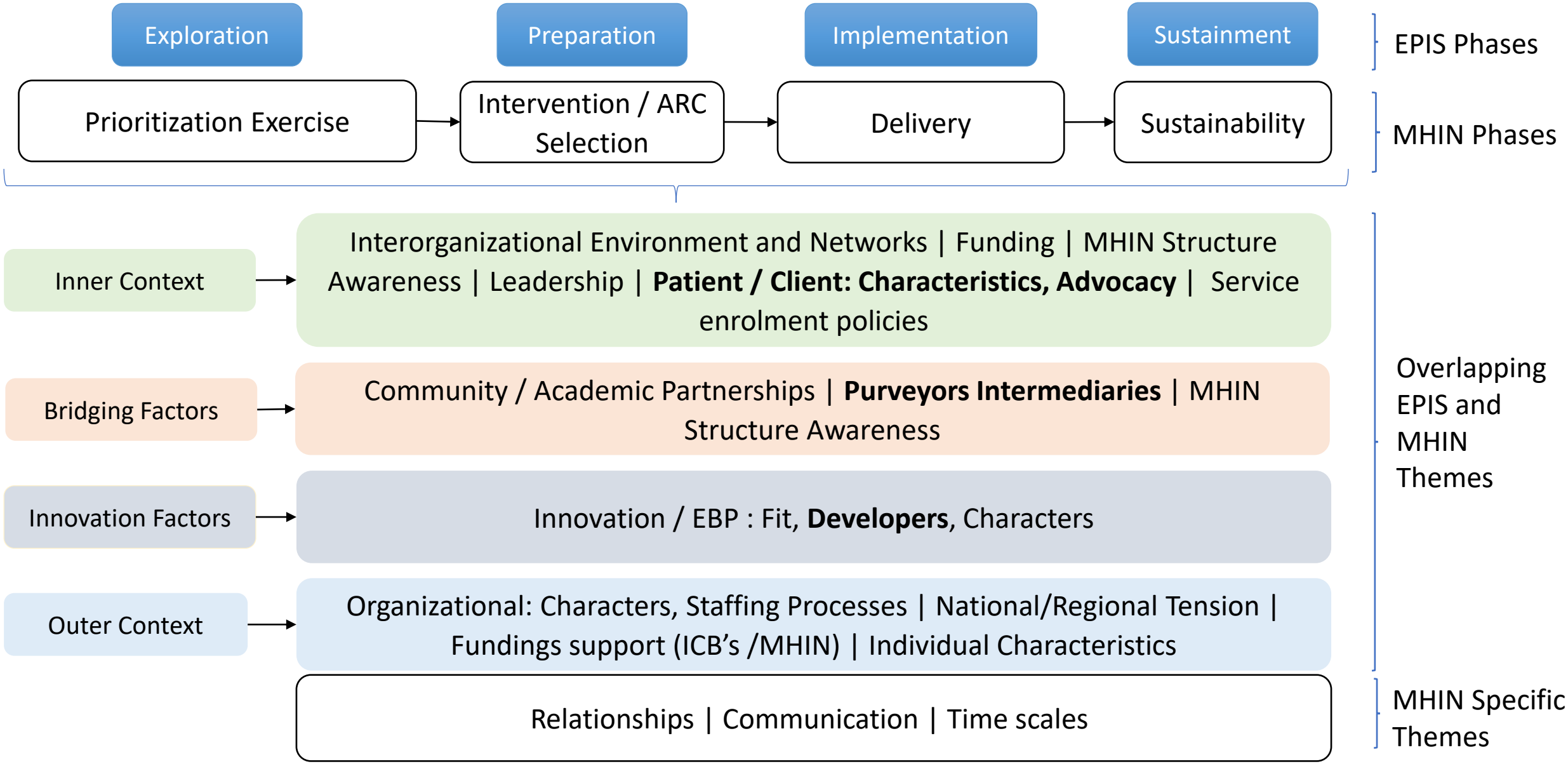
Data collection

1. Semi – structured interviews (in person / online)
2. Meeting observation
3. Meeting and event document analyses
4. Secondary analyses of activity and outcome data

Data analyses

1. Thematic Approach
2. Inductive followed by deductive, using **EPIS** (Aarons et al. 2011)

Early findings from stakeholder interviews mapped onto EPIS



Key quotes – working together

So overall I think that MHIN is a very useful network in terms of designing the project the way it should be designed. ***I'm quite impressed about the atmosphere****, it's a very friendly atmosphere for researchers.*

I feel like MHIN have been guiding all the way along if that makes sense. It wasn't like there was a point where there was no MHIN support and ***then MHIN came in and this change happened*** *because they've been all the way along, supporting and guiding.*

I don't think that clarity was there at the beginning, so it created a little bit of confusion about who does what, but ***once we settled down and we got over that hurdle of understanding it's been great****, and I think you've always been receptive and supportive.*

We've had help from working with the partner site as well *at that kind of more inter-site level help has involved sharing protocols, going to joint meetings, meeting to discuss methodologies, meeting up with various other people in both sites through this MHIN.*

It's been the communication *and the commitment to attending those kind of meetings and things… that's absolutely key and it's been key throughout, when I think about our modeling meetings that we've had, the MHIN meetings, the communities of practice, sort of going back to that being on the priority, people do prioritize it.*

Key quotes – sustainability and scale up

*I think we definitely need to do something as a whole, **so our outcomes are at a national level**.*

*I think **the timing is perfect**, I don't know whether it was accidental or not, but the timing is absolutely perfect.*

*It is really important to get that feedback and also to promote the value of the assertive outreach approach **to make it a sustainable service, not just for Salford**, but that the value of it can be seen and potentially promoted and spread elsewhere.*

*There's a lot of common sense built into the model … and I think **other services in our area want to model that**.*

*I think it's just an organic thing that we just build and if we keep talking about it doesn't create this kind of exclusive club of just these people involved. **If there's another bunch of people that would really benefit from it, let's get them involved in things**.*

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Break

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Lived experience perspectives

Stephen Blood, PPI Lead, Greater Manchester
Ruth Bean, Yorkshire & Humber
Luke Ingamells, Alcohol Project Manager, Change, Grow, Live, Yorkshire & Humber

NIHR ARC National Priorities Programme: Mental Health Implementation Network (MHIN)

PPI LEAD EXPERIENCE

MY PERSONAL EXPERIENCE

1. *A bit of background about myself.*
2. *My story of becoming a service user of needing NHS addiction services.*

GETTING INVOLVED IN THIS RESEARCH PROJECT

1. *Information for you about how I became to get involved in this project.*
2. *What I've been involved with in the project.*

INPUT/GAINS FROM INVOLVEMENT

1. *What I feel I've input into the project.*
2. *Personal gains and achievements I've made from participation.*

THANK YOU

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Communities of Practice

Afra Kelsall, Senior advisor (implementation)
Denise Holcroft, Service Manager, Assertive Outreach Team, The Big Life Group
Julie Carey, Clinical Lead, Greater Manchester Mental Health Foundation Trust

NIHR ARC National Priorities Programme: Mental Health Implementation Network (MHIN)

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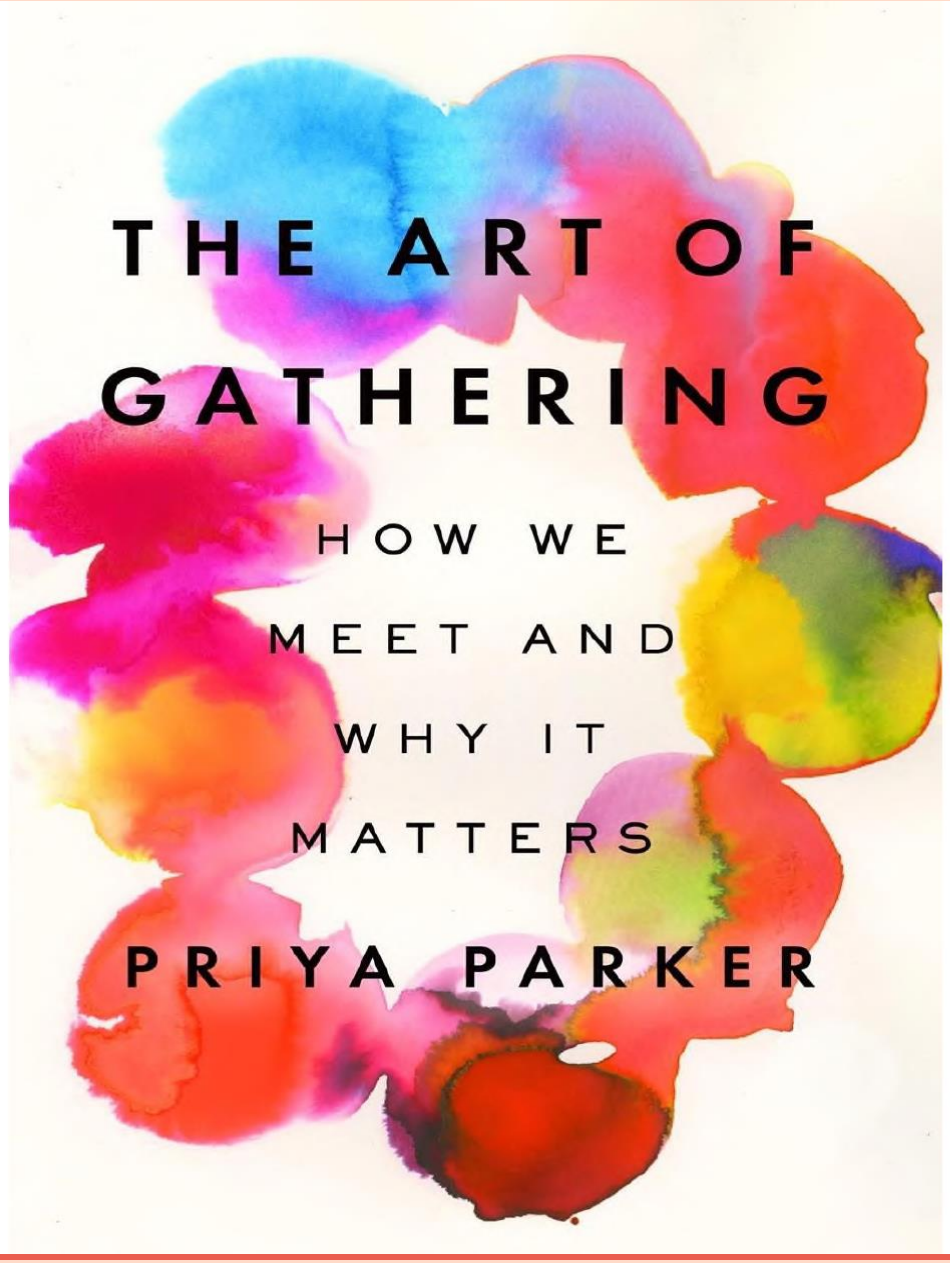
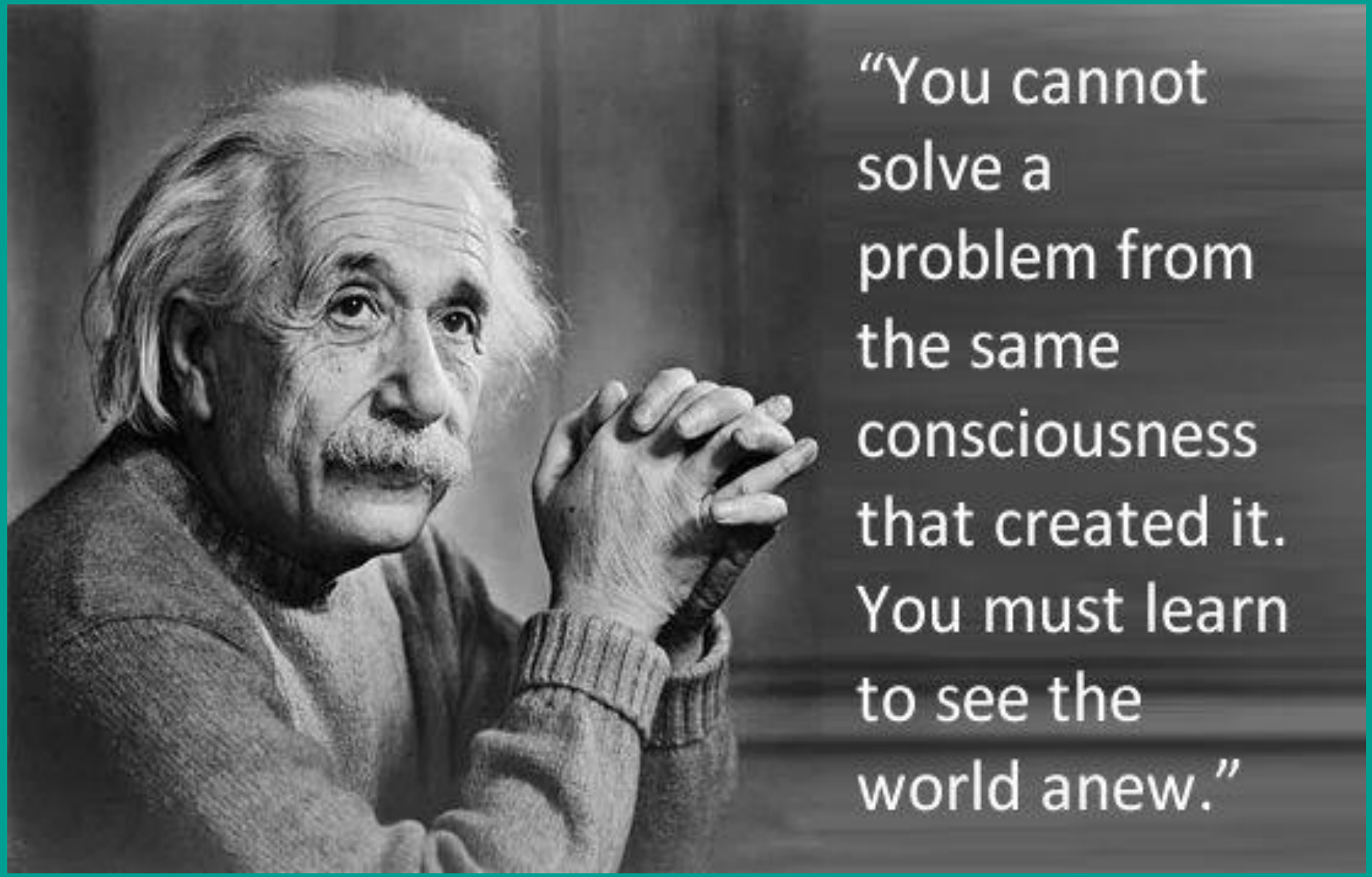
My learning Journey

NIHR ARC National Priorities Programme: Mental Health Implementation Network (MHIN)

"We gather to do the things together that we can't (or don't want to) do alone".

- The art of gathering begins with purpose: When should we gather? And Why?




"You cannot solve a problem from the same consciousness that created it. You must learn to see the world anew."

Communities of Practice – a very brief introduction

Communities of Practice – A Framework for Learning and Improvement
https://convcme.wordpress.com/2011/02/04/communities-of-practice-a-framework-for-learning-and-improvement/

Community of Practice

Northern Care Alliance

NHS Foundation Trust

Implementation of the Community of Practice

- Approach to the Management structure of GMMH/NCA which led to introduction to BLG and CGL
- Creation of the design group
- Opportunity for likeminded people coming together to create a non-hierarchical safe space within Alcohol Assertive outreach
- Learning about convening a meeting
- Launch for the CoP
- Who the participants should be?
- Shared learning
- One member one voice
- Place to listen to others view
- A place to focus on the ‘wicked problems’
- Challenges of EBE (experts by experience)

Resources

- https://www.wenger-trayner.com/introduction-to-communities-of-practice
- https://www.liberatingstructures.com/
- https://q.health.org.uk/join-q/
- https://www.liberatingstructureslondon.org.uk/

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Q&A session

Please submit any questions in the Q&A function!