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## Socio-demographic characteristics and stereotyping of people who frequently attend accident and emergency departments for alcohol-related reasons: Qualitative study

Joanne Neale<sup>1,2\*</sup>, Tom Parkman<sup>1\*</sup>, Ed Day<sup>1</sup>, and Colin Drummond<sup>1</sup>

<sup>1</sup>National Addiction Centre, Institute of Psychiatry, Psychology and Neuroscience (IOPPN), King's College London, Addictions Sciences Building, Denmark Hill, London SE5 8BB, UK and <sup>2</sup>Centre for Social Research in Health, University of New South Wales, Sydney, NSW, Australia

### Abstract

**Aims:** To provide new insights into the socio-demographic characteristics of people who frequently attend Accident and Emergency (A&E) departments for alcohol-related reasons and to explore the findings with reference to stereotyping and prejudice. **Methods:** Semi-structured qualitative interviews with 30 individuals (18 males; 12 females; aged 20–68 years) recruited from six A&E departments across London, United Kingdom. Participants had all attended A&E  $\geq 10$  times within the last year or  $\geq 5$  times in the last three months for an alcohol-related condition. Detailed data relating to participants' socio-demographic characteristics were systematically coded and analysed. **Findings:** Participants reported many years of heavy drinking, and high levels of mental and physical ill health, unemployment, dependence on state benefits, housing problems and social isolation. Frequency of A&E attendances varied greatly by participant, patterns of drinking and other substance use were diverse, and the nature and extent of self-reported health and social problems were wide-ranging. **Conclusions:** Findings suggest that people who regularly attend A&E for alcohol-related reasons collectively experience multiple and complex needs, but individually have diverse patterns of drinking and other problems. Flexible person-centred systems could help to support this patient population, whilst avoidance of terminology that overstates group traits should help to minimise stigma.

### Keywords

Alcohol, stereotyping, emergency departments, frequent attenders, qualitative research

### History

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### Introduction

People who frequently attend Accident and Emergency (A&E) departments for alcohol-related reasons have generated concern in a number of countries (Brubacher et al., 2008; Curran et al., 2003; Fleming et al., 2007; Hannon & Luke, 2006; Rockett, Putnam, Jia, Chang, & Smith, 2005; Whiteman, Hoffman, & Goldfrank, 2000). Despite this, the available information about them is limited, being derived almost exclusively from quantitative surveys and epidemiological studies that have focused on prevalence, basic demographic characteristics and costs of care. We therefore know very little about the wider personal circumstances and support needs of this patient population. Accordingly, it is difficult to determine how best to treat them. In this paper, we

seek to address this gap in understanding by reporting on an exploratory qualitative study involving semi-structured interviews with 30 individuals who repeatedly attended A&E departments for alcohol-related reasons in London, UK. Although our findings are not statistically generalizable to other locations, we are able to extrapolate from the data at a theoretical level to make suggestions for treatment provision. In so doing, we draw upon the concepts of stereotyping, prejudice, stigma and discrimination.

In 2012/3, it was estimated that problematic drinking cost the UK National Health Service (NHS) £2.7 billion annually; £1.8 billion of which resulted from hospital inpatient admissions. In 2013/14, there were an estimated hospital admission of 1,059,210 where an alcohol-related disease, injury or condition was the primary (333,010) or secondary (726,200) diagnosis (Health and Social Care Information Centre, 2015). Alcohol-related conditions account for an estimated 4% of all hospital bed days, with the majority of these (66%) attributable to just 17% of patients (British Society for Gastroenterology, 2011). This suggests that a subgroup of people with alcohol problems places a disproportionate burden on NHS bed usage (Mandelberg, Kuhn, & Kohn, 2000). These individuals are most commonly referred to as “alcohol frequent attenders” (AFAs), but they have also

\*These authors are equal joint first authors.

Correspondence: Tom Parkman, National Addiction Centre, Institute of Psychiatry, Psychology and Neuroscience (IOPPN), King's College London, Addictions Sciences Building, 4 Windsor Walk, Denmark Hill, London SE5 8BB, UK. Tel: +0207 848 0656. E-mail: Thomas.parkman@kcl.ac.uk

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been described as “frequent flyers”, “high impact users” and “high volume users” (Herring, Bayley, Thickett, Stone, & Waller, 2012; Ward & Holmes, 2014).

Local UK data indicate that people who frequently attend A&E for alcohol-related reasons experience high levels of comorbidity, social disadvantage and exclusion, but – in keeping with the international paucity of data – there is very little other information about them (British Society for Gastroenterology, 2011; Moriarty et al., 2010). Significantly, they are not mentioned in either the UK 2010 Drug and Alcohol Strategy (Home Office, 2010) or the 2012 Alcohol Strategy (HM Government, 2012). This dearth of information is compounded by variations in the number of attendances used to define somebody as a “frequent attender”, with studies adopting 3–12 attendances across different time frames (LaCalle & Rabin, 2010; Mason, 2014). Evidence on whether and how people who frequently attend A&E because of alcohol differ from other sub groups of “frequent attenders” – such as those with mental health problems, chronic somatic diseases or medically unexplained symptoms – is also lacking (Scott, Strickland, Warner, & Dawson, 2014).

One potential consequence of having limited information on the characteristics and needs of people who repeated attend A&E is the reification of assumptions and stereotypes about them (LaCalle & Rabin, 2010; Mason, 2014). Stereotypes occur as a consequence of social categorisation; the process whereby a person is seen as a member of a group based on common traits (Stangor, 2000; Tajfel & Forgas, 2000). Technically, stereotypes are value-free beliefs about the characteristics and associated attributes of social groups (Dovidio, Evans, & Tyler, 1986; Fiske, 1998). As such, they often function as helpful mental short cuts, enabling us to reduce the vast amount of complex data we have about any given social group to simple, structured, transferrable information that is easier to perceive and recall (Fiske & Taylor, 1991; Macrae & Bodenhausen, 2000).

Whilst stereotypes would not exist if they were completely inaccurate and not based on at least “a kernel of truth” (Madon et al., 1998; Stangor, 2000), they are also problematic. For example, they do not provide a reliable indication of the attributes of individuals within groups because they rely on simplified images that tend to overgeneralize or exaggerate group traits, and underestimate the individuality and diversity of group members (McGarty, Yzerbyt, & Spears, 2002; Sherman & Bessenoff, 1999; Stangor, 2000). Not all members of a social group will possess all the traits attributed to that group and group stereotypes can result in the erroneous attribution of traits to particular people (Stangor, 1995). If these traits are perceived as undesirable, prejudice can develop (Allport, 1954).

Prejudice goes further than stereotyping as it involves negative feelings or emotions towards individual group members based on the group’s perceived traits (Allport, 1954; Stangor, 1995). Such negative feelings and emotions commonly include dislike, anger, fear and hatred. Prejudice is insidious and can develop rapidly, manifesting itself in stigma and discrimination (Allport, 1954; Link & Phelan, 2001; White, 2009). People who frequently attend A&E because of alcohol are likely to be at risk of both negative stereotyping

and prejudice given the lack of information about them; their association with two dominant negative traits: “alcohol dependence” and “high use of emergency services”; and pre-existing stigma towards both “alcoholics” (Link & Phelan, 2001; Phelan, Link, & Dovidio, 2008; Schomerus et al., 2011) and “frequent attenders” (Raven, 2011; Soril, Leggett, Lorenzetti, Noseworthy, & Clement, 2015). Furthermore, there is evidence that health care professionals hold negative views of patients who present with drink problems (Jeffrey, 1979; van Boekel, Brouwers, van Weeghel, & Garretsen, 2013) and people with drink problems stigmatise themselves (Schomerus et al., 2011).

## Methods

Our study received ethical approval from a UK NHS Research Ethics Committee (REC reference number: 14/LO/1251) and we collected our data during 2015 from six A&E departments located across London. These A&E departments were chosen for pragmatic reasons. Specifically, we anticipated that it would be very difficult to schedule interviews with members of our target population. Therefore, to maximise recruitment and to minimise costs, we chose large hospitals with busy A&E departments that were located within a two-hour travel time from our own place of work. Participant inclusion criteria were based on Information Services Division (ISD) Scotland’s definition of an “alcohol frequent attender” as: “any patient aged 16 or over who attends any A&E department 10 or more times within a year or 5 or more times within a 3-month period for an alcohol-related condition” (ISD, 2014). This definition was chosen for its clarity and because it was the most recent UK-based definition available at the time the study protocol was written.

Alcohol liaison nurses and specialist alcohol workers from the participating hospitals compiled lists of all potential participants using hospital records from the previous 12 months. Potential participants were defined as all patients who had attended A&E  $\geq 10$  times within the last year or  $\geq 5$  times in the last three months for an alcohol-related condition. Hospital staff then contacted these individuals, outlined the study aims to them, and explained what participation would involve. To minimise the potential for bias, staff were asked to contact all individuals identified. If an individual was interested, the staff member secured verbal agreement to pass their contact details onto the study researcher (TP). TP then telephoned interested people, explained the study again and arranged a time to conduct the interview. TP continued to contact people until 30 participants had been interviewed. A target of 30 participants had been set, as this was considered to be both feasible and likely to be sufficient for data saturation in relation to key topics of interest and emergent themes. Only a very small number of people could not be contacted by TP ( $n=3$ ) or declined an interview when approached by him ( $n=1$ ).

Before the interview began, TP provided written information about the study with further verbal explanation and secured written informed consent. Most individuals wanted to be interviewed in their own home, but others did not have stable housing or preferred an alternative location (for example, a hostel, hospital, GP surgery, restaurant or medical

centre). All participants were sober enough to consent and to participate fully at the point of interview (as judged by TP), even though some had drunk prior to, and some drank during, the interview. Interviews took place during the day, lasted 60–120 min, and were conducted using a semi-structured topic guide that covered participants' socio-demographic characteristics; past and present alcohol, drug and tobacco use; contact with specialist addiction services; contact with wider health and social services; details of their most recent A&E attendance; details of previous A&E attendances; and types of support/treatment desired for alcohol or other problems.

Interviews were audio-recorded and individuals were each given a £15 voucher in recognition of their time. The interview data were then transcribed verbatim and entered into the qualitative software programme MAXQDA™ (version 10) for systematic coding. A coding frame was developed iteratively based on deductive codes (derived from questions asked in the topic guide) and inductive codes (based on topics that emerged from the data during the coding process). Each interview transcript was reviewed line-by-line with all interview data being indexed to one or more codes. To address the aim of this paper, analyses are confined to the deductive codes relating to participants' socio-demographic characteristics and current patterns and types of drinking, smoking and illicit drug use. Data coded to these codes were exported into Microsoft Word documents and analysed line-by-line via Iterative Categorization (Neale, 2016) and following the principles of Framework (Ritchie & Spencer, 1994). Specifically, themes in the coded data were identified, the range and nature of the data within themes were mapped, and similarities and differences between participants were explored.

Participants included 18 males and 12 females, age range 20–68 years (mean 48.0 years). Nineteen described themselves as White British; four as Asian British; three as Mixed Race British; three as European and one as African. Hospital records indicated that in the last 12 months they had attended A&E between 10 and 84 times (mean = 24 times) and been admitted to the hospital from A&E between 0 and 17 times (mean = 5 times). In presenting our data, we use pseudonyms to protect participant anonymity and quotations to illustrate key findings.

## Findings

### Substance use

#### Drinking

Nearly all participants reported many years of heavy drinking and symptoms of alcohol dependence, referring to an inability to stop drinking (“*when I have one drink, I don't... stop*”; Michelle, 25 years); acceptance that they had a drinking problem (“*it's a massive problem. I need a drink... every day*”; Shaun, 44 years); withdrawal if they stopped drinking (“*I [get] the usual shakes*”; Luke, 56 years); and increasing tolerance (“*I find it [drinking] actually increasing*”; Jack, 53 years). For some, drinking had become a life-threatening issue. Indeed, Clive explained how his doctor had told him that to continue drinking would mean almost certain death:

He [doctor] said, “Next time I see you in here [doctor's surgery], I'll be closing your eyelids down and that'll be it. It's up to you.” (Clive, 64 years)

The reasons individuals gave for continuing to drink were complex and interlinked, including: to prevent the onset of withdrawal symptoms; to self-medicate physical, health and social problems; and to be able to perform everyday tasks, such as getting dressed or going outside. For example, a number of participants explained how homelessness negatively affected their health, which in turn made them drink more. Additionally, many explained that they continued to drink because their GP or hospital staff had told them that it was dangerous to stop suddenly. None of the participants said that they now drank for pleasure. On the contrary, many recognised that their drinking had complex physical and psychological underpinnings:

After I've finished this interview with you, I'll probably go straight out and get another drink. You see, it's not just physical, it's psychological as well, I think. (Matthew, 50 years)

The types of alcoholic beverages that participants currently consumed included strong beers, ciders, spirits and wine (red and white), with most stating that they drank beer or cider daily. Those who only drank beer or cider typically consumed 10–15 cans throughout the day (usually 7–9% alcohol by volume [ABV]), often starting early in the morning. Other participants typically drank fewer cans of beer or cider (usually 5–8 cans) and between half and a bottle of spirits, generally consuming spirits after beer or cider, and later in the day. A minority of participants only drank spirits, some (mostly younger people) mixing these with non-alcoholic drinks and others drinking them neat:

I was even drinking white spirits at one point, because I couldn't walk to the off licence. I couldn't actually get to the off licence. (Gaby, 64 years)

Whilst a number of participants reported that they drank to prevent withdrawal symptoms and then to maintain a steady level of intoxication, others said that they drank until they could not physically drink any more, fell asleep or ran out of funds. Although the most common pattern was daily drinking, several participants described themselves as “binge drinkers”, explaining that they only drank at weekends or had periods of abstinence (typically a few weeks) followed by a longer binge (typically a week). In addition, one man only drank every other day.

#### Smoking and illicit drug use

In total, 22 participants reported that they smoked cigarettes and/or roll up cigarettes (averaging 10–40 a day) and one man used an e-cigarette. Some commented that they only smoked when drinking and nearly all said that they wanted to stop smoking. Only one male participant reported current illicit drug use (daily intravenous heroin), but five

others reported histories of drug taking (heroin, ecstasy, cocaine, mephedrone, diazepam and cannabis). The remaining 24 participants said that they had never tried illicit drugs.

## Health

### *Mental health*

Nearly a third of participants reported that they had received a formal mental health diagnosis, most commonly depression, but also bipolar disorder, bulimia, vascular dementia, borderline personality disorder and emotionally unstable personality disorder. Whilst participants were unable to explain whether drinking had caused or was a consequence of their mental ill health, everyone felt that alcohol made their mental health problems worse. For some, this had resulted in suicidal feelings and repeated attempts to commit suicide:

[I] took the overdose. I drank bleach. I had to go to hospital – I'd go to the bathroom, drink bleach. (Philippa, 56 years)

Several participants had not received a formal mental health diagnosis, but reported a range of self-ascribed psychiatric disorders or symptoms including: depression (*'I get the black dog... like Churchill'*; Catherine, 59 years), anxiety, general low mood, apathy, deteriorating memory, anger issues, emotional instability, post-traumatic stress disorder and psychotic symptoms (*'I see faces... hear voices... just some person in my head'*; Chris, 44 years).

### *Physical health*

Nearly all participants spoke of chronic physical health problems that they directly attributed to their drinking; for example, poor kidney functioning or kidney failure, diabetes, gastritis, hepatitis, pancreatitis, high blood pressure, angina, respiratory problems, incontinence and peripheral neuropathy. One female said that a specialist had told her that her liver was enlarged (*'50 times off the scale'*; Rebecca, 36 years). In practice, most participants reported multiple serious long-term physical problems directly related to their drinking:

My liver's failing again. One kidney's packed up... I've got lung cancer, I've got pancreatitis, I've got hepatitis, I've got everything you can imagine... I'm terminally ill and I'm going to die soon. (Emma, 48 years)

These various chronic conditions often seemed to be linked to further acute health problems; for example, strokes and heart attacks. In addition, participants routinely spoke of pain or injuries caused by falling over when drunk and more general life-style related health problems; for example, tooth decay, difficulties sleeping, malnutrition, weight gain or loss, and unspecified malaise (*'I just feel worn, drained'*; Gaby, 64 years).

Other reported physical health problems included epilepsy, arthritis, chronic obstructive pulmonary disease, visual

impairment and Guillain-Barré syndrome. All participants acknowledged that their health problems were aggravated, even if not directly caused, by their drinking and only a very small number of participants reported that they were *'in good health'*.

## Material resources

### *Education, employment and income*

Although nine participants said that they had no educational qualifications, others had attained GCE/GCSEs ( $n=12$ ); A-levels ( $n=5$ ); a university degree ( $n=3$ ); and a PhD ( $n=1$ ). Only two were in current paid work: a paralegal and a self-employed builder. Most said that they had been unemployed for many years and several reported they had never worked. Those who had once worked discussed a range of occupations including dog walker, cleaner, painter and decorator, taxi driver, shop worker, ticket officer, air steward, librarian, investment banker and hospital consultant. Reasons for leaving jobs were diverse, but alcohol was often a contributing factor:

I lost that job because of the drinking... then I got the same job with [another company], but I lost that as well because of drinking. (Nick, 24 years)

The reason I retired was because I was drinking before work and alcohol was smelt from me, and I had to go through a disciplinary. It was awful. (Hannah, 68 years)

Most participants said that they were claiming state benefits, two explained that their partners gave them money, and one commented that he was living in the UK illegally and so was ineligible for any state financial support. Whilst some expressed no interest in having paid work, others were very keen to secure a job in order to provide for themselves and/or their family and to avoid the stress, anxiety and depression that they said they experienced from unemployment and low income. For example, Adam explained how he felt both worthless and helpless for having to rely on his wife to provide money for the family:

Because my wife, she goes to work, and I am nobody, nothing. I'm helpless. (Adam, 59 years)

## Housing

Nine participants reported that they lived in social housing (either owned by the local authority or a housing association); five lived in a hostel or sheltered housing; four described themselves as street homeless; four said that they owned their own homes; three lived with family members or friends on a permanent basis; two were staying temporarily with family or friends because they were homeless; two were privately renting flats; and one lived in a nursing home.

In practice, most said that they were unhappy with where they lived. Thus, many spoke of living in deprived and violent neighbourhoods, which made them anxious about going out:

I got out of [name of area] because I was mugged eleven/twelve times out there. They took my crutches. They took

my Zimmer frame, my wallet, my passport. (Alex, 57 years)

Hostel dwellers complained that the presence of other drinkers was stressful and perpetuated their drinking; rented accommodation was described as unstable; street sleeping was associated with poor physical health; and homeowners linked their accommodation to negative memories:

That [house] is where I did all my drinking when it got really bad... I don't really want to go back there. (Gaby, 64 years)

Frequently, participants said that they drank to cope with, or forget about, their housing problems and/or the various physical, psychological and social problems caused by their living arrangements:

They [the local council] don't come and mend things. I can't shut my windows... There's a smell that comes up from the bathroom because there isn't a stench pipe. It goes on and on and on. I sit here waiting for them to come because I make the appointment and they don't turn up, and I'm just fed up with it all, the stress. (Catherine, 59 years)

## Relationships

### *Family relationships*

Participants routinely reported that they had either no or only negative relationships with family members and generally attributed this to their drinking. In turn, they said that this made them feel guilty and lonely, especially when they had lost contact with children (*"It's so hard not seeing... my children"*; Daniel, 46 years). Others, mostly females, explained that their family relationships had broken down because of physical violence or sexual assaults perpetrated against them:

He [ex-husband] would watch pornographic films, drink Bacardi, rape me, and then beat my kids and try it on with my girls. (Emma, 47 years)

In addition, a number of males and females spoke of losing positive family relationships through bereavement. Moreover, this had often made them feel lonely and depressed, and then contributed to their drinking (*"I started drinking when my daughter passed away... it hurts and hurts"*; Louise, 45). In contrast, several participants spoke of having very positive relationships with parents, siblings or children that seemed central to their wellbeing. Nonetheless, anxieties about losing these relationships could also prompt harmful drinking:

She [daughter] had cancer of the liver and ovary... I went into a very depressive mood... arranging the funeral... I wasn't sleeping, it was on my mind all the time... I just started drinking. (Hannah, 68 years)

### *Social networks*

Many participants reported that they only socialised with other heavy drinkers whilst others spoke of having friendships with non-drinkers that were abusive or threatening. For example, several women referred to male friends who pressurised them into having sex (*"people abuse me in a different way, wanted sex and all that"*; Deborah, 36 years), and some men spoke of being bullied (*"they [friends] came into my flat and started threatening me for money"*; Chris, 44 years). Participants generally acknowledged that negative relationships of this kind increased their drinking. However, some still valued them as they provided companionship and helped to counter the loneliness and boredom that pervaded their lives:

... because alcoholics help each other. They won't see each other go without a drink. (Rob, 58 years)

If I'm passing by, then I'll go see him [drinking friend]. I'll go, say, 'Hey, hi, how are you?' He's saying, 'I'm fine', whatever. I'd say, 'Where are you going now?' He'd said, 'I'm going to the off licence'. Then he would ask me, 'Do you want anything?' (Eric, 65 years)

Other participants explained that they had few social relationships, either because they had lost non-drinking friends as a consequence of their alcohol use or because they consciously avoided others (*"I don't mix with anyone else... I don't want to"*; Daniel, 46 years). Despite this, a few participants retained positive relationships, which they believed protected them from drinking. These more supportive relationships tended to be with people who did not drink or who were ex-drinkers and who offered participants practical and emotional support:

He [friend] took me home [to his house]... He had a caravan in his back garden, and he said, 'you can live in that'... He's probably the only reason I'm alive to be honest, because... every time things go tits up he scoops me up and saves me. (Nick, 24 years)

## Discussion

In this paper, we provide the first detailed insights into the socio-demographic characteristics of people who frequently attend A&E for alcohol-related reasons. Consistent with the limited existing literature, we found that our participants experienced multiple and complex needs, including considerable comorbidity, disadvantage and social exclusion (British Society for Gastroenterology, 2011; Moriarty et al., 2010). Thus, they collectively reported many years of heavy drinking and alcohol-related problems, combined with high levels of mental and physical ill health, unemployment, dependence on state benefits, unsuitable and unstable housing or homelessness, loneliness, and negative and abusive relationships. Significantly, none of our participants reported that they drank for pleasure.

Despite this, our analyses also revealed that there were many differences between our participants. In our small

sample of only 30 individuals, we found males and females, a wide age range (20–68 years), and multiple nationalities and ethnic groups. Individuals had very varied patterns of hospital attendance and admission (between 10 and 84 attendances and between 0 and 17 admissions over the last year). Patterns of drinking were also diverse, with several participants identifying themselves as binge drinkers rather than daily or chronic drinkers. In addition, we interviewed both smokers and non-smokers and some who had histories of illicit drug use as well as those who did not.

Whilst overall co-morbidity was high, the nature and extent of participants' health problems were very varied. Some said that they had received formal diagnoses of serious psychiatric disorders, whereas others reported more common mental health symptoms. Similarly, some discussed life-threatening physical health conditions, whilst others spoke of more everyday ailments, and a minority said that they were in "good health". Although most were unemployed at the time of interview, they reported very different levels of educational attainment, employment histories and work aspirations. Likewise, they described a wide range of living arrangements and gave various explanations for their limited social networks, or stated that they had positive relationships.

Our findings reveal that people who frequently attend A&E for alcohol-related reasons within even one city comprise a very diverse population. Describing them as a group that experiences complex needs and high levels of social deprivation is to an extent accurate and may help to highlight their problems and generate more and better support for them, and resources for the A&E staff who treat them. Yet, this blanket categorisation could propagate an overly simple image that underestimates their differences and downplays their personal circumstances (McGarty et al., 2002; Sherman & Bessenoff, 1999; Stangor, 2000). In consequence, there is a risk of harmful stereotyping, including the misattribution of negative group traits to individuals without those traits. Furthermore, the terms "complex needs", "deprivation" and "social exclusion" are closely associated with other traits that tend to be perceived as socially undesirable (such as, mental ill health, long-term unemployment and homelessness) (Bramley & Fitzpatrick, 2015). When these traits are used in conjunction with the terms "alcoholic" and "frequent attender", the propensity for prejudice, stigma and discrimination seems likely to be high (Allport, 1954; Stangor, 1995).

A&E departments are busy and pressurised settings where staff routinely need to make rapid decisions about patients based on limited information. In these circumstances, there will almost inevitably be a tendency to take mental shortcuts, including using stereotypes, to help define the requirements and most appropriate responses to patients (Fiske & Taylor, 1991; Kirby, Cornish, & Smith, 2008; Macrae & Bodenhausen, 2000). Moreover, since people who repeatedly attend A&E for alcohol-related reasons often have less social capital and weaker support networks than other patients, they are more likely to find themselves interacting with medical staff in an intense emergency setting without a supportive other – or "capable guardian" (Cohen & Felson, 1979) – to assist, explain or speak up for them. This may also increase their chances of being misunderstood and stigmatised.

Our findings point to the importance of treating people who repeatedly attend A&E for alcohol-related reasons as individuals with varied problems and backgrounds. It consequently seems inappropriate to assume that any single service or treatment will be able assist them uniformly or universally. Rather, a sensitive person-centred approach is likely to be required. Equally, a busy A&E department probably will not be the most suitable setting to help somebody with a complex drinking problem and a mixture of other personal and social difficulties; patients seem more likely to benefit from being linked to specialist alcohol workers and services with a broader health and social care remit. Further research evaluating alternative service models, such as more personalised case management (Substance Abuse and Mental Health Services Administration, 1998) or assertive outreach approaches (Gilbert et al., 2012), and studies investigating the views and experiences of service providers working with this patient population, would help to test these hypotheses.

Finding terms that describe people who frequently attend A&E for alcohol-related reasons in ways that mobilise resources to assist them, but without attributing inappropriate or damaging labels to them, is an on-going challenge. The expression "people with alcohol dependence and complex needs" is gaining some traction in UK policy and practice circles (National Institute for Health Care and Excellence Guidelines, 2011). People-first language is widely used to avoid subconscious dehumanization when discussing groups that tend to be defined by a condition or health problem. Linguistically, placing the person first and the condition or trait second emphasises that the trait is a secondary attribute and not the defining feature of a person's identity. The term "people with alcohol dependence and complex needs" seems preferable to "alcohol frequent attender", "frequent flyer", or "high impact user", but still assumes an inappropriate homogeneity of need, gives individuals a clinical label of dependence where this may not be the case, and does not capture the shared trait of frequent A&E attendance. Accordingly, we have retained the lengthy but more precise term "people who frequently attend A&E for alcohol-related reasons" throughout this manuscript.

### Limitations and strengths

Our analyses are exploratory, descriptive and based on a relatively small number of qualitative interviews conducted with individuals recruited from six hospitals across London. Whilst we cannot claim statistical generalizability, the data enhance current understanding of an important – but difficult to access and under-researched – patient sub group that makes disproportionate use of health services (Mandelberg et al., 2000). Participants were identified from hospital records, and nearly all individuals approached participated, so reducing the likelihood of selection bias amongst those interviewed. Given that we found great diversity within our small sample, it seems reasonable to hypothesise that this diversity would be equally evident, if not more pronounced, in a larger sample or in a sample recruited from a wider range of geographical areas. We thus suggest that further research (qualitative or quantitative) would also likely find that people who frequently attend

A&E departments for alcohol-related reasons have diverse needs and circumstances that require us to: i. develop flexible and personalised support systems (such as personalised case management or assertive outreach) and ii. avoid terminology and labels that overstate group traits to the detriment of important individual differences. Any changes to service delivery implemented based on these hypotheses would then need to be evaluated to assess their effectiveness.

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