Fear of inpatient opiate withdrawal: a modifiable barrier to health-care access for people who use illicit opiates

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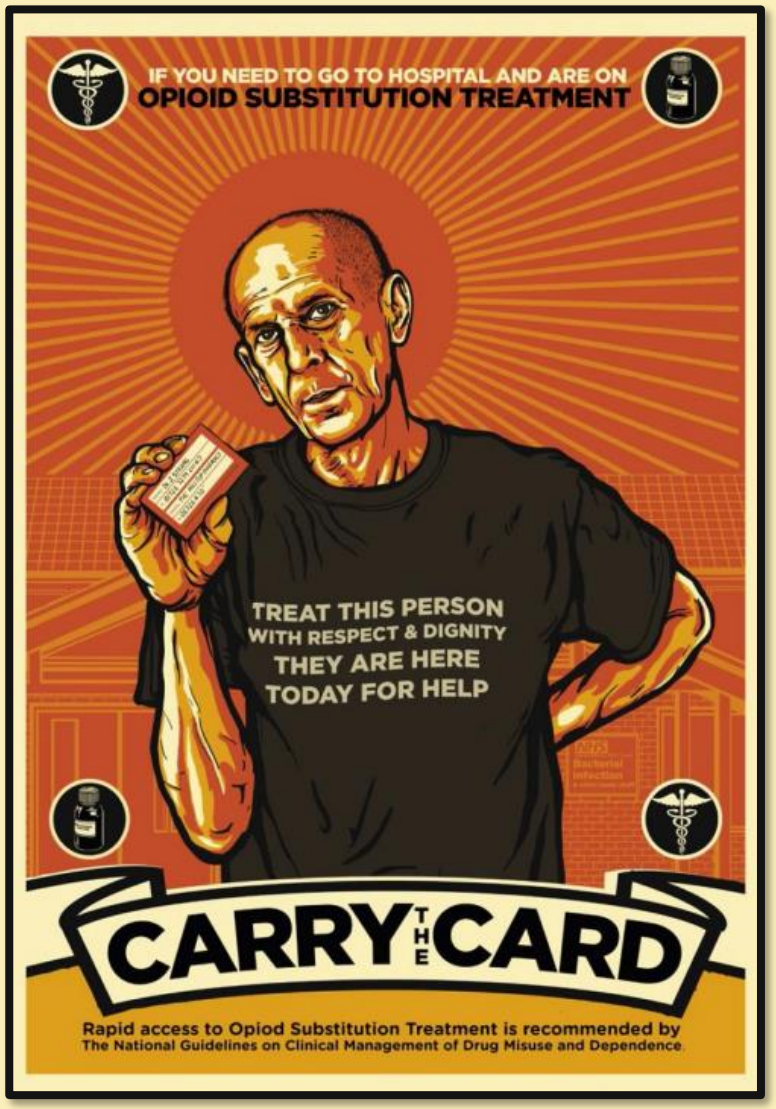

LONDON SCHOOL of HYGIENE &TROPICAL MEDICINE

iHOST
Improving Hospital Opioid Substitution Therapy

Lisbon Addictions
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Lisbon, Portugal

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We would like to thank all the community members with lived experience of injecting drug use who have contributed to this research. Including:

- Participants of the NIHR Care and Prevent Study
- Staff from Release and community members who contributed to the policy data generation and analysis
- Particular thanks to, and in memory of, Gary Sutton, Release.

From Care & Prevent to iHOST

The mixed-method **Care & Prevent study** explored skin & soft tissue infection (SSTI) prevention, risk & care among 455 people who inject drugs in London.

Context & project impetus

- From 2012: 50% increase in opioid related deaths in the UK
- Annual rise in injecting-related **hospitalisations** (~10% PWID hospitalised for SSTI annually – barriers to timely care)

Select findings

- High proportion (68%) lifetime SSTI, of **those 46% hospitalised for SSTI**
- Opioid withdrawal: **barrier to care access & completion**

Next steps

- The iHOST **(improving Hospital Opioid Substitution Therapy**) intervention study: NIHR funded, commenced March 2022

Care & Prevent

Survey Participants

n=455

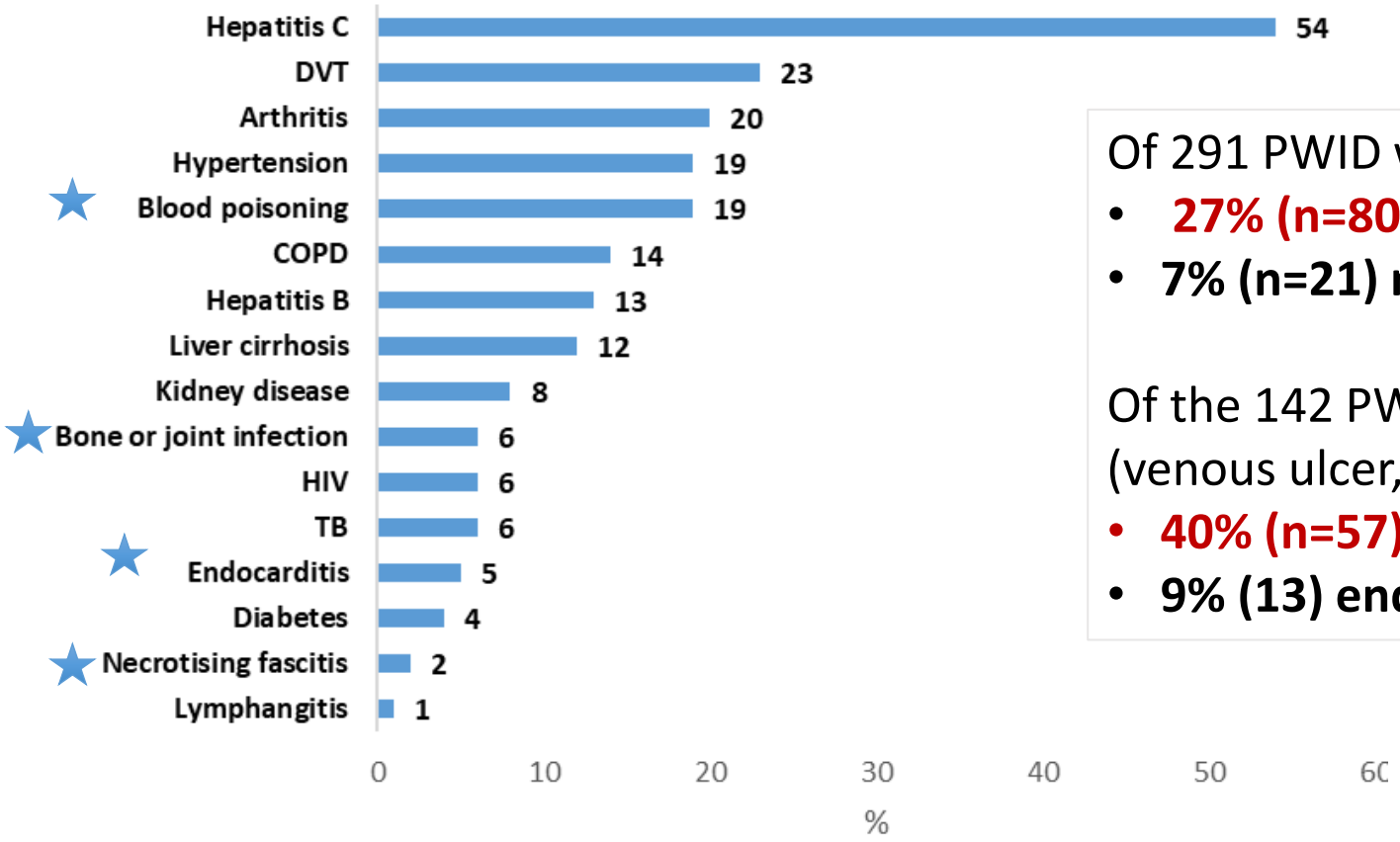
2018-19

	Men (341, 75%)	Women (114, 25%)	Total (n= 455)
Ethnicity: White British/white	248 (73%)	88 (77%)	336 (74%)
Age, range (mean)	21 - 68 (46yrs)	22 - 67 (44yrs)	21 - 68 (46yrs)
Injecting in past 12 months	224 (66%)	60 (53%)	273 (63%)
Mainly injecting: heroin & crack (past 12 months) heroin	182 (53% 61%) 129 (37% 29%)	43 (38% 47%) 70 (61% 53%)	225 (49% 58%) 199 (44% 34%)
Current OST	274 (80%)	86 (75%)	360 (79%)
Current hostel/street homeless	163 (48%)	44 (39%)	207 (46%)
Ever street homeless	277 (81%)	78 (68%)	**355 (78%)**
Ever SSTVI (abscess, cellulitis, venous ulcer, venous disease)	231 (65%)	79 (69%)	**310 (68%)**
Hospitalised for SSTVI above	96 (28%)	41 (36%)	**137 (30%)** **46% of 310**

46% of those with SSTVI hospitalised. What is going on?

- Time to seek medical advice associated with SSTVI severity: 54% (124) waited 5-9 days, **28% (83) 10+ days**
- SSTVI severity associated with hospitalisation. Systemic complications common.

Diagnosed co-morbidities



Of 291 PWID with abscess or cellulitis:

- **27% (n=80) report sepsis**
- **7% (n=21) report endocarditis.**

Of the 142 PWID with history of vascular issue (venous ulcer, venous disease or DVT)

- **40% (n=57) report sepsis**
- **9% (13) endocarditis.**

★ = potential SSTI complication

Qualitative data (n=37): additional insight

PWID incorporate serious injecting-related complications into daily lives – medical care avoided

"It was mad, like I was homeless and the right side would just randomly, out of nowhere, it would just burst with blood, like blood everywhere! Within ten seconds my entire trousers would be covered in blood."

Fear & experience of opioid withdrawal in hospital a primary barrier to treatment presentation & completion

"It was that that really scared me more than anything, was being sick in hospital … being sick [in withdrawal] is one of the scariest things in the world to be."

Stockpiling money & drugs, using illicit drugs in hospital and self discharge common:

"They give you a dose of methadone in the hospital but you have to wait for the doctor to consent, so I'm waiting days …. So going out, sick as a dog, arm bandaged up, I have to go out and find some money."

1. Harris et al, 2018; 2. Wright et al., 2020; 3. Harris, 2020

Interrogating context: hospital policies

- Hospital critical medicines lists: informed by the Delayed & Omitted Medicines tool
- We questioned the categorisation of drugs for substance dependence (webinars)

DRUG OR DRUG CLASS BY BNF CLASSIFICATION AND INDICATION (S) CONSIDERED	Potential risks as consequence of delay		
	Dose not given at the time prescribed	Dose not given within 2 hours of time prescribed	Dose omitted (i.e. not administered by the time of next scheduled dose)
4.10. Drugs used in substance dependence *For alcohol or opioid dependence*	Nil or negligible patient impact with nil or minor intervention required; no increase in length of stay	Nil or negligible patient impact with nil or minor intervention required; no increase in length of stay	Significant short-term patient impact with moderate intervention required; increase in length of hospital stay possible

- We requested substance dependence guidelines: 224 aNHS hospital trusts.
- 101 relevant policies (86 Trusts): discrepancies in approach, barriers to timely OST, punitive language

"Patients with a history of drug abuse often have unreasonably high expectations. Alleviation of all pain is not a goal."

Working with people who inject drugs & policy makers

Specialist Pharmacy Service	Dose not given at the time prescribed	Dose not given within 2 hours of time prescribed	Dose omitted (i.e. not administered by the time of next scheduled dose)
4.10 Drugs used in substance dependence 4.10.1 Alcohol dependence Benzodiazepines prescribed for alcohol dependence and withdrawal	Significant or catastrophic long-term patient impact with ongoing intervention required; long increase in length of stay possible	Significant or catastrophic long-term patient impact with ongoing intervention required; long increase in length of stay possible	Significant or catastrophic long-term patient impact with ongoing intervention required; long increase in length of stay possible
4.10 Drugs used in substance dependence 4.10.3 Opioid dependence Opioids prescribed as substitution treatment in opioid dependence	Nil or negligible patient impact with nil or minor intervention required; no increase in length of stay	Significant short-term patient impact with moderate intervention required; increase in length of hospital stay possible	Significant or catastrophic long-term patient impact with ongoing intervention required; long increase in length of stay possible
4.10 Drugs used in substance dependence (no BNF sub-code) Benzodiazepines prescribed for benzodiazepine dependence	Nil or negligible patient impact with nil or minor intervention required; no increase in length of stay	Significant short-term patient impact with moderate intervention required; increase in length of hospital stay possible	Significant or catastrophic long-term patient impact with ongoing intervention required; long increase in length of stay possible

" like a helping hand. Something that speeds up the time you get your Methadone in hospital."

People who inject drugs

Workshops to understand what would help them feel safer in hospital – more able to present early and complete their treatment:

- Advocacy card
- Advocacy helpline

"something to take to the hospital to say I've got a right to be treated with dignity"

The iHOST (improving hospital OST) intervention

AIM: To optimise OST management in hospital settings to reduce delayed presentation, self-discharge and emergency readmission among people who use opioids.

1. ‘My Meds’ advocacy card
2. Advocacy OST helpline
3. Online staff training module
4. ‘Best practice’ hospital template
5. iHOST ‘champion’

Sites: University College London Hospital; St James's University Hospital, Leeds; Royal Stoke University Hospital, and linked drug treatment services

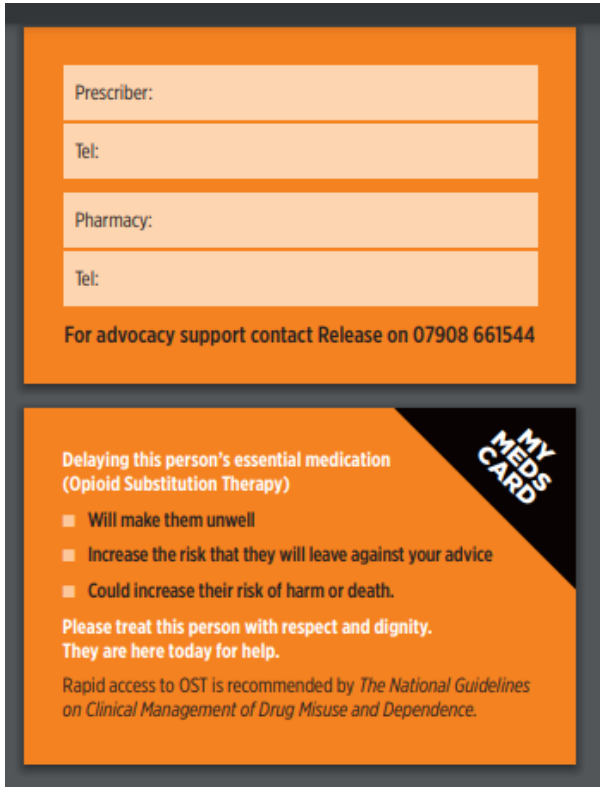
Primary outcome measures:

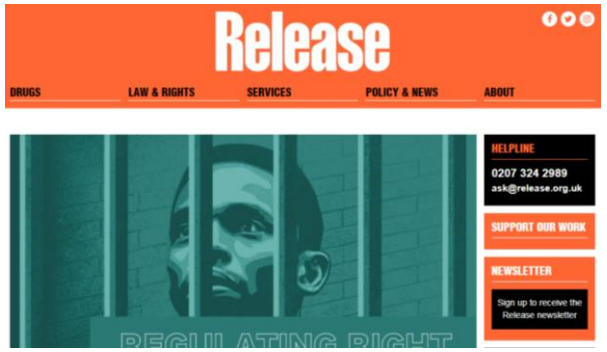
1. Discharge against medical advice (DAMA)
2. Emergency hospital readmission within 28 days of discharge

Advocacy Card, training & helpline

The MY Meds card is credit card sized, double sided, and generic rather than personalised. **It aims to:**

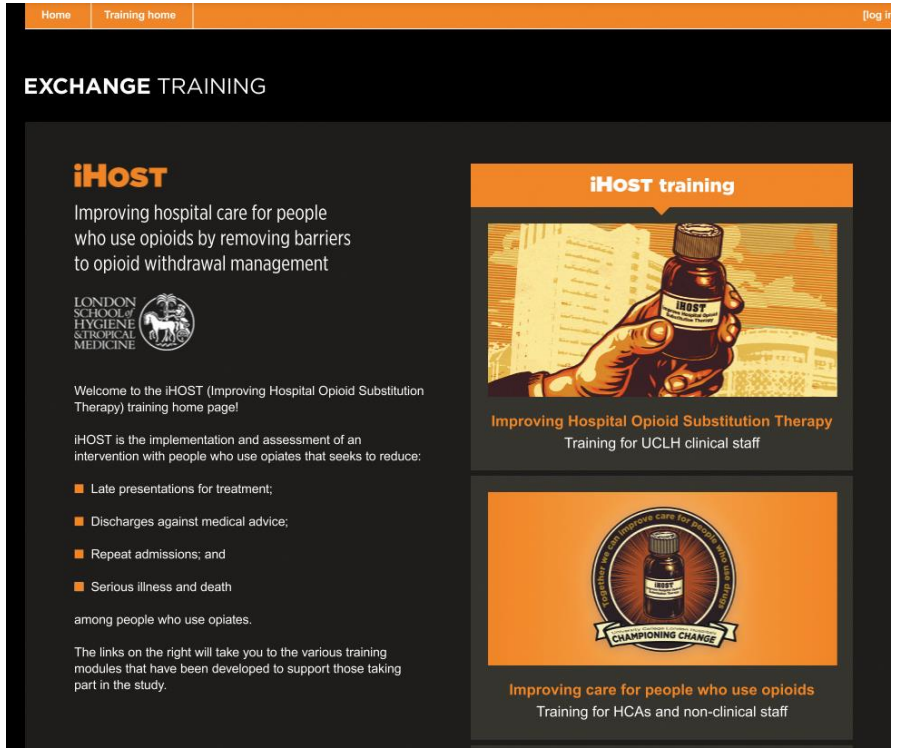
- Empower people on OST to feel safe to access hospital care and to disclose their medication requirements.
- Enable timely medicines reconciliation: prescriber and pharmacist contacts to be entered by the drug service.





Helpline, operated by Release, will ensure that patients are supported to secure their community OST or be assessed and titrated while as quickly as possible, and in line with current clinical and policy guidance.

E-learning module: a dedicated training package to support patient-centred care and communication, and enhance staff confidence in the specifics of OST dosing and management.

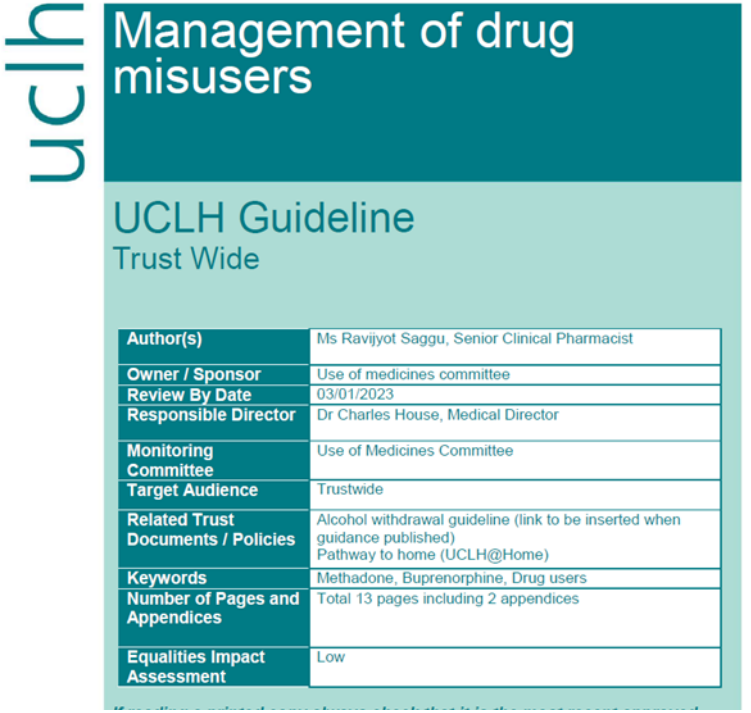


Development of best practice policy

- Drawing on policy review, clinical evidence, consultations with hospital staff & people who use opioids
- Consultation and review from key stakeholder organisations: *Addiction Professionals, Royal College of Psychiatrists, British Pharmacological Society, College of Mental Health Pharmacy, Royal Pharmaceutical Society, Office for Health Improvement and Disparities.*

Issues addressed:

1. **Urine drug screen requirement** prior to any OST prescription in hospital (even where community Rx confirmed by local drug treatment service)
2. **Low initial methadone dose** (capped at 10mg, to be titrated 4hrly to 40mg max. day-one dose)
3. **No provision for takeaway OST**/continuity of care for patients with a community Rx who are discharged out-of-hours
4. **No provision for takeaway naloxone** to address high risk of fatal overdose in days following hospital discharge



uclh

Management of drug misusers

UCLH Guideline
Trust Wide

Author(s)	Ms Ravijyot Saggu, Senior Clinical Pharmacist
Owner / Sponsor	Use of medicines committee
Review By Date	03/01/2023
Responsible Director	Dr Charles House, Medical Director
Monitoring Committee	Use of Medicines Committee
Target Audience	Trustwide
Related Trust Documents / Policies	Alcohol withdrawal guideline (link to be inserted when guidance published) Pathway to home (UCLH@Home)
Keywords	Methadone, Buprenorphine, Drug users
Number of Pages and Appendices	Total 13 pages including 2 appendices
Equalities Impact Assessment	Low

Stigma and risk

"Misuser", "Abuser", "Addict"

"Sanctions"

Maintaining "a degree of suspicion"

Regular drug testing

Supervised consumption

Behavioural contracts

Policies emphasised risk of opioid overdose: negating risk of opioid withdrawal

"Opioid withdrawal is not a life-threatening condition but opioid toxicity is"

Many policies promoted stigmatising attitudes and approaches:

- Some instructed that a patient should be made to speak or swallow water to prove they were not holding OST in their mouth
- One maternity guideline stated that new mothers must be informed that if a test were positive, they might be discharged while their baby remains in hospital until fit for discharge
- Six advised observing the patient urinate
- Some advised restricting visitors and specified that patients should not be allowed to leave the ward

Best practice policy – Process outcome and key wins

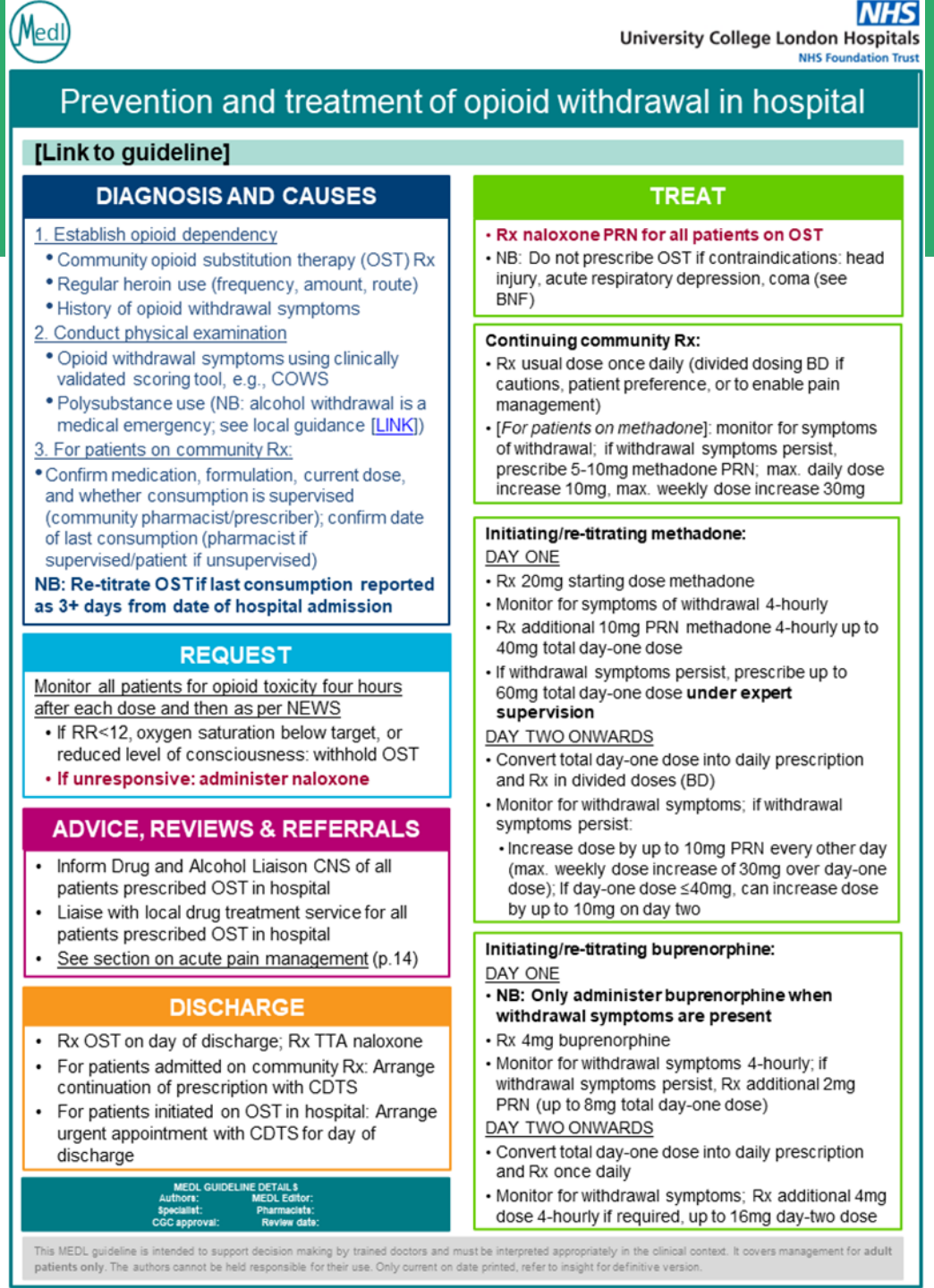
University College London Hospital amended in line with best practice template:

1. Removed mandatory urinalysis pre-OST prescribing
2. Amended OST initiation schedule (increased initial dose 10mg → 20mg; max one day dose increased to 60mg under expert supervision)
3. Introduced takeaway OST for patients on community OST prescription (with drug treatment service approval)
4. Introduced take-home naloxone

Reviewed & approved by UCLH guidelines committees (3x)

"There were claps & cheers from the AMU (acute medical unit) staff when we introduced the changes. Claps & cheers!!"

(Marisha, iHOST LSHTM Research Fellow)



Medl

NHS
University College London Hospitals
NHS Foundation Trust

Prevention and treatment of opioid withdrawal in hospital

[Link to guideline]

DIAGNOSIS AND CAUSES

1. Establish opioid dependency
   - Community opioid substitution therapy (OST) Rx
   - Regular heroin use (frequency, amount, route)
   - History of opioid withdrawal symptoms
2. Conduct physical examination
   - Opioid withdrawal symptoms using clinically validated scoring tool, e.g., COWS
   - Polysubstance use (NB: alcohol withdrawal is a medical emergency; see local guidance [LINK])
3. For patients on community Rx:
   - Confirm medication, formulation, current dose, and whether consumption is supervised (community pharmacist/prescriber); confirm date of last consumption (pharmacist if supervised/patient if unsupervised)

NB: Re-titrate OST if last consumption reported as 3+ days from date of hospital admission

REQUEST

Monitor all patients for opioid toxicity four hours after each dose and then as per NEWS

- If RR<12, oxygen saturation below target, or reduced level of consciousness: withhold OST
- **If unresponsive: administer naloxone**

ADVICE, REVIEWS & REFERRALS

- Inform Drug and Alcohol Liaison CNS of all patients prescribed OST in hospital
- Liaise with local drug treatment service for all patients prescribed OST in hospital
- See section on acute pain management (p.14)

DISCHARGE

- Rx OST on day of discharge; Rx TTA naloxone
- For patients admitted on community Rx: Arrange continuation of prescription with CDTS
- For patients initiated on OST in hospital: Arrange urgent appointment with CDTS for day of discharge

MEDL GUIDELINE DETAILS
Authors: MEDL Editor:
Specialist: Pharmacists:
CGC approval: Review date:

TREAT

- **Rx naloxone PRN for all patients on OST**
- NB: Do not prescribe OST if contraindications: head injury, acute respiratory depression, coma (see BNF)

Continuing community Rx:

- Rx usual dose once daily (divided dosing BD if cautions, patient preference, or to enable pain management)
- [*For patients on methadone*]: monitor for symptoms of withdrawal; if withdrawal symptoms persist, prescribe 5-10mg methadone PRN; max. daily dose increase 10mg, max. weekly dose increase 30mg

Initiating/re-titrating methadone:

DAY ONE

- Rx 20mg starting dose methadone
- Monitor for symptoms of withdrawal 4-hourly
- Rx additional 10mg PRN methadone 4-hourly up to 40mg total day-one dose
- If withdrawal symptoms persist, prescribe up to 60mg total day-one dose **under expert supervision**

DAY TWO ONWARDS

- Convert total day-one dose into daily prescription and Rx in divided doses (BD)
- Monitor for withdrawal symptoms; if withdrawal symptoms persist:
  - Increase dose by up to 10mg PRN every other day (max. weekly dose increase of 30mg over day-one dose); If day-one dose ≤40mg, can increase dose by up to 10mg on day two

Initiating/re-titrating buprenorphine:

DAY ONE

- **NB: Only administer buprenorphine when withdrawal symptoms are present**
- Rx 4mg buprenorphine
- Monitor for withdrawal symptoms 4-hourly; if withdrawal symptoms persist, Rx additional 2mg PRN (up to 8mg total day-one dose)

DAY TWO ONWARDS

- Convert total day-one dose into daily prescription and Rx once daily
- Monitor for withdrawal symptoms; Rx additional 4mg dose 4-hourly if required, up to 16mg day-two dose

Working with people who use drugs …

To feedback findings and iteratively develop a 'cultural safety' framework as well as other outputs and resources.

- Originating from NZ nursing practice, cultural safety aims to reduce health care practices that cause patients to feel unsafe and powerless.
- Requires providers to reflect on their own power & positioning, and how structural disadvantage and marginalisation can be reproduced in health care.
- It is the responsibility of the dominant health care culture to undertake process of change/ transformation to promote equitable health care access & outcomes.
- What constitutes cultural safety is defined from the perspective of those seeking or receiving care.
- Interactions with health care providers may be experienced by patients as unsafe despite the intentions of providers.

In summary

PWID in UK an aging population, high level of co-morbidities / mortality

- Fear and experience of opioid withdrawal in hospital is a barrier to timely presentation and treatment completion.

iHOST developed with PWUD (& clinicians, pharmacists, treatment providers)

- Co-produced, responsive to community needs
- Cultural safety: impetus on providers to examine & change practice

Hospital policies can underpin and perpetuate stigma towards PWUD

- This is a modifiable issue!
- Policy change is possible, and a positive first step toward improving hospital care for people who use drugs more broadly.

Please feel free to get in touch if you would like more information:

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Select references

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