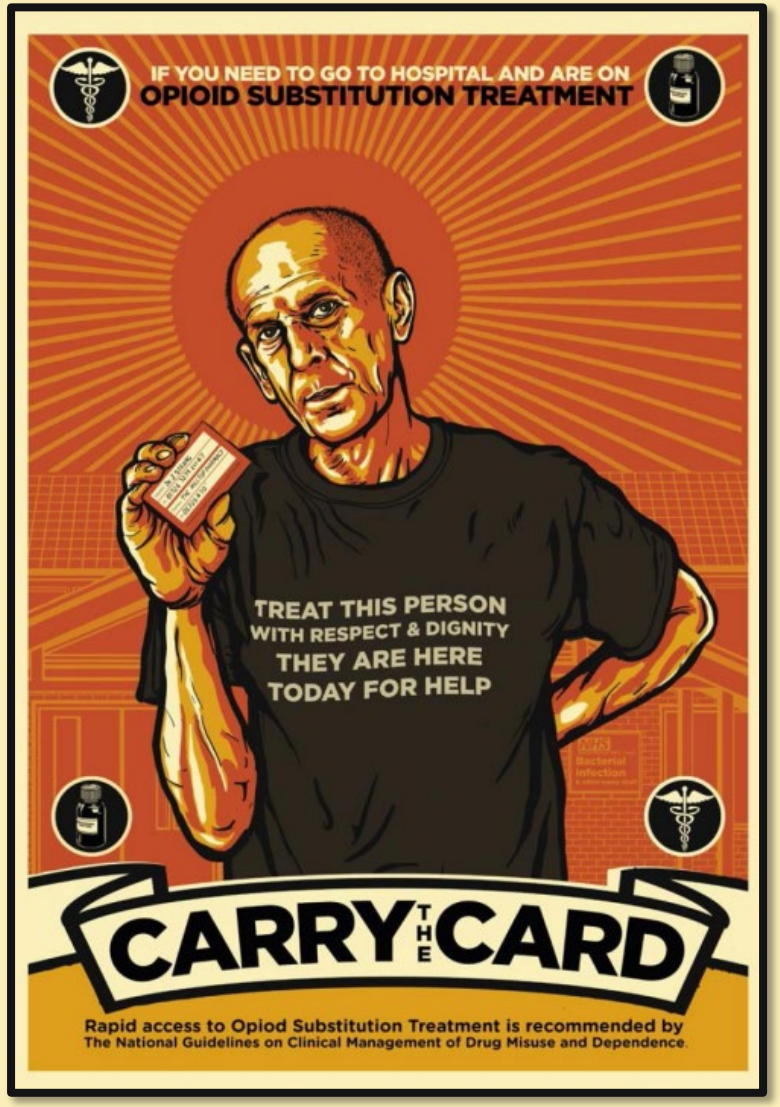
Improving opioid substitution treatment in the acute hospital setting

Prof Magdalena Harris, on behalf of the iHOST Study team

magdalena.harris@lshtm.ac.uk

https://www.lshtm.ac.uk/research/centres-projects-groups/ihost



LONDON SCHOOL of HYGIENE &TROPICAL MEDICINE

Faculty of Addictions Psychiatry Annual Conference, 27-28 April 2023, London

iHOST
Improving Hospital Opioid Substitution Therapy

Disclosures and Acknowledgments

Niamh Eastwood works for Release, which has received a grant from Ethypharm. All other iHOST study team members, including Magdalena Harris, have no conflicts of interest to declare.

We thank all community members with lived experience of opioid use & injecting who have contributed to this research. Including:

- Participants of the NIHR Care and Prevent Study
- Release staff & community members for contribution to policy review
- Policy working group members with lived experience of OST/opioid use
- iHOST peer experts group & advisory board members

Project impetus: Care & Prevent study findings

The **Care & Prevent study** explored SSTI prevention, risk & care among **455 PWID** in London (2017-20) [1]

SELECT FINDINGS:

- High reported lifetime prevalence of skin, soft tissue & venous infection (SSTVI): **68%** (310/455) [2]
- High proportion hospitalised for SSTVI: **44%** (137/310): associated with care delay (54% >5 days, 28% >10 days)
- Fear & experience of opioid withdrawal in hospital a primary barrier to treatment presentation & completion

➢ **iHOST (improving hospital OST) a co-produced response to this problem: commenced March 2022**

Today - ONE YEAR ON – I will share project impetus and progress, highlighting success in **policy change** ☺

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

Care & Prevent

Survey Participants

n=455

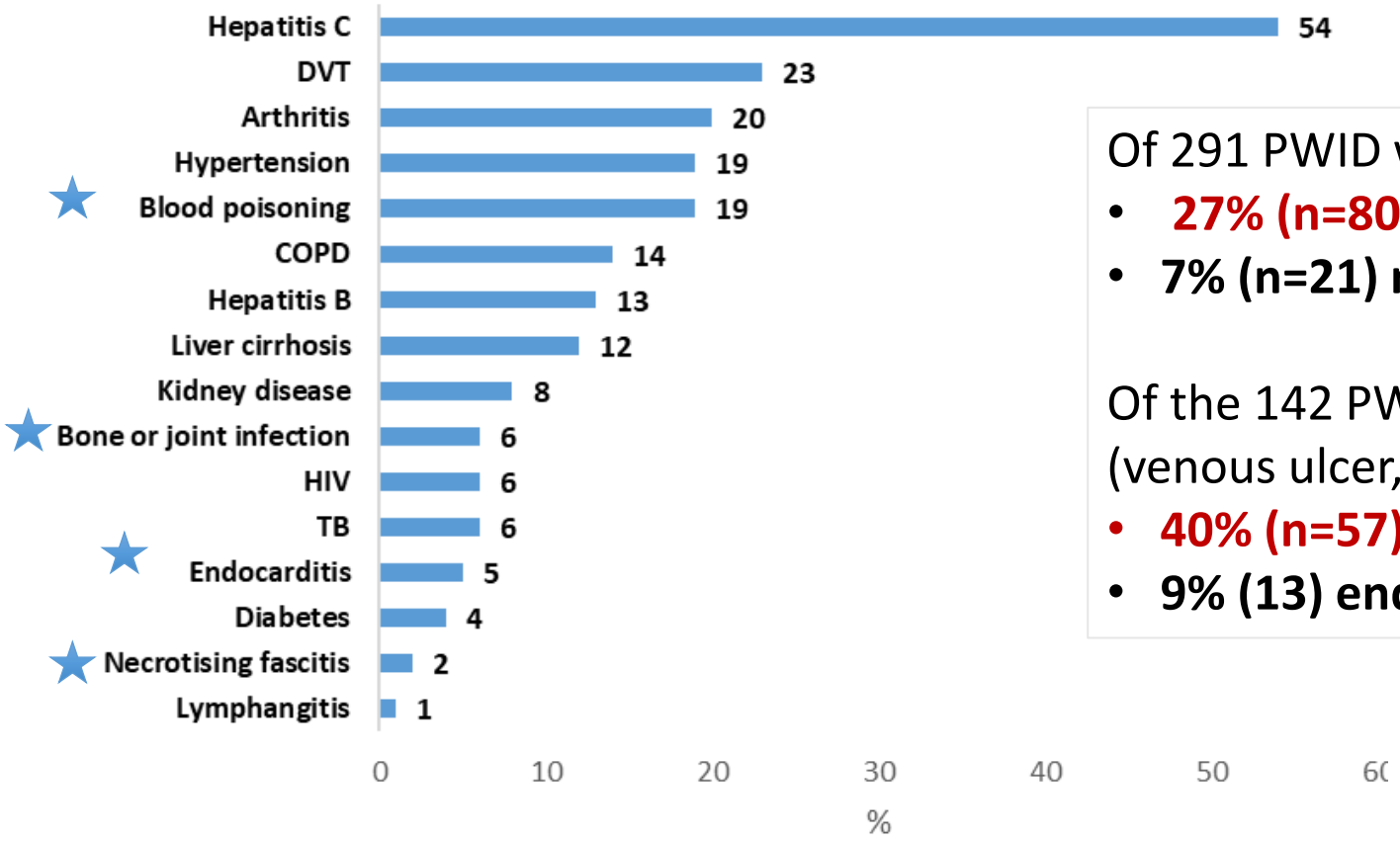
2018-19

	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

Opioid withdrawal: barrier to treatment access & completion [1]

- Medical care avoided: *"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 drugs / money: *"As long as I didn't have the money I wasn't going to the hospital"*
- Scoring / preparing/ injecting illicit drugs in hospital: *"I was injecting in the PICC line while I was in hospital"*
- Self discharge due to withdrawal: *"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, 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 NHS 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"

iHOST (improving hospital OST): a co-produced response

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

INTERVENTION:

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

Primary outcome measures:

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

- Primary outcomes will be measured through analysis of routinely collected clinical data at the intervention sites, using comparative data from the national Hospital Episode Statistics (HES) database.
- A qualitative component will assess iHOST acceptability and identify local contextual factors that might impact uptake and outcomes

FUNDER: National Institute of Health Research (NIHR)

SITES & TIMELINE: (2022-25)

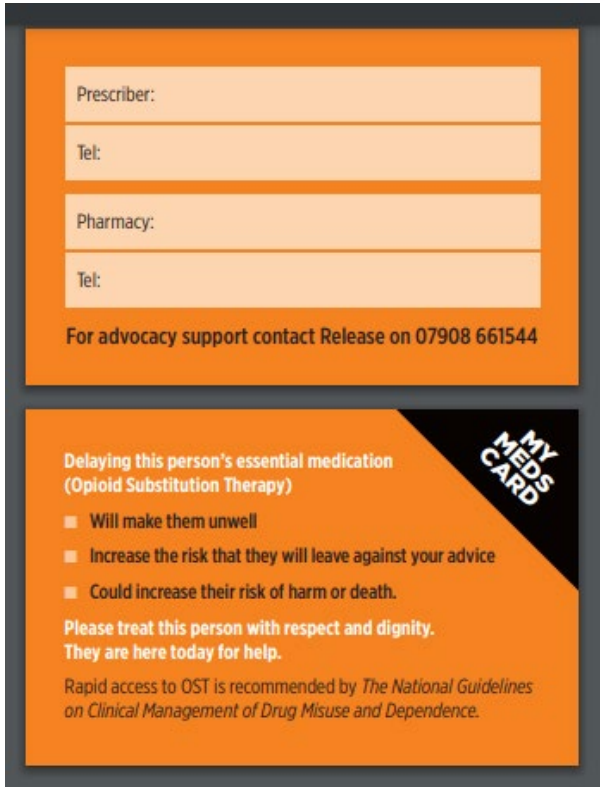
University College London Hospital: iHOST development: March – Oct 2022 | Feasibility testing: Nov 2022 – April 2023

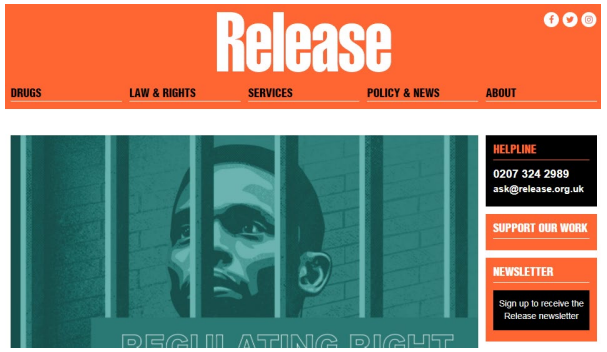
St James's University Hospital, Leeds; Royal Stoke University Hospital: iHOST evaluation May 23 – June 2024

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.

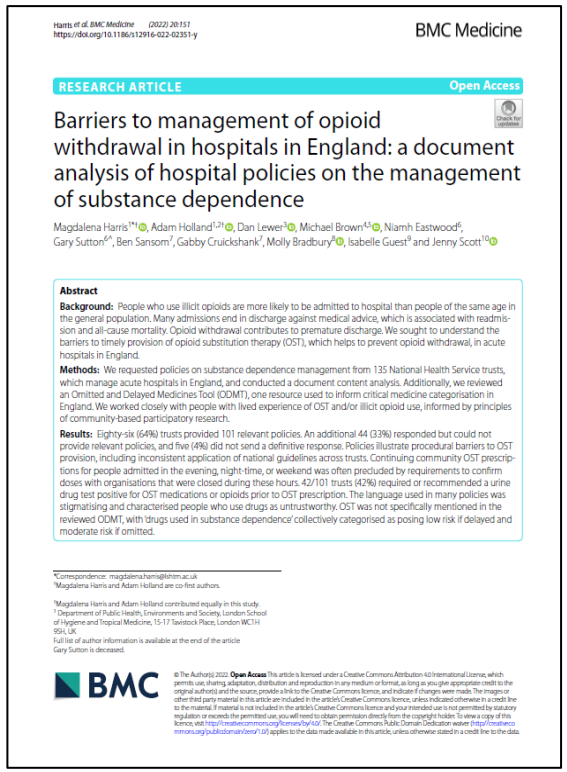
Champion role

- Role description developed with our dedicated UCLH nurses
- Aim: to help ensure iHOST is transferable to and sustainable in other settings without intensive research team input.

iHOST champion/s will:

- Be provided with enhanced training
- Encourage the adoption of iHOST
- Disseminate information regarding policy change & training availability
- Signpost to community drug teams and local pharmacies.

Akin to ‘link’ nurse role on wards.



Harris et al. BMC Medicine (2022) 20:151
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BMC Medicine

RESEARCH ARTICLE Open Access

Barriers to management of opioid withdrawal in hospitals in England: a document analysis of hospital policies on the management of substance dependence

Magdalena Harris[1*†], Adam Holland[1,2†], Dan Lewer[3], Michael Brown[4,5], Niamh Eastwood[6], Gary Sutton[6†], Ben Sansom[7], Gabby Cruickshank[7], Molly Bradbury[8], Isabelle Guest[9] and Jenny Scott[10]

Abstract

Background: People who use illicit opioids are more likely to be admitted to hospital than people of the same age in the general population. Many admissions end in discharge against medical advice, which is associated with readmission and all-cause mortality. Opioid withdrawal contributes to premature discharge. We sought to understand the barriers to timely provision of opioid substitution therapy (OST), which helps to prevent opioid withdrawal, in acute hospitals in England.

Methods: We requested policies on substance dependence management from 135 National Health Service trusts, which manage acute hospitals in England, and conducted a document content analysis. Additionally, we reviewed an Omitted and Delayed Medicines Tool (ODMT), one resource used to inform critical medicine categorisation in England. We worked closely with people with lived experience of OST and/or illicit opioid use, informed by principles of community-based participatory research.

Results: Eighty-six (64%) trusts provided 101 relevant policies. An additional 44 (33%) responded but could not provide relevant policies, and five (4%) did not send a definitive response. Policies illustrate procedural barriers to OST provision, including inconsistent application of national guidelines across trusts. Continuing community OST prescriptions for people admitted in the evening, night-time, or weekend was often precluded by requirements to confirm doses with organisations that were closed during these hours. 42/101 trusts (42%) required or recommended a urine drug test positive for OST medications or opioids prior to OST prescription. The language used in many policies was stigmatising and characterised people who use drugs as untrustworthy. OST was not specifically mentioned in the reviewed ODMT, with 'drugs used in substance dependence' collectively categorised as posing low risk if delayed and moderate risk if omitted.

*Correspondence: magdalena.harris@lshtm.ac.uk
†Magdalena Harris and Adam Holland are co-first authors.

‡Magdalena Harris and Adam Holland contributed equally in this study.
[1] Department of Public Health, Environments and Society, London School of Hygiene and Tropical Medicine, 15-17 Tavistock Place, London WC1H 9SH, UK.
Full list of author information is available at the end of the article
Gary Sutton is deceased.

Policy template

- Our review of 101 NHS Trust policies highlights procedural barriers to timely OST provision, discrepancies in approach & divergence from national clinical guidelines.
- Need for standardised ‘best practice’ template across NHS trust (‘postcode lottery’)
- Informed by evidence review & expert stakeholder input – iHOST Working Group & Policy Oversight Group with representation from key stakeholder organizations, including Addiction Professionals
- People with lived experience of opioid dependency actively involved throughout.

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:

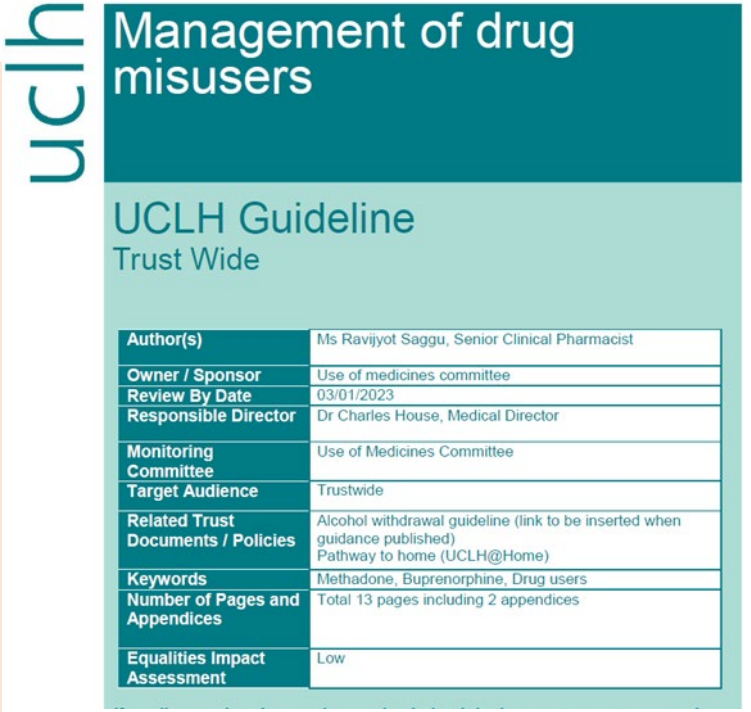
- Some instructed that a patient should be made to speak or swallow water to prove they were not holding OST in their mouth
- One maternity guideline stated that new mothers must be informed that if a test were positive, they might be discharged while their baby remains in hospital until fit for discharge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

Development of best practice policy

- Drawing on policy review, clinical evidence, consultations with hospital staff & people who use opioids
- Working group convened (clinicians, community members, prescribers etc): workshopped each policy point
- Oversight group convened: representatives 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.*

UCLH Guidelines as a template: 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

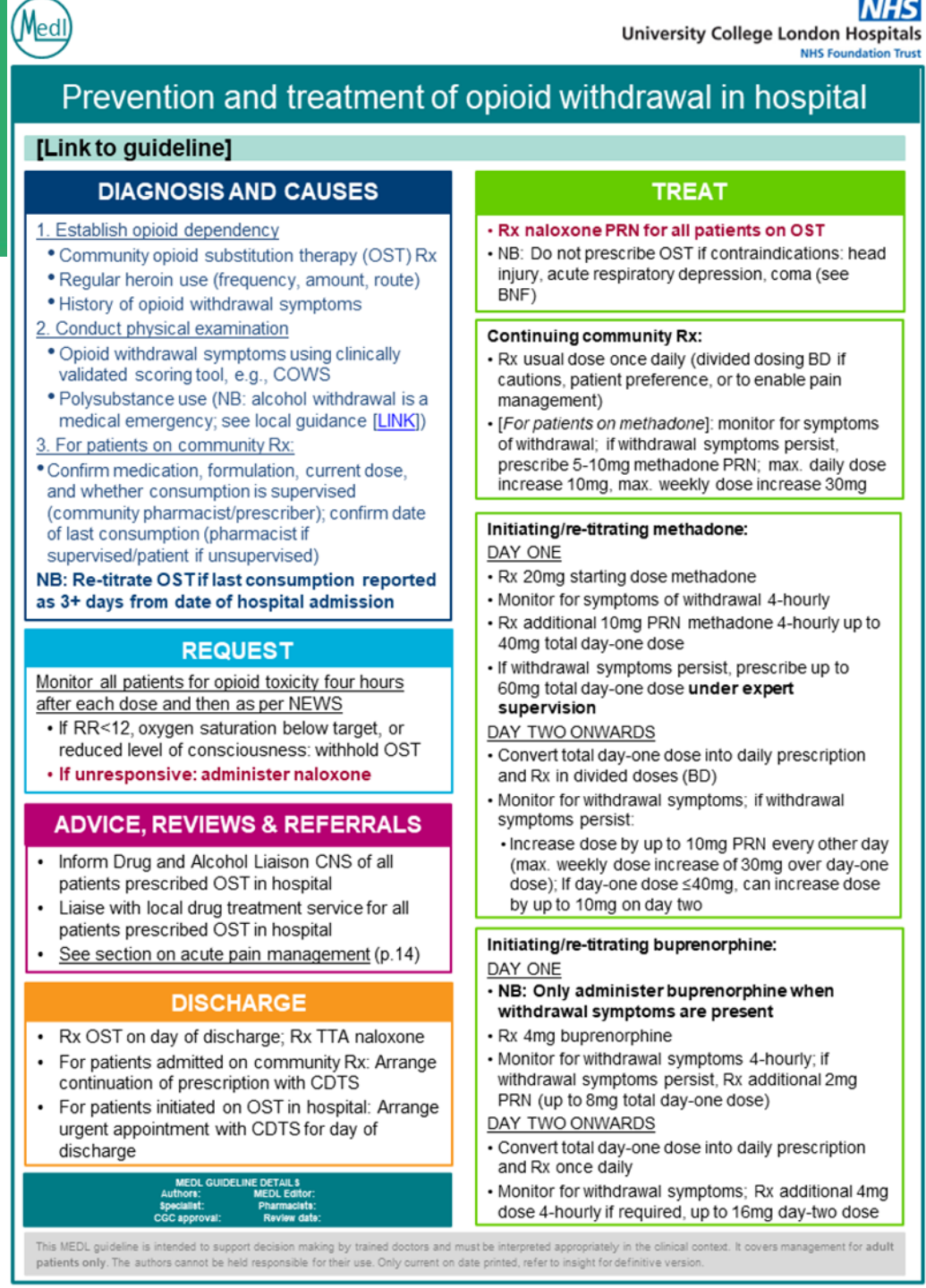
University College London Hospital Guideline revision

Key changes:

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 three UCLH guidelines committees

"There were claps & cheers from the Acute Medical Unit staff when we introduced the changes. Claps & cheers!!"



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

UCLH launch!
15 Sept 2022

Delaying or failing to offer OST can contribute to decreased tolerance, thereby putting the patient at risk of fatal overdose upon discharge.

"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. By the time I wait for the doctor I'm sick as a dog, so I end up checking myself out to go and get drugs."

"I went to the hospital three times but I weren't on script, I weren't on Methadone and they weren't going to give me no Methadone

UCLH is championing change!
What are we doing?

UCLH have changed policy. Urine drug tests are no longer required prior to methadone prescription. If we make it easier to get methadone in hospital more of those who need treatment will seek our help.

UCLH are prioritising opioid withdrawal management. Delivering high quality care will prevent discharge against medical advice and retain vulnerable people in care.

We have produced patient advocacy cards & helpline for people who use illicit opioids.

We are providing staff training to improve therapeutic relationships with people who use drugs; this will enable you to feel more confident in managing and preventing what can be challenging situations.

Together we can improve care for people who use drugs
Watch out for:

Patient advocacy cards & helpline
UCLH OST champions
Staff training
Policy change!

Driving principles

MEANINGFUL COMMUNITY INVOLVEMENT

PEER-LED/ PEER-OVERSIGHT

- Proposal informed by lived experience, research with people who use drugs & community consultation
- People with **current experience** of opioid use/OST on advisory board, policy working group & PPI lead
- Peer experts group: 4 men & 2 women (current OST/ opioid use) meet regularly to oversee project progress, provide feedback, co-produce **cultural safety framework & develop resources**

TRANSFORMATIVE / SYSTEMIC CHANGE

CULTURAL SAFETY PRINCIPLES

- 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 receiving care in terms of what makes them feel safe or unsafe in a healthcare setting
- Interactions with providers may be experienced by patients as unsafe despite the intentions of providers.

A focus for the delivery of quality care through changes in thinking about power relationships and patients' rights

Cultural safety framework

"When I had heart surgery, and I wasn't fully under, I heard the surgeon say 'Another bloody junkie'"

"You can't even be comfortable disclosing your drug use at a drug service, never mind at a hospital!"

Respectful language: *"I really appreciate when someone says 'substance use' rather than 'substance misuse"*

Clear communication: *"to have knowledge of what time the dose will come"*

Foreground trust: *"If I tell you I'm in pain, I'm in pain – not everything is drug-seeking behavior"*

Patient choice: "*make the offer', 'ask if I prefer split doses'*

Discretion & confidentiality: *"don't announce to the whole ward that I am getting my methadone"*

Dignified care: "*She gave me methadone in a syringe … [like] an animal at a vet, that's what I felt"*

"I feel like they, as medical professionals, they convince themselves they don't have attitudes about who gets treated – they tell themselves that all the time to go to work every day – that they treat everyone equal - how to make them confront that?"

Next steps / discussion

iHOST implementation/evaluation @ James's Uni Hospital, Leeds & Royal Stoke Uni Hospital: May 23 – Jun 24

- Policy process complex but rewarding! Considerable interest from other hospitals
- Issue of 'intervention spread' (to share or not?)
- Evidence of policy impact at UCLH, less so regarding cards, helpline & champion role
- 'Intervention spread' (cards to other hospitals) /internal (workload) & external factors (service recommissioning)

- DAMA still happening – complexities informing self-discharge
- Cultural safety framework an ongoing iterative process – is this concept the best to think with?
- How best to inform practitioner self reflection & cultural change throughout NHS hospitals?

"Is there something that makes themselves ask the question – are my prejudices rising to the top here? Is this based on fact what I'm thinking? Am I bringing my own morals or religion to this decision?"

In summary

- Fear and experience of opioid withdrawal in hospital is a barrier to timely presentation and treatment completion.
- Hospital policies can underpin and perpetuate stigma towards people who use drugs
- Reviewed NHS Trust policies were inconsistent throughout the UK, many included procedural barriers to timely withdrawal management.
- 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.**

Our guideline aims to:

1. **Default to trust:** counter discriminatory attitudes toward people who use drugs
2. **Re-orientate perceptions of risk:** apply a more balanced assessment of risk/benefit, where risk also includes the risks of not prescribing OST
3. **Remove harmful and stigmatizing language:** use person-first terminology
4. **Move toward parity with other patient groups:** consulting with people who use drugs as part of the policy development process

Select references

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The Care & Prevent study participants, participating drug treatment services & Research Assistants: Rachael Braithwaite & Talen Wright

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