

Re-orientating institutional perceptions of risk to meet the needs of people who use drugs: from Care & Prevent to iHOST

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*Organisational Abuse - Where is the Line? London
Network of Nurses & Midwives Conference, 9th June 2023*

Some context: From Care & Prevent to iHOST

Drug deaths have hit record high in England and Wales, says ONS

Figures for 2019 surpass 2018's record level, with rise affecting women more severely

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



		Men (341, 75%)	Women (114, 25%)	Total (n= 455)
<p>Care & Prevent</p> <p>Survey</p> <p>Participants</p> <p>n=455</p> <p>2018-19</p>	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)	182 (53% 61%)	43 (38% 47%)	225 (49% 58%)
	heroin	129 (37% 29%)	70 (61% 53%)	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

Barriers to treatment: exacerbating harm

We asked about severity of 'worst infection' (using illustrative photos)
Severe abscess (36%) or cellulitis (22%) associated with >10 days to access care¹

Barriers to care: addressing stigma is crucial (we know this)
BUT we need to **take fear of opioid withdrawal** seriously²

➤ Pain normalised, hospital avoided until near death situation

“Severe pain [for 3 weeks] ...then I had a fever ...eventually my girlfriend phoned the ambulance ... Scared, it's the fear of the not having drugs at the time ...I wasn't on the script, no.”

➤ Stockpiling money/drugs before seeking care

“As long as I didn't have the money I wasn't going to hospital”

➤ Self discharge **due to withdrawal** common

“So going out [leaving hospital], sick as a dog, arm bandaged up, I have to go out and find some money to get high ...”



Normalised pain and severe health care delay among people who inject drugs in London: Adapting cultural safety principles to promote care

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 <i>For alcohol or opioid dependence</i>	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.”



BMC Medicine

Research article | [Open Access](#) | Published: 14 April 2022

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

[Magdalena Harris](#) , [Adam Holland](#), [Dan Lewer](#), [Michael Brown](#), [Niamh Eastwood](#), [Gary Sutton](#), [Ben Sansom](#), [Gabby Cruickshank](#), [Molly Bradbury](#), [Isabelle Guest](#) & [Jenny Scott](#)

BMC Medicine 20, Article number: 151 (2022) | [Cite this article](#)

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 <u>nil</u> or minor intervention <u>required</u> ; 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 <u>nil</u> or minor intervention <u>required</u> ; 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

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 Ravijot 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

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

“Misuser”, “Abuser”, “Addict”

“Sanctions”

Maintaining “a degree of suspicion”

Regular drug testing

Supervised consumption

Behavioural contracts


The risk of inaction: additional work ...

PLOS MEDICINE

 OPEN ACCESS  PEER-REVIEWED

RESEARCH ARTICLE

Fatal opioid overdoses during and shortly after hospital admissions in England: A case-crossover study

Dan Lewer , Brian Eastwood, Martin White, Thomas D. Brothers, Martin McCusker, Caroline Copeland, Michael Farrell, Irene Petersen


Discharge from the hospital is associated with an acute increase in the risk of opioid-related death, and **1 in 14 opioid-related deaths in England happens in the 2 weeks after the hospital discharge**. This supports interventions that prevent early discharge and improve linkage with community drug treatment and harm reduction services.

PLOS ONE

 OPEN ACCESS  PEER-REVIEWED

RESEARCH ARTICLE

Opioid-related deaths during hospital admissions or shortly after discharge in the United Kingdom: A thematic framework analysis of coroner reports

Dan Lewer , Thomas D. Brothers, Magdalena Harris, Kirsten L. Rock, Caroline S. Copeland

Hospital admissions are associated with acute health crises that **increase the risk of fatal overdose for patients who use illicit opioids**. Hospitals need guidance to help them care for this patient group, particularly in relation to **withdrawal management**, harm reduction interventions such as take-home naloxone, discharge planning including continuation of opioid agonist therapy during recovery, management of poly-sedative use, and access to palliative care.

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

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)

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 DETAIL \$
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

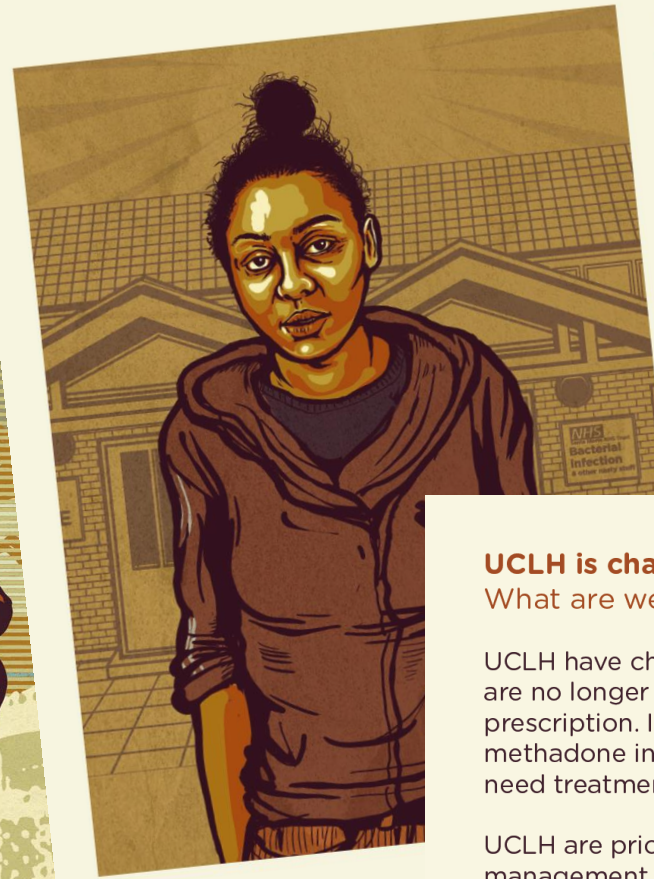
UCLH launch! 15 Sept 2022



University College London Hospitals
CHAMPIONING CHANGE



UCLH is leading a national NIHR-funded project: **improving Hospital Opioid Substitution Therapy (iHOST)**



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 I couldn’t stay in the hospital because I’d be...”

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!



Delaying this person's essential medication (Opioid Substitution Therapy)

- Will make them unwell
- Increase the risk that they will leave against your advice
- Could increase their risk of harm or death.

Please treat this person with respect and dignity. They are here today for help.

Rapid access to OST is recommended by The National Guidelines on Clinical Management of Drug Misuse and Dependence.

MY NEEDS CARD

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 for & by people who use drugs in hospital

Respectful language: *“I really appreciate ‘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”*

How to encourage reflective practice?

“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: re-orientating risk

- Fear & experience of opioid withdrawal in hospital is a barrier to timely presentation and treatment completion for people who use drugs
- NHS hospital policies can perpetuate stigma towards people who use drugs, and increase risks associated with opioid withdrawal
- Hospital discharge is associated with increased risk of opioid-related death: withdrawal management, TTA naloxone & continuity of care key
- Policy change is possible, and can be a positive first step towards improving care for people who use drugs more broadly

Our guideline aims to:

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



Closing thoughts – reflection on conference theme

Organisational Abuse - Where is the Line?



- Policy change and training all very well, but how to encourage reflective practice and systemic change in a complex environment, often hostile to people who use drugs?

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

- People who use drugs are often profoundly disempowered in a hospital environment; fear can manifest as aggression and hypervigilance to stigma is common.
- Just as not all stigmatising practice is purposeful, neither are all self-discharges!

"We asked [nurse] about whether patients were informed of the '4 hour rule' whereby they lose their bed if they are away for 4 hours or more. No, they were not told explicitly she said – but why should they be - 'they are competent adults', 'they should know that this is not a hotel', they can't leave / come and go and then expect to still have their bed there. We asked how this would then be recorded – she said as 'absconding'"

- Clear respectful communication, flexibility & small acts of kindness can save lives

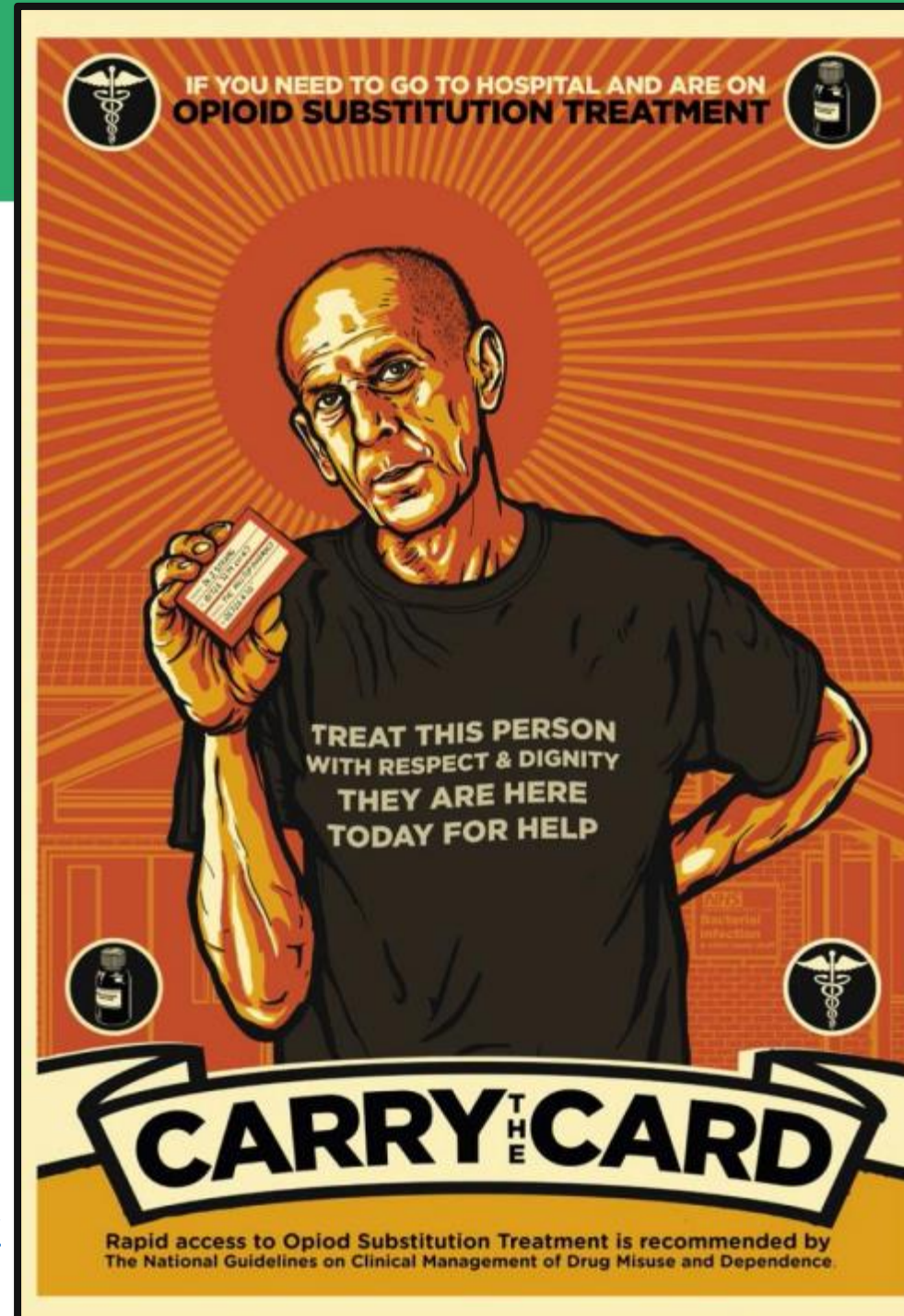
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