Barriers to Management of Opioid Withdrawal in Hospitals in England: A Document Analysis of Hospital Policies

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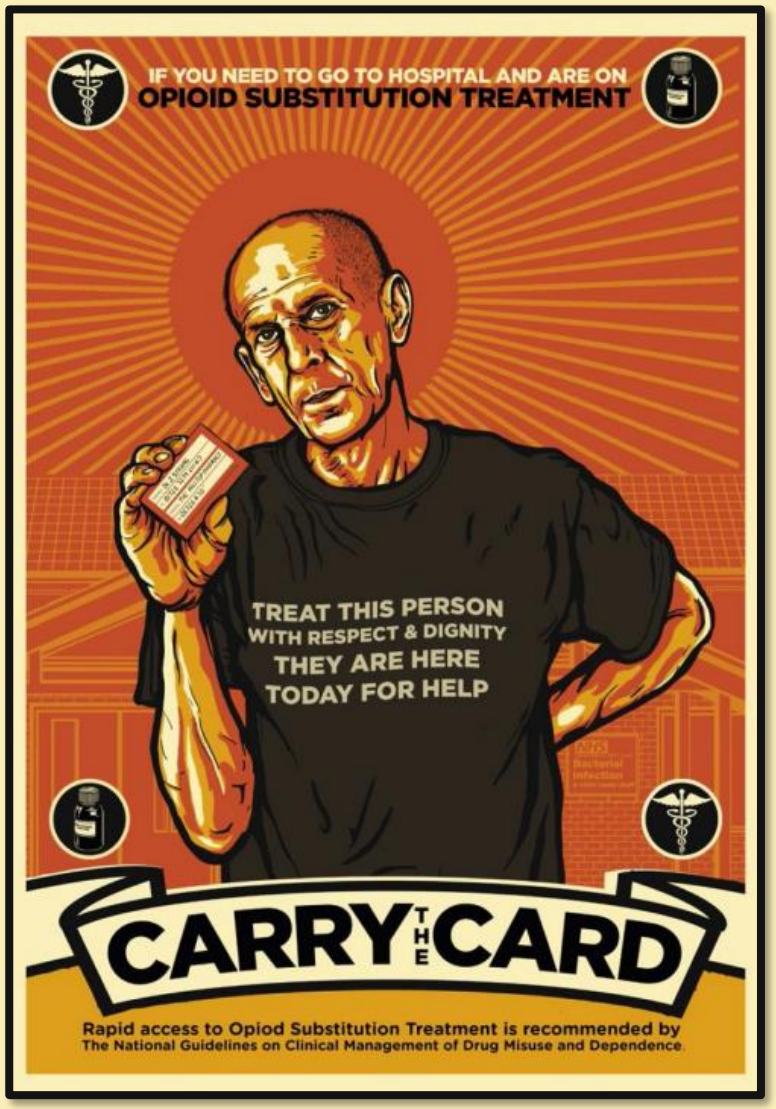

LONDON SCHOOL of HYGIENE &TROPICAL MEDICINE

iHOST
Improving Hospital Opioid Substitution Therapy

INHSU Conference
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Glasgow

Disclosures and Acknowledgments

- Niamh Eastwood works for Release, which has received a grant from Ethypharm. All other authors have no conflicts of interest to declare.

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.

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 [3]

> *"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

- With Release, we requested substance dependence guidelines from 224 acute NHS hospital trusts.
- 86 trusts provided 101 relevant policies: 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

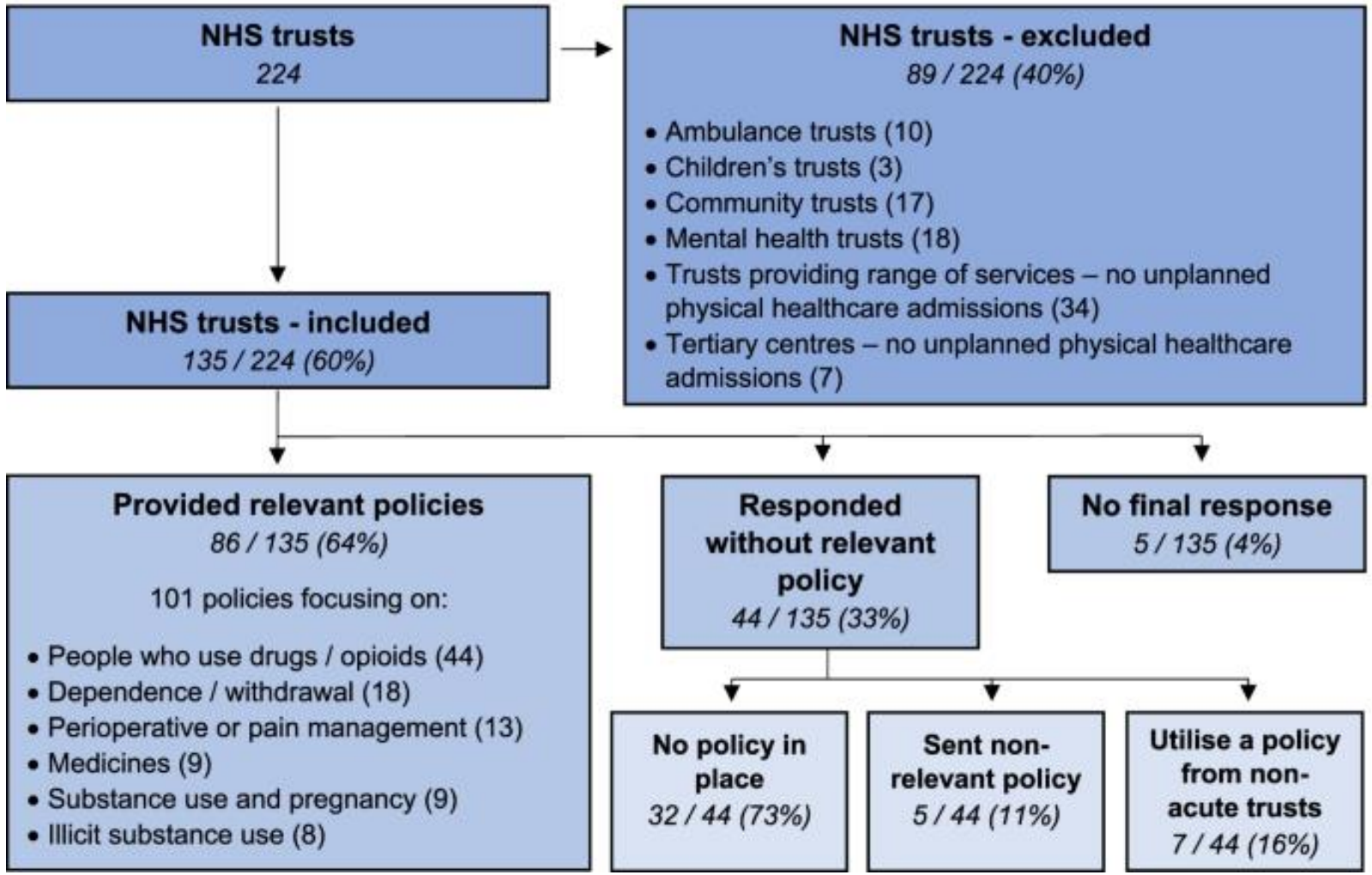
People who inject drugs

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

The iHOST intervention

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

Document analysis of NHS Trust Policies

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

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Recruitment

- 224 NHS Trusts contacted 10/19 - 07/21 (follow-up post-pandemic) requesting policies on substance dependence management under Freedom of Information Act 2000.

Inclusion

- Trusts: acute physical health admissions
- Policies: in use January 2020, ref opioid withdrawal and/or OST provision.

Analysis

- Collaborative: community members
- Thematic content analysis

Key Findings

Continuity of care: community prescriptions

All trusts: need to confirm usual doses with community services (3/86 required written confirmation).

- Only 18/86 trusts gave other options – e.g. previous hospital notes, online databases.
- Verification often not possible out of hours
  - 17/86 trusts gave no guidance on what to do; 6/86 explicitly stated no OST should be prescribed

New or unconfirmed prescriptions

- Unconfirmed prescriptions usually treated the same as new prescriptions.
- 67/86 trusts described regimen for OST initiation. 5/86 prohibited it.
- 14/86: no mention or no practical information on how initiate OST
- Initiation regimens varied – 12 trusts limited dose to 30mg on day one, 2 trusts limited to 20mg. Often restrictions on subsequent dose increments.

Key Findings

Procedural barriers to timely OST

- Requirements for **particular staff or specialist teams** to assess patients and prescribe OST.
  - 32/86 trusts specified drug liaison teams: benefits, but barrier if team not available out of hours.
- 42 Trusts required (27) or recommended (15) **urine tests** prior to OST prescription: Only 10 stated POC
  - 14 required +ve urine drug test prior to OST regardless of whether community prescription confirmed.
  - Limitations of drug tests (risk of false negatives) often not highlighted or downplayed.

Discharge

- 11/86 trusts did not highlight importance of promptly restarting community prescriptions post-discharge.
- 26/78 trusts where OST initiation was mentioned: no information on facilitating OST continuation.
- 29/86 trusts did not mention or prohibited take away OST when discharged out of hours

One policy stated hospitals should not arrange continuation of new prescriptions and patients should self-refer.

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

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

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

Best practice policy – Process outcome and key wins

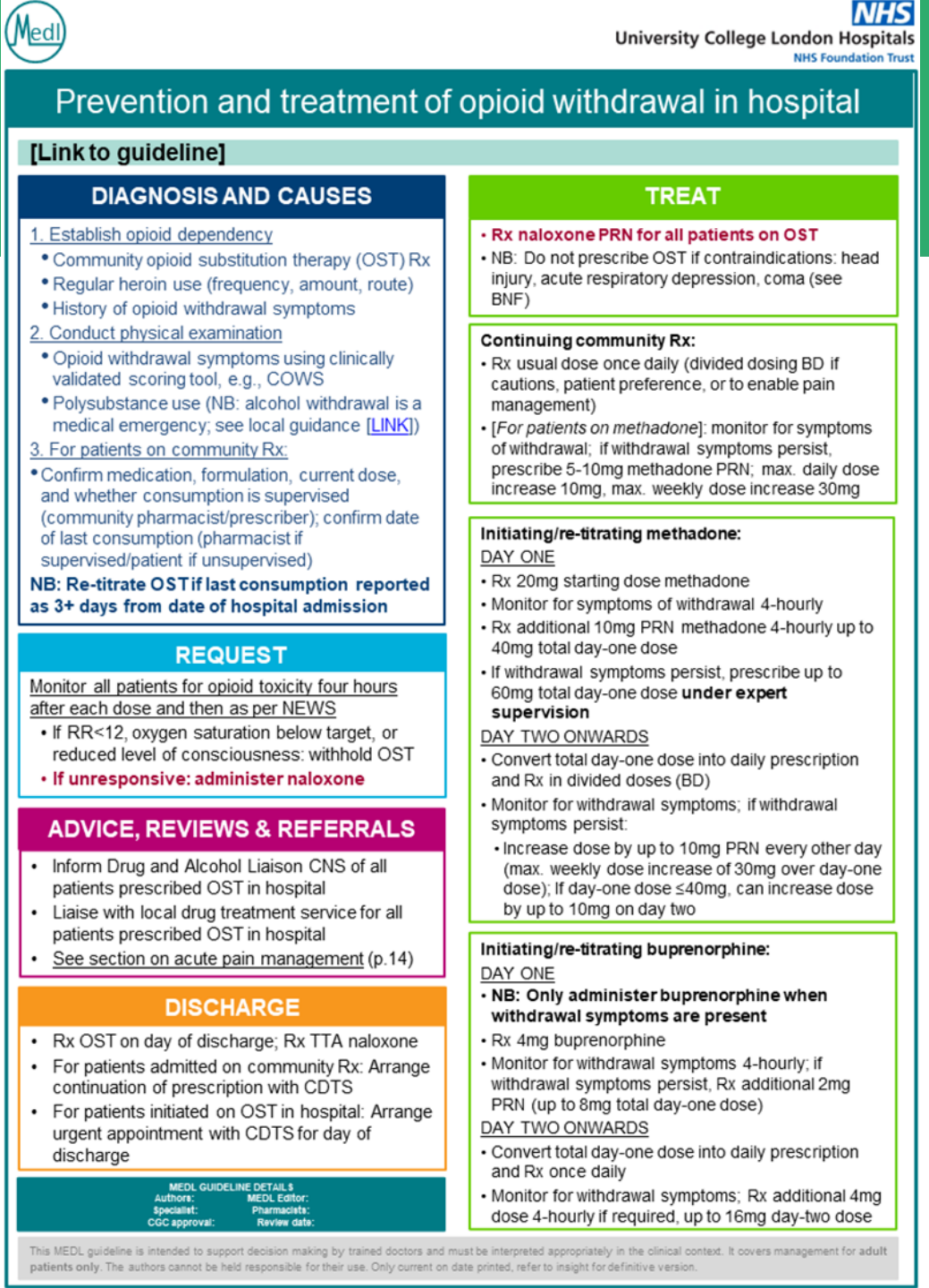
University College London Hospital amended in line with best practice template:

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

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 PWUD
- 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 to:

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

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