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

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Disclosure of interest & acknowledgement

The presenter & team have no conflicts of interest to declare

We wish to thank the participants of the Care & Prevent study, people who inject drugs in London, for their generous participation in this research.

Study context : England & austerity

- From 2012: 50% increase in opioid-related deaths
- Annual rise in injecting-related hospitalisations [1]

- ~10% PWID **hospitalised** for skin & soft tissue infections (SSTI) annually: barriers to timely care
- Fatal overdose x4 higher after hospital discharge [2]

- **Care & Prevent study** explored SSTI prevention, risk & care among 455 PWID in London (2017-20) [3]
- Opioid withdrawal: **barrier to care access & completion**

- **iHOST study** – aiming to improve hospital care for PWID

Survey participants (n=455)

Demographics comparable with national surveillance data [4]

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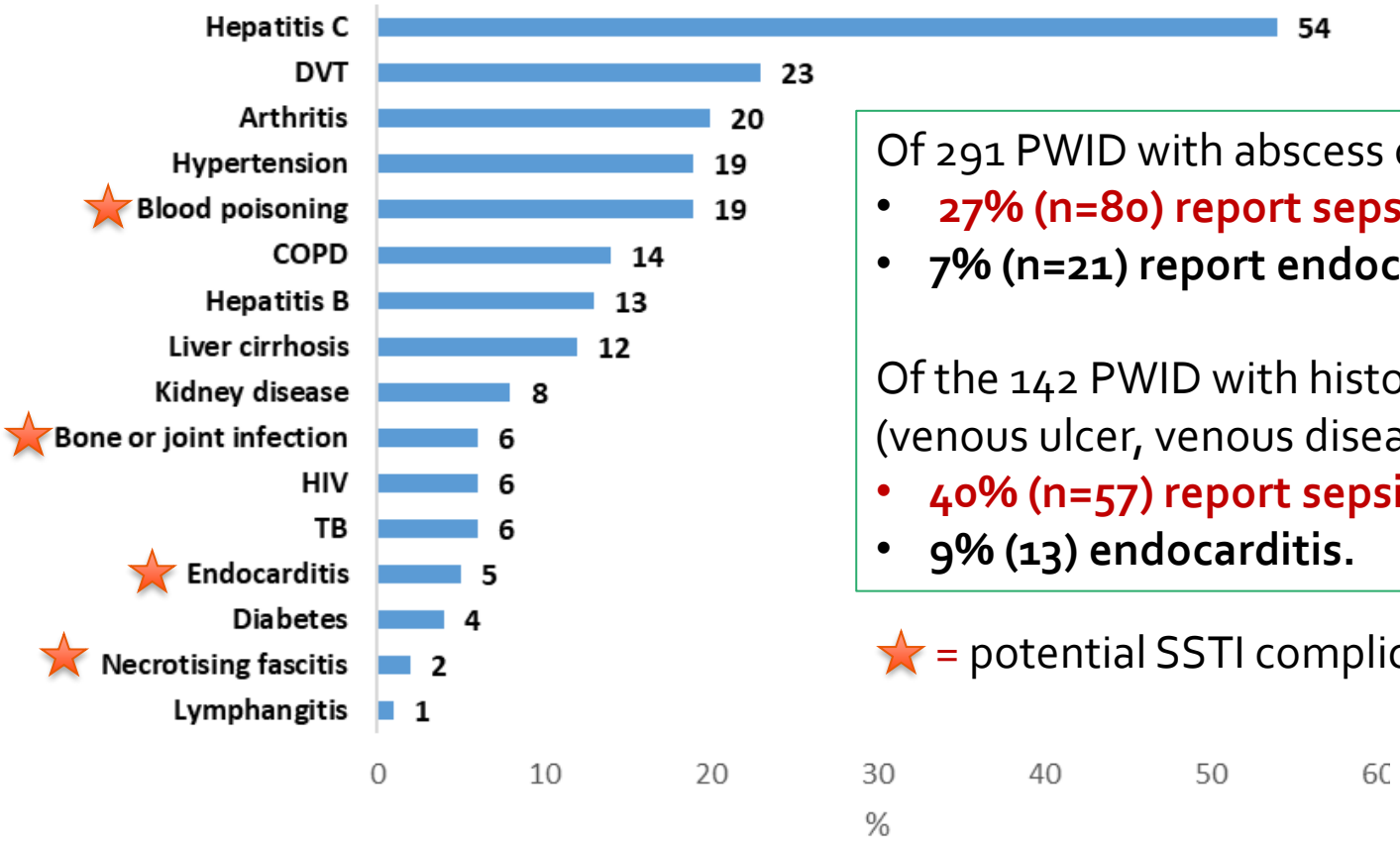
	Men (341, 75%)	Women (114, 25%)	Total (n= 455)
Ethnicity: White British/white	248 (73%)	88 (77%)	336 (74%)
Age, range (mean)	21 - 68 (46yrs)	22 - 67 (44yrs)	21 - 68 (46yrs)
Injecting in past 12 months	224 (66%)	60 (53%)	273 (63%)
Mainly injecting: heroin & crack (past 12 months) heroin	182 (53% 61%) 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 (65%)**
Hospitalised for SSTVI above	96 (28%)	41 (36%)	**137 (30%)** **46% of 310**

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

- Time taken to seek medical advice independently associated with SSTVI severity [5]
- Most (94%) sought medical care: 54% (124) waited 5-9 days, **28% (83) waited 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

1) PWID incorporate serious injecting-related complications into daily lives [6]

"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." (Lee)

2) Medical care avoided: until emergency, usually instigated by someone else [6]

3) Fear of opioid withdrawal pervasive: a modifiable barrier to care [6]

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

"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."

Opioid withdrawal: barrier to hospital care access, safety & completion

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1) Stockpiling drugs / money before going to hospital

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

2) Scoring / preparing/ injecting illicit drugs in hospital common

"I was injecting in the PICC line while I was in hospital"

3) Self discharge due to withdrawal frequently reported [6]

"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."

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 from 135 acute hospital trusts.
- 86 trusts provided 101 relevant policies. 44/135 Trusts (33%) had no policy in place
- Of the 86: 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 PWID & policy makers

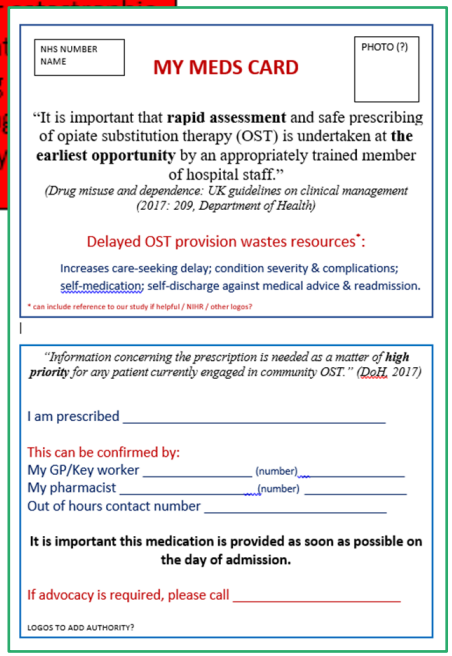
Specialist Pharmacy Service

	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 [illegible] long-term pat[illegible] with ongoing required; long length of stay

PWID

- Patient advocacy / info card
- Helpline
- Staff training module
- Policy template
- iHOST 'champion'

iHOST intervention



NHS NUMBER
NAME

PHOTO (?)

MY MEDS CARD

"It is important that **rapid assessment** and safe prescribing of opiate substitution therapy (OST) is undertaken at **the earliest opportunity** by an appropriately trained member of hospital staff."
(Drug misuse and dependence: UK guidelines on clinical management (2017: 209, Department of Health)

Delayed OST provision wastes resources*:

Increases care-seeking delay; condition severity & complications; self-medication; self-discharge against medical advice & readmission.

* can include reference to our study if helpful / NIHR / other logos?

*"Information concerning the prescription is needed as a matter of **high priority** for any patient currently engaged in community OST." (DoH, 2017)*

I am prescribed _____

This can be confirmed by:
My GP/Key worker _____ (number) _____
My pharmacist _____ (number) _____
Out of hours contact number _____

It is important this medication is provided as soon as possible on the day of admission.

If advocacy is required, please call _____

LOGOS TO ADD AUTHORITY?

The IHOST intervention

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

iHOST: improving hospital OST

AIM: To optimise OST management in hospital settings to reduce delayed presentation, self-discharge and emergency readmission among PWUD

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

Sites: London – development/testing

Leeds & Staffordshire – evaluation

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

Thinking with cultural safety

- 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.

- 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

- Hospitalisations for SSTI rising annually since austerity implementation

C&P highlights the role of OST delayed provision in hospital settings

- Late presentations, self-discharge, readmission, complex/intensive care

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

- Co-produced, responsive to community needs

Cultural safety : impetus on providers to examine & change practice

- CS framework to promote safety and equity of care for PWUD in hospitals.

iHOST due to start 2022! Thank you NIHR ☺

References

1. Lewer, D., Harris, M. & Hope, V. (2017). Opiate Injection-Associated Skin, Soft Tissue, and Vascular Infections, England, UK, 1997-2016. *Emerging Infectious Diseases.* 23(8):1400-1403. https://wwwnc.cdc.gov/eid/article/23/8/17-0439_article

2. Lewer, Dan, et al. (2021) Fatal opioid overdoses during and shortly after hospital admissions in England: A case-crossover study. *PLoS Med.* 18 (9) in press

3. Harris, M. *et al.* (2018) 'Care and Prevent': Rationale for investigating skin and soft tissue infections and AA amyloidosis among people who inject drugs in London. *Harm Reduction Journal.* 15(1):23 https://pubmed.ncbi.nlm.nih.gov/29739408/

4. Doran, J., et al. (2020). Factors associated with skin and soft tissue infections among people who inject drugs in the United Kingdom: A comparative examination of data from two surveys. *Drug and Alcohol Dependence.* 213: 108080 https://www.sciencedirect.com/science/article/abs/pii/S0376871620302453

5. Wright et al. (2020). Prevalence and severity of abscesses and cellulitis, and their associations with other health outcomes, in a community-based study of PWID in London. *PLOS One* 15(7):e0235350. https://pubmed.ncbi.nlm.nih.gov/32663203/

6. Harris, M. (2020). Normalised pain and severe health care delay among people who inject drugs in London: Adapting cultural safety principles to promote care. *Social Science and Medicine,* 260:113183 https://pubmed.ncbi.nlm.nih.gov/32682207/

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