DR SHAUN JACKSON
HOMELESS HEALTHCARE

HOMELESSNESS

HOSPITAL DISCHARGE
DR SHAUN JACKSON

* HOMELESS PATIENTS/NFA
* PATIENTS WITH COMPLEX/CHAOTIC LIVES
* HIGH LEVELS OF SUBSTANCE MISUSE

URBAN VILLAGE MEDICAL PRACTICE MANCHESTER

HOMELESS HEALTH CARE

* PRIMARY CARE BASED HEALTH SERVICE FOR HOMELESS PEOPLE – MANCHESTER CITY CENTRE

* HOSPITAL INREACH/DISCHARGE SERVICE FOR HOMELESS PEOPLE ADMITTED MANCHESTER ROYAL INFIRMARY

HOMELESS HEALTHCARE

* PERMANENT GP REGISTRATION
* MDT APPROACH TO HEALTHCARE
* DRUG WORKERS/MENTAL HEALTH/NURSES/HOUSING WORKERS/OUTREACH

MDT STREET OUTREACH

HEALTH INEQUALITIES/POOR ACCESS TO HEALTH CARE

- THE AVERAGE AGE OF DEATH OF A HOMELESS MAN IS 47, AND FOR A HOMELESS WOMAN IS 43

- ATTEND A&E 8 X MORE
- 4 X MORE LIKELY TO BE ADMITTED
- STAY 3 X LONGER
- 3 X MORE LIKELY TO BE READMITTED

- DIE OF TREATABLE MEDICAL PROBLEMS

THE IMPACT OF HOMELESSNESS

- 3057 A&E PRESENTATIONS BY HOMELESS PEOPLE IN 2017
- 25% OF THE CURRENT TOP 100 FREQUENT ATTENDERS AT MRI ARE HOMELESS
- 608 HOMELESS INPATIENTS WERE ASSESSED BY THE HOSPITAL HOMELESS TEAM IN 2016

HEALTH PROBLEMS OF HOMELESS PEOPLE

* 80 % MENTAL HEALTH PROBLEM
* 70% DRINK ALCOHOL TO HARMFUL LEVELS
* 60% HEROIN PROBLEM/POLY DRUG PROBLEM
* 60% HEPATITIS C INFECTION

* 70% HAVE ALL 4 HEALTH PROBLEMS

URBAN VILLAGE MEDICAL PRACTICE

* 900 HOMELESS PATIENTS REGISTERED
* 70 % WILL HAVE SUBSTANCE MISUSE PROBLEM
* 220 PEOPLE IN DRUG TREATMENT/SHARED CARE WITH DRUG SERVICE
* GPS ARE TRAINED IN DRUG MISUSE TREATMENT
* CLEAR EVIDENCE BASED APPROACHES TO AREA OF CARE

POSITIVE HEALTHCARE

POSITIVE HEALTHCARE

* AIM IS TO ADDRESS HEALTH INEQUALITIES
* DEVELOPING POSITIVE RELATIONSHIPS WITH PATIENTS TO ACHIEVE ONGOING HEALTHCARE AND CONTINUITY
* HOMELESS PEOPLE ARE EXTREMELY INTERESTED IN THEIR HEALTH/VALUE GOOD HEALTHCARE
* LIVE LONGER AND HEALTHIER

HOSPITAL INREACH SERVICE

* WORK COLLABORATIVELY WITH HOSPITAL TEAMS TO ACHIEVE A SUCCESSFUL HOSPITAL TREATMENT PLAN
* DAILY GP LEAD WARD ROUND/NURSE/HOUSING WORKER
* CENTRAL ROLE IN GUIDING MANAGEMENT/PRESCRIBING IN SUBSTANCE MISUSE
* HOLISTIC PLAN WHICH INCLUDES A FRAMEWORK FOR DISCHARGE/ONGOING MANAGEMENT/FOLLOW UP IN THE COMMUNITY

INREACH SERVICE INTERVENTIONS DECEMBER 2017

Attendance/admissions at MRI	June 2013	Dec 2013	% change
Number of cohort in top 100 attenders list	**29**	**15**	**DOWN 48%**
Total number of attendances by cohort	**641**	**338**	**DOWN 47%**
Total number of admissions by cohort	**64**	**33**	**DOWN 48%**
Total number of bed days by cohort	**173**	**105**	**DOWN 39%**
Total number of readmissions within 28 days	**23**	**7**	**DOWN 59%**

www.pathway.org.uk

FACULTY
FOR HOMELESS AND
INCLUSION HEALTH

pathway
Healthcare for homeless people

THE INPATIENT STAY

* MANAGEMENT OF PAIN
* MANAGEMENT OF SUBSTANCE MISUSE
* MANAGEMENT OF INPATIENT STAY/ACUTE ISSUES
* SAFE PRESCRIBING
* SAFE DISCHARGE THAT MINMISES THE RISK OF HARM TO PATIENT IN THE COMMUNITY
* ASSISTING GP IN SAFE MANAGEMENT IN COMMUNITY

CASE STUDY

* DEREK 47 YEAR OLD MAN
* NFA/ROUGH SLEEPING CITY CENTRE OF MANCHESTER
* ADMITTED FOLLOWING FALL FROM SECOND FLOOR
* MULTIPLE FRACTURED RIBS / ESTU
* HEROIN USER IN COMMUNITY NOT ON TREATEMNT PROGRAMME

CASE STUDY

* INPATIENT FOR 7 DAYS
* MST 80 MG TWICE DAILY
* PREGABALIN 150 MG BD
* METHADONE 30 MLS DAILY
* ORAMOPRH PRN UP TO 120MG DAILY

* NURSING STAFF/JUNIOR DRS REPORTED DIFFICULT/DEMANDING OFTEN HOSTILE WHEN DISCUSSING PAIN RELIEF
* MFFD so plan was to discharge that day

WHAT ISSUES DOES THIS PRESENT

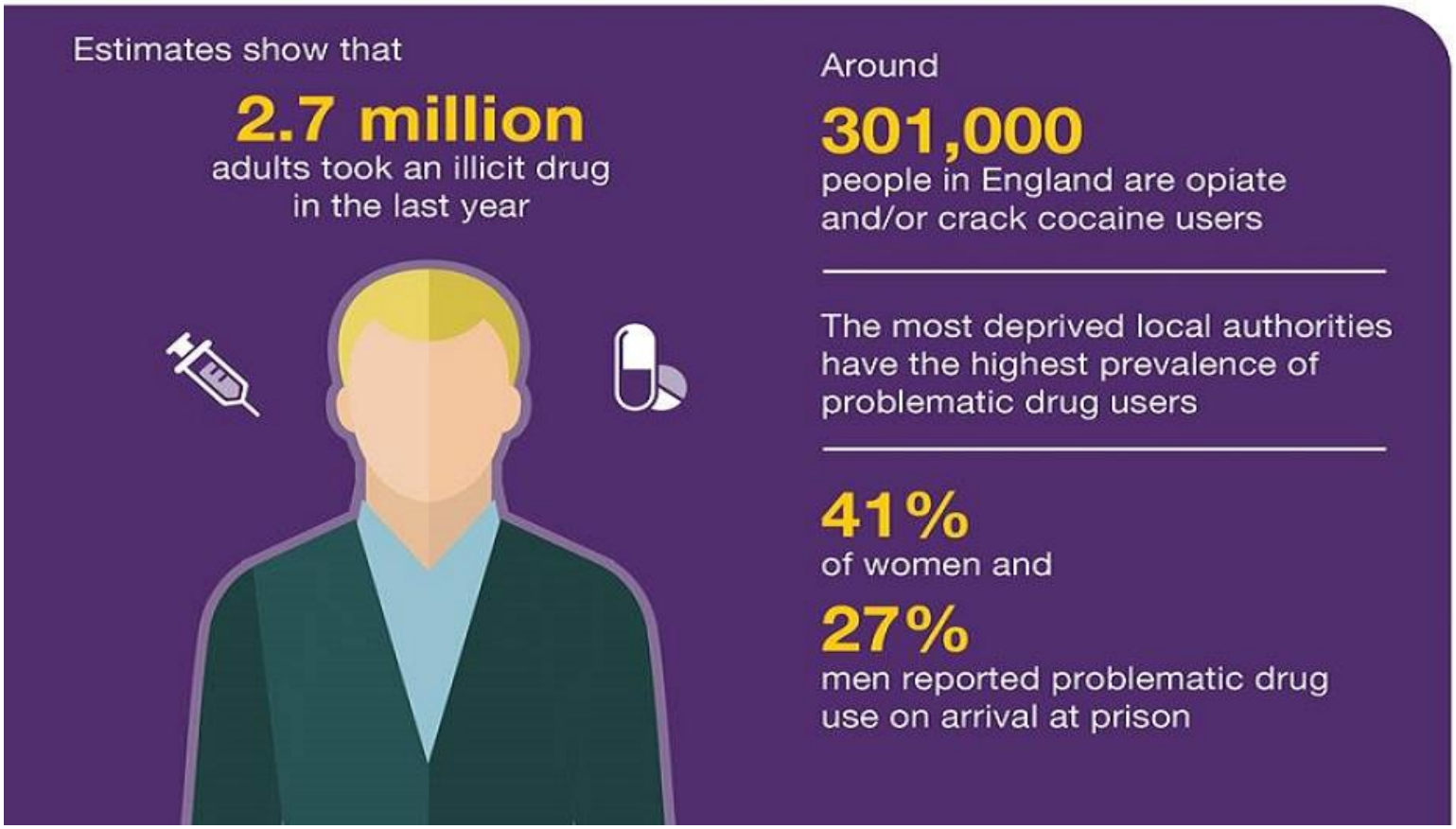
* HIGH POTENTIAL FOR HARM TO PATIENT ON DISCHARGE

* HOSPITAL AGENDA – "SURGICALLY FIT"/PRESSURE TO DISCHARGE
* JUNIOR DOCTORS AND PHARMACIST UNSURE
* PAIN TEAM CALLED LAST MINUTE AND GIVEN PROBLEM
* PAIN TEAM CALLED US

WHAT IT IS TO BE HOMELESS

Public Health England

Drug use is widespread but dependence is concentrated



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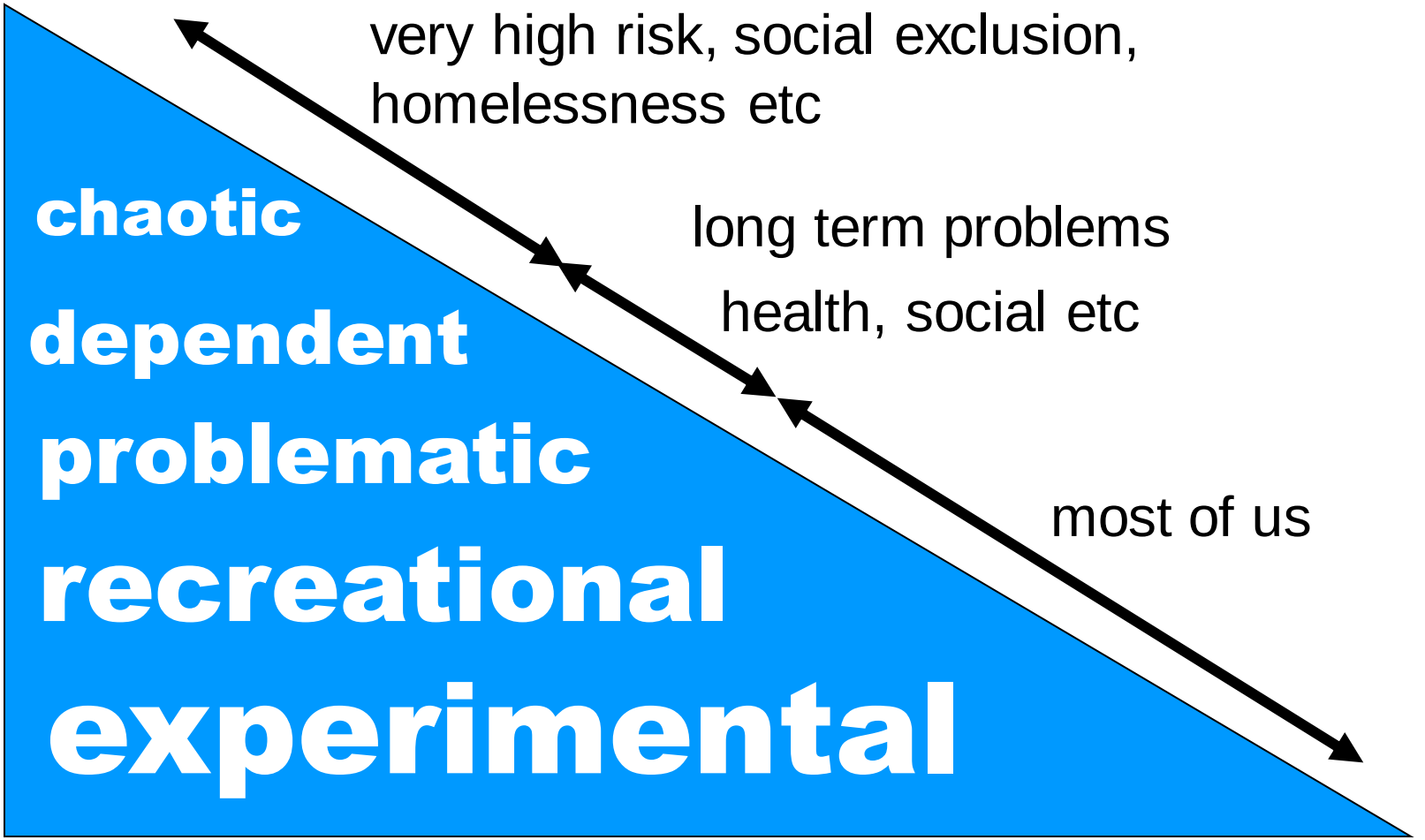
Spectrum Of Use



Heroin

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Cocaine and Crack

cocaine powders

crack / crack vial

WHAT IT IS TO BE HOMELESS

* POLYSUBSTANCE MISUSING PATIENT
* HEROIN/CRACK
* ALCOHOL
* PRESCRIBED DRUGS – BENZODIAZEPINES/GABAPENTIN/PREGABALIN
* NPS – SPICE/CRYSTAL METH/KETAMINE
* EXTREMELY CHAOTIC/HIGH RISK OF
* HARM

WHAT IT IS TO BE HOMELESS

THE LIFE OF A POLYSUBSTANCE USER

* THIS TYPE OF PATIENT WILL NOT TAKE ANY FORM OF PSYCHOTROPIC MEDICATION IN AN ORGANISED FASHION

* BINGE/SELL/LOSE/SHARE

WHAT COULD HAVE BEEN DONE DIFFERENTLY DURING INPATIENT STAY

* WHAT IS THE PATIENT IVE GOT BEFORE ME ? – EARLY IDENTIFICATION OF FACTORS THAT PUT PATIENT AT RISK
* OPTIMAL TREATMENT HEROIN DEPENDENCY
* TREAT ACUTE PAIN
* THINK BEYOND HOSPITAL/PREPARE FOR DISCHARGE

HOW DO I IDENTIFY HOMELESSNESS/COMPLEX/CHAOTIC PATIENTS

* VERY FEW PEOPLE ASK
* PATIENTS OFTEN ANTICIPATE A NEGATIVE RESPONSE
* HOMELESSNESS
* DRUG MISUSE

CONFIDENCE/SKILLS IN MANAGING PEOPLE WITH HEROIN MISUSE PROBLEM

* SUBOPTIMAL TREATMENT OF HEROIN MISUSE
* WHAT IS BEING TREATED – PAIN OR OPIATE ADDICTION ?

* - METHADONE DOSE TOO LOW – TOPPING UP WITH OPIATE PAINKILLERS
* - METHADONE NOT PRESCRIBED – PATIENT MANAGES WITH OPIATE PAIN RELIEF
* - PURE DRUG SEEKING PATIENTS

* UP FRONT COMMUNICATION/DIALOGUE
* DRUG SEEKING BEHAVIOUR/BOUNDARIES/NEGOTIATION

* SKILLS/ATTITUDES OF JUNIOR DOCTORS/NURSES/TRAINING

METHADONE VS MORPHINE

* DOSE CONVERSION IS COMPLEX – NON LINEAR RELATIONSHIP
* LONG HALF LIFE AND VARIABLE EXCRETION RATES
* I THINK SEPARATELY IN TERMS OF PAIN AND ADDICTION PROBLEM
* NEGOATIATE TITRATION OF OPIATES UP AND DOWN

HOSPITAL APPROACHES/POLICIES/TREATMENT OF HEROIN MISUSE

* HOSPITAL PROTOCOLS FOR INITIATION OF SUBSTITUTE PRESCRIBING
* TRAINING/CONFIDENCE MEDICAL NURSING TEAM
* ATTITUDINAL CHANGE TOWARDS PATIENTS
* POLICIES FOR HAND OVER OF CARE INTO COMMUNITY/DRUG TEAMS

IF IM CAUTIOUS WITH OPIATES WHAT ELSE CAN I USE

* TRYCYCLICS
* TRAMADOL/DF118S/CODEINE
* PREGABALIN/GABAPENTIN

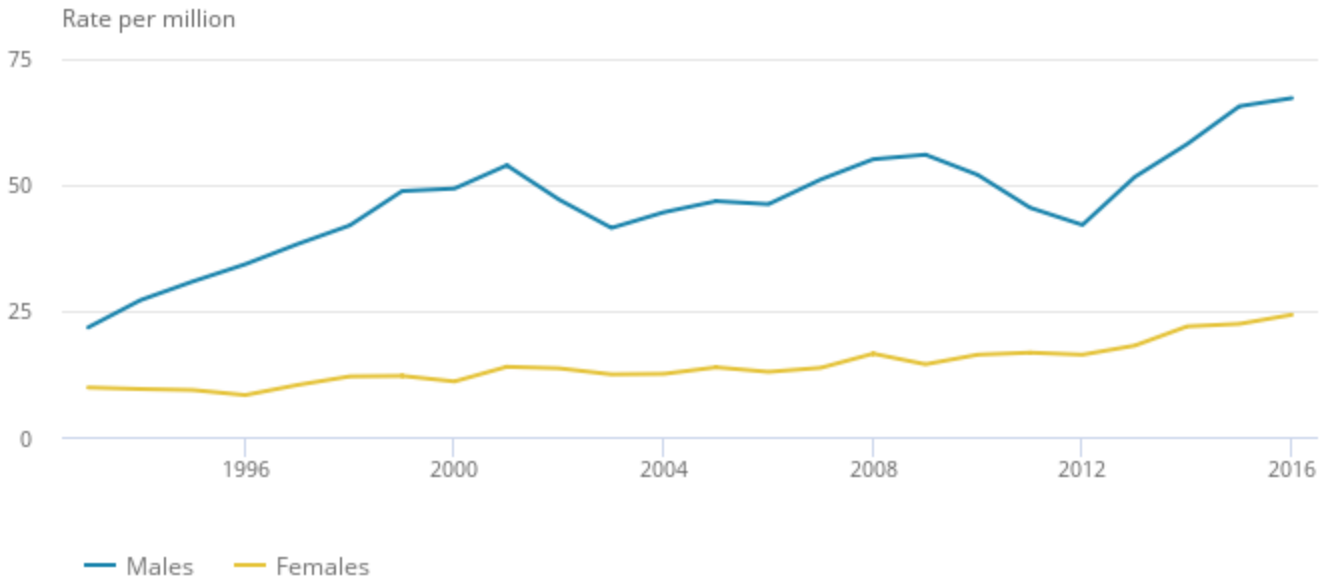
DRUG RELATED DEATHS IN THE UK

* RISING IN THE UK
* 2 % A YEAR SINCE 1993/> 70%
* COMPLEX MULTI FACTORIAL
* 69% DRUG MISUSE 31% PRESCRIBED DRUGS
* Office of national statistics 2017

* INCREASING CONCERNS RE PREGABALIN AND GABAPENTIN , OXYCODONE AND FENTANYL – PRESCRIBED
* NOVEL PSYCHOACTIVE SUBSTANCES/COCAINE - ILLICIT

Figure 1: Age-standardised mortality rates for deaths related to drug misuse, by sex, deaths registered in 1993 to 2016

England and Wales



Source: Office for National Statistics

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Table 1: Number of drug-related deaths where selected substances were mentioned on the death certificate, deaths registered in England and Wales 2012-2016[1,2,3,4]

England and Wales

Number of deaths

	2012	2013	2014	2015	2016
All drug poisoning deaths	2,597	2,955	3,346	3,674	3,744
Any opiate[4]	1,290	1,592	1,786	1,989	2,038
- HEROIN AND/OR MORPHINE	**579**	**765**	**952**	**1,201**	**1,209**
- Methadone	414	429	394	434	413
- Tramadol	175	220	240	208	184
- OXYCODONE	**37**	**51**	**51**	**51**	**75**
- FENTANYL	**22**	**22**	**40**	**34**	**58**
Cocaine	139	169	247	320	371
Any amphetamine	97	120	151	157	160
Any new psychoactive substance	55	63	82	114	123
Any benzodiazepine	284	342	372	366	406
PREGABALIN	**4**	**33**	**38**	**90**	**111**
GABAPENTIN	**8**	**9**	**26**	**49**	**59**
All antidepressants	468	466	517	447	460
Paracetamol[5]	182	226	200	197	219
Propranolol	39	46	54	55	45

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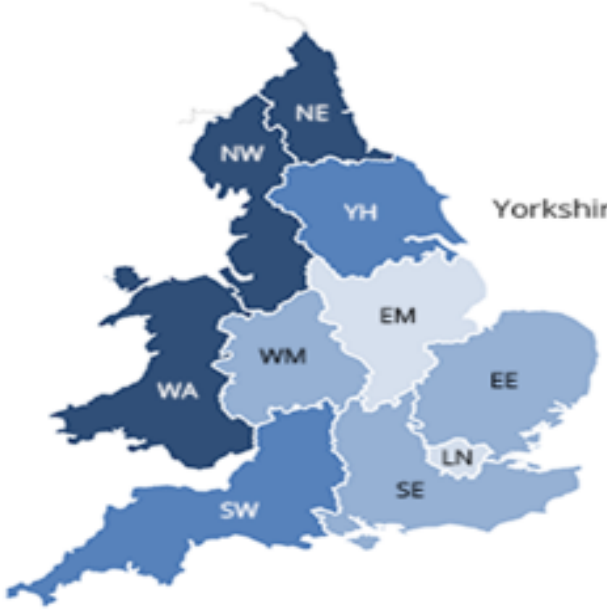
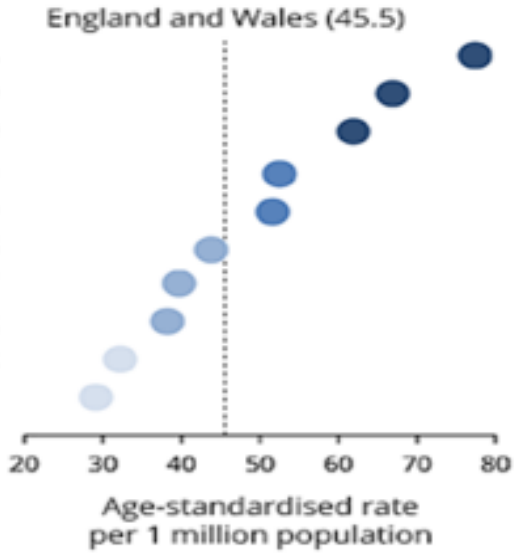
Age-standardised mortality rate for deaths related to drug misuse, by country and region, registered in 2016



England and Wales (45.5)

North East (NE)	77.4
Wales (WA)	66.9
North West (NW)	61.9
Yorkshire and The Humber (YH)	52.5
South West (SW)	51.6
West Midlands (WM)	43.8
South East (SE)	39.7
East (EE)	38.2
London (LN)	32.2
East Midlands (EM)	29.1



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Pregabalin & Gabapentin

PREGABALIN AND GABAPENTIN ARE LICENSED FOR FOCAL SEIZURES AND NEUROPATHIC PAIN.

PREGABALIN IS LICENSED FOR GENERALISED ANXIETY.

IN US, THEY ARE LICENSED FOR PAIN IN FIBROMYALGIA AND ALTHOUGH NOT LICENSED FOR THIS INDICATION IN EUROPE THEY ARE COMMONLY USED.

WHEN USED FOR NEUROPATHIC PAIN DOSES SHOULD BE CAREFULLY TITRATED TO ASSESS RESPONSE AND GIVEN FOR A TEST PERIOD AND IF INEFFECTIVE REDUCED AND STOPPED.

ALTHOUGH OFTEN PRESCRIBED FOR NON-NEUROPATHIC PAIN THERE IS NO EVIDENCE THEY'RE EFFECTIVE & SHOULD THEREFORE NOT BE PRESCRIBED.

PREGABALIN & GABAPENTIN
PUBLIC HEALTH ENGLAND/ADVISORY COUNCIL MISUSE OF DRUGS

BOTH DRUGS ACT ON AND CAN CAUSE EUPHORIA/INCREASED SOCIABILITY/SENSE OF RELAXATION.

BOTH CAN INDUCE DEPENDENCE.

EFFECTS ARE AUGMENTED WHEN USED WITH OTHER SEDATIVES SUCH AS ALCOHOL AND OPIATES.

PREGABALIN HAS A MUCH FASTER ONSET OF ACTION AND IS MORE HIGHLY ADDICTIVE. PREGABALIN USERS MAY TAKE LARGE AMOUNTS(UP TO 5G)IN ONE DOSE AND ITS PHARMACOLOGICAL PROPERTIES MAKE IT RELATIVELY MORE DANGEROUS THAN GABAPENTIN IN HIGH DOSES

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What patients say

* … The most I have done has been 4,800 mg of the 600 mg pills whilst the lowest amount that I can take to get any effect seems to be around 900 mg or more … To classify this pharm is a near impossible task. It is everything and anything in one pill. The only downside to gabapentin so far as I can tell, is the onset. These little guys take upwards of an hour to really start to kick in, but luckily, they last for 4–8 h it seems … I feel as if I'm on a super amphetamine rush and can tackle anything, yet feel so content it's like I'm on a fully sedated opiate buzz. I'm chatty and witty, deep and insightful …

* … I knew that I need at least 20 x 150 mg to get the right effect. Most everyone else I know that takes pregabalin take only 7 or 8 … so about an hour taking after them I feel a disassociation much like DXM, but only in my head and hands. My worries started to fade away. I am a very quiet, shy person normally, but when I am on pregabalin after about 1.5 h I get very friendly, very talkative, very active, very uninhibited … You really need to walk around on pregabalin dancing would be incredible …' '… The feeling was comparable to cannabis with more of a heavy feeling in the body …

PREGABALIN & GABAPENTIN

IT HAS BEEN KNOWN FOR SOMETIME IN SUBSTANCE MISUSE CLINICS AND PRISONS THAT THESE DRUGS ARE ABUSED AND THERE IS A GROWING ILLEGAL MARKET.

BOTH DRUGS HAVE BEEN IMPLICATED IN DRUG RELATED DEATHS.

DATA PROVIDED BY NHS DIGITAL SHOWS THAT PRESCRIPTIONS FOR PREGABALIN HAVE SHOT UP MORE THAN 11-FOLD IN THE LAST DECADE, FROM 476,102 IN 2006 TO 5,547,560 LAST YEAR.

PRESCRIBERS SHOULD BE CAREFUL IN PRESCRIBING THESE DRUGS AND IN PARTICULAR BE AWARE OF PRESCRIBING THEM WHEN THERE IS A HISTORY OF ADDICTION OR RISK FACTORS FOR ADDICTION.

Pregabalin & Gabapentin

PATIENTS SHOULD BE FULLY COUNSELLED BEFORE COMMENCING PRESCRIBING PARTICULARLY ABOUT THE RISK OF ADDICTION.

CLEARLY THESE DRUGS ARE A SERIOUS PROBLEM FOR PRIMARY CARE & THERE IS A VERY HIGH LEVEL OF PRESCRIBING IN THIS PART OF THE UK.

GPS NEED TO BE AWARE OF THE ISSUES AND REVIEW THEIR PATIENTS ON THESE DRUGS PARTICULARLY THOSE WHO HAVE SUBSTANCE MISUSE ISSUES. MOREOVER THEY SHOULD BE VERY CAREFUL IN CONSIDERING NEW PRESCRIBING.

LIKELY TO BE SCHEDULED UNDER THE MISUSE OF DRUGS ACT.

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PLANNING DEREKS DISCHARGE

* POSITIVE RELATIONSHIP/CONTINUITY CARE
* INDIVIDUALISED PLAN FOR DEREK WHICH INCLUDES THINKING ABOUT THE SITUATION IN THE COMMUNITY
* *****MINIMISE RISK OF HARM*****
* CLEAR DIALOGUE AND BOUNDARIES AND AGREEMENTS

INPATIENT

* STAYS INPATIENT UNTIL PRESCRIBING IS SAFE/NEGOTIATION WITH MEDICAL TEAMS
* MST DOSE REASONABLE AIM FOR 20 MG
* NO TTO PREGABALIN
* NO TTO ORAMOPRH
* OPTIMISE DOSE OF METHADONE

PLAN FOR COMMUNITY

* REALISTIC EXPECTATIONS OF PAIN RESOLVING
* ADVISE THAT MST WILL CEASE WITHIN 1-2 WEEKS AND THAT GP WILL NOT PRESCRIBE BEYOND THIS/7 DAY SCRIPTS ONLY/REG GP REVIEW
* PRN COCODAMOL
* DRUG SERVICE/TREATMENT FOLLOW UP

KEY MESSAGES

* RECOGNISE THIS TYPE OF PATIENT EARLY IN REVIEW
* RECOGNISE POTENTIAL FOR RISK/DO NO HARM
* COMMUNICATION SKILLS/MAINTIAN POSITIVE RELATIONSHIP/EMPATHIC APPROACH
* ATTEMPT TO MINIMISE RISK
* BE WILLING TO DISCUSS DRUG MISUSE VS PAIN RELIEF
* DISCUSS WHAT THE GPS APPROACH MIGHT BE IN THE COMMUNITY

KEY MESSAGES

* HOMELES PEOPLE HAVE HUGE HEALTH ANXIETIES
* EMPATHY OFTEN YIELDS POSITIVITY
* PATIENTS VALUE GOOD HEALTHCARE OVER SUBSTANCES

DR SHAUN JACKSON

CASE STUDY 1

* Jason – 36 year old man
* Rough sleeping city centre
* Ivdu/polysubstance misuse

* Admitted with pseudoaneurysm from groin injecting
* Above knee amputation

Post Operative Problems

* Ward perceived him to be a “problem”
* Negative hostile
* Established on 30 mg bd mst
* Reg oramoprh prn/switch to oxynorm
* Started on 150 mg bd pregabalin
* Methadone 30 mls daily

Rationalise approach

* Honest dialogue of problems he is experiencing
* Empathy often results in positivity

* Opiate addiction at the centre of conversations
* Plans for when leaves hospital

Rationalise/discharge planning

* Suboptimal methadone dose
* Agreement about management acute pain
* Prepare for community – reduce mst starting as inpatient
* Agree no prn opiate on tto
* Agree very clear plan for pregabalin

* Holistic offer – accommodation/continuity of care
* Seen weekly at practice with maximum 7 day scripts
* 2 weeks later was prescribed opiate free on 60 mls methadone
* Continued pregabalin for 6 weeks and then ceased

Case Presentation 2

* Julie 27 year old – admitted with fractured tibia requiring – external fixator
* Heroin dependent
* Alcohol dependent
* Cirrhosis of liver
* Rough sleeping/sex working
* Inpatient for 5 weeks

Inpatient stay

* NEGATIVE SITUATION ON WARD
* Referred to our service on 4th week of stay
* Fentanyl 50 mcg patch
* Oramorph prn 3-4 hrly
* Librium prn
* Zopiclone 7.5 mg
* Amitriptyline 50 mg nocte
* Pregabalin 300 mg bd

Preparation for discharge

* I had prior relationship with patient
* Initial hostility
* Offered continued care

* Rationalised prescribing/negotiated what would happen in community
* I had bottom lines

Agree/Rationalise prescribing

* Complicated/chaotic poly substance user discharged into hostel environment
* Stop amitriptyline/oramorph/zopiclone/librium
* Agree continue fentanyl/pregabalin
* Agreed to be reviewed weekly for meds

Follow up

* Weekly review enabled monitoring of clinical state and substance misuse
* Intial good compliance and attendance for approx 6 weeks- maintained on tto meds

* Evidence of possible relapse and poor attendance

Follow up

* Poor attendance enabled stopping fentanyl and pregabalin and revaluation of plan
* No attempt at transfer to drug treatment from prescribed medication
* Alcohol relapse and heroin relapse
* Start drug treatment
* Continue to care for physical state

Ongoing Care

* Continued positive relationship
* Continued care for physical health
* Continued opportunity to engage for substance misuse
* Stability on drug treatment/drinking less
* Leg healed/mobility improved