Beyond The Ward: How CGL Support Recovery In Hospital

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Agenda

CGL In Reach Role and Scope

Data and Presentations

Case Study One

Case Study Two

Transition to Community and Ongoing Support

Role and Remit

- Employed by CGL commissioned to work at RSCH full time
- Receive referrals from inpatient and community teams
- Supporting with clinical management – specifically management of withdrawal, detox and navigating polypharmacy
- Engaging and referring into community services / liaising with existing support
- Providing contextual / social information to support safeguarding and holistic management of patients in the acute setting
- Advocating for our patients and facilitating safe discharges
- Being a point of contact for hospital and CGL staff

Role and Remit

- We support all patients presenting with or reporting issues with drugs or alcohol
- This includes prescription drugs and illicit
- 265 patients seen with alcohol use in Q1
- 348 patients seen with drug use in Q1
- 133 referrals from A&E in Q1
- 310 referrals from the wards in Q1
- We liaise with multiple teams in the hospital especially the Pathways Team, Palliative Care Team, Mental Health Team, Adult Social Care and Safeguarding
- We help plan transition to community – for example continuing prescriptions, arranging follow up

Training, Policy and an MDT Approach

- We run quarterly teaching events for all hospital staff focusing on promoting understanding and treatment of substance use patients in hospital
- We provide training for specific wards / departments in hospital to help better manage our patients clinically and holistically
- We have worked on different policies in hospital including the alcohol withdrawal policy and are currently working on a Naloxone policy for it to be supplied to patients in A&E. We are reviewing current opiate policy
- We are involved in new ARBI pathway
- We hold a Hospital MDT every Friday discussing hospital clients with CGL clinicians
- We have regular MDTs with the Mental Health Team and are involved in High Intensity User Meetings at the hospital to support frequent attenders to A&E

Challenges

- **Stigma:** which can affect them accessing the correct or appropriate healthcare in hospital
- **Hospital Pressures:** pressure for beds and demand on all services are extreme, this can mean our patients are often the first to fall through the cracks and not receive adequate care
- **Wait for Detox / Rehab:** waitlist are long, meaning that patients often present in crisis at hospital however the hospital does not, as a policy, admit for detox
- **Dual Diagnosis:** we often find it difficult to get meaningful mental health input whilst clients are still using substances, however patients can then be caught in a vicious cycle
- **Motivation and Engagement:** hospital admissions and subsequent detoxes are almost always unplanned, meaning clients are often unprepared for abstinence

Hospital To Rehab Pathway

We have been working with the two local drug and alcohol rehabilitation services to facilitate admission straight to rehab from hospital. In the past 6 months we have supported 13 clients to rehab from hospital.

St Thomas Fund
Residential Rehabilitation
Service

Change
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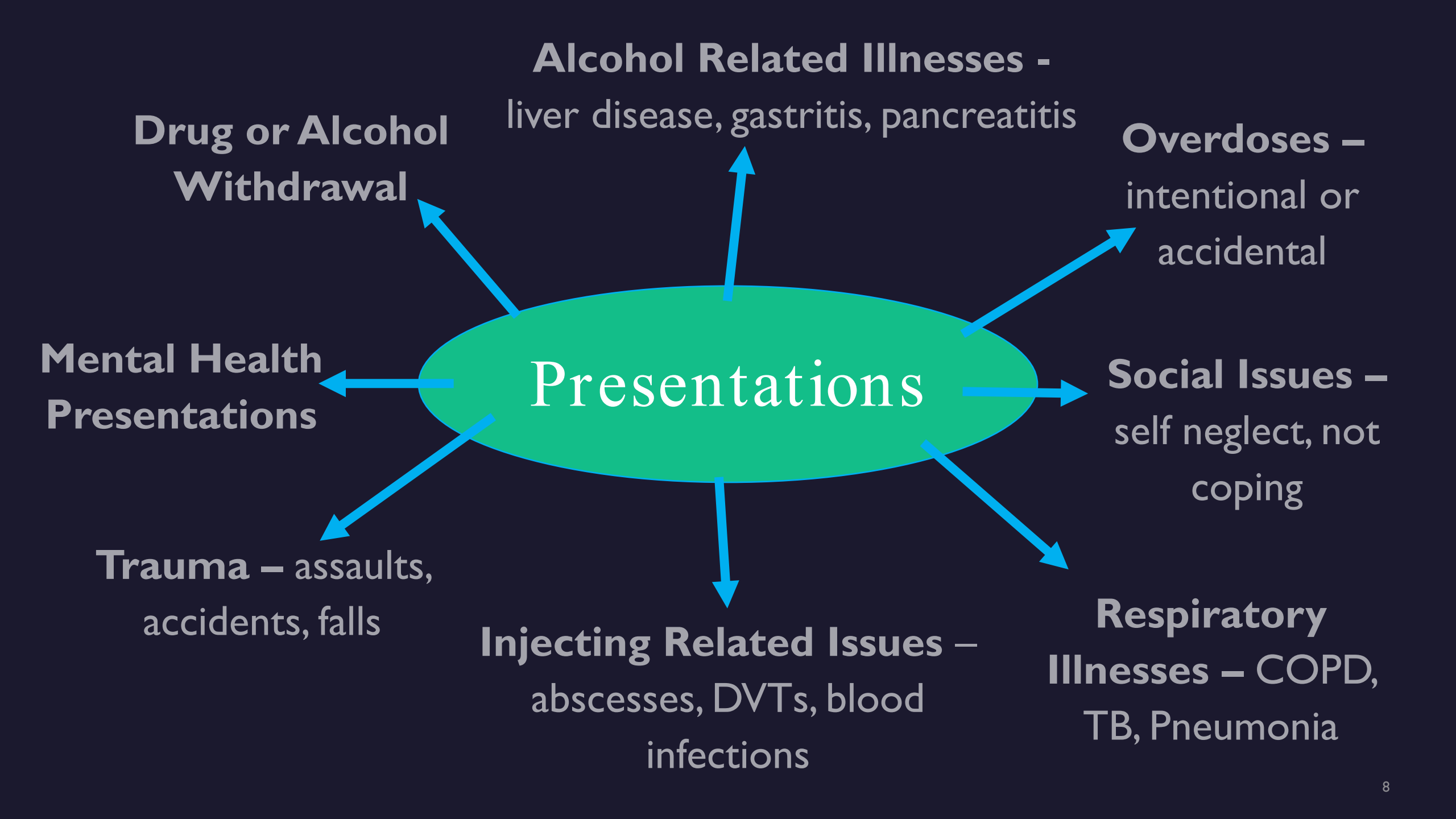

Alcohol Related Illnesses - liver disease, gastritis, pancreatitis
Drug or Alcohol Withdrawal
Overdoses – intentional or accidental
Mental Health Presentations
Presentations
Social Issues – self neglect, not coping
Trauma – assaults, accidents, falls
Injecting Related Issues – abscesses, DVTs, blood infections
Respiratory Illnesses – COPD, TB, Pneumonia

Case Study 1

Client A is a Brighton-born man with a long history of rough sleeping and social isolation. He left special needs boarding school with no qualifications and has no living family or children. Possible autism was noted in school but never diagnosed. He has a history of childhood sexual abuse and trauma There has been minimal engagement with mental health services although noted history of self-harm. Physical health issues include depression, hepatitis C, reflux, pulmonary emboli, and recurrent infections. He has a significant forensic history with multiple prison sentences. Client A has longstanding polysubstance use, including IV heroin and cocaine, spice, benzodiazepines, and alcohol, with intermittent engagement in treatment and opioid substitution therapy. He was admitted to hospital and diagnosed with a DVT, anaemia, cellulitis, and severe pneumonia which then resulted in a TB diagnosis.

Case Study 1

Key Issues:

- Repeated refusal of TB medication including hiding it / refusing to be observed
- Refusal of other treatments including blood monitoring / cannulas, sputum samples, physical assessments
- Non-compliance with ward rules e.g. extended absences despite being infectious
- Illicit drug use off the ward, collapses resulting in emergency calls
- Displayed aggressive behaviour towards staff

Key Actions and Interventions:

- Structured initiation of methadone and titration / split dosing to manage TB medication interaction
- Introduction of behaviour contract
- Collaboration with homeless team, TB team and pharmacy for supervised medication post-discharge
- Regular MDTs with CGL, ward, TB team, Hostel and Homeless team
- Ongoing liaising with Public Health England
- Preliminary Autism diagnosis and recommended reasonable adjustments on the ward e.g. shorter ward rounds, written reminders and video content to explain issues around TB and compliance with medication

Case Study 2

Client B has a long history of substance use. He first engaged with the service seeking support for opiate dependence, explaining that he had begun using opiates to help abstain from alcohol. He was subsequently commenced on Opiate Substitute Treatment (OST). Client B has continued to drink alcohol heavily throughout his treatment. Over the past year, he has had around 30 hospital admissions and A&E attendances, often requiring medical detoxification. Client B has a significant mental health history, including suicidal ideation, suicide attempts, and contact with mental health services. He also disclosed a history of childhood abuse and sexual assault. His physical health is poor, with diagnoses including alcohol-related brain damage, fatty liver disease, alcohol-induced gastritis, and upper gastrointestinal bleeding. He had previous falls and injuries relating to alcohol and periods of self-neglect. Client B previously had a career as a professional chef and long-term relationship that ended due to his substancee use.

Case Study 2

Key Issues:

- Ongoing alcohol use despite being on Opiate Substitute Treatment (OST)
- Possible Alcohol-Related Brain Injury (ARBI) with cognitive concerns
- Complex physical and mental health needs, including frequent hospital admissions and detoxes
- Difficulty maintaining abstinence and engaging with community treatment
- Need for multidisciplinary input and structured rehabilitation

Key Actions and Interventions:

- Advocated for hospital-based detoxification, supporting Client B to remain in hospital
- Supported titration off OST to safely manage substance dependence
- Arranged support from hospital-based AA meetings
- Requested brain imaging and cognitive screening to assess for ARBI
- Coordinated input from Adult Social Care, Physiotherapy, Mental Health and Occupational Therapy
- Arranged admission to BHT residential rehabilitation directly from hospital to support sustained recovery – has been there for past 5 months

Brighton & Hove: Key Statistics Summary

Drug-related deaths: 10.9 per 100,000 (significantly higher than national) *(Brighton & Hove JSNA, 2022)*

Alcohol-specific mortality: 19.4 per 100,000 (significantly higher than national) *(Sussex ICS, 2023)*

41.9% adults exceed low-risk drinking guidelines *(Sussex ICS, 2023)*

Young people: 9% cite benzodiazepines as primary substance (England: 1%) *(Brighton & Hove JSNA, 2022)*

Intentional self-poisoning admissions elevated, particularly among women *(Brighton & Hove JSNA, 2022)*

Alcohol Use and Related Harms in Brighton & Hove

Alcohol-specific mortality: 19.4 per 100,000 (significantly higher than England at 13.9) *(Sussex ICS, 2023)*

41.9% of adults drink over 14 units per week (4th highest outside London) *(Sussex ICS, 2023)*

Hospital admissions for alcohol-specific conditions significantly elevated *(Sussex ICS, 2023)*

Alcohol poisoning and acute intoxication common emergency presentations

Rising rates of alcohol-related liver disease requiring specialist input

Brighton & Hove: Opioid-Related Harm

Drug-related death rate: 10.9 per 100,000 (highest in South East, 9th in England) *(Brighton & Hove JSNA, 2022)*

Significantly higher than England average (5.0 per 100,000) *(Brighton & Hove JSNA, 2022)*

Hospital admissions for drug poisoning remain elevated *(Brighton & Hove JSNA, 2022)*

Heroin remains primary opioid of concern in treatment population

Growing concerns about strong synthetic opioids and nitazenes in drug supply

Chemsex Drugs: GHB/GBL and Crystal Methamphetamine

GHB/GBL: Risk of overdose, unconsciousness, and respiratory depression

Crystal methamphetamine: Psychosis, cardiovascular events, severe mental health impacts

Often used in combination, increasing overdose and harm risks

Hospital presentations may involve acute intoxication or mental health crisis

Require specialist harm reduction advice and mental health support

Benzodiazepines and CNS Depressants

Brighton & Hove: 9% of young people cite benzodiazepines as primary substance (vs 1% England) *(Brighton & Hove JSNA, 2022)*

Poly-substance use with opioids significantly increases overdose risk

Non-prescribed benzodiazepines in street supply (often high potency)

Hospital admissions for intentional self-poisoning elevated in Brighton & Hove *(Brighton & Hove JSNA, 2022)*

Requires cautious prescribing and monitoring in hospital and community settings

Hospital Discharge and Overdose Risk in the UK

1 in 14 opioid-related deaths occur within two weeks of hospital discharge *(Lewer et al., 2021)*

Risk of fatal overdose is 4 times higher in the first 2 days after discharge *(Lewer et al., 2021)*

Reduced tolerance during admission increases vulnerability upon discharge *(Lewer et al., 2021)*

Undertreated withdrawal and pain lead to early discharge and unsafe drug use *(Lewer et al., 2023)*

Hospital discharge represents a critical intervention opportunity *(Lewer et al., 2021)*

Framework for Reducing Post-Discharge Overdose Risk

Hospital MDT coordination and discharge planning

Optimised OST (methadone ≥60mg, buprenorphine ≥16mg, or depot)

Bridging prescriptions and continuity of care into community

Take-home naloxone provision and overdose prevention training *(Lewer et al., 2021)*

Assertive outreach and ongoing MDT discussion post-discharge

Naloxone and Take-Home Policy

Naloxone (Nyxoid®) is an opioid antagonist reversing overdose effects

All clients provided with take-home naloxone upon hospital admission *(Lewer et al., 2021)*

Critical given 4-fold increased overdose risk in first 48 hours post-discharge *(Lewer et al., 2021)*

Training provided to clients and families on recognition and administration

Evidence-based harm reduction intervention saving lives

Legal Framework : 2024 Naloxone Regulations

Human Medicines (Amendments Relating to Naloxone) Regulations 2024 came into force 2 December 2024 *(UK Parliament, 2024)*

Expanded professionals able to supply naloxone without prescription: nurses, midwives, pharmacists, pharmacy technicians, paramedics *(UK Government, 2024)*

Enabled police, prison services, probation, and youth justice services to supply naloxone *(UK Government, 2024)*

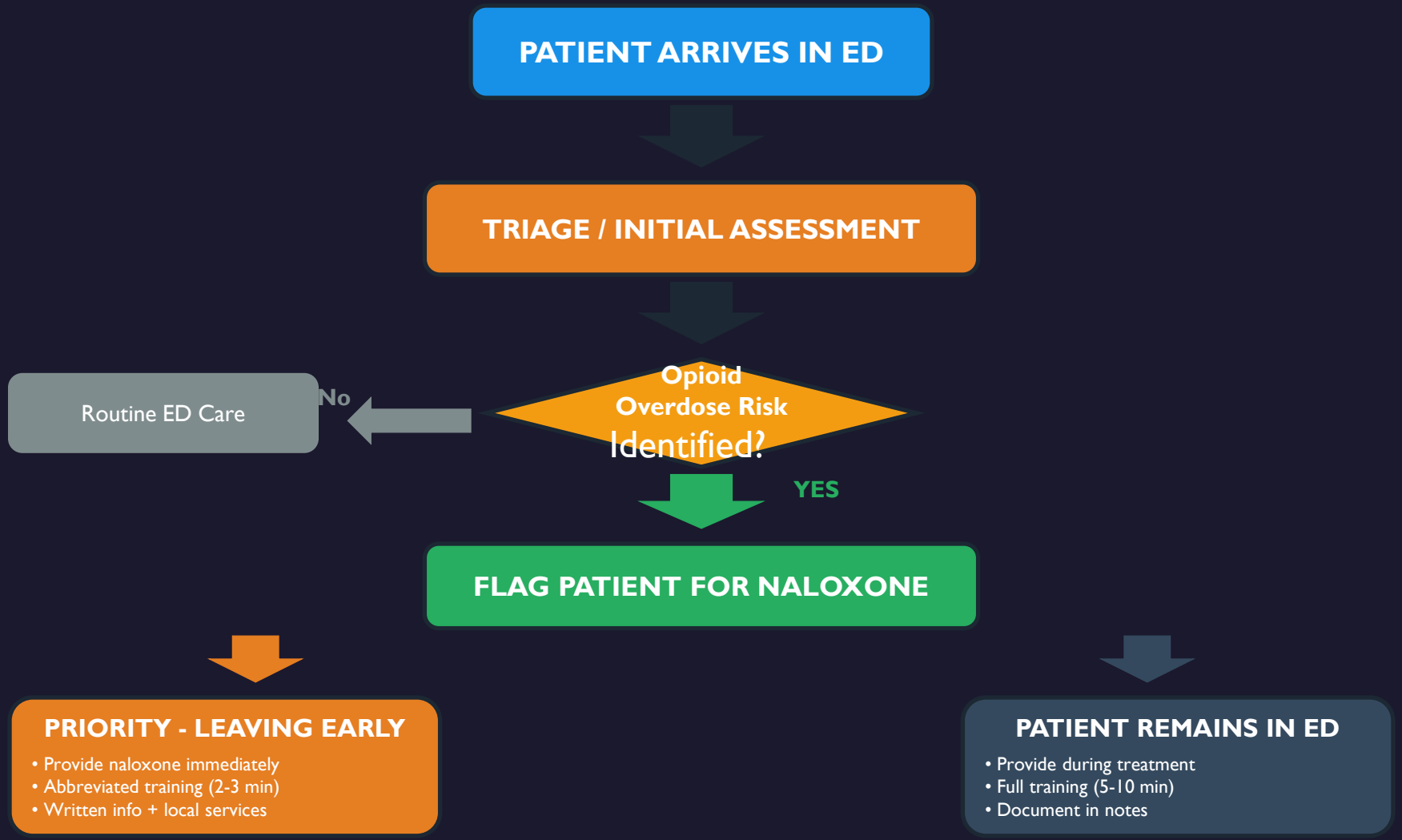
No prescription, Patient Group Direction (PGD), or Patient Specific Direction (PSD) required *(UK Government, 2024)*

Supply must be for purpose of 'saving life in an emergency' with appropriate staff training *(UK Government, 2024)*

ED Naloxone at Triage: The Rationale

- 25-30% of people who use drugs leave hospital against medical advice, vs 1-2% general population *(McNeil et al., 2014; Simon et al., 2020)*
- Patients who leave early represent highest risk group for post-discharge overdose *(Lewer et al., 2021)*
- Traditional discharge-only naloxone provision misses most vulnerable patients
- Early provision at triage/assessment ensures high-risk patients receive naloxone before potential early departure
- Naloxone distribution does not require formal discharge process under 2024 regulations *(UK Government, 2024)*

ED Take-Home Naloxone Pathway: Non-Admitted & Early-Leaving Patients



All patients receive: Prenoxad® kit + training + written information + local service details | NO PRESCRIPTION REQUIRED

Optimisation of OST in Hospital Settings

Target adequate methadone dosing: minimum 60-80mg daily

Ensure therapeutic buprenorphine levels: 16-24mg daily

Consider transition to buprenorphine depot before discharge

Address undertreated withdrawal and pain to prevent early discharge *(Lewer et al., 2023)*

Work with hospital teams to ensure OST prescribing confidence *(Lewer et al., 2023)*

Buprenorphine Hospital-to-Community Pathway

Clients can be initiated on buprenorphine during hospital admission *(NICE, 2019)*

Direct transition onto Buvidal® depot injection before discharge *(NICE, 2019)*

Ensures continuity of care from hospital to community setting

Reduces risk of treatment interruption during vulnerable transition period

Provides stable therapeutic coverage for early post-discharge phase

Buprenorphine Depot Injection (Buvidal®)

Long-acting subcutaneous injection – weekly (8-32mg) or monthly (64-160mg) *(NICE, 2019)*

Maintains therapeutic buprenorphine levels over extended periods *(Lofwall et al., 2018)*

Non-inferior to daily sublingual buprenorphine in clinical trials *(Lofwall et al., 2018)*

Reduces burden of daily dosing and risk of medication diversion *(Lofwall et al., 2018)*

Improves treatment adherence and reduces cravings *(NICE, 2019)*

Four Key Transition Processes

1. Hospital MDT – Weekly multidisciplinary team meetings

2. Bridging Prescriptions – Continuity of OST prescriptions and care

3. Nurse Wellbeing Appointments – Post-discharge support for non-OST clients

4. MDT Discussion Following Discharge – Coordination across service MDTs

Hospital MDT Process

Runs every Friday for one hour with liaison nurses presenting cases

Discusses current inpatients, planned discharges, and frequent A&E attendees

Plans made for ongoing care, bridging prescriptions, and medical review needs

Information shared with Homelessness MDT, Main Service MDT, and Alcohol MDT

Enables proactive risk management and care coordination

Community Engagement and Support

Assertive outreach by recovery workers to maintain contact

Discussion in multiple MDT forums (Homelessness, Main Service, Alcohol)

External MDT meetings with partner organizations

Coordinated approach to support vulnerable individuals post-discharge

Alcohol Community Detoxification Pathway

Monthly alcohol community detox pathway available

Hospital discharge clients can access daily attendance non-medicated detox option with daily group attendance

Provides structured support during critical post-discharge period

Reduces risk of relapse and alcohol-related complications

Social Care and Safeguarding Considerations

Complex needs clients often require joint health and social care input

Safeguarding concerns common: self-neglect, exploitation, financial abuse

Hospital discharge planning must involve social services for clients lacking capacity

Care Act assessments essential for supported accommodation and ongoing care

Multi-agency approach critical for sustainable outcomes

Repeated Hospital Admissions and Complex Needs

Clients with alcohol-related brain injury (ARBI) face particular challenges

Cognitive impairment and memory difficulties hinder treatment engagement

Brighton & Hove developing ARBI pathway modelled on Glasgow approach

Early diagnosis critical for tailored care planning and social care involvement

Homelessness, mental health, and substance use form tri-morbidity requiring integrated response

Alcohol-Related Brain Injury Pathway

Assessment and diagnosis of ARBI for clients with cognitive difficulties

Neuropsychological assessment and structured screening tools

Modified treatment approaches accounting for memory and executive function

Closer liaison with social care for supported accommodation needs

Intensive case management for this high-risk, vulnerable group

Questions and Discussion

Homelessness MDT • Brighton & Hove Substance Misuse Service

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