Substance use and addictive disorders in Palliative care

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September 22, 2017

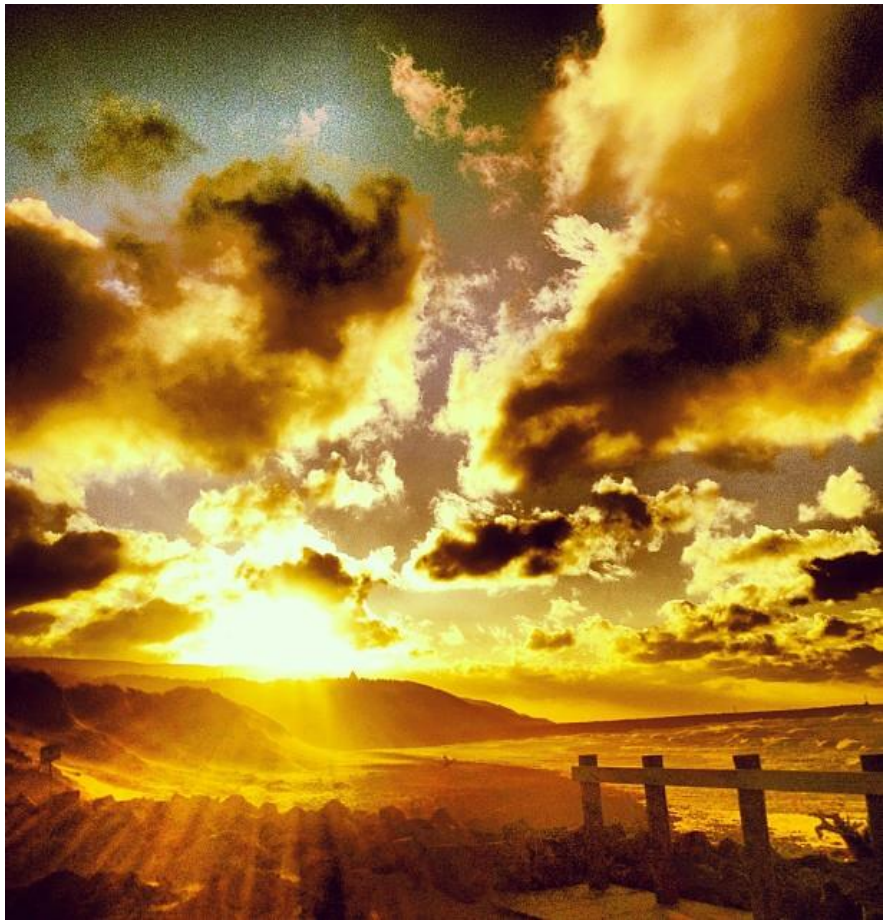
No Disclosures

SB: New referral

- 46 yo female
- Diffuse metastatic cancer of the breast
- Has not kept appointments for chemotherapy or radiation
- Felt to have “months” to live
- Chaotic home situation
- Known history of IV Drug use
- Partner also known history of opioid addiction
- NS-PMP-Multiple prescribers
- Now what?

EB

- 74 year old male
- Metastatic prostate cancer
- Weeks to live
- Caregiver calls: “Need a re-fill of his Methadone”
- People coming and going

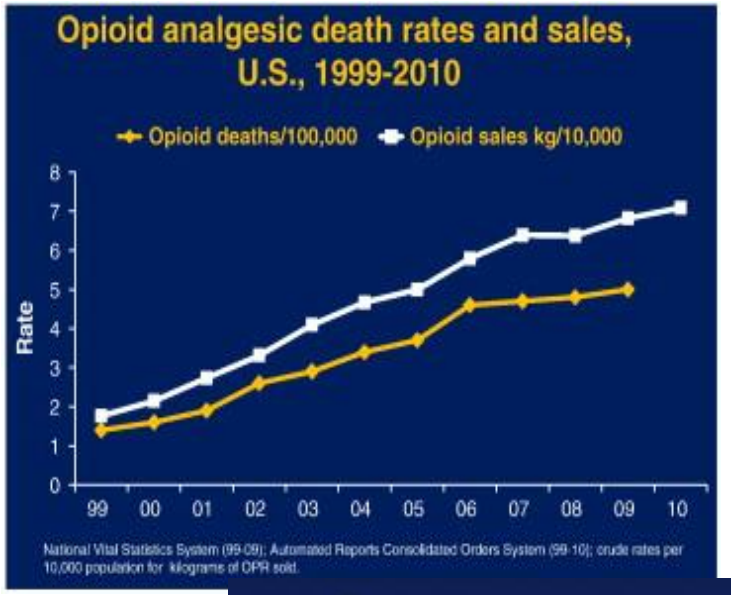


How common is substance abuse disorder in Palliative care?

- Not sure
- Under reported
- Terminology confusion
- Institutional biases
- Patient reluctant to tell previous or present drug history due to stigma

General population data

- 6-15% of Canadian population have a current or past history of a substance abuse disorder of some type and the numbers are rising
- Alcohol and Marijuana still most common
- However…Opioids have been a game changer



Opioid Analgesics

- **Important tool** but have **inherent risks** in **vulnerable** populations
- Most serious risks include:
- Opioid induced Pain
- Opioid Addiction
- Opioid Diversion

Question

- Legitimate pain protects patients from addiction to their opioid. (Cancer pain, fracture pain etc.)

  - TRUE
  - FALSE 

Opioid Addiction

- Is a ***Life-threatening complication*** of opioid use **NOT** a moral failing
- Cause of ***pain doesn't matter***
- **Risk factors** do

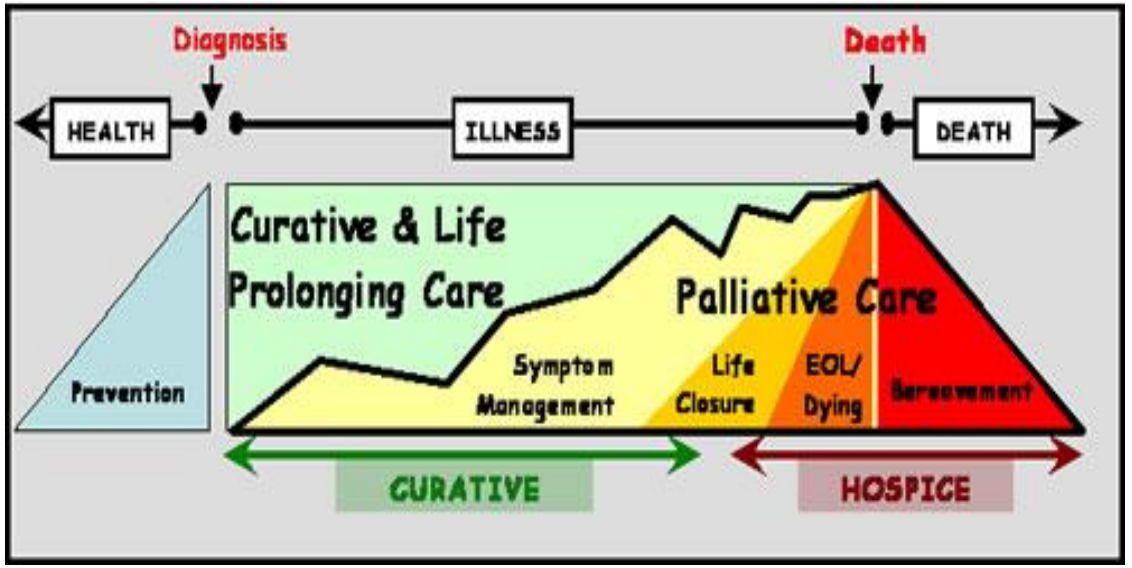
Factors Leading to Addiction

Mark each box that applies	Female	Male
1. Family hx of substance abuse Alcohol Illegal Drugs Prescription drugs	☐ 1 ☐ 2 ☐ 4	☐ 1 ☐ 2 ☐ 4
2. Personal hx of substance abuse Alcohol Illegal Drugs Prescription drugs	☐ 3 ☐ 4 ☐ 5	☐ 3 ☐ 4 ☐ 5
3. Age (mark box if 16-45)	☐ 1	☐ 1
4. Hx of preadolescent sexual abuse	☐ 3	☐ 3
5. Psychologic disease ADD, OCD, bipolar, schizophrenia Depression	☐ 2 ☐ 1	☐ 2 ☐ 1
Scoring totals:		

Scoring (Risk)
0-3 Low Risk
4-7 Moderate Risk
≥ 8 High Risk

Why is this important?

- Face of palliative care (PC) and cancer treatment is changing
- We're seeing patients **earlier**(Temel et al. 2010)
- Patient's **younger** at diagnosis
- **Surviving longer** with more complexity
- **Opioids introduced so**oner in illness trajectory
- 40% palliative care patients also have chronic pain (CP) or "persistent pain"
- PC personnel have **little if no training** in addiction medicine or chronic pain



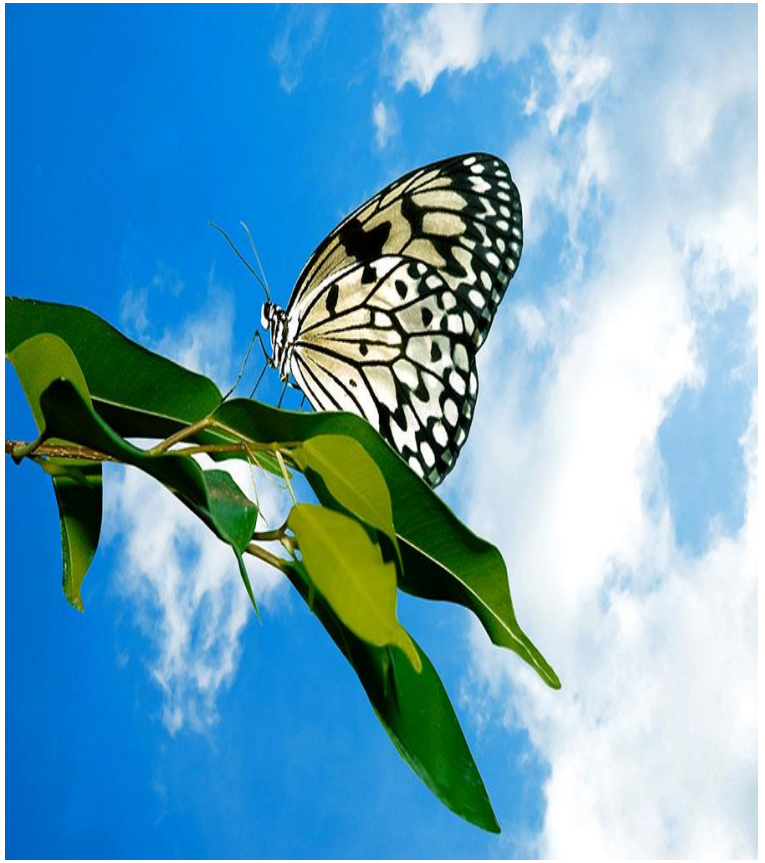
Temel JS et al. Early Palliative Care for patients with metastatic disease non-small cell cancer. N Engl J. Med 2010 ;363(8): 733-42.

The clinical dilemma when pain and addiction co-exists in the Palliative patient

- “I didn’t sign up for this”
- Do we have the same latitude to withhold pharmacology simply because of abuse concerns?

Opioids: Common Challenges

- 71% of cancer patients reluctant to take medications due to fear
- ¼ to 1/3 patients under-report symptoms and under-treat due to fear of addiction
- 40% of spouses do not think opioids should be taken routinely
- 25% of caregivers underestimate and minimize symptoms because they fear addiction and habituation

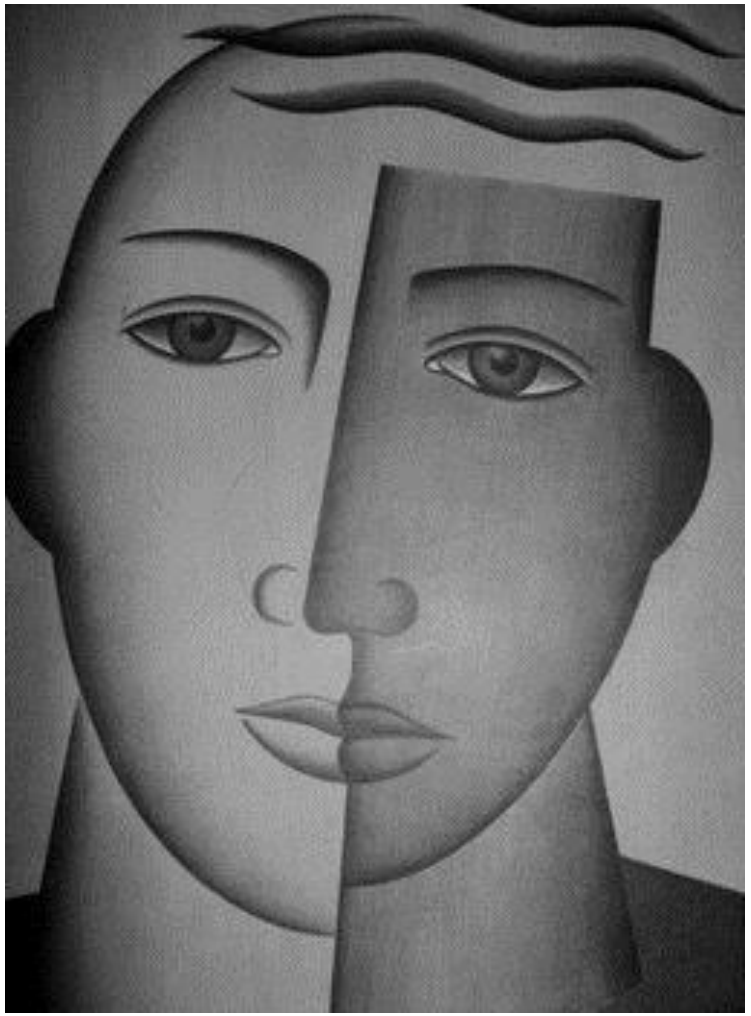


However ignoring a substance abuse problem….

- Can lead to **ineffective pa**in management
- Can contribute to **poor adherence** to medical therapy (getting to appointments)
- Put patients **safety at risk**. (Interactions with illicit drug's and prescribed medications)
- Prevent the completion of tasks that they would like to complete near the end of their lives such as mending relationships and working on **issues of legacy**
- Prevent the building of essential support networks
- Promotes **"chemical coping"** strategies during periods of stress and decision-making
- Can **prevent restoration** of self-respect and dignity

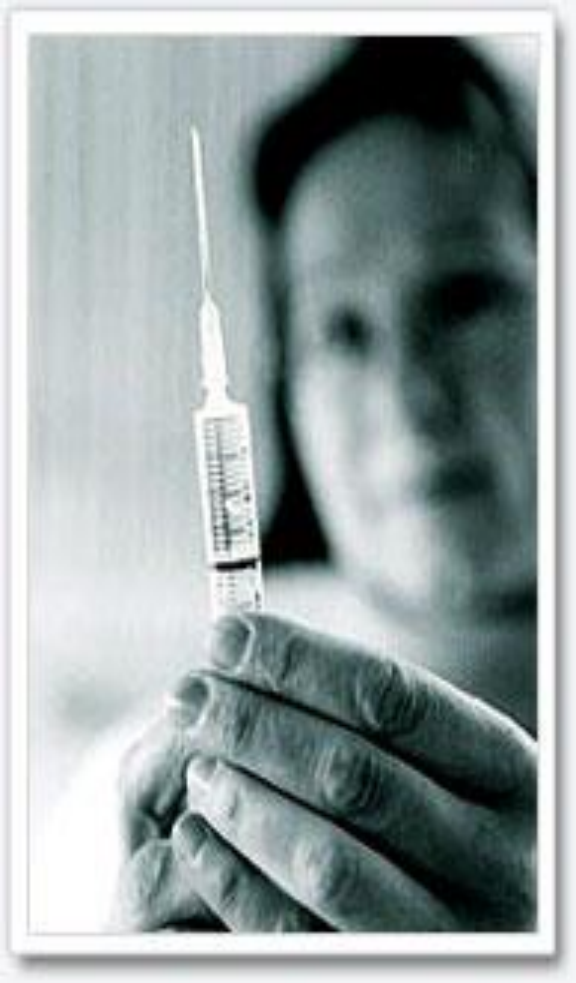
Other barriers to quality palliative care when addiction exists are the myths

- Belief that because patients are dying we *should give them what they want* to keep them comfortable and that *little is to be gained* by addressing underlying abuse of opioids or other street drugs
- Belief that *substances abused* by the patient *are a source of pleasure for them*
- Belief that *Addiction and Diversion rarely* if ever occur in palliative care



How do you know there's a substance abuse problem?

- Difficult to know
- Altering a delivery route of a drug maybe obvious
- But running out early could have multiple legitimate explanations
- Not always about being "right"
- We have an obligation to be thorough, thoughtful, consistent, careful, humane and caring but not necessarily right

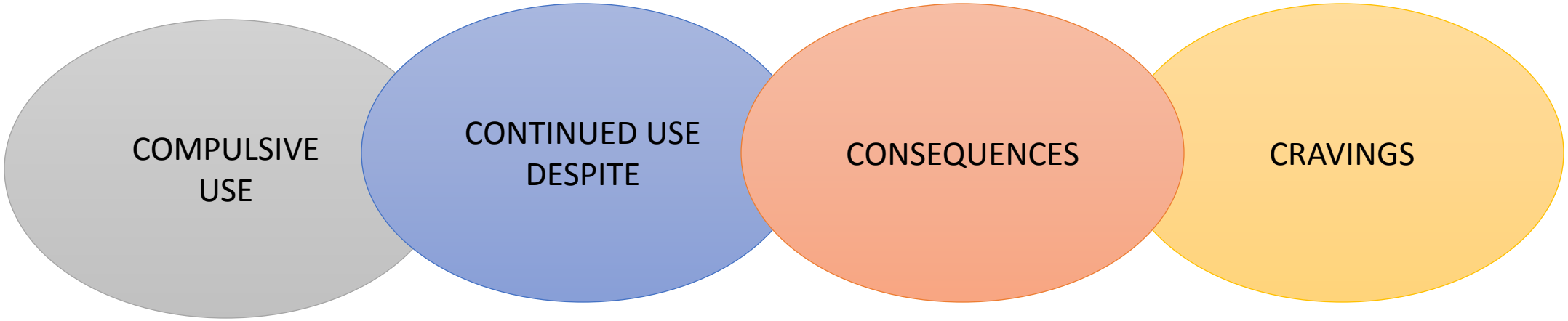


DSM-V:

Substance Use and Addictive Disorders

- Unsuccessful attempt to cut down
- Long periods spent obtaining drug or recovering from drug
- Neglecting other life activities
- Use despite on going health consequences
- Craving
- Consequences of use
- Repeated use in hazardous situations
- Repeated use despite interpersonal harm
- Tolerance
- Withdrawal
- Use for longer than was intended

4 C’s

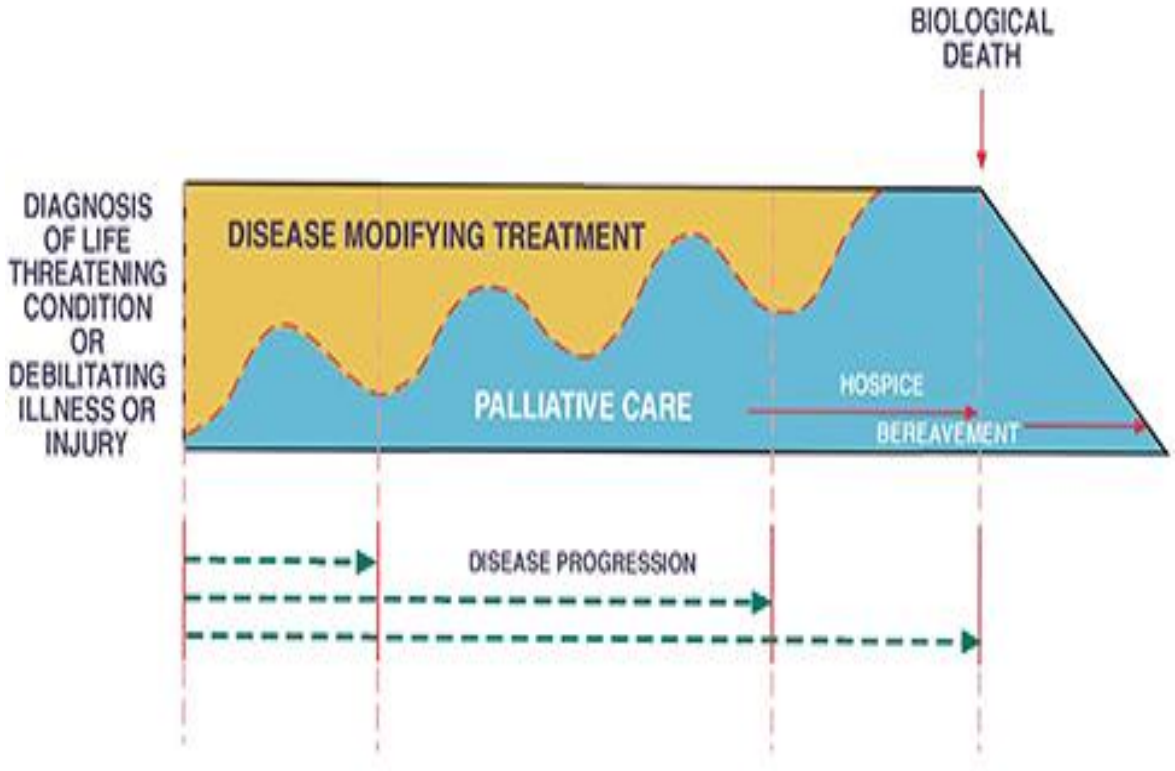

COMPULSIVE USE
CONTINUED USE DESPITE
CONSEQUENCES
CRAVINGS

Diversion

- *Unlawful channeling of regulated pharmaceuticals*
- *Everyone at risk*
- *Patient, family, friends, care givers, health professionals*

What if Pain is co-existing with addiction? What should my principles of care be?

- Where is the patient on the disease trajectory?
- Pain ***WILL NEVER, EVER*** get better regardless of how many buckets of opioids you give the patient
- Choices are abstinence for the substance OR **Methadone** , ***Buprenorphine*** or **Kaidian** in an addiction treatment framework
- Offer the patient addiction counselling and pain support wherever available.
- If patient not ready, have a community based pain and addiction strategy that may include a comprehensive pain plan
- ***Remember these are good people making bad choices***



Gratitude

- Hall mark of recovery
- Can’t save everyone
- Know the value of motivational interviewing
- Goal is to keep them and your community ***safe***
- Consider a “Harm-reduction” strategy in your approach
- Remember other pain pharmacology, alternative therapies and interventions and what your goals of care are
- Have a strategy for the “angry or confrontational” patient

Facing death in recovery

- There is no right way to die
- 12 step program can provide an individual with strength which they can continue to practice the steps until death
- Remember complimentary therapies (Reike, massage, music therapy etc.)
- Help them build bridges by making peace with people in their past
- Watch for withdrawal and treat aggressively if present (alcohol, nicotine, cannabis etc.)
- Reach out to family members who are enabling addiction (Sneak drugs in)
- They often need support and education as well

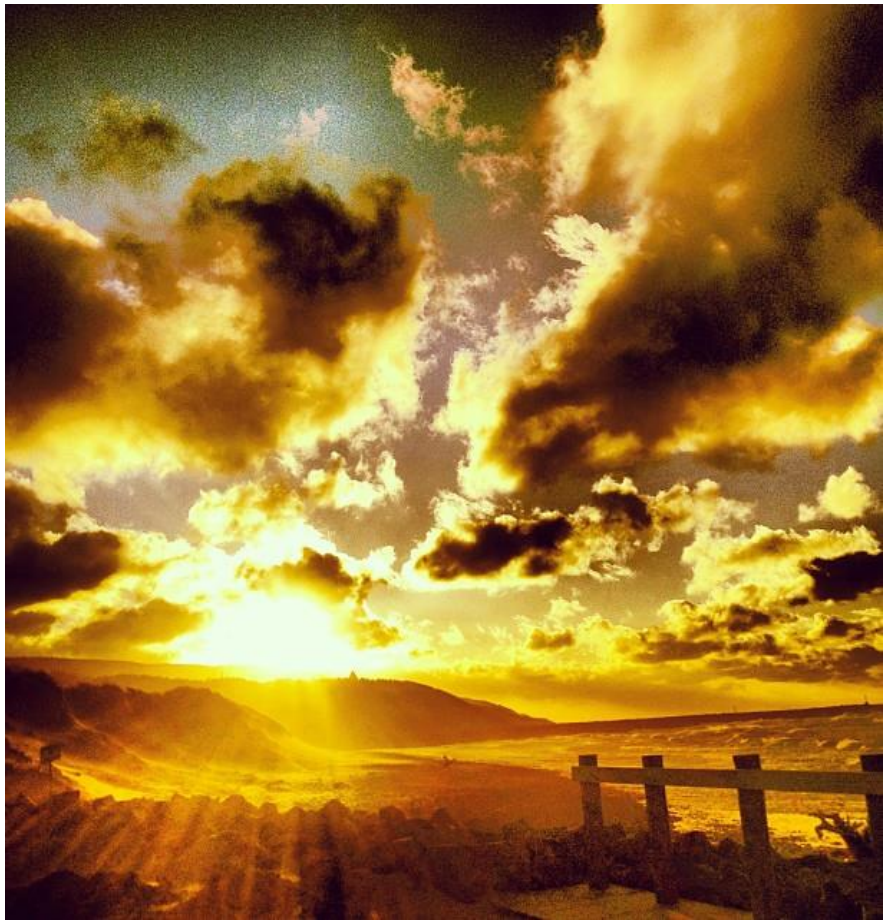
SB: New Referral

- Lost to follow-up
- Sudden death within the community
- ?Overdose
- Unsure how her death was recorded

Dr. Rhea MacDonald
Inverness

EB

- 74 year old male
- Metastatic prostate cancer
- One prescriber
- Limited quantity
- Regular Pill/Solution count
- CADD pump



Summary

- Opioid Addiction is a life-threatening complication of opioid use
- Let them know *you care enough* to set boundaries
- Comprehensive care plans keep everyone on the same page