Substance use and addictive disorders in Palliative care

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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

Passik SD, Olden M et al. Principles and Practice of Palliative care and supportive oncology. Chapter 41: Substance abuse issues in Palliative care.
Yu DK. Review of Memorial Sloan-Kettering Counselling Center Database. 2005
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

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<tbody>
<tr>
<td><strong>1. Family hx of substance abuse</strong></td>
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<td>Alcohol</td>
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<td>Illegal Drugs</td>
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<td>Prescription drugs</td>
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<td><strong>2. Personal hx of substance abuse</strong></td>
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<td>Alcohol</td>
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<td>Illegal Drugs</td>
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<td>Prescription drugs</td>
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<td><strong>3. Age (mark box if 16-45)</strong></td>
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<td><strong>4. Hx of preadolescent sexual abuse</strong></td>
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<td><strong>5. Psychologic disease</strong></td>
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<td>ADD, OCD, bipolar, schizophrenia</td>
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<td>Depression</td>
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**Scoring totals:**

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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 sooner 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

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 pain** 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 ongoing 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
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

“*Our prime purpose in this life is to help others. And if you can’t help them, at least don’t hurt them.*”

~ Dalai Lama