Prescribing for Patients with Substance Misuse

Palliative Care Master Class
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Barb Eddy MN NP(F) CHPNC(C)
Adjunct UBC & UVIC Schools of Nursing
Associate Member UBC Department of Medicine,
Division Palliative Care
Disclosure

- Nothing to disclose
What do I bring to this discussion?

- Palliative background - acute, community, hospice, educator, HCN, CNS, NP
- Primary care DTES, inner city mental health and addictions
- As a Nurse Practitioner, Rx Controlled drugs, suboxone and almost....methadone and injectable opioids for opioid use disorder.
- QI project to improve dyspnea for advanced COPD
- Chronic pain initiative to help reduce total burden prior to onset of palliative phase
Our Goal is to provide a palliative approach and end of life care to all persons in need.
Objectives

• Gain insight into your beliefs and values about persons living at risk with substance dependency.

• Consider new ways of viewing the patient who uses substances.

• Identify a few safer means to prescribing in the context of persons at risk of or, living with, a substance use disorder.
Check in

• What makes carrying for palliative patients with illicit substance dependency difficult?
Values, Beliefs & Assumptions

• Who are we talking about when we talk about “a person with addictions”?

• Is this different than “a person with substance use disorder”?

• Who do we identify as “at risk”?
Identifying Patients Who Use Substances

- How are you, your team, your organization doing with screening?
- Purposeful screening vs general screening?
- Do you collect collateral information from those who know the patient best?
Alternatively…Identifying those Persons at Risk

- Leaving AMA
- Repeated ER admissions
- Multiple prescribers
- Mental health- self or family
- Chronic pain
- Trauma or abuse history
- Living in poverty
- High risk populations
Making the Full “Diagnosis”

Seeing the Whole Person

• Assessment of
  • Substance Use- current or in recovery
  • Mental health
  • History of trauma with or without sexual abuse
  • Socioeconomic status

• Prognosis- given co-morbidity of substance use disorder and/or lack of supports?
Trauma Informed Care

• “Health care systems and individuals that stigmatize and shame individuals who have a history of trauma only serve to re-traumatize the person and deepen the suffering.” (Jackson, C.)

• “Our bodies are objects of humiliation” (patient quote)

• Is the behaviour related to withdrawal or trauma?
  • What is wrong with you? (value judgement)
  • What has happened to you? (compassionate)

• Regulate<Reason>Action
Preparing to Prescribe

• What are you treating? “Total pain” and “Total suffering”

• How long will you need to prescribe for? Is the Rx for a long term palliative trajectory, (eg dyspnea with COPD), EOL or temporary relief of a symptom?

• What are the patients goals or concerns r/t to SUD, personal risk or recovery?

• Does this patient “fit” within your usual manner of prescribing?
Key Messages
Patient-Prescriber-Patient

• I care (but never assume you are trusted).

• I don’t want to do harm or add to your burden.

• Safe action requires understanding and action from us both (but realistically who is in control)?

• Reflect understanding, What am I missing?

• What can we agree on for next steps?
Prescribe or Not?

• Have you considered the balance of risks and benefits? (patient, community and other clinicians)

• Do you have time to organize? Who needs to be on the patients “team”? 

• Can the patient return? Or how will you contact?

• It may feel difficult. Harm reduction to start?
Approach to Prescribing

• Set expectations between prescriber and patient
• UDS- office dip vs lab
• Pharmanet- ALWAYS
• Treatment agreements, mutual understandings
• What “mitte” is safe to order? Just enough!
• Prescribe so you can titrate!
  • Daily witnessed ingestion
    • Sprinkling
  • Daily delivery, daily dispense
Choose Medications to treat co-Morbidities

- Alcohol & pain - Gabapentin, baclofen, (naltrexone)
- Stimulants & mood disorder (cocaine, c.meth) – Topiramate, mirtazapine
- Stimulants & pain - baclofen
- Opioid Use Disorder & pain/dyspnea - buprenorphine (suboxone), methadone, 24 hour opioid (Kadian or Jurnista), (injectable hydromorphone)
- Depression & pain - Venlafaxine
- PTSD related insomnia - Prazosin, clonidine
Support Harm Reduction

- Safe injection sites
- Test your drugs
- Use in pairs
- Take home naloxone kits
- Write Rx
  - “daily witnessed ingestion”
  - “hold if drowsy”
Evaluation

• Consistent prescriber for refills- pharmanet

• Monitoring
  • Collateral-HCN, pharmacist
  • Urine Drug Screens

• Detailed questions to determine what you are treating- physical symptom or existential distress?

• Titration- Are you certain the patient is taking all the doses?
Home Visit for Symptom Management
Loss, Grief and Bereavement

• “Hope is to see in the eyes of others that you are understood” (Henri Nouwen)

• Complicated grief
  • Patients loss of developmental milestones
  • Family’s loss of a loved one to an (stigmatized) drug overdose
Summary

- “Pain is Inevitable; Suffering is Optional” M. Kathleen Casey.
- Manage expectations of both patient and self.
- It’s never easy to bear witness to suffering and it’s harder when suffering is “end of life” stacked on “all of life”.
- There is little evidence for treatment of pain in context of addictions but principles of care do apply.
- You will be successful when you apply palliative philosophy in a trauma informed way, combined with a harm reduction approach and detailed follow up!
Thank You & Please

advocate for palliative care services for everyone