Substance Use Disorders in Palliative Medicine

- Palliative Care ECHO at VCU Health
- August 28, 2024

Objectives

- Identify the types of substance use disorders that occur in palliative care patient populations.
- Describe assessment tools for substance use disorders in the palliative care setting.
- Explore models for the management of substance use disorders and opioid pain management co-occurring in palliative care patient populations

Case: Mr. GA

- 64 yo AA male
- On medicaid
- Met prostate cancer on anti androgen therapy
- Stable for three months on methadone with sparing oxycodone, came to all visits, UDS appropriate, working part time

IMPRESSION:
1. Status post prostatectomy without definite abnormal focality within the postsurgical bed.
2. Innumerable osteoblastic lesions throughout axial and proximal appendicular skeleton, concerning for widespread osseous metastatic disease. Osseous lesions surrounding the left hip/pelvis should be further evaluated clinically for impending pathological fracture.
3. No abnormal lymphadenopathy.
4. Patient may benefit from Xofigo or Pluvicto therapy.

But then……

Newer results are available. Click to view them now.

Component Ref Range & Units	1 mo ago	2 mo ago	7 mo ago
Amphetamine Screen, Urine Negative Comment: Negative when result < 500 ng/mL	**Negative**		
Barbiturate Screen, Urine Negative Comment: Negative when result < 200 ng/mL	**Negative**		
Benzodiazepine Screen, Urine Negative Comment: Negative when result < 200 ng/mL	**Negative**		
Cannabinoid Screen, Urine Negative Comment: Negative when result < 20 ng/mL	**Negative**		
Cocaine Screen, Urine Negative Comment: Presumptive positive when result >= 150 ng/mL Drug screens have specificity limitations which may result in false-positive results. Confirmation of unexpected screening results using a definitive method is recommended.	**Presumptive Positive !**		
Fentanyl Screen, Urine Negative Comment: Negative when result < 1 ng/mL	**Negative**	Negative CM	Negative CM
Opiate Screen, Urine Negative Comment: Negative when result < 300 ng/mL	**Negative**		

Why? And Now What?

- Because of a family issue?
- Because of housing?
- Because he caught up with old friends?
- Because we spaced out his appointments and he needed more support?
- Because????.........

Challenges to each aspect of what we do

Table 3

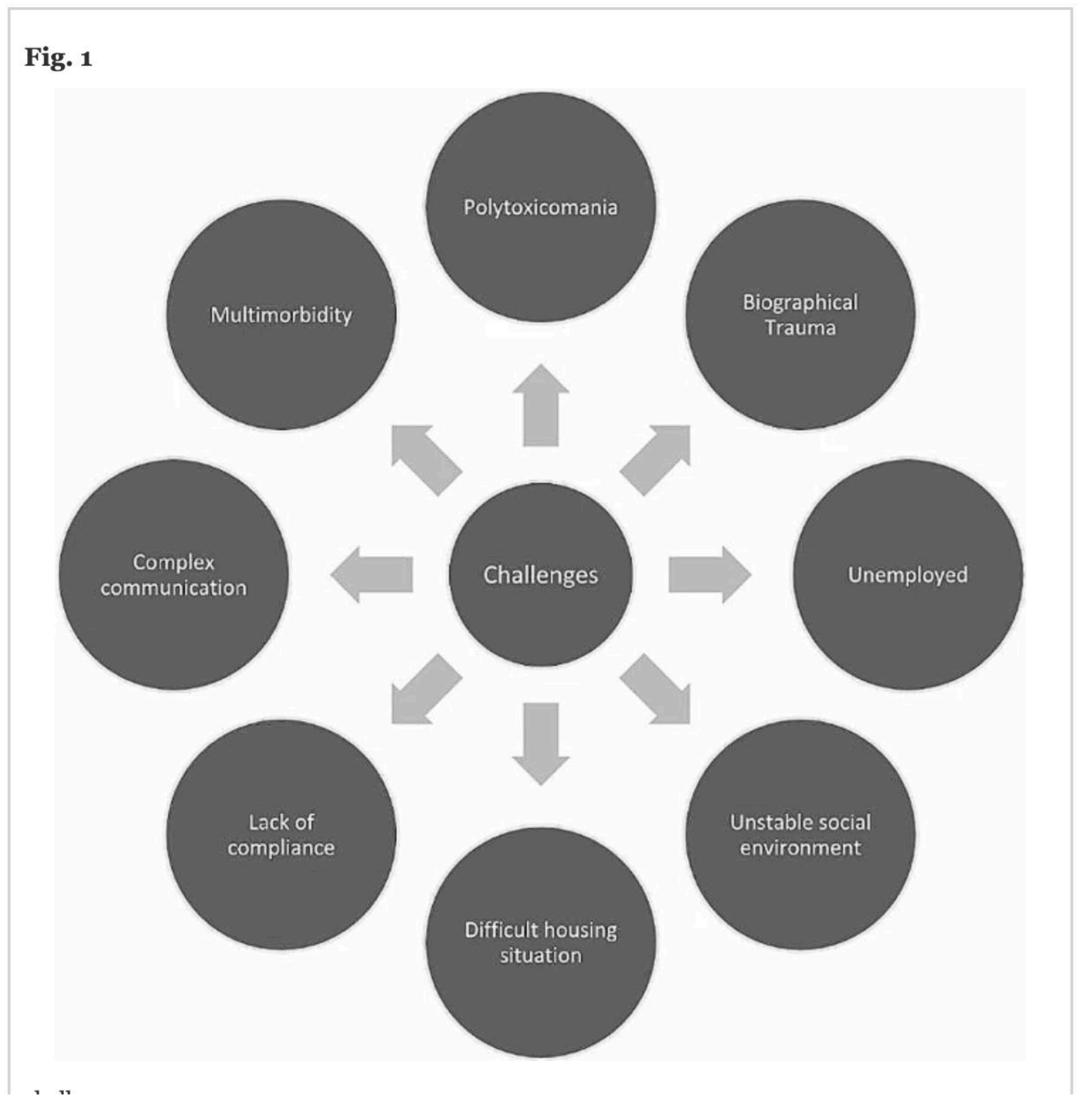
Challenging the WHO definition of palliative care

"Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual".

Part of definition	Practical challenges in PC for patients with SUD+
"their families"	There is often no social network or it is very (time- and emotionally) demanding to involve them in the provision of palliative care.
"life-threatening illness"	Patients with SUD+ can suffer from life-threatening diseases, such as cancer or COPD. However, SUD itself can be a life-threatening illness, too, but is not always recognized as such, partly because addiction care is recovery-focused. Such patients suffer from far-progressed, somatic deterioration instead of specific disease(s) and therefore, might be harder to identify as being in need of PC.
"prevention and relief of suffering by means of early identification"	Patients often suffer from a lot of pain. Since patients often still have active SUD, relief is hard. Prevention (proactive care) is challenging due to, among other things, late symptom- and disease presentation.
"impeccable assessment and treatment"	As many patients with SUD+ are limited or restrained in their expressions and experiences of symptoms and disease, assessment and treatment of pain and multidimensional problems and needs are hindered. Other barriers are that the SUD is not always known or knowledge of HCP/VE about symptoms is limited.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6961318/

For my patient, what did we need to consider?



https://bmcpalliatcare.biomedcentral.com/articles/10.1186/s12904-024-01366-x

What are the ongoing challenges?

Training gaps in the assessment, diagnosis, and treatment of SUDs	Incorporate these skills, specifically the competencies outlined by Chua et al. (2021), into fellowship training programs.
	HPC physicians can access continuing education through courses, webinars, and workshops. Free, brief online courses are offered by Yale University and the University of Missouri-Kansas City.
Stigma toward people with SUDs may lead to lower quality of care	Visual campaigns have been found to reduce stigma toward patients with SUDs (Kennedy-Hendricks et al. 2022). Physicians can champion and disseminate such campaigns in their practice settings.
	Direct contact with patients with SUDs, and specifically prescribing buprenorphine, may decrease physician stigma.
Reluctance to deprive dying patients of pleasure, without appreciating the harmful consequences of problematic substance use	Continuing education, including the concept of incentive sensitization (i.e., how with habitual substance use, pleasure diminishes as cravings increase over time) and the impact of disordered substance use on physical and mental health, end-of-life work, and pain management.
Fear that prescribing opioids for pain management will trigger a relapse or overdose	Access continuing education and follow practice guidelines (e.g., those published by the American Society of Clinical Oncology and the National Collaborating Centre for Cancer) to inform prescribing decisions.
	Only 5% of patients with a history of SUDs will develop opioid use disorder when treated with opioids for chronic pain (Moe et al. 2019); routine SUD assessment through standardized measures and urine drug screens can facilitate early identification and intervention for problematic use.
Underutilization of effective pharmacolog-ical and psychosocial interventions to treat SUDs	Continuing education to increase competence in pharmacological (e.g., acamprosate, disulfiram, and naltrexone for alcohol use disorder) and psychosocial interventions (e.g., motivational interviewing

https://www.cambridge.org/core/journals/palliative-and-supportive-care/article/substance-use-disorders-in-hospice-palliative-care-a-narrative-review-of-challenges-and-a-case-for-physician-intervention/8FAD8C5F21ED48EF7993FC8A5FA99CBB

What about the evidence?

What this paper adds?

- This paper highlights knowledge gaps in existing evidence in relation to models of palliative care for those who use drugs and/or alcohol.
- This paper discusses components of a developing a model of care, including awareness of organisational and interpersonal relationships, holistic care and collaboration with other services.

Implications for practice:

- There are significant challenges in providing end of life care for those who use drugs and/or alcohol.
- Given the small numbers of studies, it is difficult to develop evidence-based models of care.
- While components of a model of care have been highlighted, more applied research is needed to support the development of comprehensive models of care and inform practice development.

Cook et al, Palliative care needs and models of care for people who use drugs and/or alcohol: A mixed methods systematic review *Palliat Med,* 2022

Do providers feel prepared for the challenges?

Table 1. Participant Characteristics

Characteristic	*N* = 175 (%)
Role in hospice	
Physician	68 (39.5)
Nurse	68 (39.5)
Physician assistant	1 (0.6)
Nurse practitioner	28 (16.3)
Social worker	2 (1.2)
Other/declined to respond	8 (4.6)
Experience in hospice	
0–5 years	27 (19.6)
6–10 years	28 (20.3)
11–20 years	45 (32.6)
>20 years	38 (27.5)
Declined to respond	37 (21.1)
Reporting ≥2 patients per month with:	
Concern for opioid misuse[a]	81 (59.6)
Concern for OUD[b]	55 (40.0)
Concern for other SUD[c]	85 (61.2)

Do providers feel prepared for the challenges?

Table 3. Participants' Self-Reported Comfort and Attitudes Regarding Treatment for Patients With Substance Use Disorder(s) in Hospice

Statement	Percentage strongly agreeing/very comfortable	Percentage somewhat agreeing/somewhat comfortable
I feel comfortable in managing pain in patients enrolled in hospice who are currently prescribed naltrexone for OUD and/or alcohol use disorder.	10.7%	21.3%
I feel comfortable in managing pain in patients enrolled in hospice who are currently prescribed buprenorphine for OUD.	10.7%	22.7%
I feel comfortable in managing pain in patients enrolled in hospice who are currently prescribed methadone for OUD.	41.3%	32.0%
I enjoy caring for patients enrolled in hospice who have history of substance use.	6.3%	27.6%
As a hospice clinician, it is my role to treat patients for SUDs when they are enrolled in hospice.	39.4%	22.8%
As a hospice clinician, it is my role to treat pain in patients with SUDs.	86.6%	7.9%
Hospice services can be helpful for patients with ongoing substance use and life-limiting illness.	82.7%	3.2%
It is possible for someone with an active SUD to have a good death while enrolled in hospice.	85.0%	12.6%

Langman et al. Caring for patients with opioid misuse or substance use disorders in hospice: a national survey. *J Palliat Med,* 2024.

What guidelines are there?

https://ascopubs.org/doi/10.1200/JCO.22.02198#:~:text=at%20this%20time.-,Recommendations,early%20assessment%20and%20frequent%20titration

What guidelines are there?

Case: 50-year-old patient (unspecified gender) with advanced cancer (defined as cancer that is unlikely to be cured or controlled with treatment), on active anti-cancer treatment, with pain related to their cancer or its treatment.

- The patient does not have a history of an opioid use disorder (OUD).
- They have been prescribed a full agonist opioid (s) (e.g. oxycodone, morphine, hydromorphone, fentanyl, methadone doses three times daily).
- You send appropriate screening and confirmatory urine drug tests. They are positive for the opioid(s) you prescribe and for non-medical cocaine or methamphetamine. Other urine drug testing findings are as expected.
- The patient's pain control and function are acceptable.

You discuss the urine results with the patient, and they acknowledge recent cocaine or methamphetamine use.

	PANEL A: Prognosis weeks to months			**PANEL B:** Prognosis months to years		
	Round 3 Decision[a]	Median Score	Participant Number	Round 3 Decision[a]	Median Score	Participant Number
Continue the patient's opioid(s)	✓	7	49	✓	7	52
Increase monitoring (e.g. more frequent visits, short prescriptions)	✓	9	49	✓	8	52
Taper the patient's opioids slowly	✗	3	40	✗	3	51
Taper the patient's opioids rapidly	✗	1	48	✗	1	52
Transition the patient to buprenorphine/naloxone	✗	3	48	?	4	51

[a] Experts used a 9-point Likert scale, from 1 (very inappropriate) to 9 (very appropriate). Decisions were considered appropriate if the median score was 6.5 to 9, uncertain if the median score was 3.5 to 6, and inappropriate if the median score was 0 to 3.5.

Palliative and addiction experts in both panels reported that tapering opioids was "punitive" (A55, B11, B28, B39, B16), "cruel" (B22), "disruptive" (A62), "not indicated" (A09, A11, A23, A42, B36, B33), and "create more problems" (A36, B60) including "undue suffering" (A04) or

Many experts embodied the spirit of harm reduction, an approach that avoids punishment (i.e., not abruptly stopping opioids and prioritizing pain control),[43] but some experts were not overly concerned by stimulant use in a person with cancer. Surprisingly, some experts had a nihilistic stance questioning whether interventions to improve safety are worthwhile in the context of cancer.[44] This finding suggests in the context of cancer clinicians may miss harm reduction opportunities. Simply harm reduction interventions may include providing naloxone, educating people on stimulant supply, or providing fentanyl drug testing because patients may not be aware stimulant supply can contain additional opioids.[45] When

Jones et al. Expert consensus based guideline on approaches to opioid management in individuals with advanced cancer related pain and non medical stimulant use. *Cancer, 2023.*

Has anyone tried to create any models?

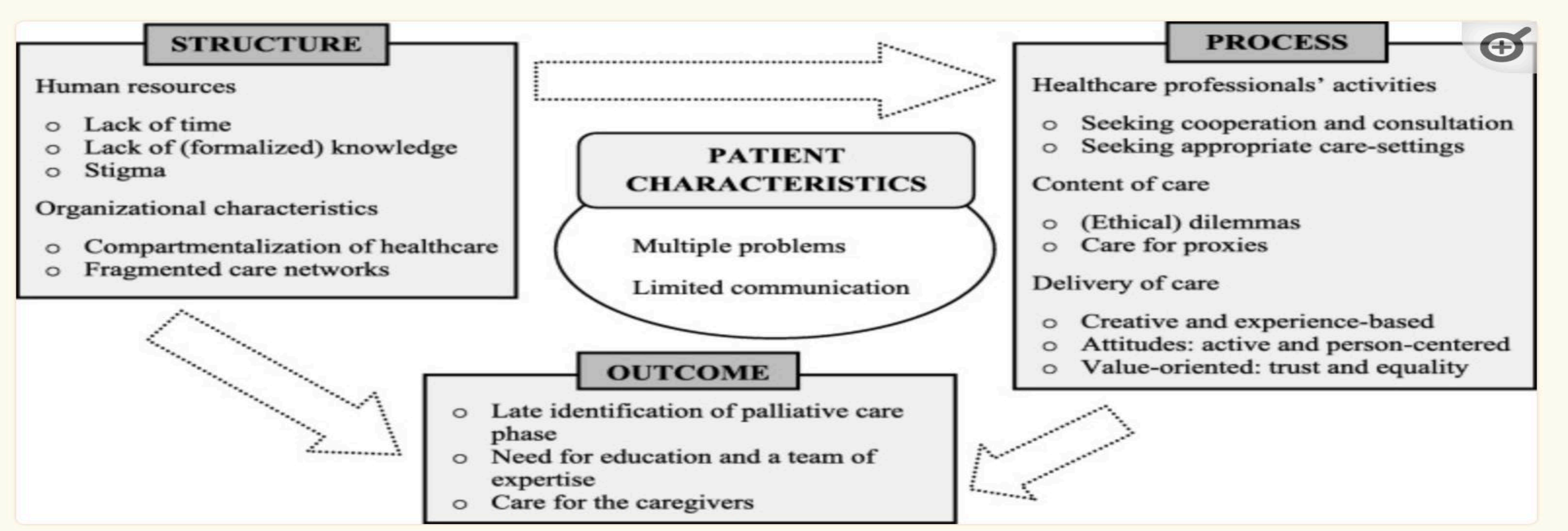


Fig. 1

Quality of care model: Palliative care for patients with substance use disorder and multiple problems

Has anyone tried to create any models?

STRENGTHS	WEAKNESSES
• Participants shared a zeal for patient group • Creativity in communication and within organizational structures • Bringing patients' 'representatives' • Proactive and structural medical checks	 • Timely identification of palliative care phase • Non-appropriate pain control • Fragmented knowledge and networks • Knowledge is experience-based, yet not formalized • Non-univocal definition of 'palliative care for people with substance use disorder' • Professionals in palliative care struggle to set boundaries • Non-appropriate care-settings
OPPORTUNITIES	**THREATS**
• Existing local care initiatives and (informal) care networks • Family reunion can be very satisfying for both patient and family • Great improvement of QoL after identification of palliative care phase • Great amount of specialized knowledge on palliative care and addiction • More extensively involving' co-clients', other proxies or volunteers in care* • Bringing together available knowledge on palliative care and addiction in education program* • Team of expertise for both care at the most appropriate place and consultation* • 'Social mapping' and peer supervision would increase mutual knowledge, consultation and cooperation* • Use of addiction-specialist* • Developing networks with regard to cooperation, consultation and knowledge exchange*	• Care compartmentalization and financial restraints withhold cooperation and knowledge exchange • Deconstruction and reconstruction of psychiatry increases patient group's invisibility • Cut-backs decrease availability in time whereas patients and their social networks are complex and time-demanding • Patients do not 'fit' settings and vice versa • Prejudice and stigma on patient group • 'Care for the caring' is often de-prioritized whereas this patient group can be emotionally demanding • Only few central figures master both palliative care and addiction • Lack of personnel in addiction care ** in potential and theory, however, mostly absent in practice*

Has anyone tried to create any models?

Table 2 Harm Reduction and Opioid Monitoring Strategies[a]

	Harm Reduction Processes			
Strategies	**Reducing Acute Harms of Use**	**Reducing Complications of Use**	**Reducing Harm by Reducing Use**	**Reducing Harm by Engaging in Care**
Increased frequency of visits and touch points				•
Distribution of naloxone and fentanyl test strips in clinic	•			
Harm reduction counseling	•	•	•	•
Pill counts and urine drug testing		•		
Buprenorphine as first line opioid analgesic	•	•		•
Shared decision making on benefits and risks of PRN opioid use		•	•	
Engagement with addiction psychiatry service				•

a Table adapted from The American Academy of Addiction Medicine (ASAM) Essentials of Addiction Medicine.[24]

https://www.jpsmjournal.com/action/showFullTableHTML?isHtml=true&tableId=tbl0002&pii=S0885-3924%2824%2900720-6

What about state regulations?

Commonwealth of Virginia

REGULATIONS

GOVERNING PRESCRIBING OF OPIOIDS AND BUPRENORPHINE

VIRGINIA BOARD OF MEDICINE

Title of Regulations: 18 VAC 85-21-10 et seq.

Statutory Authority: § 54.1-2400 and Chapter 29 of Title 54.1 of the *Code of Virginia*

Revised Date: August 8, 2018

Part I
General Provisions

18VAC85-21-10. Applicability.

A. This chapter shall apply to doctors of medicine, osteopathic medicine, and podiatry and to physician assistants.

B. This chapter shall not apply to:

1. The treatment of acute or chronic pain related to (i) cancer, (ii) sickle cell, (iii) a patient in hospice care, or (iii) a patient in palliative care;

2. The treatment of acute or chronic pain during an inpatient hospital admission or in a nursing home or an assisted living facility that uses a sole source pharmacy; or

3. A patient enrolled in a clinical trial as authorized by state or federal law.

18VAC85-21-20. Definitions.

The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"Acute pain" means pain that occurs within the normal course of a disease or condition or as the result of surgery for which controlled substances may be prescribed for no more than three months.

"Board" means the Virginia Board of Medicine.

"Chronic pain" means nonmalignant pain that goes beyond the normal course of a disease or condition for which controlled substances may be prescribed for a period greater than three months.

https://www.dhp.virginia.gov/pharmacy/

New additional regulation April 2024

https://lis.virginia.gov/cgi-bin/legp604.exe?241+sum+HB699S

2024 SESSION

CHAPTER 448

An Act to direct the Board of Medicine, the Board of Dentistry, the Board of Optometry, and the Boards of Medicine and Nursing to amend their regulations related to patient counseling for the prescription of opioids to treat acute or chronic pain.

[H 699]

Approved April 4, 2024

Be it enacted by the General Assembly of Virginia:

1. *§ 1. That the Board of Medicine, the Board of Dentistry, the Board of Optometry, and the Boards of Medicine and Nursing shall amend their regulations to require that, prior to issuing a prescription for any opioid to treat acute or chronic pain, practitioners provide patient counseling. Such patient counseling shall include providing the patient with information regarding (i) the risks of addiction and overdose associated with opioid drugs and the dangers of taking opioid drugs with alcohol, benzodiazepines, and other central nervous system depressants; (ii) the reasons why the prescription is necessary; (iii) alternative treatments that may be available; and (iv) risks associated with the use of the drugs being prescribed, specifically that opioids are highly addictive, even when taken as prescribed, that there is a risk of developing a physical or psychological dependence on the controlled dangerous substance, and that the risks of taking more opioids than prescribed, or mixing sedatives, benzodiazepines, or alcohol with opioids, can result in fatal respiratory depression. The regulations shall require that the practitioner document in the patient's medical record that the patient has discussed with the practitioner the risks of developing a physical or psychological dependence on the controlled dangerous substance and alternative treatments that may be available. The regulations shall include an exception to the patient counseling requirement for patients who are (a) in active treatment for cancer, (b) receiving hospice care from a licensed hospice or palliative care, (c) residents of a long-term care facility, (d) being prescribed an opioid in the course of treatment for substance abuse or opioid dependence, or (e) receiving treatment for sickle cell disease.*

2. That the Board of Medicine, the Board of Dentistry, the Board of Optometry, and the Boards of Medicine and Nursing shall promulgate regulations to implement the provisions of this act to be effective within 280 days of its enactment.

https://lis.virginia.gov/cgi-bin/legp604.exe?241+ful+CHAP0448

What about the future?

specialist.[97-99] Palliative care clinicians may find guidance in consensus-based recommendations for the management of patients with co-occurring cancer and SUD that is based on their prognosis and substance use characteristics.[97,100,101] As cancer therapies evolve and help patients live longer, clinicians must also evolve in their practice and acknowledge the shifting balance of risks and benefits as they engage in shared decision making with patients. Decisions involving trade-offs that might have previously seemed straightforward, such as foregoing or deprioritizing management of SUD when a patient's prognosis is limited, may require more thought as patients experience longer trajectories of advanced cancer.[102] As always, decisions should center on patients' preferences and values.

https://ascopubs.org/doi/10.1200/EDBK_100038

“Opportunities”

- Is there interest in this area?
- If so, is there anything anyone is already working on?
- **Would there be interest in a separate limited series ECHO where causes could be discussed and our addiction medicine team would join?**
- Ideas/conversation welcome ☺