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Psychiatry and Addictions Case Conference

UW Medicine | Psychiatry and Behavioral Sciences

AN APPROACH TO SERIOUSLY ILL PATIENTS WITH SUBSTANCE USE DISORDERS

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project ECHO

SPEAKER DISCLOSURES

- ✓ No disclosures to report

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OBJECTIVES

1. State the importance of managing substance use disorders in individuals with limited life expectancy
2. Describe a framework to assess pain, addiction and prognosis to develop a management plan in patients with life-limiting illness
3. Identify strategies to balance pain control with management of addiction in palliative care patients

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Where Palliative Care (PC) Started

Disease-focused Treatment	Palliative Care

Onset of disease

Death

Last few days – weeks of life
Primarily provided in hospice settings
Exclusive of disease-focused treatments

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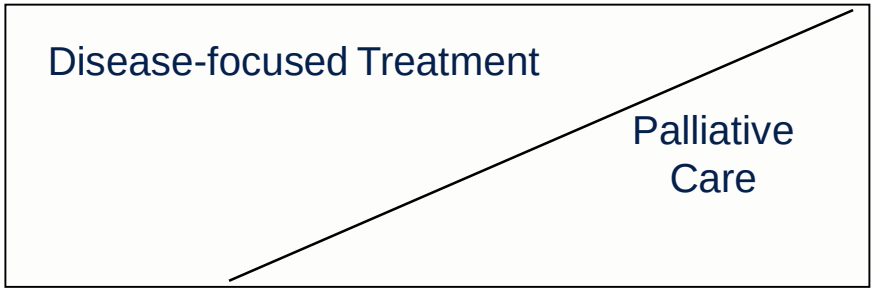
Where PC is now



People with serious illness living *much* longer:

- Better cancer treatments
- Advanced heart therapies
- Transplants
- Other technologies

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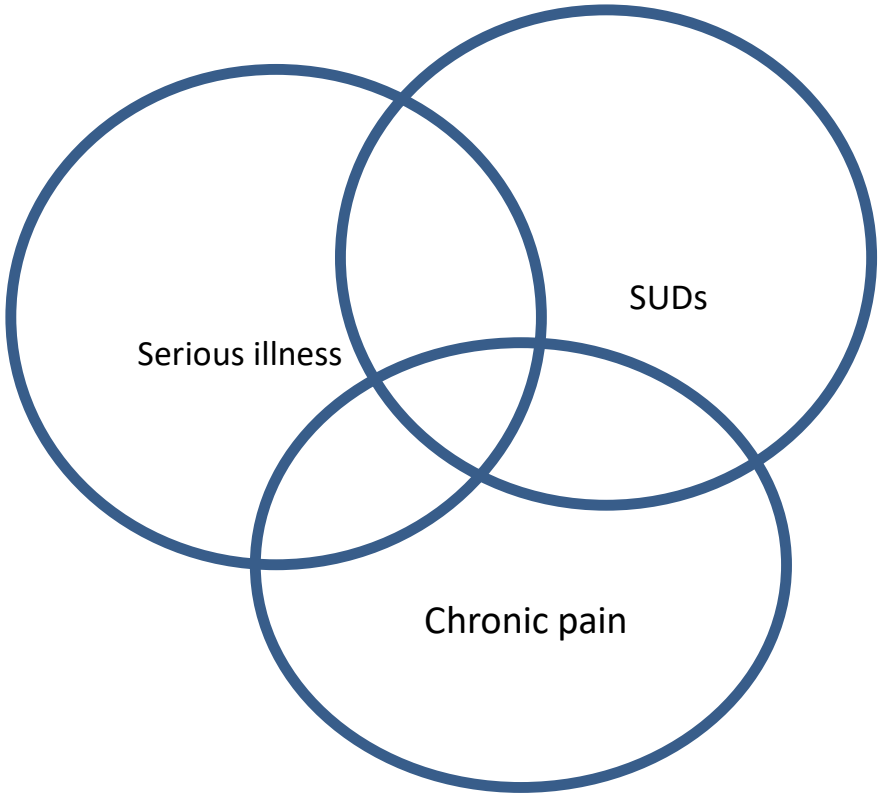
THE POPULATION



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PEOPLE WITH SUDS HAVE MORE MEDICAL COMORBIDITIES AND DIE YOUNGER

- Studies:
  - OUD: 18% of non-elderly SUD patients died over a 4 year period
  - AUD: 2 x mortality from CVD, 3x from lung disease
  - Stimulants: Persons using amphetamines had a 6.3x mortality risk of age-matched peers

- Why?
  - Tobacco use
  - Lack of preventative care
  - Social determinants of health
  - Mental health co-morbidities
  - Lack of social support

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CHRONIC PAIN IN INDIVIDUALS WITH SUDS

- Chronic pain in general population: 20-30%
- Chronic pain in individuals with SUDs: 40-60%
- Possible overlap syndrome, common pathways

WHY DO WE CARE ABOUT ADDICTION IN PATIENTS WITH SERIOUS ILLNESS?

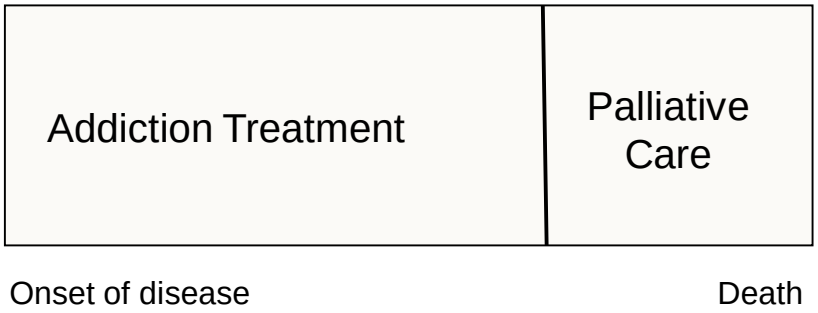
"Chemically-dependent patients spend very little time high; the lion's share of their time is spent feeling depressed, being isolated, withdrawing, being obsessed about drug procurement, behaving in a fashion that they themselves consider demeaning or degrading"

Passik SD, Theobald DE. Managing addiction in advanced cancer patients: why bother?. Journal of pain and symptom management. 2000 Mar 1;19(3):229-34

CASE

- S is a 35 year old man with history of stage II melanoma
- In treatment for opioid use disorder (OUD) on buprenorphine
- Found to have a recurrence with a painful mass in the axilla
- Started on treatment
- Buprenorphine is stopped and he is started on opioids and benzodiazepines
- Runs out of prescribed opioids several times, gets early refills

The Current Model



CHALLENGES FOR INDIVIDUALS WITH SUDS WHO DEVELOP A SERIOUS ILLNESS

- Loss of their usual routines, roles and responsibilities
- Challenges to coping mechanisms which may already be stretched
  - High prevalence of psychiatric illness
- Increased access to prescribed opioids and benzos
- Lose access to a recovery community

CHALLENGES OF CARING FOR INDIVIDUALS WITH SERIOUS ILLNESS IN THE ADDICTION CARE SYSTEM

- Patients with advanced medical needs are often disqualified from inpatient or outpatient addiction treatment
- Patients receiving intensive medical treatments don't have time to attend intensive addiction treatments
- Frequent hospital admissions interrupt addiction care and increase chance of inappropriate prescribing
- Decreased functional status limits participation

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A TRADITIONAL APPROACH

- Larger and larger amounts of opioids (often with benzos)
- No boundaries or accountability
- Lack of skills in diagnosing SUDs, and discussing substance use with patients

  Result….

- When behavior escalates so much it can't be ignored, the patient is "fired"
  - Discharged from outpatient clinic or hospice
  - Loses access to prescribed opioids entirely
  - Does not participate in further treatment of their medical illness
- Falls out of care entirely and dies a difficult, painful death

ADDICTION IN OUTPATIENT PALLIATIVE CARE

- 2018 survey of 169 outpatient palliative care clinicians
- Nearly all reported encountering at least one concerning sign for substance use disorders
- Over half reported spending more than 30 minutes a day managing concerning behaviors related to opioid or other substance use
  - 5% spent more than two hours per day
- 36% reported no access to an addiction medicine specialist
- Only 13% had a waiver to prescribe buprenorphine

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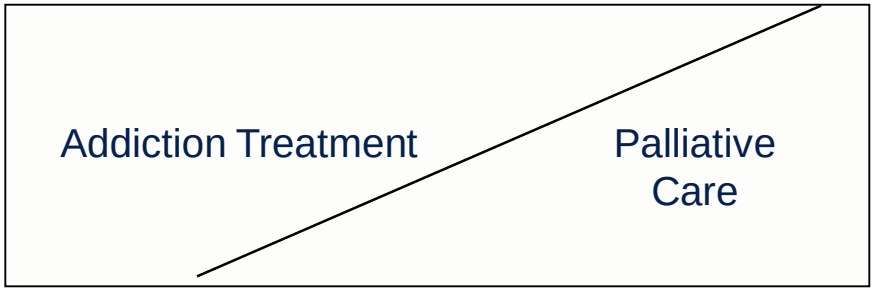
How do we accomplish this?



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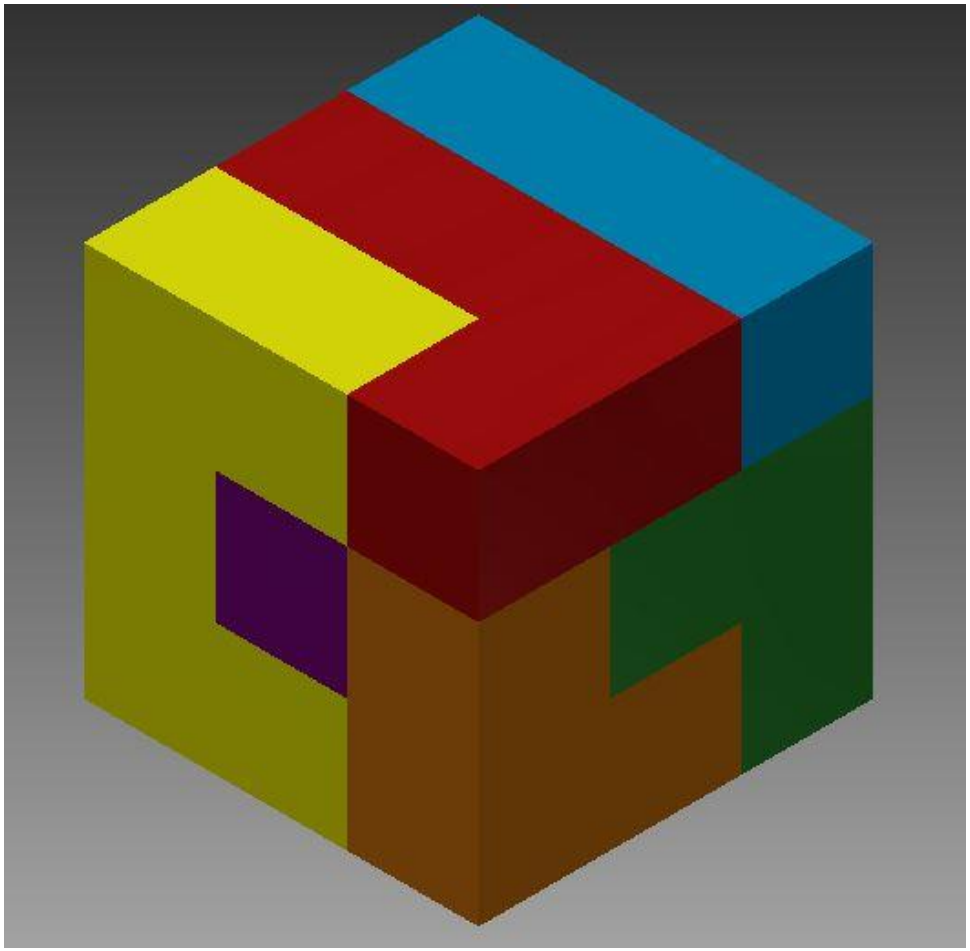
ASSESSMENT IN THREE DIMENSIONS



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1ST DIMENSION: PAIN

Principle: Not all pain is opioid responsive. Assess likelihood that opioids are likely to be helpful for the pain at all.

Is it:

- Cancer-related? (Exactly where the tumor is?)
- Chronic nonmalignant? Duration? Generalized all over body pain?
- Related to withdrawal?
- Affected by anxiety, depression, PTSD, etc?

2ND DIMENSION: SUBSTANCE USE

- Principle: Substance use disorders (SUDs) are diseases that vary in severity and time course.

- Ask:
  - Currently using substances? Which ones? How often? Attempts to control use?
  - Involved in treatment program?
  - Social network supports recovery?

3RD DIMENSION: PROGNOSIS/FUNCTION

Principle: The risk/benefit calculus changes in someone with a poor functional status and very short prognosis. And – metastatic cancer does not necessarily mean very short prognosis!

- Ask:
  - How much of the day spent in bed or chair?
  - Alert, talking, eating?
  - Are they currently taking treatments and are there more treatments after this one?
  - To their oncologist – what is expected prognosis?

RETURN TO CASE

- S is a 35 year old man with history of stage II melanoma
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- Started on treatment
- Buprenorphine is stopped and he is started on opioids and benzodiazepines

RETURN TO CASE

- S was started on buprenorphine through low-dose induction method
- Oxycodone continued
- Provided mental health counseling and treatment of anxiety disorder
- Now on buprenorphine alone

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CASE 2

- Mr. M was a 55 year old man with stage II lung cancer
- Referred to me in the outpatient PC clinic by his oncologist
- Had a history of opioid use disorder on methadone maintenance
- Told me he was “thrown out” of his methadone clinic because he was taking oxycodone prescribed by his oncologist
- Complained of all-over, aching pain
- Asking for an increase in dose and frequency of oxycodone
- How would you manage him?

CASE 3

- 48 year old woman
- On hospice for metastatic pancreatic cancer
- History of IV heroin use prior to diagnosis
- Complaining of all-over body pain
- Admitted to the inpatient hospice unit
- Stabilized on a high dose hydromorphone PCA

CASE, CONTINUED

- Discharged to home with PCA
- One day later, PCA cartridge is empty
- Patient re-admitted to inpatient hospice unit with withdrawal and uncontrolled pain

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