Individuals with substance use disorder

Introduction

Individuals with current or past substance use disorder (People who use drugs – PWUD) can have particularly complex palliative care needs.

Substance use is often associated with difficult circumstances including:

- Deprivation
- Inadequate housing
- Limited social support
- Mental and physical ill-health
- Adverse experiences such as trauma or abuse

Health care services can struggle to engage PWUD. Late presentation of advanced disease is common, pharmacology of symptom control can be complex, and continuity of care difficult.

In Scotland there is:

- A high prevalence of substance use.
- Increasing polydrug use, especially benzodiazepine co-use.
- An ageing cohort of PWUD.

Palliative care for this population is of growing importance. It is essential to offer empathetic, joined-up, non-judgemental care.

Assessment

It is preferable to identify PWUD with palliative care needs at an early stage and offer referral to Specialist Palliative Care (SPC).

- The Supportive and Palliative Care Indicators (SPICT)® tool) can be used to screen for palliative care needs.
- The Clinical Opiate Withdrawal Scale (COWS) may help to identify opiate withdrawal.

The individual should have a key coordinating professional such as Substance Use/Addictions Services (SUS) or their General Practitioner (GP).

Clear and compassionate communication is required to encourage full disclosure of substance use. Concerns around substance withdrawal can feed reluctance to be admitted to a place of care, and early reassurance on management should be offered.

A full assessment of palliative care needs and substance use should ideally be carried out jointly by SPC and the key co-ordinating professional (GP or SUS). It is important to consider both current and previous substance use. A full history of

Medication Assisted Treatment (MAT), such as methadone or buprenorphine maintenance programmes, should be included.

Consider that PWUD may be co-using benzodiazepines which may:

- Potentiate the effects of prescribed and non-prescribed substances.
- Increase the risk of respiratory depression (particularly in older people).
- Result in benzodiazepine withdrawal on admission to hospital/hospice.

Non-prescribed substance use can be dependent on drug availability and new emerging substances with variable properties. Rapid Action Drug Alerts and Response (RADAR) is Scotland's drugs early warning system. Consider accessing it to keep up to date on drug trends and targeted actions.

Management

- Treat holistically.
- Manage physical and psychosocial symptoms.
- Offer support to the individual and their loved ones.
- Be as flexible as possible, meeting at a time and place that is suitable for them.
- Regular review should be offered, and contact information provided for relevant services.
- Full multidisciplinary involvement/case conference may be of value.

Support the individual to complete a Future Care Plan (FCP). The appointment of a Power of Attorney should be considered. If there is no next of kin, offer referral to the Advocacy Service. The FCP should be shared, with consent, with relevant parties. The GP should add information to the Key Information Summary (KIS)/electronic Palliative Care Summary (ePCS).

Offer referral to financial support services such as Macmillan Benefits and complete a BASRiS (Benefits Assessment for Special Rules in Scotland) or SR1 medical report form where appropriate.

Medication

Careful liaison between the individual and care teams should allow appropriate prescribing and safe management of opioid medication for symptom control. Be mindful that under prescribing could influence the individual to seek non-prescribed substances. There may be reluctance by either the individual or clinicians to start opioid medication because of previous experience or stigma. Concerns should be sensitively addressed.

Symptom control should be assessed on an individual basis and discussion with SPC is encouraged. There should be regular clinical review.

Medication Assisted Treatment (MAT)

- Always confirm a patient's MAT dose with pharmacy/SUS and inform them of any admission/prescription changes.
- SUS may aim to stabilise MAT rather than continue to reduce.
- MAT should continue as advised by SUS and should not routinely be titrated for palliative symptom control.
- Treat the MAT as a separate prescription that is not involved in symptom management or breakthrough dose calculation.
- Opioids should be started and titrated as they normally would for symptom control. In some circumstances larger opioid doses may be required but the degree of tolerance an individual has is variable and difficult to predict.
- Controlled drugs can often be dispensed alongside the patient's usual MAT to avoid dispensing large quantities at once.
- An NHS Inform fact sheet comparing methadone and buprenorphine for opioid dependence is available.
- Naltrexone is an opioid-receptor antagonist which may be used as an adjunct to prevent relapse in patients with a history of opioid or alcohol use disorder. It should be stopped as soon as possible in patients requiring opioid analgesia. Opioid therapy introduced after discontinuation of naltrexone requires careful monitoring. There may be initial tolerance whilst naltrexone is on board following by opioid sensitivity as it wears off. Seek specialist advice.

Specific considerations for methadone MAT in palliative care

- Methadone is usually given as an oral liquid 1mg/1ml for MAT.
- Doses are taken daily and may be dispensed daily. Some patients have supervised consumption at a pharmacy.
- Typical doses for methadone MAT are 60mg-120mg/day.

Missed doses:

If 3 or more oral doses have been missed for any reason, contact SUS for advice on reintroduction dose. Usual practice is to give 50% of the previous dose and re-titrate.

Loss of oral route:

If the oral route is not available, methadone (10mg/ml injectable preparation) can be administered as a continuous subcutaneous infusion (CSCI) under the guidance of SPC. Usual practice would be conversion to a CSCI of methadone at 50% of the daily oral dose. This should be diluted in 0.9% saline and administered via a syringe pump without any other drugs over 24 hours.

Where CSCI is not appropriate/possible, Methadone can be administered at 50% of the daily oral dose split into twice daily subcutaneous bolus injections instead. Please seek specialist advice if considering this.

Practice points:

- Methadone can prolong the QT interval. Care should be taken when adding other QT prolonging drugs.
- Methadone dose may require 50% reduction where eGFR falls below 10 mL/min or in hepatic failure.

Specific considerations for buprenorphine MAT in palliative care

- Buprenorphine MAT is available in different forms including:
  - Daily sublingual dose (e.g. Subutex)
  - Daily sublingual combined with an opioid antagonist (e.g. Suboxone)
  - Depot subcutaneous injection weekly or monthly (e.g. Buvidal)
- Buprenorphine MAT is typically used at higher doses than buprenorphine in the palliative care setting (e.g. 12-16mg/day) which may result in antagonism when other opioids are required.
- Antagonism is unlikely with daily doses of under 8mg.

Missed doses:

Due to the long half-life patients can miss 2-3 days of buprenorphine before they become symptomatic of withdrawal.

If 3 or more doses have been missed contact SUS for advice regarding reintroduction and dosage.

Loss of oral route:

If the oral route is lost when using oral buprenorphine MAT, liaise with SUS for advice on the most appropriate alternative opioid and/or route. Sublingual melt buprenorphine preparation (Espranor) may be suitable or depot Buvidal conversion. Alternatively, they may advise a conversion to methadone.

Practice points:

- A switch from buprenorphine MAT to methadone MAT guided by SUS could be considered if antagonism is a concern.
- Titration of short-acting opioids to the desired analgesic effect in those treated with buprenorphine might require higher doses. This should be discussed with SPC and closely monitored.
- Where opioid analgesia is required alongside buprenorphine MAT, opioids with a high mu opioid receptor affinity, such as fentanyl and alfentanil, may be more effective. Use of these opioids should be discussed with SPC and may be limited by local guidelines/availability.
- Buprenorphine may require dose reduction in hepatic failure or where eGFR<20mL/min.

Breakthrough medication

Immediate release preparations of opioids ('breakthrough doses') may be best kept to a minimum, with titration of the background opioid preferred.

The MAT dose should not be used when calculating the appropriate breakthrough dose for symptom control.

Multiple breakthrough dose usage may represent inappropriate use or undertreated pain.

Adjuvant therapies

Non-opioid analgesics should be considered as adjuvants when appropriate, but not as substitutes for strong opioids.

There is potential for misuse of adjuvants, especially gabapentin and pregabalin. Amitriptyline has less potential for misuse but can be harmful if taken in excess.

Non-pharmacological interventions such as radiotherapy, surgery and regional anaesthetic techniques should be considered.

Anxiolytics

Where clinically indicated, consider the use of benzodiazepines and seek advice from SPC. Benzodiazepines would usually be introduced cautiously and titrated as required. There may be a degree of tolerance if there is a history of non-prescribed use, but this can be difficult to predict.

Where non-prescribed benzodiazepine use is confirmed or highly suspected consider regular benzodiazepine prescription for in-patients to prevent withdrawal.

Benzodiazepine withdrawal may present as insomnia, sleep disturbance, intrusive thoughts, panic attacks/anxiety, muscle stiffness, sensory disturbance, dizziness, palpitations, hallucinations, delirium or seizures.

Care around dying

When an individual is felt to be dying and approaching the last days of life, Take-Home Naloxone intended for opioid overdose may no longer be appropriate, and if administered, could result in severe exacerbation of pain. Patients and carers may require guidance around this.

If the oral route is lost, recently consumed substances could be replaced to avoid withdrawal. This may include the use of parenteral benzodiazepines and opioids.

Trauma, challenging social circumstances and mental ill-health frequently experienced by PWUD may increase the risk of terminal agitation.

Other considerations

The rules over medication use in certain institutions such as prisons or homeless units may impact management. Liaison may allow a solution to be facilitated on a case-by-case basis.

Summary

- The management of PWUD with a palliative diagnosis can be complex.
- Early identification of needs and referral to SPC and SUS is recommended along with close involvement of GP's.
- A collaborative approach should be adopted by health care professionals.
- Management of individuals and their families should be compassionate, holistic and non-judgemental.

References

Audit Scotland. Drug and alcohol services in Scotland 2009 [cited 2022 Apr 14. Available from: https://audit.scot/uploads/docs/report/2009/ir_090826_drug_alcohol.pdf

Beynon C, McVeigh J, Hurst A, Marr A. Older and sicker: Changing mortality of drug users in treatment in the North West of England. International Journal of Drug Policy. 2010;21(5):429-31. Available from: https://pubmed.ncbi.nlm.nih.gov/20172707/

British Pain Society. Pain and substance misuse: improving the patient experience 2007 [2022 Apr 14]. Available from: https://www.britishpainsociety.org/static/uploads/resources/misuse_0307_v13_FINAL.pdf

Galvani S, Wright S, Witham G. Good practice guidance: Supporting people with substance problems at the end of life 2019 [2022 Apr 14]. Available from: https://www.researchgate.net/publication/342260615_Supporting_people_with_substance_problems_at_the_end_of_life_Good_Practice_Guidance

Himan S, Walker G, Sykes J, Rowcroft Hospice. Palliative care prescribing for patients who are substance misusers 2015 [2022 Apr 14]. Available from: https://rowcrofthospice.org.uk/wp-content/uploads/Rowcroft-Hospice-Palliative-Care-Prescribing-For-Substance-Misusers.pdf

Neerkin J, Cheung C, Stirling C. Guidelines for cancer pain management in substance misusers 2009 [2022 Apr 14]. Available from: https://www.palliativedrugs.org/download/100615_Substance_misuse_pain_guidlines_final.pdf

Public Health Scotland. Scottish drug misuse database 2021 [2022 Apr 14]. Available from: https://publichealthscotland.scot/media/13552/2022-05-17-sdmd-report.pdf

Benzodiazepine use – current trends: evidence review. Scottish Government March 2022. [2024 Oct 07]. Available from: https://www.gov.scot/publications/evidence-review-current-trends-benzodiazepine-use-scotland/

Supportive & Palliative Care Indicators Tool SPICT®. The University of Edinburgh. [2024 Oct 07]. Available from: https://www.spict.org.uk/the-spict/

Clinical Opiate Withdrawal Scale. NHS Scotland. [2024 Oct 07]. Available from: https://rightdecisions.scot.nhs.uk/media/1855/clinical-opiate-withdrawal-scale-cows.pdf

Rapid Action Drug Alerts and Response (RADAR). Public Health Scotland. [2024 Oct 07]. Available from: https://publichealthscotland.scot/our-areas-of-work/health-harming-commodities/substance-use/surveillance/rapid-action-drug-alerts-and-response-radar/what-is-radar/

Handy fact sheet. Methadone vs buprenorphine for opioid dependence. NHS Inform. [2024 Oct 07]. Available from: https://www.choiceandmedication.org/nhs24/generate/handyfactsheetmethadonevsbuprenorphineuk.pdf.

Twycross R, Wilcock A, Howard P (eds). Methadone. In: Palliative Care Formulary 5. Nottingham: Palliativedrugs.com Ltd, 2015, pp. 433–439. Available from: https://doi.org/10.1136/ejhpharm-2015-000652