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## Discontinuation: Voluntary & Involuntary Withdrawal

Typically a process  
Not an event

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## Engagement

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- Model the high level of professionalism required to work effectively with patients who may have concurrent mental health and addiction issues, marginalized lifestyles, poor life skills, criminality, a history of abuse, and low levels of trust.
- Is your booking realistic, or are you creating congregation and problems in the waiting room?

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## Objectives

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- Review indications for discharge.
- Develop a therapeutic approach, in the context of the nature of Substance Use Disorders.
- Explore the balance between patient-centred care and the need for staff safety and mutual respect.

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## Pharmacy Related Discharge

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- Loss of pharmacy access, with no safe alternatives.
- Pharmacy discharge: typically shoplifting or abusive behaviour.
- Repeated pharmacy absences, with problematic dosing changes and increased risk.

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## Engagement

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- Ensure the program expectations for urine drug screens, appointments, communication and mutual respect are well established at intake.
- Work cooperatively, within your team, to maintain healthy boundaries with clients.

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## Program Related Discharges

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- Abuse of staff.
- Refusal to provide, or tampering with, UDS.
- Non-attendance.

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## The Discharge Process 7

- Can be immediate for egregious behaviour and non-participation.
- Typically a process however, emphasizing the need for active engagement.
- Provide enhanced support, as indicated.
- Taper dose gradually (5 mg. Q 2-4 weeks).
- Accelerate as indicated (5 mg. weekly).
- Leave the door open for their return.
- Emphasize the importance of their recovery work: this is not about the rules, their gaming, or power and control.

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## CPSS Standards: Involuntary Withdrawal 10

- 2) Daily witness during taper.
- 3) Ensure managing physician is an Initiating Physician.
- 4) Notify the CPSS of any discharges.
- 5) The physician must warn the patient about the loss of tolerance and the risk of toxicity (overdose) if they relapse.
- And provide access to naloxone.

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## CPSS Standards: Involuntary Withdrawal 8

- “Consider when continuation of treatment presents an unreasonable risk to the patient, treatment staff, prescribers, pharmacy staff, or the public.”

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## CPSS Guidelines: Involuntary Withdrawal 11

- 1) Explain the reasons to the patient and document the rationale.
- 2) May use an aggressive schedule: 10% reduction per day, or 1 mg. per day, whichever is greater.
- 3) May use pharmacotherapy in the final 1 – 2 weeks to relieve withdrawal symptoms.
- 4) Encourage engagement with other health care professionals or a treatment program.

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## CPSS Standards: Involuntary Withdrawal 9

- 1) May transfer or discharge a patient if:
  - Behaviour has been threatening, disruptive or violent.
  - They have been consistently non-compliant with the treatment agreement.
  - At high risk for an adverse outcome, and attempts to reduce the risk have failed.
  - Diversion has been confirmed.

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## Warning!

- Rapid involuntary withdrawal in the age of fentanyl is a set up for relapse, potential overdose and death.
- Warning the patient is not sufficient.
- Take Home Naloxone should be provided.
- Reserve discharge for those who truly are placing themselves or others at risk.

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### Involuntary Withdrawal: Case 1 A 13

- 29 year old male with long term poly-substance IVDU. HIV negative, HCV positive.
- Repeatedly avoids UDS. Reluctant to increase methadone dose but insistent on more morphine to address withdrawal.
- What would you do?

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### Involuntary Withdrawal: Case 1 D 16

- Repeated concerns over continued stimulant use and lack of engagement in accessing services persist at 6 - 8 months.
- Counselling is increased, as are recommendations to access detox and rehab for the stimulant use.
- Client remains ambivalent.
- What would you do?

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### Involuntary Withdrawal: Case 1 B 14

- Same patient. Reluctantly provides UDS. Has completed opioid withdrawal and is on methadone alone. Dose adjustment continues.
- UDS remains positive for cocaine or crystal methamphetamine.
- Demands carries, at 6 weeks.
- What now?

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### Involuntary Withdrawal: Case 2 A 17

- 26 year old woman with 3 children has progressed well, with opioid negative UDS and successful progress in her vocational training program.
- She has earned 1:6 carries.
- CLH is released from jail. UDS now become cocaine positive.
- She does not return to school for the next semester.
- What now?

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### Involuntary Withdrawal: Case 1 C 15

- Same patient. UDS are opioid negative at 80 mg. OD.
- Still stimulant positive at 12 weeks.
- Misses appointments, frequently misses at the pharmacy and is "challenging" for the pharmacy staff to manage. (impatient, loud, demanding)
- He refuses to access detox and drug rehab services.
- What next?

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### Involuntary Withdrawal: Case 2 B 18

- Carries are cancelled, but UDS remains cocaine positive.
- You step up your stimulant response plan: 1) offer increased counselling, detox and rehab, 2) explain your refusal to support her cocaine use.
- Your interventions are ineffective.

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## Involuntary Withdrawal: Case 2 C 19

- The pharmacy complains of increasing conflict. Her children are highly disruptive, out of control, damaging displays and knocking stock from the shelves.
- She frequently yells, disrupts other customers, and argues with the staff.
- She is threatened with a pharmacy discharge, the only one in town to dispense methadone.
- What would you do?


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## Involuntary Withdrawal: Case 2 CD 20

- You initiate a taper, but pharmacy services continue.
- Her UDS remain cocaine positive, opioid negative, until near the end.
- She relapses onto opioids, and requests continuation.
- What now?

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QUESTIONS?

**THANK YOU!**

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