Discontinuation: Involuntary Discharge

TYPICALLY A PROCESS

NOT AN EVENT

Objectives

- 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.

Engagement

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

Pharmacy Related Discharge

- Lack of pharmacy access, with no safe alternatives.
- Pharmacy discharge: typically shoplifting or abusive behaviour.
- Repeated pharmacy absences.

Program Related Discharges

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

Drug Use Discharge: Opioid

- Rare phenomenon.
- Persistent opiate positive, typically fentanyl or heroin.
- Assertive dosing, reasonable expectation of a good blockade.
- Address triggers and pattern of use.
- Is methadone being used to mitigate withdrawal, and enable continued IVDU?

Drug Use Discharge: Stimulants

- More common.
- Cocaine, methylphenidate, methamphetamine.
- Cancel carries first, ask questions later.
- Recognize role of needle craving.
- Encourage detox, rehab, increased engagement in recovery work.
- If indicated, taper gradually: often the specter of daily opioid withdrawal stimulates reflection and change.

Stimulant Use Exception

- HIV positive, on ART linked to methadone.
- Even with continued stimulant use, people can achieve improved CD4 counts and undetectable viral loads.
- Continued engagement in care may lead to eventual stimulant extinguishment.
- In the interim this represents true Harm Reduction, with demonstrable efficacy, rather than addiction treatment.

The Discharge Process

- 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.

CPSS Guidelines: Involuntary Withdrawal

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

CPSS Standards: Involuntary Withdrawal

- 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.

CPSS Standards: Involuntary Withdrawal

- 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.

CPSS Guidelines: Involuntary Withdrawal

- 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.

Involuntary Withdrawal: Case 1 A

- 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?

Involuntary Withdrawal: Case 1 B

- 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.
- Has begun to demand carries, at 6 weeks.
- What now?

Involuntary Withdrawal: Case 1 C

- 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?

Involuntary Withdrawal: Case 1 D

- Repeated concerns over continued stimulant use and lack of engagement in accessing services persist at 6 - 8 months.
- A gradual taper is initiated, with sharing of the rationale.
- Commitment to stop the taper is given, with persistently stimulant negative UDS.
- As the taper progresses, at 5 mg. q 2 weeks, the patient appears to re-engage. UDS are now stimulant negative.
- What would you do?

Involuntary Withdrawal: Case 2 A

- 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?

Involuntary Withdrawal: Case 2 B

- 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 and 3) share your next step of a tapered withdrawal.

- Your interventions are ineffective.

Involuntary Withdrawal: Case 2 C

- 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?

Involuntary Withdrawal: Case 2 CD

- You negotiate a more rapid 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?

Thank you!

QUESTIONS?