DISCONTINUATION: INVOLUNTARY DISCHARGE

Typically a process

Not an event

- 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.

OBJECTIVES

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- 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.

ENGAGEMENT

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

CPSS GUIDELINES: INVOLUNTARY WITHDRAWAL

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- 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

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- 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 STANDARDS: INVOLUNTARY WITHDRAWAL

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

CPSS GUIDELINES: INVOLUNTARY WITHDRAWAL

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

PROGRAM RELATED DISCHARGES

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

PHARMACY RELATED DISCHARGE

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- Retention in care provides the best opportunity for success.
- Regardless of associated high risk habits, continuance on OAT results in decreased HIV sero-conversion and improved access to health care.
- If persistently OPIOID positive, increase dose to improve the blockade; consider rapid metabolism and split dosing; and / or address needle craving.

DRUG-RELATED DISCHARGE?

- If STIMULANT positive, maintain OAT, ramp up counselling, offer detox and rehab and explore utility of OAT in their lives. Increase attempts at engagement.
- If HIV positive, link ART to OAT. CD4 counts can rise and Viral Load decrease even in the context of continued stimulant use.

DRUG-RELATED DISCHARGE?

- ALWAYS provide access to Take Home Naloxone to prevent relapse related opioid overdose deaths.
- Discharge can be immediate for egregious behaviour and non-participation.
- Typically a process however, emphasizing the need for active engagement.
- Provide enhanced support, as indicated.

THE DISCHARGE PROCESS

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- Consider a "therapeutic transfer" to another physician.
- Taper the dose gradually, 5 mg. q 2 weeks, or q 1 week, if indicated.
- Leave the door open for their return.
- Emphasize the importance of their recovery work: this is less about the rules, their gaming, or power and control and more about supporting them in making better choices.
- If they do re-engage, negotiate the management strategy to best address the reasons for their discharge.

THE DISCHARGE PROCESS

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- 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 1 A

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- 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 1 B

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- 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 1 C

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- You negotiate a controlled taper, she has someone to provide childcare when she visits the pharmacy, and pharmacy services continue.
- Her UDS remain cocaine positive, opioid negative, until near the end.
- She relapses onto opioids, and requests continuation.
- What now?

INVOLUNTARY WITHDRAWAL: CASE 1 D

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THANK YOU!

peter.butt@usask.ca

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