**Palliative Care in People Who Use Drugs**

**Introduction**

People with current or past problematic drug use (People who use drugs – PWUD) and / or alcohol issues have particularly complex needs when faced with a palliative diagnosis. They may have difficult social circumstances and co-existing mental ill-health. There may be a history of trauma or abuse in their past. For a variety of reasons, health care services may struggle to reach them. It is essential to offer empathetic, joined-up care in a non-judgemental fashion.

**Financial**

**Assessment**

It is preferable to identify PWUD with palliative needs at an early stage. Such patients should be offered referral to both the Specialist Palliative Care Team (SPCT) and the Community Addiction Team (CAT) within NHS Lanarkshire if not already accessing these services. A joint assessment will be offered and encouraged.

If uncertain whether or not a patient has dual needs, screening tools may be of use. The SPICT tool can be used to screen patients in whom palliative needs are suspected, the AUDIT tool for those with suspected problematic alcohol use. Any significant illicit drug use should trigger referral, except for those using cannabis or other drugs that are not felt to be interfering with wellbeing. Both SPCT and CAT would encourage discussion if there is uncertainly.

Clear, honest and compassionate communication is required to encourage the individual to fully disclose the details of their drug or alcohol use. Reassurance should be offered that this information is required to provide treatment specifically tailored to their individual circumstances.

A full assessment of palliative care needs and substance use will be carried out during joint assessment by SPCT and CAT. It is important to distinguish between active users of drugs/alcohol, individuals on Medication Assisted Treatment (MAT- such as methadone or buprenorphine maintenance programmes), and those in recovery. This will influence the approach adopted by the teams who will seek to incorporate the individual’s hopes, fears and goals in the treatment plan.

**Management**

The aim will be to treat the individual holistically; to manage physical and psychosocial symptoms and to offer support to both the patient and their loved ones. CAT will aim to stabilise dependency issues rather than actively pursue recovery.

Services should be as flexible as possible, aiming to meet with the individual at a time and place that is suitable for them. Regular review should be offered, and the individual should be given contact information for both services (key worker in CAT, Clinical Nurse Specialist (CNS) in SPCT). and whether,

With support from the specialists, the individual should be encouraged to complete a meaningful Advanced Care Plan (ACP). As the patient’s circumstances may be challenging, it is particularly important to establish their hopes for the future and to understand what they might wish for the end of their life. Sensitive discussions around cardio-pulmonary resuscitation should take place. The individual will be encouraged to consider who they would wish to represent them should they lose capacity. This might be formalised legally through a Power of Attorney. If the individual has no Next of Kin, it may be necessary to involve the Advocacy Service through Social Work Department. Once formulated, ACP information should be shared, with consent, with relevant parties. In particular, the plan should be available to the GP and Out of Hours service via the KIS/ePCS.

Those with a history of opioid use may have a degree of opioid tolerance and need larger doses of opioids for symptom control. Due to concerns around problematic opioid use and diversion, anecdotally opioids may be under-prescribed in a palliative care setting. Careful liaison between the patient, carers/relatives, SPCT, CAT, the patient’s General Practitioner (GP) and District Nursing (DN) team should allow appropriate prescribing and safe management of opioid medication for symptom control.

Two levels of intervention are offered, depending on the complexities of the situation:

**Level 1**: Joint assessment with the key worker from CAT and SPCT CNS. An SPCT medical consultant will also be involved from an early stage.

**Level 2**:

Joint assessment with medical leads from both CAT and SPCT.

**And /or**

Full Multidisciplinary Team assessment with representation from CAT and SPCT and input (as appropriate) from the patient and / or carers, GP, District Nurses, Addiction Psychologist, and any other services involved (such as psychiatry, advocacy, social work).

**Medication**

It is not within the scope of this guidance to advise on particular medication regimes for opioids or other medication for symptom control as this will be assessed on a case by case basis. However, some general principles apply.

Opioid maintenance should be considered separately from opioid use for pain or dyspnoea. Opioids should be started and titrated as they normally would for symptom control, but there may have to be dose escalation if the patient has a degree of tolerance.

Calculating opioid doses for breakthrough use may be complex. SPCT will advise. However, the rule of 1/6th of the total daily symptom control opioid dose should still apply. MAT doses should not be incorporated into breakthrough dose calculations.

If an individual is on buprenorphine opioid maintenance and requires a strong opioid such as morphine for pain management, the specialists will consider a switch from buprenorphine to methadone as buprenorphine is a partial opioid antagonist.

Immediate release preparations of opioids (‘breakthrough doses’) may be best kept to a minimum, with titration of the modified release, background opioid preferred. Sublingual fentanyl preparations pose a particular risk because for their fast onset of action.

Prescribing of anxiolytic medication is complex when there has been significant past use of benzodiazepines, with concerns around potential respiratory depression when combined with opioids and other medication. Benzodiazepine prescribing should not be excluded but specialist advice should be sought.

When a patient is nearing the end of life, it may be appropriate to offer replacement of recently consumed substances to avoid withdrawal symptoms. This may include prescribing parenteral benzodiazepines (for alcohol or benzodiazepine use) and parenteral opioids.

If the patient is in prison or a homeless unit, the rules over the use of medication for the particular institution may complicate management. Liaison between Health Care Professionals (HCPs) and staff within the institution may allow a solution to be facilitated on a case by case basis. **a**

**Practice Points**

The management of individuals with problematic substance use and a palliative diagnosis can be complex.

Early identification of needs and referral to SPCT and CAT is recommended.

A collaborative approach should be adopted by HCPs.

There is a risk of under-prescribing analgesia / anxiolytics for patients who have a degree of tolerance.

Management of patients and their families should be compassionate, holistic and non-judgemental.

**How to make a referral**

All community referrals to SPCT should be made via telephone triage on 01698 754501. Any HCP can make a referral.

Referral to CAT locality team can be made by the GP (by phone or SCI Gateway) or self-referral. Details of administrative staff are attached.



**Screening Tools**

SPICT: [**https://www.spict.org.uk/the-spict/**](https://www.spict.org.uk/the-spict/)

AUDIT: [**https://patient.info/doctor/alcohol-use-disorders-identification-test-audit**](https://patient.info/doctor/alcohol-use-disorders-identification-test-audit)

**Reference**

[good-practice-guidance-supporting-people-with-substance-problems-at-the-end-of-life.pdf (wordpress.com)](https://endoflifecaresubstanceuse.files.wordpress.com/2019/05/good-practice-guidance-supporting-people-with-substance-problems-at-the-end-of-life.pdf)

Good Practice Guidelines, 2019

Supporting people with substance problems at the end of life

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