

**FAST FACTS AND CONCEPTS #127**  
**SUBSTANCE USE DISORDERS IN THE PALLIATIVE CARE PATIENT**

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**Background** The spectrum of substance use disorders (SUDs) is characterized by increasing degrees of craving, compulsive use, loss of control, and continued use despite harm (see *Fast Fact #68*). Addiction is understood to be a disease with complex genetic, neurobiological, psychosocial, and behavioral determinants. If not properly managed an SUD can: 1) complicate the diagnosis and treatment of psychological (e.g. depression) and physical (e.g. pain) symptoms; 2) compromise compliance with the palliative treatment plan; 3) impair a stressed social support network; 4) weaken trust in patient-physician/nurse relationships; and 5) promote the use of opioids to cope with emotional distress and decision-making – “chemical coping.”

The prevalence of SUDs in palliative care is unknown, but likely reflects that of the general population in which alcoholism and abuse of prescription and non-prescription drugs is common. Bruera reported a prevalence of alcoholism of 27% in patients admitted to a tertiary care palliative medicine unit. Kwon identified an 18% prevalence of chemical coping in a Palliative Medicine clinic. Far from being a source of pleasure, SUDs are more commonly a source of suffering for affected individuals and their loved ones. Addressing addiction may allow for: 1) preservation/restoration of damaged social supports; 2) restoration of self-respect and dignity; 3) accomplishment of end-of-life work through recovery; and 4) improvement in quality of life for patients and families.

**Substance Use Disorders and Pain Management** Patients with a current or past history of an SUD are particularly challenging. Patients who are in recovery are often fearful of using opioids, even in the setting of severe pain near the end-of-life. Conversely, the ability to complete a pain assessment and use opioids effectively is challenging in patients with an active SUD. Listed below are suggested management techniques in patients with a past or current SUD.

1. Complete a thorough substance use history. Distinguish between those who have active SUDs from those who are at-risk or in recovery. Validated tools such as the Opioid Risk Tool are available for risk stratification. Explain to patients why your knowledge of this information is important for their care. Be empathic and nonjudgmental.
2. Encourage participation in recovery programs (e.g. 12-step) if the patient is willing and physically able. Consider consultation with an addictions/mental health professional.
3. Formalize a treatment plan and coordinate it with all other involved health professionals.
4. Consider use of a written opioid agreement with carefully defined patient and provider expectations; this may give motivated individuals a sense of control over their SUD. Components of an opioid agreement include: establishing a single opioid prescriber, using a single pharmacy, employing pill counts and periodic urine drug testing (see *Fast Fact #110*).
5. Use non-opioid analgesics and non-pharmacological measures to their full potential; poorly controlled pain can increase substance abuse behaviors (see *Fast Fact #69*).
6. Use opioids at appropriate doses and at appropriate intervals. Titrate long-acting opioids to minimize the need for short-acting opioids. *Note:* opioid-tolerant patients may need larger than ‘usual’ doses.
7. Address anxiety with counseling, antidepressants and, if necessary, judicious use of anxiolytics; this has been shown to reduce illicit drug use in a hospice population (8).
8. Monitor closely; frequent contact allows for close patient observation and prescription of limited quantities of opioids. Careful monitoring will usually distinguish whether deteriorating function is due to substance abuse or disease progression.
9. Recognize that addiction is a chronic, relapsing illness – and respond with increasing structure and compassion.
10. Develop system policies for identifying and appropriately treating patients with substance abuse.

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