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Typical Clinical Dilemmas and Some Ideas for How to Manage Them

There is no right or wrong way to manage a challenging situation with a patient. So many factors come into play, making each difficult situation unique. Nonetheless, there are certain "difficult" scenarios that regularly occur in our practice. Here is a description of some of the more challenging situations we cope with frequently, and how we have responded to them. Almost all of these clinical dilemmas center around how to respond effectively to a woman's relapse or lack of progress in treatment. Talking to women about their difficulty managing their addiction is frequently painful for both patient and provider, and whenever possible we try to have these conversations with more than one staff person in the room. Often this will be the MAT provider and the Behavioral Health Clinician, but other configurations are also possible. We don't recommend having the Recovery Coach being involved in difficult conversations about relapse and recommendations for change in a woman's treatment, because we feel it is important that the patient-Recovery Coach relationship be characterized by peer to peer support, free from the power dynamic that is inherent in the patient-provider relationship.

- *Missing Appointments*

  Coming to appointments regularly is challenging for many women with children, and also challenging for people with addiction and people without reliable transportation. Having a conversation at the outset of treatment about the importance of regular attendance helps set the tone. Minimizing the situations in which a prescription will be called in to the pharmacy helps reinforce this expectation (occasionally it will seem unreasonable to insist that a woman present to the clinic in order to pick up her prescription, but for the most part the expectation that a woman must come in and test before she receives her prescription is supportive of her recovery). If a woman states she is unable to come to treatment because she needs to be available for other meetings, it can be helpful for a staff member to intervene by asking permission to call the other agency involved (such as DCYF, the VNA, Probation and Parole) and asking them to schedule visits with your patient at a different time. Sometimes a woman will need to miss group; in this case, we ask her to "make up" the session somehow—this could be by going to a twelve-step meeting (and documenting this by a signed note from the speaker), coming to an individual therapy session or finding some other creative way to support her recovery that week.

- *Lost or stolen prescriptions*

  All women receiving buprenorphine/naloxone in our clinic are asked to sign a contract (see sample contracts) that states they understand that lost or stolen prescriptions will not be replaced unless a police report has been made. It can also be helpful to talk with women about how to keep their medications and other belongings safe, especially if they live with people who are not trustworthy. Occasionally, and particularly if a woman is pregnant, a provider may feel it is important to replace a lost prescription one time, but this is a rare occurrence that would not normally happen more than once. If a woman is consistently unable to keep her prescription safe, it is appropriate to refer her to a facility where she can receive daily dosing.

- *"I can't pee!" (Patient is unable or unwilling to provide urine sample for point of care drug testing)*

  In our clinic women are required to provide a UDS each time they are seen for any service, including individual therapy. The UDS should be produced before any services are received, and prescriptions are generally not given out until the patient has provided a urine sample. We feel that if we are not fairly rigid about this requirement, "I can't pee" would quickly become an epidemic.

- *UDS tampering*

  It is not uncommon for patients with addiction to attempt to tamper with the urine sample if they are unhappy with what it is likely to reveal. Point of care testing is a helpful tool that allows patients to share information they might otherwise have difficulty talking about. There are multiple pressures that cause women to want to look like they are doing better than they really are. We feel it is helpful for our patients if we make it less easy to cheat, so we ask our patients to provide observed urine tests on a random and not so random basis (if we are aware that a woman is struggling we are likely to ask for observed testing each time she presents to the clinic). We also randomly send out samples for confirmatory testing, which will screen for alcohol use, fentanyl use and other discrepancies we are not able to capture with the point of care drug testing.

- *"I don't know why my I'm testing positive for cocaine!" (Patient denies drug use in spite of UDS being positive for illicit substances.)*
  Patients will frequently deny drug use in spite of evidence to the contrary. We are sometimes taken aback by how adamantly they will insist that they have not used drugs when clearly this is not the case. We do not find it helpful to argue with patients about whether they have or have not used. We do feel it is helpful to order confirmatory testing when a UDS is positive for a substance the patient denies using, as false positives can occur with point of care testing. If it is clear that a patient has in fact been misusing

substances but she continues to deny it we try to carry the conversation forward without insisting that she admit to her drug use. For example, we might say something like "We understand that you don't know how the cocaine got into your body, but now we have to make a plan for how to make sure it doesn't get into your body anymore. We think you should consider going to a residential treatment program."

- *Patient is testing negative for buprenorphine*

  When a patient is prescribed buprenorphine and then tests negative for it, without a reasonable explanation, this is often an indication that the medication is being diverted. This may be an indication that a woman is not ready for an outpatient level of care and should be referred to a clinic where she can receive daily dosing.

- *The UDS does not indicate a problem with relapse, but a woman's behavior indicates that she has relapsed.*

  There are many substances of abuse that cannot be detected by the average point of care test, or even in a lab test. The treatment team may have reason to believe that a woman has relapsed, even though there is no biological evidence of this. In this instance, it is helpful to discuss concerns with the patient candidly, and to be specific about what causes these concerns. For example: "I've had reports from several people in the community that they are concerned you have relapsed, you missed group last week and today you fell asleep three times in group. I notice you have sores on your arms, which makes me worry that you've been injecting. Let's talk about what's going on." It does not help a woman to ignore behavior that indicates she may be relapsing, even though these conversations are usually difficult ones.

- *A woman is relapsing but refuses a higher level of care*

  It is well known that people with substance use disorders can be extremely resistant to accepting the full extent of their illness. Mothers with substance use disorders can be even more resistant than the average patient because the stigma associated with mothers who use drugs is so great, and their shame over relapse is so intense that it perpetuates the denial. Also, a serious dilemma for a mother is that if she were to accept a higher level of care—either an intensive outpatient program or a residential program—there will be no one to watch her children and she may end up losing custody of her children.

  To the extent that we are able, we try to work with women to develop treatment plans that can work for them. We try to be flexible. If we have adequate capacity, we may ask a woman to come in for more frequent visits, to attend individual therapy visits or 12-step meetings as a way of increasing accountability and support. If the only treatment plan a woman will accept seems unlikely to succeed, we feel like it is still reasonable to give her the opportunity to try it. However, if a woman has gone more

than a week or so and is unable to stop using drugs, it's probably not in her best interest to allow the plan to continue when it has proved to be ineffective.

Ultimately, continuing to serve a patient who is very ill at an outpatient level of care is not in her best interest. We would not give a patient who is having a heart attack an aspirin and hope for the best: we would admit her to the hospital and perform surgery! Similarly, when we continue to provide MAT and weekly group treatment to a woman who continues to use heroin, methamphetamine, cocaine or other drugs that place her life at risk, we do not want to imply by our actions that weekly treatment is adequate.

- *Inappropriate behavior with staff or other group members*

  Examples of inappropriate behavior include throwing things, physically threatening or assaulting another person, highly offensive language aimed directly at another person, trying to sell drugs or buy another group member's prescription, or endangering another person's safety. The response will be somewhat dependent on the seriousness of the offense. Ultimately, it is the responsibility of the program's staff to maintain an environment that feels safe and comfortable for everyone. Inappropriate behavior should never be ignored, but if a woman blows up or lashes out in the heat of the moment, it is usually best to allow her to take a break and address the issue at a later time, which could either be the next visit or in between sessions by phone or at a specially scheduled visit. It is always helpful to have two staff members present when discussing a patient's inappropriate behavior. A patient needs clear feedback about what specific things she has done that are unacceptable and what the future consequences will be (for example "Calling the receptionist names, throwing your cellphone or any other object and slamming doors is unacceptable behavior and it won't be tolerated. If it happens again we will need to discharge you from this program," NOT "We can't have you getting so upset during group. If you get upset like that again we'll have to make some changes.") It can then be helpful to make a plan with the patient about how she can use positive coping skills to avoid any future occurrence of similar behaviors.

  Obviously if a woman has broken the law or endangered the well-being of another person then more serious consequences might need to occur. In our clinic, whenever there is a strong likelihood that a woman is selling drugs or buying medication from other group members, this is grounds for discharge without much discussion.

- *Violating other group members' confidentiality*

  In order to avoid confidentiality violations, we have found it helpful to repeat our confidentiality agreements at the beginning of every single group. We remind women about what confidentiality means, and how to avoid accidental violations of confidentiality. We remind women not to mention group or who comes to group or what's said in group on Facebook or other social media platforms. We talk about how

to avoid "outing" each other when we meet in public. We have found that constant reminders about confidentiality really help. When group members (or staff!) accidentally violate each other's confidentiality we try to resolve the subsequent tension by talking about what has happened, why it happened, and how we can change our behavior so that it won't happen. A patient who is consistently unable to respect other patients' confidentiality is not group ready and will need to be transferred to a different program.

- *When to engage child protective services*

  All health care providers are mandated reporters, and if we believe a child to be at risk we clearly need to report this to child protective services. However, we are also aware that whenever we make a report to Child Protective Services we also put the patient-provider relationship at risk. It is very common for a woman to drop out of treatment if her provider makes a CPS report, and this can also have far-reaching negative consequences for the family. Therefore, we are always thoughtful about taking this step.

  Things to consider when we decide whether or not it is necessary to make a report to CPS include the degree of risk-taking behavior and the vulnerability of the child. For example, taking a Percocet is not the same degree of risk as IV heroin use. A premature baby on a strict medication regime has a different level of vulnerability than a healthy nine year old.

  If a mother is relapsing, it is important to explore with her where her children are when she is using drugs and what her plans are for making sure her children are cared for while she is struggling with relapse. If a woman is not able to make or implement a safe plan for her children, the provider needs to communicate this to CPS. Whenever possible, we try to have moms participate in making this report and share with the intake worker how they plan to improve their health.

- *Avoiding prenatal visits or other health care visits or procedures*

  This model offers addiction treatment that is co-located with perinatal and well-woman healthcare. At times, women may be more committed to their addiction treatment than to their perinatal treatment, and may avoid visits with the midwife. The reverse can also be true, that women attend perinatal visits but avoid group. Because this is an integrated care model, we believe women need to commit to good perinatal care and good addiction treatment at the same time. If a woman has missed several prenatal appointments, we may let her know that she will not receive her prescription until she has met with her prenatal care provider.