Substance Abuse and Drug Diversion in the Hospice Setting

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Objectives
• Explain the current national epidemic of illegal prescriptive drug use
• Diagnose substance abuse and/or drug diversion in the hospice setting
• Implement a staff awareness campaign and formulate a narcotic process

National Statistics
• Prescription drug abuse is the Nation’s fastest-growing drug problem
• Decrease in the use of some illegal drugs like cocaine, heroin
• 1/3 of people aged 12 and over who used drugs for the first time in 2009 began by using a prescription drug non-medically. (Results from the 2009 National Survey on Drug Use and Health National Findings, SAMHSA 2010.)
• Over 70% of people who abused prescription pain relievers got them from friends or relatives, while approximately 5% got them from a drug dealer or from the Internet. (Results from the 2009 National Survey on Drug Use and Health (NSDUH): National Findings, SAMHSA (2010)
• Prescription drugs are the 2nd most-abused category of drugs after marijuana. (University of Michigan, 2009 Monitoring the Future: A Synopsis of the 2009 Results of Trends in Teen Use of Illicit Drugs and Alcohol)
Responsibility of Healthcare Workers

Healthcare professionals have shared responsibility for solving the prescription drug abuse and diversion problem

- Legal and ethical responsibility to uphold the law and to help protect society from drug abuse
- Professional responsibility to prescribe controlled substances appropriately
  - Guarding against abuse
  - Ensure that patients have medication available needed
- Personal responsibility to protect your practice from becoming an easy target for drug diversion
  - Become aware of the potential situations where drug diversion can occur
  - Safe guards that can be enacted to prevent this diversion

http://www.deadiversion.usdoj.gov/exit_pages/dea.htm (Drug Enforcement administration web site)

Common Drugs of Concern

- 1,3-Dimethylamylamine (1,3-DMAC or 1,3-DMAB or 1,3-DMA)
  - Street Names: "Spyder Meth"
- Carisoprodol (Trade name: Soma®)
- Clenbuterol (Street Names: Clen)
- Cocaine (Street Names: Coke, Snow, Crack, Rock)
- Dextromethorphan (Street Names: DXM, DM, CCC, Triple C, Candy, Robo, Velvet, Raja)
- Gamma Hydroxybutyric Acid (Street Name: GHB, Liquid Ecstasy, Liquid X, Goop, Georgia Home Boy, Easy Lay)
- Jimson Weed (Datura stramonium)
- Ketamine (Street Names: Special K, "K", Kit Kat, Cat Valium)
- Kava (Other Names: Ava, Intoxicating Pepper, Kava Kava, Kawa, Sibak, Tonga, Unagi, Yangona)
- Ketamine Hydrochloride (Ketalar®, Ketanest®)
- Methamphetamine (Trade Name: Desoxyn®; Street Names- Meth, Speed, Crystal, Glass, Ice, Crank, Yellow)
- Ketamine (Street Names: Speed, Crystal, Glass, Ice, Crank, Yellow)

- N,N-Dimethyltryptamine (DMT)
- D-Lysergic Acid Diethylamide (Street Names: LSD, Acid, Blotter Acid, Window Pane)
- Fentanyl (Trade names: Actiq®, Fentora™, Duragesic®)
- Fospropofol (Lusedra®)
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Common Characteristics of Drug Abusers

- Assertive personality
  - Demands immediate action
- Unusual appearance
  - Extremes of either slovenliness or being over-dressed
- Unusual knowledge of controlled substances
  - Gives medical history with textbook symptoms OR
d- Gives evasive or vague answers to questions regarding medical history
- Reluctant or unwilling to provide reference information.
  - No regular doctor
  - No health insurance
- Will often request a specific controlled drug and is reluctant to try a different drug

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- Must be seen right away
- Wants an appointment toward end of office hours
- Calls in after regular hours
- States he/she’s traveling through town
  - Visiting friends or relatives (not a permanent resident)
- Feigns physical problems
  - Abdominal or back pain, kidney stone, or migraine headache in an effort to obtain narcotic drugs
- Feigns psychological problems
  - Anxiety, insomnia, fatigue or depression in an effort to obtain stimulants or depressants
- States that specific non-narcotic analgesics do not work or that he/she is allergic to them
- Contends to be a patient of a practitioner who is currently unavailable or will not give the name of a primary or reference physician
- States that a prescription has been lost or stolen and needs replacing
- Deceives the practitioner
  - Requests refills more often than originally prescribed
- Pressures the practitioner by eliciting sympathy or guilt or by direct threats
- Utilizes an elderly person when seeking pain medication

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**How to Approach the Patient/Family**

- **DO:**
  - Perform a thorough examination appropriate to the condition
  - Document examination results and questions you asked the patient
  - Call a previous practitioner, pharmacist or hospital to confirm patient’s story
  - Write prescriptions for limited quantities
- **DON’T:**
  - “Take their word for it” when you are suspicious
  - Dispense drugs just to get rid of drug-seeking patients

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- Take a non-judgmental stance
- Acknowledge a difficult situation
- Start with broad, open ended questions
- The patient is the expert in their care and needs
- Examine the patient for signs of flexibility
- State “the facts” and concerns re: patient wellbeing/plan of care
- Have honest communication

Awareness Amongst Hospice Team
- Identify the problem
- Educate staff
- Contact with patient/family and possible issues
- Develop team specific contract for all new home admits
- Develop process for suspected drug diversion

Narcotic Agreement
- Explain the expectations of the patient/ hospice team
- Explain the role of the physician
- List risks and benefits of the proposed therapy
- Provide a rationale for your policies
- Open/honest communication re: if hospice plan of care is unable to be followed
Case Study Discussion

- **Case 1 BC**
  - Case Review
  - Opportunities for Growth/Learning

- **Case 2 BK**
  - Case Review
  - Team Process in Place

Case 1 BC

- 66 y/o white female living at home with daughter as primary caregiver
- Hospice dx: COPD
- History per patient/daughter of RA and MS
- Prior to hospice, frequent hospital admissions for COPD exacerbation and anxiety
- Pt complaining of pain “all over”, pain 8/10 most of the time
Case 1 BC Continued
- Started on oral oxycodone prior to service
- Requiring escalating doses of pain medications
- Family report that only the short acting effective
- Education provided by RN Case Manager about narcotics
- Family still unwilling to try long acting narcotic

Case 1 BC Continued
- Family calling after hours and on week-end for refill of narcotics
- Covering RN Case manager report back to team regarding concerns about care giving
  - Daughter’s behavior inappropriate
  - Medication documentation inconsistent with verbal report

Case 1 BC Continued
- Team discussed at IDT
- Patient started on morphine PCA
- Family call into triage on week-end that PCA making pt too drowsy
  - Want to return to short acting oxycodone NOW
- Visit made to home by RN, MSW, and MD
Case 1 BC Continued

- At visit, family had discontinued morphine PCA without contacting hospice
- Education provided to daughter on narcotics and dosing
- Discussed other options with family
  - Decrease dose of PCA
  - Change medication to IV hydromorphone

Case 1 BC Continued

- Open communication about concerns for potential diversion
- Daughter wanting only oral short acting oxycodone
- Patient discharged from service
- MD called PCP with update
  - PCP had similar concerns about diversion in the past

Case 2 BK

- 78 y/o with lung cancer, PVD with non-healing wound on foot
- Pt at home with support from hospice team and daughter
- Hydrocodone/APAP “vacuumed up” 70 tablets by daughter
- Team discussion at IDT
- MSW had daughter sign narcotic contract
Case 2 BK Continued
- Pain unmanaged and medication reconciliation shows mis-match between patient self-report and supply
- Joint visit with RN CM, MSW, MD, daughter and patient
- Mini-cog show pt with cognitive impairment
- Offered alternative medication management of pain

Case 2 BK Continued
- Family and patient decide on morphine PCA
- Pain management improved
- A few weeks later, pain worsening again and pt telling family “I can’t do this any more.”
- Patient transferred to hospice general inpatient level of care at Bergan
- PCA titrated upward
- Pt then transferred to Hospice House

Take Home Points
- Educate your hospice team
- Listen to your instinct
- Implement narcotic contract on admission
- Set expectations with patient/caregiver/team
- Provide open communication amongst team and patient/caregivers
- Don’t be afraid to set boundaries
- Discharge may be necessary
References

- Drug Enforcement Administration. Online: http://www.deadiversion.usdoj.gov
- Results from the 2009 National Survey on Drug Use and Health (NSDUH). (2010) National Findings, SAMHSA