Drug Seeking Behaviour
Identifying & Dealing with the Issues

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North Metro Community Drug Service

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Drug Seeking Behaviour

- What is drug seeking behaviour?
- How to identify behaviours that suggest drug seeking?
- Why is it important to spot and manage appropriately?
- What shall I do? How will I manage the problem?
What is drug seeking behaviour?

- A range of activities directed towards the attainment of sought after medications
  - Attending multiple practitioners
  - Behaviours employed to manipulate the interaction outcome (i.e. in the quest for medications)
What is drug seeking behaviour?

• Non-hostile behaviours
  – Attend surgery late in afternoon / evening / weekends – pressure of time
  – Presentation of a complex problem, but “just need a script”
  – “My usual doctor is on holiday”
  – “I’m here on holiday and forgot my Endone tablets”
  – Appeal to the ego “You’re the only one who understands me”, “I heard you were good”
What is drug seeking behaviour?

• Non-hostile behaviours
  – “Nothing else works” (so let’s not waste time talking about the issue – just give me a script)
  – “I’m allergic to everything except Oxycontin”
  – Overtly falsifying symptoms in order to obtain specific medications e.g. pain (esp migraine, back pain)
What is drug seeking behaviour?

• Hostile behaviours
  – Intimidation
  – Aggression
    • Raised voice
    • Threatening behaviour / speech
  – “I’ll hurt myself / others / you if you don’t’ give me the Xanax”
What goes through your mind?

- time limits
- am I being manipulated here? Anger?
- what would my peers think?
- medicolegal issues
- own safety Vs safety of patient
- patient satisfaction
- who’s in control?
- can I help this person? Can I trust this person?
Recognising Aberrant Behaviours

- Behaviours that may suggest problem use can be categorised “Yellow Flag” and “Red Flag”

- Single yellow flag behaviours on their own do not necessarily require management change – should be considered together

- Single red flag behaviours should trigger discussion with regulatory authority or an addiction specialist
### Behaviours Outside of Consultation

<table>
<thead>
<tr>
<th>Yellow Flags</th>
<th>Red Flags</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – 2 unsanctioned dose escalations</td>
<td>Selling prescription drugs</td>
</tr>
<tr>
<td>Very occasional medication acquisition from other practitioners</td>
<td>Prescription forgery</td>
</tr>
<tr>
<td>Unapproved use of medication to treat other symptoms</td>
<td>Obtaining med’s from non-medical sources</td>
</tr>
<tr>
<td>Single script loss</td>
<td>Injecting oral med’s / other illicit use</td>
</tr>
<tr>
<td>Running out of medication early</td>
<td>Repeated unsanctioned dose escalations</td>
</tr>
<tr>
<td>Failure to attend non-script appointments e.g. physiotherapy / psychologist</td>
<td>Treatment non-compliance despite warnings</td>
</tr>
<tr>
<td>History of alcohol or other substance overuse / dependence</td>
<td>Recurrent script loss (esp if stolen)</td>
</tr>
<tr>
<td></td>
<td>Frequent seeking of medication from other Dr or DEM</td>
</tr>
</tbody>
</table>
## Consultation Behaviours

<table>
<thead>
<tr>
<th>Yellow Flags</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Request for specific medication or brand</td>
<td>Intimidation</td>
</tr>
<tr>
<td>Strong preference for specific med’ or route of administration</td>
<td>Refusal to allow examination or to provide urine for UDS</td>
</tr>
<tr>
<td>Discussion of analgesic predominant issue of visit</td>
<td>Signs of IV use</td>
</tr>
<tr>
<td>Reporting minimal or inadequate relief from medication</td>
<td>UDS +ve for illicit drugs or –ve for prescribed med’n</td>
</tr>
<tr>
<td>Lack of interest in rehab’ or self management strategies</td>
<td>Appears intoxicated / sedated</td>
</tr>
<tr>
<td>Hostile / aggressive (sudden change if not satisfied)</td>
<td>Refusal to sign treatment agreement</td>
</tr>
</tbody>
</table>
# Opioid Risk Tool - Clinician Form

*(including point values to score total)*

Mark each box that applies

<table>
<thead>
<tr>
<th>1. Family History of Substance Abuse:</th>
<th>Female*</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>☐ 1</td>
<td>☐ 3</td>
</tr>
<tr>
<td>Illegal Drugs</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>☐ 4</td>
<td>☐ 4</td>
</tr>
</tbody>
</table>

| 2. Personal History of Substance Abuse: | |
|----------------------------------------|-----|-----|
| Alcohol                               | ☐ 3 | ☐ 3 |
| Illegal Drugs                         | ☐ 4 | ☐ 4 |
| Prescription Drugs                    | ☐ 5 | ☐ 5 |

| 3. Age (mark box if between 16 and 45) | |
|----------------------------------------|-----|-----|
|                                        | ☐ 1 | ☐ 1 |

| 4. History of Preadolescent Sexual Abuse | |
|------------------------------------------|-----|-----|
|                                          | ☐ 3 | ☐ 0 |

| 5. Psychological Disease | |
|--------------------------|-----|-----|
| Attention Deficit Disorder, Obsessive-Compulsive Disorder, Bipolar, Schizophrenia | ☐ 2 | ☐ 2 |
| Depression               | ☐ 1 | ☐ 1 |

## Scoring Totals:

- **Low Risk** = 0 – 3
- **Moderate Risk** = 4 – 7
- **High Risk** = >7

*(Remove the scoring from the form if you plan to hand this out to the patient to complete!)*

*Female / Male refers to the gender of the patient NOT the relative.*

Webster I.W. Pain Medicine 2005; 6(6): 432-442
Indications for BZDs

- Supervised withdrawal from alcohol
- BZD dependence (reduction regime)
- Psychiatric emergencies (e.g. acute arousal)
- Acute insomnia (v short term)
- Anxiety disorders (short term, as adjunct to psychological therapies and other pharmacotherapies)
- ? Adjunct therapy in epilepsy
Reasons why BZDs are prescribed (appropriate)

- Supervised withdrawal from alcohol
- BZD dependence (reduction regime)
- Psychiatric emergencies (e.g. acute arousal)
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- Anxiety disorders (short term, as adjunct to psychological therapies and other pharmacotherapies)
- ? Adjunct therapy in epilepsy
Reasons why BZDs are prescribed (inappropriate)

- Because patients ask, often with high emotional fusion
- As an inadequate or misguided response to complex, difficult problems requiring intensive intervention that is frequently a challenge to access (or not readily available)
  - Anxiety, depression, dependence, chronic insomnia, social isolation
Why should I be concerned about inappropriate medication use?

- Risks to the individual:
  - Dependence
  - Association with fatal & non-fatal overdose
  - Disinhibition (e.g. aggression, inappropriate or high risk sexual encounters, shoplifting)
  - Cognitive & Memory impairment
  - Abnormal sleep patterns
  - Accidents (e.g. driving, workplace, falls esp elderly)
Why should I be concerned about inappropriate medication use?

Reinforcing maladaptive false beliefs

• This contributes to the pts refusal or inability to learn to manage

• This is the antithesis of what CBT is about – i.e. teaching & reinforcing therapeutic optimism, correcting negative beliefs (“I can’t get by without my medication”)
Why should I be concerned about inappropriate medication use?

Delay or prevent appropriate treatment

- May mask underlying pathology
- Delay or prevent appropriate EB treatment from being initiated
  - E.g. psychological therapy & self management for chronic pain
Why should I be concerned about inappropriate medication use?

Risks to the community:
- Diversion of potentially dangerous medication to people other than the intended patient (sell, swap)
- Driving under influence
Intra-arterial injection of oral medication
Injection of oral medication
Working with resistance

- “Nothing else works”
- “I can’t sleep without Mogadon”
- “Talking about it won’t help”
- “I can’t afford a psychologist”
- “I’ve done it all before”
- I haven’t got time to see a physio
Working with resistance

• “So you won’t help me then”
  – No, that’s not what I’m saying. I’m giving you my professional advice. Your health & wellbeing are important to me and this problem won’t resolve without the right treatment

• Be polite, respectful & assertive in response
Setting Boundaries

• Clear communication
• Clear boundaries
  – Written treatment agreement
• Dosing supervision in selected cases
  – Write on script “For daily pickup”
  – Important aspect in risk reduction
  – May move to 2\textsuperscript{nd} daily, twice or once weekly collection if attending scheduled appts & engaging in treatment
Opiate Dependence Treatment Options

- Detoxification
  - Inpatient or outpatient
- Opiate Substitution Therapy
  - Methadone or Buprenorphine
- Relapse Prevention Therapy
  - Counseling and psychosocial support
  - Naltrexone role
Managing Substance Misuse - further issues

- Consider on-referral:
  - Psychology
  - Psychiatry
  - Counselling via Community Drug Service
Resources

• Clinical Advisory Service (CAS)
  – 9442 5042
  – 24 hour phone line to addiction medicine doctor
  – Clinical advice for health professionals (not for patients to access doctors)

• North metro CDS – 9246 6767

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