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DRUG
PROGRAMS
Update

Recognizing and addressing “red-flag” behaviour [1]

MH is a 49-year-old male with complex regional pain syndrome, moderate hypertension, and family history of atrial fibrillation. Current daily medications include: 27 mg hydromorphone immediate-release (IR) (135 mg morphine equivalent), 900 mg gabapentin and 5 mg bisoprolol. A treatment agreement between MH and his physician was signed at the start of their professional relationship.

In January, MH falls and presents to the ER where his urine drug test (UDT) is positive for cocaine. MH admits to peer-pressured drinking. By February he states that he is clean and sober. On five separate occasions throughout the year, MH requests early medication refills through the pharmacy, citing various reasons: vacation supply; his partner left and stole them; the cat knocked them (narcotics only) down the sink.

Despite a report from another health professional that MH smells of alcohol, the physician allows the refills without any reference to the treatment agreement. In April, MH’s UDT tests positive for benzodiazepines, which he admits to borrowing from a friend. In August, he presents with nasal lesions, which should have triggered suspicion of continued stimulant misuse. In September, MH’s physician suggests methadone to treat his pain, but MH refuses, citing stigma. The physician does not bring it up again.

Red flags and possible strategies:

- Check PharmaNet at every visit. Employ random pill counts to see if quantity and dispense dates align. Address the pattern of early refills and reasons given. Question if only certain medications are requested. Normalizing the situation by noting “it’s only a few days early,” or not addressing the issue immediately, inadvertently gives the patient permission to continue the behaviour.
- Holding patients accountable for their choice to break the treatment agreement helps them understand the consequences. Question and document the reasons given—could they indicate confusion, an acute pain event, or addiction? Re-obtain a patient’s commitment to honour the agreement and remind him/her that continuing to break it may result in ending the physician-patient relationship. Send a copy of the agreement to the pharmacy they usually use.
- Document discussions about “borrowing” other people’s medications, avoidance of alcohol, risks of combining opioids and sedatives and stimulants, risks of falls and potential for overdose. Advise patients of side effects from illicit drug use, especially given personal and family history.
- If the first UDT is abnormal, discuss with the patient and be clear that further inappropriate test results will lead to changes in treatment plans, including tighter dispensing restrictions, no early refills, addictions referral and medication tapering or discontinuation. If two UDT are abnormal, increase frequency of random UDT.
- Remind patients that their health and safety is your primary concern. If prescribing is to continue, perform periodic clinical reassessment of the patient’s conditions, and risks versus benefits of psychoactive medications. Make patients aware of all possible non-pharmacologic and pharmacologic options. Assess the patient for substance use disorder, alcohol use disorder, and mental health disorders regularly, as life situations may trigger changes in status. Engage addiction services and treatment where necessary.

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