Challenging behaviours and safer prescribing

Some patient behaviours can be challenging when it comes to substance use.

What patient behaviours do you find challenging? Aggression? Sadness? 'Manipulation'? Avoidant? The 'heart sink' patient?

Patients who present with substance issues or requesting scripts for drugs of dependence are more likely to have complex biopsychosocial needs. Listed below are five broad principles to address challenging patient behaviours. Common scenarios are also explored in the case study and FAQ section below.

Principles to address challenging patient behaviours	
Principle	**Explanation**
Set boundaries early	Set boundaries early around your availability and safer-prescribing practices/policies. Setting limits does not mean that you are saying "no" to caring for a patient. Band-aid solutions are unlikely to result in meaningful change for the patient.
Support patients over the long term	A GP-led treatment approach to treating substance use is most effective when there is a well-established doctor-patient relationship, with a care plan in place that is designed to support the patient to achieve their goals. Relevant support services available locally can be used.
Manage challenging behaviours by preventing them	Be prepared to abandon your agenda if the patient's behaviour starts to change within a consult. Ask the patient, "are you OK? You don't have to answer questions if you are uncomfortable." Emotional and reactionary consultations make it difficult to engage appropriately with your patient.
Safety is paramount	In the rare instance that a patient presents in an agitated state whilst intoxicated or in withdrawal, assist the patient to move to a safe place (for you and them). Speak in a calm, non-threatening manner. Be careful to use open body-language. Actively listen and show understanding. If you feel at risk, call for help and leave the room.
Reflect on your own emotional response	Consider and reflect on which behaviours you find the most challenging. How do your emotions affect the consultation? Are you tired? Hungry? Emotionally stressed? Burnt out?

Case studies

Benzodiazepine prescribing and setting boundaries	
Video	View video.
Resource	Download video transcript.

How to set boundaries with patients seeking scripts	
Video	View video.
Resource	Download video transcript.

Frequently asked questions

What do I do if my patient is threatening to hurt themselves?

Assess for risk of suicide. Warning signs may include a recent relapse, increased substance use or severity of use, changing patterns of use or severity of self-harm. Refer to the Dos and Don'ts of managing a client who is suicidal in the Comorbidity Guidelines.

If the patient is at high risk of harming themselves, contact your local mental health triage service for advice or consider an urgent hospital admission on a voluntary or involuntary basis. If the patient is not at imminent risk of self-harm, stay calm and de-escalate. Identify a support person for the patient. Create a safety plan, ensure the patient has emergency service numbers and arrange for appropriate follow-up.

Establish the reasons for the desire to self-harm. Look at the whole person and consider alternative strategies to help them. If the risk of a severe withdrawal is high and the patient is attempting to obtain a script for drugs of dependence, consider prescribing 2-3 days' worth, or daily dose collections from a pharmacy. This will allow time to schedule a follow-up consult with you or their usual GP. Consider contacting your local mental health/AOD service for support for both yourself and the patient.

What do I do when I inherit a patient who is seeking scripts?

Set your limits and boundaries around prescribing in a respectful manner. Manage patient expectations by using practice policies and written practice contracts to support these limits and boundaries.

Consider the biopsychosocial factors driving the behaviour and provide whole-person care. Maintain appropriate clinical boundaries and practice good prescribing strategies. Consider softening any 'hard no' position to a 'prescribing if safe' approach to support a longer-term therapeutic relationship. This may also mean deferring a prescription on the first consult before a clear assessment and plan can be put together. Refer to RACGP Prescribing drugs of dependence in general practice.

What do I do if my patient is ambivalent about their substance use?

Patients use substances for a reason and the current benefits of their substance use may outweigh their motivation to change. Ambivalence is an important part of the behavioural change process where the patient weighs up the pros and cons of their substance use.

Engage the patient and help them to identify reasons why they may want to change. If you have developed rapport and the patient has a substance use disorder, consider exploring if the patient has an underlying trauma history that may need to be addressed. Highlight reasons for change that align with the patient's own motivations and values using motivational interviewing techniques. This will help to tip the patient into making changes and follow through using their own strategies.

What do I do if my patient doesn't stick to their treatment plan?

The best treatment plan is one that uses the patient's own motivations and goals. Review the plan with the patient and consider if they might have agreed to the plan to please you. Treatment plans should be actionable and realistic for the patient. Small achievable steps work best, gaining therapeutic momentum towards larger health goals. When reviewing a patient's treatment plan consider:

- are they ready for change?
- what are their motivations and agenda?
- do they have the skills and confidence to change?

- do they have competing priorities which take precedence? Eg community, social, legal, financial, relationship obligations.
- is this too much too soon? Pacing treatment is important.
- are they being coerced into treatment? Eg medical, legal, financial, family, employer.

What do I do if I feel that my patient is trying to manipulate me?

It's important to trust what our patients tell us. When a patient feels safe and trusts you, they may reveal more of their story and be open to receiving advice. Patients might be hiding something for a variety of reasons including shame/stigma, not wanting to be "lectured" or they are not ready or willing to explore the harms associated with their use. If there is a question of serious harm or risk to themselves or another, especially a child, aim for a full and truthful disclosure.

Maintain appropriate clinical boundaries and practice good prescribing strategies. Ensure your prescribing is rational, defensible, confirmed and that you are comfortable.

To establish boundaries, ensure that your patients understand that appointments are essential (schedule regular appointments and re-schedule missed appointments), the hours you are available, and the appropriate behaviour during the clinical appointments.

Agree with the patient on the medications indicated, a formal treatment plan, and (for those with complex comorbidities, or at high-risk or self-harm or suicide) to participate in psychiatric and/or psychological therapy.

Seek support from a psychiatrist or Addiction Medicine specialist who can help share the decision-making burden of diagnosis and treatment planning. Refer to the Clinical Advisory Service in your State and Territory.

What do I do if a patient presents in withdrawal or intoxicated and is agitated?

Maintain a friendly demeanour that is calm and professional using simple and non-judgemental language. De-escalate carefully, avoid confronting or antagonising the person, be solution focused and use reflective affirming statements. Move the patient to a safe and calm space.

Assess the severity of withdrawal or intoxication and determine the setting for best managing the patient - the GP clinic, at home or the emergency department for observation and management.

Consider consent regarding treatment and sourcing a support person, provide written instructions for care, and send the patient home with a trustworthy adult when safe to do so.

Do not attempt to engage an intoxicated patient into any meaningful treatment discussion - they are unlikely to recall any details and cannot provide an informed consent/decision. Make a follow-up plan and enlist support staff to make a welfare call the following day. Arrange for the patient to return for a follow-up consult and consider asking the patient what time in the day they feel at their best to see you.

Your safety is paramount, maintain a clear path to exit, call for help, keep a safe physical distance. Recognise rising levels of aggression.

Resources

- RACGP - General Practice - a safe place
- RACGP Prescribing drugs of dependence in general practice
- Comorbidity Guidelines

How do I support a patient on high levels of medication or polypharmacy?

Patients may not be aware that prescribed medication(s) can cause harm. Discuss the risk of overdose with polypharmacy and prescribe naloxone for opioids to prevent overdose, caution around other substance use (including alcohol) and prescription medicines.

Help the person to make the link between their medication use and associated harms (side effects such as hyperalgesia, cognitive disturbance, drowsiness, reduced energy, poor sleep). Implement strategies to minimise harm, such as having one prescriber and one pharmacy, discussion around weaning slowly over time, staged pharmacy supply, and reduced

quantities. For higher doses of opioids consider screening for opioid use disorder and opioid replacement therapy as a safer treatment option.

Discuss non medication options to help the patient. Build a team approach, assist the patient to build relationships with their local physiotherapist, psychologist, and pharmacist as needed. Refer to the FAQ question on the inherited patient who is seeking scripts.

How do I approach deprescribing drugs of dependence with a patient?

Patients may benefit from reducing their medications especially when taking drugs of dependence or polypharmacy. Benzodiazepines and opioids are the leading cause of overdose due to prescribed medications. Middle aged people are the most at risk. In many cases deprescribing is not an emergency but can be pursued using sound prescribing practices.

Withdrawal can be physically as well as psychologically dangerous. Patients may not be aware that their medication may be causing harm, or that the medication is no longer fit for the current goals of their care. Approach the conversation to maintain the therapeutic alliance with the aim of reducing anxiety and managing a potential flare-up in the patient's symptoms.

Using **O**pen questions, **A**ffirmations, **R**eflective listening, and **S**ummary reflections (***OARS***) will help to gain an understanding of the patient's knowledge of their medications and health benefits. Talking to patients around the risks of polypharmacy, tolerance, dependence, reduced efficacy with time (benzodiazepines/opioids) and hyperalgesia (opioids) can help the patient understand their risks, or the reasoning for not prescribing or for suggesting reducing medications.

Consult your local Clinical Advisory Service line to discuss a weaning plan. A tapering regime should involve small reductions each week. The weaning process could take several months. For opioid use this can avoid withdrawal symptoms, patient anxiety and rebound pain. GPs can still prescribe opioids under the PBS using the streamlined authority numbers. Use a whole-person care approach using physiotherapy and psychology. Excellent internet-based education for the practitioner and patient can be accessed from the AOD Resource List below.

For benzodiazepines use, be mindful that patients with high doses are at risk of withdrawal seizures and coma if use suddenly stops. Supervised pharmacy dosing, or restricted weekly pharmacy pickups can help with safety.

Resources

- NPS Medicinewise - Opioids: Communication Videos
- Insight - Withdrawal management
- Insight - Brief Interventions
- Patient resources - Betterhealth channel: Medicines - safety issues

Further Training

RACGP AOD Program training modules related to this topic are available on *gplearning* and include:

- Alcohol and Other Drugs - Essential Skills
- Alcohol and Other Drugs: Facilitating behaviour change
- Alcohol and Other Drugs: Providing trauma- informed care

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