

ASAM

TREATMENT OF OPIOID USE DISORDER COURSE

Course in Addiction Medicine

Session 5

Keeping Your Patient Safe

Session Learning Objectives

1. Examine misconceptions, stigma, and complexities (bioethical, social, clinical, public health) associated with OUD and the use of medications to treat opioid use disorder.

JENNIFER'S CASE

Jennifer:

32-year-old woman who has been your patient for the past five years. She wants to taper and withdraw from buprenorphine.

- Jennifer was diagnosed with OUD, which started with opioid analgesics and then segued into IN heroin.
- She has been on buprenorphine/naloxone film strips, 12 mg daily, for 5 years. Patient had a positive response to the medication and has had negative UDTs, with the occasional +THC, for years.

Jennifer:

32-year-old woman who has been your patient for the past five years. She wants to taper and withdraw from buprenorphine.

- Jennifer is employed as an IT specialist at a law firm. She has been careful to “hide” her medication use from her family, friends, and co-workers, for fear of a negative reaction. She also thinks that if her co-workers knew about her OUD and medication, if a wallet were stolen, they would automatically suspect she was the thief.
- One year ago, Jennifer met her future wife at the law firm. Karishma is a paralegal at the firm and has no history of “drug” use.

Jennifer:

32-year-old woman who has been your patient for the past five years. She wants to taper and withdraw from buprenorphine.

- As their relationship developed, Jennifer was ambivalent and fearful about disclosing her history of OUD and current OAT with buprenorphine. A few months before their wedding, Jennifer did disclose and Karishma was taken aback, but said it was not a problem.
- On Jennifer's last visit with you, she inquires about "getting off" buprenorphine. She relates that Karishma has never really been okay with the medication. Karishma has heard that it's "just substituting one drug for another" or "one addiction for another."

Jennifer:

32-year-old woman who has been your patient for the past five years. She wants to taper and withdraw from buprenorphine.

- Karishma has a friend who has an AUD and attends AA meetings. The friend tells Karishma that her AA group is not okay with people on buprenorphine or methadone.
- Karishma and Jennifer had also planned on having a child, but Karishma is concerned that buprenorphine would be a problem if Jennifer were to be the birth mother.
- Jennifer has resumed weekly psychotherapy and they both see a couple's therapist.

Jennifer:

32-year-old woman who has been your patient for the past five years. She wants to taper and withdraw from buprenorphine.

- You are concerned that Jennifer wants to taper and withdraw from buprenorphine because of all these misconceptions, myths, and stigmas - which Karishma believes.
- You schedule an appointment with both Jennifer and Karishma to discuss each of the misconceptions individually and provide evidence for your suggestion that Jennifer continue with her successful treatment paradigm with buprenorphine.

Case Discussion – Jennifer

Discuss:

What stigmas and misconceptions would you address with Jennifer and Karishma?

What would you suggest for Jennifer's treatment plan?

Should Jennifer still want to taper down, how would you proceed?



Stigma and Treating OUD

Provider Myths

- It's substituting one drug/addiction for another.
- It's not really "recovery."
- The shorter the duration of therapy, the better.
- You can't be on buprenorphine if you are pregnant or breastfeeding.
- I'm worried about the DEA storming into my office.

Patient Myths

- It's substituting one drug/addiction for another.
- It's not really "recovery."
- The shorter the duration of therapy, the better.
- Other people may relapse, but not me.
- It must be damaging my liver, brain, kidney, heart, or bones.
- They won't be able to treat my pain.
- The pre-employment drug test will disqualify me.
- If I miss a dose, I'll go into terrible withdrawal.

Addiction Terminology

Correct

Person with substance use disorder.

Babies born with an opioid dependency.

Substance use disorder or addiction,
use or misuse, risky or unhealthy use.

Person in recovery, abstinent, not
drinking or taking drugs.

Treatment or medication for addiction,
medication for OUD/AUD,
positive/negative results.

Incorrect

Substance abuser, drug abuser, alcoholic,
addict, user, abuser, drunk, junkie.

Addicted babies, born addicted.

Drug habit, abuse, problem.

Clean.

Substitution or replacement therapy,
medication-assisted treatment,
clean/dirty.

General Language

- *Use gender/sexuality-inclusive language.*
 - Be mindful of gender use in language, specifically during anecdotes and question response. Avoid assumptions.
 - Use “they,” “one,” and “who” as opposed to “he” or “she.”
- *Avoid jokes at the expense of patient and stigmatizing/offensive language.*



Where Patients Experience Stigma

Healthcare Setting

- Waiting room
- Intake with MA/nurse
- Pharmacy
- Other healthcare provider's practice
- Emergency Department
- Mutual help group

Outside Healthcare Setting

- Significant other
- Work
- Friend group
- Family
- Interest/hobby group
- Religious institution
- Media representation

XYZ Medical Practice

Sample Office-Based Opioid Use Disorder Policy and Procedure Manual

Policy Title: **Diversion Control for Patients Prescribed Transmucosal
(Sublingual) Buprenorphine**

Effective Date: **Month, Day, Year**

This Diversion Control Policy is provided for educational and informational purposes only. It is intended to offer physicians guiding principles and policies regarding best practices in diversion control for patients who are prescribed buprenorphine. This Policy is not intended to establish a legal or medical standard of care. Physicians should use their personal and professional

ASAM Sample Diversion Control Plan

Available online: <http://bit.ly/diversionpolicy>

Diversion

People self-treating with diverted buprenorphine reported:

- 97% take it to prevent cravings
- 90% take it to prevent withdrawal
- 29% take it to save money

Why? Limited access to treatment, lack of health insurance.

Potential Diversion

Common Signs

- Requests for early refills (medication lost or stolen).
- Inconsistent laboratory testing (e.g., bup negative).
- Claims of being allergic to naloxone and requesting monotherapy.
- Police reports of patient selling in streets.
- Reports of concerning behavior.
- Inconsistent appointments (e.g., missed).

Risk Management:

Educate Patients about Harms of Diversion of Misuse

Misuse and Diversion

- Can lead to harmful medical and social consequences, overdose, and an increase in stigma for patients and providers.

Legislation

- Periodically re-evaluated by DEA and SAMHSA for risks and benefits.

What patients do with their medications matters for us all!

Responding to Misuse and Diversion



Evaluate
and reassess
treatment plan and
patient progress.



*Intensify
Treatment*
or refer to higher
Level of Care.



Document and Describe
clinical thinking that supports a clinical response,
should be aimed at minimizing risk and treating
patient at the level of care needed.



Harm Reduction

1. Naloxone and Overdose Education
2. Syringe Service Programs
3. Polysubstance Use
4. HIV, PrEP and PEP
5. Safer Sex

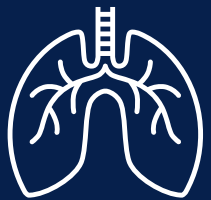
Opioid Mu Receptor Agonist Drug Effects

- *Acute Exposure*
 - Euphoria, nausea, vomiting, depressed respiration, sedation, analgesia.
- *Large Dose Acute Exposure*
 - Non-responsive, pinpoint pupils, hypotension, skin cyanotic, pulmonary edema.
- *Chronic Use Effects*
 - Physical dependence, withdrawal, tolerance, lethargy, constipation.



Opioid-induced Respiratory Depression

Opioids depress the brain stem's response.



- Depression of the medullary respiratory center.
- Decreased tidal volume and minute ventilation.
- Decreased respiratory response to elevated CO₂.
- Hypercapnea, hypoxia and decreased oxygen saturation.
- Life threatening hypoxia.
- Sedation occurs before significant respiratory depression, and, therefore, is a warning sign.

Naloxone Formulations



Injection

1 dose =
0.4mg/1ml
Intramuscular



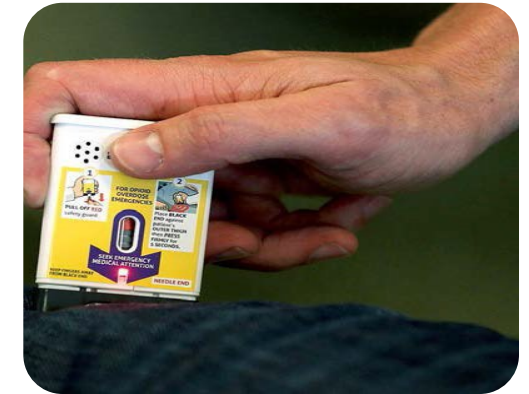
Nasal w/atomizer

“Multi-step”
1 dose =
2mg/2ml
Intranasal



Nasal spray

“Single-step”
1 dose =
4mg/0.1ml
Intranasal



Auto-injector

1 dose =
0.4mg/1ml
Intramuscular

Naloxone

Prevent Overdose

- Broader provision of naloxone has been shown to prevent opioid overdose morbidity and mortality.

Co-Prescribe

- U.S. Department of Health and Human Services urges that all patients receiving medications for OUD be co-prescribed naloxone.

Coffin PO, Behar E, Rowe C, Santos GM, Coffa D, Bald M, Vittinghoff E. Nonrandomized intervention study of naloxone coprescription for primary care patients receiving long-term opioid therapy for pain. *Annals of Internal Medicine*. 2016;165(4):245–252.



Evaluations of Overdose Education and Naloxone Distribution (OEND) Programs

- Feasibility
- Increased knowledge and skills
- No increase in use, increase in drug treatment
- Reduction in overdose in communities
- Cost-effective

Piper et al. *Subst Use Misuse* 2008; Doe-Simkins et al. *Am J Public Health* 2009; Enteen et al. *J Urban Health* 2010; Bennett et al. *J Urban Health*. 2011; Walley et al. *JSAT* 2013

Green et al. *Addiction* 2008; Tobin et al. *Int J Drug Policy* 2009; Wagner et al. *Int J Drug Policy* 2010

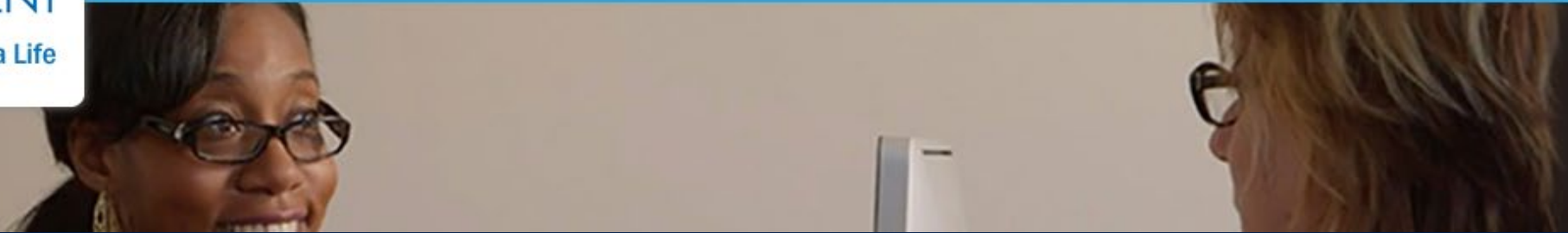
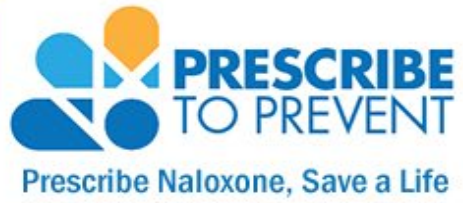
Seal et al. *J Urban Health* 2005; Doe-Simkins et al. *BMC Public Health* 2014; Jones et al. *Addictive Behaviors* 2017

Maxwell et al. *J Addict Dis* 2006; Evans et al. *Am J Epidemiol* 2012; Walley et al. *BMJ* 2013; Coffin et al. *Ann Intern Med* 2016

Coffin & Sullivan. *Ann Intern Med*. 2013

Overdose Education and Naloxone *Communicate to Patients*

- *Don't use opioids alone. Beware of fentanyl.*
 - Known overdose risk factors: mixing substances, abstinence, using alone, unknown source.
 - Opportunity window: heroin overdoses take minutes to hours; fentanyl takes seconds to minutes.
 - Call 911 before administering naloxone.



Overdose Education Education for Providers and Patients

Overdose education is important for which of the following groups?

- a. Injection opioid users themselves
- b. Family and friends of opioid users
- c. Community members who may be exposed to opioid use
- d. All of the above

Polysubstance Use

Tobacco, Alcohol, Cannabis

<i>Substance</i>	<i>Medication Options</i>	<i>Psychosocial Treatment</i>
Tobacco	Nicotine replacement therapy (patch, gum, lozenge); bupropion; varenicline	Cognitive behavioral therapy (CBT); mindfulness; telephone support and quitlines; mutual help
Alcohol	Naltrexone; acamprosate; disulfiram	CBT; motivational enhancement therapy; marital/family counseling; mutual help
Cannabis	No FDA-approved medications	CBT; contingency management; motivational enhancement therapy; mutual help

Polysubstance Use

Cocaine, Methamphetamine, Benzodiazepines

<i>Substance</i>	<i>Medication Options</i>	<i>Psychosocial Treatment</i>
Cocaine	No FDA-approved medications	CBT; contingency management; therapeutic communities; mutual help
Methamphetamine	No FDA-approved medications	CBT; contingency management; mutual help
Benzo-diazepines	No FDA-approved medications	CBT; contingency management; mutual help

Tobacco



~480,000 Deaths

Leading cause of preventable death (CDC)



~67% smoke
Smoking rates among SUD patients who enter treatment



2-4 times higher
Smoking rates higher in patients with SUD than general public



Death from tobacco
SUD patients more likely to die from tobacco than other substances



HIV and Injection Drug Use

- *Injection drug use accounts for ~1 in 10 HIV diagnoses in US.*
 - Sharing equipment increases risk: HIV can survive on a used syringe for 42 days.
 - **4th generation HIV test important (looks for HIV 1 & 2 antibodies and P24 antigen).**
 - Educate patient on Syringe Service Programs (e.g., needle exchange).
 - Educate patient on safe practices (e.g., do not share needles).

PrEP



Pre-exposure prophylaxis:

when people who don't have HIV take HIV medicine every day to reduce their chances of getting HIV.



Reduces risk of getting HIV:

from sex by ~88%.

from injection drug use by >74%.



Current FDA-Approved Medications

- Emtricitabine (200mg)/Tenofovir Disoproxil Fumarate (300mg): Truvada®.
- Emtricitabine (200mg)/Tenofovir Alafenamide (25mg): Descovy®.

Which is best?

- Truvada® vs Descovy® based on individual risk factors.
- Descovy® not for use in people assigned female at birth who are at risk of getting HIV through vaginal sex (effectiveness not yet studied).

PEP



Post-exposure prophylaxis:

when a patient takes HIV medicine very soon after possible exposure to HIV in order to prevent HIV infection.



Not meant for regular use:

PEP intended for emergency situations.

Must be started within 72 hours after a possible exposure to HIV. The sooner, the better.



PEP

Current preferred medication regimen:

- Tenofovir disoproxil (300 mg)/emtricitibine (200 mg) QD, PLUS.
- Raltegravir (400 mg) BID or dolutegravir (50 mg) QD.

Length of treatment:

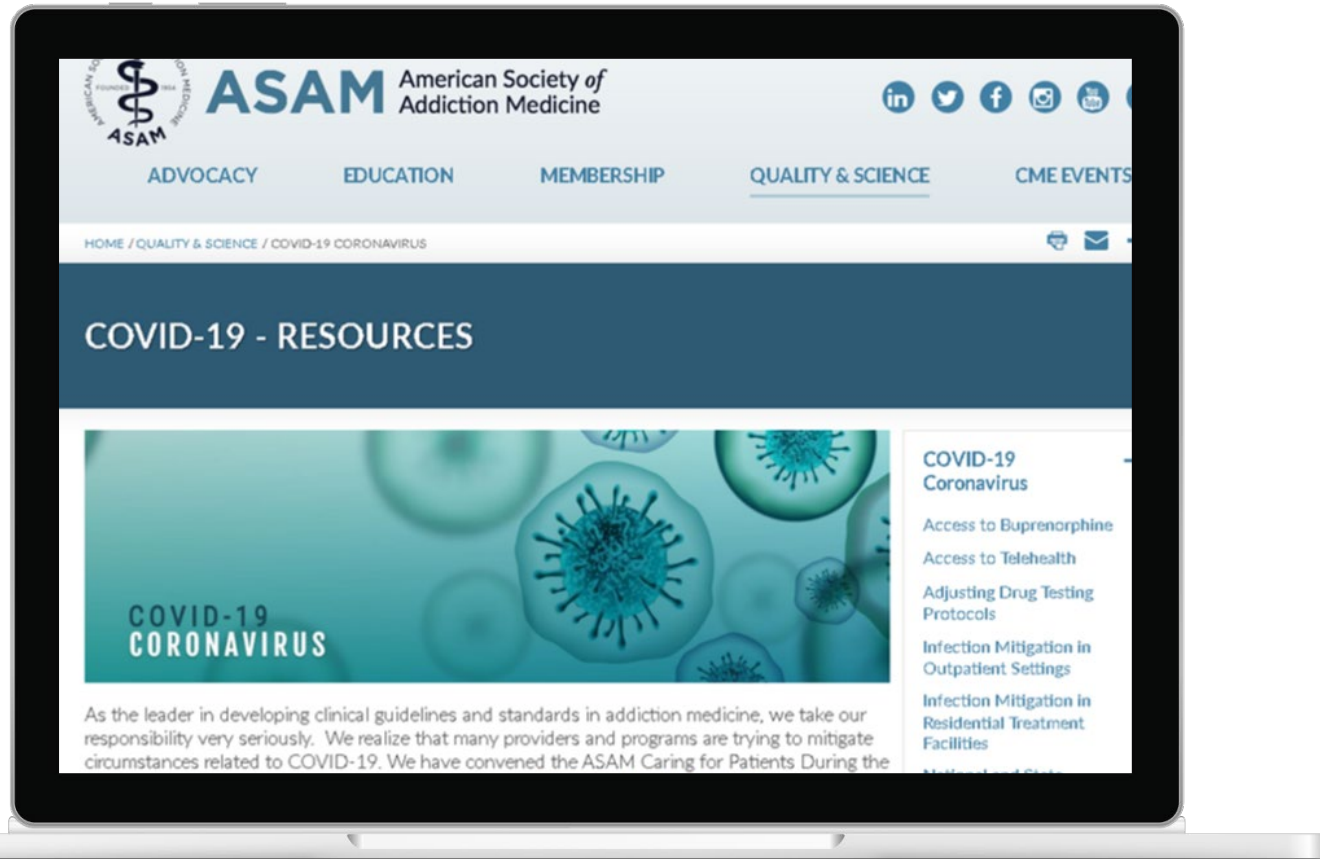
- If prescribed PEP, patient will take HIV medicine every day for 28 days.

- *People under the influence of drugs are more likely to engage in risky sex and could get HIV.*
 - Those who share needles/syringes are more likely to have unprotected sex.
 - Provider should educate patient on: contraception options, condoms, PrEP and PEP, regular STI testing.
 - Be aware of “club drug” use leading to unsafe sex.

Gyarmathy VA, Neaigus A. The relationship of sexual dyad and personal network characteristics and individual attributes to unprotected sex among young injecting drug users. *AIDS Behav.* 2009;13(2):196-206.

Buprenorphine and Naltrexone for OUD: COVID-19

Treating OUD During the COVID-19 Pandemic



Guidance for:

- Infection mitigation
- OTPs
- OBOT
- Telehealth
- Virtual Support Groups
- **Overview of Federal and State Policy Changes related to COVID-19**

Methadone Access Under National COVID-19 Emergency - Highlights

- ***Telehealth***
 - Waiver of regulations related to HIPPA compliant telehealth platforms (e.g., Apple FaceTime, Facebook Messenger video chat, Google Hangouts, Skype).
 - Expansion of Medicare Coverage for telehealth.
 - Medicaid and private payer coverage varies by state and payer – check.
 - Check state laws/regulations on licensing.
- ***Existing Patients***
 - Can treat and dispense medication via telehealth (also use of telephone).
- ***New Patients***
 - Continued requirement for in-person physical exam for methadone initiation.
 - Take steps to minimize any exposures to provider or patient.

Methadone Access Under National COVID-19 Emergency - Highlights

- ***Take-home medications:***
 - States may request exceptions for stable patients to receive 28 days of take-home medications and for less stable patients to receive up to 14 days.
 - Providers should make decisions on an individual patient bases based on a risk-benefit analysis and considerations for risk related to both OUD and COVID-19.
 - Educate patients about safe storage, use, and management.
 - Ensure patients have access to naloxone.
 - Use telehealth/telephone to monitor patients.
 - Encourage patient participation in virtual support groups.

Methadone Access Under National COVID-19 Emergency - Highlights

- ***Alternative home delivery for isolated/quarantined patients:***
 - Allows designated staff members, law enforcement officers, or National Guard personnel to make deliveries of methadone, including “doorstep” delivery using an approved lockbox.
- ***Drug Testing:***
 - OTPs still required to provide a minimum of 8 drug tests/yr for each patient.
 - Consider pausing or exploring testing at a distance.

Methadone Access Under National COVID-19 Emergency - Highlights

- **ASAM COVID-19 Resources:**

- ASAM Methadone Access Guidance:
- ASAM Telehealth Guidance: <https://www.asam.org/Quality-Science/covid-19-coronavirus/access-to-telehealth>
- ASAM's Drug Testing Guidance: <https://www.asam.org/Quality-Science/covid-19-coronavirus/adjusting-drug-testing-protocols>
- ASAM Support Group Guidance: <https://www.asam.org/Quality-Science/covid-19-coronavirus/support-group>

Buprenorphine Access Under National COVID-19 Emergency - Highlights

- ***Telehealth***
 - Waiver of regulations related to HIPPA compliant telehealth platforms (e.g., Apple FaceTime, Facebook Messenger video chat, Google Hangouts, Skype).
 - Expansion of Medicare Coverage for telehealth.
 - Medicaid and private payer coverage varies by state and payer – check.
 - Check state laws/regulations on licensing.
- ***Existing & Existing Patients***
 - New and existing patients can be evaluated and treated via telehealth including telephone; telehealth and phone for follow-up and monitoring.
 - Home induction to start new patients.
 - Do not require patients to participate in counseling – virtual or in-person – in order to access medication. (Generally recommended practice.)
 - Ensure patient access to naloxone.

Buprenorphine Access Under National COVID-19 Emergency - Highlights

- ***Flexibility prescribing using telehealth:***
 - DEA-registered practitioners may prescribe controlled substances to patients via telemedicine in states in which they are not registered with DEA.
- ***Use and Disclosure of Confidential Information (42CFR Part2):***
 - Patient information may be disclosed to medical personnel, without patient consent, to the extent necessary to meet a medical emergency.
 - Information disclosed to the medical personnel who are treating such a medical emergency may be re-disclosed for treatment purposes as needed.

Buprenorphine Access Under National COVID-19 Emergency - Highlights

- ***Oral vs. Injectable Formulations***
- ***Factors to weigh:***
 - Is the patient experiencing any symptoms consistent with COVID or have they had any potential exposures?
 - Any anticipated risk to the patient associated with switching formulations?
 - Are they likely to be compliant with the oral medication?
 - The risk to the patient associated with an in-person visit:
 - Are they at high risk for severe illness?
 - Are they living with or caring for someone at high risk?
 - Would they need to take mass transit to the visit?
 - What is their level of anxiety around coming to an in-person visit?
 - Does your facility have sufficient staff and PPE to provide injections?

Buprenorphine Access Under National COVID-19 Emergency - Highlights

- **Drug testing:**
 - Consider pausing or exploring testing at a distance.
- **ASAM COVID-19 Resources:**
 - ASAM Buprenorphine Access: <https://www.asam.org/Quality-Science/covid-19-coronavirus/access-to-buprenorphine>
 - ASAM Telehealth guidance: <https://www.asam.org/Quality-Science/covid-19-coronavirus/access-to-telehealth>
 - ASAM's drug testing guidance: <https://www.asam.org/Quality-Science/covid-19-coronavirus/adjusting-drug-testing-protocols>

Extended-Release Naltrexone Access Under National COVID-19 Emergency - Highlights

- Continued need for in-person patient contact for injection.
- Take steps to minimize any exposures to provider or patient.
- Oral naltrexone has not been proven to be effective for the treatment of OUD due to low compliance. But could be considered under limited circumstances.
 - See *ASAM's National Practice Guidelines for the Treatment of OUD*:
 - <https://www.asam.org/Quality-Science/quality/2020-national-practice-guideline>

Pregnant Women with OUD: COVID-19

Pregnant women with OUD in the Context of COVID-19: Buprenorphine

- ***Telehealth:***

- Waiver of regulations related to HIPPA compliant telehealth platforms (e.g., Apple FaceTime, Facebook Messenger video chat, Google Hangouts, Skype.)
- Expansion of Medicare Coverage for telehealth.
- Medicaid and private payer coverage varies by state and payer – check.
- Check state laws/regulations on licensing.

Pregnant women with OUD in the Context of COVID-19: Buprenorphine

- ***Existing Patients:***
 - Existing patients can be evaluated and treated via telehealth including telephone; telehealth and phone for follow-up and monitoring.
 - Do not require patients to participate in counseling – virtual or in-person – in order to access medication. (Generally recommended practice.)
 - Ensure patient access to naloxone to save the mother’s life.

COVID-19's effects on persons with opioid use disorder include:

- a. Decreased risk for opioid overdose death
- b. Increased risk for social isolation
- c. Decreased access to telehealth treatment
- d. Decreased risk of new initiation to opioids

15 Minute Break

Activity 8

Challenges to Providing Care

Share your thoughts and/or concerns with office-based treatment of OUD.

Prompting Questions

- What issues do you foresee facing in treating OUDs?
- What challenges do you anticipate that were not covered in the course material?

Allocated Time: 10 Minutes

KATIE'S CASE

Katie:

35-year-old woman who presents for follow-up care. She has diagnoses of severe opioid use disorder and moderate cocaine use disorder.

- She has been treated with buprenorphine/ naloxone 16/4 mg daily for 6 months and has stopped using heroin, which is confirmed by urine drug testing.
- However, her urine drug tests show evidence of continuous cocaine use.
 - *How will you respond to Katie's continued cocaine use?*

Activity 9

Group Discussion: Emma, Jonathan, Susan

- Assess the assigned cases with the class and identify an appropriate treatment approach for each case.
- Determine if the patient meets DSM-5 criteria for an opioid use disorder.

Prompting Questions

- What more information do you need to decide on a diagnosis(es) and treatment plan?
- Is the patient a suitable candidate for OBOT?
- Was your group in agreement or did you disagree?
- If you decide the patient is a good candidate for OBOT, what will the treatment plan include?
- Share your key takeaways with the class.

Time Allocated: 35 Minutes

EMMA'S CASE

Emma:

26-year-old assistant department store manager who has been using nonprescribed oxycodone on and off since age 18.

- Emma uses oxycodone when she feels down or socially isolated and it helps her deal with the stress of her work.
- No history of withdrawal management or addiction treatment.
- Stopped on her own for 6 months but relapsed 3 months ago and is now using daily.

Emma:

26-year-old assistant department store manager who has been using nonprescribed oxycodone on and off since age 18.

- She lives in an apartment with her fiancé.
- In the past, her boyfriend was concerned about the amount of money she spent on illicit opioids.
- Her boyfriend does not know about her current use of oxycodone.
- She is at risk of losing her job due to absenteeism.

Emma:

26-year-old assistant department store manager who has been using nonprescribed oxycodone on and off since age 18.

- No family history of alcoholism or substance use.
- She drinks alcohol “socially” with friends.
- She smokes ½ pack cigarettes per day.
- She denies other drug use.
- Her only current medical problem is mild asthma.
- She does not know her hepatitis C and HIV status.

Case Discussion – Emma

Discuss:

- Does she meet DSM-5 criteria for an opioid use disorder?
- Is Emma's OUD mild, moderate, or severe?
- What more information would you like before deciding on a diagnosis(es) and treatment plan?



JONATHAN'S CASE

Jonathan:

48-year-old engineer requesting transfer from methadone maintenance to office-based buprenorphine treatment.

- On methadone maintenance treatment program for 12 years but is tired of all the strict rules and policies.
- Current methadone dose is 95 mg.
- His 13-day take-homes were recently discontinued when he missed his 2nd group counseling session in 3 months. He is now required to have daily observed dosing.

Jonathan:

*48-year-old engineer
requesting transfer from
methadone maintenance to
office-based buprenorphine
treatment.*

- He does not think the group counseling is helping him anymore. He thinks it was helpful in the beginning but now it is just a burden.
- He is caring for his sick parents along with working full time which makes it difficult for him to reliably attend his weekly afternoon counseling session.
- Prior to methadone maintenance, he had an 8-year history of intravenous heroin use.
- Since starting methadone maintenance, he has been abstinent from heroin use.

Jonathan:

*48-year-old engineer
requesting transfer from
methadone maintenance to
office-based buprenorphine
treatment.*

- He is hepatitis C positive (never treated) and HIV negative.
- He has been in a stable relationship with a non-drug-using girlfriend for the past 7 years.
- He wants to discontinue methadone maintenance ASAP and transfer to buprenorphine so that he can “get on with my life.”



Case Discussion – Jonathan

Discuss:

- Is Jonathan a good candidate for OBOT?
- What additional information do you need?
- If you decide he is a good candidate for transfer to OBOT with buprenorphine/naloxone, what will the treatment plan include?

SUSAN'S CASE

Susan:

20-year-old community college student requesting treatment for her heroin addiction.

- She started using oxycodone with her roommate and has been using intranasal heroin (1 gram) daily for the last 15 months.
- Some of her friends are now switching to intravenous use because it takes less heroin to keep from getting sick.
- She does not want to inject drugs but may be “forced” to because she cannot keep paying the “extra cost” of sniffing heroin.

Susan:

20-year-old community college student requesting treatment for her heroin addiction.

- She has used all the money her parents gave her for school expenses to buy heroin, her credit cards are maxed out, and she has borrowed money from her friends.
- Until last semester, she had an overall B average, but this semester she is struggling academically and has been told she will be put on academic probation if her grades don't improve.

Susan:

20-year-old community college student requesting treatment for her heroin addiction.

- When she doesn't use heroin, she has anxiety, muscle aches, diarrhea, and can't sleep.
- She recognizes the symptoms as heroin withdrawal. She was surprised because she thought she could not develop withdrawal from only sniffing drugs.

Susan:

20-year-old community college student requesting treatment for her heroin addiction.

- She smokes one pack of cigarettes per day.
- She drinks alcohol on the weekends, up to 3 drinks per occasion.
- She denies other drug use.
- She has no prior history of addiction treatment.

Case Discussion – Susan

Discuss:

- Does she meet the criteria for DSM-5 moderate to severe OUD?
- Is she a candidate for office-based opioid treatment with buprenorphine/naloxone?
- What additional information would you need to make that decision?
- If you decide to treat Susan, what are your treatment plan and goals?



Susan:

20-year-old community college student requesting treatment for her heroin addiction.

- She was induced on buprenorphine in the office and given a prescription for 6-day supply of bup/nx (16/4 mg/day) and was told to participate in the clinic's 2x per week relapse prevention group and to schedule individual counseling at an off-site program.
- She was told she needed to attend the relapse prevention group in order to get her next bup/nx prescription.

Susan:

20-year-old community college student requesting treatment for her heroin addiction.

- She returns in 6 days for her next bup/nx refill.
- She has not attended the relapse prevention group nor arranged for counseling.
 - *What will be your treatment approach at this time?*

Susan:

20-year-old community college student requesting treatment for her heroin addiction.

- She was only partially adherent with the recommended counseling for 3 weeks including attending all but 1 of the relapse prevention groups but never started counseling.
- She states she has been too busy to go to counseling. She goes to school 5 days a week and has a new job working evenings as a waitress at a pub.
 - *Should you require Susan to attend counseling? Why? Why not?*

Susan:

20-year-old community college student requesting treatment for her heroin addiction.

- She then returns in 4 days (3 days before her follow up appointment) and states that one of her friends stole her bup/nx tablets.
- Her urine is buprenorphine negative and opiate positive. She states she is sniffing heroin again to prevent withdrawal after running out of bup/nx.

Susan:

20-year-old community college student requesting treatment for her heroin addiction.

- She has been missing too many classes and has had to change her status to part-time student. She told her parents that she needs time away from school to figure out what her major should be.
- She wants “one more chance” to restart bup/nx treatment.
 - *What would you recommend for Susan at this point?*

Activity 10

End of Course Reflection

Take five minutes to put in the chat what you found most valuable from the course, where you could use the knowledge gained in your work, and challenges you anticipate in treating OUD.

Prompting Questions

- What are some strategies and solutions for overcoming challenges when treating opioid use disorder?

10 minutes

Share your key takeaways with the class.

Q&A

KEEPING YOUR PATIENTS SAFE

End of Session 5

Contact Us



Address

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