MARY'S CASE – PATIENT DIAGNOSIS AND ASSESSMENT

Case Description

- **Mary** is a 22-year-old who is currently using IN and IV heroin.
- Her opioid use started in high school with oxycodone pills which her friends were crushing and sniffing to get "high."
- Mary would also binge drink at parties on the weekend, and smoke cannabis daily at this time.
- At first Mary did not like the feeling from the oxycodone—she got nauseous and vomited. But after a few more times, she found that the oxycodone was relaxing, and made her anxiety magically disappear.
- She felt like this was what her brain was "missing."
- Your colleague tells you that Mary was sexually abused by an older male cousin when she was 9 years old. She kept this a secret until very recently.
- Mary has been evaluated by a psychiatrist and a diagnosis of PTSD was made. She was prescribed an SSRI, and started seeing a therapist, but her heroin use has interfered with compliance to both.
- Mary continued to use oxycodone tablets, but in her senior year, her supplier was arrested, and a new boyfriend introduced her to heroin, which was more available and considerably cheaper. At first, she only sniffed the heroin.
- She managed to graduate high school and enrolled in her local community college. She had no idea what she wanted to study, or eventually "do with her life." She dropped out after one semester.
- Mary has been injecting heroin. She obtains her needles and syringes from a needle exchange. She has had two overdoses, which required naloxone reversal by her boyfriend and once by your colleague. Fentanyl contamination was suspected in both cases.
- Mary has been in three short term "detox" centers and one 28-day rehab. She has attended a few NA meetings with her boyfriend. She thinks medications, such as methadone and buprenorphine, would just be trading one addiction for another.
- Your colleague was reluctant to reach out to you earlier, due to a feeling of shame and guilt. There is concern about the stigma of addiction, both for Mary and your colleague.

Prompting Questions

- What are your procedures for documenting Mary's use of other substances?
- How do you identify if Mary needs medically supervised withdrawal management?
- What are your procedures for screening and assessing for comorbid medical conditions?
    - How, when, and where will they be addressed?
- What are your procedures for screening for psychiatric disorders?
    - How, when, and where will they be addressed?
- What are your procedures for:
    - screening for communicable diseases?
    - assessing Mary's access to social supports?
    - determining her readiness to participate in treatment and her goals for treatment?
- What else do you want to know about Mary?

Reflections

Questions, Thoughts, Key Terms, Main Ideas	Notes
Summary	

MARY'S CASE – PATIENT DIAGNOSIS AND ASSESSMENT

Case Description

- **Mary** is a 22-year-old who is currently using IN and IV heroin.
- Her opioid use started in high school with oxycodone pills which her friends were crushing and sniffing to get "high."
- Mary would also binge drink at parties on the weekend, and smoke cannabis daily at this time.
- At first Mary did not like the feeling from the oxycodone—she got nauseous and vomited. But after a few more times, she found that the oxycodone was relaxing, and made her anxiety magically disappear.
- She felt like this was what her brain was "missing."
- Your colleague tells you that Mary was sexually abused by an older male cousin when she was 9 years old. She kept this a secret until very recently.
- Mary has been evaluated by a psychiatrist and a diagnosis of PTSD was made. She was prescribed an SSRI, and started seeing a therapist, but her heroin use has interfered with compliance to both.
- Mary continued to use oxycodone tablets, but in her senior year, her supplier was arrested, and a new boyfriend introduced her to heroin, which was more available and considerably cheaper. At first, she only sniffed the heroin.
- She managed to graduate high school and enrolled in her local community college. She had no idea what she wanted to study, or eventually "do with her life." She dropped out after one semester.
- Mary has been injecting heroin. She obtains her needles and syringes from a needle exchange. She has had two overdoses, which required naloxone reversal by her boyfriend and once by your colleague. Fentanyl contamination was suspected in both cases.
- Mary has been in three short term "detox" centers and one 28-day rehab. She has attended a few NA meetings with her boyfriend. She thinks medications, such as methadone and buprenorphine, would just be trading one addiction for another.
- Your colleague was reluctant to reach out to you earlier, due to a feeling of shame and guilt. There is concern about the stigma of addiction, both for Mary and your colleague.

Prompting Questions

- What are your procedures for documenting Mary's use of other substances?
- How do you identify if Mary needs medically supervised withdrawal management?
- What are your procedures for screening and assessing for comorbid medical conditions?
    - How, when, and where will they be addressed?
- What are your procedures for screening for psychiatric disorders?
    - How, when, and where will they be addressed?
- What are your procedures for:
    - screening for communicable diseases?
    - assessing Mary's access to social supports?
    - determining her readiness to participate in treatment and her goals for treatment?
- What else do you want to know about Mary?

Reflections

What I Observe (Record what you see in the case)	**Questions I have** (Record questions you have)

MARY'S CASE – PATIENT DIAGNOSIS AND ASSESSMENT

Prompting Questions

- What are your procedures for documenting Mary's use of other substances?
- How do you identify if Mary needs medically supervised withdrawal management?
- What are your procedures for screening and assessing for comorbid medical conditions?
    - How, when, and where will they be addressed?
- What are your procedures for screening for psychiatric disorders?
    - How, when, and where will they be addressed?
- What are your procedures for:
    - screening for communicable diseases?
    - assessing Mary's access to social supports?
    - determining her readiness to participate in treatment and her goals for treatment?
- What else do you want to know about Mary?

Case Reflections

Case Information	My Notes
• **Mary** is a 22-year-old who is currently using IN and IV heroin.	
• Her opioid use started in high school with oxycodone pills which her friends were crushing and sniffing to get "high."	
• Mary would also binge drink at parties on the weekend, and smoke cannabis daily at this time.	
• At first Mary did not like the feeling from the oxycodone—she got nauseous and vomited. But after a few more times, she found that the oxycodone was relaxing, and made her anxiety magically disappear.	
• She felt like this was what her brain was "missing."	
• Your colleague tells you that Mary was sexually abused by an older male cousin when she was 9 years old. She kept this a secret until very recently.	
• Mary has been evaluated by a psychiatrist and a diagnosis of PTSD was made. She was prescribed an SSRI, and started seeing a therapist,	

but her heroin use has interfered with compliance to both.	
• Mary continued to use oxycodone tablets, but in her senior year, her supplier was arrested, and a new boyfriend introduced her to heroin, which was more available and considerably cheaper. At first, she only sniffed the heroin.	
• She managed to graduate high school and enrolled in her local community college. She had no idea what she wanted to study, or eventually "do with her life." She dropped out after one semester.	
• Mary has been injecting heroin. She obtains her needles and syringes from a needle exchange. She has had two overdoses, which required naloxone reversal by her boyfriend and once by your colleague. Fentanyl contamination was suspected in both cases.	
• Mary has been in three short term "detox" centers and one 28-day rehab. She has attended a few NA meetings with her boyfriend. She thinks medications, such as methadone and buprenorphine, would just be trading one addiction for another.	
• Your colleague was reluctant to reach out to you earlier, due to a feeling of shame and guilt. There is concern about the stigma of addiction, both for Mary and your colleague.	

ROBERT'S CASE – DETERMINING A TREATMENT PLAN

Case Description

- Robert is 35-year-old middle school math teacher currently using illicit hydrocodone and intranasal heroin.
- He has been using on and off since age 24.
- Robert has been through >15 episodes of medically supervised withdrawal ("detox").
- His last treatment included a 28-day residential program during his summer break, and attending daily NA meetings.
- He remained in recovery for 3 months but relapsed 1 month ago and is in some difficulty because of "calling in sick too much."
- His wife is in recovery and insisted that he return to treatment after she discovered he was taking hydrocodone pills from several doctors for a back injury following an automobile crash.
- She is unaware that he is also using heroin daily.
- There is family history of alcohol use disorder.
- He denies alcohol or tobacco use.
- His only current medical problem is mild hypertension. His back pain has resolved.
- He is hepatitis C and HIV negative.
- He states :
    - "I know I'm addicted. My wife stopped using when she was pregnant with our daughter, and she just got her 12-year chip. She moved on with her life, but I'm stuck."
- He states:
    - "My back injury threw me into a tailspin. At first, I really needed the 'painkillers,' but now I'm just using them to 'feel normal' and to 'prevent withdrawal.' I really need your help. If my wife finds out I'm back on heroin, she'll leave me this time."

Prompting Questions

- Does Robert meet DSM-5 criteria for an opioid use disorder?
- If so, how does he meet the DSM-5 criteria for an opioid use disorder?
    - Is it mild, moderate or severe?
- What medication and/or psychosocial treatment options would you recommend for Robert and why?
- Work with a partner next to you to assess Robert's case to determine if he meets DSM-5 criteria for an opioid use disorder. If so, how and is it mild, moderate, or severe?
- What are the treatment options for Robert?
- What are the treatment options for Robert?
- How would you assess the need for pharmacotherapy (e.g., methadone, buprenorphine, naltrexone) for Robert?
- Is Robert a candidate for office-based opioid treatment (OBOT)? Why/why not?
- What should the initial treatment plan include?

Reflections

Questions, Thoughts, Key Terms, Main Ideas	Notes
Summary	

ROBERT'S CASE – DETERMINING A TREATMENT PLAN

Case Description

- Robert is 35-year-old middle school math teacher currently using illicit hydrocodone and intranasal heroin.
- He has been using on and off since age 24.
- Robert has been through >15 episodes of medically supervised withdrawal ("detox").
- His last treatment included a 28-day residential program during his summer break, and attending daily NA meetings.
- He remained in recovery for 3 months but relapsed 1 month ago and is in some difficulty because of "calling in sick too much."
- His wife is in recovery and insisted that he return to treatment after she discovered he was taking hydrocodone pills from several doctors for a back injury following an automobile crash.
- She is unaware that he is also using heroin daily.
- There is family history of alcohol use disorder.
- He denies alcohol or tobacco use.
- His only current medical problem is mild hypertension. His back pain has resolved.
- He is hepatitis C and HIV negative.
- He states :
    - "I know I'm addicted. My wife stopped using when she was pregnant with our daughter, and she just got her 12-year chip. She moved on with her life, but I'm stuck."
- He states:
    - "My back injury threw me into a tailspin. At first, I really needed the 'painkillers,' but now I'm just using them to 'feel normal' and to 'prevent withdrawal.' I really need your help. If my wife finds out I'm back on heroin, she'll leave me this time."

Prompting Questions

- Does Robert meet DSM-5 criteria for an opioid use disorder?
- If so, how does he meet the DSM-5 criteria for an opioid use disorder?
    - Is it mild, moderate or severe?
- What medication and/or psychosocial treatment options would you recommend for Robert and why?
- Work with a partner next to you to assess Robert's case to determine if he meets DSM-5 criteria for an opioid use disorder. If so, how and is it mild, moderate, or severe?
- What are the treatment options for Robert?
- What are the treatment options for Robert?
- How would you assess the need for pharmacotherapy (e.g., methadone, buprenorphine, naltrexone) for Robert?
- Is Robert a candidate for office-based opioid treatment (OBOT)? Why/why not?
- What should the initial treatment plan include?

Reflections

What I Observe (Record what you see in the case)	**Questions I have** (Record questions you have)

ROBERT'S CASE – DETERMINING A TREATMENT PLAN

Prompting Questions

- Does Robert meet DSM-5 criteria for an opioid use disorder?
- If so, how does he meet the DSM-5 criteria for an opioid use disorder?
    - Is it mild, moderate or severe?
- What medication and/or psychosocial treatment options would you recommend for Robert and why?
- Work with a partner next to you to assess Robert's case to determine if he meets DSM-5 criteria for an opioid use disorder. If so, how and is it mild, moderate, or severe?
- What are the treatment options for Robert?
- What are the treatment options for Robert?
- How would you assess the need for pharmacotherapy (e.g., methadone, buprenorphine, naltrexone) for Robert?
- Is Robert a candidate for office-based opioid treatment (OBOT)? Why/why not?
- What should the initial treatment plan include?

Case Reflections

Case Information	My Notes
• Robert is 35-year-old middle school math teacher currently using illicit hydrocodone and intranasal heroin.	
• He has been using on and off since age 24.	
• Robert has been through >15 episodes of medically supervised withdrawal ("detox").	
• His last treatment included a 28-day residential program during his summer break, and attending daily NA meetings.	
• He remained in recovery for 3 months but relapsed 1 month ago and is in some difficulty because of "calling in sick too much."	
• His wife is in recovery and insisted that he return to treatment after she discovered he was taking hydrocodone pills from several	

doctors for a back injury following an automobile crash.	
• His wife is unaware that he is also using heroin daily.	
• There is family history of alcohol use disorder.	
• He denies alcohol or tobacco use.	
• His only current medical problem is mild hypertension. His back pain has resolved.	
• He is hepatitis C and HIV negative.	
• He states : o "I know I'm addicted. My wife stopped using when she was pregnant with our daughter, and she just got her 12-year chip. She moved on with her life, but I'm stuck."	
• He states: o "My back injury threw me into a tailspin. At first, I really needed the 'painkillers,' but now I'm just using them to 'feel normal' and to 'prevent withdrawal.' I really need your help. If my wife finds out I'm back on heroin, she'll leave me this time."	

PAULA'S CASE – Implementing Office-Based Opioid Treatment (OBOT) Medication Management

Case Description

- **Paula** is a 23-year-old graduate student in social work who is addicted to heroin.
- Her mother calls your office seeking treatment for her daughter.
- She is agreeable to having her mother come in with her for the consultation and evaluation.
- She is comfortable and not in opioid withdrawal during the initial consultation.
- You get Paula's history while her mother sits in the waiting room.
- She relates feeling anxious most of her life.
- She started smoking marijuana and drinking alcohol on the weekends in high school.
- In college, she fractured her ankle playing basketball, and was treated with oxycodone. She noticed that in addition to pain control, her anxiety decreased, and she reported feeling "normal" and "peaceful."
- She continued requesting oxycodone refills even though her pain had resolved.
- When the orthopedist refused to continue prescribing oxycodone she started buying them from friends increasing to ~200mg daily.
- A year ago she entered a 28-day residential program, never followed up in after care, relapsed 6 weeks later.
- She has never been on medications for her opioid use disorder.
- Due to cost and availability she switched from oxycodone to sniffing heroin ~10 bags daily—Last use 4 hours ago.
- Paula agrees to have mother present to discuss treatment options.
- You present the options of:
    - opioid agonist maintenance therapy (methadone, buprenorphine)
    - antagonist maintenance with naltrexone
    - another attempt at "detox" and medication-free treatment
- Paula and her mother have done their research:
    - Paula has a friend doing well on buprenorphine, and they decide on buprenorphine.
- They understand that some form of counseling will also be a part of the treatment plan.
- Paula has insurance, so access is not a problem.
- You explain that since Paula is physically dependent on opioids, she must be in mild-moderate spontaneous withdrawal, to avoid precipitated withdrawal. She understands.
- You tell her to discontinue all opioids for at least 12 hours. She has decided on doing the induction the next morning.
- She returns the next day with her mother. She is visibly uncomfortable and has a COWS score of 12.
- You instruct her that buprenorphine/naloxone is always administered sublingually or via the buccal mucosa—never swallowed whole.
- She is instructed on the proper administration procedures to maximize buprenorphine bioavailability.
- You give her buprenorphine 4/1 mg.
- After her initial dose you give her another 4/1 mg for continued withdrawal.

- She remained on buprenorphine/naloxone 16/4 mg per day for the next 6 months and had no relapses.
- She was adherent with weekly counseling and office monitoring including urine drug tests and pill counts.
- There were no concerning behaviors on the PDMP.

Prompting Questions

- Is Paula ready for buprenorphine induction at this time?
- If not, how will you decide when she is ready?
- Is the patient a candidate for unobserved "home" induction?
- After you give her buprenorphine 4/1 mg,
    - How long to initial effect?
    - How long to peak effect?
- After her initial dose you give her another 4/1 mg for continued withdrawal:
    - When can she leave the office?
    - Can she take more buprenorphine after leaving the office?
    - When should she contact you?
- Should the stabilization dose be divided or taken once per day?
- How often should stabilization doses be increased?
- Once dose stabilization occurs, are maintenance dose increases due to tolerance common? Or are lower doses required over time?
- How long should Paula be maintained on the buprenorphine?
- How will you decide if and when she is ready to be tapered?
- How would you taper her off buprenorphine?

Reflections

Questions, Thoughts, Key Terms, Main Ideas	Notes
Summary	

PAULA'S CASE – Implementing Office-Based Opioid Treatment (OBOT) Medication Management

- **Paula** is a 23-year-old graduate student in social work who is addicted to heroin.
- Her mother calls your office seeking treatment for her daughter.
- She is agreeable to having her mother come in with her for the consultation and evaluation.
- She is comfortable and not in opioid withdrawal during the initial consultation.
- You get Paula's history while her mother sits in the waiting room.
- She relates feeling anxious most of her life.
- She started smoking marijuana and drinking alcohol on the weekends in high school.
- In college, she fractured her ankle playing basketball, and was treated with oxycodone. She noticed that in addition to pain control, her anxiety decreased, and she reported feeling "normal" and "peaceful."
- She continued requesting oxycodone refills even though her pain had resolved.
- When the orthopedist refused to continue prescribing oxycodone she started buying them from friends increasing to ~200mg daily.
- A year ago she entered a 28-day residential program, never followed up in after care, relapsed 6 weeks later.
- She has never been on medications for her opioid use disorder.
- Due to cost and availability she switched from oxycodone to sniffing heroin ~10 bags daily—Last use 4 hours ago.
- Paula agrees to have mother present to discuss treatment options.
- You present the options of:
    - opioid agonist maintenance therapy (methadone, buprenorphine)
    - antagonist maintenance with naltrexone
    - another attempt at "detox" and medication-free treatment
- Paula and her mother have done their research:
    - Paula has a friend doing well on buprenorphine, and they decide on buprenorphine.
- They understand that some form of counseling will also be a part of the treatment plan.
- Paula has insurance, so access is not a problem.
- You explain that since Paula is physically dependent on opioids, she must be in mild-moderate spontaneous withdrawal, to avoid precipitated withdrawal. She understands.
- You tell her to discontinue all opioids for at least 12 hours. She has decided on doing the induction the next morning.
- She returns the next day with her mother. She is visibly uncomfortable and has a COWS score of 12.
- You instruct her that buprenorphine/naloxone is always administered sublingually or via the buccal mucosa—never swallowed whole.
- She is instructed on the proper administration procedures to maximize buprenorphine bioavailability.
- You give her buprenorphine 4/1 mg.
- After her initial dose you give her another 4/1 mg for continued withdrawal.
- She remained on buprenorphine/naloxone 16/4 mg per day for the next 6 months and had no relapses.

- She was adherent with weekly counseling and office monitoring including urine drug tests and pill counts.
- There were no concerning behaviors on the PDMP.

Prompting Questions

- Is Paula ready for buprenorphine induction at this time?
- If not, how will you decide when she is ready?
- Is the patient a candidate for unobserved “home” induction?
- After you give her buprenorphine 4/1 mg,
    - How long to initial effect?
    - How long to peak effect?
- After her initial dose you give her another 4/1 mg for continued withdrawal:
    - When can she leave the office?
    - Can she take more buprenorphine after leaving the office?
    - When should she contact you?
- Should the stabilization dose be divided or taken once per day?
- How often should stabilization doses be increased?
- Once dose stabilization occurs, are maintenance dose increases due to tolerance common? Or are lower doses required over time?
- How long should Paula be maintained on the buprenorphine?
- How will you decide if and when she is ready to be tapered?
- How would you taper her off buprenorphine?

Reflections

What I Observe (Record what you see in the case)	**Questions I have** (Record questions you have)

PAULA'S CASE – Implementing Office-Based Opioid Treatment (OBOT) Medication Management

Prompting Questions

- Is Paula ready for buprenorphine induction at this time?
- If not, how will you decide when she is ready?
- Is the patient a candidate for unobserved "home" induction?
- After you give her buprenorphine 4/1 mg,
    - How long to initial effect?
    - How long to peak effect?
- After her initial dose you give her another 4/1 mg for continued withdrawal:
    - When can she leave the office?
    - Can she take more buprenorphine after leaving the office?
    - When should she contact you?
- Should the stabilization dose be divided or taken once per day?
- How often should stabilization doses be increased?
- Once dose stabilization occurs, are maintenance dose increases due to tolerance common? Or are lower doses required over time?
- How long should Paula be maintained on the buprenorphine?
- How will you decide if and when she is ready to be tapered?
- How would you taper her off buprenorphine?

Case Reflections

Case Information	My Notes
• **Paula** is a 23-year-old graduate student in social work who is addicted to heroin.	
• Her mother calls your office seeking treatment for her daughter.	
• She is agreeable to having her mother come in with her for the consultation and evaluation.	
• She is comfortable and not in opioid withdrawal during the initial consultation.	
• You get Paula's history while her mother sits in the waiting room. • She relates feeling anxious most of her life.	
• She started smoking marijuana and drinking alcohol on the weekends in high school. • In college, she fractured her ankle playing basketball, and was treated with oxycodone. She noticed that in	

addition to pain control, her anxiety decreased, and she reported feeling "normal" and "peaceful."	
• She continued requesting oxycodone refills even though her pain had resolved.	
• When the orthopedist refused to continue prescribing oxycodone she started buying them from friends increasing to ~200mg daily.	
• A year ago she entered a 28-day residential program, never followed up in after care, relapsed 6 weeks later.	
• She has never been on medications for her opioid use disorder.	
• Due to cost and availability she switched from oxycodone to sniffing heroin ~10 bags daily—Last use 4 hours ago.	
• Paula agrees to have mother present to discuss treatment options.	
• You present the options of: o opioid agonist maintenance therapy (methadone, buprenorphine) o antagonist maintenance with naltrexone o another attempt at "detox" and medication-free treatment	
• Paula and her mother have done their research: o Paula has a friend doing well on buprenorphine, and they decide on buprenorphine.	
• They understand that some form of counseling will also be a part of the treatment plan.	
• Paula has insurance, so access is not a problem.	

• You explain that since Paula is physically dependent on opioids, she must be in mild-moderate spontaneous withdrawal, to avoid precipitated withdrawal. She understands.	
• You tell her to discontinue all opioids for at least 12 hours. She has decided on doing the induction the next morning.	
• She returns the next day with her mother. She is visibly uncomfortable and has a COWS score of 12.	
• You instruct her that buprenorphine/naloxone is always administered sublingually or via the buccal mucosa—never swallowed whole.	
• She is instructed on the proper administration procedures to maximize buprenorphine bioavailability.	
• You give her buprenorphine 4/1 mg.	
• After her initial dose you give her another 4/1 mg for continued withdrawal.	
• She remained on buprenorphine/naloxone 16/4 mg per day for the next 6 months and had no relapses.	
• She was adherent with weekly counseling and office monitoring including urine drug tests and pill counts.	
• There were no concerning behaviors on the PDMP.	

SOPHIA'S CASE – **PATIENT DIAGNOSIS AND ASSESSMENT**

Case Description

- **Sophia** is a 38-year-old woman being followed for ongoing management of her opioid use disorder:
- She presented to the buprenorphine induction clinic for induction and was quickly stabilized on bup/nx 16/4 mg SL qday.
- Sophia kept all her appointments and had 6 weeks of urine drug tests negative for opioids and all other tested drugs.
- Since coming into treatment with you, she kept biweekly appointments x3, and monthly appointments x4, reporting satisfaction with the treatment and increasing productivity at work as a research assistant.
- After Sophia's 8th visit with you, her urine drug test was positive for benzodiazepines, and confirmation reveals alprazolam and metabolites. Sophia admits to using a friend's "*Xanax one night to help sleep. With all the work stress, I just couldn't get to sleep*."
- Sophia notes that she is doing much better in her life now than before when she was spending all her money on heroin and struggling to keep a job.
- Sophia does not want to discontinue buprenorphine and go back to that life.
- Sophia does not believe she has "a problem" with alprazolam.
- She denies further use.
- Repeat testing at this visit comes back positive again for benzodiazepines, with +alprazolam and metabolites.

Prompting Questions:

1. How would you respond to these results?
2. Does the nature of the substance (benzos vs. stimulants) affect how you talk to Sophia?
3. How would you respond to Sophia now?

Reflections

Questions, Thoughts, Key Terms, Main Ideas	Notes
Summary	

SOPHIA'S CASE – **PATIENT DIAGNOSIS AND ASSESSMENT**

Case Description

- **Sophia** is a 38-year-old woman being followed for ongoing management of her opioid use disorder.
- She presented to the buprenorphine induction clinic for induction and was quickly stabilized on bup/nx 16/4 mg SL qday.
- Sophia kept all her appointments and had 6 weeks of urine drug tests negative for opioids and all other tested drugs.
- Since coming into treatment with you, she kept biweekly appointments x3, and monthly appointments x4, reporting satisfaction with the treatment and increasing productivity at work as a research assistant.
- After Sophia's 8th visit with you, her urine drug test was positive for benzodiazepines, and confirmation reveals alprazolam and metabolites. Sophia admits to using a friend's "*Xanax one night to help sleep. With all the work stress, I just couldn't get to sleep*."
- Sophia notes that she is doing much better in her life now than before when she was spending all her money on heroin and struggling to keep a job.
- Sophia does not want to discontinue buprenorphine and go back to that life.
- Sophia does not believe she has "a problem" with alprazolam.
- She denies further use.
- Repeat testing at this visit comes back positive again for benzodiazepines, with +alprazolam and metabolites.

Prompting Questions:

1. How would you respond to these results?
2. Does the nature of the substance (benzos vs. stimulants) affect how you talk to Sophia?
3. How would you respond to Sophia now?

Reflections

What I Observe (Record what you see in the case)	**Questions I have** (Record questions you have)

SOPHIA'S CASE – **PATIENT DIAGNOSIS AND ASSESSMENT**

Prompting Questions:

- How would you respond to these results?
- Does the nature of the substance (benzos vs. stimulants) affect how you talk to Sophia?
- How would you respond to Sophia now

Case Reflections

Case Information	**My Notes**
• **Sophia** is a 38-year-old woman being followed for ongoing management of her opioid use disorder.	
• She presented to the buprenorphine induction clinic for induction and was quickly stabilized on bup/nx 16/4 mg SL qday.	
• Sophia kept all her appointments and had 6 weeks of urine drug tests negative for opioids and all other tested drugs.	
• Since coming into treatment with you, she kept biweekly appointments x3, and monthly appointments x4, reporting satisfaction with the treatment and increasing productivity at work as a research assistant.	
• After Sophia's 8th visit with you, her urine drug test was positive for benzodiazepines, and confirmation reveals alprazolam and metabolites. Sophia admits to using a friend's "*Xanax one night to help sleep. With all the work stress, I just couldn't get to sleep.*"	
• Sophia notes that she is doing much better in her life now than before when she was spending all her money on heroin and struggling to keep a job.	
• Sophia does not want to discontinue buprenorphine and go back to that life.	

• Sophia does not believe she has “a problem” with alprazolam.	
• She denies further use.	
• Repeat testing at this visit comes back positive again for benzodiazepines, with +alprazolam and metabolites.	

SAM'S CASE

Case Description

- **Sam** is a 52-year-old man maintained on bup/nx 16/4 mg per day for the past 10 years
- His opioid use disorder began after a motorcycle crash resulting in multiple fractures and orthopedic surgeries. He was treated with high dose morphine and quickly escalated his use and lost control of his prescriptions
- He realized he had a problem when he ran out of his morphine and had severe withdrawal symptoms
- He believes buprenorphine is a "miracle drug" that has saved his life. He is not in counseling but attends AA 3-4 meetings per week and has a sponsor
- He has a history of alcoholism and has been sober for >20 years
- He has severe chronic right knee pain which he has been told is due to arthritis after his traumatic knee injury. His pain had been well controlled on split dose buprenorphine (8/2 mg TID), ibuprofen and acetaminophen
- Now is pain is so severe, he has had to take time off from work
- He is now being scheduled for an elective right total knee replacement
- He was told in the preoperative clinic:
    - To get off his buprenorphine for at least 5 days before his surgery
    - That the buprenorphine will prevent the pain medication from working
    - That the pain medications will likely put him into withdrawal if he is still taking the buprenorphine
- He was told to talk to you about his perioperative buprenorphine management

Prompting Questions

- What do you recommend regarding his buprenorphine maintenance perioperatively?
- What do you recommend regarding his pain management perioperatively?

Reflections

Questions, Thoughts, Key Terms, Main Ideas	Notes
Summary	

SAM'S CASE

Case Description

- **Sam** is a 52-year-old man maintained on bup/nx 16/4 mg per day for the past 10 years
- His opioid use disorder began after a motorcycle crash resulting in multiple fractures and orthopedic surgeries. He was treated with high dose morphine and quickly escalated his use and lost control of his prescriptions
- He realized he had a problem when he ran out of his morphine and had severe withdrawal symptoms
- He believes buprenorphine is a "miracle drug" that has saved his life. He is not in counseling but attends AA 3-4 meetings per week and has a sponsor
- He has a history of alcoholism and has been sober for >20 years
- He has severe chronic right knee pain which he has been told is due to arthritis after his traumatic knee injury. His pain had been well controlled on split dose buprenorphine (8/2 mg TID), ibuprofen and acetaminophen
- Now is pain is so severe, he has had to take time off from work
- He is now being scheduled for an elective right total knee replacement
- He was told in the preoperative clinic:
    - To get off his buprenorphine for at least 5 days before his surgery
    - That the buprenorphine will prevent the pain medication from working
    - That the pain medications will likely put him into withdrawal if he is still taking the buprenorphine
- He was told to talk to you about his perioperative buprenorphine management

Prompting Questions

- What do you recommend regarding his buprenorphine maintenance perioperatively?
- What do you recommend regarding his pain management perioperatively?

Reflections

What I Observe (Record what you see in the case)	**Questions I have** (Record questions you have)

SAM'S CASE

Prompting Questions

- What do you recommend regarding his buprenorphine maintenance perioperatively?
- What do you recommend regarding his pain management perioperatively?

Case Reflections

Case Information	My Notes
Sam is a 52-year-old man maintained on bup/nx 16/4 mg per day for the past 10 years	
His opioid use disorder began after a motorcycle crash resulting in multiple fractures and orthopedic surgeries. He was treated with high dose morphine and quickly escalated his use and lost control of his prescriptions	
He realized he had a problem when he ran out of his morphine and had severe withdrawal symptoms	
He believes buprenorphine is a "miracle drug" that has saved his life. He is not in counseling but attends AA 3-4 meetings per week and has a sponsor	
He has a history of alcoholism and has been sober for >20 years	
He has severe chronic right knee pain which he has been told is due to arthritis after his traumatic knee injury. His pain had been well controlled on split dose buprenorphine (8/2 mg TID), ibuprofen and acetaminophen	
Now is pain is so severe, he has had to take time off from work	
He is now being scheduled for an elective right total knee replacement	
He was told in the preoperative clinic: • To get off his buprenorphine for at least 5 days before his surgery	

• That the buprenorphine will prevent the pain medication from working • That the pain medications will likely put him into withdrawal if he is still taking the buprenorphine	
He was told to talk to you about his perioperative buprenorphine management	

EMMA'S CASE

Case Description

- **Emma** is 26-years-old and works as an assistant store manager at department store
- Using nonprescribed oxycodone on and off since age 18
- She 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
- 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
- No family history of alcoholism or substance use
- She drinks alcohol "socially" with friends
- She smokes tobacco ½ ppd
- She denies other drug use
- Her only current medical problem is mild asthma
- She does not know her hepatitis C and HIV status

Prompting Questions

- Does Emma meet DSM-5 criteria for an opioid use disorder? If so, how and is it mild, moderate, or severe?
- What more information would you like before deciding on a diagnosis(es) and treatment plan?

Reflections

Questions, Thoughts, Key Terms, Main Ideas	Notes
Summary	

EMMA'S CASE

Case Description

- **Emma** is 26-years-old and works as an assistant store manager at department store
- Using nonprescribed oxycodone on and off since age 18
- She 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
- 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
- No family history of alcoholism or substance use
- She drinks alcohol "socially" with friends
- She smokes tobacco ½ ppd
- She denies other drug use
- Her only current medical problem is mild asthma
- She does not know her hepatitis C and HIV status

Prompting Questions

- Does Emma meet DSM-5 criteria for an opioid use disorder? If so, how and is it mild, moderate, or severe?
- What more information would you like before deciding on a diagnosis(es) and treatment plan?

Reflections

What I Observe (Record what you see in the case)	**Questions I have** (Record questions you have)

EMMA'S CASE

Prompting Questions

- Does Emma meet DSM-5 criteria for an opioid use disorder? If so, how and is it mild, moderate, or severe?
- What more information would you like before deciding on a diagnosis(es) and treatment plan?

Case Reflections

Case Information	My Notes
Emma is 26-years-old and works as an assistant store manager at department store	
Using nonprescribed oxycodone on and off since age 18	
She 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	
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	
No family history of alcoholism or substance use	
She drinks alcohol "socially" with friends	
She smokes tobacco ½ ppd	
She denies other drug use	
Her only current medical problem is mild asthma	
She does not know her hepatitis C and HIV status	

JENNIFER'S CASE

Case Description

- **Jennifer** is 32 years old and has been your patient for the past 5 years. 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, over the years.
- Jennifer is employed as an IT specialist in 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.
- 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 enquires about "getting off" buprenorphine. She relates that Karishma has never really been OK with the medication. Karishma has heard that ,"It's just substituting one drug for another," or "one addic,tion for another."
- Karishma has a friend who has an AUD and attends AA meetings. The friend tells Karishma, that her AA group is not OK 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.
- 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, and discuss each of the misconceptions individually and provide evidence for your suggestion that Jennifer continue with her successful treatment paradigm with buprenorphine.

Prompting Questions

- 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?

Reflections

Questions, Thoughts, Key Terms, Main Ideas	Notes
Summary	

JENNIFER'S CASE

Case Description

- **Jennifer** is 32 years old and has been your patient for the past 5 years. 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, over the years.
- Jennifer is employed as an IT specialist in 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.
- 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 enquires about "getting off" buprenorphine. She relates that Karishma has never really been OK with the medication. Karishma has heard that ,"It's just substituting one drug for another," or "one addic,tion for another."
- Karishma has a friend who has an AUD and attends AA meetings. The friend tells Karishma, that her AA group is not OK 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.
- 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, and discuss each of the misconceptions individually and provide evidence for your suggestion that Jennifer continue with her successful treatment paradigm with buprenorphine.

Prompting Questions

- 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?

Reflections

What I Observe (Record what you see in the case)	**Questions I have** (Record questions you have)

JENNIFER'S CASE

Prompting Questions

- 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?

Case Reflections

Case Information	My Notes
Jennifer is 32 years old and has been your patient for the past 5 years. 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, over the years.	
Jennifer is employed as an IT specialist in 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.	
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 enquires about "getting off" buprenorphine. She relates that Karishma has never really been OK with the medication. Karishma has heard that ,"It's	

just substituting one drug for another," or "one addic,tion for another."	
Karishma has a friend who has an AUD and attends AA meetings. The friend tells Karishma, that her AA group is not OK 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.	
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, and discuss each of the misconceptions individually and provide evidence for your suggestion that Jennifer continue with her successful treatment paradigm with buprenorphine.	

JONATHAN'S CASE

Case Description

- **Jonathan** is a 48-year-old engineer requesting transfer from his methadone maintenance program to your office-based buprenorphine treatment program
- 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
- He does not think the group counseling was 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
- 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"

Prompting Questions

- Is John a candidate for office-based opioid treatment (OBOT) with buprenorphine/naloxone? Why? Why not?
- What additional information do you need?
- If you decide John is a good candidate for transfer to OBOT with buprenorphine/naloxone what will the treatment plan include?

Reflections

Questions, Thoughts, Key Terms, Main Ideas	Notes
Summary	

JONATHAN'S CASE

Case Description

- **Jonathan** is a 48-year-old engineer requesting transfer from his methadone maintenance program to your office-based buprenorphine treatment program
- 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
- He does not think the group counseling was 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
- 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"

Prompting Questions

- Is John a candidate for office-based opioid treatment (OBOT) with buprenorphine/naloxone? Why? Why not?
- What additional information do you need?
- If you decide John is a good candidate for transfer to OBOT with buprenorphine/naloxone what will the treatment plan include?

Reflections

What I Observe (Record what you see in the case)	**Questions I have** (Record questions you have)

JONATHAN'S CASE

Prompting Questions

- Is John a candidate for office-based opioid treatment (OBOT) with buprenorphine/naloxone? Why? Why not?
- What additional information do you need?
- If you decide John is a good candidate for transfer to OBOT with buprenorphine/naloxone what will the treatment plan include?

Case Reflections

Case Information	My Notes
Jonathan is a 48-year-old engineer requesting transfer from his methadone maintenance program to your office-based buprenorphine treatment program	
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	
He does not think the group counseling was 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	
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”	

KATIE'S CASE

Case Description

- **Katie** is a 32-year-old woman who presents for follow-up care
- She has diagnoses of severe opioid use disorder (injection heroin) and moderate cocaine use disorder (smokes crack)
- 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

Prompting Questions

- How will you respond to Katie's continued cocaine use?

Reflections

Questions, Thoughts, Key Terms, Main Ideas	Notes
Summary	

KATIE'S CASE

Case Description

- **Katie** is a 32-year-old woman who presents for follow-up care
- She has diagnoses of severe opioid use disorder (injection heroin) and moderate cocaine use disorder (smokes crack)
- 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

Prompting Questions

- How will you respond to Katie's continued cocaine use?

Reflections

What I Observe (Record what you see in the case)	**Questions I have** (Record questions you have)

KATIE'S CASE

Prompting Questions

- How will you respond to Katie's continued cocaine use?

Case Reflections

Case Information	My Notes
Katie is a 32-year-old woman who presents for follow-up care	
She has diagnoses of severe opioid use disorder (injection heroin) and moderate cocaine use disorder (smokes crack)	
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	

SUSAN'S CASE

Case Description

- **Susan** is a 20-year-old community college student who is requesting treatment of her "heroin addiction"
- She started using oxycodone with her roommate and is now using intranasal heroin daily for the last 15 months
- She is using about 1 gram of heroin daily
- 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
- 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 in academic difficulty and has been told she will be on academic probation if her grades don't improve
- When she doesn't use heroin, she has anxiety, muscle aches, diarrhea and can't sleep. She recognizes the symptoms as heroin withdrawal and was surprised because she thought she could not develop withdrawal with sniffing drugs
- She smokes cigarettes 1 pack 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
- 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
- She returns in 6 days for her next bup/nx refill
- She has not attended the relapse prevention group nor arranged for counseling
- 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 per week and has a new job working evenings as a waitress at a pub
- 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
- 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

Prompting Questions

- Does Susan meet the criteria for DSM 5 moderate to severe opioid use disorder?
- Is Susan 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 with buprenorphine/naloxone, what will be your treatment plan and goals?
- What will be your treatment approach at this time?
- Should you require Susan to attend counseling? Why? Why not?
- What would you recommend for Susan at this point?

Reflections

Questions, Thoughts, Key Terms, Main Ideas	Notes
Summary	

SUSAN'S CASE

Case Description

- **Susan** is a 20-year-old community college student who is requesting treatment of her "heroin addiction"
- She started using oxycodone with her roommate and is now using intranasal heroin daily for the last 15 months
- She is using about 1 gram of heroin daily
- 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
- 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 in academic difficulty and has been told she will be on academic probation if her grades don't improve
- When she doesn't use heroin, she has anxiety, muscle aches, diarrhea and can't sleep. She recognizes the symptoms as heroin withdrawal and was surprised because she thought she could not develop withdrawal with sniffing drugs
- She smokes cigarettes 1 pack 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
- 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
- She returns in 6 days for her next bup/nx refill
- She has not attended the relapse prevention group nor arranged for counseling
- 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 per week and has a new job working evenings as a waitress at a pub
- 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
- 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

Prompting Questions

- Does Susan meet the criteria for DSM 5 moderate to severe opioid use disorder?
- Is Susan 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 with buprenorphine/naloxone, what will be your treatment plan and goals?
- What will be your treatment approach at this time?
- Should you require Susan to attend counseling? Why? Why not?
- What would you recommend for Susan at this point?

Reflections

What I Observe (Record what you see in the case)	**Questions I have** (Record questions you have)

SUSAN'S CASE

Prompting Questions

- Does Susan meet the criteria for DSM 5 moderate to severe opioid use disorder?
- Is Susan 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 with buprenorphine/naloxone, what will be your treatment plan and goals?
- What will be your treatment approach at this time?
- Should you require Susan to attend counseling? Why? Why not?
- What would you recommend for Susan at this point?

Case Reflections

Case Information	My Notes
Susan is a 20-year-old community college student who is requesting treatment of her "heroin addiction"	
She started using oxycodone with her roommate and is now using intranasal heroin daily for the last 15 months	
She is using about 1 gram of heroin daily	
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	
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 in academic difficulty and has been told she will be on academic probation if her grades don't improve	
When she doesn't use heroin, she has anxiety, muscle aches, diarrhea and can't sleep. She recognizes the symptoms as heroin withdrawal and was surprised because she	

thought she could not develop withdrawal with sniffing drugs	
She smokes cigarettes 1 pack 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	
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	
She returns in 6 days for her next bup/nx refill	
She has not attended the relapse prevention group nor arranged for counseling	
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 per week and has a new job working evenings as a waitress at a pub	
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	
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	