Breakout Session – Gilmore Chung, MD
Improving Prescribing: Learn and apply approaches to manage complex patient cases

Case Studies

"Mr. B"

- Mr. B is in his early thirties. He came to Southern California to "get clean".
- History of depression, anxiety, PTSD. 2-3 psychiatric hospitalizations for suicidal ideations
- 2 years ago attempted to overdose
- Sexual abuse as a child. Brother died from overdose. Multiple family members with substance use disorders.
- Just left a private rehab recently.
- Feels judged by his family for using buprenorphine.
- Previously "hard core" in NA – judges himself for using buprenorphine. Doesn't want to take more than a tiny dose.
- Using meth. "Honestly, I microdose. I don't even like the stuff. I hardly use any. I have ADD really bad and I struggle badly." Feels that meth helps him get things done, focus, but side effects are too much, doesn't eat and sleep. "I need a fucking job. I need Adderall so I don't use meth".
- Terrified of rejection. Anything that providers say that doesn't coincide with his views is a possible betrayal.
- Tries to see different providers, make bargains to get to goals. Went to inpatient, but left after a week. Wants to get back to a "nice" rehab, but only has Medi-Cal. Has seen therapists, counselors on intermittent basis. One of our most experienced counselors left his first meeting with him with a shell-shocked look on his face.
- Multiple trials of SSRI's. Prazosin. SNRI's, gabapentin, mood stabilizers.
- Misses appointments. Doesn't have working phone usually.
- Living on the street now, after long stint couch surfing.

"Mr. H"

- Mr. H is a 20 year-old man, coming to clinic for past year and a half.
- Was going to meetings, using buprenorphine from mother about 7 months before started with our program.
- History of depression.
- Dad on meth, heroin, is homeless. Mom in recovery – doing well on bup/nal. Sister (intentionally?) died from OD.
- Lost ID over year ago, perpetually working on steps to get that done, finish school, get job.
- Was going to DMH for depression, was on SSRI.
- Doesn't engage in individual therapy/counseling
- Had a good run of making it to appointments, had a part time job. Was on a small dose of bup, negative for opiates, but always positive for meth.
- Decided that he wanted to stop buprenorphine.
- Stopped coming to groups.
- Intermittent follow-up with colleague
- Colleague frustrated with him – Negative urines.
- Wants to kick him out of the program. Three strikes and you're out.
- Colleague felt he was diverting his meds. Wanted to get a serum toxicology screen.
- Lots of "I". "I don't think he's taking his meds." "I told him to get his labs." "I don't want to lose my license." "I told him to go to meetings." "I told him to work with the therapist".

"Mr. O"

- Mr. O is a man in his late 20's, who presented for opiate and benzodiazepine use.
- Started marijuana and EtOH early teens, benzos and oxy age 18. Methadone for 3 years previously. A couple years on buprenorphine. OD 3-4 times. Multiple witnessed ODs.
- Anxiety, ADD, PTSD, depression bipolar. Was on Vyvanse, Zyprexa, Lexapro, Prozac, Adderall, abilify, lamictal, effexor. PHQ upper teens.
- Multiple mental stabilization stays at hospital in setting of substance use and domestic conflict. At least two 14-day hospitalizations for dual diagnosis.
- Girlfriend died from OD 2 years ago – he found her (he believes she intentionally OD-ed due to paranoia that he was cheating on her). She was living with his family at the time, and this was so stressful for his family that they relocated to CA. Started heavier use of benzos, heroin.
- Best friend, and others died from overdoses.
- Dad drinking, cocaine in AA.
- Using about 1g heroin daily, 10-20 mg xanax daily.
- Absolutely refuses to go to inpatient, or IOP.
- Not interested in methadone.
- Has an incredibly supportive mother