The Heroin Addict Next Door

Heroin does not discriminate — it spans all socioeconomic classes and infiltrates all communities. Heroin users of today are people you see every day – your neighbor, your in-law, your co-worker in the cubicle next to you – all seemingly normal, functional individuals, secretly dealing with a debilitating addiction.

From accident to addict

Jeff's* journey to heroin addiction began with an accident and a subsequent prescription for Vicodin, an opioid narcotic painkiller used to treat moderate to severe pain.

Though the back pain eventually subsided, his need for the pills did not, and he found himself requiring higher doses just to get the same effect. The painkillers did for him what years of taking various antidepressants and anxiety medications did not – they made him feel really good.

He was addicted. It's all he thought about… it's all he cared about. The most important relationship in his life was the one he had with the drugs.

Jeff started illegally buying any type of painkiller he could get his hands on, but his addiction soon became far too expensive.

Enter heroin.

For the next ten-plus years, Jeff lied, cheated and stole. He spent every penny of his paycheck just to get a fix. He cut himself off from everyone except his fellow users. He found himself in an endless cycle of using, bottoming out, and then trying to get clean.

Both he and his family were at their wits' end.

And then they found HOPE Center North.

A holistic approach

As the Lindner Center of HOPE is a valuable resource for meeting the mental health needs of the region, HOPE Center North, located on State Route 42 in Mason, is dedicated to addressing the community's growing heroin problem.

Dr. Jolomi Ikomi, MD, staff psychiatrist for the Lindner Center of HOPE and medical director for HOPE Center North, says that the best outcome for addiction treatment comes from a combination of counseling and medication together.

The center offers medication-assisted treatment using drugs like methadone, Suboxone or naltrexone to reduce withdrawal symptoms enough so the patient can begin the hard work of recovery.

In addition, there are an addiction psychiatrist and therapists on staff who are able to treat patients who also have a form of mental illness – which can be as many as fifty percent of the patients.

"I'd always had the medication piece, but not the counseling with it," said Jeff. "That made all the difference."

Indicators of addiction

One of the early signs of addiction is a breakdown in relationships. There's isolation from friends and family as addicts become preoccupied with obtaining the drug.

Other signs:

- Decline in school/work performance and missing multiple days due to withdrawal symptoms
- Use of other drugs, such as cannabis or alcohol, as there is a high prevalence of coexisting drug use.
- Physical signs: needle track marks on arms, wearing long sleeves even in hot weather (to cover track marks), recurring vague medical symptoms (i.e. "I feel sick")
- Social signs include persistent financial and legal issues

How to get help

Motivating a loved one to get help for their addiction can be an uphill battle.

"Don't just say 'go get help.' Identify a program, give them the phone numbers and addresses, and offer to go with them," said Dr. Ikomi.

It's also important for the family to quickly engage in support groups and get information on how to help their loved one.

"HOPE Center North staff are always available to assist families in strategizing how to help get their loved one engaged," said John Mallery, LISW, supervisor for HOPE Center North.

As for Jeff, for the first time in a long time, he is encouraged about his future. "With the HOPE Center behind me, I feel hopeful that I can get through any bumps in the road."

There is HOPE for treating your or your loved one's heroin addiction. For help, call (513) 536-0050.

* Name changed to protect client identity

Lindner Center of HOPE | UC Health

4075 Old Western Row Rd.
Mason, OH 45040
(888) 536-HOPE (4673)

Interested in touring Lindner Center of HOPE?
Contact Jennifer Pierson at **(513) 536-0316**.

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The Source

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PSYCHIATRY AND PSYCHOLOGY NEWS FOR MENTAL HEALTH PROFESSIONALS AUGUST 2016

Events

September is Self-Awareness Month and Self Improvement Month

September 5-11
National Suicide Prevention Week

September 6
Grand Rounds: Tracy McDonough, PhD, Associate Professor of Psychology, Mount St. Joseph University presents on *Our Turn to Speak at Last: Stories of Living with Schizophrenia* at Noon, Lindner Center of HOPE Gymnasium/Conference Center

September 10
World Suicide Prevention Day

September 19
Chris Tuell, EdD, LPCC-S, LICDC, presents Addiction and the Adolescent and Behavioral Addictions: Understanding Problem Gambling, Pornography, Spending, and the Interne, at the annual conference of the National Association for Forensic Counselors.

September 20
Paul Crosby, MD, presents ADHD through the Age Spectrum for Epilepsy Foundation

September 25
National Psychotherapy Day

Patient Satisfaction

Patient Satisfaction results for July 2016 averaged a rating of **4.57 out of 5**, with 5 signifying the best possible care.

Misdiagnosis of OCD is Prevalent

By Angela Couch, RN, MSN, PMHNP-BC, Lindner Center of HOPE, Psychiatric Nurse Practitioner

If you followed Dr. Charles Brady's articles in The Source earlier this year, you learned that the lifetime prevalence rate of OCD is between 1 to 3 percent of the population, and that it is one of the top causes of disability in American adults. That being said, the rate at which OCD is misdiagnosed is alarming, particularly because misdiagnosis often leads to a delay in appropriate treatment or the initiation of inappropriate treatment.

Misdiagnosis occurs both in primary care and mental health settings. Among a study of primary care physicians affiliated with five New York hospitals (Glazier, et.al., 2015) the overall misidentification rate for OCD was 50.5% (out of 208 participating physicians). The physicians participating in this study were asked to assess one of 8 clinical vignettes of OCD patient presentations; specifically manifestations of obsessions regarding aggression, contamination, fear of impulsive and disinhibited speaking, homosexuality, pedophilia, religion, somatic concerns or symmetry. Participants were asked to identify the diagnosis and also choose first line treatments. Symmetry obsessions were the least likely to be misdiagnosed. Obsessions regarding aggression, fear of saying things, homosexuality and pedophilia were misidentified 70-85% of the time, and obsessions regarding contamination, religion and somatic concerns were misidentified 32-40% of the time. The most common incorrect diagnoses were schizophrenia (31.3 % for aggressive obsessions), OCPD (80% for contamination obsessions and 33.3% for religious obsessions), sexual identify confusion (54.5% of obsessions about

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homosexuality), specific phobia (40% of somatic obsessions), Tourette's syndrome (64.7% obsessions about saying things), and no disorder (29.4% of obsessions about pedophilia). Of those vignettes misidentified as schizophrenia, antipsychotics were the front line treatment of choice, and no SSRIs were prescribed (SSRIs being the gold standard of care for OCD). Furthermore, psychodynamic therapy was recommended more often when participants correctly identified OCD in spite of the overwhelming scientific evidence supporting the efficacy of cognitive behavior therapy for treating patients with OCD. In another similar study by Glazier, et.al., 2013, that recruited mental health specialists, a random sample of 360 members of the American Psychological Association gave diagnostic impressions based on 1 of 5 OCD vignettes that included 4 about taboo thoughts and one about contamination obsessions. Rates of misidentification were 77% for obsessions about homosexuality, 42.9% for sexual obsessions about children, 31.5% for aggressive obsessions, and 28.8% for religious obsessions vs the contamination misidentification rate of only 15.8%. This data supports my own personal observation that there is a lack of understanding in the medical and mental health community about the various manifestations of OCD.

The Yale-Brown Obsessive Compulsive Symptoms Checklist is a proven instrument to assist in ruling in or ruling out OCD symptoms but does require careful questioning to determine whether the symptoms are truly related to OCD versus another anxiety disorder. The Yale-Brown Obsessive Compulsive Scale (YBOCS) is a 10 question survey that rates OCD severity on a scale of 1-40, measuring the amount of time spent on obsessions and compulsions. The Florida Obsessive-Compulsive Inventory (FOCI) part A helps identify potential symptoms of OCD which should trigger further assessment by the clinician, and part B assesses severity of those symptoms. During assessment, clinicians should ask specifically about presence of intrusive thoughts, images or urges, and repetitive behaviors or mental rituals, as well as the frequency, amount of time consumed, and extent to which the obsessions or compulsions cause distress or functional impairment, in order to distinguish OCD from other disorders or intrusive thoughts or behaviors common in the general population.

A key component in misdiagnosis may be clinicians disregarding the difference between ego dystonic or ego syntonic obsessions. Patients with OCD react with significant distress when faced with their obsessions, because they are ego-dystonic; that is to say the thoughts are counter to their personality, core beliefs, or values. If a clinician disregards the ego-dystonic or ego-syntonic nature of the obsessions, or does not ask about it, this may contribute to misdiagnosis. This may be particularly true in instances of aggressive obsessions or sexually taboo obsessions. An obsession about committing suicide that is consistent with a patient's wants and desires, with or without a plan, in a patient who is depressed, would be ego-syntonic. Bad intrusive thoughts or images about killing oneself, which are bothersome, scary, not desired, and possibly against one's personal beliefs, would be an example of an ego-dystonic obsession.

Another potential barrier to accurate diagnosis may be inexperience with the full range of OCD manifestations; in the same way that a patient who experiences obsessions or bad intrusive thoughts may overreact and find these thoughts or impulses to be more credible based on the amount of distress they experience in response to them, a clinician may also find the obsessions more worrisome based on the patient's level of distress, leading to inappropriate or more aggressive treatment than is warranted. Take the example of a patient presenting with bad intrusive thoughts of harming their child. In this case the thoughts are counter to the patient's values, beliefs or desires, and the patient is experiencing self-disgust and seeking help to make sure nothing bad could happen. Additionally, the patient is taking extreme precautions like not allowing himself to be alone with the child or touch the child, and is seeking reassurance from others that he not going to harm the child (evidence of avoidance behaviors and compulsions). This situation may cause the inexperienced clinician to misdiagnose the patient, start the wrong treatment, and/or refer the patient to social services, none of which may be helpful.

Careful assessment can prevent misdiagnosis, help ensure a patient receives appropriate treatment as early as possible, and result in better outcomes.

References:
Glazier, K., Swing, M. and McGinn, L. (2015). Half of obsessive-compulsive disorder cases misdiagnosed: Vignett-based survey of primary care physicians. Journal of Clinical Psychiatry, 76(6), 761-767.

Glazier, K. Calixte, R.M., Rothschild, R. and Pinto, A. (2013). High rates of OCD symptom misidentification by mental health professionals. Annals of Clinical Psychiatry, 25(3), 201-209.

Openings in DBT Groups

Lindner Center of HOPE has openings in their Dialectical Behavior Therapy groups, both afternoon and evening groups. To refer someone, please call Kelly at (513) 536-0634.

Lindner Center Of Hope Outpatient Addictions Program Achieves Behavioral Health Opioid Treatment Accreditation From The Joint Commission

Lindner Center of HOPE announced it has earned The Joint Commission's Gold Seal of Approval® for Behavioral Health Opioid Treatment Accreditation by demonstrating continuous compliance with its performance standards. The Gold Seal of Approval® is a symbol of quality that reflects an organization's commitment to providing safe and effective care.

Lindner Center of HOPE, specifically in its Outpatient Addictions Program, HOPE Center North, underwent a rigorous onsite survey on May 19 and 20, 2016. During the review, compliance with behavioral health care standards related to several areas, including care, treatment, and services; environment of care; leadership; and screening procedures for the early detection of imminent harm was evaluated. Onsite observations and interviews also were conducted.

Established in 1969, The Joint Commission's Behavioral Health Care Accreditation Program currently accredits more than 2,250 organizations for a three-year period. Accredited organizations provide treatment and services within a variety of settings across the care continuum for individuals who have mental health, addiction, eating disorder, intellectual/developmental disability, and/or child-welfare related needs.

"Joint Commission accreditation provides behavioral health care organizations with the processes needed to improve in a variety of areas related to the care of individuals and their families," said Tracy Griffin Collander, LCSW, executive director, Behavioral Health Care Accreditation Program, The Joint Commission. "We commend (name of organization) for its efforts to elevate the standard of care it provides and to instill confidence in the community it serves."

"Lindner Center of HOPE is pleased to receive Behavioral Health Opioid Treatment Accreditation from The Joint Commission, the premier health care quality improvement and accrediting body in the nation," added Paul E. Keck, Jr., MD, President and CEO, Lindner Center of HOPE. "Staff from across the organization continue to work together to develop and implement approaches and strategies that have the potential to improve care for those in our community. We believe this sets us apart in our approach in the fight against heroin and other opioids."

The Joint Commission's behavioral health care standards are developed in consultation with health care experts and providers, quality improvement measurement experts, and individuals and their families. The standards are informed by scientific literature and expert consensus to help organizations measure, assess and improve performance.

STAFF FEATURE

Stacey Reese Name Program Manager of Sibcy House and Williams House

Lindner Center of HOPE is pleased to announce that Stacey Reese, MSW, LISW-S, has been named Program Manager of Sibcy House and Williams House at Lindner Center of HOPE. The program manager has 24-hour responsibility for high quality clinical care and services on the milieu for Sibcy House and Williams House patients. The position works collaboratively with unit team members and other departments within the organization to assure appropriate admission, assessment, diagnosis, treatment and discharge of Sibcy House and Williams House patients. Program planning, development and implementation and program and clinical outcomes are major areas of focus for the program manager. Ms. Reese is responsible for managing the overall patient experience as well as relationships with internal and external program stakeholders.

Ms. Reese has served the last several years at Lindner Center of HOPE as manager of inpatient social work, recreation therapy, and spiritual care. She has nearly 20 years of social work experience.

Reese earned her Master of Social Work from the University of Cincinnati. She received her Bachelor of Science in Social Work degree from the Ohio State University. She is a licensed supervising independent social worker.

Sibcy House at Lindner Center of HOPE near Cincinnati, Ohio, is a specialized and intimate unit, offering comprehensive diagnostic assessment and treatment for patients 18 and older, suffering with complex, co-morbid mental health issues.

Williams House offers comprehensive diagnostic assessment and treatment for patients 11-17, suffering with complex, co-morbid mental health issues.