Change is coming in BWC: *Let's all be ready*

The Ohio BWC is recognizing that the old model providing psychological care to injured workers, which requires adding a separate psychological condition to the claim, contributes to:

- increased and entrenched psychological disturbances
- prolonged disability
- reduced return to work
- increased costs
- and finally…
- providers shaking our heads saying "If only we were able to see them earlier…"

OPA has been working with two separate administrations of BWC to attempt to address these obstacles to reasonable psychological care for injured workers in Ohio.

In the last several years, the new management of the BWC has shown itself to be open to innovation, especially where the scientific evidence shows potential for improved outcomes. A recent summit of major players in the BWC including employers, unions, trial attorneys, insurance payers, and healthcare professionals agreed on multiple points where the Bureau needs to change to reflect "what works" in helping injured workers return to work. One of the major points which was agreed upon was early access to behavioral intervention. The Bureau has agreed to implement a program to provide psychological services to injured workers, without the need for adding a psychological allowance, beginning in the fall of 2015.

This program will:

- Encourage prompt referral for psychological consultation
- Use Health and Behavior codes and an H&B model for assessment and treatment
- Not require a psychological diagnosis
- Allow for a limited number of sessions
- Focus on psychological tools to manage pain
- Emphasize appropriate return to work
- Reimburse providers at a higher rate

The program, developed jointly with OPA, will create a panel of psychologist providers who will be authorized to provide these services. Membership on the panel will require training and experience in working with medically involved patients and agreement to work and be evaluated under the program's guidelines. Completion of this training workshop will be a prerequisite for panel membership.

The workshop will:

- Be on Friday, July 31st from 8:30 AM to 4 PM at the Lindner Center in Mason, Ohio (North of Cincinnati)
- Earn participants 6 hours of CEU. Because the workshop has op in been updated, participants who attended our first workshop in Columbus on November 14, 2014 can still earn the full 6 hours
- Focus on both the theory and practice of early intervention to prevent prolonged disability in injured workers, including experiential practice
- Make participants eligible for BWC certification as an early intervention provider

We are particularly interested in psychologists who have a background in short term psychotherapy in medical settings. If you have questions about participation, please contact Joan Bowman at (614) 224-0034 or jbowman@ohpsych.org.

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 JUNE 2015

Events

July 7
Grand Rounds: Elizabeth Mariutto, PsyD, Lindner Center of HOPE Staff Psychologist, presents on Applications of Mindful Eating at Noon, Lindner Center of HOPE Gymnasium/Conference Center

July 11
Miles in Memory of Kathy, Jack Klausing send off on his bike ride from Lindner Center of HOPE to Yellowstone National Park, 9a.m. at Lindner Center of HOPE

July 31
Early Intervention BWC Provider Program at Lindner Center of HOPE, 8 a.m. to 4 p.m. email jbowman@ohpsych.org.

Patient Satisfaction

Patient Satisfaction results for April 2015 averaged a rating of **4.84 out of 5**, with 5 signifying the best possible care.

Opioid Addiction: What we need to know.

(Part 2) Opioid Detoxification and Opioid Antagonist

By Jolomi Ikomi, MD, Lindner Center of HOPE, Staff Psychiatrist, University of Cincinnati College of Medicine, Adjunct Assistant Clinical Professor of Psychiatry

Opioid addiction is a chronic medical condition, which is prevalent across most societies. It is a global burden affecting all socioeconomic classes. Despite the prominence of this disorder, accessible and affordable treatment is still a rarity in most countries. There have been numerous studies looking for the most effective treatment strategy for opioid addiction. This has evolved over time from purely support groups, to newer modules of psychotherapy as well as pharmacotherapy. Some psychotherapeutic methods used for the treatment of opioid addiction include; 12 step facilitated therapy, cognitive behavioral therapy, motivational enhancement treatment, contingency management and family/couples therapy. 12 step facilitated treatment still remains the most widely used, due to its accessibility through the teaching and support of narcotics anonymous.

Pharmacological treatment of opiate use disorders has also seen an evolution, from use of full opioid agonist treatment (methadone maintenance), to opioid antagonist treatment (oral and extended release naltrexone) and most recently to partial opioid agonist treatment (Buprenorphine). These various pharmacological treatments have all been researched and have shown different pros and cons when used for treatment of opioid addiction.

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Before we talk about the treatment of opioid addiction, we must first understand about opioid detoxification.

Detoxification is described as a period of medical treatment in which an individual is helped to overcome the physical and psychological dependence of opioids. The goal of detoxification is to discontinue dependence on opioids in a safe, humane manner, with adjunct counseling services in order to prepare and facilitate patient disposition to long-term care. Detoxification is carried out in a medically supervised setting, with close monitoring of neuro vital signs. The detoxification process can either be an opioid detoxification or non-opioid detoxification. Opioid detoxification involves administration of opioid agonists or partial opioid agonist medication and gradually tapering individuals off these medications. This is a preferred choice for the patients since it is more comfortable and completely eliminates any form of withdrawal symptoms. The problem with this form of detoxification is that this procedure is usually completed in 4-5 days after which patients are discharged from the facility. Ultimately this leads to recurrence of withdrawal symptoms upon discharge, since the long acting opioids used during detoxification merely delayed the patient's withdrawal and produced symptomatic relief to the patient while they were in the hospital. The discharged patient then experiences withdrawals a few days after discharge and ultimately relapses almost immediately upon discharge. To prevent this, opioid detoxification is preferably done over a prolonged and slow taper over weeks or even months, to prevent resurgence of withdrawal symptoms. Non-opioid detoxification is the use of non-opioid medications to target specific withdrawal symptoms to provide relief during the detoxification process. This process is less comfortable for the patients, however it reduces the possibility of withdrawal symptoms occurring post discharge and so relapse post discharge is less likely than a short stay opioid detoxification.

Detoxification alone should never be considered as treatment. It is the first step for the facilitation of long-term treatment. Unfortunately, opioid detoxification is still the most widely used treatment for all individuals with opioid addiction. This is highly problematic as there is an extremely high rate of relapse following opioid detoxification. There is also greater likelihood of death from accidental overdose due to the addict having lost their tolerance to opioids following detoxification. Detoxification by itself ultimately leads to increased morbidity and mortality from opioid overdose. For this reason, detoxification as a sole treatment must be highly discouraged in medical practice and patients must be counseled extensively about the grave risk of possible accidental overdose. Detoxification should only be considered if opioid antagonist would be initiated following treatment.

Opioid antagonists are medications that occupy the opioid receptors in the brain and prevent further binding to opioid receptors. Individuals receiving these medications are unable to achieve any of the euphoric effects of opioids. This is as a result of complete saturation of opioid receptors by the antagonist. The rational for this medication is that the addict will eventually cease to stop using the opioids when they are unable to achieve any gratification from the drug. Opioid antagonists have various indications depending on its half-life. Short acting naloxone (Narcan) is used for reversal of overdose. Longer acting naltrexone is used to initiate non-opioid detoxification as well as abstinence maintenance treatment for opioid addiction. Naltrexone can come in the form of an oral formulation or an extended release formulation. Oral naltrexone can be taken as 50mg daily or as a modified Monday- Wednesday – Friday dosing (100mg Monday, 100mg Wednesday and 150mg Friday). The advantages of this medication are that it has very minimal side effects and does not require close medical supervision. The main drawback with this medication is poor compliance. Patients can discontinue oral naltrexone and start using opioids within a few days of discontinuing treatment. Injectable Naltrexone is a long acting formulation that was developed to overcome some of the limitations of oral naltrexone such as ease of discontinuation and high risk of relapse and opioid overdose after stopping naltrexone. Injectable naltrexone is a once a month injection, this helps increase patient compliance. Several placebo controlled clinical trials and studies comparing sustained release and oral naltrexone conducted in the United States, Russia and Australia found injectable naltrexone to have better treatment retention as well as reduced rates of relapse than oral naltrexone. Injectable naltrexone reduces the possibility of opioid use, but does not eliminate this. This means individuals still have a relatively high risk of overdose with naltrexone (oral and injectable) compared to opioid replacement therapy.

Naltrexone is a well-tolerated drug with minimal side effects. It should be avoided in patients with liver damage. A relative contraindication for the use of naltrexone (oral or injectable) is an elevation of liver transaminases greater than 5 times the normal limit.

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.

IN THE NEWS

Miles in Memory of Kathy

Cincinnati, Ohio to Yellowstone National Park | Summer 2015

Miles in Memory of Kathy to Benefit Mood Disorders Research at Lindner Center of HOPE

Husband to ride bike from Lindner Center of HOPE to Yellowstone National Park to Memorialize Wife's Struggle with Depression

Kathy Klausing was loyal and devoted to her family. Sadly, her struggles with depression plagued her until her death in November 2014. Kathy's husband of 28 years, Jack, misses her every day and wanted to do something to memorialize Kathy. In his mind, a plaque in her honor just wasn't enough.

A cycling enthusiast, Jack has decided to ride his bike from Cincinnati, Ohio to Yellowstone National Park, about 2000 miles. Taking it a step farther, Jack has established a fundraiser for Lindner Center of HOPE's mood disorders research efforts. Kathy spent two-and-a-half weeks at Lindner Center of HOPE in 2013 where she had a positive experience.

Jack and his family believe that raising money to advance the field's understanding of depression will be a great legacy for Kathy and ideally benefit others who are struggling.

Jack and his family have already raised nearly $16,500. Donations can be made directly to Lindner Center of HOPE by mail or online giving at:
webapps2.uc.edu/foundation/LCOH/DonationForm.aspx

or through Crowdrise at:
crowdrise.com/MilesInMemoryofKathy/fundraiser/jackklausing.

Jack plans to depart on his journey from Lindner Center of HOPE, 4075 Old Western Row Rd., Mason, on Saturday, July 11, 2015 at 9 a.m. The Center is planning a sendoff for him.

O'Hearn to Present at International Conference in July

O'Hearn to Present at International Conference in July
Michael O'Hearn, MSW, LISW-S, Clinical Director for the Center of Stress Related Disorders at Lindner Center of HOPE, will present his theoretical paper titled, "Self-Organization of Marital and Family Therapy: A Complexity-Based Clinical Framework" at the 25th Anniversary Society for Chaos Theory International Conference. **The Conference takes place at the University of Florida in Gainesville, July 29 through 31.**