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Princeton House Behavioral Health

The New Age of ECT



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Princeton House
Behavioral Health
Princeton HealthCare System

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The New Age of ECT



Electroconvulsive therapy (ECT) has become a treatment of choice for severe depressive disorder with psychotic features, particularly for patients with suicidal tendencies needing a more immediate treatment response than medication can provide, or for those who have not responded to medication. In these patients, ECT can have a greater than 90 percent success rate, according to Philippe Khouri, MD, ECT Specialist at Princeton House Behavioral Health.

During ECT, small electric currents are passed through the brain to trigger a brief seizure. The procedure causes changes in brain chemistry that can reverse the symptoms of certain mental illnesses. While side effects can include short-term memory loss (retrograde amnesia), Dr. Khouri explains that the following advances in ECT are significantly minimizing this risk:

The increased use of right unilateral ECT. This form of ECT involves applying electrodes to only the right temple and right parietal area, vs. bilateral ECT, in which the stimulus is applied on both fronto-temporal areas.

Dose titration. There's no longer a one-size-fits-all treatment approach. Rather, the dose of the electrical stimulus is individualized for each patient.

Ultra-brief pulsation. Older ECT equipment delivered a continual current, but today much shorter, less frequent pulses are used.

Patient monitoring is also now more advanced. At Princeton House's ECT Suite, every patient is closely monitored before, during, and after the procedure by an anesthesiologist, an ACLS-certified nurse, and an ECT psychiatrist.

"In addition to checking for any signs of memory issues, we vigilantly monitor heart activity, blood pressure, oxygen consumption, and other parameters," says Dr. Khouri. "This not only makes the procedure safer, but it has also expanded our ability to treat patients with comorbid conditions like cardiovascular disease and sleep apnea."

Once a patient has completed an initial course of ECT therapy of generally 6 to 12 treatments, continuation treatment is spaced out over time to maintain progress.

"ECT is one part of a broad approach to treating certain behavioral health problems," adds Dr. Khouri. "It's important to also include psychotherapy and the right medication for each individual patient in an ongoing treatment plan."

*"For many patients, ECT makes a huge difference in terms of coping abilities. It can relieve anxiety and mood instability while restoring sleep, appetite, concentration, and the ability to feel and express emotion. It's like resetting brain function."
~ Philippe Khouri, MD*

For more information about ECT services at Princeton House, call 609.613.4780 or visit princetonhouse.org/ECT.

Addressing the Trend of Normalized Drinking Among Women

From memes and “girl-talk” comments on social media sites to the humorous greeting card section in the local store, a common theme has emerged in recent years: Alcohol is increasingly portrayed as a go-to stress reliever for women.

Many of these messages condone alcohol as something women need and are entitled to, according to Nicole Orro, LPC, LCADC, Director of Outpatient Services at Princeton House Behavioral Health’s Hamilton site. Concurrently, research reveals that alcohol consumption is increasing among women.¹

“We’ve all seen the ‘mommy sippy cup’ or ‘it’s wine o’clock somewhere’ memes,” says Orro. “Women are often very engaged in social media for interpersonal connections and self-care, and they’re being bombarded with messages promoting alcohol consumption. This kind of cultural climate can grant a pass for the overuse of alcohol, particularly for women who are already feeling vulnerable, dealing with too many stressors, or struggling with emotional issues like anxiety or depression.”

Broaching the Subject in Therapy

Orro recommends a very sensitive approach in bringing up suspected alcohol overuse with a patient who may be in outpatient therapy for other issues, such as anxiety or depression. She suggests:

- Taking a provider self-assessment on substance use views, and setting aside any judgments or assumptions to facilitate a positive connection with patients.
- Being compassionate and asking the right questions in a patient assessment.
- Encouraging patients to take their own self-assessment. Women may not recognize that they’ve fallen into a potentially dangerous pattern of alcohol use, especially given its cultural normalization.
- Providing information on what it means to have a drinking problem.
- Recommending healthier alternatives for managing anxiety.

“It doesn’t have to be an all or nothing approach,” adds Orro. “Helping patients recognize an issue before it becomes a serious problem and assisting them in identifying alternative ways to navigate stress can result in tangible progress toward a healthier lifestyle.”

For more information about substance abuse or behavioral health services at Princeton House, visit www.princetonhouse.org or call 888.437.1610.



17.5% 4.9%
FROM 2005 TO 2012, BINGE DRINKING RATES INCREASED 17.5% AMONG WOMEN VS. 4.9% AMONG MEN IN THE U.S.¹

¹Laura Dwyer-Lindgren et al. Drinking Patterns in U.S. Counties From 2002 to 2012. American Journal of Public Health: June 2015, Vol. 105, No. 6, pp. 1120-1127.



De-Stigmatizing Addictions Treatment for Law Enforcement Officers

The law enforcement field can be both physically and emotionally demanding. In fact, the U.S. Bureau of Labor Statistics reports that police, sheriff's patrol, and corrections officers have one of the highest rates of injuries and illnesses of all occupations.

When injuries necessitate prescription opioids, addiction is a risk, according to Michael Bizarro, PhD, LCSW, BCD, Director of Clinical Services for Princeton House Behavioral Health's First Responder Treatment Services.

"Once that prescription has run its course, it's not uncommon to end up 'doctor shopping' for additional scripts or even seeking opioids elsewhere," explains Dr. Bizarro, who is also a former law enforcement officer. "Proximity to drugs on the job, particularly for those working undercover, can also be an issue. In this stressful profession, officers don't always have the resources to debrief properly after traumatic experiences. In some situations, they may find themselves crossing a very fine line into addiction, depression, or anxiety."

Law enforcement officers struggling with addiction can face an additional challenge: the reluctance to seek help for fear of negatively impacting their careers. Yet seeking treatment before a crisis necessitates it is a productive step, says Dr. Bizarro.

Expanding Outreach Efforts

To promote early treatment and prevention, First Responder Treatment Services staff members have expanded their outreach efforts to educate law enforcement officers, leadership, and recruits. They recently presented the benefits of providing treatment services vs. terminating employment to 21 law enforcement departments in Union County. The team is also helping law enforcement officers better recognize addiction in their peers, and educating recruits in conjunction with the Middlesex County Police Training Center.

"We use specific well-being assessment modules with recruits to give them tools they'll need moving forward," says Dr. Bizarro. "It's very important to provide education about stress management and risk awareness right from the beginning of their careers."

To learn more about First Responder Treatment Services, please call 888.437.1610/outpatient or 800.242.2550/inpatient, or visit princetonhouse.org/firstresponder.

PEER-TO-PEER TREATMENT SERVICES

The First Responder Treatment Services team is comprised of former law enforcement officers and military veterans which can help build trust and open the door to communication among first responders. Group therapy is designed around the unique elements of a first responder's role, and the inpatient length of stay is about two weeks. The team helps coordinate with the first responder's Human Resources department and short-term disability plan when needed, and facilitates an aftercare plan to maintain treatment progress.



Understanding the Risks of **Opioid Pain Medications**

Opioid prescription medications like Vicodin®, OxyContin®, and Percocet® can be effective in treating acute and chronic pain, but they also can pose a significant danger. These medications, with an origin similar to heroin, are abused for non-medical purposes by more than 4.3 million Americans. Every day, more than 40 people in the U.S. fatally overdose on prescription opioids, according to the National Institute on Drug Abuse.

Given these risks, people struggling with pain issues should talk with their doctors about opioid medications and non-opioid methods of pain management. The Centers for Disease Control and Prevention (CDC) recently issued new guidelines for treating patients with chronic pain, recommending that physicians consider non-opioid medications or non-drug treatments instead of or in conjunction with opioids.

Addiction Recovery Challenges

Many patients are in substance abuse treatment because they have developed addictions to opioid prescription medications or their use of these medications led to heroin abuse, says Kapila Marambage, MD, Medical Director of the Inpatient Addiction Recovery Program at Princeton House Behavioral Health. The detoxification process can be challenging.

“In substance abuse treatment, pain is a driving force toward relapse,” says Dr. Marambage. “For these patients, opioids are not something they turn to just for highs — they want the drugs to alleviate pain. This creates an additional challenge for substance abusers and their treatment teams.”

Princeton House physicians collaborate with the patient’s pain management specialist to develop a plan, which may include options such as:

- Non-opioid medications, such as non-steroidal anti-inflammatory drugs and the anesthetic lidocaine patch
- Non-addictive muscle relaxers
- Non-drug treatments, such as exercise and cognitive behavioral therapy (including mindfulness and relaxation techniques)

In some cases, depending on the severity of opioid dependence and other comorbid factors, physicians may develop a specialized opioid pain management plan, which can include medications such as buprenorphine or methadone, and carefully track the patient’s usage and progress.

“It’s important to educate our patients about how the opioid system in the brain affects their pain thresholds, and why opioids shouldn’t be their first choice,” adds Dr. Marambage. “We help them understand that opioid use will only make a bad situation worse.”

To learn more about Princeton House Behavioral Health’s Inpatient Addiction Recovery Program, call 800.242.2550 or visit www.princetonhouse.org.

Young Adults a Vulnerable Target for Heroin Epidemic



Heroin use has reached the highest level in 20 years in the United States, according to a 2016 World Drug Report from the United Nations. While this alarming epidemic takes its toll on people of all ages, young adults can be a particularly susceptible target.

“The prefrontal cortex is not completely developed in young people, so they are not yet fully equipped with the ability to make the right choices — making it even easier to fall prey to addiction,” says Neal Schofield, MD, Chair of the Department of Psychiatry at Princeton House Behavioral Health. “Compounding the problem is the fact that opioid accessibility has expanded beyond our inner cities to arrive in the suburbs and in rural areas. It’s now far easier to obtain these drugs than it is to get treatment.”

Ongoing Care Helps Break the Cycle

The monetary price of opioids is low, but the ultimate cost is extremely high. Aside from the risk of overdose and death, the use of these substances creates a “cerebral diabetic” situation, according to Dr. Schofield.

“Because opioids down-regulate neurobiological systems, addiction happens very quickly,” he adds. “We have an excellent young adult detox and inpatient program, but that alone may not solve the problem without continued treatment — particularly when we find that many young patients have underlying psychiatric comorbidities like depression, anxiety, and post-traumatic stress disorder. We need to address those issues, as well.”

“Education and discharge planning play a key role,” adds Rose Ravelo, LCSW, Director of Social Work and Case Management for Princeton House. “Young people have many misconceptions about drug use. Our goal is to help them understand that opioid addiction is not a social problem, but rather a serious, life-threatening medical disorder of the brain. We try to motivate patients to choose continued treatment after detox and inpatient care, because it’s critical to recovery.”

Aside from the challenge of encouraging them to stay in the care continuum, young adults often face economic barriers. Dr. Schofield and Ravelo are hopeful that the increased government focus on the heroin epidemic in New Jersey will help expand insurance coverage and care access, particularly for this population.

Young Adult Inpatient Services

In addition to providing safe and comprehensive detox services, Princeton House Behavioral Health’s Young Adult Inpatient Program offers medical and psychiatric treatment, education about addiction and its impact, family involvement to support recovery whenever possible, and referrals to outpatient services — including those at Princeton House — to encourage continued treatment.

“Our goal is to help them understand that opioid addiction is not a social problem, but rather a serious, life-threatening medical disorder of the brain.”

~ Rose Ravelo, LCSW

For more information about the Young Adult Inpatient Program, call 800.242.2550 or visit www.princetonhouse.org.

PEOPLE NEWS



Employee Assistance Program Expands Services to Area Employers

Princeton HealthCare System's Employee Assistance Program (EAP) recently engaged six new clients, including the New Jersey municipalities of Manville,

Ewing, and Robbinsville, Cooper Pest Solutions, Passaic County Technical Institute, and The College of New Jersey. Now serving approximately 25,000 employees and their families, the EAP provides timely, confidential access to counseling for life challenges that may affect an employee's job performance, health, or personal well-being. To learn more, please call 800.527.0035 or visit princetonhcs.org/EAP.



Kate Teixeira, LCSW has been promoted to Clinical Manager for the Women's Program in Princeton, part of

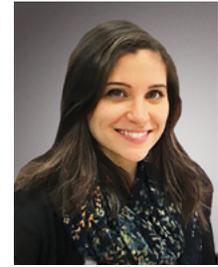
Princeton House Behavioral Health, after serving in an interim capacity for four months. In her new role, Teixeira oversees clinical staff and program development, and continues as part of a team researching the effectiveness of dialectical behavior therapy in the treatment of disordered eating.

Hepatitis C and Addictions Research

Ronald Nahass, MD, Senior Attending Physician at Princeton HealthCare System, presented a research poster on "Hepatitis C Reinfection and Injection Risk Behavior in Patients on Opioid Agonist Therapy" at the American Society of Addiction Medicine National Conference, held from April 6 to 9 in New Orleans. The project's research coordinator, **Ruth Homer, LCSW**, LCADC Intern and Linkage to Care Coordinator with Princeton House Behavioral Health, presented a separate poster on "Characterizing Barriers to Successful Treatment of Hepatitis C (HCV) among Young Persons Who Inject Drugs in New Jersey" at the same conference.



Ronald Nahass, MD



Ruth Homer, LCSW

Since 2014, more than 800 patients (70% of whom were under the age of 35) have been seen by Dr. Nahass and Kathleen Seneca, APN for HCV consultation at Princeton House, and have participated in ongoing research to identify unique trends. Researchers found that among young heroin users, the greatest impediment to successful treatment of HCV was relapse. HCV, a now curable disease, affects 3.2 million Americans, of which 50 to 80 percent are intravenous drug users.

Princeton House Behavioral Health is working with clinical partners Rutgers Robert Wood Johnson Medical School, Rutgers Center for Advanced Biotechnology and Medicine, and ID Care to develop a multidisciplinary care model that integrates addiction, behavioral health, and HCV treatment to effectively engage patients.



Sites & Services at a Glance

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GRAND ROUNDS

For information on upcoming grand rounds, please visit:
princetonhouse.org/grandrounds



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Center for Eating Disorders Care Partial Hospital Program Branches Out

To further improve the treatment experience, the Center for Eating Disorders Care at University Medical Center of Princeton Partial Hospital Program for adults is expanding and will now operate separately from the Inpatient Program.

Enhancements include:

- Direct referral to the Partial Hospital Program is welcome. The program may also serve as a step down from residential or inpatient treatment or a step up from outpatient or IOP treatment.
- The dining room, group room, and lounge are distinct from inpatient care areas.
- Flexible scheduling options meet individual patient needs:
 - › 3 meals/day, 3 to 5 days per week (8:30 a.m. to 6:00 p.m.)
 - › 2 meals/day, 3 to 5 days per week (8:30 a.m. to 3:30 p.m.)
- Additional experiential treatment opportunities help translate treatment gains to real-world settings. These include cooking groups, meals served family-style, take-out ordering, restaurant outings with staff, and grocery shopping excursions.

“Our program now more closely mirrors what patients encounter in the real world. At the same time, they can process these experiences with the care team in a safe, supportive environment that continues to offer 24/7 access to medical care if needed.”

— Melinda Parisi Cummings, PhD,
Program Director of the Center for
Eating Disorders Care

For more information about the Partial Hospital Program changes, contact Cathy Lane, Clinical Outreach Coordinator, at clane@princetonhcs.org or 609.455.7183. To learn more about the Center for Eating Disorders Care, visit princetonhcs.org/eatingdisorders.

