

April 2010

## Medical Updates



### How to Quit Smoking for Good!

by Lloyd I Sederer, MD, written with Gregory A. Miller, MD and Teresa C. Armon, RN MS

Tobacco use is the greatest preventable cause of death and medical disability in the United States. Tobacco kills and contributes significantly to the development of killers like heart disease and cancer. *Yet its deadly impact is preventable.* When people stop smoking, their risk of death and disability drops steadily and progressively.

The CDC estimates that approximately 450,000 people die prematurely in the USA, and more than 8 million Americans are medically disabled by use of tobacco (the consequences of smoking to the lungs, heart, blood vessels, and organs that develop cancer). If you think that is just someone else's problem (and don't calculate the economic costs to society) then consider that inhaling other people's smoke (second-hand smoke) has recently been shown to increase the risk of adult onset diabetes and of impaired mental functioning. It is the tars and byproducts of inhaled tobacco smoke that cause lung damage and serious health consequences. In fact, when nicotine is absorbed but not inhaled (like with patches, gum and nicotine "inhalers" which deliver nicotine through the skin and membranes of the mouth and throat) it is not a dangerous drug, even when used for long periods. <sup>(1,2)</sup>

Women smoke a little less than men and Asians smoke significantly less than Caucasian, African-Americans and Hispanics (in the US). Native Americans greatly exceed all these groups. But there is one group that blows away the others (hard to resist that pun): people with a mental illness or heavy users of alcohol or drugs. *These individuals consume near to half the cigarettes smoked in this country!* Among individuals with mental illness or with alcohol and drug problems over 70 percent smoke (compared to about one in five of the general population - whose smoking rates have dropped from 50 percent 50 years ago). About one in two people with depression and anxiety conditions smoke - twice the rate of the general population. Three out of four people with alcohol and drug problems smoke - a rate comparable to people with bipolar disorder or schizophrenia. Notably, these individuals report a desire to quit at the same rate as do others (70 percent).

There are a number of good reasons to explain the huge disparity in smoking between people with mental and substance use problems

and the rest of those who light up. The nicotine in tobacco has been shown to improve mental concentration and can improve mood, especially in depressed individuals. Smoking is well known as a way of coping with stress, and the greater the stress the greater our need to combat it. The pleasure of smoking is no small factor (Freud did get it right when he wrote that the pleasure principle warrants respect), particularly in people whose mental states find it hard to engage in and feel the pleasures of relationships, work and play. What's more, quitting takes support from friends and families and quit rates are increased by medications prescribed by doctors - both resources that are often limited in people with these conditions. Finally, doctors have not done such a good job of asking about smoking, and offering to help.

***The "5 A's", from the Public Health Service, Clinical Practice Guideline***, are one way doctors and other health care providers are being trained to inquire about smoking and to help their patients:

1. **Ask** about tobacco use during regular visits;
2. **Advise** the person to quit in a clear and personal manner (like, smoking is the most important thing you can do for your health and for your family);
3. **Assess** for a willingness to quit. On a scale of 1-10, ask "where are you?" Ask "are you willing to make a commitment to quit in the next 30 days?";
4. **Assist** in helping someone quit. Set a date for quitting. Offer medication and/or counseling;
5. **Arrange** for the person to return for a visit - soon - in a week, if possible, to support the effort and address relapse, which is common. Congratulate success!

Since some of us have trouble remembering 5 things, a simpler approach is:

- Have you had a puff of a cigarette in the past month?
- If so, do you want to do something about your smoking?

There are various treatments now available to help people quit smoking. **Medications** include *NRT*, or nicotine replacement therapy, which comes as a patch, gum, lozenges, inhaler, or nasal spray; some are available over the counter and some require a doctor's prescription. *Bupropion*, customarily used as an antidepressant, is effective for people with or without a history of depression and can reduce craving and thus improve quit rates. *Varenicline*, which seems to work like nicotine does in the brain; it enters the nicotine receptors on neurons, reducing craving and improving quit rates. It is not a

good idea to combine Varenicline with NRT agents. All medications have risks and side effects as well as benefits, so be sure to understand both before you start. **Counseling** may be through individual, group, or telephone format, and focuses on providing encouragement and support from all who can provide it (the doctor, smoking cessation counselor, friends and family) as well as problem solving - or helping people develop skills for those moments they used to rely on a cigarette to master.

Combining medication and counseling adds to the effectiveness of each one, and increases your chances of successfully quitting. For your sake, keep in mind that smoking is one of the hardest addictions to control. What is common is that most people try many times before they finally quit. But don't lose faith - when the time comes the results are priceless.

1. Murray RP, Bailey WC, Daniels K, et al: Safety of nicotine polacrilex gum used by 3,094 participants in the Lung Health Study. Lung Health Study Research Group. Chest. 1996 Feb;109(2):438-45.
2. David Moore, D, Aveyard, P, Connock, et al: Effectiveness and safety of nicotine replacement therapy assisted reduction to stop smoking: systematic review and meta-analysis, British Medical Journal, 2009;338:b1024.

*This column originally appeared in the Huffington Post on March 29, 2010.*

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## Legally Speaking

### **Federal Mental Health Parity Regulations**

*by Kristin O'Neill, OMH Counsel's Office*

On February 2, 2010, the Department of Treasury, the Department of Labor, and the Department of Health and Human Services published [Interim Final Rules](#) (rules) relating to the implementation of the 2008 Federal mental health parity law, known as the [Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 \(MHPAEA\)\\*\\*](#). These rules are effective on April 5, 2010 and will apply to plan years beginning on or after July 1, 2010 (with a special effective date for plans maintained pursuant to a collective bargaining agreement). The public comment period for these rules will end May 3, 2010.

The rules clarify several areas of the MHPAEA and provide useful guidance to mental health providers and consumers relating to mental health parity. Importantly, these regulations provide that the parity requirements in the statute apply to treatment limitations imposed by

insurers, and these requirements apply to both “quantitative” and “nonquantitative” treatment limitations.

The term “treatment limitation” is defined to include limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment. The rules also define quantitative and nonquantitative treatment limitations.

- **A quantitative treatment limitation** is a limitation that is expressed numerically, such as an annual limit of 50 outpatient visits.
- **A nonquantitative treatment limitation** is a limitation that is not expressed numerically, but otherwise limits the scope or duration of benefits for treatment.
- **Nonquantitative treatment limitations include:**
  - Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative; formulary design for prescription drugs; standards for provider admission to participate in a network, including reimbursement rates; plan methods for determining usual, customary, and reasonable charges; refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols); and exclusions based on failure to complete a course of treatment.

The rules divide benefits into six classifications: Inpatient, in-network; Inpatient, out-of-network; Outpatient, in-network; Outpatient, out-of-network; Emergency Care; and Prescription Drugs. Within each classification, if a plan provides mental health/substance abuse disorder benefits, those benefits must be provided at parity with (equal to) the medical/surgical benefits provided in that classification.

- **Example:** If a health plan imposes a \$100 co-pay for substantially all non-mental health medical/surgical inpatient hospital visits and a \$10 co-pay for substantially all non-mental health medical/surgical outpatient visits, that plan may **not** impose a \$100 co-pay for a mental health outpatient visit.
- **Example:** If a plan imposes a \$20 co-pay for an in-network medical/surgical office visit but requires the insured to pay 20% coinsurance for an out-of-network medical/surgical office visit, the plan may **not** require the insured to pay 20% coinsurance for an in-network mental health office visit.

Under these rules, if a plan provides any benefits for a mental health condition or substance abuse disorder, benefits must be provided for that condition or disorder in each classification for which any medical/surgical benefits are provided. For example, New York State Insurance Law mandates all health insurance coverage that provides inpatient hospital care must include outpatient substance abuse disorder benefits, but there is no requirement that it include inpatient substance abuse disorder benefits. Under these rules, all health insurance coverage that provides inpatient hospital care must provide both inpatient and outpatient substance abuse disorder benefits.

#### **Other Requirements:**

- The rules provide that the health plan terms that define whether the benefits are mental health or substance use disorder benefits must be consistent with generally recognized independent standards of current medical practice. (This requirement is included to ensure that a plan does not misclassify a benefit in order to avoid complying with the parity requirements.)
- The MHPAEA states that the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits may be no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan. A common plan design imposes lower copayments for treatment from a primary care provider (for example, an internist or a pediatrician) as compared to higher copayments for treatment from a specialist (such as a cardiologist or an orthopedist). Some health insurers have been identifying a large range of mental health and substance use disorder providers as specialists. These rules clarify that allowing plans to provide less favorable benefits with respect to services by these providers than for services by providers of medical/surgical care that are classified by the plan as primary care providers would undercut the protections that the statute was intended to provide. Therefore, separate classification of generalists and specialists are not permitted in determining the predominant financial requirement (i.e., co-pay, co-insurance, deductible, etc.) that applies to substantially all medical/surgical benefits.
- Furthermore, a plan may not apply cumulative financial requirements or cumulative quantitative treatment limitations to mental health or substance use disorder benefits in a classification that accumulate separately from any such

cumulative financial requirements or cumulative quantitative treatment limitations established for medical/surgical benefits in the same classification. For example, a plan may impose an annual \$500 deductible that applies to both medical/surgical benefits and mental health and substance use disorder benefits, but may not impose an annual \$250 deductible that applies to medical/surgical benefits and a separate \$250 deductible that applies to mental health and substance abuse disorder benefits.

While the MHPAEA applies to both Medicaid Managed Care (MMC) plans and large employer sponsored group health plans, these rules do not pertain to MMC plans. The Department of Health and Human Services plans to release separate regulations pertaining to MMC plans in the future.

\*\* The new health care reform legislation signed by the President (Patient Protection and Affordable Care Act - Public Law No: 111-148) extends parity beyond MHPAEA by requiring mental health and substance use benefits in full parity for all benefit packages offered on the health insurance exchanges.

## **Promoting Quality Services**

### **OMH Presents PARS Awards to St. Joseph's Villa, Cayuga Medical Center and South Beach PC**



The New York State Office of Mental Health recently presented Positive Alternatives to Restraint and Seclusion (PARS) Awards to St. Joseph's Villa, Rochester; the Behavioral Services Adolescent Unit of Cayuga Medical Center, Ithaca; and the Adolescent Unit of South Beach Psychiatric Center on Staten Island. These awards were announced at OMH's recent Positive Alternatives to Restraint and Seclusion Conference attended by over 200 individuals in Suffren New York.

The PARS Awards recognize a mental health program's exemplary work and success in reducing its use of restraint and seclusion, and include an allotment of \$5,000 to be used to further the program's restraint/seclusion reduction efforts. The award money is made possible through a State Incentive Grant to Build Capacity for Alternatives to Restraint and Seclusion, awarded to OMH by the federal Substance Abuse and Mental Health Services Administration (SAMHSA).

In addition to the three \$5,000 PARS Award recipients, OMH awarded \$1,000 to eight programs for their efforts to create a therapeutic environment through positive, coercion-free, recovery-

focused treatment. Those recipients include: MercyFirst, Syosset; Astor Services for Children and Families, Rhinebeck; Hutchings Psychiatric Center, Syracuse; Elmhurst Hospital Center, Elmhurst; The Holliswood Hospital, Holliswood; Erie County Medical Center, Buffalo; Mount Sinai Medical Center, New York City; and Richmond University Medical Center, Staten Island.

## **From the Field**

### **Randy Hill Named Regional Advocacy Specialist for WNY**



[Enlarge](#)

*The Western New York Field Office would like announce that Randy Hill has recently been named Regional Advocacy Specialist for the Western region of the State. We have asked him to take this opportunity to introduce himself to the readers of OMH News.*

Hello my name is Randy Hill and I am the Regional Advocacy Specialist for the Office of Mental Health here in the Western Region. I am an enrolled member of the Tuscarora Indian Nation and in the Bear Clan of my Nation. I am recovering from a dual diagnosis and have been in recovery since Fathers Day 1996.

My previous position was with the Native American Independent Living Services as the Mentally Ill Chemically Addicted Coordinator/ Mental Health Peer Advocate. This position had allowed me to enter local courts where I advocated for my peers to have access to treatments that would address their behavioral problem(s) such as anger management or addiction troubles; along with challenging needs of homelessness and benefit clarification such as D.S.S., S.S.D., food stamps, pantries and clothing needs. I had the honor of establishing two support groups at the Seneca Territory in Irving N.Y.: the first was a Talking Circle and the second was a Drumming Circle. We used Native American Spiritual practices during these groups, which were open to everyone who cared to join.

I have enjoyed being a member of the following organizations: the Board of Directors for the Mental Health Association of New York; the Commissioner's Committee on Families; the Native American Family Services Commission; the Haudenosaunee Prevention and Treatment Providers Coalition; the Peer Networking Group of Western New York; the Recipients Advisory Commission; along with the Niagara County Mental Health Service Providers Coalition and the Most Integrated Setting Coordinating Council. I had the honor of being part of the 2009 OASAS "Your Story Matters. I am. We are. Recovery." My story can be viewed at [www.iamrecovery.com](http://www.iamrecovery.com) 

I'd like to thank everyone for their warm welcome in my new position, and I look forward to meeting you all along my journey. My

dedication to my new position in serving nineteen counties with approximately 13,000 square miles of territory is unwavering, despite the awesomeness of my task. Peers need to have their voices heard in places where they can have an effect on policies that affect them directly. I do represent the Office of Mental Health and therefore have a direct line to Central Office in Albany where decisions are made that establish policy.

My contact information is: Randy Hill, Western New York Field Office, 737 Delaware Avenue – Suite 200, Buffalo, New York 14209. I can be reached by phone at (716) 885-4219 – ext 257; or by [e-mail](#).

## **Promoting Cultural Competence**

### **Social Considerations Important for the Provision of Culturally Competent Mental Health Care to Muslim Americans**

*Contributed by Rachel Levenson, Communications Specialist, Center of Excellence in Culturally Competent Mental Health*

*The Nathan Kline Institute (NKI) [Center of Excellence in Culturally Competent Mental Health](#) maintains on its website [research-based profiles](#) of features of cultural groups that can impact their access to, receipt of and outcomes of mental health services. This article is an abstract of a profile of Muslim-Americans; for more information please visit our website.*

Islam is one of the fastest growing religions in the United States. Estimates of the group's size range between 2.5 and 9 million, with the closest estimate placing the number at about 6 million. Approximately 16% of the US Muslim population lives in NYS. Epidemiological research suggests that the prevalence of schizophrenia, depression and anxiety are similar in Muslims and non-Muslims. The extent to which Muslims identify with the tenets of faith, and their specific cultures is highly variable. Therefore, the comments that follow will variably apply.

Devout Muslims attribute the ultimate cause of everything, including disease, to God. Mental illness is viewed as part of human suffering and often regarded as a way of atoning for sins. Reward may be greater if suffering is endured with patience and prayer. Religious Muslims follow the teachings of the *Qur'an*, which is considered "the word of God", and the *Hadith*, which is a book of traditions and sayings of the Prophet Mohammed that provides moral and ethical guidance. They believe that adherence to the principles outlined in these books serves as prevention and treatment for emotional disturbances and leads to a high quality of life and a healthy mental state.

While beliefs and practices pertaining to demonic possession, witchcraft, black magic, and the use of exorcists, charms and magic potions are not condoned or supported by the *Qur'an* or the *Hadith*, many believe that alternate beings, such as *Jinns*, can possess individuals, resulting in hallucinations, delusional beliefs and disorganized behavior. Other purported supernatural causes are black magic and the evil eye.

Imams may be consulted to guide worshippers in ways to overcome distress. A therapeutic process religiously endorsed called "*Tazkiat Alnafs*" uses elements of cognitive, behavioral and psychodynamic therapy. According to Islamic thought, mental and spiritual development is in a constant state of evolution, starting from a purely self-gratifying stage and progressing to a stage of inner peace and self-assuredness. During the therapeutic process, the individual passes through periods of self-doubt, self-accusation and ultimately self-acceptance. A combined use of *Qur'anic* healing and Western approaches has proved effective, and Imams have asked for more contact with mental health professionals. When Western approaches are used, concerns about stigmatization often result in first reporting somatic symptoms of mental illness to primary medical specialists. Political factors, such as immigration status and fear of discrimination, detention or deportation have been reported to hinder the use of mental health services. Western medication treatments rather than Western psychotherapy are better received by Muslims.

Following the tragic events of September 11<sup>th</sup>, 2001 Muslim-Americans were exposed to heightened levels of discrimination, suspicion, hostility, and hate crimes. Consequently, clinically significant depression, anxiety, and other psychological problems increased in the Muslim communities. Those for whom the trauma of 9/11 revived memories and experiences of earlier trauma, reported intensified experiences of discrimination and exacerbated political, economic, social, spiritual, psychological and medical challenges.

A clinician could benefit from education on the social, political and cultural context of Muslim clients, particularly as they relate to modifications of Western psychotherapy. Incorporating Islamic beliefs and practices, such as prayer and the importance of the *Hadith* and the *Qur'an* in Muslim culture may facilitate therapy.

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## Facility Updates

### **Elmira Psychiatric Center Creates Remembrance Group**

*by Pamela Seeley, Director of Nursing*

By now, we in OMH have all heard of the SPEAK campaign, the statewide public awareness and education program on suicide. As

providers of mental health care, we know the statistics, we know the options and tools for suicide prevention and certainly we know the warning signs. Or so we thought. Well, we at the Elmira Psychiatric Center came to the tragic realization that we were sadly mistaken. Several months ago we lost one of our most senior and beloved Therapy Aides to suicide. He worked side by side with many of us for over 20 years and was well respected by staff and patients alike. Then, without apparent warning he took his own life at the age of 57.

We were all dumbfounded. No one saw the signs. Not one Doctor, not one Psychologist, social worker, nurse...not one other co-worker recognized the signs. We were collectively devastated. We brought in crisis counselors from the community to assist with our grief, because even though we are experts in the Mental Health field, it was too much for us to bear alone. We grieved, we comforted one another and we began the healing process. And ultimately we came to the realization that we needed to do everything we could to never feel this helpless again.

It was then that our Executive Director formulated a vision...a vision of action and a vision of involvement. From this vision, a committed group of volunteers formed the **EPC Remembrance Group**. The group's mission is to educate ourselves and others on the topic of Depression Screening & Suicide Prevention and to increase awareness, involvement and visibility in our EPC Community and the larger community in which we live.

Since forming, the group has developed partnerships with the local communities and with surrounding counties to become more involved in their educational efforts and suicide prevention activities. There was so much being done already both locally and statewide that could benefit by our greater commitment. Some of these activities included Suicide Awareness Walkathons, Workshops and Adolescent Suicide assessments, interventions and prevention training. The latter training uses a new empirically-based approach – the CAMS model – for the assessment and treatment of adolescent suicidality. A cornerstone of our efforts is '**Safe TALK**', a campaign that provides widespread public education similar to that which was provided on a national level to recognize the warning signs of a heart attack. TALK stands for Tell- Ask- Listen and Keep Safe. This training prepares anyone over the age of 15 to identify individuals with thoughts of suicide and connect them to suicide first aid resources. Most people with thoughts of suicide invite help to stay safe. This training encourages participants to move beyond common tendencies to miss, dismiss or avoid suicide and to identify individuals who have

thoughts of suicide. The final step to the training is to apply the TALK steps and connect the individual with suicidal thoughts to first aid and intervention caregivers.

We at Elmira Psychiatric Center are excited about our efforts and our new community partnerships. Although we can't 'undo' the tragedy that occurred here under our noses, we can be an integral part of reducing the stigma associated with depression and suicide, increasing the public awareness of the warning signs...and of hopefully preventing the next completed suicide.



[Enlarge](#)

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### **Rockland Children's Psychiatric Center Moves into New Building**

After numerous celebrations, receptions and tours given for recipients and their families, state and local dignitaries, employees, advocates and other friends, Rockland Children's Psychiatric Center moved from its former location to a newly constructed building on the campus. The facility's telephone numbers remain the same, but the mailing address is now Rockland Children's Psychiatric Center, 2 First Avenue, Orangeburg NY 10962.

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