

# CMHC, Inc. Newswire

## Your Community Mental Health Center

CMHC, Inc. Locations at : **Nevada Mental Health Services**, 815 S. Ash Nevada, MO 417667-8352, **Cass Co. Psychological Services**, Harrisonville, MO, 816-380-4010, **Dade Co. Psychological Services**, Lockwood, MO, 417-232-4499.

### The War on the Poor Continues

- Republicans in the MO Legislature cut services for over 80,000 Missouri poor families and children in 2005.
- In addition to deep cuts which limited how many of the poor are covered in the Mo Medicaid program, the Legislature raised co-pays and spend-down (patient contributions) which knock some of the very poor out of coverage because they can't come up with cash shares.
- These cuts are viewed by some as efforts to afford the continued practice of tax breaks for the wealthy and the avoidance of tax increases during times of war and as the federal government deserts states with federal funding pull outs.

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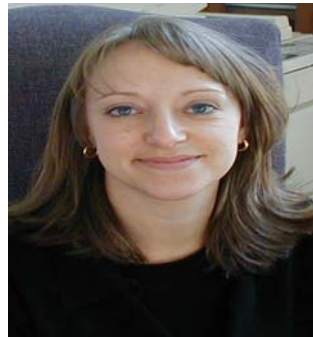
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### New Clinical Leadership at our Lockwood Clinic!

Dr. Morris and Dr. Hagy, Clinical Directors of the CMHC, Inc. system programs, recently announced the addition of highly qualified staff to the leadership circle at our Lockwood Clinic (Dade County Psychological Services). The clinic is multi-disciplinary and is currently staffed with Dr. Glen Christie (professional counselor and certified marital and family therapist), Dr. Delgado (psychologist and specialist in children's services), and substance abuse counselors and case managers.

In November and December we added Janette Eldred, MSW and Seth Jackson, MSW, clinical social workers to the Lockwood clinic staff. Mrs. Eldred holds both a master's and bachelor's degree in social work and has extensive experience working as

the Clinical director of an adolescent residential program, as a case manager for severely disturbed children, and as a case manager for a community outreach program involved in parenting and home management skills.



Mr. Jackson has a master's in social work, a bachelors in sociology and social work, and an AA degree in general studies.

He has experience as a case



manager and patient advocate, has worked in a substance abuse and domestic violence treatment center and in a child development center. CMHC, Inc. is proud to be expanding our Lockwood Clinic (serving the Lockwood, Lamar, Greenfield, & Mt. Vernon areas).

### Dr. Morris is Elected to the Board of the Academy of Family Psychology



Dr. Jerry Morris, Clinical Director of CMHC, Inc. and board certified family psychologist, nation-

ally approved AAMFT Supervisor of Marital & Family Therapists, who has published books, chapters, and scientific and professional articles was elected to the position of Secretary of the Board of Directors of the Academy of Family Psychology, the professional membership organization of all board certified family psychologists in the US and the World (see <http://www.acfamp.org>).

The American Board of Professional Psychology which supervises all specialty boards for

psychologists, and which is the super board to which the Academy of Family Psychology is affiliated is recognized by the American Psychological Association and the organization that represents specialization in psychology.

Dr. Morris will serve a three year term. He has been a trainer of family psychologists and family therapists for 15 years and is a member of the APA Division 43 (Family Psychology).

## New Staff & Staff News at CMHC, Inc.

Brandi McInroy, long-time CMHC, Inc. employee has graduated from the University of Kansas City Law school and is studying for her bar exam. She has accepted a position with Public Defender's Office, Nevada. Brandi and her family will be a great addition to the professional community of Vernon County. Welcome Counselor McInroy!



Laura Hernandez, BS, Case Manager has joined CMHC, Inc. from Dallas Texas. Laura is a graduate of the University

of Texas and is currently enrolled in the CMHC two year CD Counselor residency.



Janette Eldred, LCSW holds both a master's and bachelor's degree in social work and will be working in clinical leadership at the Lockwood

Clinic. She will also be involved in CSTAR programs, and the Barton Co Drug Court program. We welcome Janette.



Seth Jackson, MSW has a master's in social work, a bachelors in sociology and social work, and an AA degree in general studies. He is involved at the Nevada and Lockwood clinics and with the CSTAR program and the

Barton Co Drug Court program. We welcome Mr. Jackson to the staff at CMHC Nevada and Dade Co Psychological Services.

Melody Jorgenson, MSW has a masters degree in social work from the University of Missouri. Melody is involved at the Nevada Clinic and has privileges at Heartland Behavioral Health Services.



Shannon Simmons received his Masters Degree in Community Counseling from Drake University in Des Moines, IA. He received his Bachelor of Arts in Youth Ministry from Harding University in Searcy, AR. Shannon will be located at our Nevada clinic.



Eric Johnson received his Masters Degree in Psychology from Central Missouri State University and will be involved at the

## MENTAL STRESS ONE CULPRIT IN RAISING CHOLESTEROL LEVELS : NEW STUDY

There is good evidence to show that stress can increase a person's heart rate, lower the immune system's ability to fight colds and increase certain inflammatory markers but can stress also raise a person's cholesterol? It appears so for some people, according to a new study that examines how reactions to stress over a period of time can raise a person's lipid levels.

This finding is reported in the November issue of *Health Psychology*, published by the American Psychological Association (APA- Andrew Steptoe, D.Sc., and Lena Brydon, Ph.) The doctor's study found that individuals vary in their cholesterol responses to stress. So the larger cholesterol responders to stress tasks will be large responders to emotional situations in their lives. It is these responses in everyday life that accumulate

to lead to an increase in fasting cholesterol or lipid levels three years later. It appears that a person's reaction to stress is one mechanism through which higher lipid levels may develop.

At the follow up three years later, cholesterol levels in all the participants in the study had gone up, as might be expected through passage of time. However, individuals with larger initial stress responses had substantially greater rises in cholesterol than those with small stress responses. The people in the top third of stress responders were three times more likely to have a level of 'bad' (low-density lipoprotein) cholesterol above clinical thresholds than were people in the bottom third of stress responders. These differences were independent of their baseline

levels of cholesterol levels, gender, age, hormone replacement, body mass index, smoking or alcohol consumption. For some time psychologists have known that cholesterol levels were related to a complex relationship between genetics, upbringing, and personality factors. This data indicates that the treatment of chronically elevated cholesterol is complex and that patients may need to be screened for psychological components of the illness. Many internists use such screening questionnaires and refer indicated patient to psychologists for more thorough evaluation. If you have high lipids and your internists doesn't screen or refer you to a psychologist, you may want to refer yourself.

## Persistent Anxiety & Depression are Health Risk

Inability to shut off the stress response has been found to disrupt the finely-tuned hypothalamic control of neuronal, neuroendocrine, & immune systems (McKewen, *Biol Psychiatry*, 2003; charmandarl & Chrousos, *Annu Rev Physiol*, 2005). Research shows that prolonged or repeated activation of this stress axis results in a self-perpetuating cycle of enhanced stress reactivity and persistently increased inflammatory activity in chronically stressed, anxious, and depressed persons. There are also neurode-

generative effects on the hippocampus (McKinley, *PsychEd Up*, 2005).

These results and others are increasingly demonstrating that the body changes with chronic or poorly managed stress and that the treatment of stress adaptation may be as important as allopathic interventions. Loss of effective control of stress enhances the development of a variety of medical disorders (atherosclerosis and coronary artery disease, insulin resistance, abdominal obesity, bone demineral-

ization, susceptibility to infection, autoimmune disease, and neuroendocrine disorders (Fernandez-Real, *Endocrine Reviews*; 2003, Harter, Conway, Merikangas, *Arch Psychiatry Clin Neuroscience*, 2003; Raison, Miller, *Am J Psychiatry*, 2003).

The autoplacidity of the CNS, and its change ability based on experience plays great part in chemical imbalances. Changing health and psychological problems is significantly more complex than just taking a pill, though a pill is a temporary help!

## Hard-wired Emotional Decision Making the Likely Cause of Much Relational Trouble

By Jerry Morris, Psy.D., MBA, ABPP, NCSP, NBCC, CCM

New research is changing the way we think of memory and decision making. Clearly, memory is not one independent entity or phenomenon, but rather there are many types of memory and they utilize different brain mechanisms and circuits. These mechanisms and sites of memory interface with higher cortical regions where rational thought is believed to occur. However, neuropsychological evidence (LeDoux, 1994, and Bechara, & Damasio, 2000) now indicates that the deep areas of the brain (limbic system) previously thought to be controlled by higher cortical neuroanatomical regions (outer cortex) are more involved in decision making than we realized.

Early neurological theory believed that humans generally make decisions in the outer cortical regions of the brain associated with rational thought. However, more recent findings indicate that there is a “back door circuit” that runs between the sensory input channels, the thalamas, and then to the amygdale (a small, almond-sized structure located at the top of the brain stem near the bottom of the limbic lobe-it is responsible for emotional learning). This “neural back alley” as described by Akinson (2005) processes incoming signals and routes them through the thalamas! Bypassing the neocortex, they cross by a single synapse straight to the amygdale (Barrinaga, 1992; Goleman, 1995). Why is this so stunning? Well, it means that the amygdala (a center of fear and

anxiety responses with extensive afferent and efferent connections to many other fear-related neuronal structures including hippocampus, locus ceruleus, hypothalamus, and orbitofrontal cortex (Goddard and Charney theory of anxiety 1997) gets a look at all incoming information before it is processed by the neocortex!

Wow! Does that mean that people have a short, hard-wired, and pre-emptive circuit that predisposes them to emotional (as opposed to cortical/rational) decision making. You bet!

Contrary to our old belief that thought controls emotion, for some types of things and memories (remember emotional memory is also at the amygdale level) emotions rule the decisions. Therefore, we can not just learn certain thoughts to control hard-wired emotional deciding/acting, but rather must undo emotional experiences and wiring/habits that can dominate thoughts.

This is a very difficult process that takes much repetition, going through emotional loops with different reinforcement, and with some type of external containment so that old response types are prevented (so they can't be further reinforced). Literally re-wiring our mid-brain is a complex and time consuming process. It can require much guidance, patience, and a hefty commitment to change.

A short-cut is to use medications that change the capacity of neurons in the mid-brain area to fire. These medications can dampen emotions long-enough for us to

develop competing behaviors that involve new emotional learning and increased capacity to involve cortical processing. However, they also change the sensitivity of this area of the brain over time and thus can hyper-sensitize our brain (up-regulation) to certain emotional responses. Thus, medications are a helpful tool for the short-run, but they do not provide the long-run change necessary to rewire affective decision making and thus amgdala-thalamic interface.

One very successful new technique for rewiring emotional decision making and learning is the Pragmatic/Experiential Therapy for Couples (Atkinson, 2005). In this technique therapist help partners rewire their brains for more flexibility, enabling them to meet the prerequisites for relationship success. This technique set is used to help participants to obtain greater awareness of brain states that often prevent partners from implementing the habits that predict relationship success, emotional control, and which make needed thinking and action possible. Couples are helped to identify automatic thinking based on emotional learning and to change it. In this technique set therapists use state shifting interventions (frontal lobe growth and innervation) to change interpretations through integration of affective and abstract learning. Partners help each other change hard wiring based on past emotional learning by changing their reactions to the partner (controlling re-enforcers).



### Drug Court Thanksgiving Dinner

*Drug Court is a diversion program that gives individuals arrested for minor drug offenses a chance to turn their lives around rather than go to prison. This program provides treatment, supervision, and guidance for individuals with good rehabilitation potential. During the thanksgiving break*

*Judge James Bickel hosted a thanksgiving dinner for over 100 Drug Court Participants and their families. The dinner was held at the community center and afterward there was a staff vs. program participants basketball game.*

*CMHC, Inc. provides day treatment, outpatient, medi-*

*cation management, and family therapy for the Drug Court Program. JB Woolverton, CASAC, CMHC, Inc. Alcohol and Drug Abuse Treatment Program Director indicated that the program has returned many productive citizens to work, positive family leadership, and contributions to the community*

## In January CMHC, Inc. Enters Its' 29th Year of Service

CMHC, Inc. was founded in 1978 by Dr. Jerry Morris and Dr. Roger Wise. Over the years the program has employed a number of psychiatrists, psychologists, social workers, general physicians, marital and family therapists, professional



counselors, psychiatric nurses, substance abuse counselors, and administrative and clerical personnel. In addition, Drs. Morris and

Wise have helped develop Heartland Hospital in Nevada, two psychiatric units in the Nevada Regional Medical Center (Including Dr. Morris working on the committee which started the current psychiatric unit), Oakwood Hospital in Windsor MO, The Kansas Psychiatric Institute in Olathe Kansas, the Osteopathic Hospital psychiatric unit in Kansas City, Programs at Lake-land Hospital in Springfield Missouri and numerous outpatient psychiatric units. They developed an adolescent resi-

dential care center in central Missouri, several certified substance abuse treatment centers, and a juvenile detention center. Dr. Wise is licensed in MO.

As developers of inpatient and outpatient psychiatric facilities and programs Drs. Morris and Wise have created access to ser-



vices for Western Missouri patients and have created hundreds of jobs and economic development in many communities. In

their 27 years of service these licensed psychologists have acted as hospital director's of psychology, clinical directors of adolescent residential care, directors of nationally accredited internships and residency programs, and have published in national journals and several books. Dr. Morris is licensed in MO, KS, and LA and has served as the President of the Missouri Psychological Association, and has served on the Fi-

nance and Rural Committees of the American Psychological Association (APA). He was on the Council of Representatives (functional board of directors) of the APA. Drs. Morris and Wise have served on various committees of the MO Psychological Association including current membership on the MoPA Insurance and Managed Care Committee where Dr. Morris presides as chair.

During Dr. Morris' 11 year tenure as the APA Division 42 (Psychologists in Independent Practice-largest division in APA) Chair of the Hospital & Health Care Facilities Committee Dr. Morris led the advocacy movement for private practice psychologists in hospitals. During that time many states, including MO, revised their rules and regulations to allow psychologists to have privileges as full voting members of hospital medical staffs.

In January of 2006 Drs. Morris and Dr. Wise celebrate 28 years of service to Missouri & Kansas residents.

### Family Therapy-CMHC



Amy Bradley, LCSW and post-graduate institute trained Bowenian family therapist and Melody Jorgenson, PLCSW are providing family therapy from a Bowenian perspective. This technique assists family members achieve a balance between connectedness to each other and independence and a solid-self.

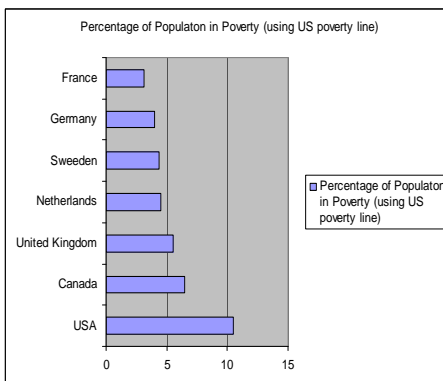


## Poverty and Medicaid Cuts: Are We Planning or Just Cutting? By Dr. Morris

As the federal and state Government rush to cut health care programs for the poor we are driven to look at some relevant facts which will influence planning. We have to do this because cutting programs for the poor won't cause the poor to evaporate! Every cut will beget the need for a correlative plan to handle the problems of the poor or they will be translated into unanticipated consequences, health cost offsets (even larger costs related to untreated health problems), and social consequences.

First, we must realize that the US has considerable poverty. In fact, of the industrialized nations we stack up very poorly when it comes to overcoming poverty. The industrial base has eroded and our economy has become a service economy (McConnell & Brue, 2005, p. 75). Poverty has gradually increased since 1970 to the point that over 30 million people in the United States of America live in poverty (Miller, 2004, p. 731). Although the US is the wealthiest and most powerful country in the world, by contrast we have far and away the most poverty of any Western industrialized nation (Rank, 2005, p. 5).

Graphically shown below, US poverty is above 11 percent and growing (Miller 2004, p. 733). Roughly one fifth of our population is either living in poverty or on the verge of descending into poverty. By the early 21<sup>st</sup> century the modal income in the US was received by 7% of households, and their income was between \$10,000-\$15,000 (Parkin, 2005, p. 416). The U.S. had a higher rate of poverty (10-13%, depending on the measure used) than most European countries (Miller, 2004, p. 733). Of the 18 most developed countries in the world,



the US has the highest percentage of children in poverty (22.3%), the second highest number of elderly in poverty (20.7%), and the third highest overall poverty (13.6%) by one recognized measure, and the highest overall poverty (17.8%) by another (Rank, 2005, p. 34).

Imagine the affect on society and the economic system when 1 of every 5 elderly persons and child lives in poverty!

Of the 12 major industrialized countries, only the poor in two other countries (Australia and the United Kingdom) have less purchasing power than the poor in the US (Rank, 2005, p.5). When the marker of the number of persons who fall below 50% of a country's median income is used as the poverty line is used the US has far and away the highest overall poverty rate of the 18 top industrialized nations.

The US is loosing the war on poverty. Cuts in programs for the poor, and especially health care will result in unanticipated costs, pushing costs for health problems to the long-term, and are likely to actually drive up healthcare inflation in the long-run. Health care costs which don't address cost drivers (drug costs and hospital costs) rather than blanket cuts for the poor are ill conceived.

Some portions of our population are hardest hit by poverty. Poverty remains a much greater problem for Hispanics and African-Americans than for European-Americans (Bade & Parkin, 2004, p. 466).

Wealth has become increasingly distributed to the point that 50.2% of the U.S. annual income for households is controlled by the top 20% of the population, and the top 40% of the U.S. population controls 73.2% of all income (McConnell & Brue, 2005, p. 75). Eighty seven percent of shares of domestic output are controlled by corporations (even though they make up only 20% of the firms in this country), yet corporations only pay 8% of U.S. taxes collected (McConnell & Brue, 2005, p. 86).

The middle class and poor are in a growing squeeze with increasing US reconsolidation of wealth at the top, in-

creased burden to fund Government on the backs of the poor and working class, increased erosion of the industrial base, and jobs that don't require significant investment in advanced education.

Thus, poverty is increasing, and dependency on Government services is also increasing for the poor and aging. The poor are considerably more likely to be in poor health and less likely than the non-poor to have used many types of health care. They are vulnerable and need health care services that can only be supplied by the Government. In the most recent reporting period (2002) the percentage of persons reporting their health status was problematic (as only fair or poor) was more than three times higher for persons living below the poverty level as for those with family income more than twice the poverty level (National Center for Health Statistics, 2004, p 26). Poor persons were four times as likely as others to report serious psychological distress and when poor and minority persons with mental disorder go to emergency rooms for treatment (the place they must often go) their mental disorders are poorly identified and they are rarely linked with specialists qualified to treat them (Kunen, Niederhauser, Smith, Morris, & Marx, 2005).

Clearly, the poor are in a more vulnerable position in the US than ever before. In the last five years hunger in American households has risen by 43% (Brandeis University, 2005). California, Texas, Arkansas, Missouri, North Carolina, New Mexico, Oklahoma, and South Carolina all have hunger rates that are significantly higher than the national average. A recent report analyzing how the children of the poor and disabled would do under the National Governors Association cost-sharing proposals before Congress (raising Medicaid co-pays and cost sharing for people already economically destitute) indicates that there would be serious negative effects (PICO National Network, 2005).

This report indicates that raising co-pays and spend downs under this plan could place unrealistic barriers to access to services for the poor.

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# CMHC, Inc.

Community Mental Health Consultants, Inc.

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**CMHC, Inc. Corporate Offices**  
815 S. Ash  
Nevada, MO 64772  
Phone: 417-667-8352  
Fax: 417-667-9216

**CMHC, Inc., a psychologist owned and operated comprehensive community mental health center in Southwest Missouri**



Jerry Morris, PsyD, MBA, ABPP  
Clinical Director CMHC, Inc.



John Hagy, Ph.D.  
Assistant Clinical Dir.

*CMHC, Inc. is a psychologist owned and operated comprehensive community mental health center with offices at :*

*Nevada Mental Health Services  
815 S. Ash, Nevada, MO,  
417-667-8352*

*Cass Co. Psychological Services  
306 S. Independence, Harrisonville, MO,  
816-380-4010*

*Dade Co. Psychological Services  
1011 S. Main, Lockwood, MO, 417-232-4499  
You may fax us at 417-667-9216  
Our email is morris49@ipa.net  
Web Page: cmhconline.com*

## WE'RE ON THE WEB AT [WWW.CMHCONLINE.COM](http://WWW.CMHCONLINE.COM) Job Openings at CMHC, Inc.

Harrisonville: Full-time Clinic Director, Full-time or Part-time Psychologist.

Nevada: Psychologist-part or full-time. CD Counselor Trainee (RASAC).

Lockwood: No Openings.

Lamar: No Openings.

Psychology Intern and Residency Openings: None

Marital & Family Therapist: Requires a masters degree in counseling, psychology, or social work.

Substance Abuse Counselor: Requires two years of sobriety and/or bachelors degree in education or social sciences.

See  
[www.cmhconline.com](http://www.cmhconline.com)  
for updates.

**For information or application for employment call Candi Dahmer, COO at 417-667-8352.**

### SATOP CLASSES

Assessments are offered by appointment at all times during the week.

### Next OEP Class:

Nevada  
January 14-15, 2006

### Next WIP Class:

Nevada  
January 20-22, 2006



### Continued from Page 5: Poverty and Medicaid Cuts

This effect ranges from 5% to 7.5% of their already inadequate family income. A family of three at 101% of poverty could pay up to \$813 annually under the plan before they could access health care, medications, early assessment and treatment of illness (a way of preventing long-term catastrophic costs and cost increases). This approach prevents health care for the poor who do not have discretionary income to invest. That is all of the poor, by definition. It functionally removes them from the Government rolls by the requiring unrealistic family health care investments. Doing so functionally removes them from the Medicaid rolls by requiring impossible financial investments before they qualify. This will reduce the Medicaid rolls and total expenditures, but the poor and their costs do not evaporate. These costs are just transferred to other programs and parts of the economic system.

Estimates indicate that such an approach, and aforementioned barriers to access, would increase the number of uninsured children (due to inability to meet co-pays and spend downs functionally disqualifying them for coverage) by between 6% to 18%. The medical cost offsets, long-term costs due to late diagnosis and late stage treatment of illness, and to lost workforce entry and productivity are likely to be greater than the

\$1.2 billion in anticipated budgetary savings over five years. The ultimate costs to counties and municipalities, juvenile justice and court programs, county and city hospitals, etc. would potentially be astronomical and has yet to be estimated by qualified economists even though the plan is already in the beginning stage of implementation.

Simply cutting across the board programs such as health care for the poor will not result in long-term savings or curtailment of health care inflation. This approach focuses on budget line items without an appreciation for the complex interplay between cost offsets such as increased uncompensated care for hospitals and doctors which must be passed on to insurance and cash customers, transferred costs to other governmental agencies (local cities and counties get these costs dumped on them as do criminal justice systems and other agencies of government), and decreased consumption and tax revenue as the health care industry is contracted.

Citizens who are concerned should ask legislators and government administrators contemplating such cuts, "what is your plan for the health of the poor?" These people won't evaporate, and their health care costs will migrate somewhere!