

Reflections on ... PROGRESS

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When I was a kid growing up in Kansas City, I lived across the street from a vacant lot . . . well actually, the vacant lot was a vacant block - a full city block covered with nothing but weeds. In the summer, several of the surrounding neighbors would plant gardens there. The boys played ball, cowboys and Indians, and tag. The girls stayed closer to home and played dolls on their front porches, or rode tricycles up and down the street. A few times I wandered to the farthest corner of the lot which stood 20 feet above the street below. There was a huge solitary tree on the edge of the drop off and some enterprising boys had attached a rope to one of the branches so we could swing out across the street like Tarzan, and arrive safely back on solid ground, breathless with excitement and fear of our daring escapades. It didn't take much to excite us back in the days before television. Life was our television.

During the winter, I would watch the brown grass across the street take on a frosty glitter that shone in the sun and longed for the snow to come. Then my brother would pull me on the sled across the frozen, snow covered stubble, since there were no hills to slide down. It was just a flat expanse of ground, a perfectly flat, square space just ripe for development and progress. Sadly, that's exactly what happened. The land was bought by a company that made pottery bases for lamps and vases. The bulldozers came in and cleared away all the stubble. One night, those mischief seeking boys started up the bulldozer, then got scared and ran off. My dad and a couple of neighbor men went out in their pajamas and had to try to figure out how to shut it off. But eventually the bulldozers did their duty, and I watched my playground disappear under a huge square of concrete. Now instead of looking out across an empty field of grass, we stared at a solid wall of concrete.

But that's progress. So often when changes come, we are told that it is for the sake of progress, and that we must keep up with the 20th century, and now the 21st century. Thank goodness I won't live long enough to see the 22nd century because I don't think I can stand any more progress. Seriously, though, the older I get the less I like change but I know that we must change in order to survive. Our country is now in the throes of a financial crisis which is always a risk to growth and progress. We can't predict the future, so our country's leaders are faced with making decisions that we hope will benefit the majority and not create despair for the minority. This is a fine tightrope to walk. I believe that the American people can survive this crisis as they have survived other crises in the past. My parents lived through the Great Depression and two World Wars. In the past few years, we have experienced years of prosperity and now that the chips are down, we can't give up and complain because times are tough.

If we look at history, both American and World History, we can see that every civilization has had good times and bad, but it is only those civilizations that refused to change and make progress that are no longer around. So progress, like death and taxes, will be with us forever, because we can't stand still or we will not survive. However, progress should not be blind. It should be met with eyes wide open and alert to red flags because whenever there is progress, someone always loses, even if it's only a vacant lot across the street. We should not go barreling down the avenue of progress, but should weigh the consequences and look for alternatives. This forces us to be creative and maybe seek even better solutions.

So, you might ask, where is the pottery factory today that took over my playground yesterday? Well, it was bulldozed down to make room for a new highway - I 70 - that flows right over the spot where my old house and the pottery factory used to stand. Well, as they say, that's progress.



Update: Mental Health Parity & Addiction Equity Act of 2008

After percolating in Congress for years, the Mental Health Parity and Addiction Equity Act of 2008, H.R. 1424, championed by Sens. Paul Wellstone (D-MN) and Pete Domenici (R-NM), has finally passed both chambers of Congress and been signed into law by the president.

The act requires certain insurers, including some Medicaid managed care entities, to ensure that mental health coverage is comparable to benefits provided for physical health care. Specifically, the law prevents insurance companies from charging higher deductibles and co-payments for mental health services or using different visitation caps on mental health services. The act, which also increases coverage for substance use disorder services, has been considered in Congress in various forms over the last 15 years and was signed by the president in early October as a part of the Emergency Economic Stabilization Act, after previously passing both chambers of Congress.

The act will likely increase services available to individuals with behavioral health disorders released from jail or prison, many of whom may be eligible for Medicaid, and is anticipated to affect 36 million children and adults covered by managed-care Medicaid programs overall. Its passage represents an increasing recognition among policymakers of the seriousness of behavioral health disorders and, more important, the effectiveness of behavioral health treatment and possibilities for recovery.

To view a fact sheet on the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 developed by the National Council for Community Behavioral Healthcare, go to www.thenationalcouncil.org. To learn more about the Justice Centers project related to people with mental illnesses in the criminal justice system, go www.consensusproject.org.

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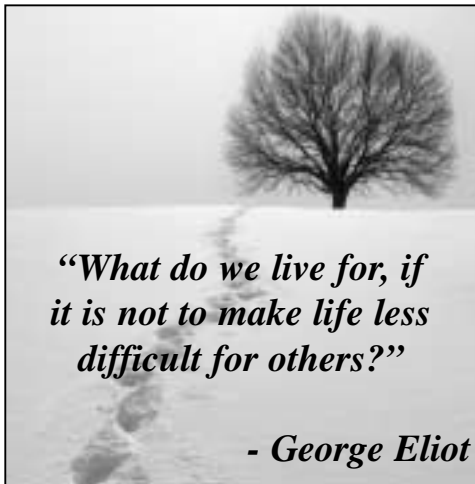
ADVISOR

"With you every step of the way."

December 2008

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"What do we live for, if it is not to make life less difficult for others?"

- George Eliot

Alcohol Taxes Go Up . . . Deaths Go Down?

A new study about two Alaska alcohol tax increases, published on the state of Alaska's website, makes an assumption that people drank less because of higher alcohol prices.

- The new study by researchers with the University of Florida relied on more than 100 earlier studies that **found when the price of alcohol goes up, people generally drink less.**
- The researchers gathered information from death certificates to examine how many Alaskans died from alcohol-related diseases such as liver cirrhosis, pancreatitis, and various cancers as well as alcohol poisoning over nearly three decades to assess the effect of alcohol tax hikes in 1983 and 2002. They didn't look at violent or accidental deaths. **They concluded that higher taxes on alcohol had a big impact.**
- After Alaska's 1983 tax increase -- just a dime per gallon of beer or wine, and \$1.50 on a gallon of hard liquor -- deaths dropped 29 percent, they said. After a much bigger 2002 increase, deaths dropped 11 percent, the study found.
- The study, just released by the *American Journal of Public Health*, was funded by the Robert Wood Johnson Foundation and will be published in their January issue.

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Why We Spend



By: Fred Overton, RN
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Money can't buy happiness. We've heard this all of our lives, yet many of us have probably attempted to use money to alleviate stress, bolster self esteem, cure

boredom, gain status or acceptance or even stave off loneliness. I'm not talking about money spent on therapy, medications, nontraditional remedies or even self help books. I'm talking about every cent ever spent to try to make us feel better. Some of us may head to the mall when we are stressed to buy shoes, clothes, cosmetics or gadgets which we have no need for before we became stressed. Some of us like to shop online, thrilled by the prospect of finding a bargain on something we will never need. It may be as simple as stopping at a convenience store during a trip. You already have cost effective drinks and snacks in the car, but there just might be something more appealing in the C-store. As economic factors squeeze our budgets tighter and tighter many of us will be forced to examine our spending habits. It is probably as important to examine why we spend as it is to look at how much or what we are spending our money on.

Spending money to fulfill emotional or relational needs can be a double edged sword. Most of the people I know do not have an endless source of funds. The money which is spent on indulgent expenditures has to come from somewhere. For many people this means skimping on more essential items or going further into debt. This leads to more stress and feelings of desperation causing us to feel worse instead of better! Almost like a drug we can also become resistant to the effects of spending. The more we accumulate the more we need to spend in order to achieve the same emotional response we first experienced.

The holiday's are just around the corner, many parents do not feel adequate unless they are supplying their children with the biggest and best presents money can buy. I recently

heard a friend quote an interesting statistic, "for all of the money our country spends on Christmas presents we could provide safe clean drinking water for the entire world." Our children develop their view of wealth and materialism based on what they see in us. When my son receives his allowance he often says, "I want to go waste my money." At least he is honest about it. We



shouldn't fault our children for displaying the same behavior we have modeled. During this holiday season when money is probably tight, perhaps it is a good time to give presents of time and attention as opposed to the newest shiniest toy which will probably be broken in a week.

I'm not saying we should never treat ourselves or our children but regular treats quickly loose their significance. To have full potential impact, treats should be unexpected surprises. These treats should not cause more misery down the road than the joy they can bring short term. With the uncertainty of our financial future, it is a good thing that money cannot buy happiness!

SUBSTANCE ABUSE TREATMENT A History of Counseling



By: **Doug Quirmbach,**
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The evolution of substance abuse treatment beginning with Benjamin Rush's 1784 proclamation that alcohol addiction was an "odious disease" to our current, evidence-based models is a path besieged by pitfalls, cross-roads and dead ends.

Homes for people that were intoxicated and asylums sprang up in the 19th century to isolate "drunkards" from society and provide reasonably safe places to "dry out." In 1879, Dr. Leslie Keeley and some partners came up with a concoction that allegedly contained, among other chemicals, the mineral gold. After laudatory claims of success were made in the press, Keeley feverishly opened institutions to house alcohol-dependent clients and administer the cure three times a day. He franchised the operation and by mid-1893 there were 118 Keeley institutions spread out throughout the United States.

Fraudulent "cures" and household miracle remedies were sold in stores throughout the nation in the early 1900s and continued despite passage of the Food and Drug reform act of 1906. Some bottled cures claimed to cure alcoholism within 24 hours.

Until the 1930s, when two visionary tee-totters founded Alcoholics Anonymous, recovery from alcohol addiction was considered a matter of religious conversion. The spiritually based 12-step group was a departure from conventional secular thinking but included story-telling rituals borrowed from Native American self-help groups formed for the same purpose a century earlier.



The state of Minnesota took an early and intense look at the problems alcohol addiction was causing its citizens and began to tax liquor license holders, reserving the revenue to build and operate a treatment center for inebriates. The state financed Willmar State Hospital to administer treatment to alcoholics up until the beginning of prohibition. In the 1940s, Minneapolis opened Pioneer House, a treatment center for impoverished alcoholics. In 1949, a private treatment center called Hazelden was opened in Minnesota and is still in operation today. The emerging and still widely used treatment approach called the "Minnesota Model" was developed through the cooperation of these institutions. This model combined psychiatric approaches popular at the time with involvement in Alcoholics Anonymous.

In 1957, the American Medical Association determined that alcoholism was a disease and providers rushed to get addicted clients into treatment that was based on a medical model. Since physicians knew little about alcoholism, agencies recruited recovering addicts to aid in administering treatment.

Recent advances in brain imaging technology have confirmed that addiction is a chronic, relapse prone disease. New research sponsored by the National Institute on Drug Addiction concludes it is a brain disease driven by the limbic system with biological, environmental and social components. Modern treatment addresses these issues with cognitive behavioral approaches designed to teach addicts new ways of thinking and behaving.

Today, treatment is administered by certified substance abuse counselors and licensed mental health professionals using evidence-based clinical models. Chemically dependent people can get help in both residential and outpatient settings. Self-help groups such as Alcoholics Anonymous, Celebrate Recovery and Narcotics Anonymous continue to be valuable resources for the ongoing recovery efforts of chemically dependent people. For more information visit www.nida.nih.gov.

Integrated Care "Healing the whole person"

By: **John Braucher, MSW, LCSW**
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For some time it has been recognized that providing services to a person in one location by a single team of healthcare professionals is superior to fragmented care. This was found to be strikingly obvious in the care of dual diagnosis persons, leading to the Integrated Dual Disorder Treatment model currently being implemented by the Comprehensive Psychiatric Rehabilitation Programs. Seamless delivery of services, coordination of care, much improved referral follow through and the addition of new, collaborative ventures are among the advantages of these types of programs. Currently, behavioral healthcare providers are exploring the model of Integrated Care, by merging Primary Healthcare and Behavioral Healthcare into one location, and having the clinicians be part of a common cohesive team.

Integrated Care is not a new idea, but until recently there were barriers or "silos" in place to keep primary care and behavioral care separate. Billing, documentation systems, differences in language and patient flow and stigma to name just a few. In recent years there has been an increase in funding of Federally Qualified Health Centers or "FQHC's" to serve as a safety net of healthcare in medically underserved areas, both inner city and rural in nature. The FQHC model includes primary care, behavioral health care and dental health care. Grants were and are being awarded to establish and expand these centers to combine these types of care. Due to the shortage of dental health professionals in these underserved areas Primary Care and Behavioral Healthcare frequently are where this integration process begins.

Recent data from several states have found that people suffering with serious mental illnesses, those served by our public mental health systems die, on average, at least 25 years earlier than the general population. Obesity, diabetes, respiratory diseases and infectious diseases account for the majority of the premature deaths. It makes sense that by combining behavioral healthcare and primary healthcare, persons in this population will not fall through the cracks, and the "team" can encourage adherence to care plans to more effectively treat, both mental illnesses and their medical conditions.

Other data, shows that between 60 and 80 percent of all anti-depressant medications are prescribed by primary care providers, indicating that many persons identified as needing behavioral healthcare are seeking this care in the primary healthcare setting. Research also shows that the combination of non-medication therapies and psychotropic medications have superior outcomes in the treatment of depression, than either one of them by themselves. By locating "Behavioral Health Consultants" alongside with primary care providers, we can vastly improve treatment of both mental disorders, and other chronic health diseases, such as hypertension, diabetes, arthritis, and many other areas where lifestyle changes, and stress management skills may enhance the outcomes of health status.

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The Complex Web of Special Education Classification in the Public School System

“According to the Department of Education approximately six million children (10 percent of school-aged children) received special education services from school districts in the United States last year.”



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Have you ever felt like your child requires special accommodations in the school setting due to some physical limitation, psychological difficulty, or learning problem that negatively impacts his or her ability to learn in the classroom setting? According to the Department of Education approximately six million children (10 percent of school-aged children) received special education services from school districts in the United States last year. Why do schools have to provide education to children who have unique physical or psychological needs? Since 1975 when Congress passed the Education for All Handicapped Children Act (also known as Public Law 94-142) and later renamed the Individuals with Disabilities Act (IDEA) millions of children have been provided "free and appropriate public education" in spite of a number of possible disabilities. These disabilities have historically included problems with speech, vision and language, physical limitations, and also emotional and behavioral problems.

In order for a child to receive special education services, the state of Missouri requires that parents and school districts follow a standardized procedure or process in order to ensure correct identification and classification. Upon appropriate identification, a child receives special accommodation for a broad range of possible disabilities he or she is entitled (required by IDEA) to receive an Individualize Education Program (IEP) that specifically outlines how the school district will accommodate to a child who has "special" needs. The IEP refers both to the educational program to be provided to a child with a disability and to the written document that describes that educational program. Additionally, the child is assessed in all areas related to the suspected disability including evaluating access to the general curriculum, how the disability affects the student's learning, choosing a placement in the least restrictive environment, and the goals and objectives to be accomplished.

So how does this apply to me if my child has a psychiatric condition? There are essentially three special education classifications that are commonly utilized for children who may exhibit symptoms consistent with a psychiatric disorder and they include an Emotional Disturbance (ED), Learning Disability (LD), or Other Health Impaired (OHI). An Emotional Disturbance is when a child's emotional or psychological condition lasts for a long or sustained period of time (usually two to nine months) and generally adversely affects a child's academic performance. More specifically, an Emotional Disturbance classification often includes one or more of the following criteria:

- A. An inability to learn that cannot be explained by intellectual, sensory or health factors;
- B. An inability to build or maintain satisfactory interpersonal relationships with peers and teachers;
- C. Inappropriate types of behavior or feelings under normal circumstances;
- D. A general pervasive mood of unhappiness or depression; and,
- E. A tendency to develop physical symptoms or fears associated with personal or social problems.

It is important to know that normal reactions to life circumstances do not generally results in this classification nor does behaviors that are generally viewed as delinquent or willful/purposeful otherwise known as Socially Maladjusted (SM). The distinction between children who are classified as either ED or SM can become very difficult .

The Learning Disability classification is when a child experiences significant learning problems that are not just based upon observation or intuition but rather statistical data from achievement testing in comparison to intelligence testing that is generally completed by the school district. The Other Health Impaired category is reserved for a variety of medical issues and problems associated with attention/concentration.

The process of special education classification is not an exact science and the aforementioned classifications are educational labels not psychiatric conditions. It is important to remember that a child does not qualify for special education services simply because he or she sees a psychiatrist, receives outpatient behavioral services, or maintains a psychiatric diagnosis. Conversely, some students can often qualify for services but are not accessing services because special needs have gone undetected. School districts attempt to follow fairly vague criteria in effort to provide each student the most appropriate public education; however, the language of the laws can often make identification of these classifications more cumbersome or difficult. If a parent suspects that his or her child has undetected or under recognized special needs then they should contact their child's school immediately.



The “For the Children” Foundation provides much needed mental health services to children and their families that may not have access to these services otherwise. The foundation is focused on bridging the gaps that exist in mental health services, especially in rural or under-served areas. To learn more about the “For the Children” Foundation, or to make a donation please visit our website, www.forthechildrenmo.org.