INSESSION

SEPTEMBER 2020

FMHCA

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"NOT ALL THOSE WHO WANDER ARE LOST"

The above quote from J.R.R. Tolkien has often been used to support the notion that it is normal and healthy for people to wander in uncertainty, doubt, fear, or just plain old decision for a period of time before finding their way, and this time in the "wilderness" can often be fruitful and productive.

I feel like many of us are wandering right now. Our lives have been so dramatically altered by the COVID-19 pandemic, and we're wishing we could just get back to "normal." We've also been exposed to events involving police brutality and racial injustice, as well as righteous indignation gone awry in the form of rioting and looting, and I think so many of us are just hurting and longing for some peace. I'm not just talking about our clients; I'm talking about us—clinical mental health counselors.

I also truly believe that this period of wandering in the wilderness will be fruitful; that we will emerge stronger, and that something good will come from our present suffering. I think that the pandemic will launch a "personal renaissance" for many, and that we'll increasingly get back in touch with what's truly important. I think that from the current period of civil unrest, we'll see more reform.

I don't know about you all, but my practice is busier than I can handle right now. People need us. People are paying more attention to their mental health and wellness. We can walk with them and offer them some hope and encouragement. And as you help your clients, we at FMHCA want to support you. We're not lost; we're finding our way.

I'm excited about what comes next. We have some good stuff in this issue of InSession Magazine. I hope you like it.

Aaron Norton, LMHC, LMFT, MCAP, CRC, CCMHC
FMHCA president, 2019-2020

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DNA Discoveries – What Happens Under the Sheets Does Not Stay There Forever

What does that mean for today's therapist?

A little over two years ago, I, like so many other curious, culture loving therapists, decided to spit into the test tube to discover my undiscovered truths. There was a rumor going around my dad's family that we had Native American blood and I was curious to see if this could even be remotely true. A friend of mine discovered she had a long-lost sister and just for fun, a group of us vowed to order our kits and see what the findings would be. "This could be fun," I said. "Maybe I will find I have a new family somewhere," I laughed. I will leave off the barbs about the family of origin and save that for another article. The end result? You guessed it. First, to define a few acronyms: NPE was originally referred to as Non-Paternal Event in Genetics. It will be referred to in this article as Not Parent Expected. BCF means Birth Certificate Father. BF stands for biological father. HB and HS mean half-brother and half-sister, respectively. Are you confused yet? I am considering I have been using my own language when I refer to my own situation since my own situation will not allow me to call my DAD (the man who raised me) as BCF. He is my dad. Since I am attempting to give you, my colleagues an overview, I will stick to the basics with the understanding that each individual situation warrants its own definition(s) and has its own defining characteristics. There are also other populations which are not addressed here but I feel they are worth mentioning. LDAs (Late Discovery Adoptees), and Donor Conceived Persons who prefer no acronym.

It is estimated by the group NPE Friends

Fellowship, a group providing support and education, that 5- 10% of the world's population are NPE's (source: npefellowship.org). Several of these individuals have found their way into my practice and it is only a matter of time before you find an NPE sitting across from you if you have not already. The attempt here is to provide an overview so that you do not find yourself in a state of shock. Fortunately, NPE stories are making their way into the media (spoiler alerts) such as the last season finale of *Blue Bloods*, an episode or two of *Designated Survivor* and an older episode of *NCIS*. These episodes pave the way for conversation and builds awareness. From what I have read on some of the NPE support group pages, it has provided some with validation and many with a way to release pent up emotions. I have used snippets of some of these episodes for presentations about NPEs on the experience and it has helped to explain an emotion that I could not find the words to describe. YouTube is filled with true accounts and experiences as well.

Initial Shock & Trauma

I recall telling a close colleague what I discovered one month after the event. "That's traumatizing," he kindly shared. "Oh, I'm fine," said I. "I'm really fine." Well, we all know that fine means anything but fine. I thought I was fine because I did not realize how numb I was at the time. I was still waiting for a phone call from my new half brother who incidentally has still never called or returned my emails, but I am fine. Fortunately, my colleague listened as I told him he better be nice to me now that I am Sicilian, whatever that means. I was trying to connect us in some way since he is Italian. I also shared some other fun cultural information that continues to blow my mind even today and the fact that I have a paternal aunt who I resemble who lived in the next town who is a clinical social worker. People used to tell me I had "an identical twin who is a therapist" in the next town and my reply was, "yes, everyone has a twin somewhere." I cringe a little when anyone says that I look like someone they have seen now. It has become a trigger of sorts that only time can heal.

Once the shock wears off, which is the first part of trauma, the storm of emotions can sometimes take over depending on the individual and where they are in their stage of development. Brush up on Erikson's Stages of Development because each person is in a different place and each person will come at this from a different perspective once the shock and trauma are resolved which sometimes feels like resolution could take forever.

Grief and Rejection

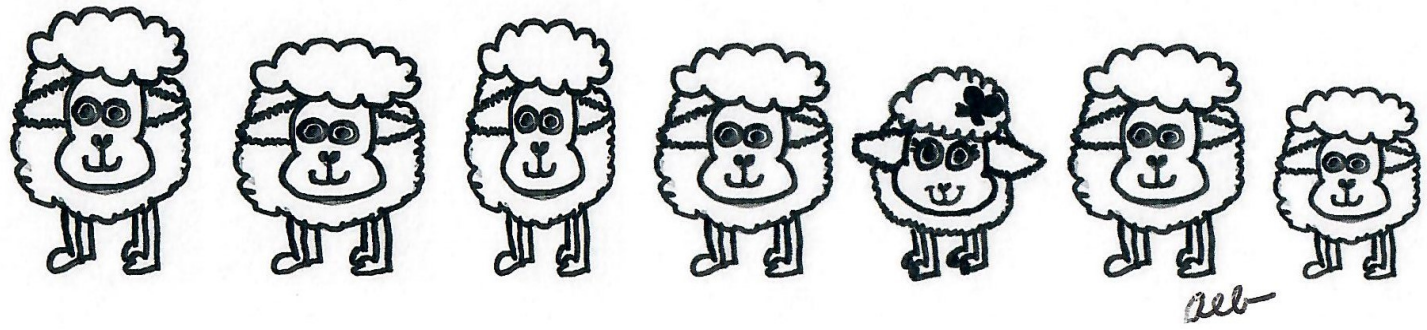
There is a great deal of grief in this process for the NPE. There is grief for the family that was, the family that was lost, the support one did not get in the process, the lack of validation, and the grief of what might have been when discovering a new family – lost hope to some degree. Each situation will vary. Having support has been helpful to me as I have been involved in several online support groups, so I have read so many stories of so many

NPEs much like myself. Having a spouse and grown children and a few relatives of origin have been a blessing. Grief and rejection appear to be a common factor though to what degree and to what the content of that grief seems to be unpredictable and certainly at times, immeasurable. So as a clinician, it is safe to do what you have always done as a seasoned professional and begin wherever the client is without judgement. When in doubt, validate whatever feelings come up for your client who is an NPE.

A Person's Right to Know

Coming to terms with your right to know may or may not be a long process. Everyone appears to be in a different place at a different time depending again on their place in their development. This whole situation got me thinking about paternal rights. What of the rights of the father to know that he has fathered a child? I did a workshop once where a man got visibly upset because his son and his daughter in law had a child who was donor conceived. He had not even considered what would happen if the child grew up and did their DNA and discovered numerous siblings. Another woman shared that she had worked with her father and did not know it. Another two individuals shared that they had attended sibling reunions in such situations. When a child does not know early in life, what of the individual who finds out there are genetic diseases that have been passed along by the donor? Can you imagine how it feels to give your health history to a life insurance agent to have to give it again in ten years only to have the whole thing changed because you find out your whole life has been a lie? What was designed for your protection turned out to cause a great deal of emotional turmoil. "You have no siblings." "Yes, I do, I have four half-sisters and two half- brothers." "How old was your father when he died?" "I don't know." These are all true stories. Insurance underwriters are not trained to handle DNA late life discoveries.

What of the family's right to know? My sister told me she always wanted a sister. So, she finds out at fifty she has a sister. I find out at fifty-seven I have another sister. Of course, she is the best thing that has come out of this discovery along with some incredibly special aunts and cousins. What about my right to know? Didn't I have a right to know my father? Based on the family I have come to know the past few years, it sounds like I would have appreciated his sense of humor and I apparently inherited his way of standing up for what he believes in (he was a business owner and a politician). My aunt gave me a magnet he gave her that said, "Women run for office, not coffee." That is progressive when you think about it. I feel like I missed out at least not getting to have a conversation with him. What of my paternal



grandparents? I did not get to know them either! Didn't I have a right to know them as well? Don't we all have a right to know where we came from?

Things you CAN Do and Things you Need to Know

- Remember that given the choice, most NPE's would rather not be a member of the group, "NPE's." There are some who had negative or non-relationships with their BCFs and welcome the opportunity to find a new parent, but sometimes these individuals are met with rejection from their BFs and/or members of their new family. It is not unusual. HBs and HSs would often like to "leave things the way they are." This is due to many reasons (infidelity, fear of being disloyal to their mother, etc.). Family of origin individuals may not be very empathetic for the same reasons. Sometimes they feel equally as betrayed or they knew something, and their lies have been exposed.
- There are identity issues that go along with finding out you are an NPE. Suddenly, you find you are not French and Swedish anymore and instead, are Sicilian and Jewish for example.
- Monitor those with pre-existing mental health concerns. It is not unusual for serious depression to occur with some individuals depending on what stages of development they are at and what conditions are already pre-existing.
- Monitor for substance abuse.
- Validate whatever feelings come up for that individual. There are no theoretical books on how to provide therapy for this experience and people buy DNA kits expecting to have fun. The results they obtain from these findings can be and are often earth shattering.
- Building strengths in these situations are doable but this is a process. Healing is a bit messy and just when you think you have it mastered; you take a few steps backwards. Identify the individual's support system and point them out regularly.
- Inner child issues are bound to surface (wounds from the past reopen) even if you have previously worked them out in therapy. Connections are made to something someone said or did that now make sense.
- Research is needed on the effects and treatment for NPEs and to their new-found families.

If you are an NPE you are not alone. There is a great deal of support out there. There are communities that have formed and connections that have been made. You may at first be met with secrecy, but remember that where there are secrets, there is shame and it is not your job to carry the shame of anyone. You are innocent. If you are a therapist, the greatest gift you can give is to get to that place where your client can internalize that. There is pain, growth, and empowerment in the truth and in telling your story. If it were easy, we would have all known our story.

Mindfulness During Crisis

The year 2020 began with a bit of turbulence caused by the COVID-19 pandemic with stressors being amplified due to current events within our legal system. As mental health professionals, it is important that we remain a sounding board and an outlet for those who are struggling. In times of crisis, we may not have all of the correct answers as to why tragedies and injustices unfold the way that they do however, we are skilled creating a safe space for our clients to process these traumatic events. Amongst the various treatment modalities that could be used to navigate traumatic events, mindfulness treatments continue to serve as a critical component of one's wellbeing.

We may hear from our clients that "meditation does not work" or "I can't concentrate for that long". It is important that we use that time to educate our clients on the various components of mindfulness that will allow them to be aware of their feelings, thoughts, and physical sensations that do not necessarily include a form of meditation. Being mindful of oneself during times of crisis and intense stress can allow a person to regain awareness of places within themselves that they feel safe and allow them to focus on grounding themselves in the present moment and shifting their sole focus from the pain of current events.

Let us take this time to help our clients regain focus on their mental wellbeing.

Author: Joshualin "Jay" Harrison is a recent graduate from Troy University's Tampa Bay Campus and is currently employed at Gracepoint Wellness as the Adult Crisis Stabilization Unit Team Lead. Jay specializes in crisis intervention, mindfulness based treatments, and trauma.

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Police Violence, Racial Injustice, and Police Burnout in the Aftermath of George Floyd's Death

Meet the collaborative team of authors

Dr. Norman Hoffman is a Certified Forensic Mental Health Evaluator, Certified Forensic Behavioral Analyst, Licensed Mental Health Counselor, and Licensed Marriage and Family Therapist who contracts with seven police and fire departments, providing fitness for duty evaluations for police recruits, officers, and other first responders. Dr. Hoffman is the President and founder of the National Board of Forensic Evaluators (www.nbfe.net).

Aaron Norton is a Licensed Mental Health Counselor, Licensed Marriage and Family Therapist, Certified Forensic Mental Health Evaluator, and Certified Forensic Behavioral Analyst who serves as Executive Director of the National Board of Forensic Evaluators, Southern Regional Director for AMHCA, President of the Florida Mental Health Counselors Association, and adjunct instructor at the University of South Florida. He has 20 years of clinical experience providing psychotherapy and clinical and forensic evaluation with court-mandated clients as well as police officers and first responders (www.anorton.com).

Ekom Essien is a Licensed Professional Counselor and Certified Forensic Mental Health Evaluator in the Atlanta Georgia area. Ekom has presented mental health topics to law enforcement officials in the CIT program in Georgia, and he as extensive experience providing mental health crisis intervention services.

The death of George Floyd, as well as numerous other violent and tragic encounters with police caught on camera, have sparked increased awareness and interest in police violence, racial injustice, and the need for police reform. In addition to implicit racial bias and systemic racism, police burnout has been cited as one contributor to police violence, and police burnout may be rising at the present time in relation to increased demands on police officers during periods of civil unrest, especially in larger metropolitan areas. Statistics related to police violence, racial injustice, and police burnout yield alarming and puzzling findings. For example:

- In 2020, 598 people have been killed by police officers, and in 2019, there were only 27 days in which police officers did not kill anyone (www.mappingpoliceviolence.org)
- 50 % of people killed by police are White, and 25 % are Black, even though only about 13 % of the U.S. population is Black, meaning Black people are about twice as likely to be killed by police compared to White people (https://www.washingtonpost.com/graphics/investigations/police-shootings-database/)
- Police disproportionately patrol neighborhoods with high concentrations of minority populations (https://scholarship.law.columbia.edu/cgi/viewcontent.cgi?article=3660&context=faculty_scholarship), sparking debate about whether this practice is a measure to protect citizens of neighborhoods with high crime rates (as many police departments contend), or whether it is a practice that "elevates Black civilians' risk of

lethal encounters with police."

- The U.S. has the fifth highest per capita rate of police killings in the world (https://worldpopulationreview.com/country-rankings/police-killings-by-country), though it also has the highest rate of civilian gun ownership in the world (https://worldpopulationreview.com/country-rankings/gun-ownership-by-country) and 99.1 % of all arrests are executed without a civilian death (https://ucr.fbi.gov/crime-in-the-u.s/2017/crime-in-the-u.s.-2017/tables/table-29)

- Much to his own surprise, data collected by Dr. Roland Fryer, Jr. from 10 major police cities in Texas, Florida, and California indicated that while police were 25 % more likely to use non-lethal force against Black citizens, Black suspects were about 25 % less likely to be shot by police than white suspects, challenging the conclusion that racial disparities in police shootings were primarily explained by an inclination to shoot Black suspects (https://www.nber.org/papers/w22399).

- There is little evidence that increasing the number of Black and Hispanic police officers, a reform strategy often touted by police departments, offsets police violence. For example, Black and Hispanic officers are statistically more likely to shoot Black and Hispanic suspects than White officers (https://www.pnas.org/content/pnas/116/32/15877.full.pdf).

- Fewer officers, one of the measures in some "defund the police" initiatives, does not mean less brutality, as officers may be more likely to use force when they are tired and/or overworked due to personnel reductions

  (https://www.kingcounty.gov/~/media/depts/auditor/new-web-docs/2017/kcao-overtime-2017/kcao-overtime-2017.ashx?la=en).
- A study published in *Police Quarterly* yielded findings that 19 % of police officers were experiencing "severe levels of emotional exhaustion," and 13 % were experiencing extreme levels of depersonalization, and this study was conducted prior to the current period of civil unrest (https://journals.sagepub.com/doi/10.1177/1098611119828038).
- According to a 2019 epidemiological study, the rate of Post-Traumatic Stress Disorder (PTSD) is as high as 15 % among police officers (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6358175/).

- Police officer suicides increased by 25% in just one year from 2018 to 2019 (https://abcnews.go.com/Politics/record-number-us-police-officers-died-suicide-2019/story?id=68031484).

- ABC News reports that the number of police officers killed surged 28 % this year as compared to the same period last year, raising questions of whether civil unrest is related to increased violence against police officers (https://abcnews.go.com/US/police-officers-killed-surge-28-year-point-civil/story?id=71773405).

- A recent study concluded that repeated exposure to high-stress service calls and ongoing exposure to stress without relief are two factors that contribute to adverse experiences among officers, but breaks between calls, breathing exercises, and mental health

treatment can help (https://www.sciencedaily.com/releases/2020/08/200818142143.htm).

- Despite the efforts of some activists to either "defund" the police or to reduce police presence in neighborhoods predominantly inhabited by minorities, the majority of Black, Asian, and Hispanic Americans do not want a reduction in police presence in their neighborhoods (https://news.gallup.com/poll/316571/black-americans-police-retain-local-presence.aspx).

In this article, three forensic mental health experts, all who hold leadership positions with the National Board of Forensic Evaluators (NBFE), propose that clinical mental health counselors (CMHCs) can play an important role in preventing and addressing police violence in at least three ways:

1. Conducting "fitness for duty" evaluations to detect signs that police recruits and police officers are not psychologically prepared for the rigors of policing;
2. Responding alongside police officers to calls for police assistance that involve individuals with mental illness or that require verbal de-escalation;
3. Providing psychoeducation, psychological first aid, coping skills training, supportive counseling, and/or trauma treatment in an effort offset, prevent, or mitigate police burnout.

Strategy #1: The CMHC's Role in Conducting Fitness for Duty Evaluations (Dr. Norman Hoffman)

In my work as a forensic mental health evaluator, I am contracted with seven police departments and fire stations. Over the past 15 years, I have been asked to conduct evaluations for police recruits, police officers and firefighters that require evaluations for their ability to continue to perform their duties.

A fitness for duty evaluation (FDE) is not a standard psychological or forensic mental health evaluation. It is a specialized inquiry conducted by specially trained and qualified mental health professionals. These evaluations are conducted in response to complaints regarding first responders. They may include police officers, firefighters, emergency medical services (EMS), deputies, etc. They are usually referred for reported inability to perform official duties in a safe and effective manner because of suspected mental illness or significant deterioration in cognitive abilities. Also, after a shooting, there is a mandate from the department to conduct a FDE of that officer to determine if he is fit to return to his previous duties.

Reason for Evaluation

After an incident, either on or off the job, where an officer's judgment or behavior raises serious concerns about his/her ability to safely perform their duties, a fitness for duty evaluation may be requested. Another reason for this evaluation would be when an officer's performance level or behavior on or off the job results in supervisory, co-worker or public doubt about the officer's competence. Occasionally, a law enforcement officer's behavior raises concerns that the officer may have one of the following issues:

- Instability
- Excessive force

- Shooting incident
- Substance use or abuse
- Arrest
- Fighting
- Domestic violence
- Excessive absenteeism
- Serious, flagrant sick leave abuse
- Anger management issues
- Erratic or unusual behaviors
- Excessive citizen complaints
- Problem with daily duties
- Unfortunately, most evaluators are untrained, ill equipped and lack the proper skills and experience to conduct these highly specialized evaluations. Basic skills and understanding of forensic mental health evaluation are taught in the certification training process described by the National Board of Forensic Evaluators (NBFE), which partners with the American Mental Health Counselors Association (AMHCA). Although, the NBFE format is highly comprehensive and not necessarily the template used in the FDE, it is instructive and an essential basic construct to use as a study guide.

Reason for Referral (Example): Mr. Jonas Jones is being referred for a fitness for duty evaluation to determine if he is fit to return to duty subsequent to a shooting incident. He has exhibited signs of extreme anxiety, depression, and difficulty concentrating since the incident.

Suggested Instruments:

- Clinical Interview
- Psychosocial Self Report
- Personality Assessment Inventory, Law Enforcement, Corrections, and Public Safety Selection Report or:
- MMPI-2 Personnel: Law Enforcement Interpretive Report
- Beck Depression Inventory
- Beck Anxiety Inventory
- Trauma Symptom Inventory (TSI) or:
- Posttraumatic Stress Diagnostic Scale (PSD)

Of course, there must be a format that includes the above-referenced testing instruments. This format must be easy to read, avoid psycho-jargon, and be seamless from the reason for referral to the recommendations (i.e., ensure that there are no surprises when the evaluator gets to the recommendations). The reader should expect, from the beginning to the end, what the recommendations should be.

Suggested Outline:

- Professional heading
- Demographics
- Interview dates
- List of sources
- List of Collateral sources
- Identifying Data
- Reason for Referral
- Summary of Significant Data
- Psychosocial Self Report
- Review of Records
- Collateral Reports
- Personality Assessment and Test Results
- Mental Status Examination
- Diagnoses
- Clinical Formulation
- Conclusion
- Recommendations

Summarization of Best Practices for CMHCs Conducting FDEs

The FDE should not be written by a client's therapist or by a CMHC that has a biased opinion. It should be a comprehensive assessment that searches for the facts. These facts cannot alone be acquired by the client. The evaluator should examine multiple sources and data points when forming an unbiased and seamless conclusion that leads to sound, succinct recommendations. In closing, the recommendations must indicate if the client is fit to return to duty. If not, the evaluator may assist the department with other options.

Strategy #2 The CMHC's Role in Responding Alongside Police Officers (Ekom Essien)

With more attention being given to the manner in which police interact with the public and enforce the law, little has been said in headlines about the ways in which a person's mental stability can impact the outcome of an interaction with the police. However, this is extremely important considering that when a person is experiencing a mental health or substance use related crisis, the police are often the first to respond to the call for help.

Many mental health professionals provide afterhours instructions for clients or for loved one's of clients to call 911 in the event of a mental health crisis. This practice highlights the importance of training for law enforcement officials to be specially trained in managing people who may be experiencing a mental health or substance use related crisis. We as CMHCs should lead the effort with the following in mind.

First, CMHCs should consider how police officers' mental health stability affects their job performance. It is easy to focus more on the uniform and the job and neglect the fact that

police officers are also human beings who are subject to the same psychological processes that all people experience. Second, CMHCs should, as advocates, consider the efforts that are already being made to improve police interactions with the mentally ill and how those efforts can be enhanced or improved by increasing the presence of CMHCs in partnership with law enforcement. Police departments can use our unique expertise as CMHCs when responding to mental health-related calls.

Humanizing Police Officers

Police officers are authority figures who deal with human interactions that pose a threat to the life, liberty, and safety of others. Many interactions between the police and the public are experienced as adversarial. However, police officers are people; They have families and friends, get sick, have hobbies, and experience events that may affect their daily functioning. As such, and especially considering the events they experience on the job such as violence, abuse, and death, it is imperative that law enforcement officials have counseling or other mental health/substance use treatment services available to them.

Police officers also have personal biases and a subjective worldview, like everyone else. Just as CMHCs are trained to be aware of their own personal biases and subjective worldview in relation to their clinical work, police officers should be trained to have such self-awareness when interacting with the public.

A common perception is that police are conditioned to interact with all individuals as if they are a potential threat. This may be a reasonable thought considering the dangers that officers face on the job. The problem is that someone experiencing a mental health crisis may not have committed a crime, and the only threat they may pose is increasing anxiety in others. However, police presence is often interpreted as a sign that someone is "a bad person" or is "in trouble," when, in fact, the person may simply be in need of help.

Police-CMHC Partnership Models

In response to the problems between police interactions with people who have mental health or substance use related problems, many police departments across the country have altered the way they train officers, using strategies such as:

- Partnering with local and national mental health organizations such as the National Alliance on Mental Illness (NAMI) to educate police officers about the ways in which mental illness may affect a person's interactions with law enforcement.
- Establishing diversion programs such as Crisis Intervention Teams (CITs), which have made incredible strides in reducing arrests of people who are mentally ill. These programs also serve to improve officer attitudes toward mental illness. The CIT model has been adopted by many law enforcement departments across the country and is based on a model developed in Memphis, Tennessee. CIT typically involves partnership between mental health and substance use counseling professionals, law enforcement, and mental health advocates/other community organizations.
- Pairing CMHCs with EMS and local police when the situation is determined to be mental health-related, often referred to as mobile response teams (MRTs) or crisis teams. MRT models have been adopted by many city and county governments throughout the country (e.g., Atlanta, GA; Dallas, Texas; St. Petersburg, FL; Orlando, FL; Okaloosa County, FL; Walton County, FL). While there may not be many news headlines that highlight the efforts of the community and of law enforcement to better meet the needs of the mentally

ill or those who have problems with addiction, there is a growing amount of research to support the efficacy of such programs at reducing recidivism and reducing incarceration of those who are mentally ill and or have substance use disorders.

- Making fitness for duty evaluations conducted by CMHCs mandatory at regular intervals for all officers (see previous section written by Dr. Hoffman).
- Incorporating mental health-related courses taught by qualified CMHCs into the police training curriculum. The courses should include subjects that encourage introspection and self-awareness, crisis prevention, verbal de-escalation techniques, and non-physical intervention. The trainings can begin while officers are in the academy and be recurring either quarterly, semi- annually, or annually.
- Establishing a phone number for mental health emergencies through which a dispatcher can alert a mental health unit comprised of mental health counselors, police officers, and even emergency medical services.
- Altering police funding: Given that most of the current CMHC-police partnership programs function on a volunteer basis or with limited funding from not-for-profit organizations and grants, it may be difficult to implement consistent, reliable, and comprehensive services. Since "defunding" the police has been a recent topic of the protests, the reallocation of funds to CMHC-police partnership programs might better serve the community and law enforcement.

Strategy #3: The CMHC's Role in Treating Police Officers (Aaron Norton)

Reflection on Experiences Shadowing Police Officers in the Aftermath of Race Riots

From the ages of 14 through 25, I attended a criminal justice academy magnet program for my high school experience rather than a traditional high school education, spent six years in my city's police explorer program (where I participated in weekly training sessions with officers, shadowed 911 operators, rode in uniform with and observed police officers on patrol, etc.), and worked for five years in correctional programs for youthful offenders.

These experiences would have a profound impact on my career path as a CMHC. They happened in the aftermath of my city's 1996 race riots sparked by the shooting of a young Black man by a White police officer. When I rode along with officers, I noticed that people often approached or surrounded officers, sometimes while yelling threats and sexist, racist, or hateful slurs towards officers of various races, ethnicities, and genders. These reactions were not precipitated by any threatening or disrespectful behavior on the part of responding officers. All an officer seemed to need to do to attract anger was "show up" after they were called to a scene.

A 2018 article authored by Jessika Redman and published in *Counseling Today* magazine encouraged CMHCs to consider law enforcement officers a "special population (like military and paramilitary personnel and other first responders) who experience coexisting medical and behavioral health issues with links to job-related stressors," citing research identifying various factors that contribute to mental health impairment of officers (e.g., shift work, long hours, unpredictable schedules, exposure to critical incidents, being the frequent focus of public attention and criticism, various physical demands, high rates of on-the-job injuries).

During and after the riots, officers had to contend not only with the usual stressors and

traumas of policing, but also the added elements of racial tension and civil unrest. Anyone who chooses to become a police officer has to develop a thick skin, but in the aftermath of the race riots it seemed like there was hatred and anger directed at officers at every call, hour after hour, day after day. As my young mind struggled to make sense of child abuse, drug overdoses, premature death, domestic violence, suicide, gang violence, and other social problems I encountered, I thought about the cumulative effect of such exposure for the officers, many of whom were having to work far too many hours a week with little sleep and low pay under stressful and dangerous conditions.

It became clear to me that some of the officers were suffering from low morale and burnout, but I also noted coping strategies like exercise, faith/spirituality, quality time with loved ones, a creative (and sometimes dark) sense of humor, reminders of their belief that they were "making a difference," and in-group comradery. I remember meeting one officer who would stop whenever she saw a stray dog, talk to it, and give it a biscuit. She told me that on some days she doesn't feel like she's making a difference, but then she sees a stray dog and finds a way to feel helpful.

I also remember rare occasions in which I witnessed police actions that I thought were unethical, unnecessary, unwise, or perhaps even illegal. There is one officer in particular, who I felt very uneasy riding with because of his misdirected and intense anger. I remember thinking to myself, "This man should not be a police officer."

I wrote an article on my ride-along experiences at a teacher's request, not realizing it would make me a target for a Black rights group in my community that erroneously assumed that one paragraph was about a Black man. That paragraph was actually about a White man and was published in the same issue as a very passionate anti-racism editorial I wrote. I wanted so badly to convince the activists that I was on their side, but they didn't seem to want to listen.

When I was being falsely accused, I noticed an uncomfortable sensation in the pit of my stomach. The sensations I experienced in my body then reminded me of how I felt when I would exit a police car and automatically be labeled a racist. They were also like what I experienced at 19 years of age when I was illegally detained by a police officer who physically assaulted one of my passengers, falsely accused us of wrongdoing, and yelled slurs at me. (It was a case of mistaken identity, though I was unable to convince the officer of it.).

I have come to recognize this physical sensation as a signal that I am sensing injustice. I felt a profoundly intense version of it when I watched the footage of George Floyd's death and subsequent videos of officers aggressing against nonviolent protestors, but I also noticed it when watching footage of protestors approaching officers of various genders, races, and ethnicities, yelling angry slurs (sometimes even sexist and racist ones) or marching while yelling "Shame!" or "F—k the police!" or "Good cops are dead cops in the faces of officers standing silently by in non-aggressive postures.

These life experiences (and others), coupled with my education, clinical experience, and research, led me to three personal beliefs:

1. Though most officers do good work and are well-intentioned, some were either never psychologically fit for a career in law enforcement or became unfit over time.
2. Police officers have very difficult and stressful jobs, and they can benefit from training,

education, guidance, coaching, and sometimes therapeutic intervention from CMHCs. Such intervention can reduce the likelihood of trauma, burnout, and excessive use of force.

3. During and after periods of civil unrest, racial tension, and riots, the majority of protestors and activists are peaceful and productive, but the righteous anger and indignation felt by oppressed populations and their advocates is sometimes misdirected in ways that unfairly victimize police officers, their supporters (e.g., defacing "back the blue" murals, which recently happened here in the Tampa Bay Area), and innocent members of the community (as is the case with looting, for example).

Interventions with Police Officers

These beliefs play a role in my therapeutic work with police officers, sometimes through employee assistance program (EAP) work, and other times through insurance or private pay. Here are seven principles I have developed in my practice that I hope you will find helpful when working with officers:

1. **Learn about the psychological challenges of police work, what a "day in the life" of an officer is like, and police culture.** Some departments provide "ride-along" programs that CMHCs providing supportive counseling to officers can participate in for educational purposes. CMHCs can also learn by reading the accounts of police officers and clinicians who specialize in working with them or by participating in continuing education related to working with officers. When a CMHC doesn't have much knowledge or experience of police work and culture, it is important to demonstrate an interest in learning about these experiences from clients. Remember that the client is the expert on police work, not you.
2. **Provide psychoeducation on stress and burnout.** I think it is important to avoid coming off as "preachy" when providing this information. I recommend keeping it brief and relevant. CMHCs may also provide in-service trainings or workshops for police departments, either as a volunteer or perhaps through an EAP contract.
3. **Assess the client's stressors and coping strategies.** Assuming it is relevant to their presenting concerns, ask officers what they most like and dislike about their work, what are some of the challenges they are most concerned about, what has been helping them to cope with the unique stressors they face, and what has not helped (i.e., coping strategies that may be self-defeating).
4. **Develop an individualized coping strategies plan.** I explain to clients that during times of unusual stress, it is common to not naturally think of effective methods for releasing pressure or managing stress, and that this problem can be remedied by having a written plan (often kept on a phone). The first items we add to this plan are those that the client has already identified as being helpful. If I do not think those strategies are sufficient (and the client agrees), then I offer the client a coping strategies checklist that can be used to generate ideas of strategies to add to the list. This plan will often include somatic quieting techniques (e.g., progressive muscle relaxation, deep breathing, the grounding 54321 technique, etc.) that can be practiced regularly to de-stress, adequate nutrition, exercise, sleep/rest, and meaningful interactions with social supports. This work can be thought of as stress inoculation therapy, prevention, and/or coping skills training.
5. **Avoid intensive trauma therapy if the officer is currently contending with unusually stressful circumstances.** Though therapies designed to treat trauma, such as prolonged exposure therapy, eye movement desensitization and reprocessing (EMDR), accelerated

resolution therapy (ART), rapid resolution therapy (RRT), emotional freedom techniques (EFT), etc., may be very helpful for officers struggling with PTSD or similar symptoms, they also can sometimes trigger temporary increases in emotional distress. If an officer has to leave a session with a CMHC and then work a double shift in riot gear at a protest where he or she may have to endure intense emotional triggers, it may be best to hold off on initiating such treatments until after the more acute phase of civil rest has subsided.

6. **Consider here-and-now approaches when intensive trauma therapy is contra-indicated.** Solution-focused therapy and cognitive behavioral therapy (CBT) may be helpful approaches. I have found that many officers have responded well to Stoic principles that constitute the theoretical foundation CBT. CMHCs can help officers identify, anticipate, and plan for triggers they will likely experience during their shift. We can also teach them a series of questions they can ask themselves (e.g., the ABCDE method of rational emotive behavior therapy) or counter-thoughts and cognitive reframes they can reflect on in moments in which they are triggered. Utilizing approaches such as Acceptance and Commitment Therapy (ACT) and Mindfulness-Based Cognitive Therapy (MBCT), we can help them to (a) be aware of their emotional states and how those emotions manifest themselves in the body, (b) detach from those experiences, as if observing them from a distance, and (c) choose value-congruent behavioral reactions carefully. CMHCs who have appropriate training can also teach officers verbal de-escalation techniques that can be used when interacting with angry protestors or suspects.
7. **Make good use of the therapeutic relationship.** As with all therapies, the therapeutic relationship is likely the single best predictor of client outcome. Officers need to know that you are nonjudgmental, that you respect their expertise in their profession, that you are making an effort to understand the unique challenges of police work, that you are in-

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A STATEMENT OF THE AMERICAN MENTAL HEALTH COUNSELORS ASSOCIATION ON RACISM AS A SOCIAL DETERMINANT OF MENTAL HEALTH

All across our nation, thousands of Americans have taken to the streets in over 50 cities to protest the killing of George Floyd by a police officer who pressed his knee into Mr. Floyd's neck for over eight minutes as he was pinned down on the ground in handcuffs. It was a collective cry of anguish and a demand for change to what has become commonplace – the killing of unarmed black people at the hands of law enforcement. It is easy to understand the response of multiracial protesters in Minneapolis. If you look closely, hundreds of white people are participating as injustices are apparent to them.

There is significant pain in the heart of our country. And there is significant inequality. While our laws have changed, the reality is that their protections are still not universally applied. Too many people have had enough. They are taking to the streets because this is the only way for them to be heard.

The killing of George Floyd is not an isolated case of the excessive use of lethal force by police. Georgia resident Ahmaud Arbery, 23, was gunned down in February during a so-called citizen's arrest led by a former police officer.

Americans of color, and all of those whose lives have been marginalized by those in power, experience life differently from those whose lives have not been devalued. They experience overt racism and bigotry far too often. They experience fear. A recent study by American University found that more than half of all African Americans surveyed fear interactions with police.

They shoulder a mental health burden that is deeper than what others face. When you must live in fear for your life just for jogging across a street or being accused of passing a bogus $20 bill, you cannot be mentally healthy at the same time.

Let's use this moment to not only address structural racism in the United States, but address disparities in mental health.

The 2001 landmark Surgeon General's report, *Mental Health: Culture, Race, and Ethnicity*, underscored significant disparities in initiation of and engagement in mental health care among persons from racial-ethnic groups. Now, almost 20 years later, these disparities persist, with higher rates of morbidity from decreased engagement in high-quality care, including use of evidence-based medications and mental health therapies.

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), only one-third of African Americans who need mental health care services receive it.

Reasons for lower treatment engagement are multifactorial and range from a lack of culturally informed treatment options to absence of a diverse mental health workforce, racism, mistrust of health care systems, variance in the quality of mental health treatment offered, and lack of attention to the social determinants of health.

Discrimination in its multiple forms (e.g., discrimination based on color or race), is an important social determinant of mental health and may be linked to other determinants including socio-economic status and gender.

We need to address the severity of the problem among adults and children from racial and ethnic groups, with consideration of cultural issues related to higher attrition rates and structural challenges associated with access to care.

For African Americans, racism affects mental health through factors such as poverty and

segregation, which have operated since slavery.

The legacy of slavery and racism, as well as the current realities of racial oppression and violence, has uniquely impacted the mental health of African Americans.

African Americans have higher rates of severe depression yet lower rates of treatment compared to white populations. African Americans are less likely to receive office-based counseling for psychological stressors and are more likely to be seen in emergency rooms.

African Americans endure more intense and frequent mental and behavioral health issues than their counterparts, in a large part related to poverty and exposure to racism and discrimination, both of which disproportionally affect people of color.

Among African Americans, having at least one everyday discrimination experience attributed to race is associated with a greater likelihood of meeting criteria for at least one lifetime anxiety disorder or a lifetime depressive or mood disorder.

Racism and discrimination are stressful events that adversely affect health and mental health, placing people of color at risk for mental health disorders such as depression and anxiety.

We need to explore strategies for dismantling structural racism, including health reform (through public health interventions focused on African American health crises, such as neighborhood violence) and criminal justice reform.

Integrated behavioral health care holds promise for reducing mental health disparities for racial and ethnic groups. Critical components of effective integrated models for people of color include cultural and linguistic competence and a diverse workforce, and emerging best practices. To successfully implement integrated models into practice with people of color will require guidance from communities, consumers and family members, and national experts.

Many African-Americans have difficulty in finding care for mental health services.

Mental health counselors and the profession have a unique role to play in eliminating racial and ethnic mental health disparities. Health care reforms provide an opportunity for mental health counselors to expand on previous efforts and advance a multilevel response to addressing the social determinants of mental health and addictions and reducing disparities.

AMHCA is calling for a multi-faceted counseling response to eliminate disparities in mental health and addiction.

To be effective, such a response must encompass varied elements, including informed counselor education; the growth of a research agenda to better understand social determinants and inform interventions; the provision of culturally responsive, evidence-based clinical services; and policy action on relevant issues such as the impact of incarceration and the criminal justice system on people struggling with mental health and substance use problems.

In AMHCA's, ***"Essentials of the Clinical Mental Health Counseling Profession"*** we emphasize that clinical mental health counselors have historically received graduate education in multi-cultural counseling. We recognize that many community problems – including discrimination and racism – have a significant mental health component. We recognize that many societal problems not only affect individual's live and relationships, but result in economic and mental health burdens on individuals, families, and communities.

Clinical mental health counselors can address discrimination and related risk factors by asking questions, listening carefully and empathically, and showing understanding and

support regarding discriminatory-related sources of stress. African Americans with a mental health condition often have to contend with double discrimination – in which individuals experience discrimination both due to race and as a person with a mental illness.

Special policy proposals to addressing discrimination as a social determinant of mental health should include several local, state and national policies and programs.

At the local and state levels, opportunities exist for the clinical mental health counseling profession to develop policies and procedures for training and education in mental health counseling to extend culturally sensitive knowledge about the nature of social determinants of mental health. Local and state organizations can also play an important role by providing guidelines and strong recommendations for addressing discrimination and bias in general and pertaining to treatments.

The most notable legislation and policies that address race and color discrimination have been at the federal level such as the Civil Rights Act, These laws must be vigorously enforced to protect against a wide range of discriminatory behaviors across our society and sectors. We need to insist that governments need to move swiftly and decisively to address complaints and move legal cases faster. The historical unequal and tardy enforcement of existing policies at the federal and state levels undermines community and citizen confidence in legal civil rights matters.

AMHCA and other associations should assume a greater responsibility in educating and developing effective anti-racism and anti-discrimination movements through collaborations and partnerships with private and government institutions and racial and ethnic communities.

Finally, we need new ideas and approaches to assure that all Americans have access to affordable health insurance coverage and quality health care, and innovative redesign of health systems that promote better access to health care and mental health care services for all communities to break down barriers to needed care and eliminate discriminatory practices.

The time is now to make a difference.

We need major systemic change so that we stop traumatizing people of color. We need new approaches to address systemic racism; address the impact of racial segregation on health outcomes; develop new federal and state policy to reduce health inequities; and identify racism's impact on health outcomes.

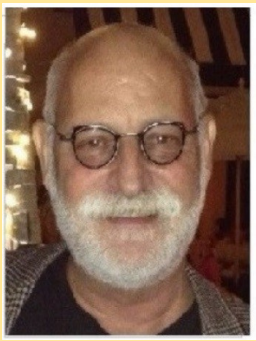
As Martin Luther King said:

"Of all the forms of inequality, injustice in health care is the most shocking and inhumane."

We stand together with all people because as individuals we are inextricably connected to one another. Anything less, is to disavow are own humanity.

American Mental Health Counselors Association

THE PTSD, TRAUMA, ADDICTION CONNECTION



Author: Richard H. Siegel, Ph.D. LMFT
As part of the North Star Centre in Boca Raton, I use Metaphor Therapy to re-associate the dissociated parts of self back into the psyche, dissolving the persistent uncomfortable feelings that fuel addiction.

The majority of adults in treatment for addiction frequently report significant trauma or abuse in their past. Current research supports an undeniable relationship between trauma / abuse and addiction disorders. This is often the result of past issues creating persistent uncomfortable feelings. Though the individual may not be aware of what's happening or why, they are looking for a way to help themselves cope. The addicted person initially attempts to self-medicate, be it with drugs, alcohol, sex, or food...any substance to ease the suffering.

Over time, however, these unwanted feelings fuel behaviors that can lead to self-sabotage, and at times personal disasters. In addition, the trance the psyche goes into while pursuing the substance creates blind spots to the disasters up ahead. To understand how to take control over uncontrollable feelings, first let's address the dynamics of how trauma and abuse create the unwanted feelings that can lead to the need to self-medicate.

The psyche, in an attempt to protect itself from something terrible (emotionally or physically) that's about to happen, freezes in time to prevent the event from occurring. (This is the reason why accident victims still see the car coming at them years later, as if it just happened yesterday.) While it's the nature of reality that time moves forward, a part of self does not. This process is called dissociation and it occurs within the subconscious mind. The term dissociation describes a state of detachment from immediate surroundings or an even more severe detachment, a split of the ego from the psyche. When the psyche splits, we lose a part of self, an unconscious form of self-abandonment.

Dissociation is the process that accounts for the birth of the wounded child within. Frozen in time, this part of self is stuck in the past and very often has custody of the adult's mind and physiology. Meaning that, thoughts, feelings and reactions that are self-destructive and frequently seem to come out of nowhere, actually come from an earlier self, still frozen in a moment of time just before something awful was about to happen. The 'child within' is born within the subconscious during moments of trauma, abuse, loss or rejection.

Frozen in time, it creates a disconnection within the self that leaves a trail of persistent uncomfortable feelings that fuel anxiety, depression and addiction. The child within, born as a survival strategy, becomes the source of an emotional and behavioral stronghold that's hard to break free of. The defense mechanisms we developed as children to prevent pain later in life become an outdated and counter-productive coping mechanism we compulsively use as an adult. So how is it possible to heal the wounded child within through the conscious mind, when the phenomena of dissociation that created the split in the psyche occurred on a subconscious or unconscious level?

The answer lies in the following law of the universe: Whatever you resist, will persist. Whatever you feel, can heal.

For example, if I asked you to resist thinking about a pink elephant for the next thirty seconds, you would be hard pressed NOT to think about that pink elephant. With regard to feelings, if I resist my real feelings, be it fear, anger, shame, guilt or sadness, it becomes inevitable that at some point I will feel these emotions with even greater intensity down the

road; albeit with less emotional control.

On the other hand, if I feel the persistent uncomfortable feelings I don't want to feel...that is if I allow myself to feel the discomfort inside my mind and body.. ??? .ifl allow myself to be with (and not push away) the weight on my shoulder, the lump in my throat, the anxiety in my chest, the knot in my gut, the weakness in my legs, these unwanted feelings will go away. Why? Simply put, feelings don't last when you allow yourself to feel them.

It's when we push feelings away with drugs, numb them with drink, or push them down with food, that, that particular addiction runs our lives. Addiction is an unwillingness to be uncomfortable even as it perpetuates unwanted feelings we want to be rid of. Like a Chinese finger puzzle that only strengthens its grip when we struggle, resisting negative feelings tightens its emotional grip. The solution to the finger puzzle is to push into it, not pull away. So to be released from the grip of anger, guilt, fear, shame, sadness or rejection you can feel your feelings until they lose their grip on you. That is to get comfortable with being uncomfortable until the emotion loses its charge...and its hold on your mind and body. This generates an emotional pain that comes from an unconscious source that is hard to endure. lf happened at a time when the patient was a child, keep in mind that the child's equation is always the same: It's my fault. Hence, we come to accept the notion that we are unlovable. ????? It's very painful to feel unlovable. And, out of that belief, we then act and react to prove this to be true. Why?

Addiction has a double payoff. Drugs and alcohol can suspend bad feelings with stimulation; fill an emptiness, or calm anxiety. Over time, however, it can destroy relationships and careers.

When you're sober and realize the damage you've done, it proves that you're right. you are defective, you are worthless. While the feelings of not being good enough are terrible, it feels good to be right. Being right is one of the strongest drives of all human emotions. Hard to imagine that feeling worthless has a payoff, but it does. Why? Because being right validates us, even when it's at our own expense. Being wrong shames us and shame hurts at the very core of our being. Ever notice how you, or other people, take great pains to avoid being wrong? How many arguments are simply about the desire to be right?

Another factor impeding our ability to stay with feelings long enough for them to lose their charge is fear. We are afraid of letting real feelings come to the surface. Most people will explain, justify, and rationalize their reasons for abusing drugs and alcohol because they're afraid of feeling the pain inside. Some are just afraid to face their fears. As the great, respected philosopher, SpongeBob SquarePants once wisely said, "I don't want to face my fears. I'm afraid of them!"

So what is the answer? The answer still lies in the equation, the law of the universe that: **Whatever you resist will persist and whatever you feel can heal.**

Just as addiction is an unwillingness to feel uncomfortable, sobriety is a willingness to be uncomfortable. In other words, to suffer. Suffering is something that most of us are not very good at, particularly on our own. In order to suffer in a way that heals and doesn't cause more needless pain and anguish, you will need a guide. A mentor— an advisor who is expert in the art of exploring and healing the wounds of the soul. in other words, you need a therapist to guide you from pain to wholeness. A specialist who will heal the pain through the subconscious, get to the core of the feelings and permanently reduce or eliminate them.

There is an old story of a group therapy session where patients were asked to describe themselves as a tree. One woman said she was a mighty oak with lush leaves, rich soil,

basking in the sunlight. When the therapist pointed out that her description sounded a little too pat and perfect, she broke down crying and said that she really felt like a burnt out stump, but was too afraid and ashamed to admit to herself or anyone else how she really felt. it was only when she acknowledged how she felt and explored what that stump looked like, that she noticed a new branch, new life growing out from the back of the bark. Again, resistance creates persistence and whatever you feel can heal.

In addition to working your program and attending meetings, your willingness to explore what's really going on inside of you with someone who can expertly guide you through to the other side, to life, wholeness and restoration, is what will finally free you from addiction.

Dr. Siegel is a Psychotherapist in Deerfield Beach in private practice over 40 years. Dr. Siegel specializes in dissolving the persistent uncomfortable feelings that fuel depression, anxiety, phobias, addictions, PTSD, as well as Wounded Chi/d Within issues. He does Motivation and Performance Coaching with sports professionals from the NFL, PGA, USPTA, NCAA Teams and University Coaches. He can be reached at 954-420-0755

Lessons Learned in Providing Online Counseling During COVID-19

Richard Long, Ph.D., LMFT is recognized as a Board Certified-TeleMental Health Provider. He is an AAMFT Clinical Fellow, Approved Supervisor and a Florida Qualified Mental Health Counselor Supervisor. He chairs AAMFT's Telehealth and Technology Interest Network. He was recently appointed to the editorial board of the Journal of Technology and Behavioral Sciences
Rlong540@gmail.com

Many counselors agree with Gayle King, Co-Anchor of *CBS This Morning*, during a recent interview recap, when she paraphrased Sara Bareilles, American singer-song writing saying, "a screen is a flimsy surrogate for human connection". Yet as Harriet Brown says in July 6, 2020, article in Vice, after trying remote therapy, some may never go back to in-person sessions. Aaron Norton, in a presentation entitled, "Telehealth for Counselors: Zooming into a New Era", relates a total of 51% of those surveyed practiced telehealth exclusively as of 5/29/2020.

What follows is an attempt to point out five lessons learned from what for many was a conversion experience. Each lesson is meant to invite counselors to reflect on their own online practice, asking—"what is working and what is not working? What am I getting right? What am I getting wrong?"

1. Online counselors should observe and comment on what they see on their screen. In-person sessions do not tell us about a client's connections to a client's pets. Are there pets in the room? Are they in the lap of the client or quietly sitting to the side? What about a beverage? Is there a cup of coffee near the lap top or a bottle of scotch? What about the art work in the room, if any? Does it tell us something about a client's connection to nature, heritage, gender, etc. What room is the client in and what is our reaction to the choice of rooms. A client choosing to the put the laptop in a bedroom is giving us different information than a client who set up the laptop in the kitchen. Of course, there is the potential a tit for tat discussion of the setting, so counselors need to be ready to talk about their own recording environment.
2. Online counselors should give their clients instructions about how to complete an intake packet. Granted there is a lot to cover, but clients will become more comfortable faster when they understand how therapy will work online. What information does the counselor require? How does the counselor secure releases of information? What is the back-up plan for those times when there are technical glitches—poor video, poor audio? What is the

counselor's plan for handling an emergency session? Even though most of these instructions are provided on a website, not all clients learn best by reading.

3. Online counselors should project more energy online than they project in-person. The premise here is that media streaming applications are the counselor's competitors. A client's attention may drift when participating in a talking-head-only 50-minute session. This means that the counselor needs to be positioned close to the webcam and must maintain eye contact that is direct and demonstrates an interest in the thoughts, feelings, and behavior of the client. Counselors need to use their voice effectively, aware that variations in vocal pitch can help project attunement to the client's concerns or issues. Above all, counselors need to recognize that more energy is required to provide effective online counseling as compared to in-person counseling.
4. Counselors should use more experientially-based approaches than psycho-educational, classical approaches when using technology-assisted services. This is not to discredit the latter models rather, the issue is one of adjusting to the requirements of the medium. Gestalt-oriented individual therapy, emotionally-focused therapy for individuals and couples, functional family therapy and structural family therapy all invite greater levels of engagement than listening to a lecture on the differences between I - Messages and You-Messages, for example.
5. Online counselors should slow down when it comes to processing the emotional content of an online session. Any counselor who has watched a recording of Carl Rogers doing a consultation is struck by the way he uses stillness during the consultation. It is when he is listening, leaning forward, and giving direct eye contact that change happens for the client. Recall the days when as counselors-in-training we were told by our supervisors to silently count backwards from 100 before jumping in with an unexpected question or insight.

While this list of lessons learned is not exhaustive, it does raise the question of how online counseling differs from in-person counseling. Of the five lessons learned, which one(s) do you agree or disagree with? What would you add to list based on your experience providing counseling during COVID-19?

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Adoption of a measurement-based care approach in a mental health counselor practice setting:

By Julia S. Finken, RN, BSN, MBA, CSSBB, CPHQ. Ms. Finken is the Executive Director of Behavioral Health Care and Human Services for The Joint Commission. In this role, Ms. Finken leads strategy and growth for the Behavioral Health Care and Human Services Accreditation program.

As most mental health professionals might know, nearly two decades of research support the benefits of measurement-based care in behavioral and mental health care settings. This method of care is also known as routine outcome measurement, outcome-informed care, feedback-informed treatment or the demonstration of client outcomes. Measurement-based care refers to the use of an objective instrument to track the impact of care, treatment or services throughout the course of those services. Client data is collected at repeated intervals (weekly, monthly, etc.) and change in an individual's condition is regularly evaluated in order to adjust the care provided as needed.

Selecting an instrument to collect and analyze client data

One of the most important decisions an organization can make when transitioning to measurement-based care is selecting an appropriate instrument to collect and evaluate data. Organizations should seek instruments that:

- Have well-established reliability and validity for use as a repeated measure.
- Are sensitive to change.
- Are capable of discriminating between populations that may or may not benefit from services (if appropriate).

While organizations may look for additional criteria specific to the population of the individuals they serve, these minimum recommendations can guide organizations as they select the most relevant tool for their clients.

For more information, this collection of instruments has been reviewed by The Joint Commission to meet the above recommendations.

Implementing measurement-based care

The Joint Commission now requires its accredited behavioral health and human services organizations to implement measurement-based care. After conducting over 2,500 surveys and having discussions with organizations

Author's note: The Joint Commission has compiled these free resources for organizations that want to adopt measurement-based care:

- R3 Report
- Outcome Measurement Resource Page

implementing measurement-based care, the most successful organizations have a few things in common.
These include:

- Integrating measurement and feedback into the existing workflow.
- Discussing data during supervision and team meetings.
- Onboarding new staff to the process.
- Evaluating staff performance in administering the tool.
- Investing in compliance audits and staff coaching.
- Reminding staff to use the tool.
- Setting expectations early on that individuals served will discuss their data and progress with their treatment team.

Each organization knows their staff and clients best and, therefore, will have their own process for rolling out the use of a measurement-based care instrument and ensuring providers properly and consistently use the instrument. However, the important takeaway here is that the organization *has* a standardized system to ensure easy compliance. This way, all staff will know what is expected of them.

Increasing clinician buy-in

For many clinicians who have relied on their clinical judgment and experience as the primary method for assessing client progress, the implementation of measurement-based care may require a significant cultural shift. While measurement-based care is not intended to replace clinical judgment, it may be the first time that clinicians and staff have incorporated objective data into the care process or used it to track progress. Leaders seeking to implement measurement-based care in their organizations should expect questions and be prepared to provide support to clinicians throughout the transition. Specifically, leaders should consider:

- ***What education/training will be provided to staff in preparation for implementation? How should this training be provided?*** Staff will require effective training to ensure they are able to use the measurement instrument and are comfortable engaging clients in discussion about the data.
- ***What training will staff receive on interpreting the data?*** Each tool may have its own nuances, and clinicians will benefit from a proper understanding of what is being measured and how to interpret changes from one data point to the next.
- ***Are staff who are supposed to use and interpret the data aware of the instrument's key elements?*** Staff should be given background on measures such as when to administer the instrument to clients, the range of potential scores, and what reliable change looks like for each client.
- ***Do leaders track instrument administration by clinician?*** Leaders can provide support to clinicians if they have a fuller understanding of how the instrument is being used and if individuals served are seeing benefit.
- ***How do leaders address low compliance rates?*** There is always a chance that some clinicians may not see the point of transitioning from their current approach to measurement-based care. Leaders should anticipate resistance to change and be prepared to address it (e.g., identifying and engaging clinician champions who can address peers with low compliance rates and emphasize the benefits of following evidence-based best practices).

Whether transitioning to measurement-based care is a minor or major shift for an organization, these considerations can provide guidance and an opportunity to reflect about how to get clinicians on board.

Adjusting to meet client and organizational goals

When an organization or clinician first implements measurement-based care for mental health services, they must make decisions about strategies and tactics as they learn to collect and analyze client data. While the instrument can serve as a guide that an organization selects, expert evaluation of the data is a vital component of client care.

So far, in discussions with our accredited organizations, The Joint Commission has observed that clinician engagement with the data is key to clients achieving maximum improvement. Clinicians and organizational leaders should always look for opportunities to improve their practices; these individuals can ask themselves the following questions to assess the use of measurement-based care:

- ***How quickly is individual client data analyzed and delivered to the service provider as objective feedback?*** Leaders can initiate conversations with clinicians to discuss how measurement-based care can be best used and improved.
- ***Is the provider using this feedback to monitor progress and inform goals and objectives?*** Objective data and clinical judgment about progress don't always align – and that is one of the key benefits of measurement-based care. Talking to both colleagues and clients about these discrepancies can help identify opportunities to adapt care and avoid missteps.
- ***Is the data used to identify potential deterioration and inform decisions related to changes in individual plans for care, treatment or services****?* Measurement-based care is generally so effective because data, rather than other subjective measures, can be used to alert clinicians to potential problems and indicate when it's time for a change in treatment plan.
- ***How does the organization aggregate data from all individuals treated?*** A valuable secondary benefit from the collection of individual client data (using a standardized instrument) is that the data can be aggregated by the organization to assess broader performance questions.
    - ***Does the organization calculate differences in pre-post scores and how are such differences compared?*** Understanding the effect of services from initial contact through the end of service is a key metric in its own right, but it can also be used to assess differences between programs or clinicians, or over time. The organization should be thoughtful about how such comparisons are made (i.e., using sound statistical tests) to ensure that variation in client severity and other factors are accounted for.
    - ***Are aggregate data used to help clinicians predict future outcomes for clients?*** If data can be used to help clinicians predict how long it will take to see change in their clients, they can help adjust their clients' and their own expectations to help foster trust in the process.

According to feedback from accredited organizations that have successfully implemented measurement-based care, clients have also found value in tracking changes in their own mental health and discussing scores with their providers.

Since clinicians' highest priorities are their clients, all should be open to strategies and methods of care that will best serve them. It is The Joint Commission's hope that all mental health organizations will move toward practicing measurement-based care to give their clients the best opportunity for improvement.

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AMHCA RELEASES NEW STUDY ON INCREASING PREVALENCE OF MENTAL HEALTH DISORDERS

American Mental Health Counselors Association

Hi Folks,

As reported at the July Board meeting, AMHCA has now released a major report today on the number of Americans reporting mental health distress over the last few months. Please see our new study – "**Beyond A Perfect *Storm – How Racism, Covid-19, and Economic Meltdown Imperil Our Mental* Health"** and our press release on the study.
https://www.amhca.org/viewdocument/beyond-a-perfect-storm-how-racism?submissionGuid=0a64b2ba-d51e-45d4-bf44-556b4586fbaa
https://www.prnewswire.com/news-releases/new-study-shows-more-than-100-million-americans-will-suffer-a-mental-health-disorder-this-year-301116506.html?tc=eml_cleartime

The Press Release was disseminated through a major news service -- **PR Newswire** – to thousands of media outlets, heath care reporters, a special media list of mental health care contacts in the media, Members of Congress, behavioral health associations, and many other decision-makers.

Based on the AMHCA report, nearly 41 percent of adults nationally are reporting that they are suffering from a mental health disorder -- or about 103 million adults in the U.S.
The AMHCA study is based on surveys developed by the U.S. Census Bureau, Centers for Disease and Prevention, and the National Center for Health Statistics. For more information, please see the link below to a key table through the *Census Bureau Pulse Survey*.
https://www.cdc.gov/nchs/covid19/pulse/mental-health.htm
Please scroll through that table and you will find specific information on your state as well.

I hope this information is useful, and for more information about the study, please contact me at 703-548-4474.
Best,
Joel E. Miller
Executive Director and CEO

THE FAMILY PRIDE MODEL

Author:
William J. Carr

Problem: Kids die from suicide
Problem: Kids often need hospitalization.
Solution: The Family Pride Model of intervention and assessment for suicidal kids and their parents has prevented youth suicide and left hospitalization rarely needed.
I want to teach this model to help clinicians help kids and families, maybe change the world. I developed this approach and used it many times. I offer thorough training on the model and have just published a book describing how to perform it. The book is called "Family Pride: The Opportunity of Crisis (Preventing Teen Suicide). Amazon.

The name "Family Pride" comes from the discovery that family pride, when combined with crisis energy, brings opportunity for very positive change.

Crisis energy creates negative action. It can involve family conflict or outside agents. However, when soothed, crisis energy can become positive and provide a fertile opportunity. So, you must soothe crisis energy and focus it.

Family pride emanates from the story of the parents' lives. It is fondness and struggle from a lifetime of experience. It is a unique force that fosters positive energy. Mixed with the soothed crisis energy, it prompts solution and family growth. So, you must generate family pride.

The focus of this approach is on youths who are feared to be suicidal, are angry, despondent, or marked as losers. And on their parents who are stressed, fearful or distanced. There may surely be family conflict, but the parents' ultimate fear is that their kid could die from suicide.

So, we have a kid in psychiatric crisis and the parents. The model simultaneously evaluates and intervenes with both. It shows how to save the teen, immediately, AND how to restore a family's hopefulness and harmony.

The model evaluates and makes change in one day, in a couple of hours. It safely resolves crisis, makes progress with ongoing issues and sets up aftercare. The youth remains at home. Hospitalization is rarely needed.
I teach how to do all of this model, step-by-step.

Seeing the youth alone, the clinician must evaluate and also help the youth to be cooperative and to feel competent. The teen then moves forward in the family, becoming calm and reachable.

However, the primary focus of the intervention is not the youth alone but drawing the family together, as an active unit, to address the problem. Seeing the parents and youth together is a key. Parental involvement is huge, especially the presence of the under-involved parent.

Together, the parents give you their perspective of things, their view of the teen. With the three together, you can see family interaction and, most importantly, you can change family interaction. People do change in this process.

So, as you continue, the parents are inspired by family pride and the youth is stabilized. Family communication is at hand. This sets up the intensive family discussion that resolves the crisis and family conflict and addresses ongoing problems. The resolution of teen crisis lies in the family, no matter how fractured it is.

Clinically based, the model is complex but employs common sense. Achieving all of this in crisis is a challenge and that is why I instruct specifically.

This is not a twenty-five minute snapshot of the kid. This approach takes a good bit of time to get to know the clients and gives them time to trust the clinician. As well, saving the cost of unneeded hospitalization is very important and requires patience.

A last thought on crisis. This model makes crisis easier to tolerate so it can be comfortably addressed. Crisis can be scary, even to seasoned professionals.

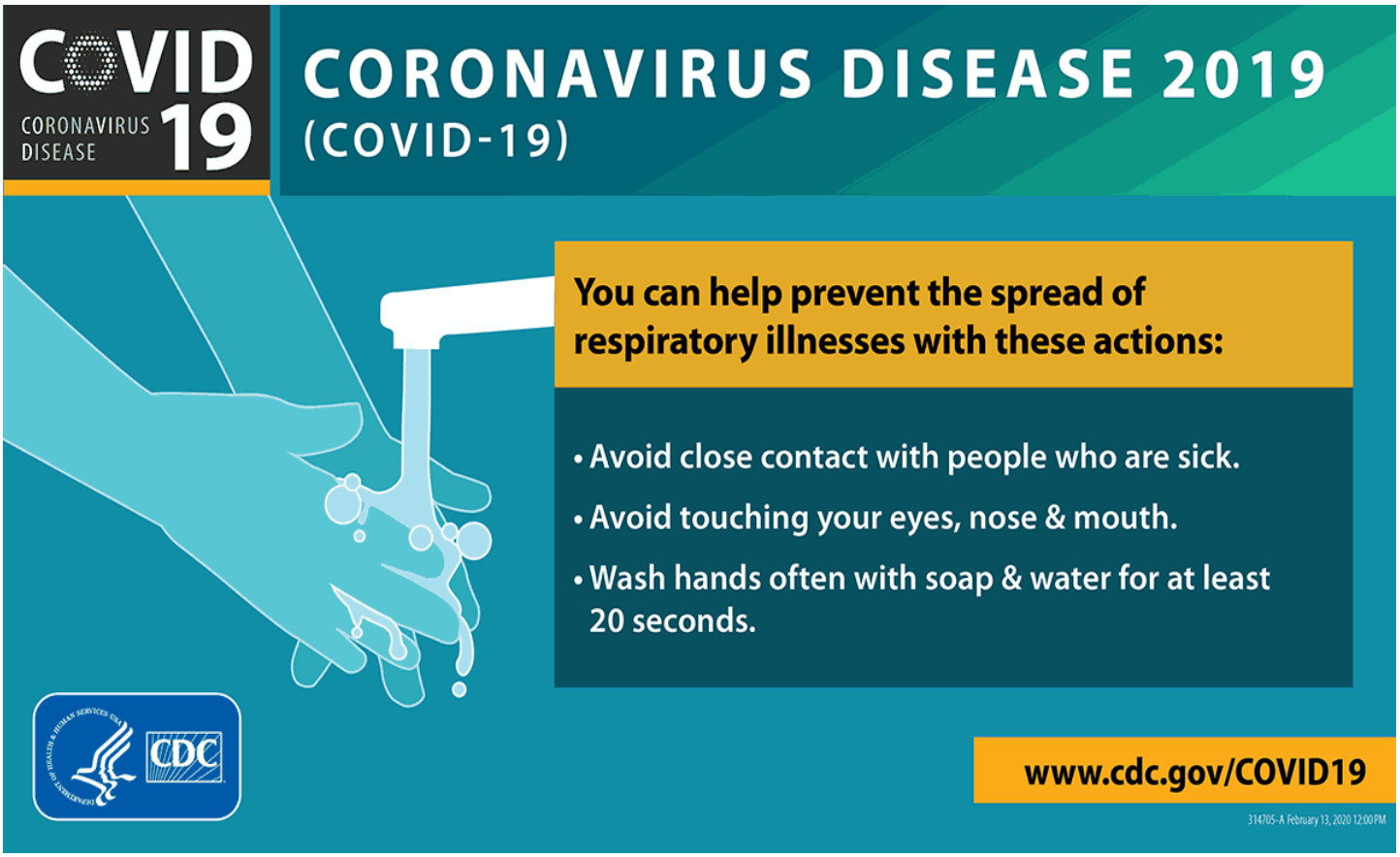
A clinician may quickly feel that the best thing to do is to send a possibly suicidal teen to a hospital. I disagree. Do not separate parents and youth without a full attempt at intervention. If you do, you will lose the opportunity of crisis. However, I do say an appropriate model of intervention is always needed.

Karen R. Koenig, LCSW, M.Ed, is a psychotherapist specializing in eating psychology, an international, award-winning author of seven books on eating, weight and body image, and a popular blogger. She has been practicing for 30-plus years and is currently living and working out of Sarasota, Florida where she is finishing her eighth book to be published in 2021.

8 Reasons That Clients Defy or Ignore COVID-19 Safeguards

Whether you're amazed or angered that clients are still gathering in large groups, hugging and waltzing around mask-free in public, it's helpful to view these behaviors as you would any others you deem as unhealthy. Here are two examples of the kinds of people, some of whom are our clients, I'm talking about.

In April, as I was pushing my shopping cart down the supermarket aisle in the direction of the floor arrow, a similarly aged older woman came straight at me with her cart. Trying to be of help, I pointed to the arrow and said, "You're going the wrong way." Instead of apologizing, she smiled as she passed by and said, "I know." An ignorer, obviously.



Then there's my local newspaper's description of Phillip Davis from Plant City, Florida who said he was "'kind of looking forward to gridlock' in Sarasota because he wanted to push back against what he described as heavy-handed government regulation." He added that "he doesn't mind greeting strangers who extend a handshake, 'although I may not touch my face afterwards.' Clearly, a defier.

Fortunately, most people—and most of our clients—practice and support COVID-19 safeguards because they believe that doing otherwise would endanger themselves, their loved ones and society at large. However, for those clients who need our help to see the light, here are eight psychological, likely unconscious, reasons they might ignore or defy COVID-19 precautions:

1. *Low frustration tolerance*. Clients who get frustrated at the drop of a hat never learned how to pace themselves, stay goal-focused, and self-soothe when life gets tough. This pandemic has produced a perfect storm for massive frustration on nearly every front and these clients are at a loss without the skills they need to survive it. It sometimes simply feels too overwhelming for them to remember to put on their masks, use hand sanitizer and social distance everywhere they go.
2. *Confusing care and control*. Clients who were raised by controlling, critical, demanding, and domineering parents often cannot tell the very real difference between being cared for and being controlled. They're convinced that others want to wrest power and autonomy from them, even when people are actually offering heartfelt concern and care. With their guard constantly up, they may interpret being asked to wear a protective mask in public not as a thoughtful reminder to stay safe, but as an attack on their autonomy and decision-making prowess.
3. *Rebellion*. Growing up with authoritarian, my-way-or-the-highway parents, clients may have had to squelch their own anger to survive and vowed that in adulthood they'd never let anyone tell them what to do. Now, still fighting childhood authority demons, they react without considering whether their actions are helpful or hurtful to themselves or others. The fact that an authority figure, even you, wants them to do something to take care of themselves is enough to make them adhere to an opposing stance.
4. *Victimhood*. Clients who as children were victimized by having their rights trampled on by parents, teachers, community or our culture may carry around wounds of victimhood as adults and see slights, insults, and unfairness where none are intended. Clients insisting "I

have rights" often comes from having had too few of them growing up and from having been victims (of parents or society) for far too long. Sadly, now, when they *can* say whatever they want, they're still fighting to be heard and validated.

5. *Fear*. Unfortunately, many clients were reared by parents who shamed and humiliated them for showing fear. As adults, they continue to hide feeling scared and vulnerable, masking their fear with a persona of toughness, even brashness. Taking dangerous risks and denying their fear to others and themselves makes them feel strong and invincible. Afraid to be afraid, they instead deny the potential threat of illness or death via pandemic.
6. *Despair*. Clients who suffered extended and chronic early powerlessness run the risk of suffering from depression and even chronic despair. Their antidote to both is a rage which makes them feel strong and invulnerable instead of puny and weak. As long as they are enraged and defiant about pandemic restrictions, they feel powerful, alive and triumphant. Without it, they feel terrified and doomed.
7. *Poor self-care*. Neglect and abuse in childhood may lead clients to believe that they deserved poor treatment and still aren't worthy of health and happiness. Their major and minor personal choices are often self-destructive, repeatedly boomeranging around to convince them of their worthlessness. They believe it doesn't matter if they take care of themselves, so they don't.
8. *Entitlement*. Clients who, as children and adolescents, were regularly allowed to break rules without suffering consequences often grow up believing that rules don't apply to them and that they can do whatever they want and nothing bad will befall them. They live in a fantasy world in which what happens to others will never happen to them and no matter what they do, they and theirs are so special and unique that they will survive COVID-19 unscathed.

Next time you're talking with a client who ignores or defies COVID-19 safeguards, rather than rear back in protest, tut-tut silently in disgust or shrug in resignation, consider how the mistreatment they endured growing up robbed them of rationality, feelings of self-worth, a healthy fear of danger, and a passion to keep themselves safe from harm. With compassion and careful timing, therapists can both make positive inroads toward clients protecting themselves from the novel coronavirus and serve the greater social good as well.

Join us on Friday 9/25/20! To register and learn more about this webinar please visit: https://fmhca.wildapricot.org/event-3849820

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Author: Maria A. Avila, LMFT, MCAP is a licensed marriage and family therapist and master's level certified addiction specialist in private practice. She has over 30 years of experience working with individuals, couples and families. Along with her extensive clinical experience she has taught at Barry University and the University of Miami and has conducted numerous workshops, presentations and facilitated different groups. Her specialization as an addiction professional has helped her deal with the effects of addiction in relationships. She created a website especially for those struggling with this issue. You can visit this website at substanceabuseanswers.com. Maria is practicing virtually and has an office in both Dade and Broward county. See her website for more details, MariaAAvila.com

Opportunity or Curse?

Relationships in today's world have evolved in many ways; some ways better and some worse. Families and couples have had challenges connecting with the developments of our time and the changing circumstances. They have also had opportunities as result of these changes. The pandemic we are facing throughout the world has created more opportunities for closeness. For those who are able to work from home it means spending less time on the road and away from loved ones, which can be an advantage, while at the same time it can be a struggle for some with this level of closeness. Could this crisis that we are all facing help us to grow and find comfort in the confinement of our living spaces with one another, or could it be a detriment to some relationships?

Let's look at some of the challenges in relationships that have existed before COVID-19. Technology has provided vast ways for us to seek information, expand our learning and connect with others far away. At the same time, we see the reliance technology has inflicted upon us. Cellphones and computers used to be novelties and luxuries that not all could afford; today they have become necessities and a way of life. There is a seductive manner in which they draw our attention and eat enormous amounts of time. This time is now monitored to inform us if our time has increased or decreased each week on these machines. This deters from our ability to focus on other important aspects of our life, such as relationships. A study from the University of California Irvine reported that it could take up to 23 minutes to refocus our attention to something else once we stop looking at a screen. Notice the type of interactions you see at restaurants or other social interactions. People's attention is downward toward their phones, rather than directly in front of them, even when they are crossing the street! Technology gives us the illusion that we are able to connect more, not less. It makes us think that we can have more interactions with others as a result. The problem is this type of interaction can be more superficial and considerably less intimate. During these times when we are forced to stay home more and travel less, are we spending the time with those important to us in more meaningful ways or are we more attuned to those screens we talk or type on?

Consider our perception of time. Technology has certainly impacted how we deal with time. The Center for Creative Leadership in 2015 came out with a study that indicated that 60% of those using smartphones work about 13.5 -18.5 hours a day. For those able to work from home during the pandemic, is the amount of time expected by employers more than usual as a result? In some countries it is said that time passes whereas in our country time seems to run. What does this say about how we live our lives? A 2012 study from the University of Toronto revealed when money is equated with time there was an increase in unhappiness and impatience. Increasing the value of work puts pressure on all time. As a result, leisure time is equated with stress as people feel the need to use it wisely. There is a common notion that being pressured is a sign of prosperity. There was a parenting conference I attended some years ago that spoke about a study that was done to assess the quality of time parents spend with their children. From this study it was found that an average of 25 minutes of day was the time parents had with their child in a meaningful way. Is COVID-19 providing us opportunities to break these patterns and deal with time differently so as to establish better connections?

Let's look at the opportunities these circumstances may give us. In looking at how we communicate, how intimate we are, how vulnerable we allow ourselves to be, we can begin to reconnect differently. If we accept that the goal of communication is the ability to connect, then how are we listening and talking to one another? Sometimes people think that they are truly listening when in fact they are only hearing. One can hear sounds, words and other noises, which does not ensure true listening. Often we can become stuck on the actual words versus more meaningful and subtle signs that tone and body language deliver. Steven R. Covey, in his book *The Seven Habits of Highly Effective People* comments on this process by saying, "Most people do not listen with the intent to understand; They listen with the intent to reply." Can we work on listening and really understanding where the other person is coming from or is being right more important?

The second component in being able to connect more fully is looking at how we speak with one another. Most people think that talking is mainly the ability to express words whereas in fact the ability to validate when one talks can have far greater benefits. Validation is simply acknowledging what you heard another say. It does not mean that you agree or even understand. Validation offers the chance for the dialogue to continue at a much deeper level. Reverend Dr. Pamela Feeser in her book *Becoming: A Spiritual Journey*, says:" We cannot assume responsibility for how others hear us; however, we can hold ourselves accountable to how we communicate with others." We should take into account the following points when talking:

1. You don't have to agree with the other person.
2. It is important to have mutual respect.
3. Be willing to look at different perspectives.
4. Take responsibility for your words and behavior versus blaming others for them.
5. Talk to one another directly versus going through other people to deliver the message.
6. Be honest, it conveys genuineness and vulnerability.

Speaking of vulnerability, here we have a very misunderstood concept that often is dismissed in our relationships. Commonly seen as a sign of weakness, vulnerability is, according to Brene Brown who is known for her research in this area as, “uncertainty, risk, and emotional exposure”. Being vulnerable allows us to be more intimate emotionally, intellectually and physically. There was a quote I discovered by Lisa A. Roberts in *Psychology Today* a few years ago that described this type of closeness. She stated that intimacy is “emotional slow food, the lovingly home cooked meal in a world of drive-thru orders.”

In summary, let's reflect on lessons learned from this pandemic to help in our relationships. Can we use the time allotted by this period of confinement in a more meaningful way to connect more deeply with one another? Can we use the lack of distractions that shopping, traffic and other daily activities prior to COVID-19 provided to be still and calm our minds? A study conducted by Matt Killingsworth in 2011 demonstrated how technology encouraged multitasking and mind wandering. The study found that 47% of people are thinking of something else other than what they are doing. The less our mind wanders the happier we are, since mind wandering tends to lead to unpleasant thoughts. This is why the concept of Mindfulness has been so helpful in our society although difficult to practice. Can we take the time to focus on what’s important rather than on what we are missing out on by not being able to live as busily as we did? Maybe the answers to these questions are what we need to help determine the future of our relationships.

Spontaneity and Creativity in the Time of COVID-19, or How I Connected both to Myself and Others through the Creative Process while Sheltering in Place

It isn't easy converting a counseling and training practice highly dependent on group interaction and arts-based interventions to a screen sized version of a world once so rich in resources. But it would be hypocritical as a social worker and expressive arts trainer not to:
1) get over my view of Telehealth as an inadequate form of communication;
2) mourn the loss of one-on-one connection and all the other grieving that was fostering in its wake and finally;
3) look for creative responses to connect to clients and training colleagues, not to mention friends and family, I so desperately missed.

JL Moreno, the creator of Psychodrama, defines Spontaneity as an adequate response to a new situation or a novel response to an old situation. It is the spark that ignites creativity. Creativity is the ability to make something or otherwise bring into existence something new.

Every one of us is inherently creative. For some of us, this may be the way we combine the various disciplines and methods we are trained in to form – through the alchemy that is creation – a practice that is rich in your own brand of individuality. We often miss our own creative process or deny or question our ability to be creative. It may take a bit of mining the day-to-day to discover or remind us that the meal we prepared, the garden we tilled or the photo we so thoughtfully snapped on an afternoon walk are all acts of creation. My belief is any gesture in which we connect – to ourselves or others – is a creative act.

So back to my quest to harness my creativity in at minimum an adequate response to this new situation we were all facing: COVID-19 and Shelter in Place. Days 1 through 5 were ones of resentment, denial and a bit of feeling sorry for myself. I had just started my first Psychodrama client group, and I suspended it after only the opening session. It had taken me three years of marketing and an agonizingly slow build-up of a private practice, and I felt cheated by the universe. Although many of my colleagues were taking the leap from in-person to cyber groups, without exception the group members had been meeting regularly and were psychodrama savvy and had coalesced as therapeutic agents of one another. Other trainers were almost immediately offering Zoom classes and Zoom groups and embracing rather than resisting technology.

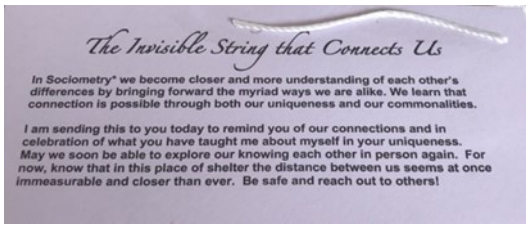
On day 6, after taking whatever webinar I could find on telehealth and checking in with whoever would listen about the injustice I was experiencing, I had my first Zoom individual session. It was successful, but still lacked the feeling of connection I was so used to. I had sent out an email to all my clients stating my availability by phone or telehealth platforms, but felt I needed to reach out in more interesting ways to manage both their and my feelings of uncertainty with where the world was going.

On day 7 I woke up after a dream of exotic locals and a spark of spontaneity was the catalyst for me to gather together the unused postcards I had accumulated over years of travel. I developed a message for clients and a separate one for friends and family and starting sending out the cards (in envelopes for confidentiality to clients) and when I ran out of unused cards, I went to the basket of postcards received from others over 40 years and pasted over the original message and sent those out. Within a week or so, I started getting postcards and invi-

tations to events postponed by COVID's arrival and homemade cards back from others – an unexpected bonus.

Zoom sessions continued, now enhanced by the snail mail connection we shared. I started working with my sister, a website developer, on re-creating my site to more reflect who I am and what I do. I found myself on Facebook for the first time, writing poetry and essays on COVID-19 and its resurgence of feelings from the AIDS pandemic of so many years ago. I created Sandtray vignettes about COVID's intrusion in our lives and posted them on social media and emailed them to clients and colleagues, captioning them with encouraging messages.

After the success of my first snail mail campaign (and I must confess I love getting cards and letters in the mail – nothing like it) I came up with campaign number two: The Invisible String that Connects Us. I sent out over two hundred of these messages to psychodrama, social work and mental health colleagues, friends, family members and clients.

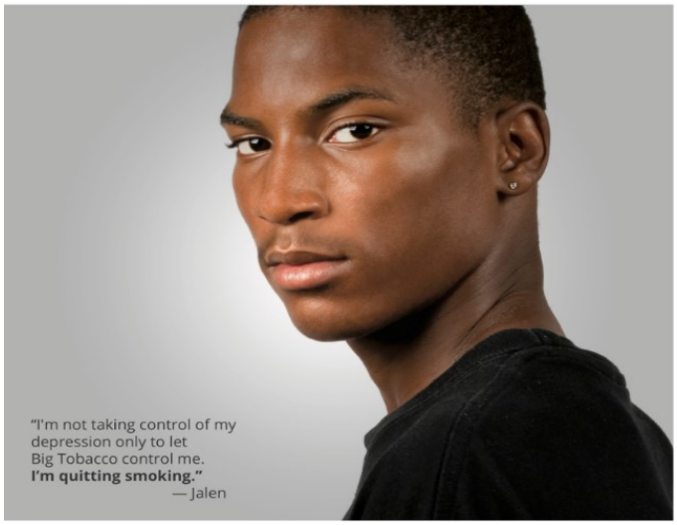


In the interim, I started receiving colleagues and friend's creative ways of coping with COVID shutdown. My friend and fellow therapist Gail Gerbie sent me a letter with lovingly created affirmation cards and writing prompts she had sent out to her clients and colleagues. All over social media people were posting their artistic efforts exploring living in shelter and uncertainty. Amist the drawings, collages and paintings there was also bread-making, Zoom Seders and Easter dinners and sidewalk chalk universes. There were essays and poetry coupling COVID-19 to unexpressed grief and unresolved pain, all such beautiful acknowledgement that we were not alone in trying to sort out some meaning and to hold onto connection to one another. On-line support venues from the social work and expressive arts communities started to blossom as well.

Moreno also stated, "All creators are alone until their love of creating forms a world around them." Now, on day 30, I have a new view of telehealth. I will take creativity and connection however I can get it. Some say COVID-19 will alter the way we do business in the mental health field forever. Some clients will prefer the distance provided by their computer screen, and others just mange to feel connected no matter what the medium. Although I will always be in the latter category, I take solace in the world that has opened up to me through technology and I look forward to finding creative, connecting ways to make it more a part of who I am. But I'm not surrendering my art supplies anytime soon.

Author: Paul Lesnik, LCSW, TEP, is a Clinical Social Worker and Psychodrama and Expressive Arts Trainer based in San Diego. He works in many Expressive Arts modalities, including Psychodrama, Sandtray and Soul Collage® with clients. He conducts training groups for clinicians and mental health professionals in infusing psychodrama and the arts into their practice. He is the only Board-Certified Psychodrama Trainer in San Diego County.

He has presented nationally on many topics, most recently on Exploring Gender Identity as an Aspect of Spirituality, Scene Setting in Psychodrama, and Exploring Identity Development through the Arts. He can be reached at paul.lesnik@gmail.com 619-780-7670, digdeepertherapy.com



Reducing COVID-19 Risks for Individuals who Smoke and Vape

The news is full of information about continued threats from the Coronavirus including risk factors which increase vulnerability to the virus. Smokers and people who vape are at a higher risk due to the fact that the virus attacks the lungs. There are well documented health consequences from smoking and vaping, particularly major health problems to the respiratory system. The smoke that is being inhaled into a smokers' lungs contains toxins and known carcinogens which damage the cells in the body that help fight off infections. These damaged cells no longer can work at full capacity thus increasing the risk of infection. The two lung conditions mostly related to vaping are cytotoxicity and popcorn lung, which is linked to the flavoring compounds, and of course the EVALI (E-cigarette, or vaping product use associated lung injury) that leads to severe breathing problems, lung injury and death. The CDC website has more information about EVALI.

About 70% of tobacco users with mental illnesses and substance use disorders want to quit (the same percentage as the general population). And with all of the information in the news about the increase risk of contracting the COVID-19 virus among smokers and vapers, we are seeing an increased interest in quitting. Mental health and addiction counselors are in a unique position to refer their clients to free Tobacco Free Florida cessation services. Although treatment for Tobacco Use Disorder is the most cost-effective and morbidity-reducing of 30 preventive services, it is often overlooked in mental health and addictions treatment. In addition to improvements in physical health, quitting leads to improvements in depression, anxiety, and overall psychological quality of life.

There are many options to help people quit. Tobacco Free Florida offers on-line classes, telephone coaching and self-help tools. The on-line classes are provided by a statewide network of Area Health Education Centers (AHEC). These free classes are listed for every area in Florida at www.AHECtobacco.com. Classes also provide free Nicotine replacement Therapy (NRT) medications (based on what is medically appropriate). Even though classes are on-line, they still have same content and instructors as in person. People will still have the tools to interact with others who are on the same journey. They are also able to invite friends and family to join the sessions. This will help them get the support needed to be a successful quitter. There are two different paths clients can take to quit. The "Quit Smoking Now" class has four weekly sessions while "Tools To Quit" is a one-time class.

Quitting tobacco is a major component of overall health and wellness, and all clinicians and Recovery Peer Specialists have the skills and experience to help clients address this neglected addiction. Even if a person does not immediately embrace quitting, receiving a recommendation from a trusted health professional or peer specialist significantly improves willingness to give quitting another try.

1. NIDA. COVID-19: Potential Implications for Individuals with Substance Use Disorders. 2020, April 6.
2. BMJ 2014;348:g2216
3. Fiore MC, Baker TB. Clinical practice. Treating smokers in the health care setting. N Engl J Med. 2011 Sep 29;365(13):1222-31. doi: 10.1056/NEJMcp1101512. Review.

Author: Andree Aubrey is the Director of the Area Health Education Center at FSU College of Medicine. Since 2007, she has been training clinicians to treat Tobacco Use Disorder with a special focus on individuals living with mental illness and other substance use disorders. Under her leadership, the FSU AHEC team has developed a nationally accredited Tobacco Treatment Specialist course which has trained over 1,000 health professionals. She is a speaker for state and national conferences and advocate for tobacco disparities populations.

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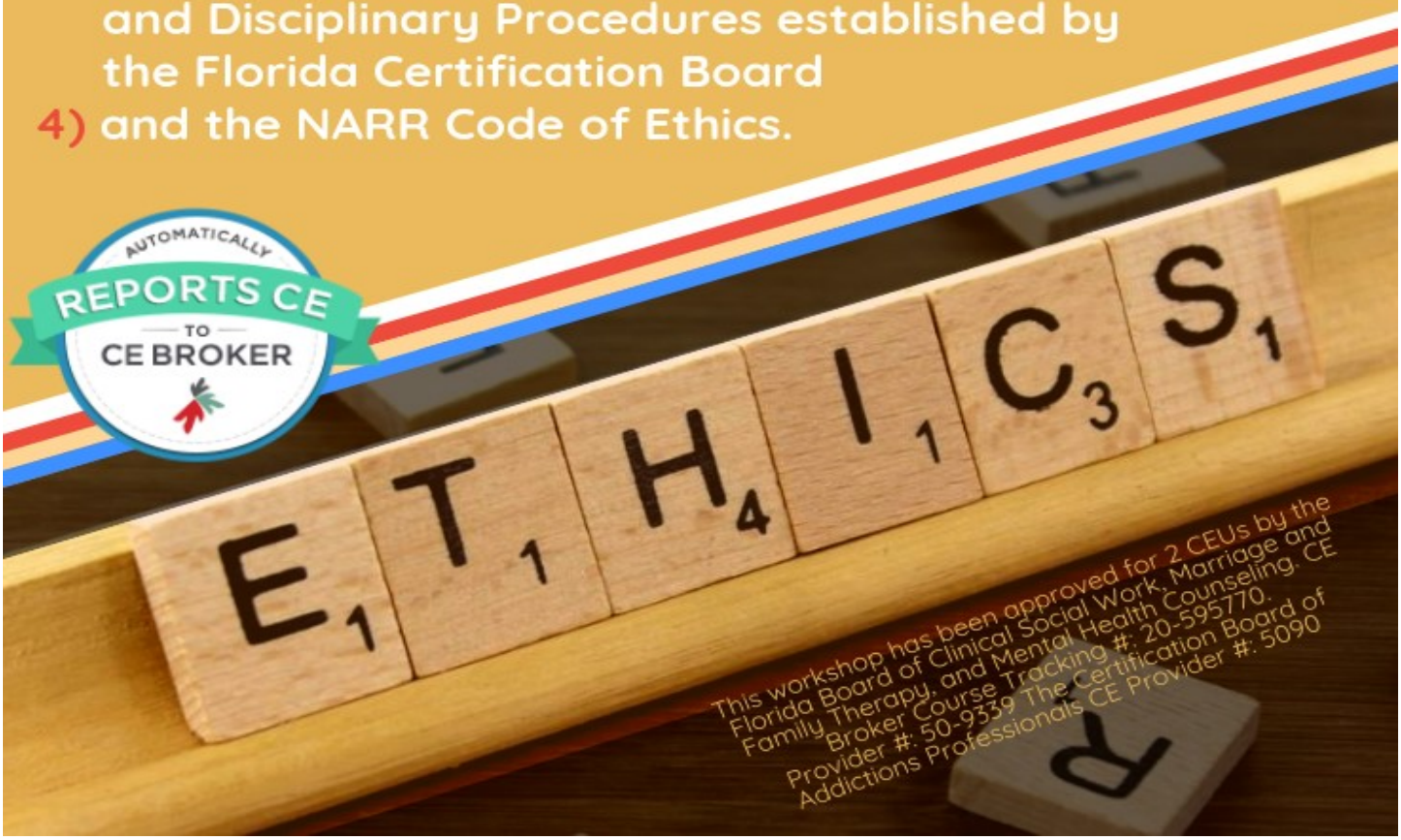
1) ACA Code of Ethics
2) The Code of Ethics of the National Association of Social Workers
3) The Code of Ethical and Professional Conduct and Disciplinary Procedures established by the Florida Certification Board
4) and the NARR Code of Ethics.

AUTOMATICALLY REPORTS CE TO CE BROKER



This workshop has been approved for 2 CEUs by the Florida Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling. CE Broker Course Tracking #: 20-595770. Provider #: 50-9339 The Certification Board of Addictions Professionals CE Provider #: 5090

HIDING IN PLAIN SIGHT: POSTPARTUM DEPRESSION

Postpartum depression (PPD) is a form of depression that develops following childbirth and impacts functioning to various degrees depending on severity. Onset is usually from the first few weeks postpartum up through the first year. Postpartum depression and a condition known as the "Baby Blues" may be confused. According to Postpartum Support International, the differences between the "Baby Blues" and PPD are the duration, intensity, and severity of the symptoms. Approximately 80% of new mothers experience the "blues" (with symptoms such as lack of sleep, exhaustion, and a roller coaster of emotions), usually due to a hormonal imbalance. However, these symptoms typically peak around two weeks and then disappear. Some mothers react more strongly than others to the changes in hormone levels during this period. Unlike the blues, postpartum depression/anxiety symptoms persist and become more severe. Mothers often report feelings of worthlessness, guilt, despair, difficulty concentrating, or other similar feelings when depressed. Appetite and sleep patterns can be disrupted and a mother coping with postpartum depression may not be able to experience pleasure or interest in the baby or her family. Other comorbid conditions such as anxiety often accompany depression and often require treatment as well. She may also have a difficult time adjusting to her new life as a mother while grieving the loss of her old identity and lifestyle. Many times, the mother may feel isolated due to lack of support. In some cases, a mother may have thoughts of wanting to hurt herself or her baby. Immediate help is required in these particular situations.

RISK FACTORS

Multiple factors are believed to contribute to PPD. Medical issues, such as hormonal changes and/or a thyroid imbalance, play a role; psychosocial factors do, too. The latter may include a lack of social support, substance abuse issues, breastfeeding issues, birth defects, etc. A family history of anxiety or depression can also contribute. When doing an evaluation for postpartum depression, it is incumbent for the practitioner to assess for all of these factors. A spectrum of PPD exists (ranging from mild to severe), and if left untreated can become increasingly severe throughout the postpartum period. Approximately 20% of new mothers experience PPD, and it can affect any mother regardless of age, race, or income.

MYTHS AND STIGMA

It is unlikely that a mother will admit to depression and anxiety. Instead, she may say something like "I cry almost every day, I don't see a way out, everything looks hopeless," or "It feels like I am a bad mother--I should have never had this baby." Many new mothers are ashamed or embarrassed to admit to feeling depressed and/or anxious for fear of judgment or for fear of an authoritative figure deeming her unfit and taking her baby away. Unfortunately, these fears leave the mother in a state of isolation and silence.

Postpartum depression is shrouded in myths and stigmas hindering the understanding, creation, and accessibility of resources. This is due, in large part, to the societal expectation

Autor: Nancy Layish, LCSW, PMH-C
Nancy Layish is a Licensed Clinical Social Worker in Orlando, Florida. She is a co-founder of Central Florida Postpartum Alliance, non-profit promoting advocacy, education, and treatment for mothers and families in the Central Florida area. She is a former volunteer for Postpartum Support International and received her formal certification in Perinatal Mental Health in May 2020.

that a new mother should be happy about her baby or that after a brief transition following the birth, she should be able to adjust fairly smoothly to her new role. The cultural expectation that motherhood will come naturally is personified and reinforced by media representations of the perky mom with her happy baby. Furthermore, the media's portrayal of postpartum depression and other perinatal mood complications is usually negative or comes to light if a celebrity is experiencing it. Media coverage is further intensified when there is a tragic outcome. For all these reasons, greater compassion, understanding, and support are crucial to break through the barriers of these stigmas. Isolation only exacerbates the depression and impairs the mother and family's well being.

THE IMPACT OF POSTPARTUM DEPRESSION ON FAMILIES

A cycle of perpetual negative reinforcement and isolation exists which leads to a continued deterioration of coping skills and a likely increase of family conflict. Postpartum depression has a ripple effect influencing the mother's ability to bond with her baby, as well as adversely affecting her relationship with her partner or other family members. Oftentimes, the partner feels bewildered by the mother's symptoms, is unsure of what to do, and/or feels helpless. S/he, however well intentioned, may expect the mother to "just snap out of it," unable to understand that what she is experiencing is out of her control. Furthermore, research is showing that fathers can suffer from postpartum depression as well and the implications of this must be considered as well. The impact of untreated postpartum depression on the child could include low birth weight, disruption of the bonding process, insecure attachments, and social/behavioral problems in the older child. Early intervention and treatment is crucial to improve the outcome of the entire family unit.

POSTPARTUM DEPRESSION AND BREASTFEEDING

Mothers experiencing postpartum depression may feel that this condition is a contraindication to breastfeeding. However, it may be a situation where the mother needs to understand issues such as the use of medication, getting enough sleep, and family interactions, then figure out a strategy to meld these factors with breastfeeding. The interplay of these factors may or may very well impact an individual mother's decision whether or not to begin or continue to nurse. For example, mothers coping with PPD may ask the following:

- "Can I breastfeed while taking a particular antidepressant/anti-anxiety medication?"
- "How can I maximize the amount of sleep I am getting while continuing to breastfeed?"
- "I can't/don't wish to continue to breastfeed...am I a bad mother?"

The bottom line is the well being of the mother and child. In her article on breastfeeding

and depression, Kathleen Kendall -Tackett points out the benefits of breastfeeding in a mother experiencing PPD. 2 Lactation consultants, Breastfeeding USA Counselors, and educators can be extremely helpful and supportive in helping the mother with breastfeeding questions and issues. This support is crucial if a mother wants to continue to nurse, especially if she is having problems. In cases of severe PPD, early intervention with medical consultation is important for the health and safety of mother and baby. The risks of untreated PPD to the infant are documented.

As Katherine Stone states, “I know some mothers who suffered from PPD that felt incredible relief when they decided to stop breastfeeding, while others found their depression worsened. The decision to breastfeed (or not) is a very personal one. It is critical to recognize that breastfeeding is more important to some mothers than it is to others (whether that is biologically, intellectually, or emotionally determined). The relationship between PPD and sleep quality is critical. Unfragmented sleep is important in helping mothers to manage and overcome PPD. But if breastfeeding is highly valued to a particular mother (and to her mental health) and if the mother is breastfeeding successfully, then the sleep advice needs to be compatible with maintaining a healthy milk supply. Bad sleep advice could cause the mother’s milk supply to plummet and unnecessarily compromise her ability to breastfeed her baby.” Whatever decision the mother chooses needs to be respectfully accepted without judgment.

SCREENING AND TREATMENT

A mother experiencing postpartum depression needs to understand that she is not alone, it is not her fault, and (with help) she will get better. Screening for PPD is crucial for Identifying risk factors as early as possible. Ideally, screening would begin during pregnancy and occur during regular intervals during the postpartum period. It is the hope that in the future every hospital and birth center will have a screening protocol in place. The Edinburgh Postnatal Depression Scale (EPDS) is an example of a widely used screening tool that is adaptable in many languages and is easy to administer and score. Please note that the EPDS is a screening tool only - it does not assess the severity of the symptoms, nor is it a diagnostic tool. Follow up with the clinician is necessary to make an accurate diagnosis. Also, if the mother answers anything other than a zero on question number 10 (harm-related question), an immediate referral for further assessment and intervention is mandated.

The good news is that effective treatment for postpartum depression is available. Treatment includes individual counseling, support groups (face to face or online), one-to-one peer support, medication, or a combination of these. Individual counseling provides a trusting, supportive atmosphere where the mother can open up about her experience, focus on her strengths, and work on solutions to improve coping skills. Support groups are very powerful in that the mother can identify with others experiencing similar circumstances. This is a powerful affirmation that she is not alone. Several online support groups are available, making it a cost effective option and allowing the mother to participate from home. One-to-

CONCLUSION

In summary, postpartum depression is an issue that needs to be brought “out of the closet.” So many new mothers experience it, yet it is an issue that is shrouded in secrecy and shame. The good news is that more attention is being focused on PPD and other perinatal mood disorders. Increasing services for advocacy, education and resources is crucial if we are able to encourage the many mothers, partners and families who require help to receive it without shame or fear of repercussion. Providers also need to be educated and provided with guidelines on how to help their patients and clients as they are often the gatekeepers to further knowledge and support. A strong personal and professional support system will make the mother feel less isolated, experience less blame and increase the outcome of a promising recovery from postpartum depression.

REFERENCES 1) Postpartum Support International. Perinatal Mood Disorders: Components of Care 2019, (2) 2) Kendall-Tackett, K. A new paradigm of depression in new mothers: the central role of inflammation and how breastfeeding and anti-inflammation protects maternal mother health. International Journal of Breastfeeding 2007, 2:6 3) Stone, K. (2013, June 6) Sleep management, breastfeeding and postpartum depression Postpartum Progress. 4) Cox, J.L., Holden, J.M. Sagovsky R. (1997). Edinburgh Postnatal Depression Scale 5) Drugs and Lactation Database (Lactmed) Bethesda (MD) National Library of Medicine (US): 2006

Hello, FMHCA family. **Original Post 6/7/2020**

I have received some requests for guidance and information on how clinical mental health counselors (CMHCs) can respond to the hurt and pain of their clients in the aftermath of George Floyd's debt and the subsequent protests and riots. I have decided to first respond personally and am not speaking on the behalf of the FMHCA Board of Directors.

When I watched video footage of Floyd's death, I felt hurt, sadness, anger, disgust, confusion, and fear. It was difficult to watch. Such footage is believed to activate mirror neurons in the pro-social human brain, stimulating what some call our universal "justice circuitry." We then feel an obligation and an impulse to protect and to respond to the aggression. I am thankful that we have such circuitry, because it compels us to take social action.

As we meet with our clients in the coming weeks, we will hear a variety of perspectives, fears, and frustrations. This week alone, I have met with both protestors and police officers, and I have had the honor and privilege to accompany them on their journeys of reflection.

The American Mental Health Counselors Association (AMHCA) 2020 *Code of Ethics* provides CMHCs with direction and wisdom that I think we can call upon during these challenging times. The code compels CMHCs to pursue multicultural competency:

> *"[CMHCs] recognize the important need to be competent with respect to cultural diversity; CMHCs are sensitive to the diversity of different populations and to changes in cultural expectations and values over time" (p. 8).*

The code also prohibits CMHCs from condoning or engaging in discrimination, to pursue a greater awareness of their own biases, and to take action to prevent those biases from interfering with the counseling process:

> *"CMHCs do not condone or engage in discrimination based on ability status, age, culture, ethnicity, sex, gender identity, race, religion, national origin, political beliefs, sexual orientation, relationship status, or socioeconomic status" (p. 8).*

> *"CMHCs have a responsibility to educate themselves about their own biases toward those of different races, creeds, identities, orientations, cultures, and physical and mental abilities, and then to seek consultation, supervision, and/or counseling in order to prevent those biases from interfering with the counseling process" (p. 8).*

Furthermore, the code calls upon CMHCs to advocate for sociopolitical change:

> *"CMHCs are encouraged to advocate at the individual, institutional, professional, and societal level to foster sociopolitical change that advances client and community welfare" (p. 11).*

However, CMHCs should exercise great caution in how they advocate for clients. We have to be aware of how our advocacy efforts impact our diverse clientele, we must avoid speaking on the behalf of our profession or of our professional organizations without authorization, and we must clearly separate our opinions from facts:

> *"CMHCs are aware of and make every effort to avoid pitfalls of advocacy including conflicts of interest, inappropriate relationships, and other negative consequences. CMHCs remain sensitive to the potential personal and cultural impact on clients of their advocacy efforts" (pp. 11-12).*
>
> *"CMHCs may encourage clients to challenge familial, institutional, and societal obstacles to their growth and development and they may advocate on the clients' behalf. CMHCs remain aware of the potential dangers of becoming overly involved as an advocate" (p. 12).*
>
> *"CMHCs generally speak only on their own behalf. When authorized to speak on the behalf of a counseling organization, they make every effort to be clear and cautious in their communication, accurately portraying the position of the authorizing organization" (p. 12).*
>
> *"CMHCs endeavor to speak factually and discern facts from opinions" (p. 12).*

These principles may sound easy to implement at first glance, but the lived experience of client advocacy is often more complicated.

For example, clients have recently asked me if engaging in rioting (i.e., property destruction, looting, or perhaps even violent response to police violence) is ever justifiable, or if protest should always be nonviolent. Some have asked which is worse; to stand idly by and contribute to injustice through silence, or to attend a peaceful protest where social distancing isn't feasible, thus potentially exposing themselves and their loved ones to COVID-19. In a recent therapy session, a client questioned whether George Floyd's death was police brutality, implicit or explicit racism, or both. He pointed out that in our sessions I have been working with him on being mindful of cognitive distortions such as mind reading, jumping to conclusions, intolerance of uncertainty, and emotional reasoning. He asked me if I thought it was rational to assume that because a White police officer murdered a Black man, then the officer's actions must be "racist" by default.

These questions posed by clients illustrate the importance of CMHCs choosing their words and actions carefully. I believe that we are tasked with walking a delicate tightrope between validating the righteous anger and hurt that we and our clients feel in response to social injustice and the ethical prerogative to advocate for sociopolitical change on one hand while modeling rationality, good will, hope, optimism, and mindfulness for how our words and actions affect our clients on the other, all while avoiding imposing our own values and beliefs.

This is no small task, and it is one that I do not think we will ever balance perfectly.

If we are not careful and are not practicing self-care, we will succumb to nihilism; a bleak viewpoint of life, humanity, and the world. Instead, I believe that CMHCs can serve as

beacons of hope during challenging times. I don't think we can accomplish this by telling our clients what to do, but we can:

- Question and challenge our own beliefs, assumptions, and limited life experiences and help our clients do the same;
- Expand our awareness of the plight of marginalized groups and help our clients do the same;
- Validate the anguish of our clients;
- Explore with our clients their options for how to respond to injustice, identifying potential benefits and drawbacks/risks of each option;
- Help our clients identify, acknowledge, and express their hurt in healthy, value-congruent ways;
- Balance our clients' focus on "bad news" with the evidence that human beings are largely loving, well-intentioned, and prosocial creatures, and that there is a great deal of "good" happening in the world (the book "The Rational Optimist" is a good read on the evidence that we are safer and healthier than ever), though it is far less likely to be the focus of news reports;
- Help our clients connect in healthy ways with world around them;
- Practice counselor self-care with the same level of dedication as our work with our clients.

Of course, we as CMHCs all adopt different techniques and strategies to accomplish these tasks. I would love for you to offer some of your thoughts. Please feel free to reply to this post with them.

Thank you all for your dedication, compassion and empathy, and perseverance. Be well.

Aaron Norton, LMHC, LMFT,

FMHCA

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How To

Congress left Washington without negotiating a fourth major COVID-19 Economic Stimulus Package. It is unclear when they will return to the table to try to hammer out a deal.

In lieu of Congressional Action, President Trump issued four Executive Orders last week:

- Unemployment insurance that would provide $400 per week -- $300 by the federal government and $100 by the states.
- Payroll tax cut for Americans earning less than $100,000 a year.
- Moratorium on housing evictions through 2020.
  Moratorium on student loan payments through 2020.

It is unclear how these actions will be implemented, and if any legal action will be taken by Congress who is responsible for funding the federal government and additional programs.

Here is your Week in Review:

CITY, COUNTY, AND STATE

CHARLESTON, WV: ***City of Charleston to hire first mental health coordinator:*** The City of Charleston announced it will hire its first mental health coordinator. The position will be funded with Community Development Block Grant funds, according to a news release from the city. The coordinator will work as a part of Mayor Amy Goodwin's CARE Office and will be responsible for coordinating the work of a mental health response team comprised of the city of Charleston's staff, mental health experts, homeless shelters and social service providers,

the release said. The CARE Office will reach out to up to 30 individuals or families each month and address mental health and social service needs.

GENESEE COUNTY, MI: ***Genesee County won't ask voters for mental health tax:*** County commissioners say additional funding for mental health services is needed but aren't ready to ask voters for a new millage that would cost property owners more than $90 million over the next 10 years. Commissioners took no action on a request from Genesee Health System to ask voters for a 0.94-mill property tax in November, a proposal that would pay for a new around-the-clock mental health crisis center and increased funding for county police departments. The proposed property tax would have funded a stand-alone crisis center and the creation of a crisis intervention team to staff it. The GHS millage would have set aside 70 percent of raised revenue -- estimated at $9.1 million in the first year -- for mental health crisis, stabilization and prevention, reducing the burden on the county jail and improving care, Russell said. Twenty percent of the tax would have been allocated to the county Sheriff's Office and 10 percent allocated to villages, cities and townships that maintain their own police departments.

GRAND RAPIDS, MI: ***Grand Rapids expands mental health partnerships:*** The Grand Rapids Police Department is exploring options to improve mental health response. Grand Rapids City Manager Mark Washington announced his intent to expand mental health partnerships as part of the city's ongoing efforts to improve public safety outcomes. Washington, Police Chief Eric Payne and Fire Chief John Lehman intend to leverage a combination of nonsworn behavioral and mental health professionals within the organization and partnerships with behavioral and mental health professionals from other governments, authorities and nonprofit organizations. Washington said he hopes to pilot the expanded partnerships by focusing on responses to those experiencing homelessness, building on the early success of the city's Homeless Outreach Team. The goal is to integrate police, fire and mental health professionals to connect individuals more effectively with the services and support that can lead to transitional and/or permanent supportive housing.

CHARLES COUNTY, MO: ***St. Charles County firefighters create mental health initiative for trauma survivors:*** Firefighters came together to create a nonprofit mental health initiative for bystanders of traumatic events after seeing the effects of post-traumatic stress disorder firsthand. Through the new Central County Fire and Rescue Community Crisis Assistance Program (CCAP), people can receive free counseling with licensed professionals in the aftermath of physical and mental trauma, according to a release from the department. Training is underway to teach volunteers to identify situations that could cause post-traumatic stress and how to refer someone for assistance. Every CCFR employee can activate the program in the aftermath of an emergency incident. CCFR said that firefighters came up with the idea after bystanders rescued two people from a burning home in June. Realizing that the bystanders were at risk of post-traumatic stress from the experience, the firefighters spent days brainstorming how to help them recognize symptoms and begin the healing process. From that, CCAP was born. Since it launched on June 27, it already has helped six local residents who stepped into traumatic events to help their neighbors. The program is funded by donations and helps families in need, conducts community education and outreach efforts and supports local community organizations.

CONTRA COSTA COUNTY, CA: ***Awarded grant to integrate EMS into long-term opioid***

use disorder care: A California county has received a two-year, $450,000 grant to evaluate a pilot program that partners EMS providers with outreach workers to improve care for those with opioid use disorder (OUD). The CARESTAR Foundation awarded the grant for Contra Costa County's CA Bridge Program at the Public Health Institute, which formed an alliance between the California Department of Public Health, Contra Costa County EMS, American Medical Response, the Contra Costa County Department of Public Health and UCLA to tackle the opioid crisis. This is the first county-wide pilot in California where EMS responders start buprenorphine treatment for OUD directly from the ambulance, and then outreach workers connect with patients within the community to provide longer-term resources," said CA Bridge EMS Director Dr. Gene Hern. "Improvement in this area of care is critical right now, given that the number of deadly opioid overdoses in many California counties is rising drastically."

MISSOULA COUNTY, MT: ***Mobile Crisis Team Underway:*** The Missoula County Criminal Justice Coordinating Council received a $125,000 grant from the state Department of Health and Human Services to fund a mobile crisis team to respond to calls for people in mental health crisis, which currently fall on the shoulders of law enforcement. The grant will help fund a 10-month pilot crisis team, which will consist of two mental health professionals with basic medical training to assess and assist a person in crisis, and a peer-support specialist and/or case manager to ensure the person receives follow-up treatment and mental health services. Missoula County and the City of Missoula approved matching funding for the project, which, coupled with other grant funds received earlier this year, totals $380,000. Data from the pilot project will be used to inform future funding decisions. When the mobile crisis team is up and running, people will be able to call 911 and have a mental health team dispatched to the scene. Depending on the situation, the dispatcher may send both police and the mental health team, or just the police if they need to go out and secure the scene first. A case manager will then follow up with the person after the phone call. The county is aiming to have the mobile crisis team active by September, and will contract with a mental health provider to deliver mobile crisis services through an RFP process expected to start next week.

SANTA BARBARA COUNTY, CA: ***State Grant Will Expand Mental Health Services For At-Risk Kids In Santa Barbara County Schools:*** A state grant is going to fund the expansion of mental health services in Santa Barbara County's schools. The $4 million dollar grant will be used by the Santa Barbara County Education Office and the county's 20 school districts to help kids in crisis. There will be a special focus on aid for students who identify as LGBTQ, students who have been suspended or expelled, and foster youth. The four-year program will including having mental health experts available to help children and their families. The funding from a state commission will also pay for what's known as Mental Health First Aid training for teachers and school staff.

ALABAMA: ***Alabama officials launch 'Stop Judging, Start Healing' campaign to address mental health:*** A new resource is available to support the Alabama Department of Mental Health and Public Health's "Stop Judging, Start Healing" campaign. An informational PowerPoint brings awareness and exposure to ending the stigmas of opioid use disorder, HIV, viral Hepatitis, substance use disorder and mental illness. The program is also designed to give supporting information to enhance the healing process for the people experiencing these stigmas, as well as the people who support them. The "Stop Judging, Start Healing" campaign was created to educate and bring awareness to create a state of mind where people with

mental health disorders are valued and treated with dignity and where stigma and barriers to treatment and recovery are eliminated.

ILLINOIS: ***State launches new mental health initiatives:*** The Illinois Department of Human Services announced three new mental health programs designed to provide additional support for Illinois residents. These new resources will be provided by community organizations through the Living Room Program, Transitional Living Centers and the Transitional Community Care and Support Programs. To achieve successful transition of individuals leaving the IDHS state-operated psychiatric hospitals, IDHS is contracting with community mental health centers and non-traditional service providers to develop capacity and to deliver clinical services and non-traditional supports. The initiatives include:

Living Room Program: This program is for those in need of services and supports designed to divert crises and break the cycle of psychiatric hospitalization. The program provides a safe, inviting, home-like atmosphere where individuals can calmly process a crisis event, as well as learn and apply wellness strategies to prevent future crises. It is staffed by recovery support specialists. Individuals seeking services are screened for safety by qualified mental health professionals upon entry and exit. Individuals experiencing psychiatric crises may self-refer or may be referred by police, fire, emergency departments, or other organizations with which an individual experiencing such a crisis may come into contact. *Transitional Living Centers:* These centers are a housing resource for individuals who have mental illnesses and need a place to stay while they work with a community mental health center to find permanent housing. Priority is given to individuals who are ready for discharge from an state-operated psychiatric hospital, but need housing. This is not residential treatment, but truly housing, with services and supports being provided through traditional avenues. *Transitional Community Care and Support Programs:* Eligible individuals are those who are in a state-operated psychiatric hospital and preparing to be discharged. The hallmark of the program is the development of engagement specialists who work in recovery support specialist roles within community mental health centers and who will be coming to state-operated psychiatric hospitals for face-to-face engagement with individuals while they are hospitalized. This will facilitate linkage and establish a trusting relationship with a provider of community-based services for state-operated psychiatric hospital patients during their inpatient stay. The program will include funding for non-traditional supports, such as cellphones, food, clothing, transportation, and other resources necessary for individuals to succeed as they transition to communities. In addition, agencies will provide clinical consultation to the state-operated psychiatric hospital treatment team during treatment and discharge planning to ensure treatment needs are anticipated and addressed prior to discharge

MICHIGAN: ***Michigan picked for CCBHC pilot project funding community mental health services:*** Michigan has been picked to partake in a federal pilot program that funds mental health and addiction services in community health clinics — an approach that's helped to keep those needing treatment out of jails, hospitals and off the streets. The pilot is tied to legislation enacted in 2014 from Sens. Debbie Stabenow, D-Lansing, and Roy Blunt, R-Missouri, to offer reimbursement for community-based mental health treatment. The program established new federal criteria for participating clinics to meet quality standards and offer a broad range of services, including 24-hour crisis psychiatric care, counseling and integrated help to treat substance abuse, and physical and mental health issues. Michigan was not selected for the

initial round of eight states for the pilot project in 2016 but has now been selected, along with Kentucky, for an expansion authorized under the federal coronavirus relief or CARES Act. Twelve centers included in Michigan's proposal will be part of the demonstration, Stabenow said, and receive funding for two years through Medicaid, the government health program for mostly low-income individuals.

MINNESOTA: ***Minnesota launches pioneering Medicaid program to combat homelessness:*** Minnesota officials this week launched an innovative program that aims to help thousands of people who are poor or have disabilities to find their own homes and avoid living on the streets. The program breaks ground in that it uses funds from Medicaid, the state-federal health insurance program for the poor, to pay for a wide range of housing-related services for people at risk of becoming homeless. It will help people search and apply for housing, negotiate leases and ultimately prevent evictions by identifying tenant problems before they become crises, among other services. State officials said they expect the benefits package — called Housing Stabilization Services — will help about 7,000 people on Medicaid find and retain housing within the program's first three years. The initiative took several years to prepare and reflects a shift in the way policymakers and state agencies are approaching the problem of homelessness. Health and housing programs historically served many of the same people, but they have been administered separately by a patchwork of nonprofits and government agencies with different funding sources. Yet a growing body of research shows a link between health and housing: that a person's overall health improves once they find a stable place to live. Other states are pursuing a similar model, but Minnesota is the first to receive federal approval to offer housing support services in its basic publicly funded Medicaid program. The new benefit comes as state and local officials struggle to find practical solutions to the affordable housing crisis, which has become more visible during the coronavirus pandemic. On Monday, police cleared a sprawling homeless encampment at Minneapolis' Powderhorn Park, which had swelled to several hundred people, citing increasing crime and health concerns. In Hennepin County alone, officials estimate there are about 80 homeless camps, most with just a few tents. The camps have grown in size and number, outreach workers say, because many homeless people fear catching the coronavirus in a shelter. In response, Hennepin and Ramsey County officials launched an unprecedented effort to move hundreds of homeless people at risk for the coronavirus to hotels, but they are still struggling to bring social services to a hard-to-reach population of people sleeping outside who have mental illness and substance abuse issues. The process for creating the new benefits package was set in motion five years ago, when the federal Centers for Medicare and Medicaid Services issued a critical bulletin outlining how Medicaid could cover housing-related services. Those who qualify for the new services would get help finding a place to live, making sure a home is safe and ready for move-in, as well as assistance negotiating with potential landlords. But unlike many short-term housing programs, the support does not end once a person moves into a home. The program also pays for a variety of tenant services, such as early identification of behavioral problems and tenant training designed to prevent evictions. The new Medicaid benefit does not cover the cost of rent, but it would help cover tenant services that are provided by a patchwork of organizations across the state.

NEW HAMPSHIRE: ***Safe Station program goes mobile to connect homeless with addiction, mental health services:*** With the original services of the once-innovative Safe Sta-

tion program now available through the Catholic Medical Center, the Manchester Fire Department has begun a new phase of Safe Station. It's gone mobile. Three times a week, a team that includes firefighters, mental health workers and shelter managers has been visiting homeless camps in the city. Fire Chief Dan Goonan said the effort is to get some 175 homeless camp residents more connected with the help they need to fight problems such as substance abuse or mental illness. And they try to convince them to move to shelters, an effort that he acknowledged is not going so well during the summer. The demand for the service may be increasing. Experts predict a 40% rise in homelessness nationwide, much of that due to economic problems associated with the COVID-19 pandemic. In 2016, the Manchester Fire Department created Safe Station, making every fire station an access point for drug users to be linked to treatment, services and medical care. It was replicated in locations nationwide, and Goonan hosted President Donald Trump and other top officials to showcase the program. But Safe Station notoriety has been fading. Gov. Chris Sununu's Doorways program leaned away from fire stations as entry points for services. And earlier this year, Catholic Medical Center assumed the formal Doorway function. Goonan said he created the mobile response team with federal CARES Act money and $265,000 annually provided by Sununu to address homeless issues. After a few visits, the people in camps realized the crisis team was there to help, he said. Conversations started. Nurses helped people with injuries. At least eight were hospitalized for psychiatric problems. At least 16 applied for government benefits. On July 1, a headcount found 173 people in 31 camps, including the four camps where officials had been supplying toilets, sinks, food deliveries, police coverage and trash pickup. The city discontinued those services late last month. The goal is to encourage camp residents to move to the shelter, but on July 1, the shelter was hosting only 18 people who came from the camps. Goonan said four out of every five people in camps are suffering from mental health problems.

EXECUTIVE

Trump Administration Renews Covid-19 Public Health Emergency

- Trump Administration extended the Covid-19 public health emergency which ensures that critical resources to fight the pandemic will continue.
- Public health emergencies last for 90 days, meaning the latest renewal will expire in late October — close to Election Day — without another extension.

FDA Requiring Label Changes to Include Information about Naloxone

- The FDA is requiring changes to opioid drug labels so that they include information on the opioid overdose antidote naloxone.
- The agency is looking for ways to prevent overdose deaths amid the opioid crisis. More recently, there were 70,980 reported deaths from overdoses in 2019, which was an all-time annual high, and a White House analysis this month showed an 11.4 percent year-over-year increase in fatalities for the first four months of 2020.
- Providers should discuss the availability of naloxone with all patients when prescribing an opioid or a medicine to treat opioid use disorder, the agency added.
- Public health and government officials will be closely monitoring whether the labeling change and other recent actions on naloxone can reduce opioid overdose deaths.

CONGRESS

Bipartisan Committee Leaders Request Information on COVID-19's Impact on Addiction & Overdose Crisis

- Bipartisan Energy and Commerce Committee leaders sent a letter to Health and Human Services (HHS) Secretary Alex Azar addressing concerns that the COVID-19 pandemic has exacerbated the ongoing substance use disorder (SUD) and overdose crisis in the United States, which the country has been battling for decades. The bipartisan leaders requested a briefing on the latest trends in substance use and overdoses, how those trends are affected by the COVID-19 pandemic, and what more the federal government needs to do to address this growing crisis.
- The letter to Azar was signed by Energy and Commerce Chairman Frank Pallone, Jr. (D-NJ), Ranking Member Greg Walden (R-OR), Health Subcommittee Chairwoman Anna G. Eshoo (D-CA), Ranking Member Michael C. Burgess, M.D. (R-TX), Oversight and Investigations Subcommittee Chair Diana DeGette (D-CO), and Oversight and Investigations Subcommittee Ranking Member Brett Guthrie (R-KY).

· In 2018, the number of fatal drug overdoses decreased for the first time in over two decades, but last year, overdose deaths increased to an all-time high. Now, recently reported increases in overdose deaths during the COVID-19 pandemic threaten to exacerbate these trends. According to the Washington Post, data indicate that, compared to the year before, suspected overdoses nationwide increased 18 percent in March, 29 percent in April, and 42 percent in May. The COVID-19 pandemic has led to more Americans suffering from depression and economic hardship, as people continue to isolate and often are unable to seek the necessary treatment. Dr. Nora Volkow, Director of the National Institute on Drug Abuse at the National Institutes of Health, recently stated, "that the support systems that were there to actually help them achieve recovery are no longer present. At the same time, access to some of the treatment programs has become much harder to get by and that actually includes emergency departments."

- To read the full letter, click HERE

IN OTHER NEWS

National Governor's Association (NGA) Releases Strategies To Address Social Isolation And Loneliness During COVID-19

- The NGA released a best practices guide for governor's across the country on how to combat social isolation, along with examples of policies states have implemented so far.
- You can view the memo here.

New Analysis Shows Suicide-related Calls Involving Over-the-Counter Painkillers are Rising

· An analysis of suicide-related calls to poison centers shows common painkillers found in household medicine cabinets — ibuprofen, acetaminophen, and aspirin — are being used more frequently in suicide attempts and are more often leading to serious medical problems than they were 20 years ago.

- Children and teenagers accounted for half the cases from 2000 to 2018; the 57% increase in overall cases was driven mostly by girls and women, who accounted for nearly three-quarters of all cases.

- Calls resulting in a serious medical outcome or hospital admission rose by almost two-thirds over the study period.

National Survey of LGBTQ Youth Mental Health Shows Increase in Suicide Ideation

- A national survey of LGBTQ youth mental health from the Trevor Project found that 40 percent of LGBTQ respondents "seriously considered attempting suicide" in the past 12 months.

New Research Shows Limiting Handgun Sales to those 21 and over May Help Decrease Suicides Among Adolescents

- According to new research states that restrict the sales of handguns to those aged 21 and older may have lower suicide rates among adolescents.

  - Scientists looked at suicide data between 2001-2017, and found that each state that limited handgun sales to those 18 and older had an additional 344 suicides among 18-20 -year-olds compared to states with a 21-and-over policy.

  - In contrast, states that limited handguns to those 21 or older had around two fewer suicides per 100,000 adolescents in the 18-20 age group.

  - Two states — Missouri and South Carolina — lowered the age limits for handgun purchases from 21 to 18 during the study period, and saw an increase in adolescent suicide rates.

  - At the same time, Wyoming and West Virginia raised their age limits to 21 in 2010 and didn't see a significant change in their suicide rates.

New Research Shows Follow-up Soon After Leaving Hospital Could Help Reduce Suicide Risk

- New research shows mental health specialists following-up in a timely fashion with those who were discharged from psychiatric wards has shown to be a way to reduce suicide risk.
  - Scientists looked at data from nearly 140,000 children and adolescents who are Medicaid recipients, around 57% of whom had a follow-up within a week of being discharged from a psychiatric ward. These patients had a nearly 55% lower risk of dying by suicide between 8-180 days following discharge. Twenty-two youths — most of whom were white and male — died by suicide within six months of being discharged. Black adolescents, those who were medically ill, or were older were less likely to have a mental health expert check-in with them soon after being discharged.

Mental Health America Announces More than 250k People Screened Positive for Depression Since Pandemic Began

- Tens of thousands of people experienced serious mental health symptoms in July as the COVID-19 pandemic continued to take a huge toll on the mental health of the nation, according to new data released by Mental Health America (MHA).
- MHA, which has been using its online mental health screening program –

www.mhascreening.org – to track the real-time impact of the pandemic on mental health conditions, reported that more than a quarter million people took a mental health screening in July. This was the largest monthly number in the six years of the program, which has now reached more than 5.5 million people with tools and resources to learn more about their mental health conditions and improve or maintain their mental health.

- "In July, more than 72,000 of our screeners indicated moderate to severe symptoms of depression, more than 39,000 had moderate to severe systems of anxiety, and more than 19,000 had symptoms of psychosis – the highest numbers we have ever seen," commented MHA President and CEO, Paul Gionfriddo. Collectively, since the end of February more than 263,000 people over and above what we would have expected have screened moderate to severe for depression or anxiety," he added. "This reflects how pervasive mental health conditions are becoming in the general population as a result of the pandemic. In addition to hundreds of thousands experiencing depression or anxiety, more than 42,000 people have also now experienced symptoms related to emerging psychosis," Gionfriddo added. This suggests that stress from the pandemic is also playing a role in the development of these symptoms. Most worrisome are the 90,000 plus people who report regularly thinking of suicide or self-harm – more than 30,000 in the month of July alone."
- Screening respondents cite loneliness and isolation, relationship problems, current events, and, increasingly, financial problems as reasons for their mental health conditions at the present time. While young people continue to be disproportionately affected by both anxiety and depression, different populations cite different reasons for their concerns. Severe mental health conditions also appear to be on the rise.

WEEKEND READING

WALL STREET JOURNAL: A Growing Push to Treat Racisms Impact on Mental Health

FORBES: How Mental Health Metrics Can Protect Employees in an Uncertain World

ASPEN INSTITUTE: How We Can Address Mental Health Inequities in the Time of Covid -19

THE WASHINGTON POST: Black Psychiatrists Are Few, They've Never Been More Needed

ED TECH MAGAZINE: How Schools Are Taking SEL and Mental Health Online

USA TODAY: Young People Struggle with Finding Mental Health Support Amid COVID-19 Pandemic

DALLAS MAGAZINE: For Mental Health 911 Calls, Dallas Found Success In Social Workers