Specialized Clinical Assessment Track  
*(All times in Eastern time)*

**Wednesday, June 24, 2020**

There are no Specialized Clinical Assessment sessions on Wednesday.

**Thursday, June 25, 2020**

5:00 – 6:30 PM Breakout Session 3

Trauma Track | Specialized Clinical Assessment  
*How to Ace Your Case Conceptualization with ACES: Transforming Your Practice With Trauma Informed Conceptualizations*  
*Presented by Russell MacKay, CMHC, NCC, SSW and Jessica Saxton, LCMHC, NCC*

Clinicians are often faced with complex cases and one of the ways that case conceptualization helps clinicians is to make decisions in these complex cases (Persons, 2013). While there are various models, one thing to note in all of these models, there is no specific way to do conceptualization and it seems that it is just left to the clinician to insert their conceptualization into the final assessment of the client (Eells, 2013). The job of a clinician is not easy. They must take the whole life-history of a client, condense it into meaningful themes and patterns, build rapport, create a treatment plan including goals, choose the best evidenced based strategies and interventions, keep in mind best practices within a multicultural framework, and many times do all of this within the first few sessions, as insurance companies, internal company policies, and funding sources all have deadlines for the diagnosis and treatment planning (Ridley, Jeffrey, & Roberson III, 2017). ACES can delay the diagnosis of certain mental health disorders (Berg, Acharya, Shiu, & Msall, 2018). This can lead to less optimal outcomes for these clients. Also, when conceptualizing cases it is important to remember that individuals who have been through Adverse Childhood Experiences may impact their ability to have conscious self-awareness which can lead to problems with traditional therapy (Zyromski, Dollarhide, Aras, Geiger, Oehrtman, & Clarke, 2018). Another area that is sometimes a struggle for clinicians is understanding the implications of adversity and the impact of trauma on cognitive functioning and seeing the client through a conceptualization model that integrates neuroscience can be helpful. Using a comprehensive approach that includes biological, psychological, social, cultural, and spiritual aspects of case conceptualization clinicians can be more trauma informed in their treatment and conceptualizations.
Friday, June 26, 2020

11:00 AM – 12:00 PM Breakout Session Number 1

Geriatric Track | Specialized Clinical Assessment

What Are The Differences Between Alzheimer's, Aging, Depression & Grief

Presented by Greggus Yahr, PhD, DCMHS

What Are the Differences Between Alzheimer’s, Depression, Grief, and Normal Aging and does this matter, the simple answer is yes. The mental health of older Americans has been identified as a priority by the Healthy People 2010 objectives (1), the 2005 White House Conference on Aging (2), and the 1999 Surgeon General’s report on mental health (3). It is estimated that 20% of people age 55 years or older experience some type of mental health concern. Yet, as noted by the Geriatric Mental Health Foundations (4), the number of mental health providers skilled in geriatrics, even the rudimentary awareness of the differences between dementia’s and other mental health issues, is significantly deficient to meet the needs of this rapidly expanding population. The most common conditions among seniors include anxiety, severe cognitive impairment, and mood disorders (i.e. depression or bipolar disorder). Although the rate of older adults with depressive symptoms tends to increase with age, depression is not automatically a normal part of growing older, and its symptomology is often mistaken for early signs of Alzheimer’s or dementia by concerned family members, caregivers, & providers not skilled in "senior care" (5). The fear, the angst, the family distress that results from this too often quick jump into thinking their loved one is in the early stages leading to dementia is easily avoided with better training and more clinicians skilled in these areas. That is purpose of this presentation - to assist the mental health professional in being able to identify the basic differences between dementia(s), depression, and the typical grief and transition reactions by knowing: a) the key differences between them b) learning the relevant questions to ask in order to flesh out those core differences c) have a list of available resources to better serve the client and their families.

3:00 – 6:30 PM 2 Part Session
Addictions Track | Specialized Clinical Assessment Track
How to Use the Clinical Mental Health Counselor’s Decision Matrix for Medical Marijuana

Presented by Aaron Norton, MA, LMHC, LMFT, MCAP, CRC, CFMHE, DCMHS

In the United States, medical marijuana is now broadly or partially legalized in 31 states, though it remains illegal under federal law. Variation in state and local laws can create confusion for mental health counselors. Additionally, many counselors were trained to be attuned to the dangers and drawbacks of potentially addictive substances such as marijuana, yet we also sometimes work with clients suffering from debilitating biomedical conditions who might benefit from medical marijuana. This training was designed to provide counselors with a decision tree for choosing an appropriate course of action when working with clients presenting with medical marijuana cards. **PLEASE NOTE: This breakout spans two sessions (3:00pm - 4:15pm and 5:00pm - 6:30pm). You must attend both sessions to receive full 2.75 CE credit.**