“Not everything that is faced can be changed, but nothing can be changed until it is faced.”
—James Baldwin

Whether fast asleep at home or out jogging in their residential neighborhood, Black people are more vulnerable to experience unparalleled bias and social dangers in American society. The intensity of racism, privilege, and power in our society and its systems has created an undercurrent of prejudice and discrimination as a daily experience.

A few weeks before George Floyd’s horrific death in May 2020 at the hands of police, I left my office to sit in my car and take a break before my next session. As I sat in my vehicle listening to a podcast with the engine off, I was abruptly interrupted by a local municipal police officer aggressively parking his police cruiser in front of me, blocking me from being able to exit the parking space. Since the officer seemed to make haste in my direction, I began to wonder if something was happening in the area that I was unaware of. Concerned, I looked out at the officer from my vehicle, and began to ask in a cooperative tone, “Officer, how can I—.”

Before I could finish my sentence, the officer demanded my license and registration with cuffs in his hand, as if to emphasize his “request.” Not only did he demand this information, he informed me that “a call came in about a disturbance and there also was a crime in the area,” and uniquely enough, I fit the description. He also reinforced that compliance was his “request.” Not only did he demand this information, he informed me that “a call came in about a disturbance and there also was a crime in the area,” and uniquely enough, I fit the description. He also reinforced that compliance was “my best option.”

I was nervous, thinking back to countless situations in recent years where this type of situation did not end well for unarmed Black males. This encounter took all of five minutes, but it will last forever in my memory. A few weeks later, George Floyd was brutally murdered, reminding me of my most recent encounter with police. In a world in which I attempt to offer my best to help people feel emotionally safe, I felt further saddened and unsafe.

Unfortunately, my experience was not unique; it happens to many more than we care to believe. It grieves me to hear political pundits, other professionals, and public opinion refer to the outcry raised in response to George Floyd’s death as “a meaningless moral gesture,” and “racist propaganda.” It is neither of these.

In fact, the Black Lives Matter movement has been birthed out of hundreds of years of intolerable experiences of Black Americans against oppressive, systematic, and direct racism. Far too many unarmed Black lives have been lost to senseless abuses of power, and though it didn’t begin with George Floyd’s death, we have the capability to end these abuses and heal from this day forward.

People who experience systematic oppression need a place to share their burden and find their voice. The defining moment happening today across the nation and the world has mental health at its core. Research shows that more Black Americans and people of color are seeking therapy and socially conscious clinicians willing to continuously check their biases at the door and help them through pain and suffering.

Our Work as Clinical Mental Health Counselors (CMHCs) Matters

Our role as clinician is critically important to help improve the quality of life for our fellow man. Whether through mental health research, clinical work, or at the academic level, we must remain innovative and effective. The world depends on clinicians to be empathy gatekeepers and to help protect the qualities of humanitarianism that leave no room for behavior that causes intentional suffering at the hands of a system, group, or individual. We must refuse to be an accomplice to another’s demise. We must not only affirm the Clinical Mental Health Counselor Declaration (see box, and visit amhca.org/publications/declaration)—but live it out with courage.
Clinical mental health counseling is a distinct profession with national standards for education, training and clinical practice. Clinical mental health counselors are highly skilled professionals who provide flexible, consumer-oriented therapy. They combine traditional psychotherapy with a practical, problem-solving approach that creates a dynamic and efficient path for change and problem resolution. The mission of AMHCA is to enhance the profession of clinical mental health counseling through advocacy, education and collaboration.
The President’s Perspective

By Angele Moss–Baker, LPC, LMFT, MAC, DCMHS-COD
44th AMHCA President, 2020–2021

We’re Energized, Empowered, Unified!

July 1 not only marks the beginning of my presidency, it also marks the midpoint of a summer that’s brought a historic and noteworthy new reality for clinical mental health counselors (CMHCs). COVID-19 has changed the way we provide mental health services, and the American Mental Health Counselors Association (AMHCA) held its first virtual Annual Conference. The 2020 conference theme—“Energized, Empowered & Unified: Shaping the Future of Mental Health!”—is the mantra for my year as your president. Although my transition into this new role has been virtual—without physical hugs, handshakes, and best wishes—I feel obliged to express a huge “thank you” to everyone who sent a virtual hug, card, or gift. I greatly appreciate your emoticons and kind words.

This is a pivotal time in our society, and I am proud to be the first African-American president of AMHCA. The confluence of George Floyd’s death and the COVID-19 pandemic crises has marked the past several months with a volatility that continues to impact the physical and mental well-being of all people. A movement is taking place, and AMHCA is front and center in it: Energized to improve practice standards and policies; Empowered to advocate for health care reform that will address inequities within our health care system; and Unified in our goal to simultaneously expand the national presence and recognition of CMHCs, who provide a service to diverse populations.

During my term as president, I will continue to implement AMHCA’s vision and mission (see amhca.org/about/about-us), and our strategic plan (see www.amhca.org/about/governance/strategicplan). My goals are to continue the trajectory toward licensure portability for CMHCs, to uphold the ethical practices of non-discriminatory practices, to increase a diversified membership, and to enhance collaborative relationships with other organizations committed to serving the needs of our most vulnerable populations. To achieve this vision, I am pleased to announce the commission of the AMHCA Interstate Portability Task Force (IPTF) and the AMHCA Diversity, Equity and Inclusion Task Force (DEITF). The energy behind each task force has been ignited to deliver great outcomes.

- **Licensure Portability.** Building on the foundation of National Counselor Licensure Endorsement Process (NCLEP 2.0) (see amhca.org/advocacy/portability), AMHCA has been on the front line with other organizations working to expand licensure portability for all licensed CMHCs. The mission of the AMHCA IPTF is to expand the horizon of licensure portability/endorsement by reducing barriers that affect portability for the CMHC licensed in one state to become licensed in any state or U.S jurisdiction. For more information, see page 6.

- **Diversity, Equity, and Inclusion.** In the wake of nationwide protests against racial injustice, and health disparities that harm Blacks and people of color, AMHCA denounces racism and reaffirms the ethical practice of non-discriminatory conduct with our clients, AMHCA initiatives, and activities. We acknowledge the history of racial discrimination and microaggressions committed against Blacks and other people of color; thus, the AMHCA DEITF mission is to raise awareness of diversity, equity, and inclusion in how AMHCA operates, and provide resources to enhance how we approach our work (see page 6). In the same vein of diversity, equity, and inclusion, we will develop a specialty certification in Gender Identity and Sexual Identity.

- **Collaboration.** We will build and engage in joint collaborative relationships with other behavioral health organizations on special projects, initiatives, and advocacy efforts as a means to strengthen the synergy to achieve common goals.

What a journey we have ahead, so let’s enjoy the ride! After all, “it takes a village” to have an impact on the community at large.😊
Making America Mentally Healthy

“The health of the people is really the foundation upon which all their happiness and all their powers as a state depend.”
Benjamin Disraeli, British Prime Minister, 1877

Due to the confluence of the COVID-19 pandemic, an economic recession, and systemic racism, the American Mental Health Counselors Association (AMHCA) projects that more than 103 million adults in the United States—more than 4 in 10 (41%)—will experience a negative mental health or behavioral health condition, and/or will develop a co-occurring substance use disorder in 2020. The projections are from AMHCA’s own study, “Beyond a Perfect Storm: How Racism, COVID-19, and Economic Meltdown Imperil Our Mental Health” amhca.org/viewdocument/beyond-a-perfect-storm-how-racism.

The numbers are jarring. The numbers mean there is untold suffering in American families across the nation. The numbers cry out for major federal and state legislative and policy solutions. But I am afraid that without a major call for action by the mental health provider community, little will be done. And our nation will suffer even more.

First, let’s look at the situation. Americans are experiencing a significantly increased incidence of mental health and co-morbid health disorders over the last six months, compared to last year. And we know based on recent data reported in our study that:

- 31 percent of adults report symptoms of anxiety disorder or a depressive disorder.
- 27 percent have a trauma- and stressor-related disorder related to COVID-19.
- 14 percent report having started or increased substance use to cope with stress or emotions related to COVID-19, and
- 11 percent report having seriously considered suicide in the preceding 30 days.
- All told, 41 percent of adults are reporting a behavioral health disorder.

Compared to similar period in 2019, only 8.2 percent of adults aged 18 and over had symptoms of anxiety disorder, and 6.6 percent had symptoms of a depressive disorder. College students and workers between the ages of 18 and 29 are faring the worst—with 74.9 percent experiencing at least one negative mental or behavioral health symptom.

We now know the magnitude and prevalence of the problem, and that it is getting worse by the day. But we also know we can take action to address the growing problem:

- We need more direct funding for mental health services.
- We need to increase the public’s access to licensed mental health care providers, including Clinical Mental Health Counselors (CMHCs), through Medicare reimbursement for older adults and disabled individuals.
- We can support the development of a robust, diverse, and culturally competent health care workforce by facilitating diversity throughout the health care system and by adequately training all staff to be culturally sensitive.
- We can ensure federal and state mental health parity laws are enforced.
- We need to integrate U.S. mental health care, including substance use disorder services and medical care so that health delivery services focus on the “whole person.”
- We need to expand access to mental health care through telemental health and increase payments for remote services so they are on a par with in-person services.
- We need to reduce complicated insurance coverage procedures for mental health services that often result in denied claims and no reimbursement.

Congress and states need to take necessary actions to stem our mental health care crisis. If mental health disorders go untreated, we will face an even more extensive crisis. Now is the time for the mental health community to mobilize for political action that represents the needs of their clients and constituents. That would be in our national interest.
INSIDE AMHCA

Diversity, Equity, and Inclusion: Owning Our Voice, Sharing Our Voice

By Beverly Smith, PhD, LPC, NCC, CCMHC, ACS, BC-TMH, CFT, MAC, AMHCA President-Elect, 2020–2021

I am elated to serve as the chairperson of the inaugural Diversity, Equity, and Inclusion (DEI) Task Force. Prior to my election as AMHCA’s president-elect, one of the tenets of my platform included creating a cultural competency training program for clinical mental health counselors (CMHCs). We can collectively own our voice and share our voice as an avenue for advocacy for all human beings, regardless of race, creed, religion, social-economic status, gender, sexual orientation, etc.

AMHCA’s inaugural DEI Task Force will initiate the work of developing a potential Multicultural standard to be included in the “AMHCA Standards for the Practice of Clinical Mental Health Counseling.” This process is projected to be completed within the next two to three years and may also lead to a new clinical mental health certification: Specialist in Multicultural Counseling. The task force will help to outline requirements for CMHCs to be scholar-practitioners with the specialization of multiculturalism by creating, modeling, and instructing from a Social Ecological Framework.

To begin its work, the DEI Task Force has developed a Mission Statement, objectives, and SMART (Specific, Measurable, Attainable, Relevant, and Time-Bound) goals:

MISSION STATEMENT

We value all human beings by promoting safe spaces for the voices of diversity and by providing opportunities to enhance cultural competencies and cultural humility by clinical mental health counselors for the delivery of professional services in the highest ethical manner.

OBJECTIVES

1. Provide training and other resources to AMHCA’s membership and the global community (all stakeholders) to increase awareness, knowledge, competencies, and skills
2. Develop a new AMHCA standard on “Multicultural Counseling” that goes beyond the training that all LCMHCs receive at the graduate level and that takes into account past and current events related to counseling as well as mental health needs related to inclusion, safety, equality, and justice
3. Collaborate with other organizations via partnerships established within memorandums of understanding to expand our advocacy efforts

SMART GOALS

1. Conduct formal and informal need assessments with the AMHCA board of directors and membership within the first quarter of the fiscal year
2. Promote cultural competencies and cultural humility of clinical mental health counselors by implementing relevant training events via partnerships established within two years
3. Develop at least two Diversity, Equity and Inclusion (DEI) external partnerships within two years
4. Publicly acknowledge the efforts, celebrations, and alignment of Diversity, Equity and Inclusion to mental health care four times within two years

To submit comments or feedback to the DEI Task Force, visit bit.ly/3kFjN5q.

[See more articles in this issue related to diversity and justice on pages 2 (Member Reflection), 8 (Counseling Tips), and 10–22 (in-depth feature articles).]

Mental Health Disorders Are Soaring Dramatically This Year

Americans are suffering from mental health disorders on a scale rarely seen before, according to the report released in August by the American Mental Health Counselors Association (AMHCA).

Congress Passes Historic Mental Health Counselor Medicare Legislation

On Sept. 23, the House of Representatives approved S. 785, sending a major VA mental health and counseling bill to President Trump for signature. The bill is the most significant new legislation for the counseling profession in over a decade and a tremendous advancement for mental health counselors working for the federal government, and particularly the Department of Veterans Affairs (VA).

This historic legislation directs the U.S. Office of Personnel Management to create the first-ever federal classification for mental health counselors, referred to as an Occupational Series. The Series will allow counselors to work in federal government agencies under the title of mental health counselor.

The bill also outlines several steps to increase the hiring, training, and advancement of mental health counselors within the VA. (For more information, see amhca.org/advocacy/medicare).
The AMHCA report—“Beyond a Perfect Storm: How Racism, COVID-19, and the Economic Meltdown Imperil Our Mental Health”—demands a response to the fact that over 40 percent of Americans now have an anxiety disorder and depression. By comparison, in 2019, only 8 percent of adults had symptoms of anxiety disorder and 6 percent had symptoms of a depressive disorder. During the last week of June 2020 alone, a staggering three-quarters (74.9%) of those ages 18–24 had at least one negative mental or behavioral health symptom, according to the CDC.

Compared to all racial groups, Black Americans are experiencing the most harmful effects of the overall crisis. Nearly 35 percent of Blacks are screening positive for anxiety and/or depression. Hispanics are experiencing similarly frightening numbers. Asian-Americans have had the largest changes in their mental health over the last year—just 3 percent screened positive for depression in 2019; that rate has soared to 22 percent in 2020.

“The confluence of events this year has created a ‘perfect storm’ that has swamped the mental health and well-being of all people, and especially those who identify as Black Americans,” said Angele Moss-Baker, AMHCA president and one of the report’s co-authors. “We must increase access to all licensed behavioral health providers so that all Americans receive timely, needed services.”

The report lays out a series of vitally needed policy changes to address the mental health crisis, including calling for federal legislative initiatives that would recognize clinical mental health counselors and marriage and family therapists in the Medicare program. Request a free copy of the report here: amhca.org/publications/reports/beyond-perfect-storm

Licensure Portability —A Path Forward

By Elizabeth R. Nelson, LPC, and Joseph R. Weeks, LMHC, AMHCA President, 2017–2018

For years, advocates within the field of clinical mental health counseling have convened to remove obstacles preventing interstate licensure portability. AMHCA, in collaboration with other professional organizations, developed the National Counselor Licensure Endorsement Process (NCLEP 2.0), one of several portability models in existence. Implementation depends heavily on years of legislation.

Portability would pave the way for future clinical mental health counselors (CMHC) to expand their practice, move freely throughout the country, and improve access to care for individuals who need our services. Licensure portability will also increase efforts to create uniform practice standards for the clinical mental health counseling profession and increase the ability to attain Medicare reimbursement.

AMHCA President Angele Moss-Baker, LPC, LMFT, MAC, DCM-HS-COD, has commissioned a task force—the AMHCA Interstate Portability Task Force—to review existing portability/endorsement models, and to consolidate and propose strategies to reduce barriers to portability and thereby increase opportunities for portability. The AMHCA Interstate Portability Task Force is chaired by Liz Nelson and Joseph Weeks, and made up of highly skilled clinicians who are passionate about making this movement a reality.

In the coming year, the task force will be reaching out to AMHCA chapters, state boards, and affiliate associations to strategize and develop a plan to propose interstate agreements that will bring us closer to the goal of licensure portability.

We need YOU! If you are interested in joining the task force, please contact Liz Nelson, liznelsonadvocate@gmail.com, or Joe Weeks, josephweeks@yahoo.com. For more information, visit amhca.org/advocacy/portability. Thank you!

Attend a Monthly Neuroscience Webinar

Tap into BrainstormLIVE is a virtual meetup for folks interested in neuroscience in the counseling field. Attend monthly webinars on neuroscience topics, and earn 1 CE for each webinar. The most recent topics were:

- **July**: “Pre-Operative Psychological Evaluation and Treatment of the Bariatric Patient,”
- **June**: “The Neuroscience of Microaggressions.”

Typically, the featured guest (or guests) makes an hour-long presentation, and then attendees break into smaller discussion groups for the final 30 minutes. For more information about the webinar series, hosted by AMHCA’s Neuroscience Network, visit webrainstorm.org. For more about the Neuroscience Network, visit bit.ly/3ccigMw.
Cultural competence:
- Is more than a discrete skill set or knowledge base.
- Requires ongoing self-evaluation on the part of the practitioner.

Culturally competent counselors:
- Are aware of their own cultural backgrounds and of their values, assumptions, and biases regarding other cultural groups.
- Strive to understand how these factors affect their ability to provide culturally effective services to clients.

Given that racially and ethnically diverse clients represent a growing portion of the client population, the need to update and expand guidelines for cultural competence is increasing. Suggestions for counselors and other clinical staff are outlined below. Counselors should explore their own cultural heritage and identify how it shapes their perceptions of normality, abnormality, and the counseling process.

Cultural Awareness

Counselors who are aware of their own cultural backgrounds:
- Are more likely to acknowledge and explore how culture affects their client—counselor relationships.
- Examine how their own beliefs, experiences, and biases affect their definitions of normal and abnormal behavior.
- Are more likely to take the time to understand a client’s cultural groups and their role in the therapeutic process, a client’s relationships, and his or her substance-related and other presenting clinical problems.

Counselors who are not aware of their own cultural backgrounds:
- May provide counseling that does not address obvious issues that relate to race, ethnic heritage, and culture.
- May discount the importance of how their cultural backgrounds—including beliefs, values, and attitudes—influence their initial and diagnostic impressions of clients.
- Can unwittingly use their own cultural experiences as a template to prejudge and assess client experiences and clinical presentations.
- May struggle to see the cultural uniqueness of each client, assuming that they understand a client’s life experiences and background better than they really do.

Racial, Ethnic, and Cultural Identities

Counselors who do not understand the process by which cultural identity develops can, regardless of their own race or ethnicity:
- Unwittingly minimize the importance of racial and ethnic experiences.
- Fail to identify cultural needs and secure appropriate treatment.
- Unconsciously operate from a superior perspective (e.g., judging a specific behavior as ineffectual, a sign of resistance, or a symptom of pathology).
- Internalize a client’s reaction (e.g., a Black American counselor feeling betrayed or inadequate when a client of the same race requests a White American counselor for therapy).
- View a client’s behavior through a veil of societal biases or stereotypes.

Worldview: The Cultural Lens of Counseling

Worldview, a set of assumptions that guide how one sees, thinks about, experiences, and interprets the world, is:
- Developed starting in early childhood, facilitated by significant relationships (particularly with parents and family members).
- Shaped by the individual’s environment and life experiences, influencing values, attitudes, beliefs, and behaviors.

For clients and counselors, worldviews shape one’s:
- Concept of time.
- Definition of family.
- Organization of priorities and responsibilities.
- Orientation to self, family, and/or community.
- Religious or spiritual beliefs.
- Ideas about success.

Counselors also contend with the clinical worldview, which:
- Reflects specific counseling theories, techniques, and treatment modalities, along with general office practices.
- Significantly shapes a counselor’s beliefs pertaining to the nature of wellness, illness, and healing; interviewing skills and behavior; diagnostic impressions; and prognosis.
- Influences the definition of normal versus abnormal or disordered behavior, the determination of treatment priorities, the means of intervention, and the definitions of successful outcomes and treatment failures.

Counselors should:
- Engage in considerable reflection to identify how their own cultural worldviews influence their interactions both inside and outside of counseling.
- Question how their perspectives are perpetuated in and shape client—counselor interactions, treatment decisions, planning, and selected counseling approaches.
- Understand multiple worldviews and how these worldviews interact throughout the treatment process—including the views of the counselor, client, family, other clients and staff members, treatment program, organization, and other agencies, as well as the community.
Are you a provider treating Veterans with PTSD?

We can help.

WE OFFER FREE
• Expert Consultation
• Continuing Education
• Assessment and Screening Tools
• PTSD Resources

CONTACT US
• Available by email or phone
• Responses are quick
• Calls are scheduled at your convenience

PTSD Consultation Program
FOR PROVIDERS WHO TREAT VETERANS

PTSDConsult@va.gov
(866) 948-7880
www ptsd va gov consult

ASK US ABOUT
• Evidence-based treatment • Medications • Assessment
• Resources • Collaborating with VA on Veterans’ care
• Developing a PTSD treatment program

National Center for PTSD
POSTTRAUMATIC STRESS DISORDER
Promoting Sanity in Insane Times
By Becoming a Modern CMHC

America is in crisis in 2020. Yes, America is facing the COVID-19 pandemic, but we’re also seeing the intersectionality of COVID-19 with the pandemic of structural racism. If I were to design a new type of clinical mental health counselor (CMHC) to meet these crises—a contemporary CMHC to promote sanity in insane times and to deal with the trauma from multiple pandemics—what would this prototype be like?

If you were to be a contemporary CMHC, you would have to have three very, very important aspects: You would have to be culturally competent, you would have to be globally literate, and there’s no way you could do your job if you were not a social justice advocate.

Cultural Competency

You can tell me all you want that you have the ability to establish, maintain, and successfully conclude a helping relationship with clients who come from diverse cultural backgrounds. But that means nothing to me. You’re going to have to show me that you have the ability to do this.

What kind of things really show cultural competence? You know how to take action to increase your own self-awareness, to be able to ask yourself:

• Who am I as a cultural being?
• Who am I as a person who comes from multiple realities in terms of culture?
• Where are my cultural blind spots, the blind spots that I have with people who are different from me?

Cultural competency is not a destination. You never really become culturally competent. You have to understand that cultural competency is a journey. We are always striving to take action, to basically develop cultural competence, to increase our self-awareness, to increase our knowledge base, to increase our skills repertoire, and to be the best social advocate that we possibly can be.

Global Literacy

Global literacy is what you know about the world—to live the breadth of information that you have about the world in which you live. It’s kind of hard to live in this country today and not know about COVID-19 and not know about what’s happening with police brutality, but do you know what’s happening in other parts of the world? And do you regularly keep up with the news? And I just don’t mean news that you agree with. I watch Fox News because I have to understand what Fox News is saying, because many of my clients believe that Fox News is the Gospel. So I need to understand how they’re establishing their worldview.

If you are a globally literate person, you have a knowledge of history from multiple viewpoints. People say, “Why do we have to have Black History Month?” Well, because most of what we know about so-called Black history was never taught. We really have to understand that there is more than one view about historical events.

If you are going to be a globally literate person, you have to have travel experience—domestically internationally, locally. Even going from your own neighborhood to a very different one in your same city or county can be an important travel experience. You have to basically see cultural differences as learning opportunities and embrace them. You also have to go beyond tolerance of diverse lifestyles to respect and understanding. I want to be able to more than just tolerate you.

If you are a globally literate individual, you are committed to embracing cultural diversity as a cornerstone of your life. When we are finally able to go out freely again on a Saturday night, choose to go places where you find people who are not like you; make it a learning experience and appreciate the diversity available to you.

Social Justice Advocate

Striving for social justice is probably the most valuable thing that we can do as counselors. Yet whenever I start to talk about social justice with CMHCs, they start to whine, “I can’t do this well. This is beyond what I’ve been trained to do.”

continued on page 11
You must intervene with and on behalf of your clients into problematic social systems. It’s very simple. If we take people who are “sick,” and we make them “well,” and we put them back into sick systems, sick environments, they’re going to get sick again. So why not really work on the real cause of the issue—the social environment, the social system—and help our clients change problematic social systems?

Being a social justice advocate also means we get outside of our office. It’s about ways that we can address local or state or federal laws and policies that hinder equitable access to resources that promote mental health and well-being.

To Become a Contemporary Mental Health Counselor

- **Explore your own life needs and commitment.** Ask yourself: Why do I do what I do? How do I do it? Who do I do it for? What do I believe about my clients or students? What do I believe about myself? Am I a leader or a follower? Leaders need followers, but if you’re going to be a follower, be a committed follower. Ask yourself: do I have courage? Being a mental health counselor today takes an awful lot of courage. Being a CMHC who is a social justice advocate takes a lot of courage. Do I have the courage of my convictions? What am I passionate about?

Regarding 2020 and America in crisis: When we see police putting their knees on the necks of unarmed black men in the streets, what makes me angry? And if you’re a mental health counselor today, and you’re not angry, there is something wrong with you. Finally, am I committed to fostering and supporting a society that is more enlightened, more just, and more humane to my life and my work?

- **Explore your personal privilege.** What privilege do you have as a result of your educational attainment, your language or your ability, your age, your race or your gender, or your income, or your sexual orientation, etc.? Don’t dwell in feeling guilty that you have privilege. Ask how can you put your privilege to work to advance social justice.

- **Explore the nature of oppression.** Ask yourself:

  1. How have I been a victim of oppression in my life or work? All of us can probably cite examples of when we have been victimized by oppression, either in our life or in our work.
  2. How have I contributed to the perpetuation of oppression in my life or work?
  3. Have I used personal or professional privilege or power in unjust ways?

These are three very, very unconscious, uncomfortable questions, but certainly if we’re going to be culturally competent, if we’re going to be globally literate, and if we’re going to be a social justice advocate, these questions are really crucial.

Next, it’s really important that you establish what I call personal social justice compass. What are the documents, the instruments, that are going to guide you through the sea of issues you’re going to deal with, particularly if you’re going to be a culturally competent, globally literate, social justice CMHC? I recommend that your personal social justice compass includes these three documents:

2. Your professional association’s Code of Ethics (download the 2020 “AMHCA Code of Ethics” at no cost from [amhca.org/publications/ethics](amhca.org/publications/ethics)), and
3. The multicultural and social justice counseling competencies, which make it very clear that culturally competent counselors intervene on behalf of clients at the interpersonal family community and political public policy levels. We are ethically bound to do it. (See [bit.ly/3hFUO0d](bit.ly/3hFUO0d))

Diagnosis and treatment planning is only a small aspect of what CMHCs need to be doing. In the crises of 2020, CMHCs must be culturally competent, globally literate, and social justice advocates. It’s very easy to talk the talk, but can you walk the walk?

As the lyrics to the song “Wake Up Everybody” by Harold Melvin and the Blue Notes (and more recently by John Legend & The Roots) say: “… so wake up everybody, the world won’t get no better unless we change it. You and me.”

To read the questions posed to Dr. Lee following his keynote address—and his answers—see [www.amhca.org/viewdocument/q-and-a-on-promoting-sanity-in-insa](www.amhca.org/viewdocument/q-and-a-on-promoting-sanity-in-insa).
Facilitating Difficult Discussions About Power, Privilege, and Race

The counseling profession has moved to become more culturally competent to meet the needs of varying populations. Cultural competence, however, cannot fully tackle issues related to power, privilege, and race within treatment. Clinical mental health counselors (CMHCs) can facilitate difficult discussions regarding such issues between each other and the next generation of CMHCs in three ways:

- By understanding the internal conceptualization of cultural humility and how it manifests by enhanced individual and community treatment,
- By providing support and education between each other regarding instances where unchecked power and privilege negatively impact treatment, and
- By presenting strategies to counselor educators to infuse such discussions in the classroom, allowing future CMHCs to gain skills for cultural humility and community advocacy.

Internalized Cultural Humility

The counseling profession has assessed the efficacy of traditional Westernized perspectives and practice on meeting the needs of a diverse population. To better serve clients from varying backgrounds, cultural competence training and education became mandatory for many CMHC education programs and community-based agencies. This education-based perspective allowed CMHCs to become more aware of their own cultural origins while also learning about varying cultures. Through such education, many CMHCs were able to identify how their cultural perspective set up expectations for clinical treatment that naturally differed—and sometimes clashed—with the client’s perspective.

Additionally, CMHCs were expected to engage in their own education, supervision, and consultation about the specific populations whom they served. While cultural competence attempted to improve connections between clients and CMHCs, many treatment centers and educational programs advocated for cultural humility.

Cultural competence maintains a perspective of internal focus on the CMHC to assess their experience and gain education about others. Cultural humility is focused on others: the CMHC has an appreciation and curiosity of other cultures, understands that their own personal cultural perspective is not a normative lens that is shared by the majority of the world, and maintains a commitment to lifelong learning. CMHCs approaching clients with cultural humility understand that they cannot possibly understand every facet of every group of people and thus are willing to learn from their clients’ experiences. Cultural humility requires historical awareness of the events experienced by marginalized populations that have made them feel disconnected from established laws, systems, and treatment. CMHCs must fully accept that previous mental health treatment often caused misdiagnoses of members of marginalized populations and further exacerbated racial inequities. CMHCs can expect that in some cases, they are viewed as an extension of law enforcement, which has often used racial profiling, contributing to overrepresentation of marginalized populations within the justice system.

Whereas cultural competence is from a perspective of individual education, cultural humility is more akin to a lifestyle, one committed to learning from others. Fully embracing how past mental health perspectives stigmatized marginalized populations, CMHCs are committed to creating a future based on humility, equity, and respect. CMHCs explore variances in cultural perspectives between themselves and their clients to adjust treatment goals. Doing so enables truly person-centered clinical treatment while causing the CMHC to consider his or her own power and privilege.

Checking Power and Privilege

The CMHC field does not truly reflect client demographics, as the vast majority of CMHCs are Caucasian women. With this majority comes a Western perspective of power expressing a belief as to what is best for others based on this perspective. Power based on a Western perspective provides resources to those...
who adhere to this perspective while also incidentally controlling others who do not adhere by restricting such resources. Those adhering to the Western cultural perspective experience privilege in the way of favors, access to resources, and the ability to have opinions heard from a micro to a macro level.

Obviously, the race and gender of a CMHC does not fully determine the effectiveness of the counseling services provided. However, there are bound to be instances in which a client’s behavior deviates from the dominant culture, which may cause a CMHC to evaluate such behaviors from their internalized cultural perspective. CMHCs may misinterpret unexpected client responses as being “resistant” to treatment without fully considering the experience of the client, the client’s cultural perspective, and the historical contexts by which the client may view CMHCs. Thus, CMHCs are encouraged to support each other by openly exploring varying intrapersonal assumptions and historical contexts that may contribute to such misinterpretations.

Holding such conversations in the workplace can be very difficult especially when the majority CMHCs working in community health centers have high caseloads with mandated clients who are linked with justice systems such as probation, parole, or family services. Nonetheless, these conversations are necessary to enhance client treatment.

Prior to having such conversations between CMHCs, it is recommended that community health centers regularly integrate cultural humility as an agency perspective. Integrating this perspective into agency policies requires administrators to become aware of their own experiences and privilege and to model cultural humility to supervisees. Ongoing conversations within regularly scheduled group and individual supervision enhances this process. While it is essential that agencies integrate a perspective of cultural humility, CMHCs are encouraged to advocate for a perspective of cultural humility when an agency may be lacking it.

Regardless of whether or not an agency has a perspective of cultural humility, CMHCs can still model values such as an appreciation and curiosity of other cultures and consideration of systems that contribute to inequities experienced by the client. Undoubtedly, CMHCs will be exposed to clinicians whose views may seem to directly conflict with cultural humility. Such behaviors can include: referring to the client as their diagnosis in statements such as, “She is borderline”; viewing client behaviors from a malicious perspective such as, “The client is trying to manipulate treatment”; and even encouraging goals from a counselor-oriented perspective such as, “Let’s work on finding ways you can adhere to your parole requirements.” As benign as all of these statements may seem, they are from the perspective that the client is genuinely broken, can’t be trusted, and needs to adhere to traditional systems of power in order to succeed. This perspective fractures treatment, causing many clients to drop out and exacerbates systems of inequity. Unconditionally, such client conceptualizations are harmful to the client.

CMHCs may be reluctant to talk about power, privilege, and race with their peers for fear of sounding accusatory of each other. Hence, it is important to approach such discussions from a perspective that is focused on the client first. For example, the CMHC struggling with cultural humility can be asked such questions as, “Has anything happened to the client in the past that may be contributing to their behaviors now?” and, “How has this client experienced systemic racism or instances of powerlessness?”

Initially focusing on the client helps to transition the discussion to the cultural-centric view of the CMHC struggling with cultural humility. This can be done by stating, “It sounds like you want the client to succeed in treatment,” followed by asking such questions as, “In what ways may your views on treatment differ from the client’s view of treatment? How are your views and their views built from personal experience? What cultural perspectives and experiences are important to the client that can be used to enhance their treatment experience?” Such questions provoke alternative client conceptualization, moving towards a focus on the client. When these discussions are encouraged, micro-changes within both the client and CMHC occur,
Facilitating Discussions About Power, Privilege, and Race

continued from page 13

improving treatment. Additionally, the CMHC obtains tools from the cultural perspective of the client that can be used to improve treatment outcomes.

The focus towards the client enhances the therapeutic relationship as well, increasing the likelihood that the client will resume sessions. Advocating at the agency level for cultural humility facilitates the connection to those receiving services, which prompts community enhancement. Agencies then have the ability to help deconstruct aspects of systemic inequities by providing culturally relevant skills, support, and advocacy on behalf of marginalized populations. The agency becomes no longer a tool to assist the individual, but a tool to enhance the community.

Strategies for Counselor Educators

The majority of prominent counseling accreditation programs identify the need for integrated cultural humility in CMHC education. Students may find this rather confusing as many future CMHCs enter their programs to provide clinical counseling as opposed to client advocacy. The need for advocacy can seem alien to the future CMHC, causing discomfort. Counselor educators who do not place an emphasis on advocacy minimize the benefits of cultural humility to meet patient needs and create systemic change. Additionally, merely discussing cultural humility and advocacy falls short of providing skills to future CMHCs to create ongoing community change.

CMHC programs are the capital that can be invested to enhance the community in which the program is located. For online programs, the town or city where the student lives is enhanced by having an additional clinician to meet community demands. With the United States spanning thousands of cities, numerous opportunities exist to advocate on behalf of marginalized populations, even in seemingly homogeneous areas.

To further enhance the advocacy skills of future CMHCs, it is recommended that counselor educators invite into the classroom those who are already engaged in community advocacy. These discussions can provide education about varying types of advocacy. People often learn from observation and experience as opposed to merely a lecture. When such discussions occur, opportunities to engage future CMHCs with community advocacy must be present.

Although most CMHCs are Caucasian women, multiple CMHCs are from marginalized populations and can offer mentoring and support. Counselor educators are encouraged to consider bringing CMHCs into the classroom who are members of marginalized groups to openly discuss power, privilege, and the instances of racism (or phobias) experienced by the marginalized CMHC.

Connecting current CMHCs and future CMHCs helps to provide evidence to support cultural humility as well as foster a safe space to explore potential concerns and instances of personal power and privilege before students engage in their practicum.

Exposing future CMHCs to community advocates and CMHCs who actively use cultural humility can be a start to conveying how CMHCs can integrate a lifestyle focused on others. Cultural humility can be infused into course instruction and practicum/internships by having open discussions about the personal cultural perspective of the future CMHC and challenging them to have open discussions among each other about their student experiences and systemic inequities they’ve experienced or recognized. Finally, counselor educators are encouraged to engage in community advocacy themselves to model for students how this can occur.

Future CMHCs may feel that community advocacy looks like joining a protest (and in some instances this may be the case). However, community advocacy also takes place when counselor-educators connect with community agencies and provide education and training about the specific experiences of marginalized populations. Counselor educators must be aware of local, regional, and national legislation regarding the CMHC field and marginalized populations. Bringing such legislation to the awareness of the future CMHCs and providing information about how to contact a local or state legislature is also advocacy.

Take the Necessary Steps to Help Clients—and Communities—Heal

The current focus on racial injustice in the United States has provided fertile ground for CMHCs to improve their services and assist with community healing and progress. CMHCs must integrate a perspective of cultural humility, demonstrating that they genuinely appreciate the client’s cultural experience and understand that historical incidents of racism impact current treatment. Agencies promoting cultural humility can enhance change within the personal lives of those receiving treatment and the community as a whole. CMHCs can support cultural humility by openly discussing power, privilege, and race in the counseling environment. Such discussions allow CMHCs to develop additional culturally appropriate tools to meet client needs.

Finally, counselor educators can foster cultural humility in future CMHCs by engaging in client advocacy themselves. They can also open up their classrooms to those engaged in community advocacy and to CMHCs from marginalized backgrounds to discuss their own experiences with power, privilege, and racism. These discussions, although uncomfortable, will contribute to improved treatment and community enhancement.
Microaggressions as a Mental Health Concern: What Is Our Role?

In the current political and racial climate in America, clinical mental health counselors (CMHCs) must embrace their role in advocacy. Advocates act on behalf of others or organizations, giving voice to the voiceless. At times, even in the role as an advocate, CMHCs may inadvertently engage in microaggressions that could further marginalize or traumatize clients, students, or supervisees.

Microaggressions are subtle, covert behaviors that individuals experience as hurtful and inappropriate. Microaggressions can be direct and indirect insults, slights, and discriminatory messages. As counselors, supervisors, and educators, we are taught to be multiculturally competent and to advocate for social justice. There may be times, however, when we unknowingly engage in a microagression.

The three types of microaggressions are microinsults, microinvalidations, and microassaults, according to Derald Wing Sue, PhD, professor of psychology and education at Teachers College, Columbia University. As mental health professionals, we must take every precaution to validate those we treat and teach, and avoid these subtle behaviors:

- **Microinsults**: Microinsults are comments that degrade an individual’s identity. For example, a client comes into your office whose last name is Sanchez. You assume she speaks Spanish and anticipate having difficulty with the intake. The client begins to tell her story and the CMHC interrupts and says, “You speak very good English—I thought I might need a translator for you.” Another example includes telling your client, “You don’t sound Black,” or “You don’t look like an Asian.” These comments may seem innocuous; however, microinsults undermine a person’s identity. CMHCs are about affirming and embracing an individual’s identity.

- **Microinvalidations**: Microinvalidations minimize or deny an individual’s thoughts, feelings, and experiences. For example, a student asks to meet with a CMHC at the university counseling center to discuss the Black Lives Matter movement and how he feels as Black man at a PWI (predominantly white institution). When meeting with the student, the CMHC says, “Well, at least you are in school and getting an education, so you are less likely to get shot.” Another example is a CMHC who works with a young adult member of the LBGTTQia community. When the client shares his concern for his safety as a transgender male, the CMHC responds, “I remember a time when I was afraid to walk down my street,” completely invalidating the client’s comment or experience. As mental health professionals, naturally we do not intentionally insult or invalidate others, but being unaware of how our comments affect others can cause serious harm.

- **Microassaults**: Microassaults are overt behaviors of discrimination. For example, calling someone a derogatory name because of their race, class, or limited abilities. Examples would include a CMHC working on a treatment team who describes her client as “ghetto,” and a counselor who, after noticing a disheveled client coming towards them, decides to avert eye contact and ignore the client. Microassaults could also include touching someone without their consent; for example, two female CMHCs are in the hallway talking. A male CMHC approaches them and joins the conversation. After some time, the male CMHC reaches out to touch one of the female’s hair and says, “Your hair looks so soft.”

Whether CMHCs are working with clients or among colleagues, microaggressions (microinsults, microinvalidations, and microassaults) are inappropriate.

Racial microaggressions are inappropriate or hurtful comments directed towards persons of a minority group. For example, several Asian-Americans experienced racial microaggressions due to COVID-19 originating from Asia. More recently, the killing of George Floyd by a police officer in May intensified the racial divide in America. African-Americans and people of Black descent in particular have experienced racial microaggressions. When working with clients, students, and supervisees who are racially diverse, topics such as racial trauma, microaggressions, and discrimination should be discussed. CMHCs may also want to ask their clients directly if the CMHC’s comments or behavior comes across as a microagression.

CMHCs need to be aware of the impact microaggressions can have on individuals as well as communities. Sometimes a client’s depression and anxiety could be from experiencing daily microaggressions at work or school. CMHCs can create a safe place in their therapy sessions for individuals to explore their experiences with microaggressions.

**Elisa Niles, PhD, LMHC, NCC, CCTP, CCMHC, RPT-S, is the clinical director at Southwest Florida Counseling Center in Florida, and adjunct faculty at Liberty University and Hodges University. Specializing in trauma and play therapy, Dr. Niles is also the Southwest Regional director of the Florida AMHCA chapter—the Florida Mental Health Counselors Association (FMHCA).**

continued on page 16
In the Counseling Session, How Can CMHCs Avoid Microaggressions?

Here are a few suggestions:

• **Do not assume you know the client.** Use the intake session to gather as much information about the client as possible.

• **If you are not sure, ask.** As multiculturally competent counselors, we seek to understand our clients’ experiences.

• **Give clients permission to tell their stories.** Although different clients may express the same emotions, each of their stories and lives is different. Affirming our clients’ stories helps to break down stereotypes and biases.

• **If it sounds offensive, then do not say it.**

• **Incorporate the principles of trauma-informed care.** Trauma-informed care is about empowering our clients and building resiliency. Microaggressions could be traumatic. Creating an environment of safety, trust, and collaboration can help to avoid re-traumatizing our clients in therapy sessions.

• **Educate yourself about microaggressions.** See a list of some suggested readings and videos in the box below.

Many times, clients may not be aware that they have experienced a microaggression. When clients who enter your office present with anxiety, depression, and work-related stress, they may not tell you that every day their boss mispronounces their name; they are overlooked for a promotion, or they are told, “You need to smile more,” or “Don’t look so angry.”

Microaggressions in the workplace can take an emotional toll on clients; hence, CMHCs need to be aware of their clients’ experiences and validate their feelings. Responding to a client with workplace stress by saying “At least you have a job,” could be a microaggression.

We can empower our clients by helping them to be aware of microaggressions and to encourage them to speak to their supervisor or to human resources when they have a workplace...
issue. However, speaking to upper management may not always be in the client’s best interests, so in those cases, CMHCs should offer other suggestions. For example, CMHCs may suggest to clients that they use assertive communication when they experience a microaggression.

A Challenge

Counselors, supervisors, and educators are not only gatekeepers to the profession, but also towards each other. I challenge you, as well as myself, to be mindful of our comments. If we are unsure how a comment might be perceived, then it is probably best not to say it. If you hear a colleague say a comment that is a microaggression, I challenge you to confront the colleague and educate them about microaggressions.

To help expand our cultural awareness, consider some of the suggested readings or YouTube videos on microaggressions listed in the box on page 16. In addition, attending workshops that address multicultural awareness and issues of marginalized groups can help increase cultural awareness.

AMHCA Home Study on Microaggressions

**TOPIC:** Microaggressions in Counseling: Reflections During a Racial Pandemic

**CEs:** 1.0 CE available to those who pass quiz

**COST:** $10, Members; $20, Non-Members

**PRESENTER:** Susan F. Branco, PhD, LPC (VA), LCPC (MD), NCC, ACS, BC-TMH

Explore research related to microaggressions in the counseling relationship and the impact they have on both clients and counselors. Implications for counselor-of-Color self-care, counselor in training education, and supervision strategies are discussed. Specific focus includes how counselors navigate discussions related to marginalized identities within the current context of the racial pandemic.

The Home Study on Microaggressions was first offered on Friday, Sept. 11, 2020, and is now available at [bit.ly/30ixfEN](http://bit.ly/30ixfEN).

---

**Providers: Are you treating Veterans at risk of suicide?**

Working with Veterans at risk of suicide can be stressful and emotionally challenging. The Suicide Risk Management Consultation Program (SRM) provides free consultation, support, and resources that promote therapeutic best practices for providers who treat Veterans at risk of suicide.

**Email srmconsult@va.gov**

**to request a free consultation.**

Learn more at [www.mirecc.va.gov/visn19/consult](http://www.mirecc.va.gov/visn19/consult)
Police Violence, Racial Injustice, and Police Burnout After Floyd’s Death

The death of George Floyd in May 2020, 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 currently 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: Police officers have killed 781 people in 2020; Black people are about twice as likely as white people to be killed by police; the majority of Black, Asian, and Hispanic Americans do not want a reduction of police presence in their neighborhoods; police officer suicides increased 25 percent from 2018 to 2019; and the number of police officers killed this year surged 28 percent compared to the same period last year. (For more statistics, and links to the statistics reported here, visit www.amhca.org/viewdocument/statistics-related-to-police-violen.)

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 by:

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 who require verbal de-escalation, and
3. Providing psychoeducation, psychological first aid, coping skills training, supportive counseling, and/or trauma treatment in an effort to offset, prevent, or mitigate police burnout.

STRATEGY #1:
The CMHC’s Role in Conducting Fitness-for-Duty Evaluations (By Dr. Norman Hoffman)

In my work as a forensic mental health evaluator, I am contracted with seven police departments and fire departments. Over the past 15 years, I have been asked to conduct evaluations for police recruits, police officers, and firefighters who 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 safely and effectively because of suspected mental illness or significant deterioration in cognitive abilities. Also, after a shooting, departments are mandated to conduct an FDE to determine if the officers involved are fit to return to their previous duties.

**REASON FOR EVALUATION**

After an incident, either on or off the job, where an officer’s judgment or behavior raises concerns about the officer’s ability to perform their duties safely, an FDE may be requested. This evaluation may also be requested when an officer’s performance level or behavior on or off the job results in doubts about the officer’s competence from a supervisor, co-worker, or the public. Occasionally, a law enforcement officer’s behavior raises concerns that the officer may have one of the following issues: anger-management; arrest; domestic violence; erratic or unusual behaviors; excessive absenteeism; citizen complaints; force; fighting; instability; problem with daily duties; serious, flagrant sick-leave abuse; shooting incident; and substance use or abuse.

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).

Many evaluators not familiar with the needs of law enforcement generally use inappropriate testing tools. It is imperative that the evaluators use appropriate testing tools, ones related to the reason for referral. Following is an example of what should be utilized when a police department requests an FDE:

**REASON FOR REFERRAL (EXAMPLE):**

Mr. Jonas Jones (not his real name) is being referred for an FDE to determine if he is fit to return to duty following a shooting incident. Since the incident, he has exhibited signs of extreme anxiety, depression, and difficulty concentrating.

The following instruments are suggested for evaluators: clinical interview; psychosocial self-report; Beck Anxiety Inventory; Beck Depression Inventory; Personality Assessment Inventory; Law Enforcement, Corrections, and Public Safety Selection Report, or MMPI-2 Personnel—Law Enforcement Interpretive Report; Trauma Symptom Inventory (TSI), or Posttraumatic Stress Diagnostic Scale (PSD).

The report derived from the FDE should include the reason for the referral, which of the above testing instruments were used, and conclude with recommendations about the officer’s fitness for duty along with any restrictions. In addition to being easy to read and free of psycho-jargon, the recommendations should flow logically from the findings laid out in the report.

**SUGGESTED OUTLINE FOR FDE REPORT:**

- 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

**BEST PRACTICES FOR CMHCS CONDUCTING FDES**

The FDE should not be written by a client’s therapist or by a CMHC who has a biased opinion. It should be a comprehensive assessment that searches for the facts, which the client alone cannot acquire. The evaluator should examine multiple sources and data points when forming an unbiased 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 (By 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 news reports 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, police are often the first to respond to the call for help.
Many mental health professionals instruct clients, or loved ones of clients, to call 911 in the event of a mental health crisis. This practice highlights the importance of law enforcement officials being specially trained in managing people who may be experiencing a mental health or substance-use-related crisis. As CMHCs, we should lead the effort with these two considerations:

1. **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, subject to the same psychological processes that all people experience.

2. **The efforts already being made to improve police interactions with the mentally ill.** CMHCs should examine how to enhance or improve those efforts 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 because they experience violence, abuse, and death on the job—it is imperative that counseling or other mental health/substance-use-treatment services are available to law enforcement officials.

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 interact with all individuals as if they are a potential threat. This may be thought reasonable, 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 others’ anxiety. Police presence is often interpreted as a sign that someone is “a bad person” or is “in trouble,” when, in fact, a person may simply need help.

### POLICE–CMHC PARTNERSHIP MODELS

In response to problems in the interactions between police officers and people who have mental health or substance-use-related problems, many U.S. police departments 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 how a mental illness may affect a person’s interactions with law enforcement.
- Establishing diversion programs, such as a Crisis Intervention Team (CIT) program, 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. Based on a model developed in Memphis, TN, the CIT model has been adopted by many law enforcement departments across the country. CIT typically involves partnership between mental health and substance use counseling professionals, law enforcement, and mental health advocates or other community organizations.
- Pairing CMHCs with Emergency Medical Services (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 U.S. city and county governments (e.g., Atlanta, Dallas, and these four Florida areas: St. Petersburg, Orlando, Okaloosa County, and Walton County). While news coverage doesn’t often highlight the efforts of a community and its law enforcement to better meet the needs of the mentally ill or those who have problems with addiction, a growing amount of research supports 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 (FDEs) conducted by CMHCs mandatory at regular intervals for all officers (see previous section, “Strategy #1,” 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 recur quarterly, semiannually, or annually.
- Establishing a phone number for mental health emergencies through which a police dispatcher can alert a mental health unit composed of mental health counselors, police officers, and even EMS.
- 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, implementing consistent, reliable, comprehensive services can be difficult. Since “defunding” the police has been a recent topic of the protests, reallocating funds to CMHC-police partnership programs might better serve communities and law enforcement.

*Continued on page 21*
STRATEGY #3: The CMHC’s Role in Treating Police Officers (By Aaron Norton)

REFLECTING ON EXPERIENCES SHADOWING POLICE OFFICERS IN THE AFTERMATH OF RACE RIOTS

From the ages of 14–25, I attended a criminal justice academy magnet program rather than a traditional high school, 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 have had a profound impact on my career path as a CMHC. They happened in the aftermath of my city’s 1996 race riots, which were sparked by the shooting of a young Black man by a white police officer. When I rode along with officers, I saw 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. Officers seemed to attract anger simply by “showing up” after being called to a scene.

A 2018 Counseling Today article by Jessika Redman, DBH, NCC, CO-LPC, FL-LMFT, 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.” The article cited research identifying 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 1996 riots in St. Petersburg, officers had to contend with not only the usual policing stressors and traumas, but also 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 that hatred and anger were directed at officers at every call, hour after hour, day after day. As my young mind struggled to make sense of the problems I encountered—including child abuse, drug overdoses, premature death, domestic violence, suicide, and gang violence— I thought about the cumulative effect of such exposure for the officers, many of whom worked far too many hours a week with little sleep and low pay under stressful, dangerous conditions.

Clearly some officers suffered from low morale and burnout, but I also noted effective coping strategies—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. I felt very uneasy riding with one officer in particular because of his misdirected and intense anger. I remember thinking, “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 the article was published in the same issue as a very passionate antiracism 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 aggression against nonviolent protestors. I also noticed it when watching footage of protestors yelling angry slurs (sometimes even sexist and racist ones) at officers of various genders, races, and ethnicities, 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 believe:

• 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.
• Police officers have very difficult, 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.

Continued on page 22
During and after periods of civil unrest, racial tension, and riots, the majority of protestors and activists are peaceful, but the righteous anger and indignation felt by oppressed people 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 in the Tampa Bay Area), and community members (as occurs with looting, for example).

COUNSELING 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 for educational purposes that are available to CMHCs who provide supportive counseling to officers. 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 about 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 cope with the unique stresses 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 not to think naturally 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 for 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.), which that can be practiced regularly to de-stress, as well as 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 will have to leave a session with a CMHC to 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 unrest 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 of 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 increasingly “getting it,” and that you genuinely have their best interest in mind.
The American Counseling Association...

is the home for professional counselors.

ACA members benefit from a range of products, services and resources designed with your professional and personal development in mind. Member benefits include Continuing Education Credits, ethics consultations, complimentary subscriptions to our publications and newsletters, access to ACA’s member-only online community and much more.

Join ACA online at counseling.org.
**Viva Las AMHCA!**

Join us for the 2021 AMHCA Annual Conference
June 23–25, 2021

REGISTER now for the lowest prices:)

- **Fall Early Bird**
- **Regular Price**
  (Jan. 1, 2021–June 11, 2021)
- **Last-Minute Price**
  (Jun 12, 2021–June 25, 2021)

For more information, visit amhca.org/conference