Help patients manage chronic pain — without medication

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ALSO IN THIS ISSUE: SPECIAL SECTION: Clinical Mental Health Counseling & The Coronavirus / PAGES 23–34
Member Reflections
Addressing Rising Rates of Suicide Among Veterinary Professionals

Julia H. F. White is a second-year graduate student at Plymouth State University in New Hampshire, studying Clinical Mental Health Counseling. Her interests include the promotion of self-care, holistic approaches to mental health, and pursuance of secular spirituality. An experienced veterinary nurse, she strongly believes in the vast benefits of the human/animal bond. She can be reached at jhwhite2@plymouth.edu.

Having worked in the veterinary field for several years, the well-being and mental health of veterinary professionals is often on my mind as I pursue a career as a Clinical Mental Health Counselor (CMHC). As a veterinary nurse, I have experienced my fair share of challenges, with compassion fatigue at the top of the list.

Compassion fatigue is of concern in the veterinary field due to the burgeoning accounts of veterinarians dying by suicide. For this reason, I chose suicidality in veterinary medicine as my topic for an advocacy project last semester. As I began my research for the project, I was dismayed to discover little available information on veterinarians and suicide in mental health literature. Instead, I relied on studies published in veterinary journals for data on mental health and suicide rates in veterinary medicine, and was left empty-handed regarding possible effective treatments and interventions.

A study published in the January 2019 issue of The Journal of the American Veterinary Association (doi.org/10.2460/javma.254.1.104) surveyed 11,000 veterinarians and found that since graduating from veterinary school, 31 percent experienced depressed episodes, 17 percent had had suicidal ideation, and 9 percent reported experiencing severe mental health issues. Furthermore, the Centers for Disease Control and Prevention (CDC) found that veterinarians are two to three times more likely to die by suicide than the general public (cdc.gov/media/releases/2018/p1220-veterinarians-suicide.html), and a study in Volume 59 of the Irish Veterinary Journal estimated that one in 11 veterinary deaths are a result of suicide—higher than the rate of medical doctors or dentists.

Risk Factors in Veterinary Medicine

When considering these trends, a number of risk factors should be taken into account, including:

- Extended working hours and overwhelming workload,
- Heightened emotional involvement in patient care,
- Professional isolation for those practicing in rural areas,
- Access to lethal medications,
- Substantial school debt versus relatively low salaries, and
- Inadequate preparation for the demands of practice while in veterinary school.

That said, I believe the two most salient factors are high client demands—which can make setting healthy professional boundaries difficult—and the daunting responsibility of humane euthanasia.

Pet owners who consider their pets beloved family members have high expectations of the people caring for their pets, resulting in high client demands on veterinarians and nurses. Veterinary staff are expected to love and care for each patient as if it were their own; and often, they do! Such devotion to patient care leads veterinary staff to work beyond scheduled hours, pick up extra shifts, and complete record-keeping and client communications from home.

This lack of boundaries and disregard for work/life balance has become the norm among veterinarians, and it contributes to compassion fatigue, burnout, and serious mental health issues.

Humane euthanasia is not only a risk factor unique to veterinary medicine; it’s a source of great distress for veterinary staff and pet owners alike. Often veterinarians and nurses find themselves “counseling” clients through this decision, and consoling them as they grieve. As an experienced veterinary nurse, I know that veterinary staff are not adequately trained to handle this responsibility, nor are we trained to care for ourselves through repeatedly experiencing so much death and sorrow. Unfortunately, we wind up adopting whatever skills seem to be effective, which in my experience consisted of detaching from the emotions and processes, and embracing stoicism over empathy. Many veterinary professionals I have worked with also choose detachment and stoicism to avoid the pain of being fully present with clients as they say goodbye to their dearly loved animal. Sadly, these habits put us in the position of internalizing our reactions to these traumatic experiences, rather than acknowledging, processing, and understanding our emotional responses.

Helping Those Who Help Care for Our Pets

Veterinary professionals are some of the most compassionate and selfless people I have met. These attributes foster an innate need to do anything within their power to help their animal patients and their owners, often to their own detriment. Compassion fatigue takes a serious toll on veterinary professionals.

Lack of emotional self-care combined with access to lethal medications can create a dangerous environment for veterinary staff. As CMHCs, we need to be cognizant of the challenges and risk factors associated with the veterinary field, and gain more knowledge of effective treatments and interventions.
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 Eric T. Beeson, PhD, LPC, NCC, ACS, CRC
43rd AMHCA President, 2019–2020

Vulnerabilities and Opportunities in the New World I Never Imagined

Hello AMHCA Family! Well, it’s June, and this is my last column as your president. It has been a privilege to serve as the 43rd AMHCA President, and as my term comes to an end, I feel our journey as an association is launching into a new era—in relation to the recovery efforts from the COVID-19 pandemic, the status of clinical mental health counselors (CMHCs) in the broader mental health care field, and the trajectory of our growth as the OneAMHCA Movement gains momentum. (If you haven’t yet heard of the OneAMHCA Movement, tune in to the 2020 AMHCA Virtual Conference [see page 9].)

I have challenged all of us many times to imagine a new world. As I write to you now, we are in the midst of a pandemic; I hope that by the time this column is published, we will be on the road to recovery. This wasn’t the new world that I had originally thought of, but it is the world we have, and I feel the need to acknowledge the weight of our recent experiences and their impact on our personal and professional lives, and to consider what’s next for the profession and those we serve. Two aspects of the pandemic have stood out to me—it has highlighted our vulnerabilities and given us an opportunity to show our strength.

What are those vulnerabilities? Personally, I’ve never been more aware of my own privilege than during the pandemic. Health care disparities among people of various sociocultural backgrounds is not new, but we saw the consequences of these inequities amplified when resources were scarce. We observed the challenges to continuity of care created by restrictive policies and regulations for practice privileges and treatment modalities across health care professions. And, if you were like me, you felt generally unprepared and uncertain.

What are those opportunities? Amidst the vulnerabilities, I have never been more proud of how our essential profession, clinical mental health counseling, rises to the occasion. I have seen CMHCs on the front lines providing service in person and virtually. I have seen AMHCA state chapters stepping up to start mental health care crisis lines alongside their state governments. I have seen active engagement in our Communities forums to crowdsource expertise, share resources, and support one another. I have participated in countless virtual calls with our sibling associations to coordinate efforts to ensure our profession is included in emergency policy. I have seen a spirit of altruism and care for one another. I have witnessed the power of an organized profession working towards the most important goal of all—the health and well-being of those we serve.

As a result of the vulnerability, uncertainty, trauma, and resilience, we changed the venue of the 2020 AMHCA Annual Conference from Las Vegas to Zoom! Since this decision was made, we have been working hard to train presenters and attendees to ensure the best possible experience in this historic event. The organizers and speakers are primed to create an atmosphere through which you will be energized, empowered, and unified to shape the future of mental health and our association.

As I close out my presidency, I reflect on the contributions of the collective. I am full of gratitude for all of you as you have leaned into the challenges and capitalized on the opportunities. I am eager to see how we will move together to usher in a new era of clinical mental health counseling, our association, and mental health in the world. Thank you for all the memories that this past year has brought me!
From AMHCA’s CEO

By Joel E. Miller
AMHCA Executive Director/Chief Executive Officer

AMHCA Is Responding to the COVID-19 Pandemic on Behalf of Members

I worked for associations during previous difficult times—the aftermath of the 9/11 terrorist attacks in 2001 and during the Great Recession of 2007–09. Like the COVID-19 pandemic, those crises had a significant economic and social impact. I learned then several important lessons on how organizations operate during those periods and how to lead. Professional associations provide stability and solid organizational structures that respond to the profession’s needs and challenges. In the context of the coronavirus outbreak, stability and reliability are significant strengths of AMHCA, and we remain fully operational. Our virtual operation for the past three years and the standard operating procedures we have in place have allowed us not to miss a beat during this period. That’s also because we have the right team in place—our governing board, committees, and staff. For example, our committee infrastructure can take on the credentialing, clinical, ethical, policy, financial, and chapter aspects of providing value to our members, addressing challenges of the pandemic, and charting pathways forward.

Reliable information and trust determine reputation and underlie the long-term relationships AMHCA establishes with our members, policymakers, and other stakeholders. They also form the backbone of AMHCA, whose structures provide the necessary continuity while enabling us to adapt to living in a world of constant change, including the COVID-19 outbreak. (For more on counseling and COVID-19, see pages 23–34.)

We have several new platforms and forums where our members can find relevant information, exchange views, and share content on best practices, tools, and strategies to thrive in today’s environment. I appreciate the full scope of our online discussion groups, communities, and other communications. Even before COVID-19, we had set up online “virtual support teams,” “roundtables,” and “cross-segment working groups” that members can access for problem-solving information. These platforms will become even more valuable for exchanging information, not only on practice and advocacy initiatives, but on the societal and economic developments we will need to anticipate over the coming months and years. The platforms we have established have created a strong sense of community. While continuing to leverage new technologies in the digital meeting environment, we will also build more virtual spaces that can replicate aspects of information-sharing, behavioral health marketplace learning, and peer connections.

AMHCA to Members: We’re Here for You!

AMHCA has plans in place to address your needs and promote your interests. We are working with policymakers and stakeholder groups to align the clinical mental health counseling profession with the current crisis and ongoing threats (see pages 6–7). Decision-makers will know that CMHCs are on the front lines as Primary Mental Health Providers, and the work you do for and with AMHCA will help pave the way to a better health care system where mental well-being is front and center. We are using this time to continue to seek collaborative opportunities with other professional associations; to make the profession more strategically integrated in the health care system; and to make AMHCA stronger. Thank you for all you do for AMHCA and on the front lines during this critical time for our nation! ✨
Let’s Get It Done! Join Your Peers in Pressing for Medicare Coverage

By David Bergman, AMHCA Government Affairs Consultant and Principal, Bergman Strategies, LLC

A new report issued April 21 by a Washington think tank recommends that mental health counselors be added to the list of Medicare providers, noting that the report’s policy recommendations offer solutions to the challenges raised by the COVID-19 pandemic. The Bipartisan Policy Center (BPC)—which prides itself on “one thing above all else: getting things done”—fosters bipartisanship by combining the best ideas from the Democratic and Republican parties to promote health, security, and opportunity.

The timing of the report couldn’t be better as it coincides with AMHCA urging clinical mental health counselors (CMHCs) to contact their legislators and ask them to include AMHCA’s Medicare legislation (House of Representatives bill H.R. 945 www.congress.gov/bill/116th-congress/house-bill/945 and Senate bill S. 286 www.congress.gov/bill/116th-congress/senate-bill/286 in future COVID-19 relief legislation.

“The next stimulus packages will be up for consideration in June, and it provides us a tremendous opportunity to make substantial strides in our Medicare policy recommendations,” said Eric T. Beeson, PhD, LPC, NCC, ACS, CRC. Beeson is AMHCA’s 43rd president, 2019–2020.

On April 20, our Medicare sponsors—Representatives Mike Thompson (D–CA) and John Katko (R–NY)—submitted a letter to the congressional leadership requesting inclusion of H.R. 945 in the next House COVID-19 relief bill. AMHCA supported that request through grassroots advocacy. Unfortunately, the House bill (H.R. 6800) passed on May 15 without our Medicare language. Our focus now shifts to the Senate, which is on a slower track.

The BPC report, “Confronting Rural America’s Health Care Crisis” (bit.ly/3e5g0LJ), was prepared by the BPC’s Rural Health Task Force, led by former Senate Majority Leaders Tom Daschle and Bill Frist, MD. The report provides bipartisan policy recommendations to stabilize and transform rural health infrastructure, promote value-based and virtual care, and ensure access to local providers. Adding licensed mental health counselors and licensed marriage and family therapists (LMFTs) to the list of Medicare-covered providers was a key recommendation for ensuring an adequate rural health care workforce.

The BPC recommendation is “splendid” news, according to Joel E. Miller, AMHCA’s executive director and CEO. “It will really help buttress our advocacy arguments and activities,” he said, referring to pages 15 and 54 of the report.

Miller also announced that the Michael J. Fox Foundation for Parkinson’s Research (MJFF) (www.michaeljfox.org) has been supporting AMHCA’s Medicare bill for the last three months and that MJFF included AMHCA’s bill in its recent Patient Forum and Hill Day. “I have reached out to their policy staff to formally bring MJFF into the Medicare Mental Health Workforce Coalition,” he added.

AMHCA is working closely with our allied organizations that represent counselors and LMFTs, as well as behavioral health clinics, to add our Medicare coverage language to the next COVID-19 stimulus legislation. We have received some interest from congressional offices, but have much work still to do.

To Be Successful, We Need Your Help!

It is imperative that U.S. Senators hear from their counselor constituents about the importance of S. 286. We urge you to contact your Senators today and ask them to include our Medicare bills in the next COVID-19 package. Find your state’s senators (see box below), and see examples of what to say when you contact them (see box on the bottom of page 7).

For more information about Medicare coverage for CMHCs, and to review past Medicare messages to legislators, visit amhca.org/advocacy/medicare.

Mental Health Liaison Group (MHLG) Asks Congress to Support Medicare Reimbursement for Mental Health Counselors

On June 5, the MHLG sent a letter to all members of Congress, as well as federal agencies, asking that they support passage of the Mental Health Access Improvement Act (H.R. 945 and S. 286). The bill will allow Medicare to reimburse mental health counselors for treating older adults with mental health conditions. A coalition of behavioral health organizations, MHLG works to strengthen Americans’ access to mental health and addiction care. The letter is significant because such broad agreement among the 75 MHLG organizations occurs infrequently. See the letter, and the list of signatory organizations, at bit.ly/30XmFnH.

Find Your Elected Senators

Find your state’s two senators, and their email address and phone number at: senate.gov/senators/index.htm

See the box on page 7 for sample messages to send to your senators.
AMHCA Goes International!

BY AARON NORTON, LMHC, LMFT, MCAP, CCMHC, CRC, CFMHE

“Meditate often on the interconnectedness and mutual interdependence of all things in the universe. For in a sense, all things are mutually woven together and therefore have an affinity for each other.” —Marcus Aurelius

Like many belief systems, Stoicism, the ancient philosophy that informs cognitive behavioral theory, teaches that although we are citizens of neighborhoods, municipalities, states, and nations, we are also citizens of the world and of the universe it is housed in. While the mission of the American Mental Health Counselors Association is focused on the advocacy of clinical mental health counselors (CMHCs) in the United States, we can also play a role in the broader international counseling profession.

continued on page 8

Sample Messages to Send to Senators Urging Medicare Inclusion

Here’s a sample message for your call or email to request Medicare coverage for CMHCs (see page 6). Replace the bracketed sections below with information about where you’re from and which senator you’re contacting:

I am a mental health counselor from [city/state]. I urge Senator [___] to include S. 286 in the COVID-19 relief bill currently under development. This legislation authorizes licensed mental health counselors to provide mental health and addiction services to Medicare beneficiaries.

Research shows the COVID-19 pandemic is likely to create a behavioral health crisis, and there are not enough mental health professionals to meet the needs of the Medicare population. I urge Senator [____] to increase the availability of behavioral health services by including S. 286 in the COVID-19 relief bill.

Thank you for your consideration.

If you would like to write your own message to your elected representatives, AMHCA President Eric T. Beeson, PhD, LPC, NCC, ACS, CRC, recommends that it:

• Remind them of your readiness to aid in the mental health care response to COVID-19 as a clinical mental health counselor.
• Urge the inclusion of all qualified mental health care providers, including clinical mental health counselors, in any new policy regarding the mental health care response to COVID-19 and beyond.
• Reference H.R. 945, The Mental Health Access Improvement Act.
• Explain why Medicare provider recognition matters to you and those you serve.

Here’s the letter Beeson plans to send to his senators, which is also on AMHCA’s Open Forum at bit.ly/2SEuqd9:

My name is Eric Beeson, and I am a clinical mental health counselor. As a qualified mental health care provider, I am uniquely trained and ready to assist in the mental health care response to COVID-19. I am also the 43rd president of the American Mental Health Counselors Association.

I am recognized by private insurance companies, the National Health Service Corps, the Department of Veterans Affairs, and TRICARE to provide mental health care to our citizens; however, I am prohibited from doing so if a client is a Medicare beneficiary.

Therefore, I urge you to ensure that all qualified mental health care providers, including clinical mental health counselors, can practice at the top of their license and are included in any new policy that is created. This call to action aligns well with H.R. 945, The Mental Health Access Improvement Act.

People are struggling and will continue to struggle to recover from the recent pandemic. Therefore, I encourage you to eliminate barriers that prevent our citizens from accessing a ready and willing workforce of clinical mental health counselors who are ready and able to care for the mental health care needs of our citizens.

Thank you for your consideration!

Respectfully,

Eric T. Beeson, PhD
Licensed Clinical Mental Health Counselor
Licensed Professional Counselor
43rd President of the American Mental Health Counselors Association
continued from page 7

Last summer, long before COVID-19-related travel restrictions, I visited Ireland with a group of American counselors through a training academy organized by the University of the Holy Cross in New Orleans. Our delegation included private practice therapists like myself, counseling students, and counselor educators. Most of us were not affiliated with the university; we heard about the training institute through the National Board for Certified Counselors. The two-week trip included collaboration with members of the Irish Association of Counselling and Psychotherapy (IACP) and the International Association of Counselling (IAC).

Over the two weeks, I spoke with Irish historians, visited historic sites, learned more about “the Troubles” in Northern Ireland, visited the town where some of my ancestors lived before migrating to the USA, attended a training conference with Irish counselors, toured a community mental health program, and interviewed Irish counselors. The experience was interesting, informative, and exciting.

I learned that throughout Europe, professional counselors aren’t licensed. Their scope of practice generally doesn’t include the diagnosis of mental disorders, a function typically reserved for psychologists or psychiatrists. Both in Europe and abroad, counselors in some countries can say that they practice “psychotherapy” aimed at treating mental disorders, and others can’t.

Due to the lack of government regulation of the profession, counseling associations understandably play an important role in establishing standards for the profession, just as they do here in the United States. I got the impression that there was openness to American associations like AMHCA providing information on the evolution of our profession here in the United States, so that association leaders abroad can determine whether anything that we have done to advocate for our profession might be helpful to them.

I also learned that some international issues just make good sense for counseling associations of various nations to collaborate on. Perhaps the current pandemic is an illustration of one such issue. Additionally, because of the tremendous diversity in American culture and the corresponding need for cultural competency among CMHCs, I believe that what we can learn from our colleagues around the world is unlimited.

I became very interested in whether IAC would be open to including AMHCA in its “roundtable” of counseling associations. I also decided to become an IAC member so that I could learn more about the counseling profession abroad. In subsequent months, AMHCA took three historic steps towards building relationships with international counseling organizations:

1. AMHCA became an organizational member of the IAC (see bit.ly/2XYjw4M, enabling AMHCA to partner with IAC on specific projects of mutual interest.
2. AMHCA’s board of directors voted to create an international membership category, permitting counselors in other countries to become non-voting members of AMHCA who enjoy benefits such as subscriptions to The Advocate Magazine and the Journal of Mental Health Counseling, access to our online forum, and all other benefits extended to associate members. AMHCA offered membership to three key international counseling leaders—now our first international members: ⊡ Naoise Kelly, the chief executive officer of the International Association of Counselling, ⊡ Ray Henry, the cathaoirleach of the Irish Association of Counselling and Psychotherapy, and ⊡ Lisa Molloy, the chief executive officer of the Irish Association of Counselling and Psychotherapy.
3. AMHCA and IAC leaders collaborated through a virtual meeting on opportunities for partnership, which will likely lead to the development of a joint task force.

The clinical mental health counseling profession, as well as the broader profession of counseling, was born here in the United States. Since then, it has grown in other countries. As those countries experience their own natural evolution of the counseling profession, AMHCA’s voice may be helpful to them. Conversely, as CMHCs here in the United States continue to develop their cultural competencies, AMHCA can benefit tremendously from the knowledge and experience of counseling associations across the globe.

I hope you find this opportunity as exciting as I do. More updates will follow on AMHCA’s collaboration with international counseling associations!
The Advocate Magazine
SPECIAL ISSUE—CALL FOR ARTICLES ON:

DIVERSITY and POLICING

The shooting deaths this spring of Black Americans by law enforcement officers have roiled the nation, and the protests that erupted in cities big and small have focused not only on excessive use of force by police, but on the pervasiveness of institutionalized racism and a determination to ensure fulfillment of the pledge “liberty and justice for all.”

The Advocate Magazine is seeking articles for its Summer Issue, which comes out in August, about:

- Issues related to diversity and multiculturalism in counseling, and
- Reflections on the protests and their significance.

**DEADLINES**

- Proposal Due (300–500 words): July 10
- Invitation for Submission to be issued: July 17
- Full Article Due (1,300–2,000 words): August 3

**GUEST EDITORS**

- Angele Moss-Baker, LPC, LMFT, MAC, EAS-C, DC-MHS–Co-Occurring Substance Use Disorders, AMHCA President–Elect, 2019–2020, and
- Beverly Smith, PhD, LPC, NCC, CCMHC, ACS, CPCS, NCSC, HS-BCP, BC-TMH, MAC
President-Elect: Beverly Smith, PhD, LPC, NCC, CCMHC, ACS, CPCS, NCSC, HS-BCP, BC-TMH, MAC, BCPCC, CFT

The owner and principal therapist of BSmith Consulting Group, LLC since 2009, Dr. Smith has professional counseling experience in various settings that include private practice, public education, corrections, and community counseling. In addition to being an adjunct professor at Mercer University, Dr. Smith serves on AMHCA’s Advancement for Clinical Practice Committee. In 2016, she was AMHCA’s delegate at the 32nd Annual Rosalynn Carter Symposium on Mental Health Policy. Her review of the symposium, which was published in the AMHCA blog “Connections,” covered the symposium presentations from leaders across the country.

As AMHCA president-elect, Dr. Smith’s goals are to promote the association’s programs, training sessions, and special meetings as well as to conduct chapter charter reviews and administration. She will also write articles promoting clinical mental health counseling awareness and practice. Her additional goals include:

- Developing a virtual training program for the resiliency of clinical mental health counselors (CMHCs),
- Creating a clinical cultural competency training program, and
- Promoting clinical mental health counseling as a critical component of integrative health from a systems perspective with sponsorship.

With more than 24 years of experience as a CMHC, Dr. Smith has served the counseling profession while being an active member of various organizations. Her leadership roles have included being a local chapter president of Delta Sigma Theta Sorority, Inc.; chapter president and president-elect of the Fulton School Counselor Association; and peer reviewer of proposals for the 30th & 31st National Youth-At-Risk Conference as well as the 21st National Conference on Child Abuse & Neglect.

Additionally, Dr. Smith has served on the American Counselor Association’s Committee for Research & Knowledge, and she is a member of the LPCA of Georgia, American Psychological Association, and the International Association of Marriage & Family Counselors. Dr. Smith has served as a volunteer for the Red Cross since 2009 in the area of Disaster Mental Health and as a Psychological First Aid Instructor. In 2015, she was accepted to the inaugural Georgia Autism Assessment Program, and she has served on the Chaplaincy Team with Emory Hospital—Saint Joseph.

Dr. Smith was invited in 2019 to serve on the launch team for the North & South Georgia Conferences (Commission of Higher Education) to integrate the topics of mental health care into the conversation of individuals across the life span, families, and youths/young adults. In 2020, she became the training leader for the United Methodist Women of North Georgia on topics related to living in an anxious world, managing anxiety, and managing emotions as they relate to diversity and advocacy for change.

Dr. Smith has conducted numerous presentations and received several awards for leadership and service to the profession as well as for service in the community.

Midwest Region Director: James Blundo, LPC, CCMHC, NCC

I have dedicated my career to the counseling profession. As a former president of AMHCA (2004–2005), I know the regional and national needs of clinical mental health counselors (CMHCs). My goals include:

- Making CMHCs the gold standard in treatment delivery,
- Increasing regional involvement in the expansion of AMHCA membership,
- Advancing the mission and vision of clinical mental health counseling
- Creating a living wage for all counselors

I also have several ideas to increase AMHCA’s membership. As an association, we should be at least 50,000 strong; instead we have fewer than 7,000 members. I am ready to help change this. The states need to be promoted and developed if we are to spread our sphere of influence. I want to share my many years of experience both as a private practice counselor and as the founder, president, and now executive director of the Michigan Mental Health Counselors Association (MMHCA).

A former school counselor, I have 40 years of experience as a CMHC, 35 in private practice, and I specialize in the treatment of couples, teenagers, and 20-somethings. I pioneered the treatment of trauma survivors using Reattachment Therapy, which I co-founded, and I’m expert in educating and treating Adult Children of Alcoholics.

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In addition, I have:

- Provided organizational developmental consulting services to nonprofits, and health-related corporations,
- Created the “Michigan Model,” a guide to help CMHCs develop a strong and viable state association,
- Created the “Bridging Initiative” to help students transition from student to MMHCA membership,
- Hosted monthly networking breakfasts across Michigan, inviting speakers who have included our MMHCA lobbyist, local legislators, and Blue Cross Consultants on how to navigate reimbursement,
- Helped lead passage of the Michigan LPC license in 1989,
- Passed a powerful new law (Public Act 96 of 2019), supported by 100 percent of the legislature and the governor, that protects CMHCs’ scope of practice—including diagnosis, psychotherapy, and testing—and improves our options for portability,
- Negotiated with Blue Cross to gain direct reimbursement for LPCs,
- Worked with government agencies and legislators to create greater access to mental health services,
- Enlisted Sen. Debbie Stabenow’s support for mental health parity and including LPCs as core providers in the Medicare legislation currently being considered, and

In WMHCA, I served as:
- President, 2003–2008
- President-elect, 2002–2003
- President-emeritus

AMHCA’s current Western Region director, I take the role seriously in serving AMHCA members who live in the West. The Western Region chapters are active in building coalitions, passing legislation in their states, offering outstanding continuing education events, and promoting clinical mental health counseling. I want to build on this foundation to create new excitement and added opportunities for members of our profession.

As a member of the AMHCA board of directors, the region director serves members by sponsoring initiatives representing the region. This includes representing the interests, needs, and concerns of CMHCs in the Western Region and serving as a liaison between the state chapters and the national organization.

The Western Region is a long distance from the national leadership. It is easy to feel left out and unheard, so it is imperative that we have a voice for the West. We must work towards the goals of the national organization while also uniting the region and supporting the regional goals developed collaboratively with the chapter leaders. Strength comes from sharing our collective wisdom to work towards our goals and build our own state chapters.

Simply stated, my goal as the Western Region director is to represent the interests of our members and work towards advancing our profession.

Terms for AMHCA board members run for three years, from July 1, 2020, through June 30, 2023. Dr. Smith’s term includes a year as president-elect, a year as president, and a year as past-president.

Karen Langer, LMHC

I am the Counseling Center director at the City University of Seattle, Seattle, where I manage all administrative aspects for a community counseling center that serves low-income clients. I also work closely with core faculty to supervise all practicum students in the CACREP-approved MA Counseling program.

Previously, I was executive director of COPE/PASAR, in Tucson, AZ, where I worked from 1984–1992. Programs there included outpatient, residential and outreach programs for the seriously mentally ill, and substance use disordered clients.

I have been active in both AMHCA and Washington Mental Health Counselors Association (WMHCA), working collaboratively to develop relationships with constituents to enhance the profession, grow the association, and promote clinical best practice.

My service in AMHCA over the past several years includes:
- President, 2012–2013
- President-elect, 2011–2012
- Western Region director, 2008–2011, 2018–2020
- Professional Development Committee, chair, 2007–2008
- Committee Member of both the AMHCA Clinical Standards Task Force and the AMHCA Advancement of Clinical Practice Committee, 2007–present (formerly Professional Development Committee)
How AMHCA’s New Book Will Benefit Your Career Development

By Joel Miller, AMHCA Executive Director/CEO (left), and Gray Otis, PhD, LC MHC, DCMHS–T, AMHCA Director of Program Coordination

“Essentials of the Clinical Mental Health Counseling Profession,” AMHCA’s latest book, includes the key documents of the profession along with a career development guide.

Purposes of “Essentials of the Clinical Mental Health Counseling Profession”

“Essentials” outlines all of the key components of the clinical mental health counseling profession and provides a unified vision for improving individual, family, and community well-being. AMHCA created “Essentials” to:

- Provide career guidance to all individuals who have chosen to become licensed in clinical mental health counseling.
- Offer information for those who may consider a vocation in clinical mental health counseling.
- Inform members of the public about the profession of clinical mental health counseling.
- Explain the distinctive characteristics of the profession to those in government, health services, and other allied associations, organizations, and stakeholders.

This guide serves as a source document that describes the values of the profession as well as the characteristics that differentiate licensed clinical mental health counselors (LMHCs) from those who practice in other mental health professions.

Components of “Essentials”

A complete understanding of the profession requires a foundation of knowledge that provides an overview of the vocation. “Essentials” is organized into two main sections, with seven chapters:

1. What Distinguishes Licensed Clinical Mental Health Counselors (LCMHCs) from Other Mental Health Professionals?

New Video Answers: “What Do Licensed Clinical Mental Health Counselors (LCMHCs) Do?”

AMHCA created “Essentials of the Clinical Mental Health Counseling Profession” to illustrate the particular benefits LCMHCs provide. We are distinguished by our ability to address the causes as well as the symptoms of depression, anxiety, trauma, substance use, and other mental disorders. Working to systematically enhance health integration, LCMHCs are on the forefront of behavioral health initiatives.

For a brief video that highlights the distinctive characteristics of LCMHCs, please see amhca.org/about/about-us.
2. The Fundamental Documents of the Profession
3. Career Guidance and the Five Phases of Professional Development for Clinical Mental Health Counselors
4. History of the Clinical Mental Health Counseling Profession
5. The Future of the Profession
6. The American Mental Health Counselors Association

Other Organizations and Associations Related to Counseling

In addition, the book includes several appendices, each containing an unabridged version of the profession’s fundamental documents: its mission and vision statements, “AMHCA Standards,” “Code of Ethics,” Statement on Conversion Therapy, Clinical Supervision Disclosure Template, Ethical Decision-Making Model, and The Clinical Mental Health Declaration.

Defining Elements of the Clinical Mental Health Counseling Profession

Those trained and licensed as LCMHCs possess distinguishing professional attributes. Although licensed under different state titles (e.g., Licensed Professional Counselor, Licensed Mental Health Counselor, etc.), the members of the clinical mental health counseling profession:

• Are licensed to diagnose and treat mental disorders,
• Have a holistic health focus expressed through evidence-based treatment, and
• Embrace collaborative partnering, not only with the client or patient, but through collaboration with other stakeholders such as family members, primary care providers, and policymakers (integrated behavioral health care).

“Essentials” elaborates on these and other qualities of the profession to strengthen our professional identity and to provide the career resources that we all need to grow in advancing the well-being and health of those we serve.

Clinical mental health counseling is a profession of licensed specialists trained to work with individuals, couples, families, and communities to resolve complex mental disorders while promoting greater mental health and vitality. The work LCMHCs do also critically affects public health on a broader scale throughout the United States. “Essentials” discusses some of the ways that the profession contributes to relieving mental health care concerns that occur in health care, the economy, and our local and national communities. For members of the profession, “it’s not just about getting better—it’s about creating a better life.”

A prepublication edition of “Essentials of the Clinical Mental Health Counseling Profession” was distributed at the 2019 AMHCA Annual Conference, and the first edition is now available from amazon.com, as either a paperback book (156 pages for $19.95), or an e-book ($12.95). For more information, visit amhca.org/publications/essentials.

Download the 2020 Updated Version of “AMHCA Standards”

The first comprehensive update since 2012 to the “AMHCA Standards for the Practice of Clinical Mental Counseling” (“AMHCA Standards”) is now available. The 2020 version of “AMHCA Standards” specifies the established benchmarks of practice for members of the clinical mental health counseling profession. In addition to identifying and describing the norms within the profession, the standards spelled out in this important document have served as the foundation of the profession since 1979, when they were first adopted.

Each standard provides central knowledge and skills that Licensed Clinical Mental Health Counselors (LCMHCs) would be expected to demonstrate.

“AMHCA Standards” is a living document that is updated on a continuing basis by AMHCA’s Advancement for Clinical Practice Committee (ACPC) to meet the needs of the public and the profession. In addition to standards of practice, it includes training and supervision standards.

The 2020 version includes two revised and updated standards, and four new standards developed since 2012. Though the entire “AMHCA Standards” continued on page 14
document was reviewed and updated with minimal changes, the two substantially revised and updated standards are:

- Substance Use Disorders and Co-occurring Disorders, which, in 2012, was referred to as Co-occurring Disorders, and
- Trauma-Informed Care, which was called Trauma Training Standards in the 2012 version.

The four entirely new standards that have been added to the 2020 edition of the “AMHCA Standards” are:

- Aging and Older Adults Standards and Competencies,
- Child and Adolescent Standards and Competencies,
- Integrated Behavioral Health Care Counseling, and
- Technology Supported Counseling and Communications (TSCC), which was originally published as Technology Assisted Counseling (TAC).

The AMHCA board and the ACPC have begun determining which new standards should be included in future updates to the Standards. Several new ones are under consideration, and may involve a slight formatting change to the “AMHCA Standards” document to include general standards that are expected for all LCMHCs, and others that provide guidance for specialized services, such as:

- Forensic Evaluation,
- Military Counseling,
- Couples and Family Counseling, and
- Developmental and Learning Disabilities Counseling.

And that’s to name just a few!

LCMHCs across the country are both generalists and also specialists in many areas. The ACPC committee is generating the best structure and procedures for adopting new, specialized standards in a way that is clear and understandable for both our membership, the profession, and also the public.

Download the unabridged version of the 2020 “AMHCA Standards for the Practice of Clinical Mental Health Counseling” at no cost from amhca.org/publications/standards.

Updated “AMHCA Code of Ethics” Is Now Available

The “AMHCA Code of Ethics,” which has just been updated to meet the changing needs of clinical mental health counselors (CMHCs), addresses CMHCs’ crucial concerns. Among them are:

- Confidentiality,
- End-of-life care for terminally ill clients,
- Conflicts of interest,
- Forensic activity,
- Relationships with students, interns, and employees
- Recordkeeping and fees,
- Clinical supervision, and
- Public statements.

The “AMHCA Code of Ethics” focuses on the specific requirements for the ethical practice of clinical mental health counselors (CMHCs), and is divided into six sections:

1. Commitment to Clients
2. Commitment to Other Professionals
3. Commitment to Students, Supervisees, and Employee Relationships
4. Commitment to the Profession
5. Commitment to the Public
6. Resolution of Ethical Problems

The association’s Ethics Committee, a standing committee, reviews, revises, and adds to the “AMHCA Code of Ethics” in keeping with current standards of practice and applicable ethical standards. This latest revision, for example, includes a new addition on technology advances in telehealth (distance counseling).

The “AMHCA Code of Ethics” is an essential component of practicing clinical mental health counseling with professionalism and integrity. While ethical guidance for the practice of clinical mental health counseling is its primary purpose, it is also intended to prompt pondering about ethical thinking and practice.

To be an ethical mental health counselor is to practice thinking ethically in an ongoing self-deliberation and in discussions with other mental health professionals.

Download the unabridged version of “AMHCA Code of Ethics” at no cost from amhca.org/publications/ethics.
Take Steps to Advance Your Career By Earning AMHCA Credentials & Certifications

**AMHCA CREDENTIALS (PHASES 1–3)**

**PHASE 1:** AMHCA CMHC Student Credential

**PHASE 2:** AMHCA Supervised CMHC Credential

**PHASE 3:** AMHCA Independent CMHC Credential

**AMHCA BOARD CERTIFICATIONS (PHASES 4 & 5)**

For licensed clinical mental health counselors who are independently licensed, AMHCA offers advanced credentialed certifications that provide evidence of increasing professional competence and expertise that can convey to clients that they hold independently recognized competencies.

**PHASE 4:**
- AMHCA CMHC Specialist Board Certification
- AMHCA CMHC Diplomate Board Certification
- AMHCA CMHC Fellow Board Certification

**PHASE 5:**
- AMHCA CMHC Laureate Board Certification

This roadmap for professional development was established to enable each individual to reach the highest standards of professional expertise. The step-by-step approach to career advancement summarized here is crucial to the clinical mental health counseling profession.

FOR MORE INFORMATION, VISIT: amhca.org/career/careerguide, and amhca.org/career/credential
A married couple, Mary and Dean (not their real names) have been spending much more time together than usual because of the spread of the coronavirus. Being physically isolated together has made it obvious that their relationship has deteriorated. They married because of mutual attraction and because being together made each other feel wonderful. Now, after seven years and two children—even without covid-19—they feel physically drained, emotionally upset, and often discouraged.

Rather than spend the unexpected abundance of at-home time tackling a house project, Mary and Dean decided to seek counseling from Rebekah, a licensed clinical mental health counselor (CMHC), to improve their relationship (see telehealth resources on page 27.)

Mary felt that she was always walking on eggshells because she never knew when Dean would become irritated with her. Dean, on the other hand, just wanted everything to be orderly, so when life was chaotic, he became frustrated. Both of them had several Negative Core Beliefs. Mary said, “No matter what I do, I always mess up. I feel like I am worthless.” Dean noted that he was angry much of the time. “Almost everyone thinks I am a good guy,” he said, “but there are times when I really explode.”

Dean and Mary had some individual concerns that needed to be addressed. But they also needed to work on the quality of their relationships with each other. It is important to note that every relationship is actually two relationships. The relationship we have with a relative, spouse, or work associate is different from the relationship they have with us. By understanding this, we can better understand five qualities of GREAT relationships.

How Can CMHCs Help Couples Understand Relationship Qualities?

Everyone can gauge the qualities of their relationships. One approach is for the CMHC to have each individual select someone they have felt close to. (In counseling, Rebekah asked Mary and Dean to identify a family member or a friend with whom they had a caring sense of connection. Mary talked about a close friend and Dean mentioned a loving grandmother.)

For each of the qualities below, ask the client to use a scale of 0 to 10 (10 is the highest possible) to rate how much the client has demonstrated that quality in their relationship with that person. Next, have the client estimate how much the other person in the relationship has demonstrated each of these qualities and score this. When the exercise is done, there should be two sets of scores—one for the client and one for the other person.

Note that the first letters of these five qualities create an acronym—GREAT. These same qualities determine the degree of caring and connection between any two people, regardless of the circumstances. Here are the questions about each quality:

1. **Genuine—Truthful and authentic**
   How much am I honest, sincere, open, and reliable with the other person? How much is he or she honest, sincere, open, and reliable with me?

2. **Respectful—Self-determination**
   How much do I honor the other person’s right to make his or her own choices and to be responsible for them—even when I disagree with their choices? How much does the other person honor my right to make my own choices and to be responsible for them—even when he or she disagrees with my choices?

3. **Empathetic—Thoughtful understanding**
   How much do I care about the other person—do I really listen and strive to understand his or her emotions, fears, and desires? How much does the other person care about me—does he or she really listen to me and strive to understand my emotions, fears, and desires?

4. **Accepting—Acknowledgment without judgment**
   How much do I fully accept the other person as they are—without criticizing or imposing my values or expectations on them? How much does the other person fully accept me as I am—without criticizing or imposing his or her values or expectations on me?

5. **Trustful—Well-intentioned**
   How much do I believe in the good-hearted intent of the other person—do I appreciate the best about them? How much does the other person believe in my good-hearted intent—does he or she appreciate the best about me?

*continued on page 17*
Using the GREAT Qualities Scores as a Roadmap to Better Relationships

Positive, caring relationships consistently score 8 or more. Mary recognized that she and her friend had average scores of almost 10. Dean said that his score was at least 8 and his grandmother a 9+. With this information, Dean and Mary realized that they could develop these same qualities in their relationships with each other. Dean said, “I really need to work on being more genuine, empathetic, and respectful.” Mary said, “Maybe I could be more empathetic and more accepting, because I am critical even though I don’t express it much.”

Once that they had a roadmap, Mary and Dean each worked to create better interactions. As they have focused on becoming more Genuine, Respectful, Empathetic, Accepting, and Trustful, they discovered that they have also been establishing stronger, more Positive Core Beliefs about themselves.

After just a few weeks, Rebekah asked each of them to review how the GREAT qualities were affecting each of them. Dean said he has been listening more to Mary and that this helped him be more understanding of the challenges she faced. That understanding somehow made him feel less frustrated and angry. Now when the children are unruly or the house is in some disorder, he just doesn’t feel as exasperated as he had before.

Mary has been very appreciative of Dean’s efforts. She no longer feels she is walking on eggshells and feels much less stress. She also worked to become more empathetically understanding of Dean and not critical of him. “It’s funny,” she said. “I am pretty pleased with myself for no longer being passive aggressive.” They both now feel closer from learning how to strengthen their five shared intimacies that Rebekah had explained to them. (For more on the five shared intimacies, please see the next Counseling Tips column, which will appear in an upcoming issue of The Advocate Magazine.)

If your relationship could use some tender loving care, and staying safer-at-home from the coronavirus has given you extra time together, try increasing your intimacy with someone you love. The GREAT qualities are the building blocks that determine how satisfied and connected we feel with others. By developing our own GREAT qualities, we can create wonderful relationships. These qualities are also fundamental in our work with individuals and couples. Indeed, LCMHCs model the GREAT qualities in their therapeutic relationships.

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
**FMHCA’s Suggestions for Pulling Off a Successful Annual Conference**

**DIANA HUAMBACHANO, EXECUTIVE DIRECTOR OF THE FLORIDA MENTAL HEALTH COUNSELORS ASSOCIATION (FMHCA), AMHCA’S FLORIDA CHAPTER**

Even though the coronavirus has dashed plans for many in-person conferences this year, we at the Florida Mental Health Counselors Association (FMHCA) are continuing to advance our plans for our 2021 conference. Although putting together a conference is a large undertaking with many complex parts to coordinate, we believe that hosting a conference gives members an opportunity to participate in and benefit from the in-person connection with peers in their state. A powerful energy fills the room at a conference of clinical mental health counselors (CMHCs), which triggers unity and movement within our profession.

We are proud that our annual conference attendance has grown consistently each year—and dramatically—from about 125 attendees in 2013, to 736 attendees in 2020. In addition, our exhibitor tables sold out, we generated a substantial profit, and our evaluation surveys reflect that our attendees are very satisfied with the quality of the conference. We’d love to share with other AMHCA state chapters the 10 steps we follow to accomplish these successes so that other chapters can grow their own annual conferences.

**STEP 1: Pick a Theme**

A conference needs an identity that will give attendees an idea of what they can expect before they even arrive. Creating the theme is a key opportunity to set the tone and start generating the electric energy that only a conference can project.

**STEP 2: Set up a Team**

Not just any team, chapters—you need to bring your A-Team to the table! A dedicated team is crucial; taking this task on alone would be detrimental to the success of the conference. At FMHCA, we break down our Conference Committee into the following smaller teams:
- Planning
- Administration
- Marketing
- Sponsorship
- Volunteers

**STEP 3: Hash Out a Budget**

Consider breaking down a budget into three categories: critical, important, and nice-to-have. Some expenses you cannot avoid. Others might be “nice to have,” like a social media backdrop. Once the categories are set, it’s time to get fiscally realistic and detail oriented, and address:
- Venue
- Speakers
- Staffing
- Signage and branding
- Food and Beverage
- Attendee Experience
- Marketing
- Event technology
- Transportation
- Equipment

*FMHCA tip: Add 15 percent to the projected cost of each category to build flexibility.*

**STEP 4: Book the Venue**

Do not make this choice lightly! The location can make or break a conference. Comfortable rooms, high-quality equipment, ease of access, and transport to and from hotels and venue are the first things to consider when choosing a successful conference venue. Take into account the perspective of each of the groups that will participate in your conference—speakers, sponsors, attendees, and volunteers—by walking in their steps when looking at potential venue spaces. We at FMHCA make it a point to hold our conference in a central area of the state to allow more exposure and accessibility for attendees.

**STEP 5: Save the Date**

Think a year ahead! The Annual FMHCA Conference Save the Date is highlighted one full year in advance to create excitement and buzz. Before settling on a date, research other events in the area to make sure you state chapter conference does not conflict with other major events. Also recognize that attendees may be attending the conference as a work requirement, making Thursday and Friday the best days to hold the conference.

**STEP 6: Call for Presenters and Agenda**

With the theme set, it’s time to start recruiting presenters, a most important step! Presenters are the stars of the conference—they bring the theme to life. Be purposeful in developing a line-up that attracts attendees and guarantees them a professional experience. There are two ways to recruit presenters:
- Reach out and personally inquire about a presenter you’d like to invite, or
- Conduct an open call for presenters.

A few things to address with presenters:
- **Compensation:** Do they require a speaker fee or other forms of compensation to participate?
- **Supporting equipment:** Does their presentation rely on specific IT equipment or other props?
- **Special requirements:** Do they meet NBCC presenter requirements?

*continued on page 19*
Once the Conference Committee has selected the presenters, develop a detailed agenda, or schedule. Ideally, the agenda should be in place at least four months before the conference. Depending on conference theme and goals, breakout sessions can last from one to three hours.

**FMHCA tip:** Have two presenters on standby for each day. If a presenter cancels, we give the standby presenters the presenter admission rate to the conference.

**STEP 7: Find Sponsors**

Design the conference to attract sponsors, keeping in mind that your conference sponsors’ values should align with the theme of your conference.

- Start by creating a list of ideal sponsors. Try to find sponsors that fund similar events or are generally associated with the main themes of your conference.
- Develop a sponsor package, with each package highlighting different types of sponsorships (i.e., refreshment break, evening reception, registration packets, etc.).
- Be able to answer these typical questions from potential sponsors:
  - What is the theme of the conference?
  - Who is the demographic?
  - What is your audience size?
  - Which other companies have already committed to sponsorship?
  - How will sponsorship benefit a sponsor (publicity/prominence/association)?
- Connect with potential sponsors. Legwork and follow-up are key!
  - Connect with sponsors by attending events, interacting on social media, reaching out on LinkedIn, or sending emails.
  - Schedule individual meetings with potential sponsors, and listen to their needs. We at FMHCA take notes about what each sponsor wants and we customize our proposal to meet the needs of each.
- Build a long-term relationship to keep sponsors. If you took a walk around the FMHCA exhibit hall, you would hear a similar refrain: “We come back year after year.” It is our goal to satisfy our sponsors’ needs so that they come back to build and grow within our conference. How do we do this? By:
  - Staying connected
  - Treating each sponsor like a VIP
  - Trying not to reflexively say “no” to a sponsor request, and instead brainstorm ways to come up with a solution or alternative that works for FMHCA and the sponsor.

**STEP 8: Promote the Conference**

Once you have the venue, key speakers, a conference-at-a-glance agenda, and a website to guide attendees to conference information, it is time to promote the conference. Here’s how we do it:

- **Reward last year’s attendees.** If you attended the FMHCA conference the year prior, you received a half-off incentive to register for the following year’s conference.
- **Offer early-bird pricing.** Have at least two different types of pricing—early bird and regular. You can even have more than one type of early-bird pricing to encourage attendees to register before prices increase.
- **Promote the conference online.** Online, you have many ways to promote your conference on a relatively small budget. For example:
  - Develop a conference hashtag. Hashtags are a must-have for conference promotion today, especially since attendee social engagement remains high.
  - Leverage sponsors and speakers to increase your conference’s online reach. Make sure you’re tagging them and thanking them publicly (on social media) when you post.

**STEP 9: Host the Conference**

Once Steps 1–8 are in place, the conference finally takes place. Although you may feel the stress of hosting the conference, you should also feel a sense of pride and excitement. Hosting successfully involves:

- Personally introducing the conference and the main speakers
- Making sure presentations do not run past the allotted time
- Participating in networking and facilitating conversations
- Gathering in-person attendee feedback as the conference unfolds
- Solving problems quickly and effectively

**STEP 10: Follow Up After the Conference**

This is my favorite part of putting on the conference, and it’s very important. At FMHCA, we follow up with everyone who is a part of the conference from AV folks to conference attendees. We both call and send out a thank-you note to convey our gratitude to each individual. We want everyone to understand why we hold a conference every year and what we do with the funds generated from the conference.

I hope these steps can enable your AMHCA state chapter to hold a conference that will bring education and unity to the clinical mental health counselors in your state.
FMHCA Strategies State Chapters Can Use to Pass a Licensure Portability Bill

DIANA HUAMBACHANO, EXECUTIVE DIRECTOR OF THE FLORIDA MENTAL HEALTH COUNSELORS ASSOCIATION (FMHCA), AMHCA’S FLORIDA CHAPTER

Licensure portability refers to the ability of counselors who are licensed in one state to become licensed in another state. For two years, the Florida Mental Health Counselors Association (FMHCA) lobbied for passage of a bill that improves licensure portability in Florida.

This bill—House Bill 713/Senate Bill 230—was inspired by the National Counselor Licensure Endorsement Process (NCLEP), which was created in 2017 by the American Mental Health Counselors Association (AMHCA) and several other national counseling authorities (visit amhca.org/advocacy/portability). The bill will enable counselors licensed in other states to obtain the Licensed Mental Health Counselor (LMHC) credential in Florida if the counselor has been licensed in another state “in good standing” for at least three of the five years immediately preceding licensure and has passed an appropriate counseling examination.

The bill also requires counselors who apply for licensure to have a master’s degree from a program accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP), effective 7/1/2025, while “grandfathering” applicants who apply prior to that date.

Additionally, the bill requires applicants seeking licensure by examination who do not have a degree from a CACREP-accredited program to have completed coursework in “addressing diagnostic processes, including differential diagnosis and the use of diagnostic tools, such as the current edition of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders,” a requirement that further clarifies the role of licensed mental health counselors in diagnosing and treating mental disorders.

Here are the strategies that volunteers of FMHCA’s Government Relations Committee (GRC) employed over two years:

- Coordinated with AMHCA leadership, including AMHCA’s Southern Regional director, as well as Jolie Long, director of state affairs for the National Board for Certified Counselors (NBCC), to ensure that NCLEP 2.0 is being properly implemented in the bill’s language
- Solicited endorsement of the bill from the state’s counseling licensure board
- Solicited endorsement of the bill from allied mental health professions—including the National Association of Social Workers (NASW) and American Association of Marriage and Family Therapists (AAMFT)—so that legislators can see consensus among the mental health professions
- Held monthly meetings between members of FMHCA’s GRC and the association’s lobbyist for collaboration
- Invited our lobbyist to present at our conference to explain the bill and what it seeks to accomplish.
- Identified when legislators were available at the state capitol, and sent our GRC and lobbyist there (which we were able to fund as a result of a successful conference this year (see page 18)) to promote the portability bill
- Identified legislators whose positions, priorities, and legislative interests are compatible with licensure portability

- Created a one-page “talking points” flyer for GRC members to use when meeting with legislators that included statistical data explaining the problem (see bit.ly/3cn4ee9 for state-level data) and logos of all major associations endorsing the bill
- Had GRC members schedule meetings with regional legislators to discuss and promote the bill, and place meeting dates/times in a shared calendar
- Held a briefing prior to the Legislative Days event to review talking points
- Used a “divide and conquer” approach to meeting legislators in which delegates were divided into small groups so that we could cover all legislative offices in less time
- Identified talking points that appeal to legislators of both major parties. Fortunately, licensure portability is an easy sell on both sides of the aisle, as it can conserve licensure board resources (often appealing to conservatives) while making mental health care more accessible to Florida’s citizens (often appealing to liberals).
- Asking legislators to take photos with chapter delegates, and then posting those photos along with a thank-you message on social media pages, tagging legislators so they are recognized for their support.

Of course, what worked in Florida may not be the right fit in other states, but we hope that some of these FMHCA tips and strategies will help stimulate some creative brainstorming energy among other chapters.
AMHCA State Chapters

AMHCA Works With Chapters to Reach Out to First Responders

In collaboration with AMHCA state chapters interested in reaching out to their communities during the coronavirus, AMHCA sent the following draft letter to all AMHCA state chapter leaders. The idea was for state chapter leaders to customize the letter and send it to the heads of professional associations in their state.

In Virginia, for example, these associations would include the Virginia Hospital Association, Virginia Medical Association, Virginia Fire-fighters Association, etc.

“I believe the goal is to communicate to those leaders who head-up those groups that the behavioral health community is ready to help the folks they represent,” said Joel Miller, AMHCA executive director and CEO. “This is an organization-to-organization outreach.”

For more about AMHCA state chapters, go to amhca.org/about/chapters.

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AMHCA Drafts Letter for State Chapters to Send to First Responders and Health Care Professionals

<table>
<thead>
<tr>
<th>Mental Health Care Is Available for First Responders and Health Care Professionals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Mental Health Counseling professionals recognize the great stress that many of your members face. As behavioral health specialists, their education and training as Primary Mental Health Care Providers puts them in a position to support your members—with compassion, empathy, and intelligence.</td>
</tr>
<tr>
<td>Behavioral health providers want to take the burden off—as much as possible—of the professionals you represent through your association or organization. We want to assist you in the critical care networks you have created during the COVID-19 crisis.</td>
</tr>
<tr>
<td>These specialists include clinical mental health counselors (such as LPCs), psychologists, clinical social workers, and marriage and family therapists. They are all licensed to address emotional and cognitive distress.</td>
</tr>
<tr>
<td>Because the novel coronavirus has so many unknowns, it is anxiety-provoking. As troubling as it is for the general population, it is chronically disturbing for first responders and medical specialists. Professionals who experience repetitive distressing experiences commonly develop the snowballing effects of trauma, anxiety, and depression.</td>
</tr>
<tr>
<td>Members of the American Mental Health Counselors Association stand with our colleagues in the other behavioral health associations in offering support resources.</td>
</tr>
<tr>
<td>What can your members do right now?</td>
</tr>
<tr>
<td>• Create a list of two or three Primary Mental Health Care Providers you can call.</td>
</tr>
</tbody>
</table>

- Daily, practice self-care activities such as deep breathing, meditation, yoga, etc. |
- Be kind to yourself—avoid self-criticism and focus on the values of your vocation. |
- Continue to be who you are—compassionate and caring. |
- Stay (virtually) connected with colleagues, friends, and family by phone, email, or video-chat.

In the face of an unremitting crisis, many health care professionals have a tendency to emotionally disconnect from others. Unfortunately, this “flight response” is an entirely ineffective protective coping mechanism. Emotionally disconnecting alienates others when they are most needed for caring support. Isolating and repressing emotions is often a precursor to serious mental concerns.

As you continue to deal with effects of COVID-19, you are not alone. Many behavioral health specialists are available to talk with the members of the organizations and associations you represent, help them find their inner strength, and work with them to overcome any concern. Often, just a phone call will be immensely helpful and encouraging.

For more information, please visit amhca.org and [insert state chapter WEBSITE here].

The [insert STATE CHAPTER name here] is here to support you. Let us know how we can help.

Sincerely,

[insert name of state chapter LEADER here]
AMHCA [insert name of STATE CHAPTER here]
**AMHCA State Chapters**

**Tips for Responding to the Needs of CMHCs During a Difficult Time**

BY AARON NORTON, LMHC, LMFT, MAC, CFMHE, CFBA, CCMHC, AMHCA SOUTHERN REGION DIRECTOR, AND PRESIDENT, FLORIDA MENTAL HEALTH COUNSELORS ASSOCIATION (FMHCA)

As states begin to open up after businesses have been shut down for two or more months because of COVID-19, I’m hopeful that state and regional chapters of AMHCA will pass along important resources to frontline clinical mental health counselors (CMHCs). (See the section on “Clinical Mental Health Counseling & The Coronavirus” on pages 23–35.)

This is a difficult time, but I also think that this crisis can bring out the best in us—helping us to connect, collaborate, and support each other. For example, the AMHCA chapter in my state, the Florida Mental Health Counselors Association (FMHCA), has been very responsive to the needs of its members, beginning with the first wave of shutdowns in mid-March.

Other state chapters may also be interested in the variety of actions that FMHCA took, including:

- On March 15, FMHCA started a “COVID-19 Resources for Counselors” discussion thread on its online forum, which is updated frequently as new resources are shared. The thread includes tips for working with clients; transitioning to telehealth; office precautions; changes in federal, state, and local laws and rules; how emergency rules and executive orders impact CMHCs; resources to help clients maintain wellness while social distancing; and more.
- On March 16, FMHCA reached out to the state licensure board to dialogue about possible emergency rules that better facilitate transition to telehealth.
- On March 23, FMHCA started a “COVID-19 and Insurance Reimbursement for Telehealth” discussion thread on its online forum, allowing CMHCs to share information on how to get reimbursed for telehealth by state insurers. That same day, FMHCA issued an open letter to all state insurers to make telehealth available to all insured customers during the pandemic.
- On March 26 and 27, FMHCA piloted two free regional COVID-19 resource webinars, which included information on changes in state laws and rules, executive orders, and emergency board rules.
- On April 2, FMHCA presented a state-wide COVID-19 resource webinar and made it available to all licensed mental health professionals in the state. Some of the more than 500 attendees were so grateful for the help that they decided to become members, seeing the important role that associations play during difficult times.
- On April 5, FMHCA partnered with a national organization, the National Board of Forensic Evaluators, to disseminate its COVID-19 resources message across the country, and a free, on-demand version of the webinar has been made available to all AMHCA members (see nbfe.net/event-3808053 to register).
- On April 6, FMHCA provided a free webinar to all members on how to transition to telehealth.
- On April 10, FMHCA issued a letter to the state Attorney General’s office in an attempt to rectify a statute that precludes some counseling interns from providing telehealth without the same premises as a licensed mental health professional.
- On April 26, FMHCA provided a free, updated version of its COVID-19 resources webinar in partnership with the state’s licensure board.
- On May 1, FMHCA provided a free webinar on how to help clients during the pandemic. That same day, we sent letters to Gov. Ron DeSantis asking him to issue an emergency order permitting interns in private practice settings to provide telehealth without a licensed mental health professional on the premises and asking for liability protections for counselors providing services during the pandemic.

I hope that some of these efforts by FMHCA will give other state chapters some ideas on how to be responsive to the needs of their members during a widespread crisis, particularly one like COVID-19. By banding together as a profession, we can remain anchored as helping professionals. In turn, we can better serve our clients with a stabilizing presence during a challenging time.

For more information about FMHCA, visit fmhca.wildapricot.org.
As the coronavirus has swept through the nation, taking more than 120,000 lives before the end of June, CMHCs have responded to the needs of their clients and communities by helping them retain or regain their mental well-being, by:

- Protecting their clients physically and preventing illness from spreading (page s 24–26)
- Increasing their availability by adding or moving their sessions online (pages 27–28)
- Recognizing the importance of mental health during periods of physical isolation (pages 28–29)
- Coping with ongoing uncertainty (pages 30–31)
- Contributing to overall health simply by allowing clients a safe place to disclose their emotions (pages 32–33)

Check out more coronavirus resources (page 33)
Read a smattering of comments, thoughts, and statistics on mental health and COVID–19 (page 34)

For more information about coping with COVID-19, see amhca.org/publications/practiceguidelines/coronavirus.
CMHCs as “Essential Workers”

As state, county, and municipal governments continue to enforce various “safer at home” orders, emergency orders, and quarantine measures related to coronavirus (COVID-19), the question of whether clinical mental health counselors (CMHCs) are “essential workers” has been an important one. Essential workers are generally permitted to leave their homes and go to work because their jobs are considered essential to the safety and welfare of the public during the COVID-19 pandemic.

Though it is ultimately the responsibility of each CMHC to understand the definition used by local authorities, most governing bodies defer to guidance offered by the U.S. Department of Homeland Security (USDHS) for determining who an “essential worker” is. USDHS identifies health care/public health workers as a category of “essential workers,” citing examples such as “caregivers (e.g., physicians, dentists, psychologists, mid-level practitioners) … social workers … community mental health” as included occupations. Though the word “counselor” is not specifically listed, it is pretty clear that licensed CMHCs are covered under this provision.

Of course, just because CMHCs are essential workers does not mean that they should continue meeting with clients in person. Ultimately, this is an individual choice that must be made by each CMHC, and the importance of attending work in person may vary depending on the work setting of the CMHC.

I anonymously polled 653 CMHCs during nine webinars presented from March–May to determine how many were still seeing clients in person and how many have transitioned to telehealth. The majority of each sample consisted of private practitioners. Their responses are represented in the line graph and the pie chart here, and they are detailed in the table on the bottom of page 25.

As you can see, about half of CMHCs (51%) are providing telehealth only, and about 29 percent are either seeing clients in person only or working with clients through a combination of in-person and telehealth services. If my samples were assumed to be representative of all CMHCs in private practice, then between a quarter and a third of CMHCs are still having in-person contact with clients.

I suspect his number would be higher if I had the opportunity to survey more agency counselors. Some of the interns I supervise, for example, work in psychiatric units of hospitals, detox centers, and residential treatment programs that are providing in-person services, so all of their client contact remains in person.

12 Tips for Office Precautions

Given that many CMHCs are still seeing clients in person, it is critical for CMHCs to take important precautions to reduce potential for COVID-19 exposure. According to the Centers for Disease Control and Prevention (CDC), COVID-19 is spread...
primarily through close contact (defined as within about six feet) with a person who has the virus. Specifically, you can be infected by the virus in two ways: 1) You can take respiratory droplets into your eyes, nose, or mouth from an infected person when they cough, sneeze, or talk; or 2) You can touch a surface or object that contains an infected person’s droplets and then touch your mouth, nose, or eyes with the same hand that touched the exposed surface.

Given the means of infection, it is essential to 1) avoid coming within six feet of an infected person; and 2) avoid touching potentially contaminated surfaces and then touching your eyes, nose, or mouth. The CDC and World Health Organization (WHO) have provided several strategies for accomplishing these two objectives. Here is a list of examples of strategies that you can use in your office to implement those recommendations:

1. **Transition as many clients as possible to telehealth appointments.** The safest way to continue practicing clinical mental health counseling while avoiding infection is not to come into contact with potentially infected persons, and telehealth provides a means of accomplishing that.

   **To reduce liability, the American Psychological Association has recommended that practitioners create an informed consent form for clients who elect in-person vs. telehealth appointments during the COVID-19 pandemic. See a sample form here:** bit.ly/37gefc9.

2. **Never come within six feet of a client.** Do not shake clients’ hands or stand near them. Ensure that the chairs in your office and waiting area are greater than six feet apart from each other.

3. **In between each client’s visit, clean doorknobs, faucets, chairs, and other surfaces that clients touch using an appropriate cleaner such as Clorox wipes, Lysol, and rubbing alcohol.** Doing this properly would make it hard for infected droplets to be transmitted by hand from one person to another. Also, ultraviolet (UV-C) lamps have historically been used to disinfect surfaces from a variety of viruses, and recently the University of California–Santa Barbara demonstrated that UV-C light in the 260–285 nm (nanometers) range was 99.9 percent effective in killing COVID-19 in just 30 seconds (see bit.ly/2Utdt6t). Used safely and appropriately, UV-C lamps may be another resource for CMHCs wishing to disinfect office surfaces.

4. **Allow only one client in the office at a time.** To avoid close contact in waiting rooms and to ensure that surfaces are disinfected between sessions, consider asking clients to remain in their car until the CMHC or another employee opens the door to invite the client in.

<table>
<thead>
<tr>
<th>Date</th>
<th>Region</th>
<th>No. of CMHCs</th>
<th>In-Person Only</th>
<th>Telehealth Only</th>
<th>Combination of In-Person and Telehealth</th>
<th>Not seeing clients</th>
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<td>9 (53 %)</td>
<td>6 (35 %)</td>
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<td>149 (46 %)</td>
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<td>3 (13 %)</td>
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<td><strong>69 (11 %)</strong></td>
<td><strong>331 (51 %)</strong></td>
<td><strong>120 (18 %)</strong></td>
<td><strong>133 (20 %)</strong></td>
</tr>
</tbody>
</table>
COVID-19 Precautions
continued from page 25

5. Remove magazines and other unnecessary items from the office. If an infected client coughs, and droplets touch the surface of a magazine, clipboard, or other item in the office, then those droplets can be inherited by the next client who touches that same object.

6. Wash your hands frequently and appropriately. If you touch anything that is potentially contaminated, assume that your hands are now contaminated and wash them for a minimum of 15–20 seconds (approximately the time it takes to hum the “Happy Birthday” song twice) while rubbing your hands with soap, producing friction. Use a clean paper towel to dry your hands, and then use that same paper towel as a barrier to turn off faucets, open the door, etc.

7. Convert all office paperwork into electronic forms. Passing potentially infected paperwork back and forth is another unnecessary opportunity for exposure. CMHCs can use HIPAA-compliant online form builders such as JotForm (www.jotform.com) to create electronic versions of office paperwork. From now through 8/1/2020, JotForm is providing free HIPAA-compliant accounts to CMHCs through the Coronavirus Responder program (apply at jotform.com/corona-responder-program). If you continue to accept paperwork, then use disposable gloves when handling the paperwork and appropriately discard the gloves. If you handle paperwork with your bare hands, assume that your hands are potentially contaminated and wash them thoroughly before touching anything else.

8. Accept electronic payments only. Passing paper cash and checks by hand is another potential way to spread infected droplets. Instead, consider using electronic payment resources such as PayPal and Square to collect contact-free payments from clients. If you accept a payment by hand, assume your hands to be potentially contaminated and wash them thoroughly before touching anything else.

9. If you have access to sufficient supplies, make hand sanitizer available to clients as soon as they enter the office and just before they leave. Also, advise clients to appropriately sanitize their hands after leaving the office.

10. Have office staff work remotely if possible. If you have office workers, consider having them perform their duties from home—scheduling appointments, accepting forwarded phone calls, and verifying insurance benefits remotely by computer. If office staff are using a personal phone for work, consider having them download Google Voice (voice.google.com/u/0/about), using it to initiate and accept phone calls from clients to protect their personal phone numbers. The fewer people in the office, the easier it is to keep the office sanitized and to prevent possible transmission of the virus.

11. Post a sign on your office door prompting high-risk clients to call instead of entering. Consider a sign that instructs clients with fever, cough, or shortness of breath not to enter the office. Instead, these clients should call their physician and then call your office to inquire about telehealth options, cancel, or reschedule. I recommend being more flexible with late cancellation fees and no-show fees. It is better to have potentially infected clients cancel late than to have them come to an appointment to avoid having to pay an administrative fee. Of course, you should not come into the office if you have symptoms either—the last thing you’d want is to infect one of your clients because you did not follow the same rules you expect them to follow. Also, take your temperature daily to ensure that you do not have a fever; don’t just go by how you “feel.”

12. Practice social distancing outside of work. If you’re still seeing clients in the office, then you’re already taking enough risk as it is. No need to add to that risk by violating social distancing outside of work.

Remember that asymptomatic people may have the virus and be contagious, so telehealth and social distancing are the only reliable way to ensure that you neither transmit nor come in contact with a contagious person.
Amidst the COVID-19 pandemic, mental health counselors answered the call to continue responding to client needs. Even so, the connection might not always have been clear, the guidelines have been fluid, the resources constantly shifting, and the personal challenges intense.

Clinical mental health counselors (CMHCs) who had never done video or phone-based therapy were suddenly thrust into the maelstrom of providing services electronically to maintain a continuity of care (American Mental Health Counselors Association Code of Ethics, section B.5 — amhca.org/publications/ethics). CMHCs who had dabbled in providing services electronically now faced challenges implementing care consistently due to myriad issues. Even the most seasoned telehealth counselors may have found responding to COVID-19 demanding.

Historically, CMHCs have reported varying degrees of comfort and experience in providing services electronically. A 2013 study (not exclusive to clinical mental health counselors) noted provider concerns in three domains:

1. Technology barriers and workflow,
2. Licensure and reimbursement barriers, and
3. Personal barriers.

As the online AMHCA Open Forum (bit.ly/3dkhiZH) will attest, these three areas seem to have held true for CMHCs during the COVID-19 pandemic. CMHCs received new telehealth training, enhanced their training experience, and rose to the challenge of providing consistent services amidst stay-at-home orders. While responding to client needs, CMHCs were also managing many behind-the-scenes issues, such as: learning how to ethically and legally maintain services for current clients, onboarding new clients, and ethical code. Follow state laws.

Tips for Providing Telehealth Services

- **Be patient with yourself.** As stress increases, our best self becomes suppressed. Give yourself permission to learn from your experiences and grow through them.
- **Stay focused on what the client needs from you at that point in time.** When we focus on our clients, we often make better decisions for them, and for ourselves. Put yourself in your client’s shoes to learn how to provide services more effectively. Put them at ease with the technology you are using.
- **Take more frequent breaks.** “Zoom fatigue” is now a phrase we use to describe spending too much time in front of a screen. Get up and move. Stay hydrated. Wash your hands. Breathe. Stretch.
- **Learn from others.** I have learned more about the nuances of providing video-based therapy not from other clinical mental health counselors but from watching the news and other people’s videos. Focus on the images in their background. What works for you? What distracts you or makes it difficult for you to stay attentive?
- **Do what you do in your “normal” practice.** When we focus on our clients, we often make better decisions for them, and for ourselves. Put yourself in your client’s shoes to learn how to provide services more effectively. Put them at ease with the technology you are using.
- **Be professional.** Get dressed. (Yup, I went there.) Focus on your posture. Maintain appropriate eye contact. Adjust the camera so we don’t see your nose hairs. Pay attention to the lighting around you.

**Susan Meyerle** is a trendsetter in telemental health and ethics education through EthicsRock.com. She is very active in several organizations: American Association of State Counseling Boards (AASCB) (former president), Association of Marriage and Family Therapy Regulatory Boards (AMFTRB), Association of Social Work Boards (ASWB), Federation of Associations of Regulatory Boards (FARB), and the Nebraska Board of Mental Health Practice (past chair). An experienced educator, regulatory board member, therapist, author, and inspirational speaker, she strives to make reviewing ethical protocols interesting, engaging, and relevant. She last wrote for The Advocate Magazine on telehealth in the Fall 2018 issue (go to amhca.org/publications/advocatemag, then click on November 2018).
Isolation Affects Mental Health and Counseling

By Ekom Essien, LPC, NCC, CFMHE, CPCS, RPT-S

Assuming that people are for the most part social beings, and considering that prolonged isolation can adversely affect mental health, it’s easy to imagine that people who already have a mental illness will be more susceptible to the adverse effects of isolation.

We clinical mental health counselors (CMHCs) have had to remain vigilant during the COVID-19 crisis on behalf of our clients. Yet as we offer our services to individuals, families, and the general public, we need to remember that while isolation brings many challenges, some good may come from it as well.

Since mid-March, all over the country businesses have closed their doors, schools moved to total online learning, and mandatory stay-at-home orders were issued. The news remains grim, with reports of 2.8 million confirmed U.S. cases of COVID-19, and more than 130,000 deaths, historic unemployment rates, and projections of a lengthy national economic downturn.

While individuals naturally are experiencing increased anxiety and even depression-related rumination, most have generally accepted that isolating from others is necessary to protect their physical health. However, this solution came with unintended negative consequences, one of which is the effects of prolonged isolation. For those who do not have a history of mental illness, mild to moderate anxiety, irritability, restlessness, and feelings of helplessness may be manageable, but for someone already struggling to overcome mental illness, isolation can exacerbate existing conditions.

Telehealth: Can You Hear (and See) Me Now?

continued from page 27

At the end of my Ethics in Telemental Health training, many CMHCs wanted to know, “What do I do in order to get paid for providing telehealth services?” “What billing code do I use? What services are covered? What are the reimbursement rates for teletherapy?” as well as answers to many other questions. The coronavirus pandemic has also spurred CMHCs to become savvy at reading and interpreting Executive Orders, Presidential Actions, and legislative bills as they passed through Congress.

Adapting to the world of telehealth can be challenging in the best of times. Deciphering how to provide services so that sessions will be reimbursed continues to be complex. Beware that headlines can prove misleading. For example: “CMS Expands COVID-19 Telehealth Reimbursement to Therapists, Phone Services” (bit.ly/2XQDopy), published by Xtelligent Healthcare Media. Yes, the federal Centers for Medicare & Medicaid Services has expanded reimbursement for therapists—but for physical therapists—not CMHCs. Readers are often left to discern whether temporary rulings by various entities within the federal government or an Executive Order issued by their state’s governor relate to their service. CMHCs have to research whether insurance companies with which they are empaneled cover telehealth therapy, and if so, which type. Thankfully, AMHCA has identified a resource for CMHCs to check their state’s Executive Orders, at web.csg.org/covid19/executive-orders.

Navigating the maze of licensing requirements is often a test of patience. AMHCA advocated for states to allow, at least temporarily, practice across state lines. As always, it behooves CMHCs to check state licensing laws to ensure they are providing services legally. (See the AMHCA Open Forum discussion about licensure portability at bit.ly/36R7xJI, the article on page 20, and the Ethics Committee statement about it on page 33.)

You may be familiar with the long-held belief, although not linguistically accurate, that the Chinese symbol for “crisis” contains the characters for both danger and opportunity. Similarly, the coronavirus pandemic, while it has affected physical and mental health, also offers an opportunity for clinical mental health counselors to enhance their existing skill set by becoming adept at providing their services electronically. (See the box on page 27 for tips on telehealth counseling and more links to online resources on telehealth counseling on page 33.)

I hope that through the responses of CMHCs during COVID-19, we have laid the foundation to encourage 1) licensure portability, and 2) insurance reimbursement of electronically provided services (dare I say video and/or phone?). These two goals become possibilities—if we provide ethically sound services. All of us as CMHCs who during this health crisis are working to respond to our clients’ needs in innovative, ethical ways are making a valuable contribution. We all want to make a difference in the lives of the people we serve, and licensure portability and telehealth enable us to continue doing that.

Disclaimer: Keep in mind that this information is changing rapidly. Sign up to get real-time updates on regulations at ethicsrock.com.
Isolation Affects Mental Health Counseling continued from page 28

To reduce the potential negative impact isolation can have on mental health, it may be helpful for CMHCs to identify their most at-risk clients and to adjust the treatment plan to support them. In my practice, I have increased my availability to clients through secure messaging in the client portal of the electronic health record I use. Some counselors have rearranged their offices to support social distancing for clients who need to be seen face-to-face (see additional tips for counseling precautions on page 24).

Other CMHCs have increased their use of activities and tools—such as journaling, daily mood tracking/recording devices, and providing additional assignments—to provide extra support to clients who may be experiencing psychological difficulty during the coronavirus isolation.

Traditional mental health counseling is challenging enough, and doing it remotely presents unique challenges such as managing a crisis, counseling young children, and processing trauma. In fact, processing trauma is a contraindicator of tele-counseling. Although some counselors continue to see clients face-to-face, much of counseling has moved to telehealth during this public health crisis (see page 25 for statistics on CMHCs’ use of telehealth, and page 27 for more on telehealth).

Counseling via telehealth may make it more difficult to notice a decompensating client. For instance, a CMHC seeing a client via telehealth may note that the client’s general appearance seems neglected—and erroneously attribute it to a common adjustment people make to their routines during isolation, rather than a sign that basic ADLs (activities of daily living) are not being tended to. Another drawback to telehealth is that smell and other subtle changes cannot be assessed.

We know that someone experiencing a mental health crisis (such as psychosis and suicidal ideation) has a high risk of being harmed by others, or by themselves if suicidal. This public health crisis may increase that risk. Someone whose mental stability has decompensated with isolation as a contributing factor may be less able to remain in isolation, placing them in danger of contracting COVID-19 and spreading it to others. If we add to that the correlations between mental illness and comorbid medical conditions, that person’s risk of health complications with COVID-19 also increases. For this reason, CMHCs should have the appropriate knowledge of and access to crisis resources.

I have found that developing a working relationship with local psychiatrists, inpatient psychiatric hospitals, emergency receiving facilities, and non-emergency medical transport can make all the difference in mitigating distress that can arise during a crisis. CMHCs should have more than a general understanding of the procedure and process for hospitalization in their state and be able to explain the benefits of hospitalization to their clients.

With that in mind, timing is crucial, and all CMHCs should develop a crisis safety plan for their clients during the coronavirus pandemic. We should be prepared to manage a crisis remotely. We should also be prepared and willing to offer additional assistance to clients and be equipped with an arsenal of therapeutic techniques that include existential therapies, mindfulness, grounding, and other cognitive-based techniques.

In spite of the many challenges we all face during this health crisis, we can look toward some positive aspects of the current state of affairs. For instance, clients who may have been resistant to telehealth, and those who may be more prone to noncompliance and missed appointments for various reasons, may now be more receptive to counseling to reduce feelings of loneliness and anxiety experienced as result of physical isolation. We CMHCs can also use this time to be more innovative and creative, thus strengthening our counseling techniques and facilitation skills. Lastly—and especially now when the virus still threatens the physical and mental health of so many people—we can make an extra effort to take care of each other as professionals.

Ekam Essien, a licensed professional counselor in Georgia, currently works in private practice at Verity Counseling & Forensic Evaluations, where he specializes in trauma, anxiety, depression, and substance-use-related disorders. Essien is the Southern Regional director of the National Board of Forensic Evaluators, and an adjunct instructor at Brenau University. He is also a member of the Association for Play Therapy, and AMHCA’s Georgia chapter, the Licensed Professional Counselor Association of Georgia. For feedback, email mressien@veritycounseling.com.
We all know the shattering impact that post-traumatic stress syndrome (PTSD) has on individuals and families. Like PTSD, chronic distress has lasting effects.

Before the coronavirus hit, some people were living with chronic distress; others developed it as a result of quarantining, losing their jobs, or the way the virus changed their future.

What Is Chronic Distress?

This distress occurs when taxing experiences accumulate over time. The unknowns of the current coronavirus crisis can be viewed as a long list of questions that do not have many answers. For example:

• Will I be employed?
• What do I need to do to protect my health?
• What are my responsibilities to family members and friends?
• If I get sick, should I see my doctor if the symptoms are different from COVID-19 symptoms?
• What should I do if a friend asks me to help out?

The list of questions is almost endless. These concerns can create excessive worry and feelings of helplessness. Worries turn into anxiety and depression. Healthy individuals begin to question who they are. Diagnosable mental disorders multiply.

Suicide, self-harm, domestic violence, addiction, and assaults are beginning to dramatically surge. For example, police are responding to escalating gun violence and in-home violence against partners and children.

What Can We Do as Licensed Clinical Mental Health Counselors (CMHCs)?

1. **Self-care.** We always need to care for ourselves as individuals, and self-care has become an even more critical factor as we face our own questions and concerns. We also need to ensure a holistic approach to our wellness.

Health integration is fundamental because it incorporates the five essentials of physical wellness and emotional well-being—health, emotions, awareness, relationships, and transcendence. Each of these essentials impacts the other four. Together they regulate our overall health. Only when we take good care of ourselves can we really provide the highest degree of mental health counseling for others.

The five essentials of total health integration create the acronym “HEART”:

- **Health**—Physical wellness based on the principles of healthy living
  Consider how you are taking care of yourself. Our health depends on getting adequate sleep, drinking enough water, and eating well. Staying active is also important. Walking is a great all-around exercise, and you can do that in your home. Research has shown that daily activity reduces stress.

- **Emotions**—Emotional balance and enjoyment through self-understanding
  Know how to take care of yourself emotionally. Deep-breathing, listening to music you enjoy, meditating, playing with children’s toys such as blocks, doing a puzzle, etc.—all of these individual activities help us destress because they reduce anxiety.

- **Awareness**—Conscious use of our mental abilities
  Stay active and use your mind creatively. Make time to learn something new such as taking an online course, reading an entertaining book, expanding your knowledge about a hobby, etc. Awareness and engagement create mental health dividends.

- **Relationships**—Caring and satisfying connections with others
  Conversation is the most common means of staying connected. It is good to have at least five people we can talk with, including family members, friends, colleagues, and others. We should try to have positive conversations about topics other than our problems.

**5 Ways to Help Clients Deal With Chronic Distress**

By Gray Otis, PhD, LCMHC, CMHC, AMHCA Diplomate–Trauma

Gray Otis is a licensed clinical mental health counselor and an AMHCA Diplomate & Clinical Mental Health Specialist in Trauma. A past president of AMHCA, he currently serves as AMHCA’s director of Program Coordination and has a private practice in Cedar Hills, Utah. A frequent workshop presenter, he has authored many counseling-related articles and “The Clinical Mental Health Counselor Declaration,” and he co-authored the book “Key Core Beliefs: Unlocking the HEART of Happiness & Health” (KeyCoreBeliefs.org). Email him at gray_otis@yahoo.com.

**continued on page 31**
Face-to-face conversations in real time are helpful and can be done using Skype, Google Duo, FaceTime, etc.

Transcendence—Enrichment through inspiring and uplifting influences

This is a good time to focus on uplifting endeavors. Any activity that is elevating, inspiring, or enriching will buoy us. Doing yoga, enjoying art and music, or appreciating nature can be transcendent. Even though we cannot attend religious services, we can be enriched by prayerfulness, reading uplifting books, watching positive online presentations, etc.

2. Emphasize self-care for our clients. When clients feel stressed, they often neglect one or more of the five essentials of health integration. As we talk with those whom we serve, we can share what we are doing to take care of ourselves, and we can encourage others to also engage in activities that provide for holistic health.

3. Normalize for our clients. As we work with individuals, families, and groups, we should help them understand that being worried and concerned is normal during coronavirus times. We can help them distinguish those concerns that they can do something about and the questions and problems over which they are powerless.

For example, we cannot visit with friends who are sheltering in place so we may feel helpless. However, we can stay connected with them through text, phone calls, FaceTime, etc.

4. Stay connected. Because many are staying home, even as some states are opening, we need to encourage our clients to overcome isolation by connecting with others. That may mean checking on neighbors, sending a homemade card to a friend, or sharing a photograph through a text or an email. During these difficult times, we want everyone to find as many ways as they can to stay in touch.

5. Encourage “can-do’s.” Even during modified sheltering-in-place, help clients focus on what they can do. With every challenge comes opportunities. If someone is bored, ask what they can do that would be satisfying and worthwhile. Maybe it’s learning to cook something new, reading a book on a subject that is different, or having a game-night marathon. By focusing on what we can do rather than what we can’t, we feel capable and empowered.

When we remind our clients of ways that they can take care of their physical and mental health, they will have the tools they need to cope with many of the challenges the coronavirus creates. And as they solve problems, or learn to live with the ones they can't resolve, their chronic distress will ease. Working toward total health integration will not only help them weather the impact of the coronavirus, it will help them build their resilience for other challenges they may face.

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Counseling Strengthens Overall Health, Too

By Steven Vazquez, PhD, LPC-S, LMFT,

Even though contagious bacteria and viruses such as COVID-19 have made many people ill, some people exposed to the bacteria or virus have not gotten sick. I think it’s important to ask why not. While there are multiple contributing factors, one of the key factors is the difference in the functioning of immune systems. Stress plays a major role in the relative strength of the immune system. Therefore, appropriate psychological counseling that reduces stress could strengthen the immune system.

As our society adapts to the impact of the coronavirus on our physical and mental health, we can be proud of the important contribution that clinical mental health counseling makes to overall health. The three basic approaches to pursuing prevention and treatment of pathogenic microbes are:

- A medicine could be developed to conquer a specific pathogen.
- An approach to strengthen the immune system could be used.
- A combination of the first two approaches could be used.

Medicine has primarily focused on the first approach, pharmaceutical, which can be effective but has limitations. Consider that when a virus or bacteria becomes prevalent, medicine attempts to develop antidotes to destroy the illness-provoking pathogen. Medicine hardly ever kills them all, however, so the most resistant pathogens remain intact. These resistant microbes reproduce. Then medicine must develop an antidote specific to that new mutation of the microbes, which ultimately leads to the development of stronger, even more resistant microbes. These increasingly resistant strains make it more difficult for medicine to find a means to destroy pathogens.

Until 1968, medical doctors presumed that the human immune system operated separately from all of the body’s other systems. Since then, numerous scientific studies have shown that psychological factors are strongly linked to immune functioning. While physicians acknowledge these facts, they rarely prescribe treatment involving factors outside of the prevailing medical paradigm (the second approach to treating illness)—such as nutrition, exercise, and mental health counseling.

One example of the effects of psychological features on strengthening the immune system is the role of disclosures. James W. Pennebaker, PhD, conducted numerous studies in which he measured the level of immune strength before and after subjects disclosed disturbing emotions. He found that the strength of the immune system had a consistent tendency to elevate after disclosures. In breast cancer cases, Elizabeth Maunsell, PhD, and her associates found that the survival rate of breast cancer patients was 56 percent. However, if a patient had one confidant, it rose to 66 percent, and if the patient had two confidants, the survival rate rose to 76 percent.

These findings have profound implications for mental health counseling because it matters not only to whom a person discloses, but how the emotions that result from disclosure progress. Obviously, disclosures take place in most counseling sessions.

Counseling that elevates disclosure and bonding has a direct bearing on health improvement. Health improves largely as a consequence of disclosure of emotion—not just cognitive facts. One caveat to disclosure is that if the disclosure produces more emotional distress after the sessions, the increased stress levels are unlikely to be beneficial because stress hormones compromise immune functioning.

Clinical mental health counselors (CMHCS) often encounter numerous defense mechanisms in clients, including denial, avoidance, dissociation, anger, etc. These defenses are rooted in attachment disorders that often occur involuntarily. To work around these defense mechanisms effectively, I use an attachment-based interpersonal approach that tailors the interaction for each client. For example, confronting an avoidant-attached client tends to make the client more avoidant; a slower, empathic interpersonal approach tends to work better.

I also use Emotional Transformation Therapy (ETT®), a method I founded that is an attachment-based interpersonal process with outcomes that are radically elevated by precise visual brain stimulation (see www.ettaustin.com for more information).

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Clinical Mental Health Counseling & The Coronavirus

Counseling Strengthens Overall Health, Too 
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By using precise angles of light at specific wavelengths during interpersonal expression, clients’ emotional disclosure is often increased. In addition, ETT® can often reduce emotional distress within minutes. This process enhances disclosure and progression to emotional resolution. Many other methods that also enhance disclosure of unresolved emotions and produce rapid resolution have the capacity to enhance the immune system, though some cathartic counseling methods do not necessarily resolve the distress.

One reason I use ETT is because it focuses on enhancing disclosure of emotion and particularly on bringing that emotion to rapid consistent resolution. It is an experiential approach that works best when a person is currently feeling the emotion. During that experience, evidence suggests that the targeted emotional neural networks of emotional distress are deconsolidated, which makes them susceptible to change. Then through ETT processes, they tend to become reconsolidated, which means the emotional distress is ended—long-term.

It’s exciting that something CMHCs do routinely—respectfully encourage their clients’ safe emotional disclosure and resolution of disturbing emotions—can be so effective in helping clients cope with a new widespread virus.

The bottom line is that emotional disclosure and resolution strengthen mental health as well as immune system functioning, both of which are important tools for improving overall health.

More COVID–19 Resources for Clinical Mental Health Counselors

GENERAL

• Coping During COVID-19: Videos and articles written by mental health professionals on COVID-19-related topics
  Psychiatry & Behavioral Health Learning Network / bit.ly/2MCYPp4

• COVID-19 Resources for CMHCs:
  Posted on AMHCA’s Open Forum by Aaron Norton, LMHC, LMFT, MCAP, CCMHC, CRC, CFMHE, AMHCA Southern Region Director and president of the Florida Mental Health Counselors Association (FMHCA) / bit.ly/2zgcnDV

• The Implications of COVID-19 for Mental Health and Substance Use: Kaiser Family Foundation, April 21, 2020 / bit.ly/2Ahto9V

• Mental Health and COVID–19—Information and Resources: Mental Health America / mhanational.org/covid19

• Mental Health and Psychosocial Considerations During the Covid-19 Outbreak (30 messages for six targeted groups): World Health Organization / bit.ly/2Xlt8kk

• Tips for Coping with COVID–19: From Jim Messina, PhD, CCMHC, NCC, DCMHS-T, co-founder of AMHCA / coping.us/covid19tipsheet.html


AMHCA’s COVID-19 Information and Resources for CMHCs

With sections on About Coronavirus, Telehealth, Continuing Education, Advocacy Efforts, and AMHCA Resources
amhca.org/publications/practiceguidelines/coronavirus

LICENSURE PORTABILITY

The AMHCA Ethics Committee’s April 2020 statement on state portability issues (bit.ly/30yHjur). Download the AMHCA Code of Ethics, free, at amhca.org/publications/ethics. (Also, see the article on licensure portability in this issue on page 20, and AMHCA members’ online discussion of licensure portability during coronavirus at bit.ly/36R7xJl.)

TELEMENTAL HEALTH

• Telehealth and Privacy: Federal Guidance for SUD and Mental Health Treatment Providers: The Center for Excellence for Protected Health Information /go.aws/37dbqsl

• Check whether your state’s Executive Orders apply to you: web.csg.org/covid19/executive-orders

• Review AMHCA’s list of telehealth resources: amhca.org/publications/practiceguidelines/coronavirus
  (See also the Telemental Health webinar under the “Webinar” section, and the article by Susan Meyerle, PhD, LIMHP, CEAP on telemental health in this issue on page 27.)

WEBINARS

Download AMHCA webinars at amhca.org/career/webinarsarchive.

• “Telemental Health Best Practices Overview,” 4/14/2020

• “Psychological First Aid During COVID-19,” free to all professionals (with NAADAC). April 29, 2020

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Talking About Mental Health & COVID–19 ...

“Making behavioral changes easy to maintain could become particularly important as lockdowns stretch on and strains build, says [Susan] Michie, [a health psychologist at University College London and director of its Centre for Behaviour Change]. Past research has found compliance during an epidemic can decline over time.”


“Just as the initial outbreak of the novel coronavirus caught hospitals unprepared, the United States’ mental-health system—vastly underfunded, fragmented and difficult to access before the pandemic—is even less prepared to handle this coming surge.”


“Mental-health experts are especially worried about the ongoing economic devastation. Research has established a strong link between economic upheaval and suicide and substance use. A study of the Great Recession that began in late 2007 found that for every percentage point increase in the unemployment rate, there was about a 1.6 percent increase in the suicide rate.”


“Adults in the U.S. report that worry and stress related to the coronavirus outbreak is affecting their mental health and well-being in various ways. Four in 10 say such worry or stress has led to problems with their sleep, while one-third say they either have had a poor appetite or have been over-eating. Some also say worry or stress related to the coronavirus outbreak has caused them to experience frequent headaches or stomachaches (18%), difficulty controlling their temper (15%), or increasing their alcohol or drug use (13%). About one in 10 (9%) say coronavirus-related stress has led to worsening chronic health conditions. Over half of U.S. adults (56%) report that worry or stress related to the coronavirus outbreak has affected them in at least one of these ways.”


“Preliminary research suggests that mind-sets about stress can be changed with short and targeted interventions. These interventions do not focus on viewing the stressor (such as the virus) as less of a threat. Instead, they invite people to recognize that we tend to stress about things we care deeply about and that we can harness the stress response for positive gain. A number of studies found that inducing more adaptive mind-sets about stress could increase positive emotion, reduce negative health symptoms, and boost physiological functioning under acute stress.”


“Of the many cruelties of the coronavirus pandemic, this is one of the hardest to accept: In a time when all we want is to be close to the people we care about, closeness is the one thing we can’t have. Six feet has never felt farther away.”

From The Washington Post, May 2, 2020: wapo.st/2UneqNV

“Find something I can control and control the heck out of it. In moments of big uncertainty and overwhelm, control my little corner of the world. I can organize my bookshelf or purge my closet. It helps to anchor and ground me when the bigger things are chaotic.”

From “What I Need to Do During This COVID-19 Pandemic,” coping.us/covid19tipsheet.html

“Its asymmetry might be the aspect of this crisis that has the most to teach us about how to live our lives better from here. When some people are getting utterly wiped out while others catch up on sitcoms, it’s a sharp reminder of what to do any time we’re feeling flush or comfortable: to make a point of looking up from our own (metaphorical) knitting, on a regular basis, to see what others might need us to do.”

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Chronic Pain: The Potential Role of CMHCs in Providing Non-Medication Pain Management

Jim Messina, PhD, CCMHC, NCC, DCMHS-T, has been an instructor at the Troy University Tampa Bay Site Clinical Mental Health Counseling Program since 2010. He has been providing behavioral medicine interventions since 1980, when he became the behavioral health consultant at United Cerebral Palsy in Tampa, working with a team of rehabilitation specialists, neurologists, and pediatricians for 20 years. After retiring from private practice in 2000, he worked at St Joseph’s Hospital for five years and spent seven years working in rehabilitation and nursing facilities with primary care physicians in an integrated care model. He has authored 16 books and several online learning sites, available free on his website coping.us. A co-founder of AMHCA and its second president, Dr. Messina was on the founding board of the National Board for Certified Counselors (NBCC). He is also the moderator for AMHCA’s online Integrated Medicine Community Forum.

Pain management is important for ongoing pain control, especially for patients who suffer with long-term or chronic pain. Since psychotherapy is one type of treatment that doctors recommend to their patients for pain relief, this is an area in which licensed clinical mental health counselors (CMHCs) can make an important contribution. CMHCs can provide non-medication pain management treatment by working in partnership with referring physicians, rehabilitation centers, hospitals, or community clinics that are dedicated to providing a wholistic approach to assisting patients with both acute and chronic pain.

Chronic pain affects about 50 million Americans, and for 20 million of them, the pain is so bad that it keeps them from doing the daily activities of life. According to the U.S. Centers for Disease Control and Prevention, chronic pain and high-impact chronic pain are more common among women, older adults, the poor, people previously but not currently employed, those with public health insurance, and those living in rural areas. Not only is chronic pain widespread, it lies at the root of the opioid epidemic.

To be effective with patients, CMHCs need to know the evidence-based practices for pain management, which will also enable them to work alongside the medical professionals treating patients in pain. Patients in pain need to see that CMHCs are focused on them as people who will benefit from proven, non-medication interventions that will lessen or eradicate pain in their lives. (For information about the U.S. Department of Health and Human Services’ 2019 report, “Pain Management Best Practices,” see the box on page 37.)

NON-MEDICATION APPROACHES TO PAIN MANAGEMENT

CMHCs who work with patients in pain should focus on providing support related to the individual patient experiences rather than the diagnostic label—think “pain in the patient” rather than “pain as pathology,” according to an April 2015 article in Health Sociology Review. To help patients manage their pain, counselors need to recognize that pain alters their definition and understanding of themselves.

It’s also important that CMHCs are aware of factors that can negatively affect outcomes of non-medication therapeutic treatment approaches to chronic pain. According to an article in the November 2016 issue of the Journal of Alternative and Complementary Medicine, these factors include:

- **Patient expectations for pain relief.** Patient expectations may be associated with outcomes of complementary and alternative medicine (CAM) treatments for chronic pain. A psychometrically sound measure of such expectations—the EXPECT Questionnaire—is now available for use. (View the original article and EXPECT Questionnaire at ncbi.nlm.nih.gov/pmc/articles/PMC5116692, and see a modified version of the questionnaire on page 40.)
- **Financial and insurance barriers:** Using alternative or non-medication solutions to treat chronic pain must always include consideration of how the costs of such services will be paid for, subsidized, and handled by the target patients. For example, a study in the November 2015 issue of Australian Health Review found that low-income patients with chronic non-cancer pain who were on long-term opioid therapy were less likely to use CAM treatments.

Continued on page 37
Limited evidence of efficacy: These same patients resisted using CAM treatments in addition to prescribed opioids because of the limited evidence of efficacy for some CAM therapies.

Some non-medication treatments found to be helpful in pain relief include both mindfulness meditation and massage. After mindfulness meditation, patients in a 2015 study reported feeling rested and in better control of their pain and its role in their life. One caveat the study raised is that patients who recognized that pain is part of their life and were living under stable conditions may have been more likely to learn and put forth more effort, making for more positive outcomes. A 2017 study published in the Journal of Back and Musculoskeletal Rehabilitation found that the majority of patients using CAM perceived benefits—in particular, women living in urban areas, the highly educated, those 40 and older, and those suffering from severe chronic back pain.

Patients who were asked about their experience with Department of Veterans Affairs (VA) health care, and which therapies they thought would most benefit other veterans, reported that massage was well-received and resulted in decreased pain, increased mobility, and decreased opioid use. Still, they noted three factors that often impeded their ability to acquire such services: the high ratio of patients to complementary and integrative health (CIH) providers, the difficulty of receiving CIH from fee-based CIH providers outside of the VA, and cost.

On May 9, 2019, the Pain Management Best Practices Inter-Agency Task Force, part of the U.S. Department of Health and Human Services, published its report: “Pain Management Best Practices.” One section in the report is Clinical Best Practices, which lists pain management approaches that include:

- Medications,
- Restorative Therapies,
- Interventional Procedures,
- Behavioral Health Approaches, and
- Complementary and Integrative Health.

Significantly, MBSR (Mindfulness-Based Stress Reduction) was listed not only as a clinical best practice under Behavioral Health Approaches, but also under Complementary and Integrative Health.

MBSR is a mind-body treatment typically delivered in a group format that focuses on improving patients’ awareness and acceptance of their physical and psychological experiences through body awareness and intensive training in mindfulness meditation. As the report points out, MBSR teaches patients to self-regulate their pain and pain-related comorbidities by developing nonjudgmental awareness and acceptance of present-moment sensations, emotions, and thoughts.

Research on MBSR points out its effectiveness in helping individuals cope with a variety of pain conditions including rheumatoid arthritis, low back pain, and multiple sclerosis (MS). In addition, according to the report, MBSR has a positive impact on pain intensity, sleep quality, fatigue, and overall physical functioning and well-being.

In the Complementary and Integrative Health Approaches section, the report notes that MBSR incorporates mindfulness skills training to enhance one’s ability to manage or reduce pain. Mindfulness enables an attentional stance of removed observation and is characterized by concentrating on the present moment with openness, curiosity, and acceptance, allowing for changes in one’s point of view on the pain experience. Further, MBSR significantly reduces the intensity and frequency of primary headache pain and has significant benefits for low-back pain.

Download a free PDF of the report at bit.ly/37megKa.
Research findings support the effectiveness of behavioral health care for pain management:

• In a 2008 review of 83 studies—comprising exercise therapy, back schools, transcutaneous electrical nerve stimulation (TENS), low-level laser therapy, massage, behavioral treatment, patient education, traction, and multidisciplinary treatment—behavioral therapy stood out as being effective in reducing pain intensity. This makes sense because the aim of behavioral therapy is not to treat pain, but to help the patient learn to modify one of the three response systems: behavioral, cognitive, and physiological reactivity. Combining different non-medication treatment strategies was also thought to have contributed to reducing pain intensity.

• A systematic meta-analysis of 42 studies of patients with chronic low back pain (LBP) who had used behavioral non-medication intervention—including Mindfulness-Based Stress Reduction (MBSR), Cognitive Behavioral Therapy, and Acceptance and Commitment Therapy—found that:
  - Behavioral therapy approaches are effective, particularly in altering pain perception and helping patients regain their functionality.
  - Behavioral therapy treatment outcomes are improved when the treatments are personalized to individual patients’ needs.
  - Multidisciplinary rehabilitation needs to include more than just physical treatment.

To increase the odds of success of a pain-treatment plan, CMHCs should encourage in their patients a positive expectation about the program of non-medication ... and a clear understanding of the potential length of time their treatment will take.

MAKING SUCCESSFUL PAIN-MANAGEMENT PLANS WITH PATIENTS

According to a 2018 Journal of Family Practice article (bit.ly/3bwHUQb) about a meta-analytic review of 42 articles on non-medication pain management, every pain-management plan should include the following non-medication modality recommendations:

1. Self-care goals
2. Exercise or movement-based treatments
3. Mind-body treatment
4. Complementary modalities

To increase the odds of success of a pain treatment plan, CMHCs should encourage in their patients a positive expectation about the program of non-medication they will be going through and a clear understanding of the potential length of time their treatment will take.

Patients also benefit when CMHCs provide them with psychoeducation about the research support that exists for the use of the planned interventions. Patients also will want to know whether the costs of such interventions are supported by their insurance health plans, and what the out-of-pocket costs are in advance so they know whether or not they can afford the treatment.

It’s crucial for success that CMHCs focus their attention on the patients’ feelings, providing information about the strategies involved in the treatment plan and emotional support, so that patients feel that they are being treated as a person rather than a “pain-diagnosed subject.”

In addition, all professionals involved on the treatment team should not only be supportive and informed, but collaborate with the patients in the use of mindfulness in their respective portion of their planned treatment for the patients.

Free Integrated Care Resources

AMHCA members can find many of the tools mentioned in this article online in AMHCA’s Integrated Medicine Community library, at bit.ly/2Hk4RZ6, and at the author’s website: coping.us.

For a guide on how CMHCs can help patients manage their pain without medication, see page 39.
A Prescription for Licensed Clinical Mental Health Counselors to Help Patients Manage Their Pain Without Medications

If patients are referred to you from their medical team and come to you saying they want help dealing with their chronic pain, here’s what you can do:

1. Ask for a release of information: It’s helpful to read the patients’ medical records to better understand what the sources of pain are, and what has been attempted previously to help relieve their pain. Also, if the patients have been to other professionals to address their pain issues, then you need releases of information so that you can get reports on their treatment and progress from the other professionals working with them.

2. Complete an Initial Clinical Assessment: Before developing a treatment plan for your patients, be sure to do a complete Initial Clinical Assessment (bit.ly/39Iun6l), which includes exploration of ACE (Adverse Childhood Experiences) Factors (bit.ly/2UZ4Ktv) and history of any other major medical, social, or interpersonal traumatic events that might account for the severity and duration of their chronic pain.

3. Utilize Motivational Interviewing Strategies: It is important once the initial assessment is completed that you utilize Motivational Interviewing Strategies (coping.us/motivationalinterviewing.html) to determine if the patients are actually ready to do the work necessary to accept their pain as a reality of life, and to work seriously at following through with the steps being outlined for them to lessen the impact of pain in their lives.

4. Present the following outline of procedures to address their chronic pain:
   - **Self-care goals:** Healthy diet, healthy seven-to-eight hours of sleep each night, use of Mindfulness Meditation to stay centered and focused. See bit.ly/2uSGJuU to lessen daily stress, and bit.ly/37AbmS3 to become relaxed enough to fall asleep easily each night.
   - **Exercise or movement-based treatments** (e.g. therapeutic exercise, yoga, tai chi): At a minimum, 30 minutes of aerobic exercise daily (start easy by just walking) and muscle-stretching daily to loosen up tightness.
   - **Mind-body treatment** (e.g. Mindfulness-Based Stress Reduction (MBSR) or Mindfulness-Based Cognitive Behavioral Therapy (MBCBT)): in group therapy and, if needed, in individual sessions as well.
   - **Complementary modalities** (e.g. physical therapy, osteopathic manipulative treatment, chiropractic, massage)

5. Have them take the modified EXPECT Questionnaire (see page 40): If the patients accept the proposed model of non-medication treatment of their chronic pain, then have them take the modified EXPECT Questionnaire (see box on page 40) to determine the level of their motivation and belief that the proposed intervention program will be successful in helping them cope with their chronic pain. Enroll your Chronic-Pain Management patients in either MBSR or MBCBT in your office, either in a group and/or individually.

6. Track your patients’ progress: Keep up on the progress of your patients’ diet management, exercise schedule, sleep record, and participation in any other complementary modalities. Send weekly progress reports to your patients’ primary care physicians during the entire course of their treatment plan with you.

7. Conclude your work together: Once the proposed length of time for the treatment approaches, ask patients to evaluate their progress. Have your patients come to an agreement with you about when the formal sessions together in your office will end.

All of the websites referred to in this “prescription” will take you to coping.us pages. For more information on non-medication pain management, visit another coping.us page: bit.ly/39IU86B.
The EXPECT Questionnaire (Modified)

I am now going to ask you a series of questions about the effects that the treatment plan presented to you may have on your physical limitations due to your pain. In each case, the question is asking about the results at the end of the treatment period.

CHRONIC PAIN: Please answer the following two questions on a scale of 0 to 10, where 0 is “no change or worse” and 10 is “complete relief.”
1. How much change do you hope for in your pain? ____
2. How much change do you realistically expect in your pain? ____

IMPACT OF CHRONIC PAIN ON YOUR LIFE: Please answer the following two questions on a scale of 0 to 10, where 0 is “no change or worse” and 10 is “pain no longer impacts my life.”
3. How much change do you hope for in the impact of chronic pain on your life? ____
4. How much change do you realistically expect in the impact of your pain on your life? ____

SLEEP/MOOD/ENERGY: If any of the following three questions about sleep, mood, and energy are not relevant for you because your pain does not impact that area of your life, please answer “not applicable” (n/a).
5. How much change do you realistically expect in your pain-related sleep problems? ____
6. How much change do you realistically expect in your mood or irritability? ____
7. How much change do you realistically expect in your energy? ____

COPING: Please answer the following question on a scale of 0 to 10, where 0 is “no improvement” and 10 is “extreme improvement.”
8. How much improvement in your ability to cope with pain do you realistically expect as a result of your proposed treatment plan presented to you? ____

9. How much change do you hope you will have in your pain-related physical limitations? ____
10. How much change do you realistically expect in your pain-related physical limitations? ____

IMPACT OF CHRONIC PAIN ON SPECIFIC AREAS OF LIFE: The next three questions ask about the effects that the proposed treatment plan may have on the impact of your pain on specific areas of your life. In each case, the question is asking about the results at the end of the treatment period.
If any of these questions are not relevant for you because your pain does not impact that area of your life, please choose “not applicable” (n/a).

11. How much change do you realistically expect in the impact of your pain on your work, including housework? ____
12. How much change do you realistically expect in the impact of your pain on your social and recreational activities? ____
13. How much change do you realistically expect in the impact of your pain on your daily activities? ____

This questionnaire is #5 in “A Prescription for CMHCs to Help Patients Manage Their Pain Without Medications”, p. 39.
The older I have become, the more I appreciate the importance of sleep. I have noticed that when I sleep better, I am a better clinical mental health counselor (CMHC), I handle stress better, and I am better able to cope with my unhelpful thoughts, feelings, and emotions. Armed with this insight, I began to emphasize sleep in my clinical practice as a CMHC, by including sleep assessment, sleep check-ins, and regular psychoeducation related to sleep.

Almost synergistically, I began working with the emerging adult population and began to see that many students had very bad sleep habits that seemed to worsen in college or graduate school. Students often pull all-nighters, and higher-education instructors often give midnight deadlines for assignments. I found that if I could get emerging adults sleeping in a healthy way, their mental health symptoms improved—and so did their academics.

I began researching sleep with the goal of developing expertise in cutting-edge sleep interventions informed by neuroscience that could complement and enhance my counseling efforts. This article is based on the culmination of my journey to becoming a CMHC with a sleep expertise, and it introduces what I have learned and implemented in my neuro-informed counseling practice related to sleep.

SLEEP STATS: THE BASICS

Sleep issues and sleep disorders are more common than most of us realize. A population study by Jane E. Ferrie that appeared in the December 2011 International Journal of Epidemiology found that daily, 20 percent of 25-to-45-year-olds got 90 minutes less sleep than they needed to be in good shape. Additionally, insomnia is the most common sleep disorder, with approximately 30 percent of adults reporting insomnia-related symptoms, and about 10 percent of adults reporting chronic insomnia. The most common types of sleep issues are insomnia (10% of population), sleep apnea, restless leg syndrome (10% of adults and 2% of children), narcolepsy (1 in 2,000), and REM Sleep Behavior Disorder.

A 2019 article published by the Netherlands Institute for Neuroscience hinted that insomnia, the most common diagnosable sleep disorder, is quite complex. The study concluded that the sleep condition has five subtypes that differ by personality traits, as well as each individual’s brain activity, risk for depression, and response to treatment. This finding suggests that clinicians will eventually develop faster-acting, and more personalized, effective treatments for insomnia.

SLEEP OVER THE COURSE OF LIFE: DIMINISHING RETURNS

One little-known aspect of sleep that is important when working with clients is that sleep needs change significantly over the course of a lifetime. The shift in sleep is one of the most significant physiological changes in humans over the life span. In utero, an individual spends between 90 and 100 percent of the day asleep, according to neuroscientist Matthew Walker, PhD, whose research examines the impact of sleep on human health and disease. Additionally, science tells us that the motor cortex is up to 30 percent more active when we sleep and also acts as a neuro-fertilizer, which is why one sleeps so much during the first year of life.
Neurocounseling
Interventions That Improve Sleep

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In adolescence, Walker notes that deep non-REM sleep increases in its amount to enable the brain’s synapses to be sculpted and trimmed in order to make our brains lean and efficient.

After emerging adulthood, the great sleep depression begins. Scientists can objectively measure the decline in an individual’s deep sleep beginning in our 30s. By the time we turn 50, we have lost almost 50 percent of our deep-sleep capacity compared with when we were teenagers; by the time we reach 70, we have lost almost 90 percent. At 80, scientists can no longer objectively measure deep-sleep brain waves, according to Walker. After 80, the brain simply cannot produce the deep sleep that individuals still need. It is important for CMHCs to know that in late adulthood, clients require just as much sleep as they did in their 40s and 50s, and the typical decline in deep sleep may account for the strong association between Alzheimer’s disease, cognitive decline, and sleep, according to Walker, who has been referred to as a “sleep evangelist.”

WHAT’S ANXIETY GOT TO DO WITH IT?

In the United States, anxiety continues to be the most treated mental health issue, with as many as one in five individuals having a diagnosable anxiety disorder according to the Anxiety and Depression Association of America (ADAA). Anxiety is also the most frequently reported mental health condition diagnosed in college counseling centers, per the 2019 annual report of the Center for Collegiate Mental Health.

What is not commonly known is that anxiety has a bi-directional relationship with sleep. This means that if you are anxious, your ability to sleep is hindered, and if you are not sleeping, you are more likely to be more anxious. The vicious sleep–anxiety cycle can become difficult to resolve. As CMHCs, however, once we become aware of this dynamic through assessment, we can then assist our clients in addressing the anxiety and sleep issues concurrently. Helpful interventions include:

• Sleep hygiene psychoeducation (see a list of sleep apps at amhca.org/publications/advocatemag,
• Traditional counseling interventions such as cognitive behavioral therapy (CBT), or CBT for insomnia, and
• New emerging neuroscience-informed interventions such as neurofeedback.

(See the box on page 44 for links to “New Neuroscience Informed Anxiety and Sleep Treatments,” and see the box on page 45 for a list of additional sleep-related resources.)

SLEEP HYGIENE: ELIMINATING THOSE SLEEP CAVITIES

Utilizing sleep hygiene psychoeducation can be effective in helping clients interrupt the notoriously difficult-to-treat bi-directional relationship between sleep and mental health. A clinician can start by discussing how much sleep is needed, based on the individual’s age. The average individual needs seven to nine hours of sleep, which is biology dependent and has some variation. However, when an individual gets below seven hours of sleep, scientists can measure objective impairments in almost everyone. Additionally, zero percent of the population—no one!—can go through the day on less than six hours of sleep without significant impairment. We also need to let our clients know that 16 hours of wakefulness is required to create enough sleep pressure to create deep, restful, sustained sleep, Walker found.

Deep sleep depends on an environment that is cool, dark, and sufficiently quiet.

• Cool enough: An individual’s body needs to drop between two to three degrees to initiate sleep. Room temperatures between 67–68 degrees are optimal.
• Quiet enough: The room in which we sleep must also be dark enough and quiet enough to be conducive to deep sleep.

Download a FREE Sleep Improvement Treatment Planner

The Sleep Improvement Treatment Planner (SITP) is a structured instrument designed to aid clinical mental health counselors and other appropriately trained mental health professionals in identifying appropriate cognitive behavioral treatment interventions for patients with a diagnosis of Insomnia Disorder.

The SITP is not a diagnostic tool and should only be used after a diagnosis has been formulated. The SITP was created by Aaron Norton, LMHC, LMFT, MCAP, CCMHC, CRC, CFMHE.

Download it, free, at anorton.com/userfiles/688392/file/Sleep%20Improvement%20Treatment%20Planner(1).pdf or at amhca.org/publications/advocatemag.

Continued on page 43
• Dark enough: Darkness releases the brakes that prevent the delivery of melatonin and therefore creates the proper timing for sleep to occur. As a general guideline related to sleep hygiene, I tell clients to decrease the lights in their home two hours before sleep. Studies have shown significant delays in falling sleep when one reads an iPad or other blue screen before bed. That’s because light tells the body to wake up and to produce the steroid cortisol, which needs to be low during periods of sleep.

Remind clients that their bed should be associated with sleep, and that doing activities in bed aside from sleep and sex confuses the body. Finally, let clients know that having consistent sleep and wake times is important, and that sleep does not function like a bank account—so “depositing” extra sleep on the weekend cannot make up for sleep deficits during the week.

COUNSELING-RELATED SLEEP INTERVENTIONS: THE OLDIES BUT GOODIES

Many evidenced-based practices have been found to be helpful in treating anxiety and depression and ultimately improving sleep (by interrupting the negative bi-directional cycle between mental health and poor sleep). CBT, dialectical behavior therapy (DBT), person-centered, and other third-wave cognitive therapies have all been shown effective in treating mood-related disorders, according to a 2017 article in *Neurotherapeutics*, the journal of the American Society for Experimental Neurotherapeutics (ASENT).

Consequently, all of these therapies are typically effective in treating sleep-related issues. However, Walker observed in 2017 that individuals who appear to have an atypical autonomic nervous system (ANS)—in particular, one that seems to be turned on high—may therefore struggle chronically with sleep-related issues and may benefit from adjunctive neuroscience-informed treatment.

NEUROSCIENCE-INFORMED INTERVENTIONS: THE NEW FRONTIER FOR ISSUES WITH SLEEP

Neuroscience-informed clinical practice continues to grow in popularity among counseling professionals. Many books related to neuroscience are commonly referenced to CMHCs who are interested in encouraging better sleep for their clients—including “Mindsight” by Daniel J. Siegel, MD; “Being a Brain-Wise Therapist” by Bonnie Badenoch, PhD, LMFT; and the soon-to-be-released book, “The Neuroeducation Toolbox: Practical Translations of Neuroscience in Counseling and Psychotherapy” (First Edition), co-edited by AMHCA President Eric Beeson, PhD, LPC, NCC, ACS, CRC, and Raissa Miller, PhD, LPC.

Even more exciting is that many new or renewed neuroscience-related technologies are showing efficacy in treating
mental health and sleep-related issues as a primary or adjunctive treatment. Here I will describe four neuroscience-related technologies of note: biofeedback and neurofeedback, HeartMath, binaural beats, and transcranial magnetic stimulation.

These technology-aided adjunctive treatments, which are readily provided in a counseling setting, can be delivered directly to clients by appropriately trained and certified CMHCs in concert with standard counseling modalities. CMHCs can also recommend them to clients as a way to enhance their treatment via a referral to a well-vetted and certified provider.

Biofeedback and Neurofeedback

Biofeedback is the method of achieving greater understanding of physiological functions by using instruments that provide information on the activity of those same systems, with a goal of being able to influence them when needed. Brainwaves, muscle tone, skin conductance, heart rate, and pain perception can all be manipulated. During biofeedback, electrical sensors are placed on your body in order for you to receive information (feedback) about your body (bio).

During biofeedback, patients are taught techniques to improve their health by developing voluntary—and greater—

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control over the physiological processes affected by stress. Stress levels are recorded using a computer, special software, and sensors placed on the body. The client can learn to manipulate normally involuntary processes such as heart rate, blood pressure, and muscle tension that rise when stressed. The computer or other device provides data or “feeds back” the intentional practice, and eventually the client will be able to relieve the stress and relax through a fine-tuned stress-recognition ability.

Neurofeedback (NFB) is a more recent variation of biofeedback that uses real-time visuals of brain activity, most commonly electroencephalography (EEG), to help clients teach themselves regulation of brain function. Most commonly, sensors are placed on the scalp to measure brain activity, with measurements displayed using sound or a video monitor. During sleep, the brain is able to sort and organize all the information taken in during the day. Interestingly, with decreased sleep, mental performance decreases nearly twice as rapidly as physical performance.

A client might have difficulty sleeping for many reasons—anxiety, burnout, trauma, stress, or habitual obsessive thinking. But whatever the etiology, the sleep-shy brain has lost the capacity to transition into the right state for sleep. Neurofeedback aids people in restoring their natural sleep rhythms. By training brain control and flexibility, a smooth and natural transition of the central nervous system (CNS) from activation to rest can result.

HeartMath

University counseling centers commonly use HeartMath, a type of biofeedback, as demand for it in higher education settings has continued to increase. HeartMath advertises its services as “a scientifically validated set of techniques, leading-edge products and programs, and advanced technologies” for “individuals interested in personal development and improved emotional, mental, and physical health.” HeartMath provides clients with practical ways to manage stress, change, and uncertainty, and to construct their “heart coherence and energy reserves.”

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Additional Sleep-Related Resources

- **Importance of Sleep**: Matthew Walker
  - Why we sleep. CIIS Public Programs podcast (guest). (2017, October 19), soundcloud.com/publicprograms/matthew-walker
  - TED Talk, April 2019, “Sleep Is Your Superpower”: ted.com/talks/matt_walker_sleep_is_your_superpower#t-71641
- **Sleep Disorders**: Hines, J. (2018). The 4 most common sleep disorders: Symptoms and prevalence. alaskasleep.com/blog/the-5-most-common-sleep-disorders-symptoms

For more resources, see “New Neuroscience-Informed Anxiety and Sleep Treatments” in the box on page 44.
Neurocounseling Interventions That Improve Sleep

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Individual heartbeats have a natural rhythm, and HeartMath is able to show clients that when they are worried, anxious, frustrated, or stressed, their heart rhythm becomes irregular. The underlying idea is that the greater the stress, the more chaotic the heart rhythm pattern becomes. HeartMath has done research that has shown that expressing positive feelings—such as love, care, gratitude, appreciation, compassion, and joy—smooths out chaotic heart rhythms. Expressing positive feelings not only feels good, the results are good for your overall health. When HeartMath is able to organize your heart rhythms, reduce cortisol, and increase DHEA (the vitality hormone), you will be able to sleep more soundly and wake up feeling more energized and refreshed.

**Binaural Beats**

Binaural beats therapy is a developing form of soundwave treatment in which the right and left ears listen to two somewhat different frequency tones, yet recognize the tone as one. For the treatment to be effective, the binaural auditory beat that a person hears (the difference in frequency created between the left and the right ear) should be at frequencies lower than 1,000 hertz (Hz) so that the brain is able to detect the binaural beat. For example, if one’s left ear registers a tone at 200 Hz and the right ear registers it at 210 Hz, the binaural beat heard is the difference between the two frequencies—10 Hz.

A human’s brainwave activity during sleep is largely dissimilar from the brain activity when one is awake. (REM sleep is one exception to this—during REM, brain activity is similar to awake states.) During non-REM sleep, the slower, lower frequency theta and delta waves dominate, compared to the alpha and beta waves that are prominent when people are alert and active. A treatment like binaural beats that slows brainwave activity, helping to produce low frequency waves, can aid in relaxation and sleep.

**Transcranial Magnetic Stimulation**

Transcranial magnetic stimulation (TMS) is a noninvasive procedure that uses magnetic fields to activate nerve cells in the brain. During a TMS session, an electromagnetic coil is placed against your scalp near your forehead. The electromagnet painlessly delivers a magnetic pulse that stimulates nerve cells in the region of your brain involved in mood control. Though the biology of why TMS works is not completely understood, the stimulation appears to affect how this part of the brain is working, which in turn seems to ease depression symptoms and improve mood.

TMS has also been found to be effective in treating insomnia. TMS and other neurophysiological studies have shown the presence of a diffuse cortical hyperarousal, or a hyper-excitable cortical state, in patients with chronic insomnia. A cortical state is the brain’s way of continuously adapting its processing mechanisms to meet behavioral demands in the environment. During wakefulness, cortical states alter frequently, becoming hyperactive in response to the behavioral context, attentional level, or general motor activity.

**SLEEP IS YOUR SUPERPOWER**

Even the ancients valued sleep, recognizing that sufficient sleep is imperative for a healthy brain and a healthy body. The poet Homer wrote, “There is a time for many words, and there is also a time for sleep.” The Greek philosopher Heraclitus wrote, “Even a soul submerged in sleep is hard at work and helps make something of the world.” More recently, in April 2019, Dr. Walker gave a TED Talk titled “Sleep Is Your Superpower,” in which he observed that “Sleep is a non-negotiable biological necessity. It is your life-support system.”

Sleep deprivation is torture, a truth most of us know from experience, and something that Kelly Bulkeley, PhD, argued in a 2014 article in *Psychology Today* about its use as a method of interrogation. When we work with clients who are suffering from anxiety and depression and also have sleep issues, we can help them accelerate their healing by encouraging healthy sleep habits. And we can grow our own understanding of neuroscience-informed sleep interventions to help our clients and ourselves develop a wellspring of resilience.
THE MENTAL HEALTH TSUNAMI

AMERICANS FACE A COMBINED COVID-19 HEALTH AND ECONOMIC CRISIS. HOWEVER, THERE IS A COMING MENTAL HEALTH DISASTER. IT WILL BE ENORMOUS IN ITS DESTRUCTIVE POWER ON:

- The elderly who are shut up and wonder if there is any point to living
- Workers who won’t be hired back and others who are uninsured
- Family members in grief
- Individuals compromised with pre-existing medical and mental health concerns
- Medical professionals and first responders
- Untold numbers who will suffer from anxiety, depression, disability, and despair

DEFICIENT MENTAL HEALTH PREPARATION

According to the Kaiser Family Foundation, nearly half of all Americans report that the coronavirus crisis is harming their mental health. Suicide, self-harm, addiction, and domestic violence are surging. Like PTSD, the chronic distress of this crisis will have horrendous lasting effects. Worries turn into anxiety and depression. Mental illnesses and addictions begin to mushroom.

Just as we failed to prepare for COVID-19, we are not preparing for the mental disruption that will horribly impact us. Many won’t have access to licensed mental health therapists.

WHO WILL HELP THEM?

Over 300,000 LICENSED MENTAL HEALTH COUNSELORS and MARRIAGE AND FAMILY THERAPISTS are prohibited from offering help to the elderly, the disabled, and the disadvantaged.

These skilled mental health therapists are sidelined because of antiquated Federal Medicare laws, inadequate Medicaid coverage, and archaic insurance regulations.

Studies show that patients in mental distress struggle to get their insurance to pay for care.

The Health Resources and Services Administration reports over 25,100 Mental Health Professional Shortage Areas for individuals with limited or no access to licensed mental health therapists.

Health insurance restrictions and obsolete federal laws are barriers to primary mental health care.

SOLUTIONS: Every dollar in mental health services results in two dollars of medical savings

CONGRESS SHOULD ACT NOW TO:

- Pass the Mental Health Access Improvement Act (S. 286 and H. R. 945) to provide Medicare coverage for elder care and for disabled individuals (stalled in Congress for over 20 years)
- Reduce the complicated insurance coverage procedures that result in denied claims
- Deliver health and mental health insurance coverage for millions of Americans through comprehensive Medicaid expansion

“One in five Americans struggle with some kind of mental illness. As a doctor, improving access to mental health care is an important personal priority of mine.”

Senator John Barrasso, sponsor of Senate Bill 286

FOR MORE INFORMATION CONTACT:

American Mental Health Counselors Association | AMHCA.org
American Association of Marriage & Family Therapists | AAMFT.org
National Board of Certified Counselors | NBCC.org
National Council for Behavioral Health | TheNationalCouncil.org
The Michael J. Fox Foundation for Parkinson’s Research | MichaelJFox.org