INSESSION

JUNE 2020

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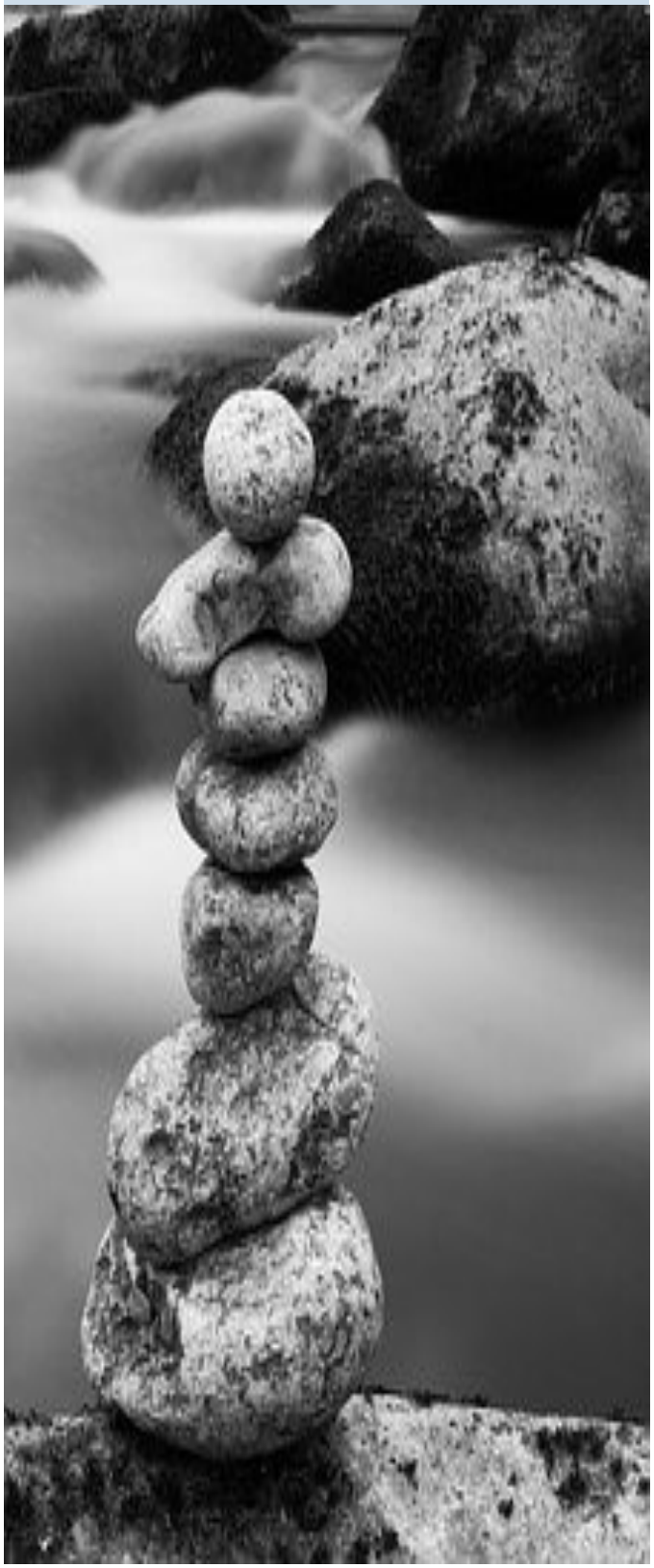
"Meditate often on the interconnectedness and mutual interdependence of all things in the universe. For in a sense, all things are mutually woven together and therefore have an affinity for each other."

–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 AMHCA's mission 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.

This 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, Louisiana. The two-week trip included collaboration with members of the Irish Association of Counselling and Psychotherapy (IACP) and the International Association of Counselling (IAC). I also got to speak to Irish historians, visit historic sites, learn more about "the Troubles" in Northern Ireland, visit the town that some of my ancestors lived in before migrating to the U.S., attend a training conference with Irish counsellors, tour a community mental health program, and interview Irish counsellors. It was an interesting, informative, and exciting experience.

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 U.S. I got the impression that there was openness to American associations like AMHCA providing information on the evolution of our profession here in the U.S., so that association leaders abroad can decide whether anything that we have done to advocate for our profession might be helpful.

I also learned that there are some international

issues that 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 there is no limit to what we can learn from our colleagues around the world. I became very interested in whether IAC would be open to including AMHCA in its "round table" of counseling associations. I also decided to become a member of IAC 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 https://www.iac-irtac.org/?q=Our%20Partners), enabling AMHCA to partner with IAC on specific projects of mutual interest.

2. The AMHCA 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 a subscription 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, who have become our first international members, including:

   a. Naoise Kelly, the Chief Executive Officer of the International Association of Counselling,

   b. Ray Henry, the Cathaoirleach of the Irish Association of Counselling and Psychotherapy, and

   c. Lisa Molloy, the Chief Executive Office of the Irish Association of Counselling and Psycho therapy.

3. Leaders of AMHCA and IAC collaborated through a virtual meeting to brainstorm 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 boarder profession of counseling, was born here in the U.S. 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 U.S. 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. Keep your eyes peeled for more about AMHCA's collaboration with international counseling associations!

Aaron Norton, LMHC, LMFT, MCAP, CRC, CCMHC

FMHCA president, 2019-2020

COVID-19 Precautions for CMHCs

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" is 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. USHD identifies healthcare/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 used, it is pretty clear that licensed CMHCs are covered under this provision.

Of course, the mere fact that a CMHC is an essential worker does not mean that he or she 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 a total of 420 CMHCs during five recent webinars to determine how many are still seeing clients in-person and how many have transitioned to telehealth. The majority of each sample consisted of private practitioners, and their responses are detailed in the table below:

Date	Region	# CMHCs	In-Person Only	Telehealth Only	Combination of In-Person and Telehealth	Not Seeing Clients
3/26/20	Tampa Bay Area, FL	17	2 (12 %)	9 (53 %)	6 (35 %)	N/A
3/27/20	Tampa Bay Area, FL	35	8 (23 %)	18 (51 %)	9 (26 %)	N/A
4/3/20	National	23	2 (9 %)	15 (65 %)	3 (13 %)	3 (13 %)
4/17/20	Tampa Bay Area, FL	18	1 (6 %)	10 (56 %)	3 (17 %)	4 (22 %)
4/20/20	Florida (statewide)	327	48 (15 %)	149 (46 %)	46 (14 %)	84 (26 %)

As you can see, approximately half of CMHCs (49 %) are providing telehealth only and about 31 % are either seeing clients in-person only or through a combination of in-person and telehealth services. If my samples were assumed to be representative of all CMHCs in private practice, then about one-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 implement 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 about six feet or two arm lengths) with a person who has the virus. Specifically, you can be infected by the virus in two ways: (1) You can take in respiratory droplets from an infected person who coughs, sneezes, or talks through your eyes, nose, or mouth; 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 6 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 to not come into contact with potentially infected persons, and telehealth provides a means of accomplishing that.

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 are greater than six feet apart from each other.

3. **Clean doorknobs, facets, chairs, and other surfaces that clients touch in between each client using an appropriate cleaner such as Clorox wipes, Lysol, and rubbing alcohol.** If this could truly be accomplished, it would be hard for infected droplets to be transmitted by hand from one person to another. Also, you may want to consider using an ultraviolet LED UV-C disinfection lamp in the 260-285 nm range to disinfect rooms in your practice at night or on the weekend, though you have to take care to ensure that you are using it safely.

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, clients can be asked to remain in their car in the parking lot until the CMHC or other employee opens the door to invite the client in.

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) while rubbing your hands with soap, producing friction. Use a clean paper towel to dry your hand, and then use that same paper towel as a barrier to turn off facets, 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 8/1/20, JotForm is providing free HIPAA-compliant accounts to CMHCs through the Coronavirus Responder program (apply at https://www.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 your hands to be potentially contaminated and wash them

thoroughly without 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 accept a payment by hand, assume your hands to be potentially contaminated and wash them thoroughly without touching anything else.

9. **If you have the supplies for it, 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 the 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, using it to initiate and accept phone calls from clients to protect their personal phone numbers. The fewer people in the office, the easier to keep the office sanitized and 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 to not 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 a potentially infected client cancel late than to have him or her come to an appointment out of fear of 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 would 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 seeing clients in the office still, then you're already taking enough risk as it is. No need to add to that risk by violating social distancing outside of work.

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PRACTICAL ADVICE ON MAINTAINING HEALTH DURING THE COVID-19 PANDEMIC

RESILIENCE AND MENTAL HEALTH

Follow regular schedules
for waking up, dressing, eating, exercising, working, entertainment, and going to sleep.

Limit caffeine intake

Establish objectives
for each day as well as for the whole week.

Try to get solar exposure
if the sun can be viewed from your window, balcony or private garden in accordance with national isolation rules and safe sun guidance.

Keep well informed
but limit the time spent focusing on COVID-19-related information.

Stay in contact
with family, friends and colleagues without breaking physical distancing guidance (2 metres or 6 feet is the typical physical distancing recommendation).

Take slow deep breaths
into your abdomen in the morning, before and after exercise and when stressed. Breathe in through your nostrils and concentrate on the temperature of the air as it goes in (cool) and as it comes out (warm). Count the time it takes to breathe in and try to make your exhalation twice as long. This diaphragmatic breathing can help you to remain calm.

Prioritise keeping your mind active
Reading, writing, playing an instrument, and working on puzzles and playing games can help.

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State Legislation

Before reading this update, it may be helpful to understand the process that a bill journeys before becoming a law. There are two chambers of the legislature-the House of Representatives and the Senate. A bill has to be passed in both houses in order to go before the governor. The governor then either signs the bill into law or vetoes it. Prior to passing a bill in either legislate chamber, the bill must be passed by three committees in each chamber.

Legislative Update

⇒ *FMHCA's licensure portability bill has been passed!* In October, we published an article in FMHCA's *InSession* Magazine on why licensure portability is so important in Florida as well as an overview of the **National Counselor Licensure Endorsement Process (NCLEP 2.0)**, which AMHCA, NBCC, AASCB, and ACES all jointly developed (read it by **clicking here**). We tried to pass a licensure portability bill last year but were unsuccessful. This year, however, **SB 230**/**HB 713**, an omnibus health department bill, included the same verbiage as our bill last year. It enables licensed counselors in other states to more easily get licensed here in Florida, requires new licensees to have a CACREP-accredited degree starting 7/1/25 (while grandfathering in all those who are already licensed), and includes some verbiage that stresses that LMHCs have training in diagnosing and treating mental disorders. Read FMHCA's press release on this historic victory by **clicking here**.

⇒ FMHCA reached out to the 491 Board earlier this week to request that the board pass an emergency rule related to social distancing and COVID-19. We asked the board to clarify that registered mental health counselor interns can provide therapy for their clients, even in private practice settings, without having to have a licensed mental health professional on the premises. Additionally, we wanted the 491 board to temporarily allow qualified supervisors to provide ALL of their supervision hours with interns through webcam rather than requiring that at least half be conducted in person. Read the emergency board rule by **clicking here**.

⇒ **SB 782**, which should have required 491 board licensees, including registered interns, to identify their credentials in their professional social media pages, died in committee.

⇒ Some of you may recall that in August 2018 FMHCA warned us about F.S. **456.072**(1)(k), which when cross-referenced with F.S. 491.009(1)(w) enables healthcare professionals to be fined and to have their licensed revoked for failing to repay student loans. **HB 115**/**SB 356**, a bill that would discontinue this practice, passed in both the House and the Senate and is expected to soon be signed into law by Governor DeSantis!

⇒ **HB41**/**SB180**, which would have prohibited licensed healthcare professionals from providing conversion/reparative therapy for minors, did not pass this legislative session. You may recall that Equality Florida wrote FMHCA and asked for its support of the bill (see their talking points by **clicking here**). As President of FMHCA, I wrote a letter clarifying that FMHCA is a chapter of AMHCA (**click here to read it**), and that AMHCA has an official position opposing reparative therapy (**read it here**). I then referred the request for support to the FMHCA Government Relationship Committee (GRC), which reviewed the bill and voted to officially support it. **Read the FMHCA press release by clicking here**. We published an article in FMHCA's *InSession Magazine* last month that provided more information about this bill as well as an update on licensure portability and discussion of the issue of the use of the term "psychological" in Florida. Read it by **clicking here**. We will likely support a similar bill next legislative session.

⇒ **HB 209** / **SB 1084**, which would have provided additional regulation regarding emotional support animals (ESAs) and housing, did not pass this legislative session. We have offered our clinical expertise for legislators considering a similar bill next year.

⇒ The 491 Board is piloting a new program called "Licensing Lucy," which would enable LMHCs and student/interns to do an automated check to see if they are missing anything in terms of documentation for licensure or renewal. Stay tuned for an announcement.

⇒ The Dept. of Health is piloting an artificial intelligence (AI) system that would provide answers to frequently asked questions on the 491 board website. Right now, the AI technology is being piloted by the pharmacy board. Stay tuned for updates.

The Government Relations Committee will have a chair position opening as of July 1st, 2020. The Government Relations Committee is responsible for advocating and implementing the FMHCA legislative platform. Issues impacting the profession of mental health counseling at the state level will be addressed by FMHCA, including issues involving legislation, agency regulation and encroachment by other entities on the practice of mental health counseling. The Government Relations Committee represents FMHCA regularly at 491 Board meetings. The committee also informs and enlists support from members as to pertinent legislative issues and positions beneficial to the membership.

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We encourage all that are interested to submit your resume!

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Covid-19, How this may affect your role as a therapist.

I heard a radio station announcer dispel the myth to a caller who refused to buy the beer Corona because he thought this was the cause of all the sickness and deaths around the world. I could hear the exasperation in the announcer's explanation, which made me think of my role as a therapist to those around me.

According to Yahoo News, "Covid-19 emerged at a seafood and live animal market in the Chinese city Wuhan, capital of Hubei province, at the end of last year." Covid-19 has no specific treatment, with care being "supportive" while a patient's immune system works to fight off the virus. To prevent infection, officials recommend regular hand washing and "social distancing".

While we deal with fears and anxiety in the therapeutic setting, whether it be in the private practice "couch" or in the agency setting, this gives us a chance to really flush out fears with clients asking many questions. These fears usually give us the chance to support and encourage through skill building and reframing. Most times, clients walk away from sessions about this with a better focus and renewed energy to reduce past fears and anxiety.

But what about the administrator, supermarket cashier, and insurance phone representative fears? We make small talk usually about the weather, traffic, or future events. Through an event like Covid-19 folks may be less likely to talk about the usual things but also may not talk or acknowledge the fear of Covid-19 and it getting passed on to them. And forget handshakes, hugs, and kisses from coworkers, family, and friends.

A couple of thoughts came to my mind in regards to dispelling fears and anxiety about this present epidemic, according to WHO (World Health Organization), with those that we run into like the scared caller into a radio person who though beer was the culprit.

1. Be a good listener. It goes without saying but when folks are expressing worry and stress over concerns they have very little control over, they might think of us therapists and the few who can empathize with this. So, I encourage you to listen and show you care. It can go a long way in reducing harmful symptoms.
2. Be the example. If colleagues, clients, and the CVS cashier know who you are then they look to us to be different in our perspective. Show your confidence in taking adequate precautions but not going overboard. It may dispel some of their myths just by you responding in a logical, calm way. Tell them you're keeping up with the news but not letting it control you or your actions. Express sympathy for the losses and those that may be sick that you know of. Being genuine is a healthy example of therapeutic greatness
3. More compassion, less judgement for others (and ourselves). We are trained to be critical of symptoms, reactions, and perspective. This helps us in properly diagnosing and articulating harmful issues that need to be addressed. Clients need this to move through negative emotions and behaviors. But in talking with the neighbor and maintenance person in the apartment complex, showing compassion for what they feel or their stories they have can help in healing. Compassion and mindfulness are the new, although not so new, therapeutic tools that are becoming mainstream. And for good reason, our culture needs more self-compassion and other-compassion, its positive energy that is supportive and reinforcing. A good motto is, "Facts not Fear"

Reference:

https://www.yahoo.com/news/coronavirus-covid19-symptoms-five-days-210041231.htm

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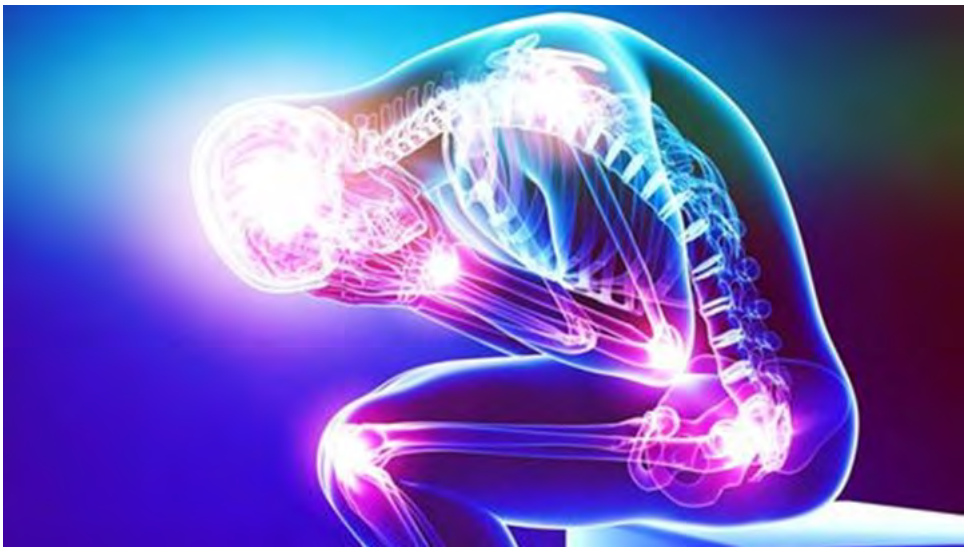
Chronic Pain:

The Potential Role of LCMHCs in Providing Non-Medication Pain Management

By. James J. Messina, Ph.D., CCMHC, NCC, DCMHS-T



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 (LCMHCs) can make an important contribution. LCMHCs 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 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, LCMHCs need to know the evidence-based practices for pain management, which will also enable them to work alongside the medical professionals treating their patients in pain. Patients in pain need to see that LCMHCs are focused on them as people who will benefit from proven non-medication interventions that will lessen or eradicate pain in their lives.

NON-MEDICATION APPROACHES TO PAIN MANAGEMENT

LCMHCs who work with patients in pain should focus on providing support related to the individual patient experiences rather than the diagnostic label—"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 LCMHCs 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.
- 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.

- 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 medication, 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 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.

What LCMHCs Can Learn From the "Pain Management Best Practices" Report

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 of the sections in the report is Clinical Best Practices for pain management, which includes:

• 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 lowback pain.

Download a free PDF of the report at bit.ly/37megKa.

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 to 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.

MAKING SUCCESSFUL PAIN-MANAGEMENT PLANS WITH PATIENTS

Every pain-management plan should include the following non-medication modality recommendations, 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:

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

It's crucial for success that LCMHCs 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.

A Prescription for Licensed Clinical Mental Health Counselors Helping Their 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 are the sources of pain 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 (coping.us/cliniciantreatmenttools/clinicalassessmentplan.html), which includes exploration of ACE (Adverse Childhood Experiences) Factors (coping.us/cliniciantreatmenttools/ acefactors.html) 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 coping.us/mindfulnessneurobiology/stressmanagement.html to lessen daily stress, and coping.us/mindfulnessneurobiology/improveyoursleep.html 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:

If the patients accept the proposed model of non-medication treatment of their chronic pain, then have them take the modified EXPECT Questionnaire 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.

For more information on non-medication pain management, visit coping.us/mindfulnessneurobiology/ painmanagement.html.

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 chronic pain and on how chronic pain impacts your life. 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). Please answer on a scale of 0 to 10, where 0 is "no change or worse" and 10 is "pain no longer affects my sleep." If pain does not impact your sleep, please answer "not applicable" (n/a).
5. How much change do you realistically expect in your pain-related sleep problems? ____
Please answer on a scale of 0 to 10, where 0 is "no change or worse" and 10 is "pain no longer affects my mood or irritability." Or you may choose "not applicable" (n/a).
6. How much change do you realistically expect in your mood or irritability? ____
Please answer on a scale of 0 to 10, where 0 is "no change or worse" and 10 is "pain no longer affects my energy." Or you may choose "not applicable" (n/a).
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. ____

LIMITATIONS DUE TO CHRONIC PAIN:
The following two questions are about effects that your proposed 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. If these questions are not relevant for you because you do not have any physical limitations due to your pain, please choose "not applicable" (n/a). Please answer on a scale of 0 to 10, where 0 is "no change or worse" and 10 is "limitations completely resolved." Or you may choose "not applicable" (n/a).
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). Please answer on a scale of 0 to 10, where 0 is "no change or worse" and 10 is "pain no longer impacts my work," including housework. Or you may choose "not applicable" (n/a) if your pain does not impact your work/housework now.
11. How much change do you realistically expect in the impact of your pain on your work, including housework? ____
Please answer on a scale of 0 to 10, where 0 is "no change or worse" and 10 is "pain no longer impacts my social and recreational activities." Or you may choose "not applicable" (n/a) if your pain does not

impact your social and recreational activities now.
12. How much change do you realistically expect in the impact of your pain on your social and recreational activities? ____
Please answer on a scale of 0 to 10, where 0 is “no change or worse” and 10 is “pain no longer impacts my daily activities.” Or you may choose “not applicable” (n/a) if your pain does not impact your daily activities now.
13. How much change do you realistically expect in the impact of your pain on your daily activities?____

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www.FMHCA.org

FOR IMMEDIATE RELEASE: 3/17/20

FMHCA Announces Passage of Licensure Portability Bill

State Lawmakers Pass HB 713 / SB 23

W. Palm Beach, FL: The Florida Mental Health Counselors Association (FMHCA) is pleased to announce that House Bill 713 / Senate Bill 23 , a bill that would improve licensure portability in Florida, has passed unanimously in both the House and the Senate and is expected to be signed into law by Governor Ron DeSantis.

Licensure portability refers to the ability of counselors who are licensed in one state to become licensed in another state. For two years, FMHCA has been lobbying for passage of this bill, which was inspired by the National Counselor Licensure Endorsement Process (NCLEP 2.0) created by the American Mental Health Counselors Association (AMHCA) and several other national counseling authorities. Once NCLEP 2.0 was created, it became the mission of each state chapter of AMHCA to pass state legislation implementing the plan, which may pave the way for an interestate compact allowing counselors to more easily be licensed in other states. HB 713/SB 230 is expected to help foster that process as well as aid Florida in addressing its shortage of licensed mental health professionals.

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 3 of the 5 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 CACREP-accredited program beginning 7/1/25 while “grandfathering” applicants who apply prior to that date. Additionally, the bill requires applicants seeing licensure by examination who do not have a degree from a Council for Accreditation of Counseling and Related Educational Programs (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 LMHCs in diagnosing and treatment mental disorders.

FMHCA would like to thank Representative Ana Maria Rodriguez and Senator Gayle Harrell for sponsoring the legislation, the volunteers of FMHCA's Government Relations Committee for two years of lobbing, our lobbyist (Corinne Mixon of Ruledge & Escenia) for her professional advocacy, the staff of the 491 Board for their support of the bill, and Jolie Long of the National Board for Certified Counselors for technical consultation.

State lobbyist update and member action items. Making in impact during uncertain times.

Composed by Corinne Mixon, Rutledge Ecenia PA

A brief reflection on the 2020 legislative year so far—

The Legislative Session came and went during the first quarter of 2020. During even numbered years, the session occurs early – from January to March. In odd numbered years, the session takes place in March and concludes in early May. While the time which has passed since the conclusion of session has been one of the most difficult periods in the Florida legislature's long history, the session still yielded positive outcomes for the people of Florida, especially the passage of HB 713, portions of which were the top priority of the Florida Mental Health Counselors Association.

Notably, the timing of the COVID-19 outbreak and associated partial shutdown of the State nearly missed Florida's 60-day legislative session. In fact, COVID-19's economic impacts could not be gauged in time for the legislature to considerably amend its budget prior to adjourning the second week in March. As a result, the Legislature is likely to return to Tallahassee to consider the impacts of the virus prior to the budget year beginning in July of 2020. A special session would take into account benchmark losses in revenue, mass unemployment and the myriad associated fallout.

A small number of bills succeeded during the legislative processes (about 8%) including HB 713, titled an Act Relating to the Florida Department of Health, for which FMHCA aggressively lobbied and advocated during the 2019 and 2020 legislative sessions. Working with state Representatives Ana Maria Rodriguez (R-Miami) and Tommy Gregory (R-Sarasota) as well as Senator Gayle Harrell (R-Stuart), FMHCA successfully secured language in HB 713 to ensure Florida-licensed mental health counselors meet the same strict standards that exist in other states.

Importantly, the bill requires that applicants who apply for licensure after July 1, 2025, must hold a master's degree from a program accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP). Ensuring that Florida meets the CACREP accreditation standards helps unify the profession with other state licensure acts; thus, increasing the likelihood of ensuring Medicare reimbursement down the road and many other positive changes.

Another important aspect of the bill is authorizing

the Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling to make a one-time exception to the 60-month limit on an internship registration. Such exceptions may only be granted in an emergency or hardship case, as defined by rule.

These are just a couple of the changes made in HB 713. If signed by Governor DeSantis, the bill goes into effect on July 1, 2020.

Looking forward—

FMHCA's government relations committee is already workshopping its 2021 legislative priorities. In the meantime, Florida is also preparing for the upcoming elections. As lobbyists for FMHCA, our firm is brainstorming ways that the membership can be proactive during this time of social distancing. In election years prior to 2020 and the arrival of the COVID-19 virus, FMHCA's leadership would be directing members to 1) meet candidates and volunteer in campaign walks and 2) set meetings with currently elected officials. In these uncertain times, it is imperative that FMHCA be at the forefront of bringing forth change. Even in uncertain times, many civic and advocacy activities can be achieved remotely. Here are some creative ways you can engage while social distancing.

Connect with your legislators through remote meetings—

Sites like zoom.us and gotomeeting.com allow for free video conferencing for small "groups" of people. Find your currently elected state representative and state senator by entering your address at https://www.myfloridahouse.gov/Sections/Representatives/myrepresentative.aspx. Email him/her directly as well as the legislative aide whose contact information can also be found on the site. Simply ask for a quick video meeting to introduce/reintroduce yourself as a constituent. During the meeting, you can thank them for their passage of HB 713, discuss how the mental health provider community is taking care of people despite the crisis (use of telehealth, etc.) and provide context for future policy making.

Engage in campaigns for state office—

Elections are scheduled to occur in November. Primary elections will take place in August. Every seat in the Florida House of Representatives is up for election as well as half in the Florida Senate. There is no better way to connect with future policy makers than to assist them in their campaigns for office. Understandably, the COVID-19 crisis has made campaigning difficult for many reasons. Under normal c cumstances, candidates would be asking anyone-and-everyone to donate to their campaigns. However, COVID-19 has changed many Floridians' fiscal reality. Some candidates are simply not comfortable asking for contributions right now. Making unsolicited, small, online donations is a memorable way to stand out between now and August. FMHCA recommends contributing if/when you can. Most candidates' websites include a phone number for the campaign. Feel free to reach out to say you're making a contribution.

Additionally, campaigns for state office are typically won by the candidates with the biggest "ground game." This entails walking door-to-door for the purpose of dropping off campaign materials while making positive comments and answering questions about the candidate for whom you are walking. COIVID-19 has changed this aspect dramatically. However, there are still ways to engage with candidates you believe in. A person can volunteer to make phone calls on behalf of a candidate or film video segments for his/her campaign election website. FMHCA members can offer to stuff envelopes and assist with direct mail pieces. The sheer reduction in campaign force and campaign cash will not result in the end of campaigning. FMHCA's members should be among the first constituents to offer creative solutions for getting involved.

These candidates will never forget your small donation or your service on their behalf…especially during times like these.

As we enter the summer months, FMHCA will be sending additional advisement regarding meeting with currently elected legislators and candidates for state office. FMHCA will have a robust legislative agenda going forward. FMHCA's members must establish themselves as resources for members of the Florida House of Representatives and Florida Senate before lawmakers return to Tallahassee for interim committee weeks in November. Please do not hesitate to reach out for more information about how you can help.

Discussing Licensure Portability with Representative Diamond on behalf of all LMHCs in Florida!

Our Amazing team meeting with Representative Killebrew regarding Emotional Support Animals! Thanks for all of your hard work team!

So proud of my collegues advocating in Tallahassee for our Mental Health professionals . Thank you so very much! We continue to need a strong membership to keep our voice heard. Join www.FMHCA.org
click the following link to view all our state legislation/bills —> https://www.suncoastmhca.org/Legislative-Update/8596608...

New on-demand webinar brought to you in partnership with Florida Mental Health Counselors Association (FMHCA)
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Paid Student Opportunity. The SRCOSTEP application window is open 6/1/20 to 9/30/20. Specific healthcare program students may apply if they will be graduating in 2022. Please read the flyer attached to learn more. BOP will select students to sponsor. #BOP #SRCOSTEP #ApplyInJune #healthcare #2022Graduates

THE STAGES OF A RELATIONSHIP:
For the single navigating the dating world!

I don't suggest that I am the "guru" on relationships, just bringing my 17 years of counseling experience as a perspective and what has helped me to explain healthy relationship patterns. And by no means are these the only stages. I frequently use these as the foundation and build as needed based on the client's history and specific challenges. These are the foundational stages I discuss when clients ask what a healthy relationship consists of, and, if stages can be explained/defined:

Communication Connection

Emotional Connection

Physical Connection

Possible Spiritual Connection if you emphasize this in your counseling

Stage 1:

I define the communication connection as the initial stage to develop. Now, we are naturally connected in this way and usually the "honeymoon" stage of a relationship has lots of talking, sharing, and connecting. Most clients can identify in past relationships the ups of this time period. But where I reframe it is speaking the language of one another, commonalities in talking and sharing, along with differences in language, nuances, along with non-verbal communication. For the client, learning to speak their language openly, honestly, kindly is what sets good boundaries without being too controlling. These inter-dynamics can get confusing and elusive. But the trick is to know how to express emotions (emotional intelligence is one worksheet that we work on together) and accept the other persons emotions and communication style. The need here is developing this even after the "honeymoon" stage is winding down to cement the patterns of healthy communication connection.

Stage 2:

Emotional connection stage develops and can intermingle with the first stage. But once the communication stage has been developed it will naturally develop into this second stage by connecting to the other person by sharing my story. Now, you may think isn't this part of the 1st stage. Yes, but it develops as a separate perspective so that it can be focused on by the client in our sessions. I find they need this visual shift from communication to emotional which helps them to see it differently. Another part of the emotional is connecting with their partner by understanding/validating their story. So, when the client can make the bridge in this way they can better develop and build the relationship. This is the primary reason for building the emotional connection. It moves now from two individuals (although they will keep that individuality) to the relationship and the needs of that.

Stage 3:

Physical connection is best to develop after the first two stages of groundwork have been set. I realize this is ideal and many clients share too many stories of how this became the 1st stage and tell me how the relationship didn't end well. If the first 2 stages can be developed with a good amount of time, then this 3rd stage has a chance for developing and building on the emotional stage. The assumption is the client and partner have made a connection and physical would be further development of the relationship. Being this is the last stage it completes the initial development. And what the physical can be is a measure of how the first 2 stages are maintaining and continuing to grow. Often, I ask couples how intimacy in the relationship at the start of the sessions as this can give a gauge of their first 2 stages.

Summary: Once again, these are beginning stages than can be expanded on, but I have found the visual of these 3 stages help clients to manage it better. I often put the stages on the whiteboard in my office as we discuss it so that they can visualize it: another great way to implement learning and applying. Also, they take a picture at the end of session to refer to in the week. I have one client that when we sit down for the session, he opens his phone to the last picture to discuss how it has helped him.

Scott Jones

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Supporting Each Other During Challenging Times

Hello, counselors! The past few weeks have been some of the most challenging times for our profession, our country, and the world. In the midst of the stress and chaos, I have found tremendous hope and encouragement in seeing our profession come together to support each other and our clients.

When the COVID-19 pandemic reached our shores, FMHCA sprang into action quickly. On March 15th, we started our COVID-19 Resources for Counselors discussion thread at www.fmhca.org, and we are continuously posting important updates on that thread. I encourage you to subscribe to our forum if you haven't already so that you can stay updated. Since 3/15, members like Dwight Bain, Dr. Denny Cecil-Van Den Heuvel, and Meaghan Flenner, as well as FMHCA Executive Director Diana Huambachano and Executive Administrator Laura Giraldo, have been posting additional resources on various forum threads.

On 3/16, we reached out to Janet Hartman, the Executive Director of the 491 Board, to inquire as to whether the board might start permitting registered interns to count telehealth hours towards their psychotherapy hours. We also asked whether qualified supervisors could start doing 100% of their supervision sessions through webcam during the pandemic. Two days later, the 491 board passed a related emergency rule, which was recently amended.

On 3/23, we started a COVID-19 and Insurance Reimbursement for Telehealth thread to provide our members with information on how to bill insurance for telehealth. That same day, we wrote an open letter to all of Florida's insurers calling on them to extend telehealth for psychotherapy benefits to all of their customers statewide.

On 3/26 and 3/27, we presented free webinars through our Tampa Bay Area chapter, the Suncoast Mental Health Counselors Association, providing counselors with information on changes in laws and rules, how to transition to telehealth, and office safety precautions to reduce risk of COVID-19 exposure.

On 4/2, we presented a free statewide version of the webinar, maxing our registration out at 700 clinicians! Many thanks to Dr. Denny Cecil-Van Den Heuvel, a former FMHCA President and current member of the 491 Board, for co-presenting. We will be presenting an updated version of that webinar on 4/24.

On 4/5, we launched a complimentary national version of that webinar through our partnering organization, the National Board of Forensic Evaluators with co-presenter Ekom Essien in Georgia. On 4/6, Dr. Susan Meyerle presented a complimentary webinar to our members on "Technological Therapy in Tough Times."

On 4/10, we issued a letter asking the Attorney General to stop enforcement of F.S. 491.004(4)(c) so that registered interns can provide telehealth sessions without a licensed mental health professional on the premises.

On 5/1, Dwight Bain presented a webinar for FMHCA entitled, "COVID-19 Mental Health Crisis Training to Manage Risks and Build Rapid Recovery."

FMHCA's board and staff will continue working tirelessly to advocate for our profession and our clients during this difficult time, and I feel confident that our members will, too! We'll get through this together. Please don't hesitate to reach out to me at anorton@flmhca.org if you need something from FMHCA. We're here for you.

Aaron Norton, LMHC, LMFT, MCAP, CRC, CCMHC

FMHCA president, 2019-2020

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March 23, 2020

An Open Letter to Florida's Health Insurers:

On the behalf of the Board of Directors of the Florida Mental Health Counselors Association (FMHCA), the largest association in Florida advocating exclusively for clinical mental health counselors and their clients, I am calling on all health insurers in the State of Florida to take immediate action to make telemental health appointments available to their policyholders in response to the COVID-19 pandemic and related practices of social distancing and quarantine.

During these stressful and challenging times, Florida's citizens are in need of access to psychotherapy using service delivery models that protect both patient and practitioner from transmission of COVID-19. Insurers can provide quality service to their customers by announcing that all policyholders will have access to telehealth sessions, temporarily waiving or reducing copayments/co-insurance rates, and/or providing clear guidance to mental health professionals on how to appropriately bill for telehealth psychotherapy sessions using location code 02 (telehealth), modifiers GT or 95, and standard CPT codes for psychotherapy such as 90791, 90834, 90837, 90847, and 90853.

When Floridians have emerged from the current crisis, they will undoubtedly reflect on the good faith efforts of their insurers and treatment professionals, and it is our hope that they will be grateful for the innovative measures taken by both to protect them during an international crisis.

Respectfully submitted,

Aaron Norton, LMHC, LMFT, MCAP, CRC, NCC, CCMHC, DCMHS
President, 2019-2020

FMHCA is a state chapter of the American Mental Health Counselors Association (AMHCA), the largest organization exclusively representing clinical mental health counselors in the United States. AMHCA supports FMHCA's efforts to advocate for Florida's citizens during the COVID-19 pandemic.

American Mental Health Counselors Association

* AMHCA recently published its new 2020 Code of Ethics. Click Here for a free download.
* AMHCA also published an updated document titled "AMHCA Standards for the Practice of Clinical Mental Health Counseling". Click Here for a free download.
* AMHCA also updated its "Practice Guidelines". Click Here for more information.

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When Shared Trauma Comes Home

Dr Kathie Erwin, LMHC, NCC, AMHCA Diplomate, Fulbright Specialist

There is an old saying that "you are not paranoid if someone is really out to get you". Well now there is an invisible stalker – Covid 19. It has changed our counseling styles, teaching styles, social engagement, travel, daily activities and economic survival. The first time I went grocery shopping after the stay home order, I stood in line laughing as I saw my reflection in the store window. People seemed to be ok with standing 6 feet away from this weird masked woman. There I was in full face mask, gloves, long sleeve shirt, jeans and carrying wipes. I looked ready to rob a 7/11 and nobody found it odd. That's when I fully realized that we had all fallen down the rabbit hole.

As this invisible enemy ravaged every state, we had to accept that we were no longer protected by two oceans. What we have read about epidemics happening many times in other nations was now in our neighborhoods. Counselors were stressed to find ways to continue working with clients and not abandon them. Counselor Educators scrambled to create online classes for campus students with no prep time. Those of us who are online faculty have attempted to help and encourage both our colleagues and students. In addition to working and studying online, some of you became K-12 home school parents while struggling with your own work and school.

Perhaps one positive has occurred from the race to Zoom into oblivion – we are developing telehealth skills that have been greatly needed. Thankfully our Florida 491 Board was quick to respond to FMHCA's request to make adaptations suitable to the current problem. For students who feared the loss of Internships and supervision, this situation threw them into unfamiliar territory yet provided a unique learning experience. On the positive side, these online counseling experiences can open the door to greater telehealth options after the pandemic.

We are certainly in a shared traumatic incident that is without known end date. As Floridians we have managed alerts for tropical storms and hurricanes with advance warning and expected that there would be a limited duration of the actual storm. We have braced for recovery and we knew it was possible. But this Covid 19 storm is different. The uncertainly, social isolation, fear and frustration are oppressive. I began to realize recently that I had fallen into what I call "elective paranoia" when having to go to stores. This is not my usual mode and realized it was a situational response not my real feelings. My greatest concern is that people transfer apprehension into an "us v. them" mentality where we fear and even demonize someone who merely sneezes from seasonal allergies.

As with any shared trauma, people will react in different time frames. Only experience and research will tell how much this situation has impacted young children in their worldview as they mature. Both now within the pandemic and afterward, counselors continue to be desperately needed to support our first responders and other healthcare colleagues in addition to clients. Researchers will be key to helping us explore and understand the options for mental health response in this type of ongoing crisis. Taking what we know about shared trauma, social isolation, depression, relationship violence and grief, we have to revise and improve our counseling skills to meet this type of challenge. As Mr. Roger's Mother advised him, "Look for the helpers". Thankfully one of the great strengths of Clinical Mental Health Counseling is our commitment as people-helpers.

The Journey of Self Love Learning Shame Resilience

"I'd rather be dead than red on the head" was a chant I heard regularly as a kid growing up in Memphis, Tennessee. "Carrot Top" became an unwelcome nickname. I hated my red hair. As far as I was concerned, it did not serve me well and I dreamed of the day that I could march into the beauty salon and be handed a chart that gave me the ability to choose a color….any color that did not have ridicule and shame attached to it.

Shame…my shame was associated with a part of my body that had been with me since birth. I was stuck with it and would regularly look in the mirror and dream of being a blonde so carefree and pretty. But the mirror told me the truth. My red hair was my nemesis, and it brought me feelings of shame.

Brene' Brown' is a shame researcher who states: "If you put shame in a Petri dish and douse it with secrecy, silence and judgement, shame grows exponentially." And it can be debilitating. The main issue with shame is the feeling that there is something wrong with me. And shame is merciless. It knows no boundaries, is no respecter of persons, race, culture or creed.

How do people experience shame? One of the markers of shame begins in our bodies. Sometimes your head might drop down, or your mouth feels dry. Your heart can beat faster, and your cheeks turn red. Not everyone has the same symptoms, so it is important to tune into the signals your body is giving regarding shame. Once you start to notice the feelings of shame, you are in a better position to address it and begin to turn it around to self-love.

As I grew up and began to learn the importance of self-acceptance, I began the journey by embracing that part of me that had brought such hurt. I decided to work on accepting my red hair and would now look at myself in the mirror and say: "I love and accept you." And words like "You are a good person and you are beautiful." The mirror was no longer an enemy but became a friend.

Therefore, one of the assignments I give to my clients who struggle with self-image is called "mirror therapy". There is a handheld mirror in my office, and I ask them to pick it up, look themselves in the eye and state: "I am beginning to love you." Of course, I am happy to show them what it looks like and I reassure them that I am not asking anything of them that I do not do for myself.

The journey of self-love begins with knowing where you have been judging or condemning yourself and determining to change your self-talk with compassion and love. Brene' Brown ends her previous statement on shame with these words: "But, if shame is doused with empathy, it cannot grow. Empathy is a hostile environment for shame."

It is my hope that each of us can walk a life of loving our bodies in a healthy way. It can be hard. And it is done one step at a time. Take the journey of learning to love that part of you that has been your enemy. I am no longer that little girl in elementary school looking for a beauty shop to erase a part of me. Instead, when I wake up and take that first look at myself, I am anticipating a good day because it will be filled with self-love and acceptance. That truly is the key to relinquishing shame and embracing who you are.

Sandra B. Stanford, MA works as a Licensed Mental Health Counselor at Charis Counseling Center. Sandra earned her Master's Degree in Psychological Counseling from Palm Beach Atlantic University. Sandra is certified in EMDR Therapy. She is the founder of Our Marriage Matters and is also a Certified Daring Way ™ Facilitator utilizing the work of Brene' Brown. Sandra is an active member of the Florida Mental Health Counselors Association and recently became a Regional Trainer for FMHCA.

Sandra will be presenting a 1-day workshop called Unmasking Shame to Heal and Move Forward on September 18th.
Here is the link for more information and to sign up: https://fmhca.wildapricot.org/event-3795151
~Sandra B Stanford, LMHC
Certified Daring Way ™ Facilitator
Certified in EMDR Therapy
Founder Our Marriage Matters Retreats Regional Trainer FMHCA
www.CharisCounselingCenter.com

Unmasking Shame to Heal and Move Forward

Presented by Sandra B. Stanford, MS, LMHC

Have you ever wondered what role shame plays in your clients' lives? And how the clinician is affected by shame in the counseling room? It is now acknowledged that shame is one of the most important and frequent client experiences in the counseling arena. **Sandra B Stanford, MA is a Certified Daring Way ™ Facilitator** for an effective and empirically established approach based on the research of Dr. Brene' Brown, a shame researcher. Sandra also studied Diane Poole Heller's Therapy Mastermind Circle: Shame Healing Hidden Wounds featuring Stephen E. Finn, Ph.D. as an expert. With Sandra's expertise and using the research of Brene' Brown, Diane Poole Heller and Dr. Stephen Finn not only will shame triggers be identified but an awareness will be gleaned of how shame affects interactions, contributes to conflict and deeply impacts relationships. The therapeutic relationship will also be discussed in recognizing when shame shows up and how to help clients and clinicians deal with it in a healthy way. In cultivating awareness about shame, a community of people can discover how to heal and utilize shame resilience strategies to live courageously.

September 18th, 2020
West Palm Beach, FL

8:00AM-5:00PM

2101 Vista Parkway Suite 134
West Palm Beach, FL 33411

Earn 8 CE Hours

CE Course Tracking #: 20-771534

How AMHCA's Florida Chapter Pulled Off Its Most Successful Annual Conference and Got Licensure Portability in the Same Year: Suggestions for Other State Chapters to Consider

Putting together a conference can be a large undertaking. The larger the event, the more factors that need to be taken into consideration.

However, it's important to look at the benefits of holding a conference in which members can participate in. We here at the Florida Mental Health Counselors Association (FMHCA) believe that there is a powerful energy that fills the room at a conference, which triggers unity and movement within our profession. We are excited to share that our annual conference has grown consistent each year from about 125 attendees in 2013 to 736 attendees in 2020, our exhibitor tables sold out, we generated a substantial profit, and our evaluation surveys reflect that our conference attendees are very satisfied with the quality of the conference. We'd love to share how we accomplished these successes in hopes that other state chapters might find some of our ideas helpful in growing their own annual conferences.

Let's focus on how a state chapter can hold a conference that will bring education and unity to the hands of clinical mental health counselors (CMHCs) in your state.

Ready to start developing that conference? Here are 10 Steps we here at FMHCA implement.

Step 1: Pick a Theme

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

Step 2: Set up a TEAM! Not just any team, chapters; you need to bring you're A-Team to the table.

A dedicated team is key, taking this task on alone would be detrimental to the success of the conference.

We here at FMHCA started breaking down our Conference Committee into the following smaller teams:

- Planning
- Administration
- Marketing
- Sponsorship

Volunteers

An effective team will allow for the conference to come together with easy.

Step 3: Hash out a budget.

Have you ever thought about breaking down a budget into three different categories: critical, important, and nice to have? There are crucial expenses you certainly cannot lose. Others might be "nice to have," like a social media backdrop. Once the categories are set up, it's time to get realistic and detail orientated, addressing the following categories:

Venue
Speakers
Staffing
Signage and branding
Food and Beverage
Attendee Experience
Marketing
Event technology
Transportation
Equipment

A tip we use is to add 15% to the projected cost of the category to allow room flexibility.

Step 4: Book the Venue

This step we believe is not one that should be taken lightly. The location of the conference can make or break a conference. Comfortable rooms, high-quality equipment, ease of access, transport to and from (i.e. hotels and venue) are the first things that come to mind when we think of a successful conference venue. Take into consideration the perspective of the following: speakers, sponsors, attendees, and volunteers by walking in their steps when looking at potential venue spaces. We here at FMHCA make it a point to hold our conference in a central area which will allow for more exposure and accessibility for attendees to come.

Step 5: Save the Date. Think a year out!

The Annual FMHCA Conference Save the Date is highlighted one full year in advance. This is done to create excitement and buzz. When selecting a date, take a moment to research other events in the area to make sure the conference does not conflict with other major events. Also, take into consideration that attendees may be attending the conference as a work requirement, which means the best days to hold the conference are Thursday and Friday.

Step 6: Call for Presenters and Agenda

With the theme set, it's time to start recruiting presenters which will allow for the theme to come to life. This may just be the most important step of all. The presenters are the stars of the conference, which would trigger the state chapter to develop a conference goal of developing a line up to attract attendees and guarantee a professional experience.
There are essentially two ways to recruit presenters.

- Reach out and personally inquire about a presenter to speak
  Conduct an open call for presenters.

Here are a few things to address:

- 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?

Put together an agenda
Once the Conference Committee team has selected the presenters, it's time to develop a detailed agenda. Ideally, you want your agenda to be in place at least four months before the conference starts.
Breakout sessions can last from 1 hour to 3 hours. This simply depends on the conference theme and goals.
A tip we use is to have two presenters on standby for each day. Should a presenter cancel, we give these standby presenters access to the presenter-admission rate to the conference.

Step 7: Find Sponsors

The key thing to keep in mind is that the sponsors and their values should align with the theme of your conference.

Start by creating a list of ideal sponsors
Try and find sponsors that fund similar events or are generally associated with your conference's main themes.
Develop a Sponsor package, with each package highlighting different types of sponsorships.
You want to design your conference to attract sponsors.
Sponsors will often ask the following questions:

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 does this benefit a sponsor (publicity/prominence/association)?

- Connect with potential sponsors, this is where the leg work and follow up begins!
  - Connect with sponsors by attending events, interacting on social media, reaching out on LinkedIn, or sending emails.
  - Once a meeting has been secured it is time to listen to the potential sponsor's needs. We here at FMHCA take notes about what the sponsor wants, and we customize the proposal to meet their needs.
- Build a long-term relationship to keep sponsors
  - If you took a walk around the FMHCA exhibit hall you will hear a similar theme: "We come back year after year." It is our goal to satisfy the needs of our sponsors, so they come back to build and grow within our conference.
  - How do we do this?
    - Stay connected
    - Treat each sponsor like a VIP
    - Try not to give a fast "No" to a sponsor request, instead brainstorm to come up with a solution or alternative.

Step 8: Promoting the Conference

Once you have the venue, key speakers, a clear conference at a glance, and a website to guide attendees to, it is time to shift focus to promoting the conference.

- Reward last year's attendees.
  - If you attended the FMHCA conference the year prior, you received incentive to register the following year's conference at half off.
- 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 buy before the prices increase.
- Promote the conference online.
  - Online, you have numerous ways to promote your conference on a relatively small budget:
  - Develop a conference hashtag.
    - Hashtags are a must-have for conference promotion these days, 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 the key points above are set into place, it is time to host the conference. This is where everything will unfold and although you may feel the stressors of hosting the conference, you should also feel a sense of pride and excitement.

However, during the "hosting" step of the conference you might want to keep in mind a few scenarios which may require your attention.

- 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
Problem solving quickly and efficiently

Step 10: Follow up after the conference

This is my favorite part of putting on the conference, I am aware that it is the last step, but I find it the most important. We here at FMHCA follow up with everyone who is a part of the conference from AV to conference attendees. We do a combination of both calling and sending out a Thank You note to allow everyone to grasp our sense of gratitude. It is important for everyone to understand why we hold a conference every year and what is done with the funds generated from the conference.

How Our Annual Conference Helped Us Pass a Licensure Portability Bill

As a result of a successful conference this year, we were able to fund our "Legislative Days" event, sending our Government Relations Committee and our powerhouse FMHCA lobbyist, Corinne Mixon of Rutldege & Ecenia, to our state capitol to meet with legislators to promote House Bill 713 / Senate Bill 23, a bill that improves licensure portability in Florida.

Licensure portability refers to the ability of counselors who are licensed in one state to become licensed in another state. For two years, FMHCA has been lobbying for passage of this bill, which was inspired by the National Counselor Licensure Endorsement Process (NCLEP 2.0) created by the American Mental Health Counselors Association (AMHCA) and several other national counseling authorities. Once NCLEP 2.0 was created, it became the mission of each state chapter of AMHCA to pass state legislation implementing the plan, which may pave the way for an interestate compact allowing counselors to more easily be licensed in other states. HB 713/SB 230 is expected to help foster that process as well as aid Florida in addressing its shortage of licensed mental health professionals.

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 3 of the 5 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 CACREP-accredited program beginning 7/1/25 while "grandfathering" applicants who apply prior to that date. Additionally, the bill requires applicants seeing licensure by examination who do not have a degree from a Council for Accreditation of Counseling and Related Educational Programs (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 LMHCs in diagnosing and treatment mental disorders.

At our annual conference, our chapter president offered a brief address offering a personal story of his interactions with CMHCs who move to another state and are then unable to practice the profession they love so dearly due to differences in licensure requirements state-to-state. Our lobbyist then provided a presentation to attendees explaining the bill and what it seeks to accomplish. We also hosted a Government Relations Committee panel (with lunch provided) for conference attendees, allowing our members to ask questions and offer feedback about the licensure portability bill. These actions helped our members to truly understand why the issue of licensure portability is so important.

The passing of this bill took two years of lobbying by the volunteers of the FMHCA's Government Relations Committee (GRC), including strategies such as:

- Coordinating with leadership at the national chapter level (AMHCA), including AMHCA's Southern Regional Director, as well as Jolie Long, the National Board of Certified Counselors (NBCC) Director of State Affairs, to ensure that NCLEP 2.0 is being properly implemented in the bill's language
- Soliciting endorsement of the bill from the state's counseling licensure board
- Soliciting 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
- Holding monthly meetings between members of the GRC and the association's lobbyist for collaboration
- Identifying strategic dates for the Legislative Days event (i.e., when legislators are available at the state capitol)
- Identifying legislators whose positions, priorities, and legislative interests are compatible with licensure portability
- Creating a one-page "talking points" flyer that GRC members can use when meeting with legislators and including statistical data explaining the problem (see https://bhw.hrsa.gov/sites/default/files/bhw/nchwa/projections/state-level-estimates-report-2018.pdf for state-level data) as well as the logos of all major associations endorsing the bill
- Having GRC members contact their regional legislators, schedule meetings to discuss and promote the bill, and placing meeting dates/times in a shared calendar for coordination
- Holding a briefing prior to the Legislative Days event to review talking points
- Using a "divide and conquer" approach to meeting legislators in which delegates are divided into small groups to cover all legislative offices in a shorter period
- Identifying talking points that are appealing to legislators of both major political parties. Fortunately, licensure portability is an easy sell on both sides of the aisle, as portability can reduce unnecessary "red tape" and conserve financial and personnel resources of the licensure board (often appealing to conservatives) while also addressing the state's shortage of licensed mental health professionals, making mental healthcare more accessible to Florida's citizens (often appealing to liberals).
- Asking legislators to take photos with 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, we here at FMHCA recognize that what worked in Florida may not be the right fit in other states, but we hope that some of the tips and strategies we've offered will help stimulate some creative brainstorming energy among other chapters.

Diana Huambachano is the Executive Director of the Florida Mental Health Counselor Association. She started working with the association in 2014 as a student volunteer and has grown within FMHCA.

Keynote address to a record crowd of 726 attendees at the Florida Mental Health Counselors Association (FMHCA) annual convention. Covered the importance of grassroots advocacy and FMHCA's work supporting the key mental health practitioner components of SB 230, HB 1143, SB 782, and HB 713.

Florida Mental Health Counselors Association
2101 Vista Parkway
Ste. 250
West Palm Beach, FL 33411

Phone: 561-228-6129
www.FMHCA.org

May 1, 2020

The Honorable Ronald D. DeSantis
Governor, State of Florida
Executive Office of Governor Ron DeSantis
400 S Monroe St
Tallahassee, FL 32399

RE: Mental Health Care Provider Liability Protections:

Dear Governor DeSantis:

Floridians rely on Licensed Mental Health Counselors and Registered Mental Health Counselor Interns to provide them lifesaving, essential mental health services each and every day.

Even in the midst of the COVID-19 pandemic, mental health counselors are dedicating thousands of hours to providing mental health care to our clients. Thankfully, many services can be provided utilizing telehealth, but on a limited basis, within the confines of guidelines set forth by the Center for Disease Control, certain medically necessary treatments must be provided in person. Providing essential mental health services in person during the pandemic entails risk even when practitioners follow the strictest social distancing standards and requirements for personal protective equipment. However, mental health counselors are ethically bound not to abandon our clients, and, for some clients, care cannot be effectively delivered via telehealth

The Florida Mental Health Counselors Association is proud of their members who have bravely put themselves in harm's way to provide a continuum of care for their clients during the period of COVID-19.

The unfortunate reality is, unscrupulous actors may seek to take advantage of these sacrifices by filing unnecessary lawsuits against mental health counselors who cared for their clients during the COVID-19 pandemic. Bad actors may choose to file lawsuits that seek to exploit the unique challenge of determining which services are medically necessary based on executive orders from the Governor.

A handful of states, as well as the federal government, have released executive orders which provide temporary protections against frivolous lawsuits. We are asking that Governor Ron DeSantis provide similar limited liability protections for Florida's licensed mental health counselors and other mental health care providers.

The Florida Mental Health Counselors Association is grateful to the Governor for any steps he may take to protect Florida's mental health care providers in this time of crisis.

On behalf of Florida's more than 13,000 licensed mental health counselors, thank you for your swift consideration.

Respectfully submitted.

Executive Board

Florida Mental Health Counselors Association

Florida Mental Health Counselors Association
2101 Vista Parkway
Ste. 250
West Palm Beach, FL 33411

Phone: 561-228-6129

www.FMHCA.org

May 1, 2020

Office of Governor Ron DeSantis
State of Florida
The Capitol
400 S. Monroe St.
Tallahassee, FL 32399-0001

Cc: Surgeon General's Office
Florida Health
4052 Bald Cypress Way
Tallahassee, FL 32399

Dear Governor DeSantis:

On the behalf of the Board of Directors of the Florida Mental Health Counselors Association (FMHCA), I am writing to request an executive order concerning F.S. 491.0046(4) and Emergency Rule 64B4ER20-24 issued by the Florida Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling (i.e., the "491 Board").

F.S. 491.005(1)(c), 491.005(3)(c), and 491.004(4)(c) require registered interns in all three mental health professions who work "in a private practice setting" to have a "licensed mental health professional on the premises when clinical services are provided." The majority of private practices in Florida have shifted to the provision of telehealth services rather than in-person psychotherapy appointments in order to comply with social distancing precautions related to the COVID-19 pandemic. Though the 491 Board's emergency rule enables interns to provide their services through telehealth as well as to attend their clinical supervision appointments through webcam, the 491 Board has no power to allow private practice interns to provide telehealth services without a licensed mental health professional on the premises due to the statute. Consequently, interns are now placed in a precarious situation in which they must either unethically abandon their clients during a pandemic on one hand or violate social distancing precautions on the other.

We are asking you to consider an executive order that temporarily permits registered mental health counselor, clinical social worker, and marriage and family therapy interns to provide telehealth session with their clients without a licensed mental health professional "on the premises" provided that (a) the intern is appropriately supervised by a qualified supervisor; (b) the intern and his or her qualified supervisor have created and appropriate telehealth protocol; and (c) the intern's qualified supervisor is available by phone or other medium should the intern require the supervisor's expertise. It is our hope that such action will protect Florida's citizens from abandonment during this international crisis.

Respectfully submitted,

Aaron Norton, LMHC, LMFT, MCAP, CRC, NCC, CCMHC, DCMHS
President, 2019-2020