Volume 18, Issue 12

President's Message

The year 2018 was a year that illuminated the nation's need for mental health care services.

We all most likely followed critical issues this year such as gun violence, the opioid epidemic, civil rights issues and healthcare reform among many other critical topics.

The Florida Mental Health Counselors Association has been at the table with our legislators to ensure that our government officials know the importance of our profession and how mental health services are a key component of addressing some of our nation's most difficult problems.

We encourage you to join us as we step boldly into 2019. Some of our planned efforts for next year include traveling to the capital of Florida in March for a dynamic Legislative Day, continuing to work with key stakeholders to establish a framework for licensure portability and capitalizing on advances in technology to provide innovative services and benefits to our members.

I would like to thank our members, board and dynamic ladies that lead operations in the FMHCA office for making 2018 such a success. I hope to see you all at our annual conference which will take place in Lake Mary, Florida from January 31st to February 2nd in 2019.

As always please feel free to reach out to me if you have any questions or feedback. Wishing you all a very happy holiday season!

Erica Whitfield, LMHC, BC-TMH
FMHCA President

December *Day*

December 1, 2018

World AIDS Day

December 3, 2018

International Day of Persons with Disabilities

December 10, 2018

Human Rights Day

Month

December 1 – December 31, 2018

National Impaired Driving Prevention Month

Safe Toys and Celebrations Month

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2018 - 2019

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FMHCA Chapters

Broward County
Central Florida
Emerald Coast
Gulf Coast
Miami-Dade
Palm Beach County
Space Coast

ED Message

Thank you to our loyal and wonderful members! If you are not yet a member, I encourage you to join our organization and let your voice be heard! Our organization offers so many great resources for our members, including education (such as FREE WEBINARS), legislative oversight, networking, and FMHCA member discounts with partner organizations.

I also want to encourage you to register for our upcoming FMHCA Annual Conference on January 31st thru February 2nd in Lake Mary, Orlando. This has been a wonderful venue for connecting with other LMHC's throughout our state, for learning innovative clinical strategies to enhance your therapeutic skills, laughing and setting aside some time to enjoy each other's company. I look forward to seeing you all there, we're going to have a great time!

In gratitude for all of your support,

Darlene Silvernail PhD, LMHC, CAP
Executive Director FMHCA

FMHCA would like to notify LMHCs, registered mental health counselor interns, counselor educators, and counseling students that LMHCs and Registered Mental Health Counselor Interns who fail to repay a student loan and do not agree to a repayment plan risk having their license suspended as well as a fine of 10% of their student loan.

Attention was drawn to this issue during the 491 Board meeting in Orlando on 8/26/18, when the board accepted a recommendation of "reprimand, suspension of the respondent's license until new payment terms are agreed upon, followed by a probation for the duration of the student loan, and a fine equal to 10% of the defaulted loan amount" for a registered mental health counselor intern who defaulted on a student loan and did not agree to a repayment plan.

Though members of the board were critical of this practice, it is clearly established in state law and therefore was adhered to. F.S. 456.072(1)(k) cites the following as grounds for discipline: "Failing to perform any statutory or legal obligation placed upon a licensee. For purposes of this section, failing to repay a student loan issued or guaranteed by the state or the Federal Government in accordance with the terms of the loan or failing to comply with service scholarship obligations shall be considered a failure to perform a statutory or legal obligation, and the minimum disciplinary action imposed shall be a suspension of the license until new payment terms are agreed upon or the scholarship obligation is resumed, followed by probation for the duration of the student loan or remaining scholarship obligation period, and a fine equal to 10 percent of the defaulted loan amount. Fines collected shall be deposited into the Medical Quality Assurance Trust Fund."

Additionally, F.S. 491.009(1)(w) calls upon the board to take disciplinary action for any violation of Florida Statute chapter 456. Thus, the board's hands are tied in this matter.

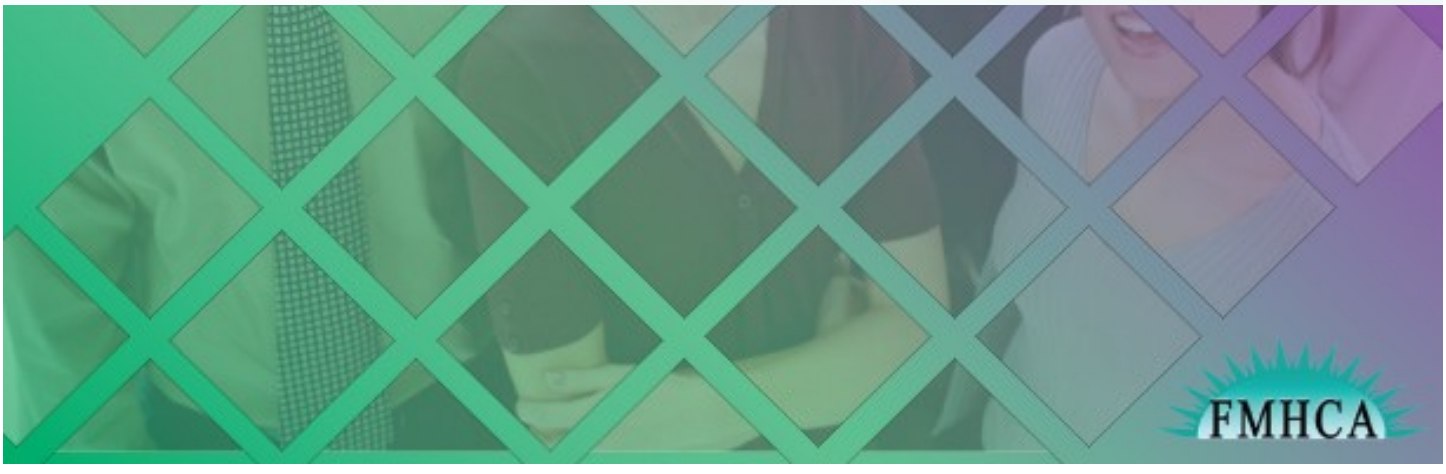
The board clarified with an attorney that a licensee need only agree to a repayment plan and does not necessarily need to pay the loan off, adding "If they keep agreeing to payment terms forever and never pay a dime, they won't get a knock on the door from us."

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

President Elect, 2018-2019

Chair of Education, Training Standards, & Continuing Education Committee

[Click Here To Register]



Schedule at a Glance: 2019 Florida Mental Health Counselors Association

Subject to Change

THURSDAY-January 31st	PRE-CONFERENCE WORKSHOP
SEE SIGNS FOR DIRECTION **7:00AM-8:00AM**	**REGISTRATION**
GRAND FOYER **7:00AM-8:00AM**	**MORNING GRAB AND GO**
SALON A **9:00AM-5:00PM** *7 Clock Hours*	**WE ARE MEMORY WORKERS** **Introducing Neurocise®, EyePointing™ & NeuroPointing™ Guided Eye Movement Strategies to work with Traumatic Events & Memories** *Elvis Lester MA, LMHC, NCC, MAC, NBCFCH* *Qualified Teacher of Hypnosis (State of FL DMQA)*
SALON B **8:00AM-5:00PM** *8 Clock Hours*	**Certified Forensic Mental Health Evaluator Training** *Dr. Norm Hoffman & Aaron Norton LMHC, LMFT, MCAP, CRC, CCMHC*
SALON D **8:00AM-5:00PM** *8 Clock Hours*	**8 Hour Laws & Rules** *Michael G. Holler, MA, NCC, CFMHE, CCCE, CCMHC, LMHC*
SALON E **8:00AM-5:00PM** • Ethics *(3 Clock Hours)* • Medical Errors *(2 Clock Hours)* • Laws & Rules *(3 Clock Hours)*	**Required State of Florida Clock Hours for Re-Licensure:** • *Bob Decker Ph.D., NCC, LMHC* • *Michael G. Holler, MA, NCC, CFMHE, CCCE, CCMHC, LMHC*
SALON G & H **8:00AM-5:00PM** *16 Clock Hours (2-Day Workshop)*	**Treating Anxiety and Phobia: EMDR Level 1** *Benjamin B. Keyes Ph.D., Ed.D., LMHC, NCC, CCMHC*
ORCHID BALLROOM **8:00AM-5:00PM** *12 Clock Hours (2-Day Workshop)*	**Qualified Supervisor Training (QST)** *Dr. Denny Cecil-Van Den Heuvel & Dr. Tom Christiansen*
LUNCH **12:00PM-1:00PM**	All participants are on their own for lunch
GRAND FOYER	**SNACK BREAK**

FRIDAY-FEBRUARY 1st	WORKSHOP	SALON	TRACK
7:00AM-8:00AM	**REGISTRATION**	**SALON C**	
7:00AM-8:00AM	**BREAKFAST:**	**GRAND FOYER**	
8:00 AM-5:00 PM *16 Clock Hours (2-Day Workshop)*	Treating Anxiety and Phobia: EMDR Level 1 *Benjamin B. Keyes Ph.D., Ed.D., LMHC, NCC, CCMHC*	**SALON G & H**	
8:00 AM-12:00PM *12 Clock Hours (2-Day Workshop)*	Qualified Supervisor Training (QST)	**ORCHID BALLROOM**	
8:00AM-9:30AM *1.5 Clock Hour (Keynote)*	The Trauma Model-A Treatment Approach for Trauma, Dissociation, and Complex Comorbidity. *Presenter: Colin A. Ross, M.D.*	**GRAND BALLROOM**	**TR**
9:30AM-9:45AM	**SNACK BREAK**	**GRAND FOYER**	
9:45AM-11:45AM *2 Clock Hours*	Tobacco Use Disorder: The Neglected Addiction *Presenter: Andree Aubrey, LCSW; CTTS*	**SALON A & B**	**AT**
	Filicide - How Hidden Hostility at Home Leads to Murder *Presenter: C. Dwight Bain, NCC, LMHC*	**SALON D**	**EB**
	Domestic Violence, Human Sex Trafficking, Military PTSD and the way Forward in Trauma Informed Care *Presenters: Dr. Patrick Nave, LMHC, MCAP, CET, ABD & Diena Cannavino, CAC*	**SALON E**	**RC**
	Unspoken Family Trauma - Reverse Culture Shock *Presenters: Kathie Erwin, PhD, EdD & Kelly Erwin, BA*	**SALON F**	**TR**
11:45AM-1:15PM *1.5 Clock Hours*	**WORKING LUNCH** *(All participants are on their own for lunch unless RSVP)*		
	Government Relations Panel	**SALON A & B**	**General/ Other**
	Student Panel	**SALON D**	**General/ Other**
	Military Sexual Trauma Symposium. *Presenters: Greg Dawson, Ph.D., Carlos Garcia , Ph.D., Tatyana Harris, Ph.D., Maria Giuliana, LMHC, Ellsworth "Tony" Williams*	**SALON E**	**MV**
1:15PM-3:15PM *2 Clock Hours*	What Mental Health Professionals Need to Know About Medical Marijuana: A Clinical-Forensic Perspective. *Presenter: Aaron Norton, LMHC, LMFT, MCAP, CRC, CFMHE, CCMHC*	**SALON A & B**	**EB**
	From Crisis to Solutions in Treatment Community *Presenters: John Hulick MS, Jonathan Belolo ,LCSW Joe Bryant, Whitney Lehman, CRRA,* Micah Robbins	**SALON D**	**AT**
	HIV/AIDS *Presenter: Cortina Peters, LMHC, CLC, CSE*	**SALON E**	**RC**
	Putting the Tools to Work: Tools Regarding Psychological First-Aid *Presenter: Dan Casey, PhD*	**SALON F**	**TR**
3:00PM –3:15PM	**SNACK BREAK**	**GRAND FOYER**	
3:30PM-6:30PM *3 Clock Hours*	The Icecream Kid with No Hands. Kids and the Power of Metaphor Therapy. *Presenter: Erica Whitfield, LMHC, MACP, DCC*	**SALON A & B**	**CH**
	Past Life Regression: Connecting Your Past, Present and Future Through Mining the Unconscious. *Presenter: Bob Decker, Ph.D., NCC, LMHC*	**ORCHID I**	**EB**
	Ethical Issues in Special Populations *Presenter: Patsy Evans, Ph.D., LMHC, DOM*	**ORCHID II & III**	**RC**
	Compassion Fatigue Part 1: Overview of Mindfulness with Compassion Fatigue *Presenter: Donna White, RN, PhD* Part 2: The Three-legged Chair: The Third Leg of Trauma Informed Care - Compassion Fatigue Prevention and Compassion Rediscovery *Presenter: Heather Dziewlski, MSW, LCSW* Part 3: Family Dynamics - How PTSD Affects Family of First Responders and Military. *Presenter: Richard A. Baker, MA, PhD and Sandra Baker, MA, MSW*	**SALON F**	**TR**
6:30PM-10:00PM *1.5 Clock Hour (Keynote)*	**RECEPTION & STUDENT POSTER SESSION** Innovative Research: Where Science, Technology and Consciousness Meet *Presenter: Dr. Tania Diaz*	**GRAND BALLROOM**	

Conference Schedule has been finalized!

SATURDAY- FEBRUARY 2nd	WORKSHOP	SALON	TRACK
7:00AM-8:00AM	**REGISTRATION**	**SALON C**	
7:00AM-8:00AM	**MORNING GRAB AND GO**	**GRAND FOYER**	
8:00 AM-12:00PM *4 Clock Hours*	Qualified Supervisor Continuing Education Update *Presenter: Dr. Denny Cecil-Van Den Heuvel*	**ORCHID BALLROOM**	
8:00AM-9:30AM *1.5 Clock Hour (Keynote)*	Counseling in the Modern Era *Presenter: Courtney Robinson, MACP, LMHC*	**GRAND BALLROOM**	
9:30AM-9:45AM	**SNACK BREAK**	**GRAND FOYER**	
9:45AM-11:45AM *2 Clock Hours*	Involuntary Commitment to Substance Use Disorder Treatment Saves Lives *Presenter: Joseph Considine, Juris Doctor and Licensed Attorney in Florida*	**SALON A & B**	**AT**
	The Other Eating Disorders: Pica, Avoidant Restrictive Food Intake Disorder, and Other Specified Feeding and Eating Disorders. What You Need To Know *Presenter: Joann Hendelman, PhD, RN, FAED, CEDS*	**SALON F**	**EB**
	I AM MORE THAN ENOUGH: Lessons of Transformation from Adult Children of Alcoholics *Presenter: Daniella Jackson, Ph.D., LMHC, Certified Health Coach*	**SALON G**	**EB**
	Immigrant Survivors of Domestic Violence No Longer Protected By Asylum: Implications for Therapeutic Practice *Presenters: Elizabeth Ringler-Jayanthan, LMSW & Martha Vallejo, LCSW*	**SALON H**	**TR**
12:00PM-1:30PM *1.5 Clock Hours*	**AWARDS LUNCHEON/ANNUAL MEMBERSHIP MEETING** *Legislative Update* *Presenter: FMHCA Lobbyist Corinne Mixon*	**GRAND BALLROOM**	
1:30PM-3:30PM *2 Clock Hours*	Soul Tending: A Warrior's Grief *Presenter: Louise Sutherland-Hoyt, LMHC, CCMHC, NCC,MAC*	**SALON A & B**	**EB**
	The Neuro-biology of Domestic Violence *Presenter: Matthew Fox, LMHC*	**ORCHID BALLROOM**	**RC**
	Culturally Competent Care for the LGBT Community *Presenters: Dona Leith LPC, CRTS, CDP & Paula Lupton, LCSW*	**SALON G**	**CD**
	Trauma Model Therapy: Techniques, Strategies and Case Examples *Presenter: Colin A. Ross, MD*	**SALON H**	**TR**
3:30PM –3:45PM	**SNACK BREAK**	**GRAND FOYER**	
3:45PM-6:45PM *3 Clock Hours*	Ethical Considerations in Safety Planning and Legal Issues with Clientele *Presenters: Amanda Patterson, LMHC, NCC, CAP & Adam D. Rossen, Esq.*	**SALON A & B**	**RC**
	Dealing with Opioid and Heroin Epidemic & Non-Medication Treating of Pain *Presenter: Jim Messina, Ph.D., CCMHC, NCC, DCMHS-T*	**SALON F**	**AT**
	Using Story Therapy in Counseling *Presenter: Nathaniel Webster, LMHC*	**SALON G**	**EB**
	Trauma Part 1: Creating and Effective Trauma Institute. *Presenters: Vanessa Snyder, Ph.D. and Amy Kenney, MA* Part 2: Hurricane Maria 2017 - Dominica's Experience. *Presenter: Earl Hernandez, Post-MBA, EMDM, Dip. EM, Cert. EM, NREMTP, CCEMTP, PNCCT.* Part 3: Moving Forward, Putting the Past Where it Belongs. *Presenter: Diana Canant, BA*	**SALON H**	**TR**

What LMHCs Should Know About Medical Marijuana in Florida

Medical marijuana is now legal in 32 states, including Florida. Simultaneously, marijuana is the most commonly abused illicit substance in the United States. On one hand, Licensed Mental Health Counselors (LMHC)s treat substance use disorders as well as mental disorders, but on the other hand we also work with clients with co-occurring biomedical conditions that might benefit from medical marijuana. Education on medical marijuana, which is relatively new to our state, is therefore important. In this article, I will briefly introduce eight facts that I believe LMHCs should know about medical marijuana in Florida.

Fact #1: Not All Medical Marijuana is Psychoactive and Potentially Addictive

Five years ago, I watched attorney John Morgan tell viewers of my local cable news station that "nobody's addicted" to marijuana. Having treated clients with cannabis use disorders for about 13 years by that point, I was concerned about such misinformation being disseminated to the public. I contacted the local news station, which then referred the concern to PolitiFact, a nonprofit political fact-checking resource owned by the Poynter Institute. After a thorough investigation, they rated the statement as "false," and to his credit, Morgan acknowledged his mistake publicly and clarified his position. In fact, according to the National Institutes of Drug Abuse (NIDA), approximately 10 percent of people who ever use marijuana develop a cannabis use disorder.

But when we say that marijuana is addictive, it is helpful to clarify that marijuana addiction is primarily attributed to D-9-tetrahydracannabinol (THC). There are many other chemicals in marijuana, and some of those chemicals are also termed "medical marijuana." When the term "medical marijuana" is used, it likely refers to one of two compounds—THC or cannabidiol (CBD). Unlike THC, CBD is non-addictive and has been declared by the World Health Organization (WHO) to not pose a threat to public health. Therefore, when you read or hear about "medical marijuana" in the news, or when a client tells you that he or she is using medical marijuana, it is important to determine whether THC (which poses a risk of addiction) or CBD (which does not), is the subject of discussion.

Fact #2: In Florida, Medical Marijuana Can Only be Prescribed for Certain Disorders

F.S. 381.986 permits medical marijuana to be described for the following conditions: cancer, epilepsy. glaucoma, HIV/AIDS, PTSD, amyotrophic lateral sclerosis (ALS), Crohn's disease, Parkinson's disease, and multiple sclerosis. It is important to note that the only mental disorders included in the legislation is PTSD. However, in my experience, prescribers have prescribed medical marijuana for several other mental disorders, including ADHD, Panic Disorder, Obsessive-Compulsive Disorder, and Generalized Anxiety Disorder. How do they get away with this? My guess is that they are very liberally interpreting a clause in the statute clarifying that medical marijuana can also be prescribed for "medical conditions of the same kind or class as or comparable to those" previously mentioned. They may reason, for example, that because people with PTSD tend to experience anxiety, people with any anxiety disorder should also be treatable by medical marijuana.

Fact #3: Medical Marijuana is Helpful for Some Disorders, and Not So Helpful for Others

Because there is a great deal of misinformation out there about medical marijuana, it is important to find current, objective, and unbiased resources for sifting fact from fiction. I favor the National Academy of Science, Engineering, and Medicine's (NASEM) 2017 report entitled *The Health Effects of Cannabis and Cannabinoids: The Current State of Evidence and Recommendations for Research*. NASEM's report presents nearly 100 research conclusions about medical marijuana, lumping them into different levels of strength ranging from *conclusive or substantial evidence* down to *no or insufficient evidence*. They determined that the evidence is moderate, conclusive, or substantial for at least some therapeutic benefit for chronic pain, chemotherapy-induced nausea or vomiting, spasticity associated with multiple sclerosis, and short-term sleep outcomes for several biomedical conditions.

Conversely, they concluded that there is limited, insufficient, or no evidence to support that medical marijuana is helpful for increased appetite and decreased weight loss associated with HIV/AIDS, clinician-measured spasticity associated with multiple sclerosis, Tourette syndrome, anxiety symptoms, PTSD, improved outcomes (i.e., mortality) after a traumatic brain injury, dementia, glaucoma, depressive symptoms in individuals with chronic pain or multiple sclerosis, cancers, cancer-associated anorexia, irritable bowel syndrome, epilepsy, spasticity associated with spinal cord injury, amyotrophic lateral sclerosis, motor symptoms associated with Parkinson's disease, dystonia, addictions to other drugs, and schizophrenia/psychosis.

I should note that just because research does not yet support that medical marijuana can be effective for a disorder does not meant that it doesn't help; it just means that we can't prove it at this time. Nonetheless, I think it is also important to point out that several of the disorders that the NASEM report concluded were not yet supported by research include disorders that F.S. 381.986 permits physicians to prescribe medical marijuana for here in Florida, begging the question of whether legislators are waiting until there is sufficient evidence to conclude that medical marijuana helps a disorder before including those disorders in legislation.

Fact #4: There Are Many Health Risks Associated with Marijuana

Part of the controversy about medical marijuana centers around a well-established body of research demonstrating that marijuana can be harmful to human beings. For example, the NASEM report from 2017 found moderate to substantial/conclusive evidence that marijuana use correlates with respiratory symptoms and more frequent episodes of chronic bronchitis (for long-term smokers), increased risk of motor vehicle crashes, increased risk of overdose injuries including respiratory distress among pediatric populations, lower birth weight among offspring

of mothers who smoke marijuana, impairment in the cognitive domains of learning, memory, and attention, the development of schizophrenia and other psychotic disorders, increased symptoms of mania and hypomania, a small increased risk for depressive disorders, increased incidence of suicidal ideation, attempts, and completion, social anxiety disorder, and the likelihood of developing addictions to other substances. I think it is important to note, however, that some of these associations are correlational rather than causal.

An additional major risk is the development of a cannabis use disorder, which may or may not include physiological symptoms such as tolerance and withdrawal. Daily medical marijuana users often develop tolerance to marijuana, which means that they either will require more of the substance to get the same effect, or they will get diminished effect from the same dosage, and the higher the dosage, the greater the likelihood that the client will experience the above risks.

Fact #5: Medical Marijuana Prescriptions Vary in Dosage and Route of Administration

One concern about medical marijuana centers around the traditional route of its administration—inhalation of marijuana smoke. This route of administration raises issues and concerns of increased risk for respiratory problems. However, medical marijuana is often applied through nasal sprays, vaping (i.e., inhalation of smokeless vapors), oral ingestion, topical, and even vaginal/rectal means, possibly reducing risk of respiratory problems.

Dosage is another important variable. According to Dr. Gregory Smith, an expert medical marijuana prescriber and designer who wrote *Medical Cannabis: What Clinicians Need to Know and Why—Basic Science and Clinical Applications*, if a client can feel a "high" or euphoria from medical marijuana, then the client is over-medicated. To avoid this impairment, THC doses should be under 10 mg. Additionally, most medical conditions should respond to CBD to THC ratios of 1+ (CBD) to 1 (THC) or higher, whereas recreational marijuana ratios are often 1 (CBD) to 15+ (THC).

Unfortunately, I doubt that medical marijuana dispensaries in Florida are reading Dr. Smith's books or attending his lectures. In online searches of products in our State's dispensaries, I generally see dosages of 10 mg to 600 mg of THC and CBD to THC ratios of between 1 (CBD) to 20 (THC) and 1 (CBD) to 826 (THC), raising serious doubt about whether clients are being over-medicated.

Fact #6: Medical Marijuana Card Holders Are Not Protected from Employment Discrimination

Because marijuana is illegal under federal law, and because the Americans with Disabilities Act (ADA) specifically excludes "any employee or applicant who is currently engaging in the illegal use of drugs" from protection against employment discrimination, federal law does not currently protect medical marijuana users. Additionally, F.S. 381.986(1)(j)5c specifically delineates that medical marijuana "in a qualified place of employment, except when permitted by his or her employer," is not permissable under state law. Also, medical marijuana patients who work in jobs designated as "safety-sensitive" by the U.S. Department of Transportation, such as boat captains, pilots, bus drivers, pipe layers, bridge painters, workers on assembly lines that produce controls for public transportation, and a myriad of other jobs, risk violation of 49 CFR Part 40, which can result in being pulled for safety-sensitive job duties and/or termination from employment. It is therefore important for your clients to understand that they risk job loss or other employment sanctions if they use medical marijuana.

Fact #7: Many Medical Marijuana Users are Recreational Users and/or Addicts Seeking a Legal Means to Use or Abuse Marijuana

This shouldn't come as much of a surprise to LMHCs. We are accustomed to working with clients who are addicted to other legally prescribed medications, such as opioids, benzodiazepines, and stimulant medications designed to treat ADHD. The same can be said for medical marijuana users .

Fact #8: Most Medical and Psychological Professional Organizations Oppose Medical Marijuana

The prescription of medical marijuana is either strongly opposed by or at least cautiously discouraged by the American Medical Association, American Psychiatric Association, American Society of Addiction Medicine, American Academy of Pediatrics, NAADAC (the Association for Addictions Professionals), and the U.S. Dept. of Veterans Affairs (VA). Reasons given for these positions include lack of evidence of efficacy, substantial health risks posed by medical marijuana, the need for additional research, and the availability of effective and lower-risk alternatives. Criticism is especially sharp for prescription among children and adolescents due to developmental impairment and for prescription of medical marijuana for psychiatric disorders, which tend to be much more effectively treated by other means, including safer medications and psychotherapy .

In the interest of full disclosure, I voted in favor of medical marijuana legislation in Florida, albeit primarily for political and philosophical reasons. However, I must admit that the well-articulated and widespread criticism of medical marijuana among our professional associations raises questions about whether legislators who claim that the benefit of medical marijuana is well-established are getting ahead of themselves.

Clinical Application and Resources

Because the prescription of potentially addictive medications is generally contraindicated for clients with substance use disorders due to the risks of cross-addiction, it is sometimes important for LMHCs to assess whether a client taking prescribed marijuana has one or more substance use disorders. Additionally, because of the potential for medical marijuana to exacerbate co-occurring mental disorders, questions of whether or not medical marijuana is appropriate, whether there are safer and more effective alternatives, and whether the client is using the medication safely are all important considerations. And what about situations in which a client is court-ordered to participate in substance abuse treatment but is also legally using prescribed marijuana? How does an LMHC determine that the client is recovering sufficiently and unlikely to be a threat to public safety under those circumstances? If an LMHC determines that a client's marijuana is likely causing significant problems for a client, what can he or she do? To further explore these questions, I recommend watching a recording of a two-hour webinar I presented on this topic for the National Board of Forensic Evaluators, which can be viewed for free at https://youtu.be/TDQkztqlq8s. If you would like CEUs for watching that webinar, you may register and pay a small administrative fee at https://nbfe.net/event-2983898.

Aaron Norton, LMHC, LMFT, MCAP, CRC, CCMHC
President Elect, 2018-2019
Chair of Education, Training Standards, & Continuing Education Committee

1. https://www.vox.com/identities/2018/8/20/17938366/medical-marijuana-legalization-states-map
2. https://www.drugabuse.gov/drugs-abuse/marijuana
3. https://www.politifact.com/florida/statements/2013/oct/08/john-morgan/john-morgan-says-nobodys-addicted-marijuana/
4. https://www.drugabuse.gov/publications/research-reports/marijuana/marijuana-addictive
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12. https://www.tandfonline.com/doi/full/10.1080/10826084.2017.1413391
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18. https://www.aap.org/en-us/about-the-aap/aap-press-room/pages/American-Academy-of-Pediatrics-Reaffirms-Opposition-to-Legalizing-Marijuana-for-Recreational-or-Medical-Use.aspx
19. https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=3&cad=rja&uact=8&ved=0ahUKEwis-bHukNLbAhUEbK0KHcPGCcUQFgg2MAI&url=https://www.psychiatry.org/File Library/Learn/Archives/Position-2013-Marijuana-Medicine-PTSD.pdf&usg=AOvVaw2JwdYIRHyhRF4QGJJYQa
20. https://www.asam.org/docs/default-source/public-policy-statements/marijuana-cannabinoids-and-legalization-9-21-2015.pdf?sfvrsn=38e06fc2_0
21. https://www.naadac.org/assets/1959/naadac_position_statement_-_recreational_marijuana_aar_spr2013.pdf
22. https://www.publichealth.va.gov/marijuana.asp
23. https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/substanceuse.pdf

THE FMHCA PAC NEEDS YOUR SUPPORT!

Between 3,000 and 4,000 bills are introduced each year of the Florida Legislative Session.

FMHCA PAC (Political Action Committee) contributions will help elect candidates that are 1) likely to support FMHCA's priorities (pro-mental health counseling/health policy) and that 2) have a chance to win their respective seat, regardless of political party affiliation.

The FMHCA PAC provides you with the opportunity to have an impact on the election of officials who will shape the future of your practice.

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FMHCA members that are passionate about legislation & government relations may request to join the Government Relations Committee.

See reverse for more details on FMHCA Committees.

BRIDGESINTERNATIONAL

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GREAT NEWS! FMHCA Secures Bill Sponsor!

I'm thrilled to share with you some great news on the legislative front !

The Government Relations Committee, with help from Aaron Norton, has been work-shopping language that will have a positive impact on the profession both nationally and at the state level. The below email, sent to Rep. Tommy Gregory (R-Sarasota), details this group effort.

Rep. Gregory has just agreed to file this legislation on our behalf. As many of you know, securing Republican bill sponsors in the House is difficult since each legislator is only allowed to file six bills. A member of the Air Force for 20 years, Rep. Gregory appreciates the healing your professions provide to veterans. He's excited to work on this bill with us. I can now move on to finding a Senate sponsor.

Jennifer Wenhold, executive director of the state board, is beyond thrilled that FMHCA (Rutledge Ecenia) was able to find a bill sponsor to champion this effort on behalf of the Board, Department of Health and the three professions. I think her appreciation will be mirrored by the members of the state board as well.

Dear Representative-Elect,

It was great meeting with you at your law office a couple of weeks ago. We are thrilled about your strong win.

As you will remember, we discussed the possibility of working together on legislation relating to Licensed Mental Health Counseling (LMHC), Marriage and Family Therapy (LMFT), and Clinical Social Work (LCSW). These three Masters and PhD-level-professions, which compile the majority of the State's behavioral health workforce, care for a significant number of Floridians each year, including many veterans. In fact, a good portion of the LMHC profession, my client, is comprised of veterans who now serve veterans (a highly effective model).

The bill draft we discussed will help streamline licensure standards for all three professions in Florida and around the country. The legislation would help align national standards to foster an environment for licensure portability. States with portable licensure standards and inclusion in interstate compacts are able to treat more people because their workforces are not overburdened by unnecessary regulation. In addition, insurance companies are more easily able to support the patients seen by CSWs, MFTs and MHCs because they recognize each profession as equal across state lines.

In a nutshell the bill will:

- Align the three professions' licensure acts with the national standards by updating outdated requirements (testing and course requirements*) *outcome—creation of an environment where licensure compacts are possible*
- Remove the overreliance on provisional licenses and replace it with permanent licensure **outcome—more people become fully licensed versus having to first be provisionally licensed; thus, we reverse overregulation and overspending by prospective licensees*

Give the State Board of Clinical Social Work, Marriage and Family Therapy and Mental Health Counseling the ability to let registered interns remain interns beyond the 5-year cap if they leave to serve in the military or have other special circumstances **outcome—retention of highly qualified interns until full licensure is possible*

In short, the draft will improve access to mental health services and remove regulation. We are happy to send you a copy of the bill draft and I'd be happy to meet with you in November or December.

We would be pleased to work with you and we believe you'll find these concepts are strongly supported by your legislative colleagues. In addition, you have the support of the tens-of-thousands CSWs, MFTs and LMHCs across the state of Florida, the staff of the Department of Health, and the State Board of Clinical Social Work, Marriage and Family Therapy and Mental Health Counseling (voted and approved). This is truly a group effort.

Thank you for your consideration.

Corinne Mixon
FMHCA Lobbyist, Rutledge Ecenia, P.A.

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Daniella Jackson, Ph.D., LMHC
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Counseling the Victim

Betty came to my office with the presenting problem of family issues. She began to tell the story of her sister and how they fight most times when they speak to each other even though they are 5 states away and hardly see one another. Betty described arguing with her mother, her daughter, her husband. A pattern was starting to develop that I hope you already see. Betty responded in multiple relationships like she is the victim. But what does this mean? Victimization is a lens a person may look through in regards to relationships. While relationships have many lenses, this particular one is harmful. Victimization uses the lens, "I am being attacked", or "I am being judged" by another person and I must defend myself.

As Betty was telling her stories I began to probe more about the individual relationships with her family to help her see their side of the situation and to help her make less assumptions about her role and responsibility in the relationship.

One of the positive advantages I see in therapy is a person has more reason to listen and follow the advice and perspective of you the therapist than most others in their life. Its similar to the doctor giving advice and sometimes can be seen to be clearer and without judgment coming from the therapist rather than say, a family member or friend who may have some ulterior motive.

I began to explain what self esteem is and gather a more decisive history of this growing up as a child. She explained that her mother had poor self-esteem and may have nurtured this in Betty. We also discussed distortions that the mind uses to increase the victimization and decrease self-esteem such as: personalization, catastrophizing, black and white thinking, and jumping to conclusions. Betty's homework was to be more aware when she uses these distortions in her relationships and using the alternatives we discussed to increase her self-esteem. Amazingly, after having a few sessions she was complaining less about previous people in her life and setting better limits and boundaries both emotionally and physically. And overall, she seemed happier and more at ease with her day-to-day. We still meet from time to time and she now explains when the victim role creeps up in her communication.

While we as therapists deal with problems, difficulties, and challenges daily, the influence we have in helping and healing has just as much power and sustainability. I encourage you to keep striving for this healing power.

Scott Jones
LMHC (Licensed Mental Health Counselor)
CAP (Certified Addictions Specialist)
Qualified Supervisor, State of FL
Email: scottjones@newdirectionscounselingfl.com
Website: newdirectionscounselingfl.com
Based out of Orlando FL

How to Get Licensed as a Mental Health Counselor in Florida
14 Dec 2018
12:00 PM - 1:00 PM CE Broker Tracking :# 20-637585

Counselingstudentsandregisteredinterns: Do you want a comprehensive overview of the LMHC licensure process in Florida?

Counseloreducatorsandclinicalsupervisors: Do you want an update on the licensure process to help ensure that you are providing your students and supervisees with relevant information to aid them in the licensure process?

LMHCsinFlorida: Do you want to learn more about licensure portability (i.e., the process for becoming licensed in other states)?

Counselorsinotherstates: Are you considering applying for the LMHC credential in Florida?

If you answered "yes" to any of the above questions, then this webinar was designed for you!

Learning Objectives

Participants will:

1. Review the current requirements for the Licensed Mental Health Counselor (LMHC) credential in Florida
2. Learn how to find an appropriate Qualified Supervisor
3. Learn about the national licensure portability plan officially endorsed by the American Mental Health Counselors Association (AMHCA), National Board for Certified Counselors (NBCC), American Associaiton for State Counseling Boards (AASCB), and Association for Counselor Education and Supervision (ACES) known as NCLEP 2.0
4. Review the process for obtaining dual licensure in Florida using a case example of a Licensed Professional Counselor (LPC) in Georgia seeking the LMHC credential in Florida.

About the Presenter

Aaron Norton, LMHC, LMFT, MCAP, CRC, CCMHC, DCMHS is a Licensed Mental Healh Counselor, Licensed Marriage and Family Therapist, and Qualified Supervisor in the Tampa Bay Area who has more than 15 years of experience as a clinician, clinical supervisor, forensic evaluator, and counselor educator. He teaches at the University of South Florida's Rehabilitation and Mental Health Counseling program, maintains a part-time private practice at Integrity Counseling, and serves as Southern Regional Director of the American Mental Health Counselors Association, President-Elect and Chair of Education for the Florida Mental Health Counselors Association, and Executive Director of the National Board of Forensic Evaluators. He is a doctoral candidate at the University of South Florida's Counselor Education and Supervision program, has been awarded MentalHealthCounseloroftheYearby AMHCA and CounselorEducatoroftheYearby FMHCA in 2016, and has been published in TheAdvocateMagazine, AddictionProfessional, the JournalofGayandLesbianSocialServices, and the AmericanJournalofOrthopsychiatry.

In the most extreme cases, parents exhibit hostile behavior, either overt or covert. They unconsciously or with forethought vilify the other parent—usually the absent parent—in the eyes of the children. Courtroom battling and domestic conflict cause children to feel insecure. "Children commonly interpret conflict as caused by the rejected parent and as abusive and victimizing of the aligned parent (and by extension, the child)."[92] This process is often described as alienation.

Given the high incidence of divorce, there is also a high probability of escalated or 'high' conflict evidencing the anger between the parents. Further, that divorce and custody are resolved through litigation in family courts, these angers are heightened, and the tactics used lead to greater tensions, and argument. This is not just 'theater', it is a horrific means for deciding the most tender of issues, parenting. This author has observed, read of and heard the testimony of vicious attacks used in the courtroom for child custody battles which utilize misinformation, exaggeration, and deceit.

When a parent is emotionally distraught, hurt and angry, as with others, it is not uncommon to for child brainwashing to occur. This brainwashing has been itself a source of argument by those who seek to demonstrate its presence and those who seek to deny its reality. Yet, this brainwashing, frequently referred to as parental alienation is common. Gardner, forensic psychiatrist and original researcher who labeled Parental Alienation Syndrome, or PAS defined it as "a disorder that arises primarily in the context of child-custody disputes. Its primary manifestation is the child's campaign of denigration of the parent, a campaign that has no justification. The disorder results from the combination of brainwashing, indoctrination by the alienating parent, and the child's own contributions to the vilification of the alienated parent." [93]

PAS poses a concept that confuses many professionals who find it too complex. Many attorneys argue that PAS and also PA cannot be reliably determined since neither condition is yet in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM V). However, it is also argued by some that although the concept is not in the DSM as a diagnosis, its symptoms are and are characterized by emotional abuse, narcissism, bipolarity and borderline personality disorders. The courts frequently expect that forensic psychologists who interview and evaluate family members for custody and child access determinations will reliably testify as to mental health conditions of parents and children. The courts generally accept an evaluating psychologist's opinion in determining their own. However, psychologists differ in their interpretation of data. "Thus," writes Turkat, "the attorney attempting to assist a client by making a referral to a mental health practitioner in certain PAS cases may unwittingly be causing the client even more problems."[94]

A parent who believes their child is a victim of the other parent's alienating behavior must go to great lengths to demonstrate that PA or PAS is present. Review of state custody laws show that most parents who battle for custody must do so in a defensive posture.

When the other parent objects to sharing custody, legal arguments become clouded with allegations. As cited earlier, accusations of child abuse, sexual misconduct, incapacity, and malfeasance dominate the arguments. According to a study by Dunne and Hedrick, "PAS does not necessarily signify dysfunction in either the alienated parent or in the relationship between that parent and child. PAS appears to be primarily a function of the pathology of the alienating parent and that parent's relationship with the children."[95]

Determining whether alienation is present is complicated. It requires diagnosticians, i.e., forensic psychologists who specialize in identifying an alienated child and the source of alienation. "As in all child custody evaluation reports, the data that are relied on to form an opinion should be included."[96] Inclusion of this material helps show the perspective of the forensic therapist or other appointed evaluator.

According to Lee and Olesen, "A failure to appropriately identify and intervene in the early stages of these cases may result in the alienating parent being given professional support for his/ her position, reinforcing the child's need to maintain or expand complaints about the alienated parent."[97]

Parental Alienation :From PRESERVING FAMILY TIES, AN AUTHORITATIVE GUIDE TO DIVORCE AND CHILD CUSTODY (WestBow Press, Feb 2018) Continue

Available from Amazon, Barnes and Noble and WestBow Press

With permission of Dr. Mark D. Roseman, Author

92 Gregory, Understanding Family Law, 15.

93 Richard Gardner, "Recent Trends in Divorce and Custody," Litigation 20, no.

3 (1985): 6.

94 Ira Turkat, "Parental Alienation Syndrome: A Review of Custody Issues," Journal of the American Academy of Matrimonial Lawyers 101, no. 18

(2002): 173. 95 John Dunne and Marsha Hedrick, "The Parental Alienation Syndrome: An Analysis of Sixteen Selected Cases," Journal of Divorce and Remarriage 21, no 3/4 (1994): 27.

96 Ibid., 28.

97 Margaret S. Lee and Nancy W. Olesen, "Alienated Children in Divorce: Assessing for Alienation in Child Custody and Access Evaluation," Family Court Review 70 (July 2001): 284.

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Please contact David San Filippo, Ph.D., LMHC, Clinical Director, BlueLine Support for an application to join our BLS-MHP Network **or** scan the code below. David.SanFilippo@woundedofficersinitiative.org	WOUNDED OFFICERS INITIATIVE .ORG

Pick a saddle: Encouragement for choosing a dissertation topic

Being enrolled in a doctoral program offers a strange dichotomy of emotions. Often, we consider the doctoral journey as one that ends in riding off into the sunset with a completed, bound dissertation in one hand and a faculty job offer in the other. The journey to get to this point is far more important, however, than making this vision a reality. While the journey to conferment can be exhaustive, it is fair to note that it is completion of the dissertation that truly separates the many from the few.

The doctoral journey is encompassed by twists and turns that can truly cause mental, physical, and emotional stresses. Several people have fallen victim to mental breakdowns, excessive weight gain, and overall relationship strain. If you asked anyone with a doctorate, they would agree that the doctoral journey is filled with highs and lows and is truly not for the faint of heart. There is strength in pursuing a terminal degree, prestige in being referred to as "Doctor So-and-So", and optimism of the financial security that having the degree offers. On the contrary, pursuing this degree can force relationships to become estranged, and those enrolled are forced to miss many gatherings, parties, and outings as they are nose first in scholarly, peer-reviewed journal articles. There may be a stigma associated with and by family members who perceive that you are better because you are pushing further academically. Many do not understand the self-inflicted torture and strain that pursuing a doctoral degree can bring on. Because of these culture specific feelings, those currently in and graduated from doctoral programs

Michele Pinellas, M.Ed.
Argosy University Tampa

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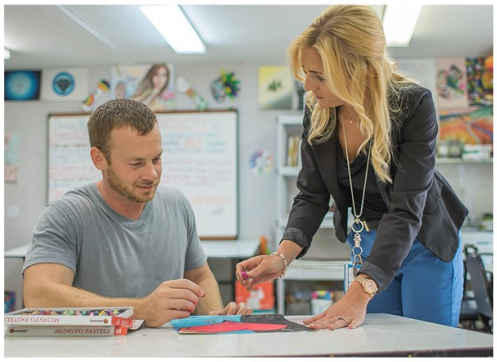


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