Volume 39, Issue 3
Summer 2013

Ohio Counseling Association
GUIDELINES

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Attention professionals, students and counselor educators; please consider submitting your papers, ideas or proposals to the *Guidelines*. Each issue strives to provide information on legal/ethical issues, advocacy, current trends, student perspectives and articles from professionals in the field. OCA will take into consideration all manuscripts. Manuscripts can be directed to the editor, Shawn Grime, at: *ohiocounseling@gmail.com*

Guidelines is published by the Ohio Counseling Association, a branch of the American Counseling Association. The opinions expressed in the articles and advertisements within this newsletter are those of the authors and not the association. Direct questions, suggestions and comments to the editor, Shawn Grime, at: *ohiocounseling@gmail.com*

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PRESIDENT'S MESSAGE

Dear Members of OCA,

Spring is my favorite time in Ohio! The green green grass and the flowering trees make me glad to be alive and living here!! As counselors we are privileged to work with and walk with our clients in their journey to wellness. And as we do this it is important for us to tend to our own wellness. What are you doing this spring and summer to care for yourself, to recharge your batteries, to refresh your body and mind? I encourage you to schedule some "me" time.

I am fortunate to have had the honor of serving as president of OCA this year. I have been impressed with the dedication of counselors in Ohio and of the many examples of the fine work you do. OCA and Ohio counselors were in the spotlight at the American Counseling Association conference in Cincinnati in March. The conference was well-attended and I heard many positive comments regarding the conference venues, affordability, and the warmth of Ohioans. Thank you to everyone who represented OCA so well. Thanks to the our Executive Director Tim Luckhaupt's planning and keen eye for detail we had a lovely joint reception along with the Kentucky Counseling Association and Cincinnati chapter, Greater Cincinnati Counseling Association. We also had a great booth thanks to the efforts of Mia Hall, Tim Luckhaupt and volunteers: Christine Ferens, Jessica Henry, Carrie VanMeter, Ruthann Anderson, Thelma Greaser, Gregg Pollock, Nick Piazza, and John Petry. Thank you all!

I would like to extend sincere and heartfelt thanks to the Executive Council of OCA for their hard work and continued focus on the greater good of OCA. Leaders of OCA chapters and divisions were intentional about setting goals and working for the benefit of members of OCA. I hope you noticed the enjoyed the opportunities to network and have professional development within specific areas of interest or within your local region. One of my goals was to work on promoting the work of counselors with the general public. This is a work in progress and I encourage you to continue to seek out opportunities to talk about counseling and the work you do.

At the end of this year, Shawn Grime who serves as our Technology Director and Newsletter co-editor will be leaving us. Thankfully he will continue to work with us for the All Ohio Counselors Conference. I would like to recognize and thank Shawn for his many contributions to OCA. Thank you Shawn! Please join me in welcoming our incoming president Meghan Fortner. I am confident OCA will continue to thrive under her leadership. Thank you to each one of you for our membership in OCA. We value you and welcome your thoughts on how we can serve you better.

Namaste and happy spring and summer to all,
Christine Suniti Bhat, PhD, PC

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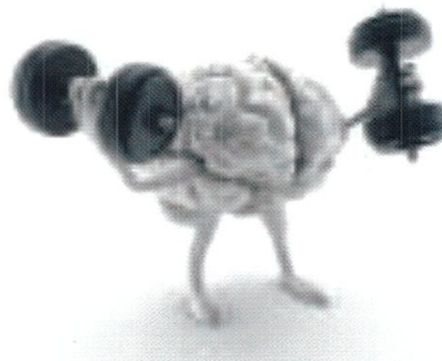
"Through professional training in wellness counseling, counselors have an opportunity to be at the forefront of the professional and cultural re-imagining of what it means to be healthy and well."

Wellness Counseling: Integrating the Wellness Paradigm into Professional Counseling

By Stephen C. Davis, MA, LPC

Western discussions of health and well-being have been rooted in the belief that a separation exists between the mind and the body. Traditional approaches to illness have focused on interventions almost exclusively, neglecting preventative measures. Today an increasing number of professionals are examining the nature of prevention, holism, and wellness in an effort to overturn traditional notions of health. Contemporary research continues to reveal the impacts of these themes on physical health, mental and emotional health, longevity, and life satisfaction. Through professional training in wellness counseling, counselors have an opportunity to be at the forefront of the professional and cultural re-imagining of what it means to be healthy and well.



Shifting Notions of Health and Well-Being in America

The health care landscape is shifting in the United States. This shift is evident in the current health insurance trends. Insurance providers are experiencing the increasing impact of chronic illness on the management and implementation of health care coverage. In the early 20th century, most Americans died of acute sickness, such as infectious diseases (Centers for Disease Control and Prevention, 1999). Today, however, most Americans are living with and dying from lifestyle related illness; such as, heart disease, cancer, respiratory disease, stroke, and diabetes (Murphy, Xu, & Kochanek, 2012).

The prevalence of chronic illness in the United States creates an increasingly unmanageable system for insurance providers. This difficulty is due to the usually continuous involvement with the health care system necessitated by chronic illness. To address these issues, insurance providers have begun offering discounts for policy holders who address health risks such as smoking, obesity, and sedentary lifestyle. Although these initiatives reflect a limited definition of wellness their preventative nature provides a glimpse into what a wellness orientation would look like in the United States.

The Wellness Paradigm

The wellness paradigm is more robust than physical fitness and nutrition alone. Multiple models of wellness exist and include different domains of wellness. Most models endorse creativity, spirituality, interpersonal functioning, and work/vocation as domains which impact overall well-being (Granello, 2012; Meyers & Sweeney, 2008). Contemporary research consistently affirms the construction of these models by revealing the correlations between

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wellness domains and physical health, mental and emotional well-being, longevity, and life satisfaction (Turiano, Spiro, & Mroczek, 2012; Moreira-Almeida & Koenig, 2008). A cornerstone belief among these models is that a change in one domain will lead to increased functioning and subsequent change in multiple domains.

This belief, in a so-called ripple effect, reveals a foundational belief of the wellness orientation. Wellness is crafted around the notion that there is no disconnect between the mind and the body as implied by Cartesian dualism. The wellness philosophy proposes that cognition and emotions impact immunity, metabolism, and the respiratory and cardio-vascular systems. Reciprocally, wellness suggests that the physical state of the body and its systems impact memory, perception, emotion, and other mental tasks. This view is often referred to as holism and, like the domains of wellness, is consistently supported by contemporary research (Jamieson, Nock, & Berry, 2012; Godbout &Glaser, 2005).

History of Wellness

The wellness viewpoint has existed for centuries in many cultures worldwide. It is reflected in the practices of traditional Chinese medicine and Ayurveda. These whole medical systems, along with practices such as yoga and acupuncture, are typically referred to as Complementary and Alternative Medicine (CAM). CAM practices are often viewed as fringe approaches, but are gaining mainstream acceptance as the National Center for Complementary and Alternative Medicine, a section of the National Institute of Health, continues to fund empirical research regarding CAM and its benefits. Although it has existed for centuries, holism diminished in the West as the contemporary medical model took shape during the late Renaissance period.

Wellness Counseling

The wellness paradigm includes many implications for the evidenced based development of wellness counseling. The first implication of holism for the mental health community is that the ontology of mental health issues is not rooted solely in the biological, social, or psychological. Rather, the wellness approach suggests that mental health issues arise when factors in each of these realms impede the well-being of an individual. This hypothesis is not new to the mental health fields as it closely resembles the reciprocal effects theory of pathology. The reciprocal effects theory suggests that the intensity of one pre-disposing factor increases the intensity of other factors (Comer, 2010) and is an extension of the biopsychosocial model. The prominence of the biopsychosocial model predates the discussion of the wellness paradigm in counseling (Suls & Rothman, 2004). This theory of mental illness is an early suggestion of the fit between wellness and counseling.

Wellness counseling involves an accurate assessment of the balance between the client's domains of wellness. Based on formal assessment and work done in session, counselors and clients collaborate to create treatment plans which emphasize strengths while addressing areas for improvement (Granello, 2012). In this way, the work during sessions is more than addressing clients' presenting issues. Wellness counselors facilitate the development of skills which clients can use to maintain well-being and increase resiliency against mental health issues. In contrast to the medical model, which emphasizes the identification and removal of pathogens, the wellness model of counseling seeks to identify and increase salutogens (factors which add to health and wellbeing) (Granello, 2012).

Wellness counseling emphasizes the long-term nature of well-being. The medical model suggests that at one point in time, an individual goes from being healthy to ill. Treatment is then introduced, and at a subsequent moment in time, an individual becomes healthy. The wellness paradigm proposes that we are not un-well in one moment and fully well in another moment. Rather, the pursuit of wellness is a life-long endeavor during which individuals may experience more or less balance. There is no single point in time which demarcates a time before and after wellness. Thus, the focus of clinical work is no longer about addressing a single instance, but rather about instilling life-long behaviors (Granello, 2012).

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To facilitate the development of wellness skills, wellness counselors must reach across the professional barriers which compartmentalize the varying facets of client/patient care. Wellness counselors reach out to other health care providers involved in the treatment of an individual. Commonly, this means connecting with a client's primary care physician. However, this could also mean reaching out to clergy members, CAM practitioners, or educators. The wellness counselor helps clients consolidate their personal wellness information. Wellness counselors simultaneously advocate for client wellness while emphasizing client responsibility for establishing and perpetuating personal wellness.

Conclusion

Wellness counseling is an approach to clinical work which emphasizes balance and diligence in a client's pursuit of well-being. Wellness counselors work with clients to identify strengths and areas for growth across multiple domains of wellness. The wellness counselor consolidates and processes information relevant to well-being with clients. Treatment planning emphasizes salutogens and incorporates evidence-based models of behavior change and goal setting. Through the integration of wellness into mental health counseling, the counseling profession can work to bring about a culture of balance in America which emphasizes prevention, longevity, and life satisfaction.

Stephen Martin is a Professional Counselor in private practice at The Wellness Institute in Worthington, Ohio.

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Victoria Kress Elected as OCA 2013-2014 President-Elect

OCA would like to congratulate Dr. Victoria E. Kress, Ph.D./LPCC-S, NCC as the newly elected president-elect. She earned her doctorate degree from the University of Akron. She is an adjunct professor at John Carroll University, counseling clinic director, and the director of the clinical mental health and addictions counseling programs at Youngstown State University. She is passionate about supporting counselors in Ohio and she been an OCA committee chair or member since 1998. She recently completed two terms as a governor appointed member of the Ohio Counselor, Social Worker, and Marriage and Family Therapist Board. She is the current president of Chi Sigma Iota International, and the chair of the ACA's Graduate Student Committee.

Counseling Intellectually and Developmentally Disabled Clients: Basic Considerations for Practice

By Chelsey A. Zoldan and Julie M. Plesich

It is of particular importance for professionals in the field of counseling to recognize the need for effective treatment modalities among the ID/DD population. According to the American Association on Intellectual and Developmental Disabilities (2012), intellectual disability is a disability characterized by significant limitations both in intellectual functioning and in adaptive behavior, which covers many everyday social and practical skills. The term developmental disability indicates a severe, chronic disability that:

- is attributable to a mental or physical impairment or a combination of those impairments;
- occurs before the individual reaches age 22;
- is likely to continue indefinitely;
- results in substantial functional limitations in three or more of the following areas of major life activity: (i) self-care, (ii) receptive and expressive language, (iii) learning, (iv) mobility, (v) self-direction, (vi) capacity for independent living, and (vii) economic self-sufficiency; and
- reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.

Before the age of ten, an infant or child with developmental delays may be considered to have an intellectual or developmental disability if his or her disabilities are likely to meet the above criteria without intervention (The Arc, 2011).

An estimated 4.6 million Americans have an intellectual or developmental disability (The Arc, 2011), however this statistic may not accurately reflect the true prevalence of people with intellectual disability as many school age children receive alternative diagnoses such as behavior disorder or Autism. While there are no specific statistics regarding dual diagnosis of mental illness among the ID/DD population, it is estimated that 30-40 percent of ID/DD individuals are dually diagnosed. This is a much higher rate than that of the general population. By this estimation, Ohio would have between 99,000 and 132,000 people with intellectual and developmental disabilities, who would, at some point in their lives, experience mental illness (Schroeder, Eddy, Eberlein, Benson, & Wilkerson, 2000).

Due in part to diagnostic overshadowing, the tendency to attribute all problems to a major condition once a diagnosis is made, there is a failure to recognize and subsequently treat the emotional and behavioral expressions of mental illness in the ID/DD population. The frequency and type of psychiatric or behavioral disorder varies according to the severity of intellectual disability, as well as a variety of other conditions, including medical problems, environmental changes, and life circumstances (Powers, 2005). Older age, seizure disorder and institutional placement may also place clients at greater risk for psychiatric disorders. Therefore, when considering treatment modalities for improving symptomology in ID/DD clients, all factors must be examined.

Combined samples of the 1994 and 1995 National Health Interview Surveys and Disability Supplements revealed that of the persons with ID/DD sampled in the NHIS-D, an estimated 84% of non-institutionalized

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individuals with ID/DD live with relatives, 6.7% live with a spouse, 7.0% live alone, and 1.6% live with a non-relative (Larson, Lakin, Anderson, & Kwak, 2001). Living independently is less common for ID/DD adults than in the general population, which may be why many counseling interventions are focused on the families of ID/DD individuals. However, as caregivers age, supervision and skillset of the ID/DD individual become of increasing concern. Additional attention to this population and specific therapeutic treatment considerations are warranted and will be valuable to this population of clients.

The Counseling Relationship

Counselors should seek to involve ID/DD clients in all aspects of the counseling process. Contracts may be useful in helping clients to understand the goals and the rules of therapy, especially if clients have a preference for processing visual information. Written contracts can be adapted to include illustrations, and spoken contracts can be used depending upon the client's abilities. Each client's uniqueness and individuality should be acknowledged, as it may be easy to group clients based upon diagnosis if the counselor is inexperienced in working with the ID/DD population. Clients may feel socially isolated or lonely, and counselors should convey support and practice empathic listening. Strength-based approaches focused upon empowering the client have been found to be rewarding to both ID/DD clients and their counselors (Read, 2001).

Bridging Barriers to Effective Communication

Verbal communication is an integral part of the counseling process, and can prove to be a major challenge for counselors working with ID/DD clients. Patience is key, as individuals with disabilities may have difficulty articulating their thoughts and emotions due to language deficits and difficulties understanding abstract concepts. The client's progress may be slower due to communication difficulties, and counselors may do most of the talking (Read, 2001). The use of frequent pauses in conversation can allow clients to process information, and have adequate time to form a response (DiMarco & Iacono, 2007). Closed ended questions can be useful in eliciting more specific information from clients (DiMarco & Iacono, 2007). Counselors should also speak in terms that are simple and concrete, and integrate the client's vocabulary if possible, to ensure that the client is able to understand. Special attention should be given to nonverbal communication, as ID/DD clients may engage in a specific behavior to express an emotion. Problematic behaviors that bring ID/DD individuals into treatment are often a result of frustration with the inability to verbally express thoughts and emotions (Clute, 2001). Many ID/DD clients, especially those diagnosed on the Autism spectrum, may process visual information more easily than auditory information (Mesibov & Shea, 2009). Because some clients may show a preference toward visual information, illustrations and social story worksheets may be useful in helping ID/DD clients to learn skills and understand concepts. Several iPad applications and online resources are available that allow for social stories to be generated, and offer pre-made social stories that address numerous behavior and self-care topics. Illustration cards that depict an emotion or an action are also available online, and can be printed and laminated for use in sessions to help clients express themselves.

Providing Structure and Routine

ID/DD clients often find comfort and security in structured routines, and therapy sessions should reflect this if possible. Sessions may be scheduled on a designated day of the week or specific time. Providing structure and routine can be particularly helpful in working with clients experiencing grief or life transitions due to their reassuring nature. Counselors may incorporate schedules into sessions to help clients visualize the activities that will take place, and when those tasks will begin and end. Schedules may be written out or utilize printed illustrations to represent the activities that will be engaged in. Clients may have a limited attention span, and counselors should be mindful of this when assembling schedules. Integrating clients' interests into sessions may be helpful in keeping clients focused and engaged (Mesibov & Shea, 2009). Counselors should also seek to minimize distractions within the therapy environment. One consideration for reducing distracting stimuli is to seat clients facing away from doors and windows (Mesibov & Shea, 2009).

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Many ID/DD individuals experience difficulties in generalizing skills and knowledge gained in one setting to another, and counselors can consider providing interventions in the client's natural learning environment (i.e., school, residence, day program) (Read, 2001). Clients will then be able to practice skills and behaviors in a familiar and comfortable environment (Read, 2001).

Collaboration with Caregivers and Support Staff

Forming a collaborative team with primary caregivers (i.e., parents, guardians), teachers, support staff, and other health professionals can help counselors gain a greater understanding of the client's overall functioning and allow for coordination in planning interventions. Involvement of family, support staff, and other professionals can create a network of support for the client, and communication between all parties can be helpful in assessing the client's progress. Counselors working with ID/DD clients have reported feeling that their interventions were only useful to one aspect of their clients' lives, and desired to be more involved (Read, 2001). Collaboration can allow for treatment to extend outside of therapy sessions and provide long-term support for clients. Counselors can provide educational information to help primary caregivers and support staff to understand what the client is experiencing and ways to best support the client. Additionally, counselors can provide referrals to other professionals (e.g., psychiatrists, speech and occupational therapists) and specific services. Input from primary caregivers and support staff can also be invaluable to counselors, especially in providing interpretations of nonverbal behavior cues that indicate a client is experiencing a particular emotion. Primary caregivers and support staff can also help counselors to understand whether a behavior is an imitation or reaction to a roommate/classmate/coworker, and the influence that the environment has on the client's behavior. Collaboration with medical professionals and a review of medical history can also be valuable in determining association between a client's behavior and prescribed medications or diagnoses.

Counselors are likely to come across clients with intellectual and developmental disabilities in their practice. Recognizing each client's individuality, including them in all aspects of the counseling process, establishing effective communication, providing a structured environment, and incorporating family members, support staff, and interdisciplinary team members in treatment may improve treatment outcomes counselor can provide to this population. Being mindful of these basic considerations and making appropriate modifications to intervention strategies can help ID/DD clients to increase their levels of functioning and quality of life.

Chelsey A. Zoldan and Julie M. Plesich are graduate students in the Clinical Mental Health Counseling Program at Youngstown State University. They can be contacted at cazoldan@gmail.com.

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Time to Get Out of the Barnyard and into the Trenches

By Cheryl Eresman, MS, LPCC

When I was a child, I was fond of a story called "The Little Red Hen." If you missed that classic, here is a summary: The Hen and the other farmyard animals are wishing they had some bread. Being good at setting quantitative goals, the Hen points out the need to plant the wheat, tend the wheat, harvest it and turn it into flour, and, finally to make it into bread and eat it. (Managed care would have loved LRH!) When she asks for help to do these things, all the other animals refuse. When the bread is finally baked, the Hen says, basically, that since no one helped, she'd eat it all herself.

I'm sure you're wondering why I am telling this story. The first 17 years of my life as a Licensed Professional Clinical Counselor, I was a disengaged farm animal. I admit that I used the fact that I was raising my children, in addition to holding 3 counseling jobs, to keep from getting involved with any of my professional organizations. I did pay dues, and I've always belonged to ACA, OCA and MVCA (Miami Valley Counseling Association,) but it wasn't until my son graduated high school that I actually sought out a meeting of my local chapter (MVCA.) I have found my two years worth of participation since to be interesting, exciting, and even fulfilling.

Years ago, I heard someone who studied organizations say that in most organizations, 11 percent of the members do 90 percent of the work. I suspect that is true with OCA and with the chapters and divisions. I didn't realize, until I became involved, that the people in our organizations put many, many hours into helping Professional Counselors become recognized, reimbursed, educated, and supported. For instance, in MVCA, alone, we are trying to arrange for free CEU's for members, provide education, increase public awareness of counseling, and, most importantly, assist with advocacy for counselor reimbursement from the organizations who do not recognize us.

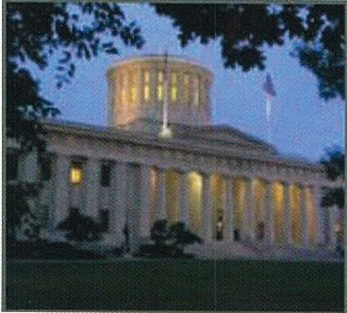
The good news is that the leaders of our professional organizations are not as punitive as the Little Red Hen. The fact they've done so much work, while most members do none, has not resulted in them saying, "Well, then, you don't get any bread! (benefits.)" I benefited from all their labors the years I wasn't involved. However, I can tell you, now, that I feel very good about being part of the changes that need to happen, and I believe you would, too.

Remember, your very reasonable OCA membership fees also give you free membership in your local chapter. All you have to do is check the box indicating in which area you live. Show up at a chapter meeting, and you'll meet wonderful, committed counselors who will befriend you, welcome you with open arms, and put you to work doing things that will benefit you, now and in the future.

Cheryl Eresman is President of the Miami Valley Counseling Association. She can be reached at Crusselleresman@yahoo.com.

OHIO STATEHOUSE REPORT

By Towner Policy Group



House Bill 59 - Biennial Budget Bill

The 130th General Assembly is off and running with the state's biennial budget bill. In February, Governor Kasich unveiled his budget proposal. On April 9, 2013, the House Finance Committee unveiled a substitute version of HB 59. The bill was then substituted again on April 16, 2013, reported out of Committee and passed the Ohio House of Representatives on April 18, 2013. The bill is now under review in the Ohio Senate Finance Subcommittees. A final version of the bill must be agreed to by both chambers and signed by the Governor by June 30, 2013.

Medicaid Expansion – the House Finance and Appropriations Committee removed the Governor's Medicaid expansion proposal from the legislation. The House did add an additional $30 million per year to counties for mental health services and an additional $20 million per year for drug treatment for a total of $100 million new dollars in the biennium. At least 50% of the $20 million set aside in each fiscal year for allocation to community alcohol, drug addiction, and mental health services boards for addiction services is to be used for drug treatment using non-opiate drugs. The House also added an amendment on the floor that will require the legislature to continue studying healthcare/Medicaid reform.

Tax Reforms – the House Finance and Appropriations Committee removed the Governor's expansion of the sales tax base to include more services and removed the tax cut for small business owners. The House Committee did include an immediate 7% across the board income tax reduction that will be funded with the current state surplus.

Education Reform - The Governor's proposal calls for the State Board of Education to review and revise the operating standards set for schools to make sure that the standards do not set requirements that exceed what is needed to ensure students attend safe and healthy places of learning and receive the same core curriculum. As passed the House of Representatives, House Bill 59 maintains the Governor's proposal with some adjustments. The bill provides a 100% guarantee of FY 13 funding, and caps increases at 6% for both fiscal years. Under the House plan, approximately 175 districts will remain on the "guarantee". The House passed version also modifies the language relating to minimum school year in terms of hours instead of days.

Ohio Department of Mental Health and Addiction Services - Merges Ohio Department of Mental Health and Ohio Department of Alcohol and Drug Addiction Services into the Ohio Department of Mental Health and Addiction Services. Current ODMH Director Tracy Plouck will serve as Director of the newly merged Department. Ohio Department of Medicaid -- Creates a stand alone Department of Medicaid led by the current Medicaid Director John McCarthy.

Senate Bill 43 and House Bill 104 – Court Ordered Treatment

Senators David Burke (R –Marysville) and Charleta Tavares (D – Columbus) introduced Senate Bill 43 and Representatives Margaret Ruhl (R – Mt. Vernon) and Peter Stautberg (R – Cincinnati) introduced House Bill 104, which would make changes to court ordered treatment of those with mental illness. The intent of the legislation is to provide clarity to the courts that they have within their purview to order out-patient treatment, not just court ordered hospitalization. The bill removes references to "hospital" when discussing treatment, so the courts could order any treatment. The bill also places the affidavit to initiate court ordered treatment into the law. The legislation modifies the term "treatment plan" and specifically states that a treatment plan may include the following services: Community psychiatric supportive treatment; Assertive community treatment; Medications; Individual or group therapy; Peer support services; Financial services; Housing or supervised living services; Alcohol or substance abuse treatment; and any other services prescribed to treat the patient's

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mental illness and to either assist the patient in living and functioning in the community or to help prevent a relapse or a deterioration of the patient's current condition. Senate Bill 43 is being considered by Senate Civil Justice Committee and House Bill 104 has been referred to the House Judiciary Committee. Both bills have had sponsor hearings.

OSCA Representative Sarah Collins Participates on School Safety Panel; Greg Pollock Also Testifies

In reaction to the school shooting in Chardon and Sandy Hook, the Ohio Senate put together a school safety work group. Senator Peggy Lehner, Chair of the Senate Education Committee reached out to OSCA for a school counselor representative. Legislative Advocacy Chair, Sarah Collins, has made herself available to participate in discussions. Sarah participated in an initial meeting on January 29th at the Statehouse. Sarah was also invited to testify before a panel on February 12, 2013. Additionally, the Senate established a joint committee to address school safety and the prevention of violent acts in public places. The bipartisan Committee on Safe and Secure Schools included members of the Senate Public Safety and Education committees and was co-chaired by Senator Frank LaRose (R-Copley) and Senator Peggy Lehner (R-Kettering).
Sarah Collins testified, on behalf of the Ohio School Counselor Association, before the Joint Committee on February 12, 2013 as part of panel with School Social Workers and School Psychologists. Sarah told the Committee - On a school based mental health team, School Counselors often serve as the gatekeeper for the referral process. In my school, all requests for intervention - be it academic or behavioral - are given to the School Counselors. From there, we pull all necessary stake-holders together to meet about the student's needs. Within the school system, we work side by side with other mental health professionals to provide holistic support to all students. School Counselors also serve as the bridge between counseling services offered by the school, which are often brief and solution focused, and community mental health agencies, where students can receive more in-depth services. Additionally, Gregg Pollock testified before Joint Committee, of behalf of the Ohio Counseling Association on February 26, 2013. Gregg testified that: It is important that mental health counselors and school counselors work together in terms of communication and cooperation when it comes to dealing with school related issues such as bullying. I have seen firsthand the damage that bullying has on a personal and professional level and it is my hope that substantive changes can be made at the state level to increase awareness of this important issue. The Committee will soon issue a report with their recommendation for possible legislation to address the issue of school safety. They will take into account testimony they have heard and suggested they received. Co-Chair Lehner has also indicated that a survey will be going out to members of the Senate to gage support for certain proposals before final recommendations are made.

Senate Bill 42 – School Safety Levies

Senate Bill 42, sponsored by Senators Gayle Manning (R – North Ridgeville) and Randy Gardner (R – Bowling Green), would allow school districts to levy property taxes exclusively for school safety and security. In sponsor testimony, they indicated that the issue was brought to them by Vermillion School officials who requested the permissive change to state law, saying restricting funds raised for safety and security will ensure taxpayers that future school boards or superintendents won't have the ability to divert that money to other purposes. The bill is also supported by the Fraternal Order of Police, the Ohio School Boards Association, Buckeye Association of School Administrators, the Ohio Association of School Board Business Officials, and the Ohio Education Association. During the bill debate on the Senate floor, Senate Peggy Lehner, who co-chaired the Committee on Safe and Secure Schools, indicated that SB 42 was not the beginning or the end of the discussion on school safety and that recommendations from her committee were forthcoming. The legislation was considered by the Senate Ways and Means Committee. It was passed by the Ohio Senate on April 10, 2013 by a vote of 31-2. SB 42 has been referred to the House Ways and Means Committee.

Licensees Will Be Disciplined if Convicted of Human Trafficking

During the lame duck session, which wrapped up in December, 2012, the legislature added an amendment to House Bill 247 (a bill not related to counselors) that will require the suspension of a license upon notice of conviction by a court for the offense of trafficking in persons (human trafficking) and make this grounds for disciplinary action by the Counselor, Social Worker and Marriage and Family Therapist Board and most other licensure boards in Ohio. HB 247 was signed by Governor Kasich on December 20, 2012. The bill was effective March 22, 2013.