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Professionalization of the Field of Clinical Mental Health Counseling

Chapter 2:

Historical Perspective on the Creation of Credentialing Standards for the Clinical Mental Health Counseling Profession

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Introduction

Though founded in 1976, the Clinical Mental Health Counselors movement needs a new and reconstituted "Call to Awareness" to keep help them evolve as a profession and know their historical roots, collective goals and aspirations, and the fundamental pillars of their profession. This section reviews the developmental challenges that have occurred as a result of incompatible goal of leaders, organizations and institutions. This will be a call to realign Clinical Mental Health Counseling Professionals and their leaders with original core and common goals and aspiration if the field is going to evolve as a distinct recognizable and undifferentiated core profession in the future. In addition, when counselors are knowledgeable about professional distractions and diversions of the past, they can ensure the progress of their professioanal evolution and emerge stronger.

Early Beginnings

In 1976, when Nancy Spisso and Jim Messina were in the process of founding the American Mental Health Counselors' Association (AMHCA) as a division of the ACA, they encountered

an immensely complex task to create a new profession with the Clinical Mental Health Counseling identity. As they progressed in the journey, Spisso chose to pursue other professional goals which offered Messina the opportunity to incorporate AMHCA into full division status with ACA and to also take the steps to insure the professional identity for Clinical Mental Health Counselors (Weikel, 1985).

Early Perceptions of Credentialing in the Counseling Profession

In 1977, after AMHCA was founded two articles appeared in the APGA's *Personnel and Guidance Journal.* The first article (Forster, 1977) reviewed the various forms of credentialing including 1) Accreditation; 2) Certification; 3) Licensure. In this article, the author pointed out that over fifty percent of the graduates of counselor education programs at the time did not intend to work in schools which were the primary place of employment for which most counselor education programs prepared their students. The article pointed out that many counselors were working various settings including private practice and serving the same clientele who were in the past served by psychologists and social workers. Since the counseling field had relied so much on the methods of psychology, psychiatry, social work, education and sociology it was hard and confusing to many to distinguish MHC's from the other professions for any number of reasons, but a most pronounced on being due to a lack of appropriate and uniform credentialing. The credentialing process required clarification, but the path to that goal was unclear. What was clear was that standards, accreditation, certification and licensure were all components of other professional mental health and behavioral health professions. At the time of the introduction of the profession, in the counseling profession only post teaching certifications or masters degree were needed in guidance and counseling specialties to practice in schools and there were some post baccalaureate and masters certifications in rehabilitation counseling. These certifications and program accreditations were administered by the states and not by professional associations. State universities were accredited to offer these certification and graduates became certified by the state. There was no certification at all for those doing mental health counseling in local, state or federal institutions and agencies or in private agencies or professional practice. Literally anyone could call themselves a counselor, mental health counselor, psychotherapist or professional counselor. Agencies in which these individuals were employed would give them titles which would range from counseling technician, to counselor aid, to counselor to mental health counselor and other job specific titles essentially with no value beyond the job description and the particular employment venue.

Arbuckle (1977) discussed the issue of licensure and focused interest on licensing counselors in schools. This article clearly demonstrated a lack of awareness that many of the students in these programs ended up practicing in non-school venues. In a timely fashion, AMHCA positioned itself to address the needs of counselors who transitioned from school counseling into the mental health counseling field. However what was becoming readily apparent is that "counselors" were graduating from educationally based masters level programs and competing for positions in mental health with graduates from psychology and social work programs which had begun the process of becoming independent differentiated and defined core professions nearly a decade earlier. Counselors wishing to provide psychotherapy and diagnosis were frequently locked out of positions because of what appeared to be substandard preparation as a result of the professionalization of the other two professions.

Roadmap for the Professionalization of Mental Health Counselors

In spring of 1978, the American Counseing Association (then the American Personnel and Guidance Association) formally recognized AMHCA as an official division and Jim Messina became the first president of AMHCA as a division of APGA.

The AMHCA Board of Directors soon recognized that it would be an uphill journey to achieve the recognition of Clinical Mental Health Counseling as a legitimate profession -- not only within the counseling community but also in the broader mental health community. To advance this goal, the AMHCA Board of Directors first set out to establish a roadmap to insure the long term professionalization of the mental health counseling field (Messina et al., 1978).

First, Gary Seiler and Jim Messina wrote an article about professional identity which appeared in the first edition of the *AMHCA Journal*. In this 1979 article, they detailed the definition of a Mental Health Counselor (Seiler & Messina, 1979). In that same journal, AMHCA published Messina's call for national certification of Mental Health Counselors which resulted in the establishment of the National Academy of Certified Clinical Mental Health Counselors (Messina, 1979). Finally, to set the stage for the creation of the National Academy of Certified Clinical Mental Health Counselors, AMHCA's Board of Directors compiled standards for the practice of clinical mental health counseling. They used initially the title Professional Counselor, but chose to change the name to Clinical Mental Health Counselor to differentiate themselves from other professional counselors who did not work in the clinical mental health field. These standards have been revised over the years and in 2011 AMHCA published the most recent edition of these standards.

National Certification for Clinical Mental Health Counselors Used to Promote LMHC Licensure and Establishment of the National Board for Certified Counselors (NBCC)

In 1985, the history of the National Academy of Certified Clinical Mental Health Counselors (NACCMHC) was published in the *Journal of Counseling and Development* (Messina, 1985). In this article, Messina pointed out that the national certification standards of the NACCMHC were utilized in the writing of the licensure law for the State of Florida which was fully enacted in 1982. By using the Academy's standards, all fifty states could utilize these parameters to ensure consistent licensure standards nationwide. At the same time the Academy commenced work, the organization assisted ACA (then APGA) leaders to establish the National Board for Certified Counselors (NBCC). Many of the procedures of NBCC were adapted from the NACCMHC's protocols. Stone (1985) captured the early history of NBCC and detailed the the contributions of the NACCMHC's efforts to establish NBCC.

Early Perceptions of State Licensure for Professional Counselors

Snow (1981) demonstrated at that time counselors and psychologists were in favor of separate licensure for their respective professions. Counselors wanted more control of their

own profession and wanted to insure their independence from oversight of psychologists .In the same journal, Davis (1981) presented a cautionary caveat to counselors who were promoting licensure for counselors. By 1981, four states licensed professional counselors: Virginia, Arkansas, Alabama and Texas. All specified LPC's (Licensed Professional Counselors) in the licensure rules. In 1982, the first LMHC (Licensed Mental Health Counselor) law was enacted in Florida. Davis (1981) warned that counselors must beware of becoming a self-serving interest group of professionals. He conversely recommended that counselors pursue national certification to support professional standards of practice that protect and enhance public well-being. Davis concluded: “Certification, in sum, allows counselors the freedom to practice their chosen profession as qualified, recognized mental health care providers”(1981, p.85).

Davis (1981) in the same journal warned counselors not to use licensure to "overkill" and that National Certification such as the NACCMHC was an excellent alternative to protect society and to promote the competency of Clinical Mental Health Counselors. Davis also pointed out that licensure was a sign that counseling had moved from an occupation to a profession. Swanson (1981) reported on research in Oregon as to counselors’ favorable opinions concerning the need for licensure in that state. Huber (1982) reviewed a proposal for a licensure model which would use competency-based measures to qualify counselors for licensure in their states. The proposal also would require better self-disclosure by these licensed counselors as to their academic and professional training and areas of expertise to better protect the public. Edgar and Davis (1983) pointed out how the licensing bill in Idaho was passed by addressing two issues: 1) a bill which insured licensed counselors in the state would be bound by a single code of ethics and 2) a bill which would provide a means by which abuses by the licensed professionals could be investigated and adjudicated. Clearly, in the early days of state licensure for counselors, the profession was still searching to clarify the professional role and function of counselors in all states through licensure. However, most of these early legislative efforts disregarded the advances of the NBCC and NACCMHC in the formulation of state regulations.

Developmental Challenges to Professional Identity for CMHCs

In 1990, Fong suggested that the counseling profession was generating confusing and wasteful duplicate structures and stated that the scope of counseling and mental health counseling is the same; the terms are synonymous and thus, the proper name for the entire profession of counseling is “mental health counseling.” Fong further argued that while some specialties are named for the environment in which intervention occurs (e.g., school counseling, community counseling) and others for the main concern addressed (e.g., vocational counseling, marriage and family counseling), all encompass the same core and are a form of mental health counseling. Fong’s conclusion was that Mental Health Counseling is the essence of professional counseling (Fong, 1990). Unfortunately her perspective was ignored by many, including prominent leaders in the profession. In 1990 counterproductive attempts at clarification and conformity of licensure requirements yield mixed results. These efforts overlooked the fact that those who called themselves Mental Health Counselors who graduated from Mental Health Counseling Programs would need licensure and certification radically different than what that the ACA was proposing in the form of Professional Counselor licensure and Community Counseling Standards. As a result , the professional identity of Clinical Mental Health Counseling has taken a back seat to the Professional

Counseling identity and has suffered from non-standardized licensure models in the fifty states. Sadly, though the program accreditation models have evolved, the post degree certification, similar to specialty certifications on law, medicine and other professions, the National Certified Clinical Mental Health Counselor certification has largely been ignored and and abandoned by the counseling profession because of the compromises. This further devalues the professional identity and creates the confusion that a Licensed Professional Counselor is automatically certified to practice mental health counseling which certainly is not the case.

In 1990, ACA published a special edition of its *Counseling and Development Journal* which reviewed the credentialing history of Psychology (Cummings, 1990a & 1990b); Social Work (Garcia, 1990a & 1990b) and Marriage and Family Therapy (Everett, 1990a & 1990b). Cummings (1990a & 1990b) pointed out that many similarities exist between psychologists and counselors in the struggle to become credentialed, legally regulated, and approved for third party reimbursement in the field of mental health. Garcia (1990a & 1990b) pointed out similar issues for social work which established in 1960 the Academy of Certified Social Workers (ACSW). This organization functions somewhat like the NACCMHC which offered the CCMHC credential. Very different, however, was the commitment of Social Workers to the ACSW and in 1990 over fifty per cent of social workers who belonged to NASW were also ACSWs. This trend is extremely important for CMHCs to consider when they look to the future trajectory of their profession. It would be wise for CMHCs to promote the CCMHC credential to demonstrate that self-regulation of the profession will ensure national credentialing standards which could be utilized by state licensing boards in their own state statutes for CMHCs.

Everett (1990a & 1990b) pointed out that most contentious of inter-professional relations existed between AAMFT and ACA (then the AACD). However, he did point out that there was on the state level many collaborative efforts. The State of Florida an excellent example in 1981. LMHCs and LMFTs and LCSWs were all licensed in a collaborative effort once the Licensed Psychologist Board had been sunset in 1980 and psychologists joined the inter-professional effort to gain state licensure for all four professions. Unfortunately, the authors from the ACA (AACD) who included their views in this 1990 publication, did not contribute to the recognition that a need existed to make the national and state regulation of Clinical Mental Health Counselors the priority for the counseling profession. Instead, the majority of the articles in this issue encouraged professional counselors to promote a generic counselor credential when developing state licensure and to leave the issue of specialty credentialing at the national level for the NBCC and NACCMHC.

Brooks and Gerstein (1990a) in the lead article of that journal posited that counselors see their clients as healthy and that counseling helps people grow. They asserted that the preferred intervention of most counselors is likely to be psychoeducational strategies, based on the idea that psychotherapy is an educational process -- because behavior change is a learned process (Brooks & Gerstein, 1990a, p. 477). They pointed out that the CCMHC standards had been endorsed by AMHCA as the standard for independent clinical practice and that ACA (AACD at the time) had adopted standards similar to the CCMHC as the standards in its efforts to gain third-party reimbursement (Brooks & Gerstein, 1990a). Even

with these facts presented, they still did not support the idea that the CCMHC standards ought to be used for state licensure efforts. The article suggested that that state licensure should be generic and not specific to the mental health treatment and diagnosis mode of CCMHC. For this reason they proposed that states to adopt the title Licensed Professional Counselor for licensure thus ignoring the efforts of AMHCA (of which Brooks was the tenth president) and the state of Florida's LMHC model (based on the standards for the CCMHC). These options would have solidified the profession of Clinical Mental Health Counseling in a more proactive way.

Most telling was the response to Brooks and Gerstein by Metcalf, Dean and Britcher (1991), who countered the proposition that counselors were trained to diagnose and treat clients with mental illness. They claimed that their counselor education programs did not train practitioners to work with such clientele. They went on to say that learning to deal with clinically symptomatic conditions and clients occurred only after students began to work in the "real world." This position should have "raised a red flag" for the leadership of the professional organizations. It was clear that Counselor Education Programs were not committed to teaching counselors entering the mental health field how to adequately diagnose and treat individual with mental health disorders at that time. Unfortunately, this opinion was ignored by both ACA and AMHCA and the move towards a focused professional identity of Clinical Mental Health Counselors was delayed until much later. This article alone should have been a wakeup call for Counselor Educators to move towards the 1986 CACREP standards for Clinical Mental Health Counselor Training, but these standards had not been supported counselor educators at the time.

Bloom et al. (1990) presented the model licensure standards for LPCs. They assumed that specialties in counseling such as the Clinical Mental Health Counselors would be best served by national certification bodies and not through licensure such as the Licensed Mental Health Counselor title in 17 states. This LPC model continued to confuse the identity issue for mental health counselors who worked in mental health agencies and private practices. AMHCA could have advocated more forcefully to stop the effects of this proposal.

Van Hesteren and Ivy (1990) proposed that "Counseling and Development" should become the mantra not only for the profession of counseling but also for counselor education. The authors emphasized that formal and substantial study of the DSM diagnosis system be incorporated into counselor education curricula with a positive person-environment interactional perspective which is consistent with counseling and development. They encouraged the study of the relationship between crisis/trauma aspects of human experience and developmental growth. Additionally, a corresponding focus on psychopathology and its clinical treatment should be integrated within a developmental process (Van Hesteren & Ivey 1990). This vision has become reality over time as the new AMHCA 2011 standards emphasize the need for trauma-informed standards which are environmentally, culturally and biologically related. In another article in that same issue, Ivey and Van Hesteren (1990), in reaction to a comment on their original article, stated that counseling and development embraces the three C's of counseling, consultation and coordination which goes beyond the purely individualistic psychological approach. This is how Clinical Mental Health Counselors approach their work with clients: They take into consideration the impact of the client's family

of origin, school, community and employment experiences and the impact of the cultural and economic realities of the community from which the individuals come. But because Van Hesteren and Ivy called for “Counseling and Development” as the title for the profession, the need to promote Clinical Mental Health Counseling title took a back seat in 1990.

Brooks and Gerstein (1990b) -- who were the guest editors of the special journal edition -- concluded that “we all have skeletons in our organizational closets, and that we have a long way to go before consumers and providers alike enjoy the benefits that only interprofessional collaboration can bring” (p.509). However, they were encouraging such collaboration with psychology, social work and marriage and family therapists ignoring the internecine issues with the ranks of the counseling profession. These editors had an opportunity to help clarify the role and function of Clinical Mental Health Counselors in the field of mental health and it was an opportunity missed.

Ambivalence towards Professional Credentialing in the 1990s

The rest of the first half of the 1990’s found authors encouraging credentialing but lacking in a full appreciation for the need to pull in the ranks behind a single identity for counselors who worked in the mental health field. VanZandt (1990) encouraged counselors to get on the professionalization bandwagon, but evidently did not seem to grasp the impact of professional identity which needed bolstering. Anderson (1992) encouraged standards in the counseling profession which included sound disclosure statements to clients with sound ethical practices in the provision of such services. Alberding, Lauver & Patnoe (1993) had researched counselors’ awareness of the consequences of state licensure regulations and found that most counselors at the time lacked understanding of the impact of licensure. A need remained for increased education for counseling professionals. This situation highlighted the lack of tradition in the counseling field which left a dearth of constructive discussion; Few leaders and clinicians even conversed about the impact of this movement on counselors. Finally, to emphasize the lack of sophistication regarding the rationale and impact of national certification, Weinrach and Thomas (1993) expressed little acceptance for national certification of counselors by taking on the NBCC. To date, no effort has been mounted to clarify the value and worth of national certification of counselors now that states provide licensure. This situation is disappointing given that national certification was a hallmark proposed when AMHCA formulated a plan of action and national standards with the NACCMHC (Messina, 1979).

Bradley, in 1995, pointed out that there were no uniform licensure standards at the time and that it is extremely difficult to bring uniformity across licensing laws (Bradley 1995, p.185). Bradley called for a unified counselor licensure and certification process with discontinuing specialization procedures similar to those used for Licensed Mental Health Counselors (LMHC) and Certified Clinical Mental Health Counselors (CCMHC) (Bradley 1995). A theme in an ACA Journal of 1995 was that the field of counseling is one profession with individual practitioners who possess skills and expertise that give them special qualifications for practice in environments and to assist clients with concerns in a number of identifiable areas of practice and specializations (Pate, 1995). Pate pointed out that specialization in counseling will be important to external constituencies only if there is an accepted method by which the counseling profession certifies specialty attainment (Pate, 1995). The author overlooked the

CCMHC credential developed in 1979 and the LMHC first established in Florida in 1981. Instead, Pate called for the counseling profession to distinguish between initial qualification for work in an environment and specialization in types of client concerns (Pate 1995). Bradley (1995) and Pate (1995) reflected a belief that specialty licensure (LMHC) and specialty certification (CCMHC) were a threat to the concept of a unified Counseling Profession. This clearly pushed AMHCA Leadership to reconsider its divisional status in the ACA which had just laid the foundation for a new crisis in the professionalization of Clinical Mental Health Counselors nationally.

To increase the confusion, after conducting a study of Certified Clinical Mental Health Counselors in 1997, Vacc, Loesch, and Guilbert (1997) concluded that "for most of their work, CCMHCs (certified clinical mental health counselors) do not need specialized knowledge and skills for counseling mentally disordered clients" (p. 168). However, James Hansen (1997) challenged their findings stating: “I agree with Vacc et al. (1997) that "CCMHCs need to have skills in the psychodiagnosis of more severe mental disorders" (p. 168). The authors correctly point out that even if counselors choose not to treat clients with severe disturbances, counselors must have the ability to identify these clients to make appropriate referrals or to recommend a suitable course of treatment”(p. 187). Hansen (1997) went on to argue that the formal training of Clinical Mental Health Counselors must include treatment of clients with severe disturbances. His rationale was that over time when clients come into a mental health agency they will be looking for help from a professional and will not take the time to differentiate ones who were formally trained to work with them and those who were not so trained (Hansen, 1997).

Complacency and Confusion about the Clinical Mental Health Counseling Identity

Smith and Robinson (1995) gave a somewhat short-sighted perspective on the progression of the profession of Clinical Mental Health Counseling. It was clear from the title that by leaving out the term "Clinical" they were not on board with the original vision, trajectory, or goals of creating the profession of Clinical Mental Health Counseling, despite the fact that both authors were past presidents of AMHCA. Adding to this complacency, Sweeney (1995) discussed accreditation without encouraging Counselor Education Programs to support the CCMHC training standards devised in 1986 while less than twenty programs nationally adopted these standards. Bradley (1995) called for unified licensure and certification of Professional Counseling to prevent the profession from fragmenting. Pate (1995) called for a special conference of professional counseling organizations to clarify the goals for accreditation, licensure, and certification to reduce the disunity and internal disputes over specialty credentialing.

Finally, in 1995, to add to the confusion about who ought to be licensed to provide Mental Health Services, Remley suggested the elimination of specialty licensing (i.e. Clinical Mental Health Counseling) in Professional Counseling since all counselors belong to the same profession. He continued,“Those who provide mental health services to the citizens of the United States already are licensed in five different areas: medicine (psychiatry), psychology (clinical and counseling), social work (clinical), nursing (psychiatric), and professional counseling. None of the first four fields license specializations within the areas listed, although professionals within each of the areas specialize. It would seem inappropriate for

counseling to license specializations when other mental health professionals have not found the practice necessary" (Remley, 1995, p. 127).

It should have been pointed out at the time that the titles Clinical Psychologist and Counseling Psychologist are specialist titles in the field of Psychology. Clinical Social Worker is a specialist title in the field of Social Work. Psychiatric Nurse is a specialist title in Nursing and finally Psychiatry is a specialist title in Medicine. Clearly, the logic of licensing the specialty of Clinical Mental Health Counselors had been derailed in the 1990's.

A Call to Action by the Orlando Project to Recalibrate Credentialing in Clinical Mental Health Counseling

In 1992-95 under the leadership of AMHCA's seventeenth President Roberta Driscoll Marowitz, the Orlando Project called for a revitalization of the hallmarks of the profession for Clinical Mental Health Counselors. This effort spearheaded the establishment of the National Commission for Mental Health Counselors. This commission aimed to identify the competencies needed by Clinical Mental Health Counselors to do their work well and to insure that future Clinical Mental Health Counselors would not only have excellent competency-based graduate programs, but also competency-based continuing education programs and evidence-based treatment research- driven publications. Altekruse and Sexton (1995) published their research on the identification of competencies as perceived by current CMHC practitioners. In that monograph, Jim Messina wrote about the purpose of the Orlando Project (Messina, 1995) as well as about goals and purpose of the National Commission for Clinical Mental Health Counselors (Messina, 1995). Unfortunately, at that time, AMHCA was making moves to become a freestanding Association and did not choose to support the establishment and operation of the National Commission. With this roadblock, efforts slowed to get back on the right track towards the professionalization of the Clinical Mental Health Counseling Profession.

Back to Square One

By 1997, forty-two states had achieved either licensure or certification for counselors (mostly LPCs), so Goldin surveyed the presidents of the state chapter of AMHCA to determine levels of professional collaboration among mental health professions in state licensure of counselors. His findings showed significant collaboration in the states where other professional groups were unlicensed or presently certified, and/or where licensed groups sought to improve their own regulatory legislation and/or where other professional groups hoped for inclusion or greater influence in determining third-party payment legislation (Goldin, 1997). His research revealed another issue which slowed the process for gaining Clinical Mental Health licensure: Namely, the lack of inter-professional cooperation and collaboration needed to bring the CMHCs to the licensing table.

In 1999, three ex-presidents of AMHCA pleaded with the association to get refocus and fulfill the vision and potential of the Mental Health Counseling profession. Weikel (1999) pointed out that the early leaders of AMHCA had commitments to certification, licensure, government

relations, and a knowledge base for the profession. Furthermore, in its twentieth year, such efforts need to be continued and supported by the emerging AMHCA leadership.

Beck (1999) spoke of success in 1998 when mental health counselors received an encouraging word in their quest for national professional recognition: Congress passed S1754 and President Clinton signed the Health Professions and Partnership Act. This law designated graduate students in counseling as grant-eligible under the Clinical Training Program of the Center for Mental Health Service (CMHS) and mandated that the Health Resources and Services Administration (HRSA) recognize professional counselors as "core mental health providers." This change made professional counselors [not named mental health counselors] eligible to participate in the National Health Service Corps (NHSC) Scholarship and Loan Repayment Program. It is interesting that in 1998, Beck pointed out the appellation “Clinical Mental Health Counselor” was not the identification used by the lobbyists from ACA and AMHCA; Clearly, this fact hinted at hurdles for the professionalization of the field of Clinical Mental Health Counseling.

Beck (1999) also pointed out that the causes for the slow pace in the professionalization of the CMHC Profession consisted of five core areas where conflict and confusion existed up to that point in time. They were conflicts regarding:

- An acceptance of a common unique definition of mental health counseling professional practice by members and leaders despite organizational pronouncements
- An acceptance of a common unique professional identity for mental health counselors by the various professional counseling organizations, members, and legislatures
- An acceptance of a universally accepted set of training and legal standards for mental health counselors by states in certification and licensure
- An acceptance of a universally accepted professional organizational structure to represent those doing mental health counseling, those who train them, and those who certify them
- Leadership factions causing internal dissension, abandonment of organizational growth, and setbacks in the shared professional aspirations of the all-important membership.

Beck went on to call all AMHCA members and leaders to address these challenges and move the profession forward.

At the same time and in the same journal, Jim Messina invited AMHCA membership and leadership to refocus on the original Six Pillars of the Foundation for Profession he had posited in 1979 which are: National Voluntary Professional Membership Organization (AMHCA); National Standard for recognition of competent professional via a National Certification process (Certified Clinical Mental Health Counselor (CCMHC) awarded by the Academy of Certified Clinical Mental Health Counselors which is an arm of the NBCC); National Accreditation Standards for the educational and training of Clinical Mental Health Counselors (which at that time was CACREP's CMHC's Standards which only had 17 programs accredited as such at that time): Uniform standard of licensure in all 50 states for Clinical Mental Health Counselors (which at that time was muddied due to the LPC's vs LMHC licensures in various states around the Union; National standard of clinical standards and professional competencies (Knowledge, Skills, and Abilities) which are the foundation for

the profession's national certification, national accreditation and state by state licensure and Body of research and theory about the practice of Clinical Mental Health Counseling, which distinguished this profession from the other professions that are engaged in similar work efforts (Messina, 1999).

Clearly, in 1999 the state of the Clinical Mental Health Counseling profession was disorganized. The national certification and accreditation as well as the state licensure movements were not in line with the unified perspective that these six pillars of the profession framed. Again, this call was ignored to reorganize and get back to using these pillars as building blocks for the future.

Pistole and Roberts (2002) pointed out the identity dilemma which results from the profusion of professional counselor licensing titles and the practicalities of licensure that accompany this predicament. Mental Health Counselors can be licensed under most states' professional counselor licensing laws because their course work and experience usually meet the necessary requirements. This license will not, however, reflect their identity as a Mental Health Counselor.

Gale and Austin (2003) further expanded on this identity bind stating that although the title “Professional Counselor” is the most common one found in state licensure laws, that other titles are used such as the “Licensed Mental Health Counselor”. They stated that the diversity of titles has contributed to confusion about the profession's identity. They pointed out that the occupational title “Professional Counselor” lacks sufficient specificity to secure its role in the eyes of other mental health professionals and the general public (Gale & Austin, 2003). Unfortunately, they did not argue that licensed counselors who work in the mental health field alongside other behavioral health professionals ought to have “mental health” in their licensing title.

Jason King in 2006 recommended that AMHCA and ACA adopt the title “Clinical Mental Health Counselor” as the preferred occupational title for members of the profession. He believed it would help CMHCs better advocate for their occupation, define their unique niche, and secure their marketplace among health care providers (King, 2006). He pointed out that the term Professional Counselor lacks specificity when considering the definition of the word “Professional”: Relating to, or characteristic of a profession and engaged in one of the learned professions characterized by or conforming to the technical or ethical standards of a profession. King asserted that the word “professional” does not accurately convey the specialty of the work CMHCs perform. At best, the word indicates that CMHCs are learned and operate within an ethical framework, but it does not clarify what the ethical framework that CMHCs function within, or of what their specific learning consists (King, 2006). He pointed out the definition for “clinical”: Direct observation and treatment of living patients based on observable and diagnosable symptoms of disease and applying objective or standardized methods to the description, evaluation, and modification of human behavior. King also defined “mental health”:The condition of being sound mentally and emotionally that is characterized by the absence of mental disorder (as neurosis or psychosis) and by adequate adjustment especially as reflected in feeling comfortable about oneself, positive

feelings about others, and ability to meet the demands of life. He concluded that counselors who work with clients who have mental health disorders and difficulties ought to be titled "Clinical Mental Health Counseling."

Three years later, Colangelo (2009) presented a revisionist history of AMHCA which seemed to ignore the early foundation instituted in AMCHA's first decade. Instead, the article presented AMCHA as a strong and vibrant professional organization despite the lack of progress toward a unified national identity, national recognition, and national respectability for this mental health profession.

In 2010, J.T. Hansen resurrected the issue the unique identity of Clinical Mental Health Counseling when he said: "Counselor identity has probably been debated so vigorously in the literature because the nature of the counseling profession makes it difficult to agree on the precise identity factors that distinguish counselors from other helping professionals" (Hansen, 2010, p. 102). It is reasonable given this reality that there was a struggle for CMHCs to gain unique professional niche in the counseling profession.

In 2010, Cannon and Cooper surveyed Counselor Educators regarding the new CACREP standards for Clinical Mental Health Counselors. The results were mixed and clearly reflected the ongoing tension since 1976 about the creation of and ongoing training in the field of Clinical Mental Health Counseling. Since the majority of these programs were still located in Colleges of Education, the lack of appreciation and adoption of the standards was predictable (Cannon & Cooper, 2010).

Also in 2010, Martin and Cannon called for changes in the training of counselors given that the largest percentage of Counselor Educators in Tennessee at the time were psychologists (36%), social workers (5%), MFTs (7%) and those with no Identifiable mental health training (49%). Only 4% were counselors. Clearly the call for counselor training to utilize the CACREP standards made sense given the need for the profession to be nurtured by members of the profession itself. This issue alone explains how the professionalization of Clinical Mental Health Counseling got off track since its founding in 1976.

20/20 Vision for the Future of Counseling

The "20/20 Vision for the Future of Counseling" began in 2005, sponsored by the American Counseling Association (ACA) and the American Association of State Counseling Boards (AASCB) to develop a vision for the counseling profession by the year 2020 in the areas of legislation, unity, identity and public awareness.

David Kaplan encouraged that the 20/20 delegate conversation and debate be focused on

counselor professional identity by addressing four myths which were impeding a unified counselor professional identity: (a) we do not know who we are, (b) counseling specialties

can be considered separate professions, (c) licensure defines the profession of counseling, and (d) counseling's historical roots are passé and inhibit moving forward (Kaplan, 2006). King and Stretch pointed out that the "4 myths" are realities today in the counseling profession and for that reason there must be stronger steps taken to strengthen the profession (King & Stretch, 2013).

The 20/20 delegates began in 2006 to meet annually at the time of the ACA convention. This effort is addressing the issue of licensure portability across states with differing licensure requirements. The goal is to clearly define and unify the counseling profession. This effort involves thirty-one organizational stakeholders in the profession of counseling collaborating in this effort. The first official meeting was held at the ACA convention in 2006 where delegates voiced the hope that the profession would be: (1) more unified and synergetic;(2) the first group that prospective clients think of when they need therapy; (3) offering the most cost-effective, non-pathologizing form of treatment; (4) leading the way for social justice by making quality counseling services available to all people in society and (5) achieving common ground with portability and licensure across the states (Rollins, 2006).

In 2007 the delegates to the 20/20 effort approved the following seven consensus goals for the 20/20 delegates to work on until the year 2020 (Kaplan & Gladding, 2010).

The 20/20 Consensus Guiding Principles for Advancing the Future of Counseling

I. Strengthening identity

1. The counseling profession should develop a paradigm that identifies the core commonalities of the profession.

2. The counseling profession should identify the body of core knowledge and skills shared by all counselors.

3. Counselor education programs should reflect a philosophy that unifies professional counselors who share a body of core knowledge and skills.

4. The counseling profession should reinforce for students that we are a single profession composed of counselors with specialized areas of training.

5. The accreditation of counseling programs must reflect one identity.

II. Presenting ourselves as one profession

6. The counseling profession should investigate the best structure for the future of counseling.

7. The counseling profession should create a common counselor identification that would also allow for additional designations of special interests and specialties.

8. While being unified, the counseling profession should respect counseling specialties.

III. Improving public perception/recognition and advocating for professional issues

9. The counseling profession should develop a clear definition of counseling for the public.

10. The counseling profession should present a stronger, more defined voice at the state and federal levels.

11. The counseling profession should promote one licensure title across the different states.

12. The counseling profession should work to educate the insurance industry about who we are, what we do, and the outcomes associated with counseling interventions.

IV. Creating licensure portability

13. The counseling profession should establish common counselor preparation standards that unify both the Council for Accreditation of Counseling and Related Educational Programs and Council on Rehabilitation Education standards into a single training model.

V. Expanding and promoting the research base of professional counseling

14. The counseling profession should encourage interest in research by practitioners and students.

15. The counseling profession should emphasize both qualitative and quantitative outcome research. At this time, many “best practices” are dictated to counselors by other mental health professions.

VI. Focusing on students and prospective students

16. The counseling profession should more actively work with undergraduates and undergraduate programs.

17. The counseling profession should promote mentor/practicum/internship relationships.

18. The counseling profession should endorse/require student involvement in professional counseling associations.

VII. Promoting client welfare and advocacy

19. The counseling profession should offer ongoing education and training for counselors on client and student advocacy.

20. The counseling profession should identify one advocacy project that would be completed annually within a selected community as a way to strengthen our counseling identity, present ourselves as one profession, and improve public perception.

21. The counseling profession should promote optimum health and wellness for those served as the ultimate goals of all counseling interventions.

22. The counseling profession should encourage evidenced-based, ethical practice as the foundation for counselors in training and professional counselors’ interventions across settings and populations served

A major driver behind the 20/20 effort is portability of state licensure. Mascari, a 20/20 delegate from the American Association of State Counseling Boards (AASCB), in discussing

the efforts of this movement in 2007 said that “Portability is important for two reasons. First, it makes new graduates seamless in terms of the job market, and, second, it is a reflection of the end product of professional preparation. Unfortunately, everything that is unresolved in counselor preparation standards seems to be reflected in licensing standards“(Rollins, 2007, p. 28).

In 2008, Kennedy pointed out that the 20/20 seven guiding principles were critical to moving the profession of counseling forward (p. 40). This initial achievement of the 20/20 groups was described in this way: “As the profession expands and develops, continued attention to a unified counselor identity is important. The opportunity to establish a cohesive counseling identity leads to multiple benefits for professional counselors, including the presentation of a clearer image of professional counseling to clients, students and the general public, and the promotion of legislative efforts that are in the best interest of the counseling profession and the people we serve”(Kennedy, 2008).

In 2010 the 20/20 delegates approved the following consensus definition of counseling:

20/20 Definition of Counseling (Kaplan, Tarvydas & Gladding, 2010)

Counseling is a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals.

Rollins in 2010, in *Counseling Today,* polled some of the delegates to the 2010 conference of the 20/20 effort as to their reaction to the proposed definition. Of note was the response of Thomas Clawson, Executive Director of the NBCC who said the “definition says that we are a mental health, not a mental illness, profession. The developmental approach sets us apart from other mental health professions” (p.38). Carol Bobby, the Executive Director of CACREP said “This definition has many important elements that acknowledge who we are apart from other professions. First, it includes the mental health and wellness components that we have emphasized. Just saying these words out loud differentiates us from professions that focus on illness and disease. Second, it acknowledges our history, because we continue to believe in the importance of examining the educational and career goal components of those who come into counseling” (p. 38).

King and Stretch (2013) pointed out that “While unknown if the 20/20 delegates assumed *growth and development* into the words *mental health* and *wellness*, the 2010 definition of counseling no longer directly promotes growth and development—a fundamental counseling value that distinguishes counselors from psychologists, marriage and family therapists, and social workers (King, 2012).”

The ACA Definition of Counseling (1997)

Counseling is the application of mental health, psychological, or human development principles, through cognitive, affective, behavioral or systemic intervention strategies, that address wellness, personal growth, or career development, as well as pathology.

Adopted by the ACA Governing Council, October 17-19, 1997

The 20/20 consensus definition was distinct from the 1997 definition adopted by the ACA Board. The changes between the 1997 and the 2010 definition of counseling King and Stretch (2013) point out are “characteristic of identity searching, a process of elimination, and an effort for personal, occupational, and political understanding. Such efforts reinforce the counselor professional identity crisis.” The reality, then, was that the effort for a consensus to bring the counseling profession together succeed in pulling it more apart or at the least added to increase professional credentialing identity confusion.

Pistole and Roberts (2002) advocated that counselors obtain the CCMHC credential to support their professional identity. Developed by AMHCA, the CCMHC is a distinct counseling profession with its own ethical code, educational curricula, supervision expectations, and licensure examination (Messina, 1985; Weikel, 1985). Pistole and Roberts (2002) advocated that counselors obtain the CCMHC credential to support their professional identity, and Pistole (2001) pointed out the important role of education, identity, and differentiation in the establishment of the CCMHC from other counseling specializations. Developed by AMHCA, the CCMHC is a distinct counseling profession within the Professional Counseling Profession with its own ethical code, educational curricula, supervision expectations, and licensure examination (AMHCA, 2012; Colangelo, 2009; Messina, 1985; Palmo, 2006; Weikel, 1985). The founders of AMHCA and CCMHC made sure that the obtaining of the CCMHC credential requires the prerequisite NCC credential, indicating that the core identity is mental health counseling as a specialty profession within the Professional Counseling profession, not a distinct profession (Pistole & Roberts, 2002).

Of note in King’s and Stretches (2013) analysis of the four myths they pointed out that The Institute of Medicine only recognizes counselors working for the VA who hold the Certified Clinical Mental Health Counselor (CCMHC) credential and successfully pass the National Clinical Mental Health Counselor Examination (NCMHCE; Rollins, 2012). The CCMHC and the NCMHCE both originated with AMHCA (Messina, 1985). This supports the contention that the standards of the CCMHC ought to be used to support and move forward the portability of state licensure from state to state for licensed counselors, especially if they are LMHC with standards and credentials based on the CCMHC standards.

In 2006, Kennedy reported on the progress of the 20/20 summit and quoted the NBCC President and Summit Chair, Tom Clawson, to present the field of professional counseling with a single definition: “This topic is one that I have pondered for years. It is close to the heart of what the NBCC Board discusses so often. Being able to start a dialogue that includes ideas for real change and real possibilities of unity within the profession, while

respecting the differing needs of twenty-eight different counseling organizations, is energizing" (p. 16).

After their first official 2006 conference, the delegates to the 20/20 decided to continue to work on the Building Blocks to Portability Project. The goal of this project was to facilitate license portability by crafting a consensus licensure title, licensure scope of practice and licensure education requirements endorsed by the counseling professionals.

At the ACA Conference in San Francisco in March, 2012 the 20/20 delegates reached consensus on "Licensed Professional Counselor" as the designated licensure title. They also endorsed the concept that having a single education accrediting body would be a clear benefit for the counseling profession. Finally, the delegates decided that the two 20/20 work groups focused on counselor education requirements and counselor scope of practice should develop their respective recommendations by mid-September so the 20/20 delegation as a whole can reach consensus on these two areas at the 2013 ACA Annual Conference in Cincinnati (Rollins, 2012). The Chair of the Single Licensure Title Work Group, Burt Bertram, stated that recommending LPC as the consensus licensure title to the overall 20/20 delegation wasn't a difficult decision. He said it was an obvious choice after his group considered the following factors: (1) How easy the title would be for the public to grasp; (2) Whether the title would offer a "pathway" for all counselors; (3) Whether the title aligned with the previously established consensus definition of counseling; (4) How consistent the title was with terms already in use in jurisdictions across the United States; (5) How well the title distinguished "professional" counselors from other groups using *counselor* in their names (such as funeral counselors, financial counselors, camp counselors and so on). Bertram said that the title *LPC* is already in use in thirty-two states and he favored all fifty states adopting this single title (Rollins, 2012).

The 20/20 Common Licensure Title work group's leader Bertran said. "When you put something in front of the word *counselor* — for example, clinical mental health counselor — that narrows it" (Rollins, 2012). He went on to say that the counseling profession has confronted a long-standing identity struggle in part because many counselors identify themselves by a specialty title rather than by a title that presents their core identity as a counselor. (Rollins, 2012). The 20/20 Delegate accepted that the title LPC would readily communicate the core identity of Professional Counselor and reduce confusion and increases understanding. At the same time, the licensure title work group also recommended that an ability to recognize specialties be included for counselors, similar to physician licensing laws (Rollins, 2012).

At that 2012 meeting of 20/20, Carol Bobby the Executive Director of CACREP pointed out that: when the Institute of Medicine (IOM) conducted research to determine whether counselors should be recommended to work as independent providers in the TRICARE health system, it raised concerns, saying there was "substantial variability among the states in training programs and requirements for licensure as a counselor." IOM also noted that only some counselor education programs were accredited by CACREP and that in some states, a counseling license could be obtained with a postgraduate degree in a field other than counseling. "One of the primary reasons that the IOM included graduation from a CACREP-accredited Clinical Mental Health Counseling program in its final recommendations to

Congress was to ensure consistency in the educational preparation of counselors hired within the TRICARE system. The IOM report indicated that they could not guarantee this level of consistency through acceptance of the use of the LPC status only (Rollins, 2012). This information about the IOM's ruling has bearing since that organization oversees the credentialing of mental health professionals in federal funded programs and facilities. It was the IOM's findings which resulted in the VA accepting for their Mental Health Counselor career slots only licensed counselors who were graduates of the Clinical Mental Health Counseling CACREP programs.

In March 2013, at the ACA Conference in Cincinnati, the 20/20 Building Blocks to Portability Project delegates met again to discuss the issue of a unified statement. The Scope of the Independent Practice of Professional Counselors describes qualifications for licensing by the respective states to assist in the portability process. They unanimously accepted the following statement for the Scope of Practice (ACA, 2013)

Scope of Practice of Professional Counseling

Populations Served	• The independent practice of counseling encompasses the provision of professional counseling services to individuals, groups, families, and couples through the application of accepted and established mental health counseling principles, methods, procedures, and ethics. • The practice of counseling also includes services to collective entities such as organizations and schools.
Primary Purpose	• The primary purpose of counseling is to promote mental health wellness, which includes the achievement of effective social, career, and emotional development across the lifespan, as well as preventing and/or treating mental disorders and providing crisis intervention.
Assessment	• The practice of counseling includes the administration and interpretation of assessments for appraisal, diagnosis, evaluation, and referral determination to help establish individualized counseling plans and goals that may include the treatment of individual with emotional, mental, and physical disorders.
Consultation/ Program Evaluation	• The practice of counseling also includes consultation and program evaluation, and program administration within and to schools and organizations.
Supervision	• The practice of counseling also includes the training and supervision of interns, trainees, and pre-licensed professional counselors through accepted and established principles, methods, procedures, and ethics of counselor supervision.

Limitations	• Professional Counselors possess the training and competencies to practice independently and to use clinical judgment in the performing their counseling responsibilities as described in this Scope of Practice statement. The practice of counseling does not include functions or practices that are not within the professional's training or education.

In June 2012 in *Counseling Today,* Ostvik-de Wilde, Hammes, Sharma, Kang & Park provided a student's commentary on the 20/20 initiative and concluded that "How can we expect to reflect a professional identity when educational practices and licensure certification standards are not uniform? All states should be held to the same degree of accountability and training, thus ensuring that all counselors are equally able and qualified to practice. Maintaining these high standards of practice, counseling licensure should also expand to national/international regulation" they prposed. (p.46). Interestingly, the purpose of licensure and certification were not mentioned in their commentary leaving students of the field less informed as to the type, title and structure of licensure and certification for which the 20/20 effort was advocating. At their March 2013 meeting the 20/20 delegates reviewed what they had accomplished. They celebrated the historic nature of 20/20 with the significant accomplishments in delineating the *Principles for Strengthening and Unifying the Profession*, the consensus definition of counseling, and the licensure title of "Licensed Professional Counselor" as the first building block for the Building Blocks to Portability Project (ACA, 2013).

King (2012) created a comparison chart for the CMHC's in Utah to understand the State's new requirements for their Licensed Clinical Mental Health Counseling regulation. It is important that this chart be reviewed by students entering the field to recognize that the CMHC standards required by CACREP CMHC programs are in line if not more rigorous than their sister professions.

State Licensing Board Minimal Education Requirements for Licensed Therapists

Degree	**Degree**	**Degree**	**Degree**
Masters, 60 credit hours (CACREP accreditation)	Doctoral 120 credit hours (APA accreditation)	Masters, 48 credit hours (COAMFTE accreditation)	Masters, 60 credit hours (CSWE accredited)
Courses Professional Orientation and Ethical Practice (based on the American Counseling Association, American	**Courses** *Scientific and Professional Ethics and Standards* (*Italics* represent core	**Courses** Professional Ethics	**Courses** Social Work Practice Methods (application of key values and principles of the

Mental Health Counselors Association, or National Board of Certified Counselors)	areas of study for psychology. According to the APA, non-core areas of course work must have a theoretical focus as opposed to an applied, clinical focus.)		National Association of Social Workers Code of Ethics and resolution of ethical dilemmas)
Human Growth and Development Across the Life Span	Human Development	Human Development and Family Studies (the individual and family over the life course)	Human Growth and Development (includes an emphasis on human growth and development across the lifespan, from conception to death)
Research and Evaluation in Clinical Mental Health Counseling	*Research Design and Methodology*	Research Methodology and Data Analysis	Research Methods in Social Work
Social and Cultural Diversity	Issues of Cultural and Individual Diversity	Issues of Gender and Ethnicity	
Assessment of Mental Status (maladaptive and psycho-pathological behavior)	Psychopathology and Abnormal Psychology	Psychopathology and Assessment in Marriage and Family Therapy (including DSM)	
Helping Relationships (including counseling theory and personality theory)	Individual Differences in Behavior and Personality Theory (including counseling theory)	Theoretical Foundations of Marital and Family Therapy	
Substance Use Disorders or Addictive or Compulsive Behaviors (formally Dysfunctional Behavioral)	Dysfunctional Behavior		

Assessment of Mental Status (including the appraisal of DSM)	Theories and Methods of Assessment and Diagnosis	Systematic Assessments and Appraisals Assessment and	
Helping Relationships (including theory and skills in counseling and psychotherapy with individuals)	Effective Intervention, and Evaluating the Efficacy of Interventions	Individual and Relational Therapy	
Group Work			
		Child and Adolescent Therapy	
Helping Relationships (including theory and skills in counseling and psychotherapy with couples or families)		Family and Multigenerational Psychotherapy	
[Biological Aspects of Behavior & Psychopharmacology –AMHCA 2011 standards]	Biological Aspects of Behavior (physiological psychology, comparative psychology, neuropsychology, psychopharmacology, perception and sensation)		
Psychometric Test and Measurement Theory	*Psychometric Measurement* (including test construction and measurement)		
Career Development			
	Consultation and		

	Supervision		
	Statistics and Techniques of Data Analysis		
	Social Aspects of Behavior (social psychology, organizational psychology, general systems theory, and group dynamics)		
	Cognitive and Affective Aspects of Behavior (learning, thinking, cognition, motivation and emotion)		
	History and Systems of Psychology		
Practicum (100 therapy hours) and Internship (900 therapy hours – including group work)	Practicum (1,000 therapy and testing hours) and Internship (2,000 therapy and testing hours)	Practicum (600 therapy hours)	Internship (1,050 therapy hours)
3-4,000 hours	3-4,000 hours	3-4,000 hours	3-4,000 hours (must include individual, family, & group therapy; crisis intervention; intermediate treatment & long term treatment)

In line with the 20/20 efforts for identifying the distinctiveness of Professional Counseling, this chart points out that two required courses differentiate CACREP CMHC graduates from their sister mental health professionals namely they are trained in group counseling techniques and they learn how to incorporate Career Development within their psychotherapeutic practices

In the spirit of the 20/20 effort, Messina (2013) presented a proposal to “Put Health Back into Clinical Mental Health Counseling.” The goal was to get all licensed professional counselors and licensed mental health counselors to become CCMHC's so as to support this national credential to not only provide a commitment the Professional Counseling field but to the specialty of Clinical Mental Health Counselors whose standards are the only counseling standards recognized federally by the IOM. By becoming CCMHC, the licensed counselors nationwide would commit to a common core of specialty clinical standards, specialty ethics and specialty clinical practice that provides the community with a tool by which then can identify how Mental Health Counselors differ from the other mental health professions. Messina’s proposal is accepting that the singular title for counselor licensure set out by 20/20 would be “Licensed Professional Counselor” by giving the effort some credibility in the Mental Health Field. This CCMHC proposal would help counselors seeking employment at the VA who are not graduates of a CACREP CMHC program until 2015 when Tricare closes its grandfathering process. This effort would also enable all state licensing boards to use the CCMHC credential as an alternative credential to allow licensed counselors to move freely from state to state. This effort would assist licensing boards to have a national standard they could incorporate into their state board regulations to assist in the portability of licenses from state to state. This effort with the CCMHC would also provide such groups as the VA and Tricare with an alternative path to entrance for professionals who had graduated from Counselor Education Programs which were not Clinical Mental Health Counseling CACREP approved programs.

In March 2013 the Department of Defense clarified its Interim Final Rule (IFR) policy on recognizing counselors who are not graduates of the CACREP CMHC program for Tricare coverage. During the transition period, the IFR allows certification of counselors with a degree from a regionally (but not CACREP) accredited program, completion of 2 years/3,000 hours of post-master’s supervised experience, and passage of the National Clinical Mental Health Counseling Exam (NCMHCE). When the transition period ends, on Jan. 1, 2015, the certification criteria will require that counseling degrees be from CACREP accredited programs. This means that if ACA and other state associations accept the proposal that all LPC or LMHC get certified as CCMHC, it would continue this process of federal recognition for the quality standards set by CACREP and NACCMHC.

NBCC Changes Requirements for NCC beginning Janaury 1, 2022

On November 17, 2014 the National Board of Certified Counselors sent out the following message:

> November 17, 2014
>
> I am writing to share a historic change regarding future NBCC application requirements.
>
> We want you to know that this change will affect only new applicants for national certification. This change does not affect your present certification status. Any counselor who is currently certified by NBCC will be able to maintain their certification through the existing policies and procedures (i.e., payment of maintenance fees, completion of

continuing education and compliance with the NBCC Code of Ethics).

The change specifically applies to national certification applications received by NBCC after January 1, 2022. After this date, applicants must document completion of a master's degree or higher from a program accredited by the Council for Accreditation of Counseling & Related Educational Programs (CACREP).

The NBCC Board deliberations and decisions over the past few years involved listening to, researching and discussing a variety of issues in counseling. The development of counseling as a profession is similar to other professions. It is common for early professionals to complete training in related fields, and it is the work of these pioneers to create a path that promotes further growth. I strongly believe that the counseling profession exists because of the many contributions of previous and current experienced professionals. It is because of these contributions that counseling is now recognized by licensure laws in all 50 states, the District of Columbia, and Puerto Rico.

We have listened to the countless counselors who have described difficulty relocating to other states and demonstrating eligibility for positions in federal programs. We have lobbied for many years for improvements in both of these areas and continue to do so. Policymakers have clearly communicated that inconsistent educational standards represent an impediment to inclusion in federal programs as well as state recognition of counselors. They have further indicated that state licensure in its wide variety of forms does not address the need for a uniform method of recognizing professionals. We know that counselor education programs work hard to prepare their graduates; however, legislators, regulators and policymakers see the failure to universally adopt specialized accreditation as problematic because of inconsistent standards and a lack of accountability.

NBCC recognizes that any successful professionalization effort requires effective communication. Legislative leaders listen, but they are also charged with sharing the questions and concerns raised by others outside of the counseling profession. To be successful, we must address all concerns with accurate information. We must also be willing to consider how we can, as leaders within the profession, help resolve areas of difficulty and move toward required uniformity. Other professions require specialized accreditation to ensure consistent quality of education and training. Our new application standards will address these issues in a manner that promotes continued growth and recognition of the counseling profession.

We believe that embracing one accreditation will help resolve these issues. We also owe it to future counseling students to create a clear, consistent professional identity. This must begin with a specialized accreditation process that ensures a more uniform

system for educating future counselors. Counseling has a specialized accreditation organization in CACREP. For over 30 years, CACREP has provided national educational standards that are developed from contributions from the entire profession, and these are regularly reviewed to enhance the continued development of the profession. Currently, CACREP accredits more than 700 programs (e.g., school, clinical mental health, addictions) in approximately 300 colleges and universities.

NBCC will always recognize current NCCs, and we urge state licensure boards to do the same. Furthermore, we are aware that there will be many who disagree with this decision. Many of these individuals graduated from programs that identified themselves "CACREP equivalent," which is no more descriptive than ”licensure equivalent.” Accreditation shows a willingness to be accountable. Many NCCs graduated from such programs, and we want them and those who become NCCs before 2022 to continue to identify as counselors with national certification. I graduated with my counseling degrees before CACREP and continue to hold licensure and the NCC.

NBCC was established to help propel the counseling profession. Our recent decision offers a significant opportunity for experienced counselor to demonstrate their professional identity and commitment while simultaneously planning a more uniform system for educating future counseling professionals. We hope that all counselors will take the time to consider the issues the profession is currently facing and recognize that this historic change represents future opportunity and clarity.

On behalf of NBCC, thank you for being the future of our profession and for your recognition of the importance of maintaining national counselor certification.

Sincerely,

Thomas W. Clawson, Ed.D., NCC, NCSC, LPC
President and CEO

This effort by the NBCC is in line with the recognition that the IOM has given the Standards of CACREP and is also in line with the 20/20 movement of ACA. To read their notice online click here.

It is clear it remains to be seen what effect this change in requirements for the NCC will have on the portability of State Licensure which is one of the major issues being addressed by this change.

Lessons to Be Learned from the Past

Lastly the history of credentialing and standards for Clinical Mental Health Counselors sounds very convoluted, however it is no different a path than other professions in the mental health field. CMHC could learn a great deal about the long road to recognition by reviewing

Nick Cummings history of what it took for Clinical Psychology to become recognized as its own specialty in the field of psychology, as presented below:

What Can Be Learned from the Past Professionalization Efforts of Psychology?

It is beneficial to look into the history of other professions to see if the problems, concerns and issues experienced in the life of the Clinical Mental Health Counseling Profession are simply unique to them or part and parcel contained in the establishment of any profession in the mental health field.

Nicholas Cummings, a Psychologist, Past-President of APA, and founder of both American Biodyne (one of the first Mental Health Managed Care Companies) and the California School for Professional Psychology (CSPP) (The first non-University based school for Clinical Psychologists) was invited to give a history of Clinical Psychology in the 1990 issue of the ACA's Journal of Counseling and Development (Cummings, 1990).

Major points Cummings (1990) pointed out are:

1. Psychology was the first field to challenge the dominance of psychiatry over the field of mental health blazing the trail for clinical social workers, clinical mental health counselors, marriage and family therapists and substance abuse counselors (Cummings, 1990).
2. In 1977 Psychologist were formally licensed in all 50 states (Cummings, 1990).
3. The field of professional psychology was born during World War II due to the shortage of psychiatrist to work on the front lines in battalion aid stations to deal with "battle neurosis" which constituted 40% of the causalities in World War II (Cummings, 1990).
4. To fill the need for trained professionals to address the wounds of War, the Veteran's Administration training programs to fill their clinical/counseling psychology positions (Cummings, 1990).
5. The VA and NIMH then proceeded to establish stipends for graduate education in the field establishing the Ph.D. as the journeyman level of the new profession in psychology and APA was then asked to establish standards for the training of these Ph.D. programs (Cummings, 1990).
6. Even though the VA and NIMH were training psychologist for Public Service more and more were entering the private practice under supervision of Psychiatrists who were universally licensed in those days (Cummings, 1990).
7. 1950 marked the time when serious efforts began to get psychologists licensed in New York and California. The psychologist in California found out to their chagrin that the academically dominated APA showed no interest, financial or emotional support for this effort. It was due to this that State Psychological Associations were established with the avowed purpose of passing statutory credentialing for professional Psychologists. It took 27 years but all 50 states finally licensed psychologists. (Cummings, 1990).
8. In the 1960's professional psychologist were confronted by the academically dominated APA which showed disdain, disinterest and even hostility towards their professional needs. This led the professional psychologists to consider a pull out of APA but they decided to stay and to work within APA (Cummings, 1990). This is a

lesson for Clinical Mental Counselors that working with the academically minded ACA could support and strengthen their credentialing and regulatory needs as long as a good collaborative working relationship is established.

9. By the 1970's the clinician psychologists had accomplished something which made APA what it is today, they became the leaders and major constituency in APA with Cummings becoming the APA president in the 70's. In 1988 the non-clinical members of APA founded the American Psychological Society (APS) due to their outright bitterness over the dominance of professional psychologist in their ranks (Cummings, 1990).
10. In 1967, APA was in a position to get Clinical and Counseling Psychologists covered under Medicare, but APA never filed the petition to make that happen. Every effort from that point on for 25 years to gain Medicare coverage had been defeated. Seeing the writing on the wall, Psychologists wanted Medicare coverage just in case National Health Insurance would become law and those covered by Medicare would be first to be covered by such a new law. In 1990 President Bush signed a bill which passed both houses to recognize psychologists as providers in Medicare. Cummings and Bryant Welch in giving testimony on this bill were asked if they favored inclusion of Social Workers. They strongly recommended this and as a result Social Workers were included at a fee not to exceed 7% of the fee approved by psychologist (Cummings, 1990). This was a major victory for psychology and its collaboration with Social Workers has helped both professions as our country now faces the Affordable Care Act and the impact on Clinical Mental Health Counseling, Marriage and Family Therapy not being covered by Medicare makes more challenges for these professions as they look forward to full implementation of the ACA.

In reviewing this short history of the credentialing of Clinical Psychology we learn that Clinical Mental Health Counselors must become more involved in their local, state and national professional advocacy efforts to insure that one day the CMHC will also be able to look back and recognize that through developing a strong effort of self-advocacy in the professional counseling ranks they will be able to achieve the level of national credentialing and statutory regulation need to bring it into the next decades more solidly rooted and supported.

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