AMHCA Standards for the Practice of Clinical Mental Health Counseling

Adopted 1979
Revised 1992, 1993, 1999, 2003, 2011, 2015, 2016, 2017, 2018, 2019, 2020, 2021, and 2023

AMHCA

AMERICAN MENTAL HEALTH COUNSELORS ASSOCIATION

The only organization working exclusively for the mental health counseling profession

AMHCA STANDARDS FOR THE PRACTICE OF CLINICAL MENTAL HEALTH COUNSELING

The Essential Standards
for the Art and Science of the Profession

Preface: How are the *AMHCA Standards* applied in practice?

The American Mental Health Counselors Association's *Standards for the Practice of Clinical Mental Counseling (AMHCA Standards)* specifies the established benchmarks of practice for members of the clinical mental health counseling profession. As noted throughout "Essentials of the Clinical Mental Health Counseling Profession," the acronym LCMHC is used to refer to all categories of clinical mental health counselors. These categories include Clinical Mental Health Counseling Students (CMHC Students) in supervised internships, postgraduate Supervised Clinical Mental Health Counselors (Supervised CMHCs), and fully Licensed Clinical Mental Health Counselors (LCMHCs). Regardless of graduate-degree program title or state license title, *AMHCA Standards for the Practice of Clinical Mental Health Counseling* provides professional development standards for each of the clinical mental health counselor categories.

AMHCA Standards identifies and describes the norms within the profession. The standards spelled out in this important document have served as the foundation of the profession since 1979, when they were first adopted. *AMHCA Standards* has been periodically revised and extended as the profession developed. In the past, the explicit requirements for practice, education, and supervision were used to validate clinical mental health counselor qualifications as one of the four recognized mental health professions (the other three are psychology, social work, and marriage and family therapy).

The National Academy of Medicine (formerly the Institute of Medicine) in its 2010 report cited the *AMHCA Standards* for members of the profession to be eligible and qualified for federal employment and reimbursement, saying in its first recommendation: "Independent practice of mental health counselors in TRICARE in the circumstances in which their education, licensure, and clinical experience have helped to prepare them to diagnose, and where appropriate, treat conditions in the beneficiary population" ("Provision of Mental Health Counseling Services Under TRICARE," Chapter 6, page 207, at *https://bit.ly/3RjwWED).*

AMHCA Standards is a living document that is updated on a continuing basis to meet the needs of the public and the profession. In addition to standards of practice, it includes training and supervision standards.

The Two Types of Standards

Of special note are the specific clinical mental health counseling knowledge and skills for each standard that LCMHCs should understand and apply. Each standard falls into one of the following two categories:

❑ *Core Standards:* These are the standards that all LCMHCs should be familiar with. AMHCA recommends that all graduate degree programs in clinical mental health counseling provide students with general working knowledge in the following standards:

    A. Biological Bases of Behavior (including psychopathology and psychopharmacology)

    B. Specialized Clinical Assessment (including mental health assessment and diagnosis of mental disorders)

    C. Trauma-Informed Care (including assessment of traumatic experiences and trauma resolution)

    D. Substance Use Disorders and Co-occurring Disorders

    E. Technology Supported Counseling and Communications (TSCC) (including the use of telemental health)

    F. Integrated Behavioral Health Care Counseling (including psychological and physiological considerations)

❑ *Specialization Standards:* These standards require that LCMHCs have advanced understanding in order to apply the knowledge and skills of each of these specialization areas. All of the core standards are also specialized standards, but the knowledge and skills must be more comprehensively applied:

A. Biological Bases of Behavior

B. Specialized Clinical Assessment

C. Trauma-Informed Care (revised and updated in 2020)

D. Substance Use Disorders and Co-occurring Disorders (revised and updated in 2020)

E. Technology Supported Counseling and Communications (TSCC) (new in 2020)

F. Integrated Behavioral Health Care Counseling (new in 2020)

Additional areas of clinical specialization include:

G. Child and Adolescent Counseling Standards and Competencies (new in 2020)

H. Aging and Older Adults Counseling Standards and Competencies (new in 2020)

I. Forensic Evaluation Standards and Competencies (new in 2021)

J. Gender Identity Counseling Standards and Competencies (new in 2021)

K. Affectional Identity Counseling Standards and Competencies (new in 2023)

LCMHCs who specialize in these specialization areas or the other specialist areas should possess a superior, in-depth understanding of the knowledge and skills that are applied in practice.

The need is expanding for mental health professionals who have advanced, postgraduate training and experience in treating populations with special needs. AMHCA's Advancement for Clinical Practice Committee has been at the forefront of identifying the knowledge and skills required for members of the clinical mental health counseling profession to become specialists.

AMHCA's Advancement for Clinical Practice Committee (ACPC) continually reviews and revises standards as appropriate. The AMHCA board and the ACPC have included one new standard—Affectional Identity Counseling—in the 2023 edition of the *AMHCA Standards*. Other need-based competencies that have been identified as future standards are under development and will be included in future publications and distribution. These include:

❑ Military Counseling,

❑ Couples and Family Counseling, and

❑ Developmental and Learning Disabilities Counseling.

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

This unabridged version of the latest *AMHCA Standards for the Practice of Clinical Mental Health Counseling* is downloadable at no cost from *www.amhca.org/publications/standards*.

AMHCA Standards for the Practice of Clinical Mental Health Counseling

Adopted 1979 / Revised 1992, 1993, 1999, 2003, 2011, 2015, 2016, 2017, 2018, 2020, 2021, and 2023

V. Recommend AMHCA Training *—continued from previous page*

I. Introduction

Since its formation as a professional organization in 1976, the American Mental Health Counselors Association, AMHCA, has been committed to establishing and promoting vigorous standards for education and training, professional practice, and professional ethics for clinical mental health counselors. Initially, AMHCA sought to define and promote the professional identity of mental health counselors. Today, with licensure laws in all 50 states, AMHCA strives to enhance the practice of clinical mental health counseling and to promote standards for clinical education and clinical practice that anticipate the future roles of clinical mental health counselors within the broader health care system. As a professional association, AMHCA affiliated with APGA (a precursor to the American Counseling Association [ACA]) as a division in 1978; in 1998, AMHCA became a separate not-for-profit organization, but retained its status as a division of ACA.

In 1976, a group of community mental health, community agency and private practice counselors founded AMHCA as the professional association for the newly emerging group of counselors who identified their practice as "mental health counseling." Without credentialing, licensure, education and training standards, or other marks of a clinical profession, these early mental health counselors worked alongside social workers and psychologists in the developing community mental health service system as "paraprofessionals" or "allied health professionals" despite the fact that they held master's or doctoral degrees. By 1979, the early founders of AMHCA had organized four key mechanisms for defining the new clinical professional specialty:

1. Identifying a definition of mental health counseling

2. Setting standards for education and training, clinical practice, and professional ethics

3. Creating a national credentialing system

4. Starting a professional journal, which included research and clinical practice content

These mechanisms have significantly contributed to the professional development of clinical mental health counseling and merit further explication.

A. Scope of Practice

A crucial development in mental health counseling has been defining the roles and functions of the profession. The initial issue of AMHCA's *Journal of Mental Health Counseling* included the first published definition of mental health counseling as "an interdisciplinary, multifaceted, holistic process of: 1) the promotion of healthy lifestyles; 2) identification of individual stressors and personal levels of functioning; and 3) the preservation or restoration of mental health" (Seiler & Messina, 1979).

In 1986, the AMHCA board of directors adopted a more formal, comprehensive definition: "Clinical mental health counseling is the provision of professional counseling services involving the application of principles of psychotherapy, human development, learning theory, group dynamics, and the etiology of mental illness and dysfunctional behavior to individuals, couples, families and groups, for the purpose of promoting optimal mental health, dealing with normal problems of living and treating psychopathology. The practice of clinical mental health counseling includes, but is not limited to, diagnosis and treatment of mental and emotional disorders, psycho-educational techniques aimed at the prevention of mental and emotional disorders, consultations to individuals, couples, families, groups, organizations and communities, and clinical research into more effective psychotherapeutic treatment modalities."

Clinical mental health counselors have always understood that their professional work encompasses a broad range of clinical practice, including dealing with normal problems of living and promoting optimal mental health in addition to the prevention, intervention and treatment of mental and emotional disorders. This work of clinical mental health counselors serves the needs of socially and culturally diverse clients (e.g., age, gender, race/ ethnicity, socioeconomic status, sexual orientation, etc.) across the

life span (i.e., children, adolescents and adults including older adults and geriatric populations). Clinical mental health counselors have developed a strong sense of professional identity since 1976. AMHCA has sought to support this sense of professional identity through legislative and professional advocacy, professional standards, a code of ethics, continuing education, and clinical educational resources, and support for evidence based best practices, research and peer-reviewed dissemination of developments in the field.

B. Standards of Practice and Research

A key development for the profession was AMHCA's creation of education and training standards for mental health counselors in 1979. The Council for Accreditation of Counseling & Related Educational Programs (CACREP) adopted and adapted these AMHCA training standards in 1988 when it established the first set of accreditation standards for master's programs in clinical mental health counseling. In keeping with AMHCA standards, CACREP accreditation standards for the mental health counseling specialty have consistently required 60 semester hours of graduate coursework. AMHCA remained an active advocate for vigorous clinical training standards through the 2009 CACREP accreditation standards revision process, during which community counseling accreditation standards were merged into the new clinical mental health counseling standards. After careful review, AMHCA endorsed the clinical mental health counseling standards.

Another important step in the further professionalization of clinical mental health counseling, AMHCA established the National Academy of Certified Mental Health Counselors, the first credentialing body for clinical mental health counselors, and gave its first certification examination in 1979. In 1993, this certified clinical mental health counselor credential (CCMHC) was transferred to the National Board for Certified Counselors (NBCC). NBCC provides the Board Certification of CCMHCs. AMHCA clinical standards have always recognized and incorporated the CCMHC credential as an important means of recognizing that a clinical mental health counselor has met independent clinical practice standards, despite significant differences that exist among state counselor licensure laws, as well as among educational and training programs.

Finally, since 1979, AMHCA has published the *Journal of Mental Health Counseling,* which has become widely recognized and cited as an important contributor to the research and professional literature on clinical mental health counseling.

Taken together, these four mechanisms (definition of scope of practice; educational and training standards; professional practice standards and code of ethics; credentialing; and professional journal) resulted in the recognition of clinical mental health counseling as an important profession to be included in our health care system. In recognition of the central importance of vigorous professional educational and clinical practice standards, AMHCA has periodically revised its professional standards—in 1993-94, 1999, 2003, and 2010-11, 2015, 2016, 2017, 2018, 2020, 2021, and 2023—to reflect evolving practice requirements. These professional standards, as well as the 2020 *AMHCA Code of Ethics,* constitute the basis from which AMHCA continues to advocate for, and seek to advance, the practice of clinical mental health counseling.

II. Educational and Pre-Degree Clinical Training Standards

Required Education: Master's in Clinical Mental Health Counseling (60 semester hours)

A. Program

CACREP-accredited clinical mental health counseling program—based on 2009 standards (endorsed by AMHCA Board) or master's degree in counseling (minimum of 48 semester hours) from a regionally accredited institution. The 48 semester-hour minimum will increase to 60 semester hours in January 2016.

B. Curriculum

Consistent with 2009 *CACREP Standards,* clinical mental health counseling programs should include the core CACREP areas and specialized training in clinical mental health counseling. The core CACREP areas include:

1. Professional Orientation and Ethical Practice

2. Social and Cultural Diversity

3. Human Growth and Development Across the Life Span

4. Career Development

5. Counseling Theories and Helping Relationships

6. Group Work

7. Assessment

8. Research and Program Evaluation

C. Specialized Clinical Mental Health Counseling Training

These areas of clinical mental health counselor preparation address the clinical mental health needs across the life span (children, adolescents, adults and older adults) and across socially and culturally diverse populations:

1. Ethical, Legal and Practice Foundations of Clinical Mental Health Counseling

2. Prevention and Clinical Intervention

3. Clinical Assessment

4. Diagnosis and Treatment of Mental Disorders

5. Diversity and Advocacy in Clinical Mental Health Counseling

6. Clinical Mental Health Counseling Research and Outcome Evaluation

AMHCA recommends additional training in Clinical Mental Health Counseling described in the following standards:

1. Biological Bases of Behavior (including psychopathology and psychopharmacology)

2. Trauma-Informed Care

3. Substance Use Disorders and Co-occurring Disorders (generally refers to addictions and accompanying mental disorders)

This training may be completed as part of the degree program, in post-master's coursework, or as part of a certificate or continuing education or CCMHC credential.

D. Pre-Degree Clinical Mental Health Counseling Field Work Guidelines

1. Students' pre-degree clinical experiences meet the minimum training standards of 100 Practicum and 600 Internship hours.

2. Students receive an hour of clinical supervision by an independently and approved licensed supervisor for every 20 hours of client direct care. This field work supervision is in addition to the practicum and internship requirements for their academic program.

3. Students are individually supervised by a supervisor with no more than 6 (FTE) or 12 total supervisees.

III. Faculty and Supervisor Standards

A. Faculty Standards

Faculty with primary responsibility for clinical mental health counseling programs should have an earned doctorate in a field related to clinical mental health counseling and identify with the field of clinical mental health counseling. While AMHCA recognizes that clinical mental health counseling programs have the need for diverse non-primary faculty who may not meet all of the following criteria, the following knowledge and skills are required for faculty with primary responsibility for clinical mental health counseling programs.

1. **Knowledge**

   a. Demonstrate expertise in the content areas in which they teach and have a thorough understanding of client populations served.

   b. Involved in clinical supervision either as instructors or in the field have a working knowledge of current supervision models and apply them to the supervisory process.

   c. Understand that clinical mental health counselors are asked to provide a range of services including counseling clients about problems of living, promoting optimal mental health, and treatment of mental and emotional disorders across the life span.

   d. Demonstrate training in the following:

      i. Evidence-based best practices

      ii. Differential diagnosis and treatment planning

      iii. Co-occurring disorders and substance use disorders

      iv. Trauma, and its related forms (developmental, complex, situation, chronic or toxic distress, family generational trauma, historical trauma, etc.)

      v. Biological bases of behavior including psychopharmacology

      vi. Social and cultural foundations of behavior

      vii. Individual family and group counseling

      viii. Clinical assessment and testing

      ix. Professional orientation and ethics

      x. Advocacy and leadership

      xi. Case consultation and supervision with peers or specialists

      xii. Clinical supervision with a hierarchical or regulatory supervisor

   e. Possess knowledge about professional boundaries as well as professional behavior in all interactions with students and colleagues.

2. **Skills**

   a. Demonstrate clinical mental health skills by completing licensure requirements including successful completion of coursework, fieldwork requirements, licensure exams, and licensure renewal requirements.

b. Demonstrate identification with the field of clinical mental health counseling by their academic credentials, scholarship and professional affiliations including their participation in organizations which promote clinical mental health counseling including AMHCA, ACA and ACES etc. Faculty who provide clinical supervision in the program or on site are able to lead supervision seminars which promote case analysis, small group process and critical thinking.

c. Complete the equivalent of 15 semester hours of coursework at the doctoral level in the clinical mental health specialty area or a comparable amount of scholarship in this area.

d. Possess expertise in working with diverse client populations in areas they teach including clients across the spectrum of social class, ethnic/racial groups, lesbian, gay, bisexual and transgendered communities, etc.

e. Demonstrate and model the ability to develop and maintain clear role boundaries within the teaching relationship.

f. Demonstrate the ability to analyze and evaluate skills and performance of students.

B. Supervisor Standards

AMHCA recommends at least 24 continuing education hours or equivalent graduate credit hours of training in the theory and practice of clinical supervision for those clinical mental health counselors who provide pre- or post-degree clinical supervision to clinical mental health counseling students or trainees. AMHCA recommends that clinical supervisors obtain, on the average, at least 3 continuing education hours in supervision per year as part of their overall program of continuing education. Clinical supervisors should meet the following knowledge and skills criteria.

1. Knowledge

a. Possess a strong working knowledge of evidence based and best practices orientation with clinical theory and interventions and application to the clinical process.

b. Understand the client population and the practice setting of the supervisee.

c. Understand and have a working knowledge of current supervision models and their application to the supervisory process. Maintain a working knowledge of the most current methods and techniques in clinical supervision knowledge of group supervision methodology including the appropriate use and limits of this modality.

d. Identify and understand the roles, functions and responsibilities of clinical supervisors including liability in the supervisory process. Communicates expectations and nature and extent of the supervision relationship.

e. Maintain a working knowledge of appropriate professional development activities for supervisees. These activities should be focused on empirically based scientific knowledge.

f. Show a strong understanding of the supervisory relationship and related issues, not limited to power differential, evaluation, parallel process and isomorphic similarities and differences between supervision and counseling, and qualities that enhance the supervisor/supervisee working alliance for the benefit of clients served.

g. Identify and define the cultural issues that arise in clinical supervision and be able to routinely incorporate cultural sensitivity into the supervisory process.

h. Understand and define the legal and ethical issues in clinical supervision including:

       i. Applicable laws, licensure rules, and the *AMHCA Code of Ethics,* specifically as they relate to supervision

      ii. Supervisory liability, respondent superior, and fiduciary responsibility

     iii. Risk-management models and processes as they relate to the clinical process and to supervision

i. Possess a working understanding of the evaluation process in clinical supervision including evaluating supervisee competence and remediation of supervisee skill development. This includes initial, formative and summative assessment of supervisee knowledge, skills and self-awareness with provisions for clearly stated expectations, fair delivery of feedback and due process. Supervision includes both formal and informal feedback mechanisms.

j. Maintain a working knowledge of industry recognized financial management processes and required recordkeeping practices including electronic records and transmission of records.

2. Skills

a. Possess a thorough understanding and experience in working with the supervisees' client populations. Be able to demonstrate and explain the counselor role and appropriate clinical interventions within the cultural and clinical context.

b. Develop, maintain and explain the supervision contract to manage supervisee relationships with clear expectations including:

       i. Frequency, location, length, and duration of supervision meetings

      ii. Supervision models and expectations of the supervisee and the supervisor

     iii. Liability and fiduciary responsibility of the supervisor

     iv. The evaluation process, instruments used, and frequency of evaluation

      v. Emergency and critical incident procedures

c. Demonstrate and model the ability to develop and maintain clear role boundaries and an appropriate balance between consultation and training within the supervisory relationship.

d. Demonstrate the ability to analyze and evaluate skills and performance of supervisees including the ability to confront and correct unsuitable actions and interventions on the part of the supervisees. Provide timely substantive and formative feedback to supervisees, along with providing cumulative feedback and to train supervisees in techniques and methods in self-appraisal.

e. Present strong problem-solving and dilemma resolution skills and practice skills with supervisees.

f. Develop and demonstrate the ability to implement risk management strategies.

g. Practice and model self-assessment.

h. Seek consultation as needed.

i. Conceptualize cultural differences in therapy and in supervision. Incorporate and model this understanding into the supervisory process.

j. Possess an understanding of group supervision techniques and the role of group supervision in the supervision process.

k. Comply with applicable federal, state, and local law. Take responsibility for supervisees' actions, which include an understanding of recordkeeping and financial management rules and practice.

IV. Clinical Practice Standards

A. Post-Degree/Pre-Licensure

Clinical mental health counselors have a minimum of 3,000 hours of supervised clinical practice post-degree over a period of at least two years. In the process of acquiring the first 3,000 hours of client direct and indirect contact in postgraduate clinical experience, AMHCA recommends a ratio of one hour of supervision for every 20 hours of on-site work hours with a combination of individual, triadic and group supervision.

B. Peer Review and Supervision

Clinical mental health counselors maintain a program of peer review, supervision and consultation even after they are independently licensed. It is expected that clinical mental health counselors seek additional supervision or consultation to respond to the needs of individual clients, as difficulties beyond their range of expertise arise. While need is to be determined individually, independently licensed clinical mental health counselors must ensure an optimal level of consultation and supervision to meet client needs.

C. Continuing Education

Clinical mental health counselors at the post-degree and independently licensed level must comply with state regulations, certification and credentialing requirements to obtain and maintain continuing educational requirements related to the practice of clinical mental health counseling. Clinical mental health counselors maintain a repertoire of specialized counseling skills and participate in continuing education to enhance their knowledge of the practice of clinical mental health counseling.

In accordance with state law, AMHCA recommends that in order to acquire, maintain and enhance skills, counselors actively participate in a formal professional development and continuing education program. This formal professional development ordinarily addresses peer review and consultation, continuum of care, best practices and evidence-based research; advocacy; counselor self-care and impairment, and the *AMHCA Code of Ethics*. Clinical mental health counselors who are involved in independent clinical practice also receive ongoing training relating to independent practice management, accessibility, accurate representation, office procedures, service environment, and reimbursement for services.

D. Legal and Ethical Issues

Clinical mental health counselors who deliver clinical services comply with state statutes and regulations governing the practice of clinical mental health counseling. Clinical mental health counselors adhere to all state laws governing the practice of clinical mental health counseling. In addition, they adhere to all administrative rules, ethical standards, and other requirements of state clinical mental health counseling or other regulatory boards. Counselors obtain competent legal advice concerning compliance with all relevant statutes and regulations. Where state laws lack governing the practice of counseling, counselors strictly adhere to the national standards of care and ethics codes for the clinical practice of mental health counseling and obtain competent legal advice concerning compliance with these standards.

Clinical mental health counselors who deliver clinical services comply with the codes of ethics specific to the practice of clinical mental health counseling. *AMHCA Code of Ethics* outlines behavior which must be adhered to regarding commitment to clients; counselor-client relationship; counselor responsibility and integrity; assessment and diagnosis; recordkeeping, fee arrangements and bartering; consultant and advocate roles; commitment to other professionals; commitment to students, supervisees and employee relationships.

Clinical mental health counselors are first responsible to society, second to consumers, third to the profession, and last to themselves. Clinical mental health counselors identify themselves as members of the counseling profession. They adhere to the codes of ethics mandated by state boards regulating counseling and by the clinical organizations in which they hold membership and certification. They also adhere to ethical standards endorsed by state boards regulating counseling, and cooperate fully with the adjudication procedures of ethics committees, peer review teams, and state boards. All clinical mental health counselors willingly participate in a formal review of their clinical work, as needed. They provide clients appropriate information on filing complaints alleging unethical behavior and respond in a timely manner to a client request to review records.

Of particular concern to AMHCA is that clinical mental health counselors who deliver clinical services respond in a professional manner to all who seek their services. Clinical mental health counselors provide services to each client requesting services regardless of lifestyle, origin, race, color, age, handicap, sex, religion, or sexual orientation. They are knowledgeable and sensitive to cultural diversity and the multicultural issues of clients. Counselors have a duty to acquire the knowledge, skills, and resources to assist diverse clients. If, after seeking increased knowledge and supervision, counselors are still unable to meet the needs of a particular client, they do what is necessary to put the client in contact with an appropriate mental health resource.

V. Recommended AMHCA Training

Core Standards. In addition to the generally agreed on courses and curricula endorsed by the Council for Accreditation of Counseling & Related Educational Programs (CACREP), AMHCA recommends that all graduate education in clinical mental health counseling will include the basic knowledge and skills of the core standard subject areas. In graduate school, knowledge and skills related to the core standard subject areas may be covered in a single course, or more commonly, across several courses or topics of inquiry.

Further, Supervised CMHCs and LCMHCs are encouraged to obtain post-master's training. For example, this training could be obtained from:

❑ Postgraduate coursework

❑ Reliable and reputable training workshops and seminars provided by qualified presenters

❑ Specialized consultation with experts

❑ Membership and participation in professional associations and conferences that offer standard-specific training and development

❑ Other counseling-related training resources

AMHCA's recommended core standards:

A. Biological Bases of Behavior

B. Specialized Clinical Assessment

C. Trauma-Informed Care

D. Substance Use Disorders and Co-occurring Disorders

E. Technology Supported Counseling and Communications

F. Integrated behavioral health care counseling

Specialized Standards. LCMHCs with advanced postgraduate education, training, and experience may become specialists in each of these preceding standards if they have achieved advanced application of the knowledge and skills. In addition, LCMHCs may also become specialists in the following specialization:

G. Child and Adolescents Counseling Standards and Competencies

H. Aging and Older Adults Counseling Standards and Competencies

I. Forensic Evaluation Standards and Competencies

J. Gender Identity Counseling Standards and Competencies

K. Affectional Identity Counseling Standards and Competencies

For those who desire to become recognized through AMHCA board certification as an AMHCA Clinical Mental Health Counseling Specialist (CMHC Specialist), the skills outlined in this document can be documented, for example, through:

❑ Comprehension testing

❑ Elective procurement of certifications

❑ Verification of standard-specific attendance at training events

❑ Approval from insurance panels to meet their credentialing standards

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[See www.amhca.org/career/credential/apply for information on professional board certification and CMHC Specialist requirements.]

A. Biological Bases of Behavior

The origins of human thought, feeling, and behavior, from the more adaptive to the less adaptive, are the result of complex interactions between biological, psychological, and social factors. There is an increased need for an expanded exploration and understanding of the biological factors as well as the way that they influence and are influenced by the psychological and social factors. A deeper understanding of the biological bases of behavior helps clinical mental health counselors not only be more precise in our diagnosis and treatment of mental disorders, but also in the promotion of wellness, peak performance, and quality of life.

1. Knowledge

   a. Understand the structure and function of the central nervous system (CNS) (brain, spinal cord) and the peripheral nervous system (PNS) (somatic, autonomic, sympathetic, and parasympathetic).

   b. Understand how the human nervous system interacts with other physiological systems (endocrine, immune, gastrointestinal, etc.).

   c. Possess a basic understanding of neural development across the life span (e.g., genetic, social, and/or environmental factors that influence the development of the human nervous system).

   d. Comprehend structural and functional neuroanatomy as well as physiology of the sympathetic and parasympathetic nervous systems.

   e. Understand physiological and biochemical mechanisms of intraneuronal communication (e.g., neurotransmission).

   f. Comprehend methods used to evaluate functioning in the central and peripheral nervous systems (e.g., quantitative electroencephalography, MRI, galvanic skin response).

   g. Possess an introductory knowledge of the neurocognitive processes underlying executive function, feelings, learning, memory, sensation, and perception across the life span.

   h. Understand the neurobiological mechanisms underlying neurodevelopmental, neurodegenerative, and psychiatric disorders.

   i. Comprehend the neurophysiological causes and behavioral implications of various medical conditions (e.g., autoimmune disorders, epilepsy, stroke, obesity) and traumatic brain injury.

   j. Understand current research (e.g., mechanisms, efficacy, effectiveness) related to the use of biofeedback (e.g., neurofeedback, actigraphy data) for enhancing therapeutic outcomes in clinical mental health counseling.

   k. Understand how drugs are absorbed, metabolized and eliminated.

   l. Understand the pharmacokinetics and pharmacodynamics of psychotropic drugs used in the treatment of mental health disorders and neurodegenerative diseases.

   m. Understand how psychotropic medications influence behavior change and is able to identify possible contraindications and adverse effects.

   n. Understand the biological components of the therapeutic relationship.

2. Skills

    a. Integrating Research into Practice

        i. Acknowledge how science and evidence-based practice may be leveraged to improve outcomes and increase collaboration in integrated care settings.

        ii. Identify the limits of one's knowledge and professional expertise and regularly engage in ongoing continuing education and certification for additional specialty practice (e.g., biofeedback, neurofeedback).

        iii. Is able to locate, appraise, and assimilate research from allied fields such as neuroscience, endocrinology, immunology, nutrition, and psychiatry into clinical practice.

        iv. Critically evaluate peer-reviewed literature, communicates findings in a clear and accurate manner, and avoids overstating or overgeneralizing research findings.

        v. Demonstrate the ability to discuss the biology of reproduction and prenatal development with both clients and colleagues.

        vi. Describe the aging brain and how it may change across the life span.

        vii. Explore the mechanisms and common clinical features of neurocognitive disorders in addition to offering strategies designed to improve functioning (e.g., agitation and anxiety, cognitive function, caregiver support) with clients, family and colleagues.

        viii. Articulate how physiological (e.g., genes, molecules, circuits, immune functioning, endocrinology, gut microbiome), psychological (e.g., neurocognitive, personality, symptom), and environmental (e.g., individual, family, community, society, cultural) factors may interact to modulate human behavior.

        ix. Articulate the basic principles of pharmacology (e.g., dose-response, side-effects, interactions pharmacokinetics, pharmacodynamics, routes of administration, distribution) and adaptation (e.g., tolerance, sensitization, withdrawal, placebo, nocebo) associated with commonly used drugs.

        x. Review and critically appraise all research investigating the reliability and validity of any diagnostic and/or interventional technology intended to augment the practice of clinical mental health counseling, which may include emerging tools/methods used for collecting data from self-report or laboratory tests, mobile devices, and/ or other methods of physiological data collection (e.g., electroencephalography).

    b. Clinical Intervention

        i. Counsel clients from a biologically grounded life span developmental approach in concert with one's theoretical orientation.

        ii. Acknowledge the strengths and limitations of drugs commonly used to treat major psychiatric disorders.

        iii. Counsel clients about how to communicate with providers regarding the risks and benefits of medication, method of adherence, and common adverse effects.

        iv. Effectively and accurately translate mental health information into plain language, without using scientific jargon, while also communicating empathy and ensuring a warm, non-judgmental, and supportive therapeutic alliance.

        v. Render suitable diagnoses grounded in the synthesis of assessment data obtained from various methods (e.g., clinical interview, psychometric instruments, quantitative EEG) across multiple levels of explanation (e.g., genetic, molecular, cellular, neurocircuitry, physiology, behavior, and self-report).

vi. Produce timely, detailed, and accurate clinical reports which demonstrate: (1) the use of appropriate clinical terminology; (2) a commitment to ethical practice; (3) the ability to systematically collect and synthesize relevant data, and (4) how treatment is routinely refined and/or modified over time.

vii. Implement, at a minimum, formative and summative assessments to monitor progress and outcomes. viii. Effectively communicates and collaborates with medical and other allied health professionals.

viii. Use an appropriate biopsychosocial assessment to explore and enhance the quality of the therapeutic relationship.

c. Professional Advocacy

i. Consult with clients, the public, the media, and other professionals regarding the neurophysiological underpinnings of behavior and how the human nervous system adapts to life circumstances including traumatic brain injury, physical and sexual abuse and substance use.

ii. Remain up to date on emerging trends in mental health research (e.g., Research Domain Criteria) and practice (e.g., neurofeedback, precision psychiatry) so as to ensure that assessment, diagnosis, and interventions are continuously aligned to evidence-based treatments.

iii. Critically analyze emerging developments in mental health and social policy and engage in professional advocacy efforts to ensure that all clients have equitable access to ethical, sensitive, timely, and effective services.

iv. Partner with professional associations to offer ethical guidance and professional expertise to policy makers, the public, and colleagues from allied disciplines on emerging issues related to mental health policy.

B. Specialized Clinical Assessment

Licensed Clinical Mental Health Counselors (LCMHCs) are trained and qualified to conduct assessment and evaluation of clients' and their needs related to a plethora of dimensions in mental health functioning, not limited to the presence of symptoms and risk factors, mood, diagnostic measures for the purposes of treatment planning, intelligence, abilities, aptitude, personality, chemical dependence, impact of traumatic events on one's functioning, family structures and family dynamics, vocational and career development, and more. Graduate school standards and ongoing specific training and development prepare counselors to assess, diagnose, and provide feedback, form treatment planning goals, and anticipate future challenges or improvements. The range of assessment measures that LCMHCs utilize in clinical care are quite numerous, not limited to mental status examinations in the clinical session, clinical symptom checklists, non-structured and structured clinical interviews and observations, authenticated published assessment tools, understanding self-report, and qualitative measures.

This introduction to the standard on assessment and evaluation emphasizes three important considerations that LCMHCs should be mindful of when preparing, selecting, administering and interpreting or reporting test results. The first is a reminder to LCMHCs to be familiar with laws and ethics, with one's state of licensure, its laws and any stated limits that licensure codes assert related to the type of assessment that is legally permitted in the state within which one is licensed. State regulations, codes, and laws may evolve and change at a rate that is not synchronized with the routine updates to the *AMHCA Standards,* and so LCMHCs will want to remain informed and updated on one's legislative or licensure standards. Concomitantly, laws co-exist with a profession's codes of ethics, and LCMHCs are reminded to be fluent with the *AMHCA Code of Ethics* and its guidance on assessment and evaluation.

Secondly, as with all clinical care provided to consumers, related to all AMHCA standards, LCMHCs are urged to remain culturally sensitive in the process of selecting, administering and interpreting assessments with clients who may be members of minority groups. LCMHCs will select tests that have been normed on populations similar to the client, and consider cultural issues when interpreting assessment including primary language of the client, the use of translators, cultural bias of the test questions, and differences in performance on standardized tests among different racial/ethnic groups and by gender. Research and development of culturally sensitive assessments has been improving in recent years. However, LCMHCs are urged to remain at the forefront of best practices in assessment that respect and strive for maximal inclusivity and sensitivity to the cultural traits of diverse populations.

Finally, LCMHCs should be aware that training and scope of competence is not limited to graduate school training. For the myriad of assessment measures available on the market to assess traits important to clients' functioning, each publisher of any given measure may recommend or require its own criteria for training, certification, or approval as a competent administrator of said assessment. Some publishers may require credentials above the baseline of a graduate degree in counseling and may require training or ongoing renewal of certifications to maintain proficiency with the use of specialized assessments.

LCMHCs are encouraged to consult with AMHCA's collaborators, that is, a joint statement of *Standards for Assessment in Mental Health Counseling* that was developed collaboratively with the former Association for Assessment in Counseling and Education (AACE) and AMHCA. AACE is now the Association for Assessment and Research in Counseling (AARC). In addition to consulting this statement for updating and revising the Specialized Clinical Assessment standard, the ACPC also referred to two other position papers. The *CACREP Standards* (2016) provided a reminder of the baseline assessment and evaluation skills that counselors are trained in, and also the committee consulted an analysis by the National Board of Forensic Evaluators, *Can Licensed Mental Health Counselors Administer and Interpret Psychological Tests?* (2018). The ACPC referred to these position papers in the development of this version of the standard and gratefully acknowledge their contributions.

Clinical mental health counselors may administer and interpret psychological tests provided they receive appropriate training, which shall include the following:

1. **Knowledge**

    a. Examine the nature, meaning and purpose of assessment in counseling (including historical perspectives).

    b. Differentiate between methods of preparing for and conducting initial assessments.

    c. Understand the use of assessments for diagnostic and treatment planning purposes with developmental, behavioral, and mental disorders.

    d. Distinguish basic concepts of standardized and non-standardized testing, and other assessment techniques (e.g., norm-referenced and criterion-referenced assessments, structured and semi-structured, and qualitative procedures, etc.).

    e. Interpret and apply statistical concepts (e.g., scales of measurement, measures of central tendency, indices of variability, shapes and types of distributions, and correlations, etc.).

    f. Interpret the concept of reliability as it applies to the use in assessments (i.e., theory of measurement error, models of reliability, and the use of reliability information).

    g. Interpret the concept of validity as it applies to the use in assessments (i.e., evidence of validity, types of validity, and the relationship between reliability and validity).

    h. Understand the use of assessments relevant to personal/social development, environmental/behavioral, and personality/psychological testing.

i. Distinguish factors related to the assessment and evaluation of individuals, groups, and specific populations (e.g., aggression, suicide, trauma, individuals from diverse backgrounds, etc.).

j. Differentiate between ethical strategies for selecting, administering, and interpreting assessment and evaluation of test results.

k. Understand the intent, purpose, scoring/analysis and interpretive expectations for each utilized assessment (as defined in the assessment manual/protocol).

2. **Skills**

a. Apply effective methods to select, administer, score, analyze and interpret assessment results.

b. Select, administer, analyze and interpret test results with special attention to cultural traits of the clients, using primary language of the client appropriate use of translators, any cultural bias of test questions, differences in performance on standardized tests among different racial or ethnic group or by gender.

c. Critically evaluate assessments, identifying basic statistical concepts (such as types and acceptable levels of reliability and validity, norming methods, etc.) and obtaining instruments for mental health counseling and special populations (e.g., visually impaired, intellectual disability, mental health disability, etc.).

d. Demonstrate the ability to effectively prepare for and conduct initial assessment meetings.

e. Employ a broad spectrum of assessments, including personal/social development, environmental/behavioral, and personality/psychological instruments.

f. Utilize assessment results to develop effective treatment plan goals, objectives and interventions.

g. Provide quality client care in the explanation of assessment, informed consent and communication of results.

h. Demonstrate the ability to identify the appropriate use for assessments (e.g., the intended use of the test, promotion of greater mental health and in a manner that will cause no harm to the participant).

i. Understand the use of assessments for diagnostic and treatment planning purposes with developmental, behavioral, and mental disorders.

j. Understand the use of assessments relevant to personal/social development, environmental/behavioral, personality/psychological testing.

k. Distinguish factors related to the assessment and evaluation of individuals, groups, and specific populations (e.g., aggression, suicide, trauma, etc.).

C. Trauma-Informed Care

Many individuals seek counseling to resolve symptoms associated with traumatic or chronically distressful experiences. Those experiences may include single-episode traumatic events (such as a mugging, assault, tornado, etc.), or complex trauma (sometimes referred to as developmental trauma or poly-victimization) experienced in childhood, adolescence, or adulthood featuring chronic abuse, neglect, or exposure to other harsh adversities.

The types of traumatic or persistently distressful experiences that can result in symptoms and disorders are many. As more is learned about the causes of trauma-related symptoms, the nomenclature within a trauma-informed care approach has grown, and the descriptors for trauma are numerous. Some examples in this non-exhaustive list that are based on existing literature, research, models and methods might include betrayal trauma, domestic trauma, forced displacement trauma, historical trauma, military trauma, moral trauma, polytrauma, system induced trauma and re-traumatization, refugee and/or war zone trauma, medical trauma, toxic stress, and more. For the purposes of this standard, the terms trauma, chronic distress, toxic stress, and/or complex trauma will be used to encompass the meaning of all types and causes of trauma.

LCMHCs obtain knowledge and skills to treat clients who experience(d) traumatic events or conditions, chronic distress, and complex trauma; this preparation is essential for the practice of clinical mental health due to the high incidence of trauma and distressful events or contexts. Individuals who have the symptoms of unresolved complex trauma, chronic distress, or other traumas are at risk for a variety of emotional, cognitive, and physical illnesses that can potentially last throughout their lives. Therefore, these individuals frequently present with related co-occurring disorders, such as anxiety, depression, and substance use, and often form negative core self-beliefs. Recent research reveals that physical health later in one's life span may be compromised due to trauma. The presence of resilience is an important mitigating variable in the progression of symptoms related to traumatic experiences. Complex trauma can often compromise an individual's resilience or capacity to thrive after traumatic experiences compared to persons who survived a single-episode traumatic event such as a car accident.

It is important to note that the traumatic event is a cause of the related disorders or symptoms as contrasted with unwittingly regarding the client as the cause of the symptoms. Though the aftereffects of traumatic experiences can be very profound and experienced internally within traumatized individuals, the cause of the trauma is almost always related to external events, actions, or contexts that are outside of the individual. LCMHCs also want to note if the cause(s) of the trauma are natural (e.g., a tornado or hurricane) or human caused (e.g., domestic violence, maltreatment, terrorism). Human-caused traumas frequently create more vexing emotional repercussions. Additionally, clinicians should remain well-informed about neurological effects of chronic distress or exposure to repeated traumatic experiences which compromise a person's ability to develop effective coping measures.

All competent clinical mental health counselors possess the knowledge and skills necessary to offer trauma assessment, diagnosis, and effective treatment while utilizing techniques that emerge from evidence-based practices and best practices.

1. Knowledge

a. Recognize that the type and context of trauma has important implications for the etiology, sequelae of symptoms, diagnosis, and treatment of symptoms (e.g., ongoing sexual abuse in childhood is qualitatively different from war trauma for young adult soldiers).

b. Know how trauma-causing events may impact individuals differently in relation to social context, prior history of traumatic experiences, age, gender, sexual orientation, developmental level, culture, ethnicity, access to care, resilience, etc.

c. Understand that symptoms faced as a result of traumatic experiences can be multifaceted and therefore LCMHCs should be familiar with its many forms including relational, acute, chronic, episodic, and complex, as well as the implications for effective, evidenced-based treatment approaches.

d. Recognize the circumstances or indicators when a referral to a more qualified mental health professional who specializes in trauma is warranted. Indications that a more trauma-focused approach is needed may be related to severity, complexity, responsiveness of the client to lower-level of care, capacity of the LCMHC to provide specialized care, etc. More specialized care may be found in services such as inpatient care, trauma intensive-care, Eye Movement Desensitization Reprocessing, Trauma-Focused CBT, and other recognized evidence-based approaches.

e. Understand the impact of various types of trauma (e.g., sexual and physical abuse, war, chronic verbal/emotional abuse, neglect, natural disasters, etc.) may have on the Central Nervous System (CNS) and the Autonomic Nervous System (ANS) and how this might impact one's sense of secure attachment, affect regulation, personality functioning, self-beliefs and self-identity, self-care, etc., as well as the potential for trauma-related re-enactment in relationships.

f. Recognize the long-term consequences of trauma-causing events on social groups, communities, and cultures, including the incidence of collective trauma, generationally-transmitted and "historical" trauma. LCMHCs may serve communities and assist with the impact of collective trauma in a variety of formats or settings, such as with families, agencies and organizations, municipalities, multisystemic collaborations, etc., through various modalities such as psychoeducation, consultation, information provision with the media, follow-up initiatives, preventative initiatives, etc.

g. Understand how promoting and developing resiliency and other protective factors for individuals, groups, and communities can diminish the risk and impact of trauma related disorders.

h. Recognize differential strategies and approaches necessary to work with children, adolescents, adults, couples, and families in trauma treatment.

i. Recognize, from an organizational or management perspective, the need to design, train, and implement trauma-informed care policies and practices for a systemically responsive approach to serving clients impacted by traumatic experiences (e.g., train the Security Guards who work in a domestic violence shelter how to carry out their duties with trauma-informed awareness).

j. Understand familiarity with trauma stewardship and effective practices for self-care, as well as strategies to protect from secondary or vicarious traumatization.

k. Understand the indicators or target outcomes of effective and enduring trauma resolution (e.g., the integration of traumatic memory into the client's regular memory, traumatic event recall without debilitating emotional distress, individual generalized affect regulation, the alleviation of traumatic triggers, post-traumatic growth, etc.).

l. Understand the well-timed exploration of the potential for and themes for post-traumatic growth (PTG) among traumatized clients after effective counseling and symptom reduction. LCMHCs may assist clients to discover ways in which a survivor may change for the positive (e.g., changes in one's sense of priorities, a greater appreciation of life, a deepened sense of personal strength, more meaningful relationships, a sense of new possibilities for oneself, developing views and philosophy about life, and/or the meaning of suffering, perspective, or a strengthened belief system).

2. **Skills**

    a. Demonstrate the ability to use evidence-based assessment measures to evaluate and differentiate the clinical impact of various trauma-causing events, not limited to evaluation measures/resources focused on early life trauma and distress, such as the Adverse Childhood Experiences Survey, along with the many other trauma assessment tools available for type-of-trauma measures throughout the life span.

    b. Demonstrate the ability to apply established counseling theories that are evidence-based or best trauma resolution practices. Best practices promote the integration of brain functioning and resolution of cognitive, emotional, sensory, and behavioral symptoms related to trauma-causing events for socially and culturally diverse clients across the life span.

    c. Demonstrate sensitivity to individual and psychosocial factors that interact with trauma-causing events in counseling and treatment planning.

    d. Demonstrate familiarity with trauma stewardship and effective practices for self-care, and for protection from secondary or vicarious traumatization.

    e. Demonstrate the ability to recognize that any of the clinical mental health counselor's traumatic experiences may impact his or her trauma-surviving-clients and the counseling process. LCMHCs should seek appropriate trauma resolution counseling and/or consultation as necessary.

    f. Apply age-appropriate strategies and approaches in assessing and counseling children and adolescents and modify these techniques when working with adults.

    g. Use differentially appropriate counseling and other treatment interventions in the treatment of couples who encounter re-enactment trauma, trauma of a partner, or secondary trauma from traumatized family members.

    h. Demonstrate the ability to advocate with payors of counseling fees (e.g., insurance companies, treatment centers, etc.) by monitoring diagnosis and treatment needs with utilization review of sessions allotment. Clinicians may have to advocate rigorously for the client with the payor of counseling fees and itemize thoroughly all diagnosed comorbid disorders while also assuring the client about the differences of "what's wrong with me" vs. "what happened to me."

    i. Demonstrate how to comprehensively assess the degree of trauma resolution as a measure of client recovery as well as an indicator of therapeutic efficacy. LCMHCs should monitor ongoing clinical progress toward target outcomes, using assessment measures, and client self-report to ensure that mutual counselor/client termination of care (contrasted with premature cessation of counseling by either party) yields healthy and positive outcomes.

    j. Demonstrate the ability to facilitate the development of clients' sense of safety and resilience.

    k. Provide assessment and guidance with a traumatized client related to post-traumatic growth (PTG) in a clinically time sensitive manner (after symptom reduction) to explore possible avenues for the client to discover personal changes or qualities within oneself, in relationships, or in belief systems and meaning-making that may have emerged from the traumatic experience(s) and its impact on self.

D. Substance Use Disorders and Co-occurring Disorders

Substance use disorders (SUDs) are commonly comorbid with other mental health disorders. In other words, individuals with substance use often have a mental health condition concurrently. For example, having Post-Traumatic Stress Disorder (PTSD) is frequently a significant contributing factor to the development of a substance use disorder. Many experts acknowledge that one mental health diagnosis can result in a substance use disorder, and also, it is possible for a substance use disorder to cause mental health disorders or other illnesses. Failure to address both the mental health disorder or other illnesses as well as the substance-related disorder can result in ineffective and incomplete treatment, stabilization, or recovery.

There can be are many consequences of undiagnosed, untreated, or undertreated comorbid disorders including a higher potential for homelessness, incarceration, medical illnesses, suicide, danger to others, and premature death, to name a few. It is incumbent on LCMHCs to apply thorough and comprehensive assessment and treatment for co-occurring disorders to prevent such neglect, harm, and possible death. The knowledge and skills recommendations below are a guide to effective practice when working with clients affected by SUDs and co-occurring disorders.

1. **Knowledge**

   a. Understand the epidemiology (incidence, distribution, and control) of substance use and co-occurring disorders for socially and culturally diverse populations at risk across the life span.

   b. Understand theories and models about the etiology of substance use and co-occurring disorders including risk and resiliency factors for individuals, groups, and communities. Explanations for the development of SUDs are multiple, including:

      i. Psychological Models (behavioral, learning, cognitive, psychoanalytic, personality, social learning)

      ii. Multi-Causal Models (biopsychosocial, syndrome, integral)

      iii. Biological/Physiological Models (disease, genetic predisposition, co-occurring)

      iv. Educational/Knowledge Models (educational, public health, developmental)

      v. Psychosocial Model (peer-cluster, problem behavior)

      vi. Sociocultural Models (sociocultural, culture-specific, prescriptive, sanctioned-use)

      vii. Family Models (general systems, parental influence)

      viii. Lifestyle/Coping Models (stress-coping, lifestyle, spiritual)

      ix. Progression Models (gateway, final common pathway)

      x. Choice/Moral Models

      Additionally, LCMHCs should become familiar with "abstinence-focused" and "harm reduction-focused" views of and approaches for understanding and treating substance use.

   c. Possess a working knowledge of the neurological and biological aspects of SUDs, both related to the causes and treatment implications for SUDs.

   d. Possess a working knowledge of SUDs including drug types, routes of administration, drug distribution, elimination, dependence, tolerance, withdrawal, dose response interaction, and how to interpret basic lab results.

e. Recognize the capacity for substance use to present as one of a range of psychological or medical disorders, to cause such disorders, and understand effective assessment and differential diagnosis among SUDs and other diagnoses.

f. Understand treatment and clinical management of SUDs with the presence of co-occurring mental health disorders with an emphasis on best practices, risk management and prioritization of clinical goals, medication management, and theory/method/ approach match for each condition (such as cognitive behavioral, trauma-focused, dialectical behavioral, etc.).

g. Possess a working knowledge of how prevention, treatment, aftercare, and recovery policies and programs function.

h. Understand the working definition of recovery and recovery-oriented systems of care for mental illness and SUDs with familiarity and promotion of recovery support strategic initiatives that focus on health (physical and emotional well-being), home (stable, safe living arrangements), purpose (meaningful daily activities to participate in society), and community (social relationships involving support, friendship, love and hope).

i. Possess a working knowledge of the 10 guiding principles for recovery from mental illness and SUDs (hope, person driven, many pathways, holistic, peer support, relational, culturally based, addresses trauma, strengths and responsibility, and respect).

j. Possess a working knowledge of recovery support tools and resources that include peer support programs or models that demonstrate peer-navigators' competencies, decision-making tools, use of narratives and stories, parents and families, communities and social resources, and other training tools.

k. Study the rapidly developing facts and emerging community and clinical responses related to the widespread abuse of opioid and other prescription drugs, along with initiatives and response strategies, such as the evidenced-based publications from researchers, experts, foundations, and advocacy groups.

l. Understand which medications and psychopharmacological treatments may be effective for the treatment of alcohol use disorder, and abuse of opioid and other prescription drugs, as well as pharmacological treatments of other co-morbid conditions (such as mood and anxiety disorders, etc.).

m. Understand the current history, philosophy, and trends in substance use counseling, including treatments that incorporate:

   i. Stages of change

   ii. Motivational interviewing

   iii. Self-help, spiritual, and secular groups and communities (not limited to 12-step groups, Self-Management and Recovery Training [SMART], Secular Organizations for Sobriety [SOS], Refuge Recovery, Life Ring Secular Recovery, Moderation Management, Celebrate Recovery, etc.)

   iv. Medication-assisted treatment in conjunction with clinical mental health counseling

n. Understand the application of existing therapeutic approaches and counseling techniques empirically-validated for addictions counseling, such as Motivational Interviewing, Cognitive Behavioral, Contingency Management, Motivational Enhancement Therapy, Life Skills Training, Acceptance and Commitment Therapy, Dialectical Behavioral Therapy, Functional Analytic Therapy, Mindfulness Based Cognitive Behavioral Therapy, etc.

o. Understand ethical and legal implications related to counseling practice for substance use disorders and cooccurring disorders in diverse settings, particularly, including familiarity with the

co-occurrence of legal problems with SUDs. LCMHCs should be familiar with addiction-oriented treatment options for legal difficulties, inpatient or outpatient units, partial or day programs, recovery houses or sober living communities. LCMHCs are advised to be aware of criminal justice system options, with attention to community "mental health courts" or "drug courts" that encourage alternative sentencing as a treatment strategy in lieu of incarceration and should be familiar with Title 42 Code of Federal Regulations (42 CFR) when working with individuals who have protection under this code.

2. **Skills**

   a. Demonstrate the ability to effectively assess and screen for unhealthy substance use such as but not limited to alcohol, marijuana, tobacco, and other licit and illicit drugs, that relies on validated screening and assessment procedures, including recommendations for placement criteria.

   b. Demonstrate the ability to gauge the severity of clients' cooccurring disorders and to assess their stage of readiness for change.

   c. Demonstrate the ability to provide brief interventions and counseling, care management, for unhealthy alcohol, tobacco, prescription drug and opioid use disorders.

   d. Conceptualize cases and develop treatment plans based on stages of change that address mental health and substance use disorders simultaneously.

   e. Demonstrate skills in applying motivational enhancement strategies to engage clients.

   f. Provide appropriate counseling strategies when working with clients who have co-occurring disorders while first prioritizing symptom reduction or symptom management in order of most dangerous (if left untreated) to client or others.

   g. Demonstrate the ability to provide counseling and education about substance use disorders, and mental/emotional disorders to families and others who are affected by clients with cooccurring disorders, including incorporating systemically oriented family counseling into treatment planning and/or providing appropriate referrals.

   h. Demonstrate the ability to modify counseling systems, theories, techniques, and interventions for socially and culturally diverse clients with co-occurring disorders across the life span that are consistent with evidence-based best practices.

   i. Demonstrate the ability to recognize one's own limitations when treating co-occurring disorders and to seek collaboration, consultation, training, supervision appropriately, and/or one's own therapy, or refer clients as needed.

   j. Demonstrate the ability to apply and adhere to ethical and legal standards in substance use disorders and co-occurring disorder counseling. This includes competence related to assisting clients who navigate the legal implications of SUDs and systems such as drug courts, mental health courts, legal case management, court-recommended treatment, incarceration and sentencing trends, 42 CFR, etc.

   k. Broaden counseling and therapy skills to provide multiple modalities of counseling-related functions not limited to psychoeducation and client education, case management, multisystem collaboration (for example, with "Drug Courts," housing, women and infant care resources, group counseling and support group provisioning, sober living and independent living resourcing, etc.).

E. Technology Supported Counseling and Communications (TSCC)

Technology supported counseling and communications (TSCC) has been described as tele-mental health or telehealth, e-health, telecare, distance counseling, virtual counseling, etc. It is an intentionally broad term referring to the provision of mental health services from a distance to clients through the use of technology. TSCC occurs when the counselor and the client are in two different physical locations. TSCC also refers to the use of technology to support the administration or non-clinical management of counseling services, often related to communications, practice/agency software and portals, and social media.

The mental health profession is swiftly adapting to the use of advanced communication technologies for not only the delivery of care and mental health services, but also for supporting the provision of services administratively such as making or confirming appointments, record-keeping, billing and collecting fees, etc. By using advanced communication technologies, Licensed Clinical Mental Health Counselors (LCMHCs) are able to widen their reach to clients in a cost-effective manner, making available services to clients in many geographic areas, ameliorating the mal-distribution of general and specialty care, while increasing services for persons who otherwise might have found counseling to have been inaccessible for a variety of reasons. The establishment of clear TSCC guidelines for counselors and clients improves clinical outcomes while promoting informed consent and reasonable client expectations.

This section provides guidance on clinical, technical, administrative and ethical issues related to electronic counseling and communication between LCMHCs and clients using advances in TSCC. Counseling may be provided synchronously via audio/video or virtual conferencing, by voice telephonically, or with synchronous chat, text, or SMS medium, or asynchronously through email. Communications used to support the provision of counseling services may include counseling practice software, portals, and data management options for record-keeping including but not limited to "cloud" storage options, appointment management, and the billing and collecting of fees.

The standard emphasizes two of the more important dynamics related to technology supported counseling and communications: 1) safety, risk prevention, and risk management for clients who may be more vulnerable when receiving counseling via technology, and 2) protection of identity and confidentiality. These guidelines also serve as a companion to *AMHCA's Code of Ethics*, specifically its section on Technology Supported Counseling and Communications.

Additionally, since each state may have variable laws and regulations related to technology and mental health service delivery, LCMHCs are urged to be familiar with the legal guidance in their respective states and plan to provide counseling to clients who have residence where the LCMHC is licensed. For example, state regulations have varying rules related to whether or not the LCMHC or the client has to be in the same state geographically simultaneously at the time of the service, whereas other states may allow bi-state or two locations as long as the client is a resident of the state or territory wherein the LCMHC is credentialed.

The following will review Knowledge and Skill digital competencies for both the counseling functions and the communications functions.

As a final note, AMHCA's Advancement for Clinical Practice Committee has asserted the need and expectation that this particular standard will be reviewed and updated more frequently than other standards that come up for review on a regular rotation, due to the rapid emergence of knowledge, software, application, products, and best practices related to technology supported counseling and communication.

1. **Knowledge**

   a. Counseling

      i. Recognize that training and certification are recommended prerequisites to provide ethical and clinical counseling services using technology. LCMHCs should familiarize themselves with the training and certification options. They should prepare to obtain and update valid proficiency to provide TSCC. Fifteen hours of course instruction is recommended as a minimum.

      ii. Possess a strong working knowledge of TSCC, which includes:

         a) Synchronous modalities (telephone, audio/videoconferencing [or virtual conferencing], text/chat/SMS-based)

         b) Non-synchronous modalities (e-mail)

      iii. Prior to providing services to a client, understand the elements involved in conducting a fitness-for-technology-supported counseling risk assessment.

      iv. Know how to partner with counseling resources near the client.

      v. Know that, whenever possible, LCMHCs will meet in a face-to-face session to assess client needs prior to utilizing TSCC. Whether a first appointment is face-to-face or technologically supported, a fitness-for-technology-supported counseling risk assessment will still be conducted prior to providing mental health counseling.

      vi. Demonstrate understanding of best practices of service delivery described in the empirical literature and professional standards—including multicultural considerations—relevant to the TSCC service modality being offered not limited to the clients' technological and other abilities to engage in TSCC, communication mores and technology-specific language use, along with abilities or symptoms that may preclude or impede face-to-face counseling services.

      vii. Understand all aspects of informed consent and the procurement of prospective and current clients' informed consent related to the risks and benefits of TSCC, the collaborative selection process of choosing a modality, and agreement between client and TSCC counselor about how the technology will be used or not used in the provision of services.

      viii. Recognize the need to communicate clearly and to obtain written informed consent for all TSCC modalities utilized, understand how to adhere to all ethical and legal guidelines for counseling (especially those germane not only to the profession but also to one's respective state laws and codes), and provide informed consent related to confidentiality specifically with TSCC, encryption, availability, determination of emergency intervention measures if needed, etc.

      ix. Understand that TSCC is changing rapidly and anticipate that new modalities of communication with clients will continuously emerge and require clinical, ethical and legal guidance and/or training and even possibly renewed certification.

      x. Understand and comply with one's respective state laws governing or relating to TSCC which may include the following considerations:

      xi. Understand and recognize scope of practice and jurisdiction matters related to many state laws which commonly require that mental health professionals be licensed in the state in which a client is receiving or residing counseling.

xii. LCMHCs who regularly provide mental health counseling across state borders should be fully compliant with all applicable state laws where the client resides and have prior approval from the client's state's board of examiners in counseling to provide said services. Prior familiarity with other states geographic rules is essential, for example, to determine if regulations expect that both the client and the LCMHC be in the same state simultaneously with the provision of the service.

xiii. Become knowledgeable with protocols when circumstances may require special ethical and clinical consideration be afforded to clients in unique situations for short term counseling service and continuity of care. In the event that clients who generally reside in a state where the LCMHC is licensed, but who will be away from their residence, LCMHCs will assure continuity of care while also seeking provisions to either refer or obtain permission from a distant state's or country's regulatory body in examples when:

    a) Individuals who temporarily travel out of their state for business, personal, or other purposes need to receive services from their LCMHCs.

    b) Individuals who relocate to another state who require continuing care until they have obtained the services of a new LCMHC/mental health professional if the current practitioner is not licensed in the client's new state of residence.

    c) Individuals who are relocating to another country where psychotherapy services may not be available, and who may warrant continuing treatment.

    d) Familiarity with the "other" state's or country's provisions for a "grace period" and for how long that period permits service provision or if the state issues a longer-term distance counseling license expressly for that LCMHC and client to work together.

xiv. LCMHCs will provide timely and ample informed consent to clients who change residences or locations about the need for referral if distance counseling is not possible with the existing credentials of or authorizations extended to the LCMHC.

xv. Stay up to date with relevant changes to laws and continuously consult with ethical and legal experts about ongoing developments and trends in the confidential, safe, and therapeutic dynamics related to distance counseling.

xvi. Have a working knowledge of how TSCC adheres to policies within the Americans With Disabilities Act (ADA). LCMHCs will seek ways to make appropriate accommodations, provided that the client or prospective client is not in risk and is assessed for "fitness for distance counseling."

xvii. Know that provisions for emergency intervention will include, as a priority when possible, face-to-face counseling or the provision of a geographically accessible (to the client) LCMHC or other mental health provider, with the inclusion of the TSCC counselor as part of a comprehensive care management plan. The TSCC-LCMHC will have identified and established geographically nearby (to the client) emergency response resources such as known agencies and options prior to beginning counseling if there arises an emergency or threat of harm or danger to self of others. Some examples (non-exhaustive here) may include direct 9-1-1 phone lines in specific localities, fire and first responder agencies, emergency rooms and hospitals, domestic violence shelters, and local crisis response services. The LCMHC will have established, prior to beginning counseling, the client's safe therapy partner with contact information so that the partner can be engaged in emergency situations with immediacy.

xviii. Recognize that synchronous or live communication counseling modalities compared to non-synchronous communication are generally easier to monitor a client's safety and therefore is recommended or preferred in the interest of quality assurance and safety of

the client when crisis or emergent situations seem imminent, are unfolding or require active intervention.

xix. Recognize the importance of retaining records and copies of all correspondence in regard to text-based communications and related electronic information (including emails, text messages, written correspondence, etc.) in a manner that protects privacy and meets the standards of HIPAA regulations and the Health Information Technology for Economic and Clinical Health Act (HITECH Act).

xx. Know that confidential and privileged communications using text-based communication TSCC should be encrypted securely whenever possible.

b. Communications

i. Understand the importance of maintaining boundaries in the use of social media which should be continuously monitored and updated, including privacy settings in all social media. LCMHCs should differentiate personal and professional forms of social media and keep these separate, including maintaining personal account names that are unlikely to be identified or known by clients.

ii. All informed consent materials along with disclaimers on the LCMHC's social media, such as but not limited to Facebook, Twitter, Instagram, Linked In, etc., will clarify exactly how a client will appropriately and securely contact the LCMHC in ways other than through social media, and also explain that social media is not a means through which personal information can be or will be shared. Further, the LCMHC does not provide direct care and response through social media and clients should be instructed clearly in both informed consent forms and prominently on social media sites to not rely or expect this.

iii. LCMHCs will refrain from searching for or obtaining information about clients via the clients' identities in the internet and will not search or study clients' narratives via any social media options, unless the client has specifically directed the LCMHC to do so for a specific therapeutic purpose with proper documentation, and within a certain timeline.

iv. LCMHCs will understand that they should not solicit from clients their feedback for social media sites or other published media in order to promote or authenticate the LCMHC's performance or services. Additionally, clients should be pre-informed that if the client offers feedback about their LCMHC, there will be no response from the LCMHC, and that confidentiality may be compromised if the client posts such feedback.

2. **Skills**

a. General

i. Demonstrate proficiency with technological modalities being used such as synchronous modalities (e.g., video-conferencing or virtual conferencing) and non-synchronous modalities (e.g., texting, emailing).

ii. Demonstrate digital competence and the ability to anticipate and adapt to emerging technologies and adopt those techniques to address the needs of clients to enhance quality of care to them. Conversely, the LCMHC will discuss appropriate options for the client if or when TSCC becomes counter-therapeutic.

iii. Possess the ability to carefully examine and to assess for the unique benefits of delivering TSCC services (e.g., access to care, adaptive technology for differing abilities, etc.) relative to the unique risks (e.g., safety of client, information security, therapeutic alliance, etc.) when determining whether or not to offer TSCC services.

iv. Continually communicate any risks and benefits of the TSCC services to the client, and document such communication, preferably during in-person contact with the client, and facilitate an active discussion on these issues when conducting screening for fitness for distance counseling, intake, and initial assessment.

b. Assessment

i. Demonstrate digital competence in assessing the appropriateness of the TSCC services to be provided for the client. Assessment may include:

a) The examination of the potential risks and benefits of TSCC services for clients' particular needs;

b) A review of the most appropriate medium (e.g., video teleconference, text, email, etc.);

c) The client's situation/locality within the home or within an organizational context;

ii. Prepare for service delivery options (for example, if in-person services are ever available);

a) The availability of geographically near crisis or emergency, or technical personnel or supports;

b) The multicultural, ability level, legal, clinical and ethical issues that may impact the client's safety or therapeutic conditions;

c) Risk of distractions or possible technological limitations or failures in session related to reception, connectivity, band width, streaming, power sources, etc.;

d) Potential for privacy breaches and subsequent protective measures; and

e) Other impediments that may impact the effective delivery of TSCC services.

iii. Demonstrate the ability to monitor and engage in the continual assessment of the client's progress when offering TSCC services to determine if the provision of services is appropriate and beneficial to the client while anticipating and providing other therapeutic supports if needed.

c. Emergency Considerations:

i. Demonstrate reasonable efforts, at the onset of service, to identify and learn how to access relevant and appropriate emergency resources in the client's local area. These should include:

a) Emergency response contacts,

b) Emergency telephone numbers,

c) Hospital admissions and/or emergency department,

d) Local referral resources,

e) Client-safety advocate (clinical champion) at a partner clinic where services are delivered, and

f) Other support individuals such as a trusted family member, friend, or ally in the client's life when available.

ii. Establish clear and specific instructions that is provided to all clients for what to do in an emergency.

d. Multicultural Considerations

    i. Demonstrate an understanding of specific issues that may arise with diverse populations that could impact assessment when providing or considering TSCC. LCMHCs should make appropriate arrangements to address those concerns including but not limited to language or cultural issues; cognitive, physical or sensory skills or impairments; transportation needs; rural resident needs; elderly considerations and needs for appropriate adaptive technology.

e. Special Needs

    i. Demonstrate reasonable skill in accepting and addressing special needs of clients in adhering to appropriate ADA provisions.

    ii. Make appropriate arrangements for individuals with differing abilities to accommodate special needs, for example, such related to sight and hearing impairments.

f. Communications

    i. LCMHCs should explore and install all available technologically advanced features for telephone, computer, and devices such as laptop and tablet services that ensure encryption and which safeguard the identity and confidentiality of a clients' communications and records with the LCMHC for both counseling and general administrative communications (e.g., setting up appointments, billing and collecting fees, etc.). These features may include practice management software, documentation of sessions, billing, appointment management, texting, or emailing communication, etc.

    ii. The Social Media Policy will contain clearly stated instructions for the LCMHC's preferred methods of contact, including:

        a) LCMHCs will instruct clients that the LCMHC's professional social media sites will not be a venue for direct contact, and that clients' posts may be a breach of their confidentiality.

        b) LCMHCs will maintain their own personal social media with identity and monikers distinctly different from their professional social media sites.

    iii. LCMHCs will develop a Social Media Policy (SMP) that will be included with, shared, explained, and updated in the informed consent process. Some elements of the SMP should include but may not be limited to the following:

        a) *Friending:* The LCMHC addresses the concept of "friending" and explains that they will not be able to accept friend requests or issue friend requests via social media apps.

        b) *Liking or Following:* Similarly, the SMP defines clients' "Liking" or "Following" and that they present threats to the client's confidentiality, while also explaining that the LCMHC may delete clients' posts at their discretion.

        c) *Texting or Messaging:* The LCMHC will use encrypted texting apps if texting is formally considered to be a way for the client and clinician to communicate.

        d) *Emails:* Emailing will be done only with encrypted protection, and if it is a formally accepted and stated way to communicate. Otherwise, emails will be limited and used with discretion.

        e) *Search Engines:* Using search engines and researching clients' online thumbprint or identity will be prohibited unless at the specific and documented request of the client for a specific therapeutic reason and duration.

  f) *Business Site Reviews:* Clarify the implications if the client uses business review sites to rank or provide feedback about the LCMHC and their services, that the LCMHC may not see this feedback, and will not be able to provide a response to it outside of the counseling session. The LCMHC will refrain from requesting clients to provide reviews.

  g) *Location-Based Services:* Encourage the client to disable Location-Based Services (LBS) which may signal to the client's social media followers that they are visiting a counseling agency address.

 iv. Emphasize that LCMHCs will refrain from using social media to conduct counseling or communications with clients and instruct clients clearly that social media cannot be a way to get in contact with the LCMHC.

F. Integrated Behavioral Health Care Counseling

The integration of clinical mental health counseling with primary care and other medical services is required to achieve better patient health outcomes. Integrated systems of medical and behavioral care are comprehensive, coordinated, multidisciplinary, and co-located through the latest technologies. Clinical mental health counselors must continually increase their knowledge and skills to participate in these emerging practices and systems through the use of evidence-based treatment approaches. In order to stress the vital importance of integrated behavioral health counseling, please see the AMHCA white paper entitled Behavioral Health Counseling in Health Care Integration Practices and Health Care Systems.

Integrated health care is the systematic coordination of behavioral health care with primary care medical services. Episodic and point-of-service treatment which has not included behavioral health care has proven to be ineffective, inefficient, and costly for chronic behavioral and medical illnesses. By contrast, the integrated behavioral health care assessment and treatment of patient psychiatric disorders strongly correlates with positive medical health outcomes. For example, many gastro-intestinal health outcomes rely on the effective treatment of anxiety disorders. By employing all-inclusive behavioral health interventions, skilled LCMHCs assist patients to realize optimal human functioning as they alleviate emotional and mental distress.

LCMHCs have the ethical responsibility to possess the training and experience to promote health from their unique perspective of prevention, wellness, and personal growth. They must be able to work as members of multidisciplinary treatment teams and provide holistic behavioral health interventions. Integrated care models hold the promise of addressing many of the challenges facing our health care system. LCMHCs as "primary care providers" are invaluable in developing innovations in integrated public health. These knowledgeable and skilled LCMHCs will be prepared to dramatically reduce the high rates of morbidity and mortality experienced by Americans with mental illness.

1. Knowledge

 a. Understand the anatomy and physiology of the brain with particular relevance to mental health.

 b. Gain a working understanding of the most common medical risks and illnesses confronted by patients (e.g., obesity related diseases, substance use disorder related diseases, cardiovascular disease, cancer, diabetes, COPD, etc.)

 c. Understand the processes of stress which relate to impaired immune systems as well as its affects regarding depression and anxiety.

 d. Understand the correlation of trauma, chronic distress, and anxiety with medical health issues, medical diagnoses, medical treatment, and recovery (e.g., post-surgical trauma).

e. Understand how to triage patients with severe or high-risk behavioral problems to other community resources for specialty mental health services.

f. Understand and address stressors which lead individuals to seek medical care.

g. Understand primary (preventing disease) and secondary (coping and ameliorating symptoms) prevention interventions for patients at risk for or with medical and mental health disorders.

h. Understand and conduct depression, anxiety, and mental health assessments.

i. Understand and provide cognitive-behavioral interventions.

j. Understand and assist clients to cope with the medical conditions for which they are receiving medical attention.

k. Understand and operate in a consultative role within primary care team.

l. Understand and provide recommendations regarding behavioral interventions to referring medical providers.

m. Understand and conduct brief interventions with referred patients on behalf of referring medical providers.

n. Understand the importance of being available for initial patient consultations.

o. Understand the importance of maintaining a visible presence with medical providers during clinic operating hours.

p. Understand and provide a range of services including screening for common conditions, assessments, including risk assessments, and interventions related to chronic disease management programs.

q. Understand and assist in the development of behavioral health interventions (e.g., clinical pathway programs, educational classes, and behavior focused practice protocols).

r. Understand medical concepts needed to effectively function on an integrated health team including these topics and others:

    i. Medical literacy

    ii. Population screening

    iii. Chronic disease management

    iv. Educating medical staff about integrated care

    v. Group interventions

    vi. Evidence-based interventions (See the AMHCA Practice Guideline entitled *Behavioral Health Counseling in Health Care Integration Practices and Health Care System*s)

s. Understand the basic knowledge about key health behaviors and physical health indicators (e.g., normal, risk, and disease level blood chemistry measures) that are routinely assessed and addressed in an integrated system of care, including but not limited to:

    i. Body mass index

    ii. Blood pressure

    iii. Glucose levels

    iv. Lipid levels

v.   Smoking effect on respiration (e.g., carbon monoxide levels)

vi.   Exercise habits

vii.   Nutritional habits

viii.   Substance use frequency (where applicable)

ix.   Alcohol use (where applicable)

x.   Subjective report of physical discomfort, pain or general complaints

t.   Understand psychopharmacological treatment of mental health disorders.

2. Skills

a.   Demonstrate the ability to understand the dynamics of human development to capture good psychosocial histories of patients.

b.   Diagnose and treat for behavioral pathology.

c.   Provide evidenced-based psychotherapy practices to provide credible treatment to patients.

d.   When appropriate, facilitate and oversee referrals to specialty mental health providers and primary care providers.

e.   Support collaboration of primary care providers with psychiatrists or other prescribing professionals concerning medication protocols.

f.   Monitor psychopharmacological treatment of mental health disorders.

g.   Apply motivational interviewing skills.

h.   Demonstrate consultation liaison skills with other primary care providers.

i.   Provide teaching skills and impart information based on the principles of adult education.

j.   Provide comprehensive integrated screening and assessment skills.

k.   Provide brief behavioral health and substance use intervention and referral skills. Coordinate the treatment of trauma, chronic distress, and anxiety with medical health issues, medical diagnoses, medical treatment, and recovery (e.g., post-surgical trauma).

l.   Provide triage for patients with severe or high-risk behavioral problems to other community resources for specialty mental health services.

m.   Identify and address stressors which lead individuals to seek medical care.

n.   Provide comprehensive care coordination skills.

o.   Provide health promotion, wellness, and whole-health self-management skills in individual and group modalities.

p.   Apply brief interventions using abbreviated evidence-based treatment strategies including, but not limited to:

i.   Solution-focused therapy

ii.   Behavioral activation

iii.   Cognitive behavioral therapy

iv.   Motivational interviewing

q. Employ behavioral health care techniques to address the needs of geriatric population to address their chronic health issues, disabilities, and deteriorating cognitive needs.

r. Treat the full spectrum of behavioral health needs, which minimally include:

   i. Common mental health conditions (depression, anxiety)

   ii. Lifestyle behaviors (self-care, social engagement, relaxation, sleep hygiene, diet, exercise, etc.)

   iii. Substance use disorders

s. Coordinate overall patient care in coordination with the treatment team, including:

   i. Reinforce care plan with other primary care providers

   ii. Summarize goals and next steps with patient

t. Lead group sessions for patients (e.g., pain groups, diabetes management, etc.).

u. Provide concise information to the primary care team verbally, through EHR notes, and other appropriate communication channels.

G. Child and Adolescent Counseling Standards and Competencies

An estimated one in five youth struggles with mental health challenges. Like adults, children and adolescents struggle with mental disorders that include anxiety, depression, obsessive-compulsive disorder, and post-traumatic stress. Children and adolescents often present different symptomatic presentations of these disorders compared with adults, requiring specialized knowledge of diagnosis and treatment. Several notable neurodevelopmental conditions emerge during early childhood, including autism and spectrum disorders and attention-deficit/ hyperactivity disorder. Late adolescence is also the time when major mental disorders such as bipolar disorder and schizophrenia develop, with prodromal symptoms often appearing earlier in adolescence. The teenage years are a time of experimentation, identity formation and exploration that can have lasting implications throughout the life span (e.g., risk-taking related injuries, substance use and experimentation, sexual experiences, and possible pregnancy).

Licensed Clinical Mental Health Counselors (LCMHCs) can provide more effective services to youth after obtaining knowledge and skill in assessing, diagnosing, and treating these conditions during childhood and adolescence while also remaining informed about developmental neurodevelopmental conditions and other issues that occur during the process of child development.

Treatment approaches to counseling youth can vary substantially, depending on their developmental level and age. For example, younger children do not have the capacity for higher-order cognition and are more likely to benefit from play therapy, and interventions that address parent-child interaction. Mentalization abilities, sometimes referred to as metacognition and theory of mind, develop during adolescence, and this new ability to "think about thinking" provides foundational ability for talk therapy approaches such as cognitive-behavioral therapies, among others.

Early intervention has the potential to improve prognosis of mental disorders over the course of the life span. For example, early behavioral intervention for children with autism spectrum disorders at 2 or 3 years of age can have a greater impact on the acquisition of social skills and language development compared with later remediation. Early intervention with many disorders often yields better prognosis over time.

Family involvement is often a crucial component of treatment for children and adolescents with mental health struggles. Working with parents/guardians to address family dynamics and interactions through family counseling can often facilitate sustained treatment gains and prevent recurrent episodes of

symptoms. LCMHCs also need to understand minors' rights in the state that they currently reside, pertinent to the age of consent for adolescents, and parent/guardian rights to see the treatment record. Knowledge and skills pertinent to assessing for child abuse and neglect are also crucial.

LCMHCs working with children and adolescents require specialized culturally competent knowledge and skills pertinent to the inter-related domains of development--cognitive, neurological, physical, sexual, and social development. Additionally, LCMHCs need to understand the educational and academic requirements of P–12 education, the rights and responsibilities of students in their educational systems, the impact of mental health challenges on academic achievement and vice-versa, and study skills required to enhance academic achievement. LCMHCs also need specialized knowledge and skills in working with family systems that support and promote child and adolescent development. An understanding of social influence from peer relationships is also important, particularly during adolescence.

1. **Knowledge**

   LCMHCs must demonstrate knowledge of the following subject areas specific to working with children and adolescents:

   a. Neurophysiological Development

      i. Understand postnatal and infant mental health.

      ii. Understand developmental milestones, transitions, and life span theories relating to children and adolescents.

      iii. Understand neurological brain development during childhood and adolescence, and its impact on executive functioning and decision-making.

      iv. Understand physical and sexual development during childhood and adolescence.

      v. Understand the development of sexual/affective orientation, including the exploration and questioning of sexual and gender identity.

   b. Social, Cultural, and Familial Influences

      i. Understand the role of gender and gender identity on development, including the influence of gender role socialization practices.

      ii. Appreciate sociocultural differences among children and adolescents, including race/ethnicity, acculturation level, family background, and culturally relevant strategies to promote resilience and wellness.

      iii. Understand socioeconomic influences on development, including the impact of poverty, homelessness, and displacement.

      iv. Understand social support system in childhood and adolescence, including family, peer, community, and school-based supports.

      v. Understand the impact of bullying experiences and stigma.

      vi. Understand family relationships, including parent-child relationships, sibling relationships, relationships with extended family, and the impact of domestic violence.

      vii. Understand family events that can generate distress in childhood and adolescence, including parental divorce, and transitions such as stepfamily integration.

      viii. Understand technology and social media use among children and adolescents, including healthy limits with mobile technology use, internet safety, cyber bullying, and appropriate parent/guardian involvement.

  ix. Understand risk factors for externalizing problems such as school truancy, peer influence, substance use, high risk behavior, gang involvement.

 c. Diagnosis and Treatment Planning

  i. Understand risk factors for internalizing problems such as adjustment problems, anxiety, and depression.

  ii. Understand pre-morbid factors associated with the development of severe and persistent mental disorders such as schizophrenia and bipolar disorder.

  iii. Understand behaviors associated with neurodevelopmental disorders that include autism, particularly during crucial early developmental period (< 3 years of age).

  iv. Understand differential diagnosis for mental disorders that can have similar presentations in children, such as anxiety and attention-deficit/hyperactivity disorders.

  v. Understand risk factors for suicide attempts by children and adolescents, and differentiating suicidal from non-suicidal self-injury.

  vi. Recognize when referrals are needed for evaluation by a psycho-pharmacologist.

  vii. Recognize how psychopharmacological medication prescribing may differ between children/adolescents and adults, such as dosing.

  viii. Recognize when consulting with school-based professionals is indicated to inform the treatment process when counseling children and adolescents, including school counselors, psychologists, social workers, teachers, and other school-based mental health professionals.

  ix. Understand specialized personality, psychopathology, intelligence, and aptitude assessments for children and adolescents, compared with adults.

  x. Understand drug use among children and adolescents, and its impact on development.

 d. Academic, Vocational, and Career Development

  i. Understand factors associated with academic achievement and underachievement.

  ii. Understand school-based legal rights of minors pertinent to special education services and academic accommodations.

  iii. Understand career development and vocational aspirations during childhood and adolescence, including early career exploration, influence of social environment on career choice, and impact of school environment on college readiness and vocational training.

 e. Legal and Ethical Considerations

  i. Understand parent/guardian rights during childhood and adolescence, including minors independently seeking health care services in the U.S. state where the counselor and client reside.

  ii. Understand state-based laws pertinent to adolescent emancipation and removal of parental/guardian rights.

  iii. Understand physical and emotional signs of child abuse and neglect, interviewing procedures, and appropriate steps required to report such abuse/neglect within timeframes established by state law.

2. **Skills**

LCMHCs must demonstrate skills in the following subject areas specific to working with children and adolescents:

a. Neurophysiological Development

    i. Demonstrate the ability to help children and adolescents explore their emerging identity, including cultural, sexual, gender, and vocational identities.

    ii. Implement developmentally-appropriate practices when counseling youth, such as using play therapy approaches.

    iii. Implement theoretical approaches that are evidence-based practices when counseling child and adolescent clients, not limited to, for example, parent-child interaction therapy, cognitive-behavior therapy, multisystemic family therapy, applied behavior analysis and video modeling (recommended for the care of youth who have autism).

b. Social, Cultural, and Familial Influences

    i. Demonstrate the ability to communicate respectfully and effectively with children, adolescents, and their families, adjusting communication style to match developmental level and considering ethnic, racial, cultural, gender, socioeconomic, and educational backgrounds.

    ii. Demonstrate sensitivity and responsiveness to the child and adolescent's individual and family culture, age, gender, ethnicity, disabilities, socioeconomic background, religious beliefs, and sexual orientation.

    iii. Advocate for the prevention of mental health problems through the creation of social environments in schools and community settings that support optimal mental health and wellness.

    iv. Directly address social problems facing children and adolescents, including intervention related to peer pressure, bullying, gang involvement, and stigmatization.

    v. Support children and adolescents in the aftermath of a crisis, disaster, or other trauma-causing event, including deaths within the local community; prevents contagion of suicidal behavior through public advocacy related to media coverage and responses (e.g., public memorials) of schools and communities.

    vi. Demonstrate the ability to address social problems facing children and adolescents, including bullying, gang involvement, peer pressure, and stigma.

    vii. Demonstrate the ability to strengthen healthy family functioning that impact child and adolescent development, including, inter-parental conflict, domestic violence, parent-child relational problems, parental/guardian over- or under-involvement, authoritarian or passive parenting styles, and addiction in the family.

    viii. Demonstrate ability to address problematic technology and social media use by children and adolescents, including setting healthy limits with mobile technology use, internet safety, cyber bullying, and appropriate parent/guardian involvement.

    ix. Demonstrate an ability to assist youth in the development of face-to-face and technology-based social interaction skills, and address adverse effects of social media dominated communication systems.

c. Diagnosis and Treatment Planning

 i. Demonstrate the ability to assess the various presentations of mental health disorders in children and adolescents, with consideration for developmentally typical and atypical behavior.

 ii. Conduct developmentally appropriate interviewing procedures for assessing suicide risk, homicide risk, and child abuse/neglect.

 iii. Demonstrate ability to assess and treat attachment distress and relational patterns, including attachment-based disorders.

 iv. Demonstrate the ability to plan treatment, including a biopsychosocial formulation, mental status examination, diagnosis, and psychological assessment as it pertains to children and adolescents.

 v. Demonstrate familiarity with the diverse micro, meso, and macro systems within the community that are involved in the care of children, adolescents, and their families

 vi. Demonstrate the ability to effectively interface with integrated health care professional and collateral sources, enlisting a multidisciplinary approach to the treatment of children and adolescents.

 vii. Demonstrate ability to effectively consult with school-based professionals, for example school counselors, psychologists, social workers, teachers, and school-based mental health professionals.

 viii. Implement parent education programs and family therapy when indicated.

 ix. Implement operant conditioning procedures when appropriate, including behavioral modification and token economy programs.

 x. Demonstrate ability to deliver effective psychoeducation to children, adolescents, and families that is matched to developmental level, heeding adaptations designed for adolescents and youth, specifically when available (for example, DBT, CBT, etc.)

 xi. Demonstrate ability to form groups that are considerate of developmental level, such as smaller sizes for younger children, and excluding younger children in adolescent groups.

d. Academic, Vocational, and Career Development

 i. Demonstrate the ability to assist children and adolescents with strategies (e.g., self-efficacy, planning, organization, etc.) to improve academic performance that is affected by clinical diagnoses and/or concerns, for example autism and spectrum disorder difficulties, ADHD, etc.

e. Legal and Ethical Considerations
 i. Navigate the unique legal challenges related to counseling children, such as age of consent and assent, confidentiality, competence, parental involvement, guardianship, and state laws related to the reporting of child abuse/neglect.

H. Aging and Older Adults Counseling Standards and Competencies

Older adults, those aged 60 or above, make important contributions to society as family members, volunteers and as active participants in the workforce. While most have good mental health, many older adults are at risk of developing mental disorders, neurological disorders or substance use problems as well as other health conditions such as diabetes, hearing loss, and osteoarthritis, to name but a few illnesses that may present in older persons. Furthermore, as people age, they are more likely to experience several conditions at the same time.

The key components to successful aging include physical health, mental activity, social engagement, productivity and life satisfaction. When any one of these components are compromised, it can have a negative impact on quality of life. MHC's must understand and address the interaction of these components when working with aging adults.

In addition, older adults are more likely to experience events such as bereavement, a reduction in one's socioeconomic status with retirement, or a disabling condition. All of these factors can result in isolation, loss of independence, loneliness and psychological distress in older adults.

Mental health problems can be under-identified by health care professionals and older adults themselves, and the stigma surrounding mental illness can make older adults reluctant to seek help. Substance use problems among the elderly can also be overlooked or misdiagnosed.

1. **Knowledge**

    LCMHCs in this area of specialization should demonstrate knowledge of the following physical and mental health subject areas specific to working with older adults:

    a. Understand life span developmental theories relating to older adults.

    b. Understand social processes, including topics such as the cultural context of relationships, social engagement and support, leisure and recreation, isolation, productivity (i.e., retirement, loss of identity), sexuality, intimacy, caregiving, self-care, stress relief, abuse and neglect, victimization, and loss and grief.

    c. Understand skills necessary to cope with the emotional and physical challenges associated with the aging process, including how society responds to older adults.

    d. Appreciate psychological aspects of aging, including topics related to the meaning and end of human life according to various religious and cultural viewpoints in relation to topics such as the quality and sacredness of life, end-of-life moral issues, grief and mourning, satisfaction and regret, suicide, and perspectives on life after death.

    e. Recognize and have knowledge of the incidence of suicide among older persons, including warnings signs, risk factors, protective factors, acute vs. chronic risk, the ability to formulate the level of suicidal risk (none, low, moderate, high) using qualified assessment techniques, and managing risk.

    f. Appreciate cultural and ethnic differences among older adults, including culturally relevant strategies to promote resilience and wellness in older adults.

    g. Understand the integration and adjustment of life transitions that occur as part of normal aging (i.e., functional mobility, family constellation, housing, health care, level of care etc.).

    h. Recognize the comorbidity of aging-related and health-related vulnerabilities and strengths.

    i. Recognize the interplay between general medical conditions and mental health, including an understanding of common medications, side effects, drug interactions, and presentation.

    j. Understand drug use and misuse among older adults.

2. **Skills**

    a. Demonstrate the ability to assess the various presentations of mental health disorders (e.g., mood disorders and cognitive and thought disorders, etc.) in older adults and their impact on functional status, morbidity, and mortality.

    b. Demonstrate the ability to communicate respectfully and effectively with older adults and their families, accommodating for hearing, visual, and cognitive deficits.

    c. Demonstrate the ability to communicate respectfully with older adults and their families, recognizing all multicultural considerations unique to older adults, particularly generational values and age-related abilities.

    d. Demonstrate the ability to navigate and address issues associated with the emotional and physical challenges of the aging process, including how society responds to older adults using appropriate counseling strategies.

    e. Demonstrate an ability to navigate the unique challenges related to confidentiality of patient information, informed consent, competence, guardianship, advance directives, wills, and elder abuse.

    f. Demonstrate the ability to plan treatment, including a biopsychosocial conceptualization of predisposing, precipitating, and protective factors, mental status evaluation, diagnosis, and mental health assessment as it pertains to older adults.

    g. Demonstrate familiarity with the diverse systems of care for patients and their families, and how to use and integrate these resources into a comprehensive treatment plan.

    h. Demonstrate the ability to effectively interface with integrated health care professional and collateral sources, enlisting a multidisciplinary approach to the treatment of older adults.

I. Forensic Evaluation Standards and Competencies

Forensic evaluation involves the process of forming professional opinions for courts of law or other legal proceedings, based on professional knowledge and expertise, and supported by appropriate data. These evaluations play an important role in the legal system, as many legal decisions require the specialized expertise of mental health professionals.

Knowledge and skills in forensic evaluation is a prerequisite when providing competent service to the judicial system and its stakeholders. In many judicial jurisdictions throughout the United States, there is a shortage of trained forensic mental health professionals to meet the demands of the criminal justice and family court systems, resulting in delays that risk violating defendants' constitutional due process rights.

In addition, because of the unique barriers they experience, individuals affected by mental illness and/or substance use disorders are disproportionately involved in the criminal justice and civil court systems. Within the legal system, advocacy for such individuals must be balanced by a concern for the welfare and safety of the general public, and this delicate balance is difficult to achieve.

As the single largest sector of the nation's licensed mental health professional workforce, appropriately trained Licensed Clinical Mental Health Counselors (LCMHCs) can play a vital role in resolving the national shortage of qualified forensic evaluators. This is due to LCMHC training in mental health, differential and co-occurring diagnoses and treatment, trauma-informed care, substance use disorders, and multicultural competencies. Additionally, because of their unique training and expertise in psychotherapy and treatment planning, LCMHCs are exceptionally suited to answer questions about the treatment needs of individuals involved in legal processes.

AMHCA recommends obtaining credentials or certification such as the Certified Forensic Mental Health Evaluator (CFMHE) offered by AMHCA's partner, the National Board of Forensic Evaluators, and then obtaining the more advanced Clinical Mental Health Specialist in Forensic Evaluation (CMHS-FE) offered by AMHCA. Questions posed in the legal process require the advanced forensic expertise of LCMHCs trained to provide an objective approach to evaluation. This approach may involve a shift in ethical prerogatives that many LCMHCs are unaccustomed to when providing direct care with clients.

Medscape, one of many medical information websites, clarified this point by emphasizing the following: *The need for a forensic evaluation is generally prompted by the need for an objective opinion regarding the presence, severity, or treatment of a mental illness. Forensic evaluations fundamentally differ from routine provision of clinical care, despite significant overlap in how they are performed. The opinion generated by the interview could be helpful, harmful, or neutral to the person being evaluated.*

LCMHCs who provide forensic evaluation find themselves in a very different role than the one in which they are primarily tasked with helping a client. In the context of forensic evaluation, ethical principles are more broadly applied to all stakeholders of the legal process, not just the client, and ethical principles of veracity (honesty and the pursuit of truth) and justice (equal treatment of individuals in proportion to relevant differences) often predominate. This requires a paradigm shift for LCMHCs who are more accustomed to client advocacy, thus underscoring the importance of specialized training in forensic evaluation.

1. **Knowledge**
    a. Understand the definition of forensic mental health evaluation, the various types of forensic mental health evaluations (e.g., competency to participate in legal proceedings, criminal responsibility, violent risk potential, guardianship, civil commitment, immigration, disability, personal injury, domestic violence, parenting/child custody, workplace discrimination and harassment, etc.), and the differences between forensic and clinical/therapeutic evaluations.
    b. Understand psycholegal questions not commonly understood by mental health professionals who do not have expertise in forensic evaluation (e.g., "is this individual competent to waive the right to an attorney?" or "Was this individual able to appreciate the nature of and ramifications for the actions that constitute the alleged offense?")
    c. Understand federal, state, and local laws governing forensic evaluation.
    d. Understand ethical principles and ethical guidelines that relate to forensic evaluation as published in the American Mental Health Counselors Association (AMHCA) *Code of Ethics* and other authoritative references in the forensic mental health field.
    e. Understand appropriate sources of information when conducting a forensic evaluation.
    f. Understand specialized clinical assessment as outlined in *Part V-B, Specialized Clinical Assessment*, a standard within this document (see page 13), as well as the administration and interpretation of psychological tests commonly used in forensic evaluation.
    g. Understand the most current editions of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), the *International Classification of Diseases* (ICD), and the differential diagnosis process.
    h. Understand the provision of and how to obtain informed consent process as it relates to forensic evaluation.
    i. Understand the importance, purpose, and common requirements of forensic evaluation reports.
    j. Understand the role of the expert witness in legal proceedings and how it differs from the role of the fact witness (including a working understanding of Daubert and Frye standards for expert witness testimony).
    k. Understand the legal process, including the court hearing process and the roles of various entities involved in the legal system (e.g., judge, prosecutor, defense attorney, witness, juror, probation officer, etc.).
    l. Understand questions commonly posed by attorneys and other official representatives during initial and cross-examination, and understand the relevance of those questions.

m. Understand rules and standards of professional etiquette in the courtroom.

n. Understand how to demonstrate to legal entities, and ultimately to the judge in a legal proceeding, that standards to be considered an expert witness have been met.

o. Understand the process, requirements, and potential role of certification in demonstrating specialized expertise in forensic evaluation (i.e., the Certified Forensic Mental Health Evaluator credential offered by AMHCA's partner, the National Board of Forensic Evaluators, and the Clinical Mental Health Specialist in Forensic Evaluation credential offered by AMHCA).

p. Be knowledgeable of the rules established by their local jurisdiction regarding qualifications and methodology for being placed on the district's court-appointed evaluator listing, which varies from jurisdiction to jurisdiction.

q. Be knowledgeable about how to make their local Public Defender Office, Office of the Attorney General, probation offices (state and local), and American Bar Association chapter aware of their services and the types of evaluations they can conduct. They should be able to differentiate between which types of forensic evaluations lie within their expertise and which would warrant referral to a different evaluator.

r. Be knowledgeable about differentiating between which types of forensic evaluations lie within their expertise and which would warrant referral to a different evaluator.

s. Be knowledgeable about any unique statutes or rules that limit their abilities to accept certain types of referrals in a given jurisdiction.

t. Be knowledgeable about keeping a running transcript of their forensic experience and a Curriculum Vita that is more robust and detailed than the average clinician's in order to verify their expertise to provide certain types of evaluations.

2. **Skills**

a. Define and describe forensic mental health evaluations, various types of forensic mental health evaluations (e.g., competency to participate in legal proceedings, criminal responsibility, violent risk potential, guardianship, civil commitment, immigration, disability, personal injury, domestic violence, parenting/child custody, workplace discrimination and harassment, etc.), and the differences between forensic and clinical/therapeutic evaluations.

b. Demonstrate the ability to collect appropriate data from multiple sources of information to answer specific questions posed by legal entities.

c. Demonstrate the ability to answer verbally and in writing the questions posed by referral sources for forensic evaluations.

d. Demonstrate the ability to apply laws, rules, and written standards of government (national, state, and local) and court jurisdictions to the forensic evaluation being conducted by the LCMHC.

e. Demonstrate the ability to apply the ethical standards published in the Forensic Activity section of the *AMHCA Code of Ethics* and other well-recognized authorities in the forensic mental health arena to all forensic evaluations conducted by the LCMHC.

f. Demonstrate the ability to select, administer, interpret, and report the results of appropriate psychological tests, structured interviews, and other appropriate assessment and appraisal tools as relevant, and be able to effectively answer the questions posed by referral sources. (For additional details, see the Skills section of *Part V-B, Specialized Clinical Assessment* in this document on page 15.)

g. Demonstrate the ability to formulate an accurate diagnosis from the most current editions of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) and the *International Classification of Diseases* (ICD) when appropriate in forensic evaluations for answering referral questions.

h. Demonstrate the ability to provide and obtain an appropriate informed consent from individuals participating in forensic evaluation.

i. Demonstrate the ability to testify effectively in the capacity of an expert witness in a legal proceeding.

    j.   Demonstrate the ability to write an appropriate forensic evaluation report answering the questions of the referral source that is professionally and well-written and articulates information in a manner appropriate for the intended reader(s) (e.g., judges, attorneys, jurors, probation officers).

    k.   Demonstrate the ability to describe and define, and also manage and navigate, boundaries related to the roles of entities involved in legal proceedings (e.g., judge, prosecutor, defense attorney, witness, juror, probation officer, etc.).

    l.   Demonstrate the ability to articulate appropriate and professional responses to questions posed during initial and cross-examination.

    m.   Demonstrate the ability to appropriately adhere to rules and standards of professional etiquette in the courtroom.

    n.   Articulate to judges, attorneys, probation officers, and other legal entities that the LCMHC is qualified as an expert witness in a legal proceeding, including obtaining specialized training and/or credentialing in forensic evaluation. AMHCA recommends that LCMHCs who provide forensic evaluations obtain the Certified Forensic Mental Health Evaluator (CFMHE) credential offered by AMHCA's partner, the National Board of Forensic Evaluators, and then obtain the more advanced Clinical Mental Health Specialist in Forensic Evaluation (CMHS-FE) offered by AMHCA.

    o.   Demonstrate the ability to appropriately apply ethical practices in the acquisition of forensic evaluation referrals.

J.   Gender Identity Counseling Standards and Competencies

In an effort to articulate the distinction between gender and affectional or other identities, AMHCA has taken the pioneering approach of differentiating the standards. While the common practice has been to combine the identities in an acronym of varying letters, gender and affectional identities specifically are often conflated. AMHCA recognizes that, given the distinct nature of the identities and the requisite knowledge and skills that are unique to each, the standard should be unique.

Affirmative counseling is an inclusive and advocating approach that honors clients' self-defined identities and acknowledges and addresses the impact on clients' lives of a society prone to viewing identities as binary. An affirmative approach is to be utilized in an expansive manner, rather than as merely applying to gender, and ought to be considered with regard to all client identities. The term "self-defined identity" underscores the notion that clients must be able to explore and express their identities in multidimensional ways, which may include a range of identities and their combinations.

Gender-expansive populations, which encompass those whose gender identity differs from the sex assigned at birth, have been and continue to be harshly judged by many persons in society and often report feeling invisible. People in this population attempt and die from suicide at devastatingly higher rates than does the cisgender population (those whose sex assigned at birth matches their gender identity).

Gender-expansive individuals often present with myriad issues, arising from and complicated by their marginalized place in a predominantly binary society. Common among their presenting concerns are: rigid and binary thinking; extreme codependency; fear or avoidance of public restrooms; complications related to coming out to family/friends and navigating their variable levels of acceptance; difficulty shopping for clothing; social stigma in presentation; overwhelming feelings of failing to belong in society; low self-esteem; lack of self-love; amplified levels of substance abuse; eating disorders; body dysmorphia; homelessness; admission to jails/institutions; anxiety; depression; and heightened suicide risk.

Furthermore, mental health professionals who themselves may be insufficiently aware of, or biased against, the needs of this population, may overdiagnose or misdiagnose mental health conditions, leading

to further stigmatization and subsequent psychological suffering, including but not limited to recommending inappropriate psychopharmacological treatments.

In order to provide affirming and competent care to gender-expansive individuals, Licensed Clinical Mental Health Counselors (LCMHCs) must know about gender-expansive specific needs and use affirming language; they must understand the idiosyncratic challenges that gender-expansive clients face; and they must be prepared and willing to provide effective and competent support.

LCMHCs' use of appropriate and affirming language encourages clients to feel validated, supported, and understood. Oftentimes, gender-expansive individuals feel invalidated by language (terminology, names, and pronouns) across a spectrum of relationships and social groups, ranging from large-scale social systems to close friends, family members, and health care professionals. In contrast, affirming language in the counseling setting creates a validating foundation that may, for some clients, be their first experience of unconditional acceptance. LCMHCs should be guided by and use clients' identified pronouns and other terminology that is consistent with their identities and needs. Comprehensive lists of vocabulary and nomenclature are available from counseling professional associations that maintain and update glossaries regularly as the field evolves, and LCMHCs are encouraged to be familiar with these.

Counselors assisting gender-expansive clients must be especially attuned to their own body language, facial expressions, and vocal qualities. Given the extent of societal discrimination and stigma, gender-expansive clients are likely to have heightened sensitivity to nonverbal signals. To protect themselves from incompetent counselors, they may have interviewed clinicians prior to entering counseling in order to assess counselors for their signs of discomfort or bias with gender-expansive clients. They may need to continue to search for well-trained and self-aware clinicians who are responsive to the needs of gender-expansive persons. Continuous screening of approachable LCMHCs is a hardship borne by stigmatized members in the gender identity community.

LCMHCs have an ethical responsibility to honor diversity, and to promote health, wellness, and personal growth for all, no matter a person's uniqueness or social and cultural context. In order to abide by this core value, LCMHCs' practices must be guided by relevant knowledge and skill. Thus, it is incumbent that the following be internalized and further employed in working with the gender-expansive community.

1. **Knowledge**
    a. Understand variability in life span development for persons with gender-expansive identities and implications for the counseling process.
    b. Recognize how shame and innate stigma may affect the personality development of gender-expansive clients, and the potential repercussions on world view and decision-making.
    c. Understand gender-expansive language, with awareness of its ongoing evolution.
    d. Understand the ecological and environmental experiences or hardships disproportionately affecting gender-expansive clients, such as homelessness, financial hardship, and addiction.
    e. Acknowledge intersectionalities within the gender-expansive community that may pose additional strain on clients' internalized beliefs about themselves and the world.
    f. Understand and acknowledge pervasive pathologizing notions of gender.
    g. Understand that individuals affirm gender in multiple and divergent ways, and that physical affirmation is not a necessary part of gender-expansive experience.
    h. Understand, recognize, and acknowledge that transphobia, prejudice, and gender discrimination are prevalent throughout society and may influence an LCMHC's own attitude toward a gender-expansive client.
    i. Understand gender-expansive clients holistically. Avoid *a priori* assumptions that all concerns presented by gender-expansive clients are primarily identity concerns. Allow clients to determine the salience of their gender identity.

j. Know the history of oppressive mental health theories and practices relevant to gender-expansive clients. Recognize contemporary manifestations of these professional malpractices. Understand and anticipate the resulting, wide-ranging reactions among gender-expansive clients, including but not limited to fear and resentment.

k. Recognize that many counseling tools developed for practice, such as assessments, theories, interventions, etc., may not have included the experiences of gender-expansive persons and may be oppressive.

2. Skills

a. Establish an affirming environment in practice, where forms and paperwork are inclusive to varying genders, and welcome intersectionality, such as allowing clients to include their pronouns, having a section for their name as it may be represented on their insurance information and also a place for the name they use in session.

b. Demonstrate the ability to distinguish between sex, gender identity, gender expression, and affectional identity.

c. Demonstrate competence with documentation changes, World Professional Association for Transgender Health (WPATH) letter writing, and the counselor's role as an advocate and ally rather than gatekeeper.

d. Demonstrate enhanced levels of insight, self-awareness, and introspection into personal biases. Further, an LCMHC who has concerns around personal biases demonstrates the ability to seek out supervision and/or consultation from people in the community who have shown competent and affirmative care in working with the gender-expansive community.

e. Honor each client's self-identity, and definition of their gender and other identities, and affirm them for who they say they are as unique individuals.

f. Assist clients to explore themselves in an expansive way so that they may learn to affirm themselves and practice resiliency in a binary-oriented society.

g. Advocate for gender-expansive inclusion in LCMHCs' own communities.

h. Demonstrate the ability to select and utilize standardized counseling tools, theories, and interventions in an adaptive way to meet the needs of the gender-expansive population.

K. Affectional Identity Counseling Standards and Competencies

In an effort to articulate the distinction between gender and affectional or other identities, AMHCA has taken the pioneering approach of differentiating the standards. Because the common practice has been to combine the identities in an acronym of varying letters, gender and affectional identities are often conflated. AMHCA recognizes the need for specific standards addressing gender and affectional identities, given the distinct nature of the identities and the requisite knowledge and skills that are unique to each.

The term affectional identity is utilized to indicate the attraction an individual has for others—both physical and otherwise. Individuals who identify as an affectional identity other than heterosexual are faced with unique challenges within a society that has historically excluded them. In this standard, individuals with underrepresented affectional identities are referred to as "affectional-identity-diverse."

To offer an acceptable standard of care for the affectional-identity-diverse community, clinicians must utilize appropriate and inclusive language. An affectional-identity-diverse individual refers to a person who identifies with an identity other than heterosexual. Identities that make up said group include, but are not limited to gay, lesbian, bisexual, asexual, pansexual, and demisexual, as well as other varying identities. The term "affectional identity" is not exclusive to these groups, however, as language and cultural understanding is constantly evolving.

Often individuals within the affectional-identity-diverse community face challenges not only present within the context of work, school, and family and friend relationships, but also within the context of health care—mental health care and otherwise. The affectional-identity-diverse community faces higher rates of trauma, internalized shame, and microaggressions than others. Therefore, they are also more likely to experience mental health concerns due to the unique stressors they are exposed to daily.

Additionally, inadequate training, expertise, and self-awareness among LCMHCs likely contributes to individuals within the affectional-identity-diverse community being less likely to receive long-term mental health care. LCMHCs may internalize biases against members of this population. Studies indicate that to unknowingly demonstrate microaggressions is one of the most detrimental mistakes made by mental health professionals when working with this community. When LCMHCs are aware of their internalized biases and are trained in the unique problems that affectional-identity-diverse individuals experience, therapy is more likely to be successful.

Affectional identity differs from sexual identity. In the current heterosexual-predominant society, utilizing the term "sexual identity" tends to reduce the focus of the relationship simply to sex. This shift contributes to further stigmatization of folks who identify as affectional-identity-diverse. While sex can be and is often a part of someone's affectional identity, many other psychological and physiological factors also determine attraction. Therefore, "affectional identity" is often the most inclusive term to use when working with this population.

When members of the affectional-identity-diverse community are in the care of mental health professionals, the baseline of their therapeutic experience should begin with the use of inclusive language. In addition to language, clinicians should monitor their own internalized biases. These biases often emerge as microaggressions in the form of gender-role stereotyping in relationships, feeling discomfort when working with marginalized individuals, and utilizing outdated methods of intervention for this population.

When counselors use inclusive language and self-awareness in their approach, it is likely that affectional-identity-diverse individuals will feel more supported and accepted in mental health care. This is vital to the therapeutic process, as studies show that the relationship itself between clinician and client indicates the success of the therapeutic process more than any other factor.

Mental health professionals have an ethical, legal, and clinical responsibility to honor diversity and intersectionality within the therapeutic process. Often, this includes not only awareness of the unique stressors that varying populations encounter, but also an advocacy-based mindset when working with individuals who have diverse backgrounds—whether it be race, ability, sex, gender, affectional identities, or other factors. Therefore, it is necessary that the following knowledge and skills be learned and applied when working with individuals in the affectional-identity-diverse community.

1. **Knowledge**
   a. Recognize the broad and various sources of bias against people with diverse affectional identities.
   b. Identify and provide support for the unresolved effects of internalized bias that an affectional-identity-diverse person may experience.
   c. Understand the harm that unethical practices such as conversion therapy or efforts to change affectional identity have had on those with diverse affectional identities, ultimately creating patterns of generational trauma.

d. Be aware and acknowledge that those who identify with a diverse affectional identity often experience complex trauma, internalized homophobia, heightened rates of suicidal ideation, and domestic violence.

e. Acknowledge that various intersectional subgroups (i.e., those with marginalized affectional identities who also identify with other diverse identities such as race, gender, etc.) may experience trauma differently.

f. Recognize and acknowledge the biases and gaps in current research with respect to affectional identities (including techniques, approaches, assessment tools, etc.), that may have been limited or inaccurate in its authentication process due to sampling bias—for example, using only majority heterosexual samples.

g. Understand that those with diverse affectional identities experience a variety of traumas from within a broad spectrum of systems (e.g., family unit, educational, employment, societal, health care, etc.) at a disproportionately higher rate than their heterosexual peers.

h. Understand the ecological and environmental hardships that disproportionately affect affectionally marginalized clients, such as homelessness, financial hardship, and addiction.

i. Understand affectional identity language, with an awareness that nomenclature is not static but rather constantly evolving.

j. Recognize explicit and implicit bias, and understand the harmful impact of these biases on society.

2. **Skills**

a. Demonstrate enhanced levels of insight, self-awareness, and introspection into personal biases. Further, when concerns around personal biases arise, seek out supervision and/or consultation related to competent and affirmative care.

b. Engage in ongoing professional development related to competent care for the full spectrum of affectional identities.

c. Establish and maintain an affirmative, inclusive office or therapeutic environment that recognizes intersectionality.

d. Demonstrate the ability to adapt to changes in the field, such as changes in language, standards of care, and client preferences.

e. Demonstrate the ability to distinguish the definitions of, differences among, and connotations of sex, gender identity, gender expression, and affectional identity.

f. Demonstrate the ability to consistently act as a client-centered advocate and ally.

g. Demonstrate the ability to affirm a client's self-identity as a unique individual, affirm clients' definition of their affectional and other identities, and affirm clients for who they say they are.

h. Assist clients to explore their identities in an expansive way so that they may learn to affirm themselves and practice resiliency in a heteronormative society.

i. Advocate for the inclusion of the full spectrum of affectional identities into the client's local community and into the mental health counseling profession.