

# AMHCA Standards for the Practice of Clinical Mental Health Counseling

*Adopted 1979*

*Revised 1992, 1993, 1999, 2003, 2011, 2015, 2016, 2017, and 2018*



**AMERICAN MENTAL HEALTH  
COUNSELORS ASSOCIATION**

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The only organization working exclusively for the  
mental health counseling profession

I. Introduction.....1  
    A. Scope of Practice.....2  
    B. Standards of Practice and Research.....3  
II. Educational and Pre-degree Clinical Training Standards.....4  
    A. Program.....4  
    B. Curriculum.....4  
    C. Specialized Clinical Mental Health Counseling Training.....5  
    D. Pre-degree Clinical Mental Health Counseling Field Work  
    Guidelines.....5  
III. Faculty and Supervisor Standards.....6  
    A. Faculty Standards.....6  
    B. Supervisor Standards.....8  
IV. Clinical Practice Standards.....11  
    A. Post-degree/Pre-licensure.....11  
    B. Peer Review and Supervision.....11  
    C. Continuing Education.....11  
    D. Legal and Ethical Issues.....12  
V. Recommend AMHCA Training.....13  
    A. Biological Bases of Behavior.....14  
    B. Specialized Clinical Assessment.....19  
    C. Trauma Informed Care.....21  
    D. Substance Use Disorders and Co-occurring Disorders.....27  
    E. Technology Assisted Counseling (TAC) .....32  
    F. Integrated Behavioral Health Care Counseling.....38  
    G. Aging and Older Adults Standards and Competencies.....44  
    H. Child and Adolescent Standards and Competencies.....47

## **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; and
- 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, socio-economic status, sexual orientation, etc.) across the lifespan (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 and 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 for 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 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 to reflect evolving practice requirements. These professional standards, as well as the *2015 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:

- Professional Orientation and Ethical Practice;
- Social and Cultural Diversity;
- Human Growth and Development across the lifespan;
- Career Development;
- Counseling theories and Helping Relationships;
- Group Work;

- Assessment;
- 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 lifespan (children, adolescents, adults and older adults) and across socially and culturally diverse populations:

- Ethical, Legal and Practice Foundations of Clinical Mental Health Counseling;
- Prevention and Clinical Intervention;
- Clinical Assessment;
- Diagnosis and Treatment of Mental Disorders;
- Diversity and Advocacy in Clinical Mental Health Counseling; and
- Clinical Mental Health Counseling Research and Outcome Evaluation.

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

- Biological Bases of Behavior (including psychopathology and psychopharmacology);
- Trauma Informed Care and;
- Co-occurring Disorders and Substance Use Disorders (mental disorders and substance abuse).

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**

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

- 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 lifespan.
- d. Demonstrate training in the following:
  - Evidence-based best practices
  - Differential diagnosis and treatment planning
  - Co-occurring disorders and substance use disorders
  - Trauma, and its related forms (developmental, complex, situation, chronic or toxic distress, moreal trauma, historical trauma, etc.)
  - Biological bases of behavior including psychopharmacology

- Social and cultural foundations of behavior
- Individual family and group counseling
- Clinical assessment and testing
- Professional orientation and ethics
- Advocacy and leadership
- Case consultation and supervision with peers or specialists, and
- 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 CMHC 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:
- applicable laws, licensure rules and the *AMHCA Code of Ethics* specifically as they relate to supervision;
  - supervisory liability, respondent superior, and fiduciary responsibility; and
  - 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:
  - frequency, location, length and duration of supervision meetings;
  - supervision models and expectations of the supervisee and the supervisor;
  - liability and fiduciary responsibility of the supervisor;
  - the evaluation process, instruments used and frequency of evaluation; and
  - 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. Seek consultation as needed.
  
- h. Conceptualize cultural differences in therapy and in supervision. Incorporate and model this understanding into the supervisory

process.

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

j. 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 *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. The *AMHCA Code of Ethics* outline 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**

AMHCA recommends that clinical mental health counselors have specialized training in addition to the generally agreed upon courses and curricula endorsed by CACREP. These include the biological bases of behavior, clinical assessment, trauma, and co-occurring disorders technology assisted counseling, and integrated behavioral health care counseling, working with children and adolescents, and working with older persons. Knowledge and skills related to

the biological bases of behavior may be covered in a single course or more commonly across several courses or domains of inquiry. The skills outlined in this document can be measured through standardized testing, participation in class or team role-playing exercises, case studies, research papers, reviews of treatment plans, and reviews of progress notes in field work settings. It is recommended that the following be addressed for students in mental health counseling programs of study.

### **A. Biological Bases of Behavior**

The origins of human thought, feeling, and behavior, from the more 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 lifespan (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 interneuronal 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 lifespan.
- 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 lifespan.

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 lifespan 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.

ix. 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**

*(Summarized and adapted from the AMHCA-AACE joint agreement 2009)*

At the heart of clinical mental health counseling, in both theory and practice, is the process of comprehensive individual assessment. A fundamental belief held by clinical mental health counselors is that each client, regardless of presenting problem or circumstance, brings to counseling a unique pattern of traits, characteristics, and qualities that have evolved as a combination of genetic endowment and life experience. Through the use of assessment techniques, both client and counselor can gain an awareness of the unique constellation of traits, qualities, abilities, and characteristics that defines each individual as unique. The assessment process considers mental and emotional well-being, physiological health, as well as relationship and contextual concerns.

### **1. Knowledge**

- a. Identify the purposes, strengths and limitations of objective clinical mental health assessment instruments including:
  - Advantages and disadvantages of qualitative assessment procedures.
  - Differences and advantages of structured and semi-structured clinical interviews.
  - The use of structured and semi-structured clinical interviews to develop goal setting and treatment plans in clinical mental health counseling practice.
  - Limitations of clinical mental health assessment instruments in diagnosing thoughts, emotions, behavior or psychopathology of socially and culturally diverse clients across the lifespan. Defines and describes the

various types of reliability and validity, as well as measures of error, in clinical mental health assessment instruments.

- b. Identify acceptable levels of reliability and validity for personality, projective, intelligence, career and specialty assessment instruments.
- c. Identify where and how to locate and obtain information about assessment instruments commonly used within clinical mental health counseling.
- d. Identify the means to locate and obtain clinical mental health assessment instruments for special populations (e.g. visually impaired persons, non-readers).
- e. Understand how to use assessment instruments according to the intended purpose of the instrument.
- f. Understand how to use assessment instruments in research according to legal and ethical practices to protect participants.
- g. Understand the use of clinical assessment instruments and procedures in the evaluation of treatment outcomes and mental health treatment programs.

## **2. Skills**

- a. Demonstrate the ability to select, administer, score, analyze, and interpret clinical mental health assessment instruments.
- b. Demonstrate the ability to use computer-administered and scored assessment instruments.
- c. Demonstrate the ability to use the mental status examination, interviewing procedures, and formal clinical assessment instruments to assess psychopathology among socially and culturally diverse clients across the lifespan.
- d. Demonstrate the ability to use personality, projective, intelligence, career, and specialty instruments to develop

counseling plans and clinical interventions.

e. Develop mental health evaluation reports, diagnosis, and treatment plans from multiple assessment sources (e.g. direct observation, assessment instruments, and structured clinical interviews).

f. Demonstrate the ability to follow legal and ethical principles for informed consent and confidentiality when using assessments.

g. Communicate assessment instrument results in a manner that benefits clients.

h. Present assessment results to clients and other nonprofessional audiences using clear, unambiguous, jargon-free language that recognizes both client strengths and client problems, and communicates respect and compassion.

i. Demonstrate the ability to select standardized instruments that can measure treatment outcomes and design evaluations to assess mental health treatment program efficacy.

j. Comply with the most recent codes of ethics of the American Mental Health Counselors Association (AMHCA), American Counseling Association (ACA), and National Board for Certified Counselors (NBCC) (if certified), and with the laws and regulations of the licensing board in any state in which the counselor is licensed to practice clinical mental health counseling.

k. Practice in accordance with the *Code of Fair Testing Practices in Education, Standards for Educational and Psychological Testing, Responsibilities of User of Standardized Tests, and Rights and of Test Takers: Guidelines and Expectations*.

### **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, and more. For the purposes of this standard, the terms trauma, chronic distress, and/or complex trauma will be used to encompass the meaning of all types and causes of trauma.

CMHCs 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 abuse, and often form negative core self-beliefs. Recent research reveals that physical health later in one's lifespan 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. CMHCs 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 multi-faceted and therefore CMHCs 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 CMHC 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. CMHCs 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, multi-systemic 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, posttraumatic growth, etc.).
- l. Understand the well-timed exploration of the potential for and themes for posttraumatic growth (PTG) among traumatized clients after effective counseling and symptom reduction. CMHCs 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 lifespan.

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. CMHCs 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. CMHCs 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 posttraumatic 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. Failure to address both the mental health disorder as well as the substance-related disorder can result in ineffective and incomplete treatment, stabilization, or recovery. There 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

CMHCs to apply thorough and comprehensive assessment and treatment for co-occurring disorders to prevent such neglect, harm, and possible death.

### **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 lifespan.

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 Psychological Models [behavioral, learning, cognitive, psychoanalytic, personality, social learning]; Multi-causal Models [biopsychosocial, syndrome, integral]; Biological/Physiological Models [disease, genetic predisposition, co-occurring]; Educational/Knowledge Models [educational, public health, developmental]; Psychosocial Model [peer-cluster, problem-behavior]; Sociocultural Models [sociocultural, culture-specific, prescriptive, sanctioned-use]; Family Models [general systems, parental influence]; Lifestyle/Coping Models [stress-coping, lifestyle, spiritual]; Progression Models [gateway, final common pathway]; and the choice/moral model. Additionally, CMHCs 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 abuse 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 ten 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 current opioid and prescription drug abuse epidemic along with emerging initiatives and response strategies, such as the emerging 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, opioid and prescription drug abuse, along with pharmacological treatments of other co-morbid conditions (such as mood and anxiety disorders, etc.).

m. Understand the current history, philosophy, and trends in substance abuse counseling including treatments that incorporate 1. stages of change (e.g. motivational interviewing), 2. 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, LifeRing Secular Recovery, Moderation Management, Celebrate Recovery, etc.), and 3. 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 co-occurring disorders in diverse settings, particularly, including familiarity with the co-occurrence of legal problems with SUDs. CMHCs 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. CMHCs 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 that 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’ co-occurring 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 co-occurring 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 lifespan 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, multi-system 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 Assisted Counseling (TAC)**

Technology assisted counseling or TAC (also has been described as tele-mental health, distance counseling, etc.) is an intentionally broad

term referring to the provision of mental health and substance abuse services from a distance. TAC occurs when the counselor and the client/patient are in two different physical locations.

Mental health is adapting to the use of advanced communication technologies and the Internet for delivery of care and care support. By using advanced communication technologies, clinical mental health counselors (CMHCs) are able to widen their reach to clients/patients in a cost-effective manner, ameliorating the mal-distribution of specialty care. Establishing guidelines for TAC improves clinical outcomes and promotes informed as well as reasonable patient expectations.

This section provides guidance on the clinical, technical, administrative and ethical issues as related to electronic communication between CMHCs and clients/patients using advances in TAC. These guidelines also serve as a companion document to *AMHCA's Code of Ethics*.

## **1. Knowledge**

a. Possess a strong working knowledge of technology assisted counseling (TAC) between clinical mental health counselors (CMHCs) and clients/patients which can include the use of:

i. synchronous modalities (telephone, videoconferencing, e-mail), and

ii. non-synchronous modalities (e-mail, chatting, texting, and fax).

b. Recognize that CMHCs and their clients/patients must be technologically competent in the modality of communication being used.

c. Understand that TAC is changing rapidly and anticipates that new modalities of communication with clients/patients will continuously emerge and require clinical, ethical and legal guidance.

d. Understand and complies with all state laws governing or relating to TAC which may include the following considerations:

- i. Emerging state laws commonly require that mental health professionals must be licensed in the state in which a client is receiving counseling.
- ii. CMHCs who regularly provide mental health counseling across state borders should be fully compliant with all applicable state laws where the client/patient resides.
- iii. However, ethical consideration should be given to providing reasonable continuing care for counseling services when:
  1. Individuals who temporarily travel out of their state for businesses or other purposes need to receive services from their CMHCs.
  2. Individuals who relocate to another state who require continuing care until they have obtained the services of a new CMHC if the current practitioner is not licensed in the client's new state of residence. This should be for a limited time as agreed to by the client/patient and CMHC.
  3. Individuals who are relocating to another country where psychotherapy services may not be available, may warrant continuing treatment.
- iv. CMHCs will provide 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 the CMHC.
- e. Stay up to date with relevant changes to laws and continuously consult with ethical and legal experts.
- f. Have a working knowledge of how TAC adheres to policies within the Americans for Disabilities Act (ADA). CMHCs will find ways to make appropriate accommodations.

- g. Understand that, whenever possible, CMHC's will meet in a face-to-face session to assess client needs prior to utilizing TAC.
- h. Know the need to obtain written informed consent for all TAC modalities utilized, understand how to adhere to all ethical and legal guidelines for counseling, and provide informed consent with appropriate matters to include confidentiality specifically with TAC, encryption, availability, determination of emergency intervention measures if needed, etc.
- i. Know that provisions for emergency intervention will include as a priority face-to-face counseling or the provision of a geographically accessible CMHC or other mental health provider, in addition to the inclusion of TAC as part of a comprehensive care management plan.
- j. Recognize that synchronous or live communication counseling modalities compared to non-synchronous communication are generally easier to monitor and therefore preferable in the interest of quality assurance.
- k. Recognize the importance of keeping records and copies of all correspondence in regard to text-based communications and related electronic information in a manner that protects privacy and meets the standards of HIPAA regulations.
- l. Know that confidential and privileged communications using text-based communication TAC should be encrypted whenever possible.
- m. 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. CMHCs should differentiate personal and professional forms of social media and keep these separate

## 2. Skills

### a. General

- i. Demonstrate competence with technological modalities being used such as synchronous modalities (e.g., video-conferencing) and non-synchronous modalities (e.g., texting).
- ii. Demonstrate competence and the ability to anticipate and adapt to emerging technologies, and adopt those techniques to address the needs of clients/patients.
- iii. Possess the ability to carefully examine the unique benefits of delivering TAC services (e.g., access to care) relative to the unique risks (e.g., information security) when determining whether or not to offer TAC services.
- iv. Demonstrate the ability to communicate any risks and benefits of the TAC services to the client/patient, and document such communication preferably during in-person contact with the client/patient, in order to facilitate an active discussion on these issues when conducting screening, intake, and initial assessment.

### b. Assessment

- i. Demonstrate competence in assessing the appropriateness of the TAC services to be provided for the client/patient.

Assessment may include:

1. the examination of the potential risks and benefits of TAC services for the client's/patient's particular needs;
2. a review of the most appropriate medium (e.g., video teleconference, text, email, etc.);
3. the client's/patient's situation within the home or within an organizational context;
4. service delivery options (e.g., if in-person services

- are available);
- 5. the availability of emergency or technical personnel or supports;
- 6. the multicultural and ethical issues that may arise;
- 7. risk of distractions or possible technological limitations or failures in session related to reception, band width, streaming, power sources, etc.;
- 8. potential for privacy breaches, and
- 9. other impediments that may impact the effective delivery of TAC services.

ii. Demonstrate the ability to monitor and engage in the continual assessment of the client/patient progress when offering TAC services to determine if the provision of services is appropriate and beneficial to the client/patient.

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/patients local area. These should include:

- 1. emergency response contacts;
- 2. emergency telephone numbers;
- 3. hospital admissions and/or emergency department;
- 4. local referral resources;
- 5. patient-safety advocate (clinical champion) at a partner clinic where services are delivered, and
- 6. other support individuals in the client's/patient's life

when available.

ii. Make a reasonable effort to discuss with and provide all clients/patients with clear written instructions as to what to do in an emergency.

iii. Demonstrate the ability to prepare a plan to address any lack of appropriate resources, particularly those necessary in an emergency, and other relevant factors which may impact the efficacy and safety of the service.

d. Multicultural Considerations

i. Demonstrate understanding of best practices of service delivery described in the empirical literature and professional standards – including multicultural considerations – relevant to the TAC service modality being offered.

ii. Demonstrate understanding of specific issues that may arise with diverse populations and which could impact assessment when providing TAC. CMHCs 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. Have a reasonable skill in accepting and addressing special needs of clients in adhering to appropriate ADA provisions.

ii. Make appropriate arrangements for disabled individuals to accommodate special needs such as sight and hearing impairments.

## **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, multi-disciplinary, 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 CMHCs assist patients to realize optimal human functioning as they alleviate emotional and mental distress.

CMHCs 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 multi-disciplinary 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. CMHCs as “primary care providers” are invaluable in developing innovations in integrated public health. These knowledgeable and skilled CMHCs 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:
- medical literacy
  - population screening
  - chronic disease management
  - educating medical staff about integrated care
  - group interventions
  - evidence-based interventions (See the AMHCA white paper entitled *Behavioral Health Counseling in Health Care Integration Practices and Health Care Systems*)
- s. Understand the basic knowledge about key health behaviors and physical health indicators (e.g. normal, risk, and disease level blood chemistry measures) which are routinely assessed and addressed in an integrated system of care, including but not limited to:
- body mass index
  - blood pressure
  - glucose levels

- lipid levels
- smoking effect on respiration (e.g., carbon monoxide levels)
- exercise habits
- nutritional habits
- substance use frequency (where applicable)
- alcohol use (where applicable)
- 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. Facilitate and oversee referrals to specialty mental health and substance abuse (MH/SA) services and when appropriate, support a smooth transition from specialty MH/SA services to primary care.
- 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:

- solution-focused therapy
- behavioral activation
- cognitive behavioral therapy
- 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:

- common mental health conditions (depression, anxiety),
- lifestyle behaviors (self-care, social engagement, relaxation, sleep hygiene, diet, exercise, etc.)
- substance use disorders

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

- reinforce care plan with other primary care providers
- 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. Aging and Older Adults 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. 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 drop in socioeconomic status with retirement, or a disability. 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 abuse problems among the elderly can also be overlooked or misdiagnosed.

### **1. Knowledge**

CMHC's must demonstrate knowledge of the following physical and mental health subject areas specific to working with older adults:

- a. Understanding of lifespan developmental theories relating to older adults
  
- b. Understanding of 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. Understanding of skills necessary to cope with the emotional and physical challenges associated with the aging process, including how society responds to older adults
  
- d. Appreciation of 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. Recognition of and 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. Appreciation of cultural and ethnic differences among older adults including culturally relevant strategies to promote resilience and wellness in older adults.
- g. Understanding 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. Recognition of the comorbidity of aging related and health-related vulnerabilities and strengths
- i. Recognition of the interplay between general medical conditions and mental health including an understanding of common medications, side effects, drug interactions and presentation.
- j. Understanding of drug use and abuse amongst older adults

## **2. Skills**

- a. 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 healthcare professional and collateral sources, enlisting a multidisciplinary approach to the treatment of older adults.

## **H. Child and Adolescent 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 posttraumatic 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 lifespan (e.g. risk-taking related injuries, substance use and experimentation, sexual experiences, and possible pregnancy).

Clinical mental health counselors (CMHCs) 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 lifespan. 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. CMHCs 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.

CMHCs 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, CMHCs 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. CMHCs 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**

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

#### **Neurophysiological Development**

- a. Understanding of post-natal and infant mental health.
  
- b. Understanding of developmental milestones, transitions, and lifespan theories relating to children and adolescents.
  
- c. Understanding of neurological brain development during childhood and adolescence, and its impact on executive functioning and decision-making.
  
- d. Understanding of physical and sexual development during childhood and adolescence.
  
- e. Understanding of the development of sexual/affective orientation, including the exploration and questioning of sexual and gender identity.

#### **Social, Cultural, and Familial Influences**

- f. Understanding of role of gender and gender identity on development, including the influence of gender role

socialization practices.

g. Appreciation of socio-cultural differences among children and adolescents, including race/ethnicity, acculturation level, family background, and culturally relevant strategies to promote resilience and wellness.

h. Understanding of socio-economic influences on development, including the impact of poverty, homelessness, and displacement.

i. Understanding of social support system in childhood and adolescence, including family, peer, community, and school-based supports.

j. Understanding of impact of bullying experiences and stigma.

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

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

m. Understanding of 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.

n. Understanding of risk factors for externalizing problems such as school truancy, peer influence, substance use, high risk behavior, gang involvement.

### **Diagnosis and Treatment Planning**

o. Understanding of risk factors for internalizing problems such as adjustment problems, anxiety, depression.

- p. Understanding of pre-morbid factors associated with the development of severe and persistent mental disorders such as schizophrenia, bipolar disorder.
- q. Understanding of behaviors associated with neurodevelopmental disorders that include autism, particularly during crucial early developmental period (< 3 years of age).
- r. Understanding of differential diagnosis for mental disorders that can have similar presentations in children, such as anxiety and attention-deficit/hyperactivity disorders.
- s. Understanding of risk factors for suicide attempts by children and adolescence, and differentiating suicidal from non-suicidal self-injury.
- t. Recognition of when referrals are needed for evaluation by a psycho-pharmacologist.
- u. Recognition of how psychopharmacological medication prescribing may differ between children/adolescents and adults, such as dosing.
- v. Recognition for 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.
- w. Understanding of specialized personality, psychopathology, intelligence, and aptitude assessments for children and adolescents, compared with adults.
- x. Understanding of drug use among children and adolescents, and its impact on development.

## **Academic, Vocational, and Career Development**

y. Understanding of factors associated with academic achievement and underachievement.

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

aa. Understanding of 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.

## **Legal and Ethical Considerations**

bb. Understanding of parent/guardian rights during childhood and adolescence, including minors independently seeking healthcare services in the U.S. state where the counselor and client reside.

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

dd. Understanding of 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**

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

### **Neurophysiological Development**

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

b. Implement developmentally-appropriate practices when

counseling youth, such as using play therapy approaches.

c. 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).

#### Social, Cultural, and Familial Influences

d. 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.

e. 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.

f. 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.

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

h. 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.

i. Demonstrate the ability to address social problems facing children and adolescents, including bullying, gang involvement,

peer pressure, and stigma.

j. 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.

k. 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.

l. 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.

#### Diagnosis and Treatment Planning

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

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

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

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

q. 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

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

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

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

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

v. 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.)

w. 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.

#### Academic, Vocational, and Career Development

x. 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.

## Legal and Ethical Considerations

y. 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.

American Mental Health Counselors Association  
107 S. West St, Suite 779  
Alexandria, VA 22314  
*info@amhca.org*  
703-548-6002  
*www.amhca.org*