

# AMHCA Standards for the Practice of Clinical Mental Health Counseling

*Adopted 1979*

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



**AMERICAN MENTAL HEALTH  
COUNSELORS ASSOCIATION**

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The only organization working exclusively for the  
mental health counseling profession

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## 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 seeks 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) 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 over the last 35 years. 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.

## 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 absorbed into the National Board for Certified Counselors credentialing process where it remains. 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, 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;
- 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.

The current AMHCA standards also recommend additional standards related to faculty, supervision and the following:

- Biological Bases of Behavior (including psychopathology and psychopharmacology);
- Trauma and;
- Co-occurring 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 practices
- Differential diagnosis and treatment planning
- Co-occurring disorders and trauma
- 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



- Consultation and supervision

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. Faculty who provide clinical supervision in the program or on site are able to lead supervision seminars which promote case discussion, 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.

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 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.

d. Identify and understand the roles, functions and responsibilities of clinical supervisors including liability in the supervisory process. Communicate 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.

g. Identify and define the cultural issues that arise in clinical supervision and be able to incorporate the cultural aspect 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 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. Supervision includes both formal and informal feedback mechanisms.

j. Maintain a working knowledge of industry recognized financial management processes and required record keeping 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;
- 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.

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 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 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 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 effectiveness research; advocacy; counselor issues 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, 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 and ethical standards 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 course areas 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. 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, 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 most mental health disorders are currently thought to be related to some combination of genetic and environmental factors. There is increasing consensus that biological factors exert especially pronounced influences on several disorders not limited to depression and attention deficit disorders, for example. Biological irregularities or anomalies of the central nervous system that influence behavior can be caused by genetic predisposition, injury or infection. A number of biological risk factors exert important effects on the brain structure and its functioning, and increase the likelihood of developing subsequent mental health disorders, either short or long term.

#### 1. Knowledge

a. Understand the organization of the central nervous system.

b. Understand the role of plasticity and recovery of the brain

across the lifespan.

c. Possess introductory knowledge of the neurobiology of thinking, emotion, and memory.

d. Understand current information about the neurobiology of mental health disorders (mood, anxiety and psychotic disorders) across the lifespan.

e. Possess an awareness of basic screening tools used to assess CNS functioning.

f. Possess basic understanding of reproductive health and prenatal development and how the brain changes across the lifespan.

g. Understand the process of early development including attachment and social environmental factors that influence brain development.

h. Possess knowledge about dementia, delirium and amnesia.

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

j. Possess knowledge about disorders and symptoms that may indicate the need for medication.

k. Possess working knowledge about antidepressants, antipsychotics, anxiolytics, mood stabilizers, cognitive enhancers and drugs of abuse.

## 2. Skills

a. Demonstrate the ability to counsel clients and describe to colleagues the basic organization of the brain as it may relate to mental health.

b. Demonstrate the ability to counsel clients and work with colleagues to understand the ability of the CNS to change and



adapt to life circumstances including traumatic brain injury, physical and sexual abuse and substance abuse.

c. Discuss with clients and colleagues how the neurobiology of thinking, emotion, and memory can impact behavior.

d. Identify current research findings and resources about the neurobiology of mental disorders and discuss these findings with clients and colleagues.

e. Identify and briefly describe common assessment instruments used in brief neuropsychological screening instruments.

f. Demonstrate a working knowledge of the biology of reproduction and prenatal development and discuss with clients and colleagues.

g. Counsel clients from a biologically grounded lifespan developmental approach.

h. Understand and describe the aging brain and how it may change across the lifespan.

i. Understand and explain to clients, family and colleagues the most common signs and symptoms of dementia and strategies to improve functioning.

j. Describe how the body metabolizes drugs and the names of drugs commonly used to treat mental disorders and drugs of abuse.

k. Identify the most common side effects for the most commonly used medications.

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

## 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 define 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. Demonstrate the ability to use developmental 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 Training Standards

The treatment of trauma and chronic traumatic distress is essential for the practice of clinical mental health. Many clients/patients seeking counseling deal with symptoms associated with traumatic experiences. Patients who suffer from the aftereffects of traumatic events or related chronic distress can develop a variety of related disorders and often form negative core self-beliefs. The U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) has addressed trauma in the publication, *Concept of Trauma and Guidance for a Trauma Informed Approach*.

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 its etiology, diagnosis and treatment (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, age, gender, and culture/ethnicity.

c. Understand the distinctions among relational, acute, chronic, episodic, and developmental traumas, and the implications of these for treatment.

d. Understand the impact of various types of trauma (e.g. sexual and physical abuse, war, chronic verbal/emotional abuse, neglect) may have on the central nervous system and how this might impact attachment styles, affect regulation, personality functioning, self-identity, and trauma re-enactment.

e. Recognize the long-term consequences of trauma-causing events on communities and cultures.

f. Understand resiliency factors for individuals, groups and communities that diminish the risk of trauma-related disorders.

g. Understand the application of established counseling theories to trauma treatment.

h. Recognized differential strategies and approaches necessary to work with children and adolescents in trauma treatment.

## 2. Skills

- a. Demonstrate the ability to assess and differentiate the clinical impact of various trauma-causing events.
- b. Demonstrate the ability to use established counseling theories, and evidence-based trauma resolution practices, to promote the integration of brain functioning and help resolve cognitive, emotional, sensory, and behavioral symptoms related to trauma-causing events for socially and culturally diverse clients across the lifespan.
- c. Demonstrate the ability to facilitate client resilience and to resolve long-term alterations in attributions and expectancies.
- d. Demonstrate sensitivity to individual and psychosocial factors that interact with trauma-causing events in counseling and treatment planning.
- e. Demonstrate the ability to recognize that the impact of his/her trauma may impact counseling trauma survivors.
- f. Use differentially appropriate strategies and approaches in assessing and working with children and adolescents in trauma treatment.
- g. Use differentially appropriate counseling and other treatment interventions in the treatment of developmental and chronic traumas.

#### D. Co-occurring Disorders

Substance-related and addictive disorders are most commonly comorbid with other mental health disorders. In other words, individuals with substance use normally have a mental health condition at the same time and vice versa. For example, unresolved PTSD is frequently a significant contributing factor to an addictive disorder. Failure to address both the mental health disorder as well as the substance-related disorder will frequently result in ineffective and incomplete treatment. There are many consequences of undiagnosed, untreated, or undertreated

comorbid disorders including: higher likelihood of experiencing homelessness, incarceration, medical illnesses, suicide, and premature death and it is incumbent upon CMHCs to apply thorough and comprehensive assessment and treatment for co-occurring disorders to prevent neglect, harm and possible death.

1. Knowledge

a. Understand the epidemiology of substance use and co-occurring disorders for socially and culturally diverse populations at risk across the lifespan.

b. Understand theories about the etiology of substance use and co-occurring disorders including risk and resiliency factors for individuals, groups and communities.

c. Possess a working knowledge of the neurobiological basis of addiction, and the mechanisms that underlie substance use disorders.

d. Understand how drugs work including routes of administration, drug distribution, elimination, dependence, withdrawal, dose response interaction, and how to interpret basic lab results.

e. Recognize the potentials for addictive disorders to mimic a variety of medical and psychological disorders and to cause such disorders.

f. Understand treatment and clinical management of common co-occurring disorders (anxiety, depression, PTSD and trauma-related disorders, dissociative disorders, personality disorders, eating disorders, psychotic disorders, disruptive behavior, and mood disorders) with substance use disorders.

g. Understand the current history, philosophy, and trends in substance abuse counseling including treatment relying on stages of change (e.g. (motivational interviewing) and self-help (AA and NA).

h. Understand ethical and legal considerations related to the practice of addiction, and co-occurring disorders in diverse settings including inpatient units and the criminal justice system.

## 2. Skills

a. Demonstrate the ability to screen clients' stage of readiness for change and gauge the severity of their co-occurring disorders.

b. Conceptualize cases using stage-wise approach to addiction and mental health treatment, and develop a treatment plan based on the conceptualization that addresses mental health and addiction issues simultaneously.

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

d. Provide appropriate counseling strategies when working with clients co-occurring disorders.

e. Demonstrate the ability to provide counseling and education about substance used disorders, and mental/emotional disorders to families and others who are affected by clients with co-occurring disorders.

f. Demonstrate the ability to modify counseling systems, theories, techniques, and interventions for socially and culturally diverse clients across the lifespan with co-occurring disorders.

g. Demonstrate the ability to recognize his/her own limitations as a co-occurring disorder counselor and to seek supervision or refer clients when appropriate.

h. Demonstrate the ability to apply and adhere to ethical and legal standards in addiction and co-occurring disorder counseling.

## 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/patient's 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.



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