

## INVITED ARTICLE

# Clinical Mental Health Counseling: A 40-Year Retrospective

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*In 2016, the American Mental Health Counselors Association (AMHCA) celebrated its 40th year. This retrospective article incorporates documents and interviews with key leaders to examine the development of clinical mental health counseling and outline projected future directions. Particular attention is given to the importance of events during the past decade and the needs of the membership for the coming decade.*

Since its inception in 1976, the American Mental Health Counseling Association (AMHCA) has taken a strong position on the need for high counselor preparation standards in the establishment of licensure, credentialing, and reimbursement for services by third parties such as federal and private health insurance companies. The willingness of AMHCA leaders to continue advancing this agenda over 40 years has resulted in the rapid growth of clinical mental health counseling (CMHC) over the past decade that has further established the position of CMHCs in the marketplace. This article traces the origins of CMHC to understand critical events of the past 10 years.

### THE HISTORY AND ROLE OF THE AMERICAN MENTAL HEALTH COUNSELORS ASSOCIATION

The father of vocational guidance, Frank Parsons, had coined the term “counselor” in the pre-World War II era to distinguish between his legal work as an attorney (“counsellor-at-law”) and his work in vocational guidance (“counselor”; T. Clawson, personal communication, April 12, 2016). The profession of counseling initially focused on the specialties of vocational guidance and school guidance counseling, as reflected in the national organization’s original title of the National Vocational Guidance Association (NVGA). As the profession evolved, its association was renamed the American Personnel

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*Several key figures were interviewed in the development of this article, specifically: Nancy Benz, Carol Bobby, Gary Gintner, Steve Giunta, Mark Hamilton, Jim Messina, Keith Mobley, Ted Remley, and Tom Clawson. In addition, Jim Finley and Karen Langer provided editorial assistance. This article substantially benefitted from their insights.*

and Guidance Association (APGA), the American Association for Counseling and Development (AACD), and finally the American Counseling Association (ACA). For ease of understanding, this organization will be referred to only as ACA throughout the remainder of the manuscript regardless of the time period under discussion.

CMHC was launched as a specialization within the counseling profession in the mid 1970s. The foundation of AMHCA has been well documented in several sources, including Weikel (1985), Colangelo (2009), and recently Messina (2016). In 1976, Jim Messina and Nancy Spisso were working at a community mental health center that had been established by Federal funding as part of the de-institutionalization movement of the 1970s (J. Messina, personal communication, March 11, 2016). In February 1976, Messina and Spisso read a newsletter entry in the ACA's *The Guidepost* that called for the creation of a new organization to represent mental health counselors who worked in community agencies and other clinical settings (Messina, 2016). Messina and Spisso formed a group that established AMHCA as an independent non-profit organization in Florida after their application for the establishment of a new ACA division was delayed because of an existing moratorium on starting new divisions (Colangelo, 2009). Messina modeled the AMHCA name after the American School Counseling Association (ASCA), as he was active in ASCA during the early and mid-1970s (J. Messina, personal communication, March 11, 2016). By 1977, ACA had resolved their moratorium on the creation of new divisions and welcomed AMHCA to re-apply. AMHCA members voted to join ACA as a division, which was completed in 1978. At the time of writing, AMHCA remains affiliated as an ACA division though it assumed financial independence from ACA in 1998.

By 1981, the new organization had established six “pillars” on which CMHC would be upheld. One of these pillars was a position on ideal licensure and credentialing standards. These standards reflected Messina’s forward-thinking vision of defining and regulating CMHC in a manner that was comparable with other clinical service providers in the mental health services landscape such as clinical social workers (Colangelo, 2009).

## TRAINING AND CREDENTIALING STANDARDS

Several years later, two important organizations were founded independently from ACA. In 1981, the Council for Accreditation of Counseling and Related Educational Programs (CACREP) was established with the mission to accredit counseling programs. The initial CACREP Standards were developed from earlier educational standards created by the Association for Counselor Education and Supervision (ACES) under the leadership of Robert Stripling. In 1982, the National Board for Certified Counselors (NBCC) was established to support the national credentialing of counselors. This has included the administration of examinations required for counselor licensure, most notably the National Counseling Exam (NCE) and National Mental Health Counseling Exam (NCMHCE).

AMHCA worked collaboratively with these organizations to establish educational standards and credentialing requirements. Messina and other AMHCA leaders had created their own separate credentialing organization in 1979 prior to the establishment of NBCC, called the National Academy of Certified Clinical Mental Health Counselors (NACCMHC). The NACCMHC's original requirements included completing 60 semester hours and passing an examination. The semester hour and examination requirements would become a hallmark of how Messina and AMHCA envisioned recommended CMHC preparation requirements for independent practice (J. Messina, personal communication, March 11, 2016). By 1993, NACCMHC was struggling financially and agreed that its CCMHC certification was to be subsumed by NBCC. Following the merger, NBCC bolstered the CCMHC requirements by crafting a more elaborate exam known as the NCMHCE (T. Clawson, personal communication, April 12, 2016).

AMHCA's relationship with CACREP has been one of mutual respect, support, and engagement. From the mid-1980s until 2009, AMHCA urged CACREP toward more rigorous preparation standards for CMHCs. In 1984, the CACREP Board of Directors had established Community and Other Agency Counseling Programs as one of three CACREP specialization areas (C. Bobby, personal communication, March 23, 2016). Following AMHCA's advocacy that the earlier title did not reflect an appropriate professional identity, the title was changed to Mental Health Counseling: Community and other Agency Settings (Colangelo, 2009).

CACREP's first Standards Revision Committee of 1986-87 proposed that three specializations be retained for CACREP's 1988 Standards, with the Mental Health Counseling: Community and other Agency Settings title reduced to Mental Health Counseling. AMHCA was in support of this change. However, AMHCA wanted the Mental Health Counseling specialization to require 60 semester hours and 900 internship clock hours, which ran contrary to the Committee's proposal that all three programs should require 48 semester credits and 600 internship clock-hours. This was the first time that CACREP had proposed a set credit hour requirement for program accreditation (Bobby, 2013). CACREP did not believe at the time that the field could sustain this leap to 60 semester hours, and feared programs would drop CACREP accreditation or cease seeking it (C. Bobby, personal communication, March 23, 2016). Since CACREP accredited only 45 separate institutions as of 1986, there was a fear that losing accredited programs could put CACREP out of business (C. Bobby, personal communication, March 23, 2016). CACREP avoided an impasse in 1988 by establishing two separate specialization tracks: Community Counseling (48 semester credits, 600 internship clock hours) and Mental Health Counseling (60 semester credits, 900 internship clock hours). This move resulted in confusion among the profession because it effectively created a two-tier system (Bobby, 2013). Over the next seven years, only four more programs were accredited under the Mental Health Counseling specialization compared with 77 programs under the Community Counseling specialization (Bobby, 2013). The slow trickle of Mental Health Counseling programs

accredited by CACREP continued for the next eight years. As of 2001, only 22 Mental Health Counseling programs were accredited compared with 118 Community Counseling programs (Bobby, 2013).

AMHCA continued to advocate for Mental Health Counseling to be the sole clinical counseling specialization area in the CACREP standards. Eventually, CACREP's 2009 Standards resolved this issue by replacing the two specializations with one specialization entitled Clinical Mental Health Counseling (Bobby, 2013). This single specialization reflected a compromise; the CMHC specialization was 60 semester credits, as AMHCA had initially wanted (Community Counseling had remained at 48 semester credits). However, the CMHC specialization also required only 600 internship clock-hours, as opposed to the 900 internship clock hours that AMHCA had initially proposed (Bobby, 2013). CACREP's creation of a CMHC specialization was significant. By 2014, graduation from a CACREP-accredited CMHC program became a phased-in requirement for independent practice within the military healthcare system known as TRICARE.

In 2016, the CACREP Common Core Standards were revised to incorporate many of the CMHC specialization standards into the common standards for all specialization areas (C. Bobby, personal communication, March 23, 2016). Furthermore, all CACREP specialization areas were increased to 60 semester hours as of 2020. CACREP's eventual willingness to incorporate AMHCA's desired changes was one example among several over the past decade of how AMHCA's strong and persistent stance toward high standards for the CMHC specialization eventually led to change and progress.

## STATE LICENSURE RECIPROCITY AND PORTABILITY

Within the past decade, counseling has become recognized as a regulated profession in all 50 states. The first counselor licensure law was passed in Virginia in 1976 when a group led by Carl Swanson of James Madison University opposed an attempt by psychologists to license master's-level practitioners so that psychologists could supervise their practice (T. Clawson, personal communication, April 12, 2016). In response, Swanson's group successfully lobbied for professional counselors to be licensed for independent practice. The "licensed professional counselor" title required applicants to complete 36 semester-credits at the time (T. Clawson, personal communication, April 12, 2016). Virginia's law was followed by the efforts of a group led by Messina in Florida, who established a counselor licensure law in 1981. Messina's group selected "licensed mental health counselor" for the title. The differing titles for counselor licensure would become problematic as counselor licensure extended across all 50 States.

In 2010, California became the last state to institute counselor licensure. Despite this significant achievement, state licensure laws have differed with regards to licensure title (e.g., "licensed professional counselor," "licensed mental health counselor"), educational requirements (e.g., 48 vs. 60 semester hours), hours of supervised experience (usually anywhere from 2,000 to

4,000 hours), examination requirements (NCE or NCMHCE), and even scope of practice (e.g., some states do not allow counselors to diagnose clients with a mental disorder). For example, 34 states require a 60 semester credit master's-degree, whereas nine states require a 48 semester credit degree. The differences among state counselor licensure laws have created problems with the portability of the counseling license. If a counselor decides to re-locate and practice in another state, the new host state may not allow the re-located counselor to transfer the license from their home state to their new host state (known as reciprocity), because licensure requirements may be inconsistent between the two states. In some cases, host states require re-located counselors to complete additional education or supervised experience to meet their requirements. Problems with counselor licensure reciprocity and portability were addressed as part of a series of summit meetings from 2006 to 2013. These meetings were co-sponsored by ACA and the American Association of State Counseling Boards (AASCB) and entitled *20/20: A Vision for the Future of Counseling* (hereafter, the 20/20 Initiative). It should be noted that the ACA had proposed model licensure language much earlier in 1990 (Bloom et al., 1990). The model licensure language had minimal success in addressing the lack of standardization in counseling licensure laws across states.

AMHCA was an active participant in the meetings of the 20/20 Initiative through the presence of several leaders including its CEO, Mark Hamilton, and AMHCA Past-Presidents such as Gary Gintner, Linda Barclay, and Steve Giunta (M. Hamilton, personal communication, March 25, 2016). Delegates from all but two of the 31 groups (29/31) reached consensus on the common definition of counseling, scope of practice, and also proposed that the title “licensed professional counselor” become the standard title across states. The agreed-upon common definition was as follows: “counseling is a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals” (Kaplan, Tarvydas, & Gladding, 2014, p. 368). AMHCA representatives supported this definition but opposed the title, since it was felt to be too broad and to not adequately represent CMHCs. Although consensus could not be originally reached on educational requirements for licensure, this issue was later resolved when CACREP and CORE merged into one accrediting body for counseling. Despite the significant efforts of the 20/20 Initiative, perhaps a more important factor in mobilization towards reciprocity and portability occurred later when an external panel commissioned by the National Academy of Sciences appraised counselors for potential inclusion as independent practitioners within the military healthcare system known as TRICARE.

### RECOGNITION BY FEDERAL AGENCIES

The counseling profession has attempted to gain recognition by Federal agencies as core providers of mental health services for more than 25 years. Both AMHCA and ACA have focused their legislative agendas on achieving the authority for licensed counselors to independently bill for reimbursable

services without having another medical practitioner sign off on the insurance claim within the military healthcare system known as TRICARE, the Veterans Affairs system, and the Medicare system.

### ***Military Healthcare and Veteran's Affairs Recognition***

An important legislative priority for the counseling profession was establishing CMHCs as providers within the Veteran's Affairs and independent practitioners within the military healthcare system known as TRICARE (G. Gintner, personal communication, March 18, 2016). Prior to this, CMHCs could only be reimbursed for services within TRICARE if a physician signed off on their work (i.e., counselors were non-independent practitioners). The process towards achieving independent practice status within the TRICARE system was lengthy and involved the appraisal of the counseling profession by an external independent agency (Institute of Medicine, 2010). In response to an ACA proposal for the Federal government to evaluate the qualifications of professionals providing mental health counseling services under TRICARE, the United States Congress passed legislation in the late 2000s that commissioned a component of the National Academy of Sciences, the Health and Medicine Division (HMD, formerly known as the Institute of Medicine), to form a committee that would evaluate the counseling profession (T. Clawson, personal communication, April 12, 2016). Two counselor educators were asked to serve on the panel of 12 healthcare professionals: Ted Remley, a former ACA Executive Director, and Vilia Tarvydas, a rehabilitation counselor educator. The ten other panel members were medical professionals, such as physicians, nurses, and physical therapists. The task of the panel was to determine equitable preparation standards in comparison with other professions (T. Remley, personal communication, March 25, 2016). Seeing the dearth of standardized licensure requirements across states, the panel invited national counseling organizations to present to the committee. Representatives from AMHCA (Mark Hamilton), ACA (David Kaplan), CACREP (Carol Bobby), and NBCC (Tom Clawson) all presented their organizations to the committee, though did not participate in decision making. In addition, CACREP was asked to provide a copy of their 2009 Standards (C. Bobby, personal communication, March 23, 2016), and NBCC was asked to provide a copy of their NCE and NCMHCE examinations (T. Clawson, personal communication, April 12, 2016). After reviewing this information, the panel decided to uphold national clinical counseling standards and to require the highest preparation criteria for independent practice within the TRICARE system (T. Remley, personal communication, March 25, 2016). The 2015 modification of the final rule required that after 01/01/2021, CMHCs operating independently within the TRICARE system must graduate from a CACREP-accredited CMHC program and pass NBCC's NCMHCE exam. These requirements were a surprise to many, including ACA, AMHCA, CACREP, and NBCC. Following on the panel's recommendation in 2010, the U.S. Veteran's Administration (VA) decided to recognize licensed counselors as qualified professionals within their system, provided that

they are graduates of a CACREP-accredited program. Hiring rates within the VA have been slow following this decision. This is likely caused more by the gradual nature of change within the system rather than by institutional policies (J. Finley, personal communication, May 25, 2016).

The leadership of AMHCA was generally supportive of the HMD panel's recommendations and the TRICARE regulation that derived from it. In part, AMHCA supported the Federal rule because both the CACREP CMHC specialization and NBCC NCMHCE examination were highly influenced by AMHCA's original preparation standards. Mark Hamilton later stated:

AMHCA felt favorable about the standards coming out of the panel's work. We were pleased with what was done. The bar was set high for what CMHCs needed to do [to be recognized as independent practitioners within the TRICARE system], and this was in-line with what AMHCA wanted all along. (M. Hamilton, personal communication, March 25, 2016).

The Department of Veteran's Affairs decision and TRICARE regulation (Department of Defense, 2014) effectively validated CACREP's CMHC specialization as *the* educational standard for CMHC practice. Some leaders believe that the TRICARE Final Rule effectively defined professional preparation standards for counselors, since federal standards are appraised as having greater impact on professional unification than state standards (M. Hamilton, personal communication, March 25, 2016; T. Remley, personal communication, March 25, 2016). The support for CACREP as the educational standard for counselor licensure has been increasingly reflected in state licensure requirements. Currently, 23 states recognize licensure applications from CACREP graduates and three states (Kentucky, North Carolina, and Ohio) require all future licensure applicants to be graduates of a CACREP-accredited program. As of 01/01/2022, national certification through NBCC (including the CCMHC) will also be limited exclusively to CACREP graduates. As a consequence of the HMD panel recommendations and TRICARE Final Rule, CACREP experienced a "groundswell" of CMHC programs. In 2015, the CMHC specialization, in combination with the older Community Counseling and Mental Health Counseling specializations, overtook School Counseling as having the most accredited programs (C. Bobby, personal communication, March 23, 2016).

AMHCA has long supported CACREP standards as the single educational requirement for future licensure, and initiated discussions with NBCC and later ACES between 2014 and 2016 to craft a portability plan that supported CACREP as the educational requirement for licensure, to include generous grandfathering provisions and several alternative routes such as certification as an NBCC National Certified Counselor, or fulfilment of standards adopted by a state counseling licensure board (NBCC, 2015). The plan was finalized in 2015, and recommends that counselors hold an active license within their home state for two years before being able to transfer their license to another state. Within a few months, CACREP retired its previous portability statement

and supported the AMHCA, ACES, and NBCC portability plan (K. Mobley, personal communication, May 11, 2016). Subsequently, the AASCB published a portability plan that largely supported the AMHCA, ACES, and NBCC portability plan, but also required counselors to be licensed in their home state for at least five years before transferring their license to another state. In 2016, the ACA announced their support for CACREP as the educational standard for licensure. These portability plans resulted in 11 states (at the time of writing: Delaware, District of Columbia, Idaho, Iowa, Kansas, Louisiana, Michigan, Ohio, Oklahoma, Utah, and Vermont) being willing to license counselors from another state provided they have been licensed for more than five years in their home state, with an additional two states (Arizona, Virginia) licensing counselors provided they have been licensed for two and three years in their home states, respectively.

Ted Remley, one of the two HMD panel members, experienced a change in his opinions about the HMD panel decision based on this growth:

At first, I was very disappointed with this recommendation because I believed it discriminated unfairly against licensed counselors. However, I now see that this decision has propelled the counseling profession forward and was good for the development of the profession. I believe the movement in states to require graduation from a CACREP-accredited master's degree program for licensure is a direct result of the panel decision. Ultimately this movement will solidify the position that CACREP is the recognized accreditation required of programs that prepare professional counselors. If preparation from a CACREP-accredited counseling master's degree program would be adopted by all states as a minimum for counselor licensure, and if all states would adopt the same examination for counselor licensure, then the most difficult issues related to the portability of licensure from one state to another would be resolved (T. Remley, personal communication, March 25, 2016).

### *Medicare Recognition*

One of the most important legislative priorities for the counseling profession has been to establish Medicare independent provider status for CMHCs (M. Hamilton, personal communication, March 25, 2016). Medicare provider status is seen as a vital step for the deeper inclusion of CMHC in an integrated care environment. Moreover, Medicare provider status for CMHCs would ensure adequate mental health care for the increasing population of older adults. Over the next 20 years, it is anticipated that the U.S. population of older adults will double, resulting in the number of older adults with mental health conditions rising from eight to fifteen million (AMHCA, 2016). The current number of Medicare providers would not be able to meet this anticipated greater demand for services. CMHCs are well positioned to be of assistance.

As with other professions, such as psychology, which waited 25 years to obtain Medicare independent provider status, the counseling profession has



experienced multiple roadblocks to establishing CMHCs as independent providers within the Medicare program (J. Finley, personal communication, May 25, 2016). Federal legislation to establish CMHCs as Medicare independent providers has been introduced several times, and first passed the Senate in 2003 (J. Finley, personal communication, May 25, 2016). Currently Congress is concerned with the cost of the Medicare program and follows budgetary procedures to limit any additional costs to the program (J. Finley, personal communication, May 25, 2016). When professions such as counseling lobby to be recognized as Medicare independent providers, the Congressional Budget Office (CBO) must prepare a cost estimate of the anticipated cost to the Federal budget (J. Finley, personal communication, May 25, 2016). CBO scoring principles generally assume that additional Medicare providers would likely result in more services being provided, resulting in higher cost to the program. Increasing the cost of the Medicare program has been met with resistance in the current political climate, because of concerns about the long-term affordability of the Medicare program (J. Finley, personal communication, May 25, 2016).

Medicare has become the focal legislative priority for AMHCA following the advent of the Patient Protection and Affordable Care Act (PPACA) in 2010 and implementation of the TRICARE Final Rule beginning in 2014. The PPACA established several demonstrations of integrated care models, including *patient centered medical homes* that provide comprehensive integrated primary medical and behavioral healthcare. AMHCA expects that these demonstrations would prioritize the recruitment of practitioners who can independently bill Medicare (S. Giunta, personal communication, May 11, 2016). If CMHCs are not included as an independent provider in the Medicare system, it would likely affect CMHC hiring rates and earning potential. To prevent this from becoming a reality, AMHCA plans to continue its lobbying for support of Medicare provider status legislation. In 2015, the AMHCA Board crafted its own definition for CMHC that reflected the need for CMHCs in integrated healthcare settings and positioned the profession as one that was worthy of Medicare core provider status:

Clinical mental health counselors (CMHCs) are primary mental health providers (PMHPs) who offer high-quality, comprehensive, integrative, cost-effective services across the lifespan. Uniquely qualified licensed clinicians, CMHCs are trained to provide mental health assessment, prevention, diagnosis, and treatment. CMHCs promote wellness and human development through early intervention and personal empowerment (AMHCA, 2015).

In addition, AMHCA has provided trainings to state chapters regarding advocacy for Medicare core provider status, and AMHCA's current public awareness efforts such as the Older Americans and Aging campaign are focused on highlighting the CMHCs role in mental healthcare for seniors.

## CONCLUSION

Since its origins, AMHCA has sought rigorous standards for CMHCs because it believed that strong preparation standards would result in the profession being compared favorably with other clinical mental health professions such as clinical social work and clinical psychology, which had already established Federal recognition. The HMD panel's decision to uphold these same high standards as requirements for independent practice within the military healthcare system validated AMHCA's position, particularly because the panel reached their decision after comparing CMHC standards with related healthcare professions.

AMHCA's strong stance and unshakable persistence towards preparation standards has been renegade at times, yet arguably has resulted in the rapid growth of the CMHC profession over the past 10 years (K. Mobley, personal communication, May 11, 2016). Advancements such as CACREP establishing CMHC standards as a specialization within the broader professional counseling field and CMHCs being identified as independent practitioners within TRICARE seem to be strongly influenced by AMHCA's strong stance on unified high standards for education and training. AMHCA anticipates that its vision and support for high CMHC preparation standards will eventually be reflected in any future law that establishes CMHCs as independent providers in the Medicare system (J. Finley, personal communication, May 25, 2016).

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