Counselor Credentialing and Interprofessional Collaboration

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The history and development of counselor credentialing are presented, including the dimensions of standards, accreditation, certification, and licensure. Unresolved issues critical to the success of interprofessional collaboration are analyzed. The authors offer predictions for the future of the nonmedical mental health professions, based on their assessment that collaboration is an essential but often neglected ingredient.

The profession of counseling is the most recent entrant of the nonmedical provider groups into the arena of credentialing. Psychology and social work were already well established with statutes in most states by the time professional counselors became active in seeking credentialing in the early 1970s. Marriage and family therapists had been successful in passing licensure legislation in California and in two other states in the mid-1960s, but because of their comparatively small numbers in many parts of the country, their state affiliates had achieved relatively few other legislative victories by the time mental health counselors began to score gains at the rate of several states per year in the early 1980s. As of this writing (winter 1990), laws regulating the use of the title and/or the practice of counseling had been passed in 33 states. Accounting for this impressive record, especially during a time when state legislatures have been increasingly reluctant to pass new licensure laws, requires first a look at the philosophical and therapeutic traditions of the counseling profession.

"COUNSELING HELPS PEOPLE GROW"

The heading for this section appeared several years ago on bumper stickers and other promotional items distributed by the American Association for Counseling and Development (AACD). While to our knowledge it won no public relations awards, the slogan is an expression of perhaps the most basic difference between counseling and the other mental health disciplines. From its beginnings in vocational guidance, professional counseling has insisted upon the necessity of viewing clients as basically healthy individuals whose problems are essentially developmental in nature. The first principle of therapeutic intervention springing from this philosophical premise is that counselors focus on clients' strengths and build on them.

Even in those instances in which other than situational or developmental problems are at issue, counselors still see their clients as primarily healthy, but as wrestling with temporarily disabling conditions. The preferred interventions of most counselors are likely to be psychoeducational, based on the idea that psychotherapy is an educational process because behavior change is a learning process. Furthermore, counselors are more likely than most other providers to be involved in skills training activities that are aimed at prevention of emotional distress as well as its remediation.

The Core Knowledge Base

In 1973 the Association for Counselor Education and Supervision (ACES), one of the founding divisions of AACD, adopted *Standards for the preparation of counselors and other personnel services specialists* (ACES, 1973), which spelled out the knowledge base fundamental to counselor training. Even though several years passed before any graduate programs were accredited using the standards as criteria, the knowledge base defined therein represented a professional consensus as to the practice of counseling. This knowledge base consisted of eight core areas: (a) *human growth and development* (emphasizing that counseling is a developmental process); (b) *social and cultural foundations* (counseling considers gender, ethnicity, poverty, and other cultural and environmental variables in the intervention process); (c) *the helping relationship* (counseling theories and techniques and relationship formation and development); (d) *group counseling and group dynamics* (understanding the potency of group dynamics as a curative element and being skilled in its application); (e) *lifestyle and career development* (more than any other mental health professionals, counselors are well versed in the theory, practice, instrumentation, and information base of career development); (f) *appraisal* (skills in the selection, administration, interpretation, and application of objective and projective tests); (g) *research and evaluation* (skills in the evaluation of individual and group counseling and psychotherapy as well as the assessment of other interventions); and (h) *professional orientation* (training in the history, philosophy, ethics, governance, and credentialing structures of the counseling profession).

Additional Training Standards

In addition to the eight core knowledge areas just enumerated, counselor education programs must include environmental and specialized studies and clinical instruction as elements in students' training. The environmental studies focus on knowledge and skills related to the settings in which students will practice, while specialized studies deal with specific populations and practice modalities.

Clinical instruction encompasses the acquisition and application of clinical counseling skills. This component requires extensive laboratory, practicum, and internship experiences, all under supervision. Depending on the program in which a student is enrolled, these experiences may range from 700 to 1,000 hours.

COUNSELOR ROLES IN THE SERVICE DELIVERY SYSTEM

Long established in educational roles and settings, counselors are relative newcomers to health care settings. With the excep-

tion of rehabilitation counselors, who had their origins in medical settings in the post-World War II period, counselors as health care providers began to emerge in the late 1960s and early 1970s.

Mental health counselors were originally conceived (Seiler & Messina, 1979) as being members of multidisciplinary treatment teams within community mental health centers. The American Mental Health Counselors Association (AMHCA) was founded in 1976 with the expectation that the primary work setting of its members would be in the community mental health centers. What has recently emerged is that private practice is now the dominant work setting not only for AMHCA members but also for AACD members generally. Sometime in the mid-1980s the private practice contingent became more numerous than counselors working in K–12 educational settings within the AACD membership as a whole.

Other than in private practice and community mental health centers, mental health counselors work in group practices, hospitals, drug treatment centers, rehabilitation facilities, college and university counseling and mental health centers, veterans centers, gerontological facilities, business and industry, and social services agencies. They serve as psychotherapists, consultants, administrators, faculty members, researchers, supervisors, and trainers. They collaborate with physicians, psychologists, social workers, marriage and family therapists, nutritionists, physical therapists, nurses, evaluation specialists, and personnel directors, among others (Nicholas, Gerstein, & Keller, 1988). In short, mental health counselors fill a wide range of roles in the service delivery system (see Table 1), even though they are relative newcomers, are not credentialed in 17 states, suffer from status inferiority compared to psychologists and social workers, and often suffer from job discrimination.

Table 1 portrays on a comparative basis the service delivery roles and functions of nonmedical mental health professionals. While mental health counselors perform most of the same tasks as the other provider groups, we suspect that there are substantial differences in treatment philosophies. For example, mental health counselors would approach clinical issues from a psychoeducational, developmental, and psychopathological perspective, while marriage and family therapists would rely on a systemic point of view, psychologists a psychopathological perspective, and social workers a sociological point of view.

ACCREDITATION, CERTIFICATION, AND LICENSURE

The elements that make up the counseling profession's credentialing mechanisms each have different, but somewhat parallel, histories. Although there have been attempts to coordinate these procedures, each has developed more or less independently, responding to different demands. The relationships among the components of counselor credentialing are not clear or systematic. Ideally, accreditation, certification, and licensure would all proceed developmentally from the standards originally adopted by ACES in 1973 and subsequently revised by the Council for Accreditation of Counseling and Related Educational Programs (CACREP).

Accreditation

CACREP was established by AACD in 1981 as a free-standing, legally incorporated accreditation body. Representatives of AACD, interested AACD divisions, and, potentially, other professional organizations make up the Council, which renders accreditation decisions based on revisions of the standards adopted by ACES in 1973. Approximately 65 counselor education programs are accredited by CACREP as of this writing. These programs offer master's level training in mental health, community, and school counseling, in three areas of student affairs practice, and doctoral training in counselor education and supervision.

Professional Certification

Counselors may avail themselves of credentials awarded through one generic and three specialty certification procedures. The generic certification is known as National Certified Counselor (NCC), administered by the National Board for Certified Counselors (NBCC). The specialty certifications are Certified Rehabilitation Counselor (CRC), Certified Clinical Mental Health Counselor (CCMHC), and National Certified Career Counselor (NCCC), administered by the Commission on Rehabilitation Counselor Certification, the National Academy of Certified Clinical Mental Health Counselors, and NBCC, respectively.

National Certified Counselors and *National Certified Career Counselors.* By 1988 there were more than 17,000 National Certified Counselors (NCC). In order to obtain their certificates, these

TABLE 1
Functions of Mental Health Professionals in Health Care Settings

	Degree						
	Master's			Doctorate			
Functions	Mental Health Counseling	Marriage/ Family Therapy	Social Work	PhD/EdD Couns. Educ.	PhD Couns. Psych.	PhD Clin. Psych.	PsyD Clin. Psych.
Psychoeducation	x	x	x	x	x		
Clinical or direct service	x	x	x	x	x	x	x
Supervision	x	x	x	x	x	x	x
Administration	x	x	x	x	x	x	x
Program development	x	x	x	x	x	x	x
Program evaluation				x	x	x	
Consultation	x	x	x	x	x	x	x
Research				x	x	x	

Note. An x equals a competency, assuming appropriate coursework and training experiences have been completed.
From "Behavioral Medicine and the Mental Health Counselor: Roles and Interdisciplinary Collaboration" by D.R. Nicholas, L.H. Gerstein, and K.E. Keller, 1988, *Journal of Mental Health Counseling, 10,* p. 81. Copyright 1988 by the American Mental Health Counselors Association. Adapted by permission.

individuals submitted application forms, graduate transcripts, records of supervised experience, and letters of recommendation and sat for a knowledge-based examination. The NBCC has maintained that those whom it certifies are individuals who meet its standards but stated in its first national register that "It is not the intent of this register to in any way evaluate the competency or quality of services provided by counselors listed or not listed" (National Board for Certified Counselors, 1985, p. viii).

While it is difficult to construe the NCC as anything other than a generic, entry-level credential, those who hold it, especially in states without a counselor licensure board, view it as recognition of clinical competency far beyond any criteria evaluated in the credentials review process. With the exception of those who hold the state counselor license, there are more persons in private clinical practice with the NCC than with any other credential.

The NCCC is a specialty certification administered by NBCC that recognizes individuals who choose to meet additional standards in the area of career counseling. Most NCCCs focus their practices on career development issues and do not consider themselves clinical practitioners.

Certified Rehabilitation Counselors. Rehabilitation counseling claims the earliest certification process within the professional counseling "family" (Livingston, 1979). Since its origins in 1973, the Commission on Rehabilitation Counselor Certification has administered its examination to more than 12,000 persons. A relatively small number of CRCs, however, are primarily engaged in clinical counseling. Most CRCs work with clients with physical disabilities, with the goal of returning them to productive employment. After more than 15 years, the CRC is a credential whose appeal is based on professional identity and development as opposed to being a widespread statutory or regulatory requirement for rehabilitation counseling positions.

Certified Clinical Mental Health Counselors. Since 1979 the National Academy of Certified Clinical Mental Health Counselors has certified more than 1,400 professionals. The Academy based its credentialing standards on its founders' judgment of criteria that were necessary for the independent practice of clinical mental health counseling as well as those criteria likely to be recognized by insurance carriers as meeting requirements for third-party reimbursement. Like the CRCC the Academy was founded before CACREP or NBCC had come into being, but after the 1973 standards had been adopted. Thus while its founders were knowledgeable about the standards, the Academy promulgated certification criteria that went well beyond the 1973 document in their emphasis on diagnosis and treatment of mental and emotional disorders. The CCMHC credential has been recognized by the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) as meeting standards for reimbursement with physician referral, the only one of the professional counseling certifications to be so endorsed.

Nearly all CCMHCs are engaged in clinical practice, either privately or in agency settings. The certification process is the most stringent of all those discussed in this section, requiring a taped clinical work sample, in addition to transcripts, evidence of clinical supervision, recommendations, and a national examination with a strong clinical emphasis. The CCMHC has been endorsed by AMHCA as the standard for independent clinical practice. Criteria roughly equivalent to the CCMHC have been adopted by the AACD Governing Council as the standards by which the association's government relations efforts in the area of third-party reimbursement will be measured.

State Licensure of Counselors

Efforts to achieve passage of state licensure laws regulating the title and/or practice of professional counseling began in the early 1970s. Several lawsuits by state psychology boards against professional counselors over the right to practice as well as emerging identity issues within counseling itself led to the creation of the AACD Licensure Committee in 1974 (Brooks, 1986). [*Reader note:* Prior to 1983 AACD was known as the American Personnel and Guidance Association (APGA). For the sake of simplicity, AACD is used throughout this article to refer to the umbrella national professional organization for counselors regardless of the historical time period under discussion.] In the years since 1974, through the efforts of active state committees and of hundreds of volunteer political activists, counselor licensure laws have been passed in 33 states (see Gerstein, 1988).

When the first of the counselor licensure statutes was passed in Virginia in 1976, the standards were only 3 years old and enjoyed less than the overwhelming prestige that incorporation by CACREP and NBCC later conferred upon them. The language of the counselor laws from the very beginning was vague as to specification of academic course work, wisely leaving such determinations to board rules and regulations after the laws were passed. The laws in most states directed the boards to take the standards of national professional organizations into account when establishing such regulations. The result to date is that there is variable conformity of state licensure requirements to the 1973 standards as well as little uniformity between licensure and certification requirements.

Academic requirements in the legislation vary from 30 to 60 graduate semester hours, including a master's, while supervised experience requirements vary from 2 to 4 years. Most states use the examination developed by NBCC for its certification process, but at least two other examinations are in use in various jurisdictions (Gerstein, 1988). The American Association of State Counseling Boards (AASCB) was founded in 1986 to foster communication and shared problem solving among the boards (Dingman, Swanson, Brooks, & Schmitz, 1988).

REQUIREMENTS FOR LICENSURE

The counseling profession engaged in an extended internal debate during the late 1970s and early 1980s as to the requirements for counselor licensure. As has already been mentioned, many of these kinds of decisions leave the profession's hands once a bill is introduced into a legislative body. It is important to note, however, that the AACD Licensure Committee has taken positions in such matters that, in most instances, have borne some resemblance to the legislative outcome.

The requirements for licensure, as specified in both model legislation recommended by the AACD Licensure Committee (see Bloom et al. on page 511 in this special feature; copies of the model legislation are also available from Sylvia Nisenoff, AACD librarian) and in legislation actually enacted, fall into three categories—academic, supervised experience, and examination requirements.

Academic Requirements

All statutes (or board regulations where applicable) and the model legislation specify that applicants possess at least a master's in counseling or a closely related field. There is substantial variability in both the number of credits composing the graduate course of study as well as the actual content thereof.

Alabama (passed in 1979), for example, requires only 30 semester hours, whereas Virginia (passed in 1976), in its board regulations rather than in its law, requires 60 semester hours. Other states specify 36, 45, or 48 credits, a 2-year master's, or leave the matter up to the boards to decide (see Gerstein, 1988).

In terms of course content, there is similar variability. Some states are quite specific, either in statute or in board regulations, while others make a general reference to the standards of national professional organizations. In nearly all cases, graduates of programs that are similar in length and content to the CACREP standards, whether they were actually accredited or not, would likely meet academic requirements. Exceptions would occur in those states that require 60 semester hours or in those that have differential standards. Ohio, (passed in 1984) for example, has two levels of licensure, one generic and the other clinical. For the clinical license, holders of which are specifically empowered to diagnose and treat mental and emotional disorders, the statute specifies particular course work beyond the generic requirements.

Supervised Experience Requirements

The inclusion of supervised experience requirements in licensure legislation is the result of a 1977 decision by the AACD Licensure Committee. Prior to that time members of the committee had proposed drafts of suggested legislative language at the doctoral level only. Insistence by the American School Counselor Association (ASCA) that licensed status not be limited to those with doctoral training forced the committee to adopt what amounted to a trade-off between advanced graduate training and supervised clinical experience.

The initial inclusion of recommended language requiring supervised experience was undertaken without consensus as to what constituted such experience, by what criteria it was to be evaluated, and by whom it was to be rendered. It was assumed by the committee that state boards would adopt regulations that were satisfactory to them, which was in fact what happened. When state board members came together in the AASCB in 1986, they discovered how widely different their supervision criteria were and how problematic the area was for all of them. Some states required as few as 2 years, while others required as many as 4 years. The criteria for determination of approved supervisors varied even more widely.

Not until 1987—10 years after the adoption of the supervised experience requirement by the committee—did the professional organizations, led by ACES, propose a statement of standards for supervision and supervisory training. This area, however, needs further attention, even though the current model counselor licensure law addresses these issues.

Examination Requirements

All states require that licensure applicants pass a written examination. Some also require oral examinations conducted by the board, but this requirement appears to be in some jeopardy because of the difficulty of ensuring standardization in an oral examination. Although no counseling board has reported being sued by an applicant who failed an oral examination, legal counsel have advised boards in some states that this requirement should be dropped.

The written examination used by most boards is the NBCC examination (Gerstein, 1988). A handful of boards use the examination developed by Professional Examination Service (PES) for the Academy, while Texas uses its own examination. In discussions at AASCB meetings many boards have reported that their adoption of the NBCC examination has more to do with its psychometric defensibility than with its clinical content. The AASCB has explored the possibility of developing its own examination, which it would then subcontract to member boards.

With the exception of recommendations from clinical supervisors, the licensing mechanisms of most states do not evaluate the clinical competency of applicants. The PES examination does contain more clinically oriented test items than does the NBCC examination, but it is still a paper-and-pencil instrument that can only approximate an estimate of an applicant's clinical skills. The Virginia Board of Professional Counselors requires the presentation of a written case study as the basis of the oral examination process, but it is the only state with such a requirement. As is the case with the development of supervision standards, the assessment of clinical competency for purposes of licensure is still very much in its infancy.

THE POLITICS OF LICENSURE

The knowledge base of counselor licensure politics is constantly changing and continually expanding as new bills are introduced, passed, and implemented, and as existing laws are modified by amendment, regulation, legal opinion, judicial decree, and custom and usage. All that is now known about lobbying, political influence, coalition building, and related matters is far beyond the scope of this article. What follows therefore is a discussion of the most salient issues.

The Legislative Process: Political Obstacles

The political barriers that have hindered the passage of counselor licensure laws are numerous and varied. The three most common, however, have been the reluctance of state legislators to consider legislation regulating additional professions, the political naiveté of many counselors at both the leadership and grass roots levels, and the opposition of other professions, especially those already licensed.

Legislative reluctance. In the eyes of many state legislators, occupational licensure laws serve the interests of the profession or occupation being regulated rather than those of the public. Severe critics of licensure maintain that such legislation is a restraint of trade because it controls the number of credentialed professionals and therefore the potential market share available to them. More moderate observers point to the dismal record of many licensure boards in disciplining those found guilty of unethical conduct. The task of convincing legislators that counselor licensure legislation is intended to overcome the abuses of previous laws is thus a formidable one indeed.

Political naiveté. During the 1970s relatively few counselors possessed the political sophistication to successfully lead a licensure effort. The most likely candidates functioned at best at the "civics lesson" level of awareness. Of at least equal concern was the lack of a political infrastructure within most state counselor organizations, exemplified by the inability of these groups to mobilize grass roots counselors to even write letters to their legislators.

Opposition by other professions. At the time professional counselors first entered the licensure arena in the early 1970s, applied psychology had achieved passage of credentialing laws in every state but one. At this same time social work was regulated in nearly 30 states, and marriage and family therapy had successfully lobbied for laws in roughly a half dozen states (see the accompanying articles for more detailed and current informa-

tion). It is not surprising that counselors seeking statutory credentialing were met by the sibling professions with indifference in some cases, with suspicion in other cases, and with vitriolic opposition in yet other cases.

There were several reasons behind this opposition. Chief among these was the fear that the livelihoods of already credentialed professionals would be placed in jeopardy by competition from counselors. Of lesser concern, but more frequently voiced, was the issue that counselors were inadequately trained to function in independent practice as mental health professionals. Most counselor education master's programs during the 1970s required 30 semester hours and trained school counselors. Accreditation by CACREP of programs of at least 48 semester hours with a more clinical emphasis was several years away.

Overcoming the Obstacles

The fact that counselors have been successful in promoting passage of licensure laws in 33 states indicates that they have overcome these political obstacles to a considerable extent. Legislative reluctance in most instances yielded to counselor persistence. Once lawmakers became aware that initial or even repeated defeat would not deter counselors from trying again, they became less resistant. While this more receptive attitude is not yet universal, legislators in more and more states are at least willing to listen to counselors' arguments.

Counselors have demonstrated that they are quick studies in acquiring the skills of legislative politics. At least in part because of the communications network fostered by the AACD Licensure Committee, counselors in most states soon became aware of successful and unsuccessful political practices from other states. Leadership in most states devolved upon small cadres of increasingly experienced politicos who provided each other with the emotional support necessary to continue until victory was achieved. Communications networks within states became more effective, with the result that legislative mailrooms could be flooded within a few days with letters and mailgrams generated by a few telephone calls.

There are several results when a group, especially a group that has not been previously active in legislative issues, becomes more politically skilled and experienced. One result, as mentioned above, is the increased self-confidence that group members acquire, even when they have tasted defeat several times. There is empowerment in knowing what went wrong and why and how to avoid such pitfalls in future efforts.

A second result is that legislators pay more attention when the group comes back in subsequent legislative sessions. State legislatures, especially in their leadership, are very stable bodies. A state counselor licensure committee is likely to encounter the same committee chairs and members in several succeeding legislative sessions. This is usually good news, because the better known a group becomes to legislators, the more likely they are, in most cases, to eventually respond favorably to that group's issues. Of course, the opposite is sometimes true as well. State counselor licensure committees have experienced frustration in some states because an influential legislator who was an implacable foe of licensure refused to be convinced, to accept another leadership assignment, or to retire.

Beginnings of Interprofessional Collaboration

A third result of increased political savvy on the part of a new entrant into the licensure arena—and the one most relevant to the content of this article—is that members of other groups, especially leaders of already licensed professions, gradually take the new group seriously. What usually begins as grudging acceptance has in numerous cases turned to respect and then to the realization that there is more advantage in forging alliances than there is in continued opposition.

Sunset review. This emerging interprofessional collaboration has usually developed in one of two ways, depending upon the credentialed status of the groups involved. If one or more of the other professions is already licensed, collaboration with these bodies has typically occurred only in cases in which they were facing "sunset" review. Sunset legislation is on the books in approximately half of the states, mostly in the south and west. Such laws provide for periodic review of the performance of licensure boards by another agency of state government, usually the attorney general or an auditing unit established particularly for this purpose. If the board under scrutiny receives an unfavorable report, it is in jeopardy of being abolished.

One way that licensed professions have sought to avoid disestablishment of their boards through the sunset process is by seeking to ensure that other professional groups do not oppose them. Such opposition often takes the forms of providing adverse testimony to the review agency or open or covert political maneuvering in the legislature itself. Prevention of these types of opposition has usually been accomplished by political agreements with other professional organizations, especially with those that are seeking licensure. The substance of these agreements is typically that the profession under sunset review will not oppose the unlicensed profession's attempts to secure licensure if the latter group will not oppose the former in its efforts to survive the sunset process.

Coalitions among unlicensed professions. The other principal way that interprofessional collaboration has developed in the context of the legislative process involves unlicensed professions. In cases in which two or more professional groups are seeking licensure, coalitions among these organizations have tended to occur.

Political necessity rather than altruism has usually been the rationale behind the formation of these coalitions. In fact, the political advantage behind such alliances has sometimes been suggested by legislators before it has become obvious to the potential partners. Professions with a longer track record in seeking licensure are usually the more reluctant partners, while those groups just entering the arena are almost always quite receptive.

The goal of such coalitions is the passage of legislation that will regulate all of the constituent professions. Because of the nearly impossible task of passing separate laws that regulate each of them, "omnibus" bills that regulate two or more professions have become more and more the rule in recent years. Omnibus bills are never a profession's first choice. Watchmakers and tree surgeons have separate boards, so why should not counselors and marriage and family therapists? Political reality, however, usually dictates otherwise.

Sometimes the coincidence of the approaching success of an omnibus effort with the sunset review of an existing board has created situations in which a broader omnibus bill is proposed. While such a situation could involve any existing board, in most instances it has been the case that psychology boards have been unwilling partners in forced marriages. It is too early to tell how well these "sunset/omnibus" combinations work, but they are much more attractive to legislators than they are to the professions involved.

OMNIBUS BOARDS AND INTERPROFESSIONAL COLLABORATION

If political coalitions, regardless of the circumstances under which they are forged, are the first level of interprofessional collaboration, then the next level must be a licensing board that regulates more than one profession—an omnibus board. We will discuss two different manifestations of this type of regulatory body.

The Omnibus Board: Background

Approximately half of the licensure boards that presently regulate counseling also regulate at least one other profession (Gerstein, 1988). The first such board was established in Virginia in 1976, as a result of legislation that repealed the psychology licensure statute, abolished its board, and created the Virginia Board of Behavioral Sciences. This board coordinated three subboards—those of psychology, counseling, and social work. Through an amendment to the statute in the mid-1980s, Virginia abolished the Board of Behavioral Sciences and transferred the administration of the three subboards (now elevated to independent status) to the Department of Health.

Subsequent omnibus boards. Five of the next six states to pass licensure laws established boards that regulated counseling alone. Legislation implementing the next omnibus boards was not passed until 1984, when Ohio established a board regulating counseling and social work, Tennessee set up a board regulating counseling and marriage and family therapy, and Georgia created a board to govern all three disciplines.

These boards were constituted as single entities, with representatives from the respective professions and from the public at large, which was in opposition to the Virginia model of subboards operating under a coordinating board. Under the multidisciplinary board model, the members representing a given profession have usually constituted a standards committee for that group. Such committees have typically formulated the standards and rules for their profession, which are adopted upon their recommendation by the entire board. In most instances the standards committees' continuing function is to evaluate applicants seeking their discipline's credential. Upon their recommendation licenses are granted by vote of the board as a whole. The single board approach has since been followed by approximately a dozen states in which multiple disciplines were to be regulated. Virginia's earlier model, now discarded, has not been enacted by any other state.

The Future of Omnibus Boards

Given the political realities in most states, it is reasonably safe to predict that the majority of the counselor licensure laws that will be enacted in the next several years will be omnibus laws. The discipline that will be most often included with counseling in these laws will be marriage and family therapy. The two principal reasons for this likely pairing are that these disciplines' national associations have developed a relatively positive political relationship that is mirrored in many states and that marriage and family therapy is presently unregulated in even more states than is the case with counseling.

It is unlikely that psychology and social work will be included in these omnibus licensing bills unless one of two things happens. The first possibility is that existing boards regulating these disciplines will occasionally be abolished as the result of an unfavorable sunset review. In such cases, reenactment by inclusion under an existing or proposed omnibus statute is a viable alternative. The other potential development is that the regulatory climate in a state may change dramatically, such that all boards are reorganized and severely reduced in number. In such a situation it is highly likely that all boards and potential boards (for those professions as yet unlicensed) dealing with a broad area (such as nonmedical mental health services) could be reorganized into omnibus boards.

INTERDISCIPLINARY COLLABORATION: PUTTING POLITICS ASIDE

Apart from strictly licensure-related areas of concern, instances in which the four professions represented in this special feature regularly or occasionally collaborate with each other principally involve other legislative issues, most often at the federal level. While there is much consumer-oriented rhetoric connected with such endeavors, closer examination reveals that professional self-interest most often dictates collaborative priorities. The authors by no means condemn such activity, firmly believing that professional organizations must advocate for their members' interests. The point is raised to call attention to the fact that there is a great deal of room for interprofessional collaboration that is strictly in the public interest.

Past and Present Collaboration

The four nonmedical provider disciplines regularly combine in ad hoc coalitions that focus on particular pieces of federal legislation. A recent alliance centered on the Federal Employees Health Benefits Program (FEHBP), which was undergoing a major restructuring to provide additional mental health services benefits. Interested parties addressed the legislation in terms of ensuring that they would be included as eligible providers. While there is clearly consumer interest involved here, professional organizations were expending resources for their members' benefit first and for better mental health coverage for federal workers second. Again, there is nothing wrong with these priorities, so long as one does not take the consumer-oriented rhetoric too seriously.

In recent years similar cooperative efforts have been undertaken in support of military and dependents health benefits, veterans services, counseling for older Americans, and funding counseling services in connection with AIDS and substance abuse. Clearly there are important societal implications for each of these focal areas, but there are also dimensions of professional self-interest that must be acknowledged.

Possibilities for Future Collaboration

There can be only one goal of future efforts at interprofessional collaboration, and that is the improvement of the nation's mental health. Achieving this goal means not only increased levels of funding for mental health *services*, which is the objective of most of the current collaborative political activity, it also means becoming active on fronts not yet even contemplated.

Prevention and education. All of the mental health disciplines know the devastating effects on mental health of poverty, child and spouse abuse, other family dysfunction, malnutrition, and chemical addiction. A massive communications campaign aimed at building support for new public policy initiatives in these areas should be studied. These causes are usually framed in terms of physical health effects or economic effects, rather than as mental health issues to be addressed directly.

Another possible thrust for interprofessional collaboration is

in designing new mental health curricula for the public schools. Virtually all of the proposals for educational reform have been aimed at strictly academic goals. The mental health professions have been silent when they should have been speaking with one voice in support of affective education programs as being essential rather than peripheral elements of curriculum.

Research. With the exception of some hospital studies, there have been relatively few interdisciplinary research studies on the process and outcome of mental health interventions. Within individual disciplines, especially psychology and to some extent psychiatry, the recent focus has tended to be more on outcome than on process. We thus know more than we did about what happened as the result of an intervention, but not much more about how and why. A new interdisciplinary thrust is needed that will shed light on process and outcome *and* on the impact of involvement of the respective disciplines as members of treatment teams.

Training. Nowhere are the fragmentation and turf obsession of the mental health professions more apparent than in the area of training. Why, for example, do the disciplines not routinely seek input from peer professions when revising their training standards? Why are faculty positions in training programs often restricted to members of the profession? Why are internships limited to students from a given discipline's training programs? Are the professions so insecure that their training cannot stand scrutiny and cannot benefit from input from members of other professions? This is an area in which the greatest opportunities for collaboration exist and in which the professions have almost total control over changing present conditions.

Improving organizational communication. In one of the articles that follows, Nicholas Cummings describes the formation of the Joint Commission on Interprofessional Affairs (JCIA), a leadership group composed of the American Psychiatric Association, the American Psychological Association, the National Association of Social Workers, and the American Nursing Association. This leadership group meets periodically to discuss policy and strategy with respect to mental health issues. Intentionally or inadvertently excluded from membership are AACD, AMHCA, and the American Association for Marriage and Family Therapy (AAMFT). What is from all appearances a professional snub does nothing to advance the cause of interprofessional collaboration.

While passing reference has been made to the American Association of State Counseling Boards (Dingman et al., 1988), no mention has been made of the corresponding organizations for the other professions. Each of the other disciplines has such an association of state boards, the most recently established one for the area of marriage and family therapy. It is not unreasonable to expect that there would be active communication among these organizations and that they would be engaged in numerous ongoing projects of mutual interest. Such is not the case, however. Each behaves as though the other organizations and their member boards do not exist. Clearly, there is much room for improvement here.

Collaboration within states. Reference was made earlier to the somewhat spotty record that licensing boards have attained with respect to disciplining their licensees for unethical conduct. One of the real scandals of state level credentialing is the successive licensing of practitioners who have had their licenses revoked or suspended. A celebrated case in Texas involved an individual whose license was revoked by the state psychology board for sexual misconduct with a client. The therapist was subsequently licensed and revoked by the social psychotherapy board (a regulatory body unique to Texas, a curious pseudodiscipline that was sunsetted after only a few years) and then licensed by the professional counseling board. When charges were brought for the same kind of offense as before, the counseling board discovered the individual's sordid record. Had there been a systematic means by which an applicant's credentialing history could have been checked prior to becoming licensed, much consumer suffering could have been avoided.

The Texas case is not atypical. Boards within states have all too often behaved as though bodies regulating similar professions did not exist. This situation is being addressed not by the professions themselves as much as it is by the Council of State Governments. The council has established a national clearinghouse to facilitate the exchange of the kind of information that would have prevented the Texas case just mentioned.

FUTURE TRENDS IN THE LICENSURE MOVEMENT

If current trends continue, it seems fairly safe to predict that several elements of counselor licensure will become even more salient in the next few years. These issues center on preparation and training, examinations, accountability and consumer protection, collaboration, and reimbursement.

Preparation and Training

There is a clear consensus within counseling that a 2-year master's is the minimum academic requirement for admission to the profession. What is emerging as a new consensus is that the definition of a 2-year program as one comprised of 48 semester hours is insufficient. An increasing number of training programs are setting 60 semester hours as the standard for academic preparation. This criterion is also reflected in several of the more recent licensure laws and in the revised model legislation developed by the AACD Licensure Committee. In addition, there is an increasing emphasis on diagnostic skills and on treatment planning within the curricula of many training programs (see Seiler, Brooks, & Beck, 1987).

A similar trend seems to be emerging in supervised experience. A new standard of at least 3,000 hours of clinical experience (comparable to the requirements for the CCMHC) is the level that more and more licensure boards are setting as a minimum level, with 100 or more hours of direct face-to-face supervision. In addition, new standards for training and designating professionals who can provide supervision are being implemented by both certification bodies and licensing boards. It is expected that these trends will become even more prominent in the next several years.

Examinations

There is a growing dissatisfaction with academically oriented written examinations as measures of counseling competence. The NBCC examination is both valid and reliable as an exit measure for graduates of CACREP-approved programs, and it meets all the psychometric requirements thought to be necessary for legal challenges. It is not intended, however, as a measure of an applicant's clinical skill.

Two developments hold some promise for improving this aspect of the licensure process. The first development may grow out of an extensive research project on assessment of clinical judgment being conducted by J. Elizabeth Falvey of the University of New Hampshire, with funding from AMHCA. The second development may emerge from a new job task analysis being conducted by Larry Loesch of the University of Florida, with funding from NBCC. Both of these developments hold

some promise that the next generation of examinations will measure what counselors can *do* as well as what they *know*.

Accountability and Consumer Protection

As new licensure laws are passed, as existing boards seek to survive sunset review procedures, and as mental health counseling becomes more accustomed to being regulated, it is safe to predict that there will be even more emphasis on consumer protection as the raison d'etre for licensing boards. State legislators will insist on accountability and will probably pass new laws with increased consumer representation in board composition. Citizen advocacy groups such as the National Alliance for the Mentally Ill will insist that boards act to protect client rights. And the professional associations, if they have their wits about them, will become more active as monitors of public interest than they have previously been.

Collaboration

There can be no doubt that the nonmedical professional associations will continue and probably expand their collaboration in the political arena. Whether the focus is licensure at the state level or some benefits program at the federal level, experience to date has indicated that collaboration is an essential dimension for political success.

The future challenge to collaboration is in the nonpolitical areas discussed previously. Professions and professional organizations do not survive on self-interest alone. There must be a revolution in attitudes if new collaborative ventures in research, education, and client advocacy are to be undertaken.

Reimbursement

Following closely behind licensure successes in many states have been efforts to achieve recognition for counselors as providers eligible for health insurance reimbursement. These efforts have been mostly political and have been anything but collaborative. The better established professions have been joined by the insurance lobby in opposition to such recognition for counselors.

Such opposition is shortsighted on the part of other professions and the insurance industry because it is counter to consumer interests. Persons covered by health insurance should be able to choose a counselor instead of a psychologist if they wish, just as they are free to choose an osteopath instead of a physician. Interprofessional bickering in this arena must cease if mental health professionals, their associations, and the respective licensing boards are to reach their goal of delivering the best mental health services possible.

CONCLUSION

The counseling profession has made remarkable progress in the nearly 15 years since its first licensure law was passed. Licensure in 32 states, professional certifications affecting more than 25,000 professionals, more than 5 dozen accredited training programs, and recognition as health care providers by federal insurance programs constitute an incredible record in such a short time.

This special feature is perhaps a more qualitative measure of such progress. The invitation to present a multidisciplinary perspective on these critical issues came, after all, not from a psychology or social work journal, but from the archival journal of the counseling profession. The guest editors hope this special feature will stimulate interest and dialogue leading to greater interprofessional collaboration. One measure of the growth of such collaboration might be an invitation, say, 5 years hence, to participate in a similar feature to be published in the *American Psychologist*.

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