Journal of Counselor Practice, 10(2):70–89, 2019
DOI: 10.22229/bri1022019
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Mental Health Counselor Preparation to Work with Adolescents in Internship

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Prevalence data have raised concerns that child and adolescent mental health issues are at an epidemic level. Yet, the training of clinical mental health counselors who work with adolescent populations has received limited attention in the counseling literature. The present study surveyed 188 clinical members of the American Mental Health Counselor Association to establish baseline data on the training that mental health counselors received in their graduate program prior to working with adolescent populations in internship. Data were analyzed through linear regression models to explore the impact that program accreditation, taking specific coursework in counseling adolescents, and infusing adolescent content into the core coursework had on perceived preparation to work with adolescents at internship. Preliminary findings demonstrated that having more adolescent content infused in core coursework or taking specific coursework predicted higher levels of perceived preparation.

Keywords: *counselor education, adolescents, youth, clinical mental health counseling*

Prevalence studies have demonstrated that adolescent mental health disorders are at an epidemic level (Centers for Disease Control and Prevention [CDC], 2013). In a nationally representative sample of U.S. adolescents, Merikangas et al. (2010) found that 49.5% of

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adolescents met the criteria of a diagnosable mental health condition within their lifetime, with 22.2% being considered severe. Consistent with the high prevalence, adolescents have been seeking mental health services in record numbers, with 3.6 million adolescents receiving mental health services in a specialty mental health setting in 2016 (Substance Abuse and Mental Health Services Administration [SAMHSA], 2013). Unfortunately, researchers have also noted shortages in qualified mental health clinicians prepared to work with adolescents, leaving questions about whether the current workforce can meet the needs of the adolescent population (Huang, Macbeth, Dodge, & Jacobstein, 2004; National Academies of Sciences, Engineering, and Medicine [NASEM], 2017; SAMHSA, 2013).

With the high prevalence of adolescents with clinical mental health concerns and shortages in qualified mental health clinicians, it is paramount to ensure that clinical mental health counselors are prepared to work with this population. In 2015, the Council for Accreditation of Counseling and Related Education Programs (CACREP) postulated that clinical mental health counselors' education included the principles and practices of diagnosis, treatment, referral, and prevention; and their training prepared them to work with clients across a spectrum of mental and emotional disorders throughout the lifespan. Still, the CACREP (2015) educational standards for clinical mental health counseling did not specify standards for counselors who worked with adolescent populations in particular. Similarly, the Masters in Psychology and Counseling Accreditation Council's (MPCAC, 2017) most recent educational standards also did not specifically discuss adolescents. By contrast, clinical psychologists and social workers have established and maintained guidelines for preparing their graduates to work with adolescents. For example, the Council on Social Work Education (2015) suggested guidelines for social work programs that offered specialized training with a specific population, while the National Association of Social Workers (2003) adopted a set of 11 standards that guided social workers dealing with adolescents. Likewise, Roberts et al. (1998) offered a model for training clinical child psychologists that included 11 domains specific to the child and adolescent population. Pidano, Kurowski, and McEvoy (2010) then surveyed psychology programs and demonstrated the competencies exhibited in training psychologists to work with youth.

Both the American Counseling Association's (ACA, 2014) and American Mental Health Counselors Association's (AMHCA, 2015) code of ethics state that counselors are to practice within the scope of their training; yet, CACREP (2015) does not maintain specific training requirements for clinical mental health counselors when working with adolescents. This lack of specialized training for clinical mental health counselors working with adolescent populations is problematic because mental health concerns manifest differently at various developmental stages. For example, depression in adolescents does not always present as sadness; instead, it may be characterized by irritability, boredom, or anhedonia (Brent & Birmaher, 2002). The symptoms of adolescent depression are also difficult to differentiate from the distress typical during this stage of development (Stanard, 2000). Given these considerations, counselors should not provide treatment to adolescents as if they were adults (Lawrence & Kurpius, 2000). Furthermore, adolescents who did not receive adequate care were more likely to experience functional difficulties in areas such as home, school, and peer relationships, including other serious issues like substance misuse, self-destructive behavior, and suicide (National Institute of Mental Health, [NIMH], 2016).

Although counselor educators valued prevention and developmentally appropriate approaches, the lack of training guidelines in the counselor education literature suggested that the counseling field was not prepared to meet the increased demand (Mellin & Pertuit, 2009). Mellin (2009) first suggested that the counseling profession should evaluate their training to ensure that counselor education programs were producing graduates capable of responding to the children's mental health crisis. As a solution, Mellin and Pertuit suggested that offering coursework specializing in child and adolescent concerns or infusing youth-specific coursework into core courses was crucial to ensuring that the counseling field met the needs of this population.

Hence, the purpose of this study was to survey clinical mental health counselors within the counseling profession to determine the extent of their training with adolescent populations. By exploring the training that had been offered, data were gleaned to assist in understanding the current level of coursework specific to adolescent populations. This study established a baseline of information to inform future educational practices and

CACREP standards to ensure that the next generation of counselors will be adequately trained to meet the mental health needs of the adolescent population. The study examined the following research questions:

1) How have clinical mental health counselors been prepared to work with adolescent populations in their coursework?
2) What factors of graduate training predict higher levels of perceived preparation in counseling adolescent populations prior to internship?

Methodology

Procedure

The population for the present study consisted of mental health professionals who were clinical members of the American Mental Health Counselors Association (AMHC). Of the approximately 4,000 clinical members, 2,000 potential participants were randomly sampled from the AMHCA membership database by selecting every third member. After the researcher obtained university institutional review board approval, the potential participants were sent a recruitment email inviting them to participate in the study. The recruitment email consisted of an introduction to the study, a link to the informed consent document, and the survey instrument. To encourage participation, participants were entered into a drawing to win one of twenty $20 Amazon gift cards. Of the 2,000 potential participants, 188 (9.4%) completed a usable survey. Partially completed surveys were reviewed for similar demographic information to prevent multiple submissions. There were no duplicative responses; thus, all partially completed surveys were included in the analysis.

Participants

Of the 188 participants in the study, 172 identified their gender. There were 53 (30.8%) participants who identified as male, and 119 (69.2%) participants identified as

female. No participants in this study specified a gender identity other than male or female. Additionally, 173 participants identified their race, with 152 (87.9%) identifying their race/ethnicity solely as White. Of the remaining participants who identified their race, five (3%) identified as Black or African American, four (2.4%) identified as Hispanic or Latino, and two (1.2%) identified as Asian. Another seven (4%) identified their race as *Other,* and three individuals selected two of the race/ethnicity categories. The mean age of the sample was 52.78 with a standard deviation of 13.8, while the mean graduation year was 1998.7 with a standard deviation of 10.91.

Regarding their training programs, the majority of this sample graduated in two regions, with 84 participants (52.83%) graduating in the North Atlantic region and 60 (37.73%) graduating in the Southern region. Of the 172 participants who answered the question concerning the accreditation status of their master's programs, 84 (48.8%) reported that their master's program was accredited by CACREP, and 61 (35.5%) reported that their master's program was not accredited by CACREP. Twenty-seven (15.7%) participants reported that they could not remember whether or not their program was CACREP accredited. Finally, 112 (66.7%) indicated that their master's degree concentration was in Clinical Mental Health Counseling, and 27 (16.1%) reported that their master's degree concentration was in the closely related Community Counseling field. Additional concentrations included School Counseling (14 participants, 8.3%), Marriage and Family Counseling (6 participants, 3.6%), and College Counseling (2 participants, 1.2%). Finally, 28 (16.7%) selected *Other* regarding the concentration of their master's program.

Materials

The author of the present study developed the survey materials by adapting two instruments (Pidano & Whitcomb, 2012; Mellin, Hunt, & Lorenz, 2009). Both included questions modified for the counseling profession about program information and accreditation, coursework, and clinical experiences related to youth. Additional questions related to training experiences with specific mental health concerns, diverse adolescents,

and postgraduate training were also included in the survey. The adaption process resulted in a 24-item questionnaire designed to explore the training that clinical mental health counselors received in preparation to work with adolescent populations. The first section of the survey instrument consisted of seven questions that captured the participants' demographic information. The participants provided information on their gender, race and ethnicity, and age. The first section also gathered information on the participants' training program, including the year they graduated, the state in which their graduate program was located, and whether their program was CACREP accredited. The survey also inquired about the concentration of the participants' master's degree and offered the options of clinical mental health counseling, community counseling, school counseling, marriage and family counseling, or other.

The second section explored the coursework completed by the participants with the following questions: *Did your program offer a specific course focusing only on counseling children and/or adolescents? Was it a requirement? Did you take it?* Other questions asked whether adolescent populations were covered in the eight CACREP common core areas: professional counseling orientation and ethical practice, social and cultural diversity, human growth and development, career development, counseling and helping relationships, group work, assessment and testing, and research and program evaluation. Additionally, participants were asked how prepared they were [from their training] to work with adolescents in internship.

Data Analysis

Variables were described with counts and percentages. The primary outcome (perceived preparation to work with adolescents at internship) was treated as a continuous variable. To answer the research question, linear regression was used to determine if CACREP accreditation, taking specific coursework in counseling children and/or adolescents, or having adolescent content infused into the eight core content areas identified by CACREP predicted increased perceived preparation to work with adolescents during internship. The first two predictive variables were dichotomous, while the third

predictive variable was continuous. In the third variable, each of the core content areas was treated as individual ordinal variables, with possible responses including *Not covered*, *Not satisfactorily covered*, and *Satisfactorily covered*, which were coded from 1 to 3. The data for this variable were derived from the summation of these responses, with answers from those who selected that they could not remember being excluded. The Cronbach's alpha for this scaled variable was .856. Because demographic characteristics could influence association, potential confounders (gender, race, and Master's concentration) were also included in the multiple variable regression model. The confounding variable of the number of years since a participant has graduated was also included in the model. Including this confounder addressed potential changes in training curriculum, including the different versions of the CACREP standards that programs could have been accredited under during the participants' graduate studies.

The influence of the predictive variables on the outcome measure was explored individually in the first model and collectively in the second model. Including the predictive variables together in the second model was necessary to determine if they were independently predictive of perceived preparation. Additionally, the associations between these variables while adjusting for the potential confounding variables were also investigated in the third model; the independent variables of interest least square means (SE) for each level of the categorical variable or beta-estimates (SE) for continuous variables were reported.

Results

Adolescent Content in Participant Coursework

Participants also were asked whether their master's program offered a specific course that focused only on counseling children and/or adolescents. Of the 172 participants who responded, 99 (57.7%) reported that their program did offer a course; 58 (33.7%) reported that their program did not offer a course; and 15 (8.7%) reported that they could

not remember. Thirty-six (20.9%) participants reported that the course was required by their program, and 94 (54.65%) participants reported that they took the course.

Participants reported on whether the adolescent population was satisfactorily covered in respect to each of the eight core CACREP competency areas. Respondents reported that work with adolescent populations was most satisfactorily infused with the Human Growth and Development, Professional Orientation and Ethical Practice, and Helping Relationships areas (Table 1). Furthermore, adolescent counseling content was notably lower in the remaining concentration areas, with the least coverage occurring in the Career Development and Research and Program Evaluation areas (Table 1).

Table 1

Perceived Level of Adolescent Content Infused in the CACREP Core Competency Areas

	Satisfactorily Covered	
	N	%
Human Growth and Development	149	89.2
Professional Orientation and Ethical Practice	121	71.6
Helping Relationships	116	69.5
Assessment	107	63.7
Social and Cultural Diversity	101	60.1
Group Work	99	58.6
Career Development	92	55.0
Research and Program Evaluation	86	50.9

Perceived Level of Preparation

Of the 160 participants who reported their perceived level of preparation to work with adolescents during their internships, 67 (42.4%) reported that they were not prepared

to work with adolescents. Another 55 (34.8%) indicated that they were moderately prepared. Only 36 (22.8%) reported that they were very prepared to work with adolescents during their internships.

Comparison of perceived preparation. When run independently in the first model, two of the predictors were found to be significant (Table 2, Model 1). CACREP accreditation status did not have a significant effect on the degree to which individuals felt prepared to work with adolescents during internship [F (1,132) = 0.19, p = .667], while there was a significant positive effect for those who took a specific course focusing on counseling children and/or adolescents [F (1,151) = 10.55, p = .0014]. Those who took a specific course focusing on children or adolescents felt more prepared to work with adolescents during their internships than those who did not. Similarly, participants who had more infused content in their graduate program felt more prepared to work with adolescents in their internships [F (1,157) = 29.66, $p < .0001$]. Considering predictors simultaneously in a regression model (Table 2, Model II), the same predictive variables remained significant suggesting that they both independently predict perceived preparation. Finally, the third model demonstrated that the addition of the control variables of *gender, minority status, master's degree concentration, and years since graduation* suggested few adjustments. Even after adjusting for potential differences in participant characteristics, these factors remained predictive of perceive preparation (Table 2, Model III).

Table 2

Regression Analysis for Perceived Preparation to Work with Adolescents at Internship

	Model I	Model II	Model III
Variables of Interest			
CACREP Accreditation	t(132) = -0.43 p = .667 B = 0.076 (0.177)	t(122) = -0.17 p = .863 B = 0.028 (0.164)	t(118) = -0.44 p = .664 B = 0.074 (0.17)
Yes	2.88(0.12)	2.87 (0.11)	2.89 (0.11)
No	2.81(0.13)	2.84 (0.12)	2.81 (0.13)
Specific Coursework	t(151)) = 3.25 p = .0014 B = 0.533(0.164)	t(122) = 2.84 p = .005 B = 0.464 (0.163)	t(118) = 2.6 p = .011 B = 0.431 (0.166)
Yes	3.09 (0.11)	3.09 (0.11)	3.07 (0.11)
No	2.56 (0.13)	2.63 (0.12)	2.64 (0.12)
Infused content	t(157) = 5.45 p = <.0001 B = 0.105 (0.019)	t(122) = 4.62 p = <.0001 B = 0.096 (0.021)	t(118) = 4.46 p = <.0001 B = 0.095 (0.02)

Note. The dichotomous variables of interest were presented with least squares means for each level. For continuous variables of interest, the beta-estimates (SE) were presented.
Model 1 included the variables of interest run separately.
Model 2 included the variables of Model 1 run together.
Model 3 included the variables of Model 2 with the potential confounding variables: Gender, Race, Master's concentration, and years since graduation.

Discussion

Due to the high prevalence of adolescents with mental health issues and the shortage of mental health clinicians trained to work with them (CDC, 2013; Hansen, 2002; Huang, Macbeth, Dodge, & Jacobstein, 2004; Merikangas et al., 2010; NASEM, 2017;

SAMHSA, 2013), the present study sought to explore how the current workforce of clinical mental health counselors were trained to work with the adolescent population in their master's level coursework. Through a national survey of clinical members of AMHCA, baseline information was collected. Ultimately, the counselors surveyed in this study did not feel adequately prepared to work with adolescents in their internships, a finding that contrasted Pidano and Whitcomb's (2012) survey of psychologists who reported having a broad training in youth populations during their clinical child psychology programs. Given that adolescents are a vulnerable population with unique needs (Lawrence & Kurpius, 2000), this finding should not be overlooked.

Knowing that a high degree of individuals encountered adolescents during their internship (Russ, 2016), there was a high likelihood that these adolescent clients were being counseled by underprepared interns. Without adequate training and expertise, counselors could be violating the ACA Code of Ethics (2014) by operating outside of their scope of practice and, more dangerous, could be providing an ineffective service or doing unintended harm to young clients. Incompetent service could also result in missed risk factors, leading to suicide or homicide, the second and third most common causes of death among young people (Centers for Disease Control [CDC], 2017).

The present study found that participants who took specific coursework reported higher degrees of confidence in working with adolescents going into their internship; therefore, it was concerning that fewer than 60% of participants attended a program that offered specific coursework on counseling adolescents, and only 20% of the programs required this coursework. This was contrary to recommendations of Cardaciotto and Tonrey (2012), who suggested that counselor education programs should expand their scope of training as they integrated clinical mental health into their professional identity. Mellin and Pertuit (2009) also recommended specialized clinical mental health coursework for youth to enhance counselor preparation for this population. Outside of specific coursework, counselors-in-training reported receiving the most adolescent content from their Human Grow and Development course, with nearly 90% of the participants reporting that adolescent populations were adequately covered in this class. Still, Bradley and Fiorini (1999) discovered that only 50% of counselor education programs in their national study

required students to complete Human Growth and Development prior to practicum, indicating that many counselors-in-training may have had no training in adolescent populations prior to seeing actual clients.

It was also notable that the data demonstrated that higher degrees of infused adolescent content led to higher levels of perceived preparation in working with adolescents in internship, but closer examination of the level of infused content uncovered discrepancies between those core areas that had high levels of infused content and those that did not. Overall, the participants did report high levels of infused content in the core courses, with the strongest infusion occurring in the areas of Human Growth and Development, Professional Orientation and Ethical Practice, and Helping Relationships. Still, there were core areas in which the participants reported less infused content. The areas of Career Counseling, Assessment, Group Work, and Research and Program Evaluation were found to have less adolescent content infused into course than the other core courses. This was of concern because these courses had unique components relevant to adolescent populations that were likely to be encountered in a clinical mental health counselor's internship. Most alarming, though, was that only 60% of the participants reported that adolescent populations was adequately covered in their Social and Cultural Diversity coursework, even when the ACA (2014), CACREP (2014), and the counseling literature stressed the importance of preparing multiculturally competent counselors (Erickson Cornish, Schreier, Nadkarni, Henderson Metzger, & Rodolfa, 2010; Ponterotto, Casas, Suzuki, & Alexander, 2010; Sue, Sue, Neville, & Smith, 2019) With adolescence being a primary stage of ethnic identity development (French, Seidman, Allen, & Aber, 2006), it was concerning that counseling professionals could be inadequately trained to deal with the unique needs of adolescents of color when working with them in internship.

Also highlighted in the present study was that CACREP accreditation did not statistically impact the participants' curricular experiences. This finding was not resoundingly remarkable, as researchers have previously noted CACREP accreditation's lack of impact on counselor preparation (McGlothlin & Davis, 2004; Schmidt, 1999; Vacc, 1992). Still, researchers were not unanimous in this finding, with other scholars demonstrating positive outcomes when comparing graduates of CACREP and non-

CACREP programs in the areas of standardized test scores and ethical violations (Adams, 2006; Even & Robinson, 2013).

Limitations

As found in any research study, the present study had limitations. the study was limited in that the research was, fundamentally, based on the self-report of the participants. In survey research, the study will always be limited by the potential for participants to report inaccurately. Social desirability, for instance, can influence participants to represent their qualities inaccurately, because they want to be perceived in a more positive manner. Accurate recall of information can also be an accuracy concern, especially with the mean graduation year of the sample being 1999. This is a limitation of any retrospective study, and may be mitigated by the assumption graduate counseling training is likely a memorable event.

Another limitation was related to the generalizability of the sample. Since the study only included clinical members of AMHCA, any clinical mental health counselor who was not a member was excluded. Further, only half of the clinical members of AMHCA were emailed the survey, and less than 10% completed the survey. Some members may have had invalid or unused emails registered in the AMCHA database. Subgroups within AMHCA were not overtly represented, as the sample was predominately White, female, over the age of 40, and had completed graduate training in the Northeast or Southern regions.

Finally, the research instrument did not receive rigorous examination of its reliability and validity, because it was crafted from two survey instruments previously used in published studies. Additionally, participants could have responded to the study multiple times, although the statistical analysis sought to eliminate this by looking for surveys that had similar answers.

Implications for Counselor Education

Counselor education programs should explore their methods of disseminating content related to adolescent counseling throughout their curricular offerings. Specific

coursework and infused content were both shown to have merit; and, therefore, counseling programs should, at least, be intentional about infusing adolescent content across the core courses, in addition to offering a specific course in counseling youth populations. Requiring such a course would improve the likelihood that counseling program students were competent to work with adolescents going into their internship experiences.

Also highlighted in the present study was that CACREP accreditation did not have a statistically significant effect on the participants' perceived preparation to work with adolescents in internship. Recognizing the importance of programs preparing counseling graduates to work with adolescent populations, CACREP should focus on measures to address this concern. CACREP could add more specific language to the next edition of their training standards mandating that programs require curricular experiences with more individuals across the lifespan, in particular with adolescents. Secondly, CACREP should require programs to infuse adolescent content into their coursework; and, thirdly, CACREP could have programs requiring specific coursework in counseling children and adolescents.

Additionally, counselor education programs should be aware of possible deficiencies in their training specific to diversity issues among adolescents. Again, only 60% of those surveyed reported that adolescent populations were adequately covered in their Social and Cultural Diversity coursework. Counselor education programs should ensure, therefore, that their faculty adequately prepare their graduates to understand the social and cultural issues that affect adolescents, including identity development.

Recommendations for Future Research

The present study highlighted the positive influence that a specific youth counseling course and infused content had on the participants. A qualitative study to explore the contextual data related to how graduate students experience infused content would be beneficial. Furthermore, since only about 20% of the participants attended a program that required specific coursework on this topic and the strength of adolescent infused content varied, a survey of graduate program directors that included questions about the barriers preventing graduate programs from offering this specific coursework could explain why

only about half of programs offered specialized curricula. Also, program directors could be interviewed about their program's approach to infusing adolescent content, which could offer more context to the current methods of training.

In the regression models, CACREP accreditation did not have a statistically significant effect on the perceived preparation of the sample. It has been noted that surveying counselors who have attended training programs accredited under evolving versions of the educational standards limits the clarity of the results. Still, further exploration of the impact of accreditation on training outcomes is necessary to ensure that CACREP's (2019) vision of promoting excellence in the professional counselor preparation of is being met. Additional research focusing on other unique populations along the life cycle could also provide insights into whether CACREP should include additional standards related to lifespan in their next revision.

Conclusion

With the high prevalence rates of mental illness among adolescent populations (CDC, 2013; Merikangas et al., 2010), counselor education programs must ensure that their trainees are adequately prepared to work with youth prior to internship. The present study suggested that counseling interns have historically not felt prepared to work with adolescents following their coursework, and that taking specific coursework in counseling adolescents or attending a counselor education program that infused adolescent content into the core coursework predicted higher levels of perceived preparation. Since the ACA (2014) Code of Ethics states that a core professional value of the counseling profession is "enhancing human development throughout the lifespan" (p. 3), the counseling profession needs to ensure that the care of adolescents is included in this statement.

References

Adams, S. A. (2006). Does CACREP accreditation make a difference? A look at NCE results and answers. *Journal of Professional Counseling: Practice, Theory, and Research, 34*(1/2), 60-76.

American Counseling Association. (2014). ACA Code of Ethics. Alexandria, VA: Author. https://www.counseling.org/resources/aca-code-of-ethics.pdf

American Mental Health Counselors Association. (2015). AMHCA Code of Ethics. Alexandria, VA: Author. Retrieved from http://connections.amhca.org/HigherLogic/System/DownloadDocumentFile.ashx?DocumentFileKey=d4e10fcb-2f3c-c701-aa1d-5d0f53b8bc14

Bradley, C., & Fiorini, J. (1999). Evaluation of counseling practicum: National study of programs accredited by CACREP. *Counselor Education and Supervision, 39*(2), 110-119.

Brent, D. A., & Birmaher, B. (2002). Adolescent depression. *The New England Journal of Medicine, 347*(9), 667-671. Retrieved from https://dx-doi-org.lmunet.idm.oclc.org/10.1056/NEJMcp012249

Burns, B. J., Costello, E. J., Angold, A., Tweed, D., Strangl, D., Farmer, E. M., & Erkanli, A. (1995). Children's mental health service use across service sectors. *Health Affairs, 14*(3), 147-159. https://www-ncbi-nlm-nih-gov.lmunet.idm.oclc.org/pubmed/7498888

Cardaciotto, L., & Tonrey, D. A. (2012). The training, value, and reality of master's level mental health counselors. *Journal of Cognitive Psychotherapy: An International Quarterly, 26*(3), 183-195.

Centers for Disease Control and Prevention. (2013, May 17). Mental health surveillance among children – United States, 2005-2011.*Morbidity and Mortality Weekly Reports.* Retrieved from https://www.cdc.gov/mmwr/preview/mmwrhtml/su6202a1.htm?s_cid=su6202a1_w

Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. (2017). *Webbased Injury Statistics Query and Reporting System (WISQARS).* [online]. Retrieved from https://webappa.cdc.gov/cgi-bin/broker.exe

Council for Accreditation of Counseling and Related Educational Programs. (2015). *2016 standards.* Retrieved from http://www.cacrep.org/wp-content/uploads/2018/05/2016-Standards-with-Glossary-5.3.2018.pdf

Council for Accreditation of Counseling and Related Educational Programs. (2019). *About CACREP*. Retrieved from https://www.cacrep.org/about-cacrep/

Council on Social Work Education. (2015). *2015 Educational policy and accreditation standards for baccalaureate and master's social work programs.* Alexandria, VA: Author. Retrieved from https://cswe.org/CSWE/media/AccredidationPDFs/2015-epas-and-glossary_1.pdf

Erickson Cornish, J. A., Schreier, B. A., Nadkarni, L. I., Henderson Metzger, L., & Rodolfa, E. R. (Eds.). (2010). *Handbook of multicultural counseling competencies.* Hoboken, NJ: Wiley.

Even, T. A., & Robinson, C. R. (2013). The impact of CACREP accreditation: A multiway frequency analysis of ethics violations and sanctions. *Journal of Counseling and Development, 91*(1), 26-34.

French, S. E., Seidman, E., Allen, L., & Aber, J. L. (2006). The development of ethnic identity during adolescence. *Developmental Psychology, 42*(1), 1-10.

Hansen, M. (2002). The need for competence in children's public mental health services. In D. T. Marsh & M. A. Fristad (Eds.), Handbook of serious emotional disturbance in children and adolescents (pp. 93-111). Hoboken, NJ: Wiley.

Huang, L., Macbeth, G., Dodge, J., & Jacobstein, D. (2004). Transforming the workforce in children's mental health. *Administration and Policy in Mental Health, 32*(2), 167-187. Retrieved from http://dx.doi.org.lmunet.idm.oclc.org/10.1023/B:APIH.0000042745.64582.72

Lawrence, G., & Kurpius, S. E. R. (2000). Legal and ethical issues involved when counseling minors in nonschool settings. *Journal of Counseling and Development*, *78*(2), 130–6. Retrieved from

http://web.a.ebscohost.com.lmunet.idm.oclc.org/ehost/pdfviewer/pdfviewer?sid=63bcb742-90a5-4884-9e34-14013e08d7d5%40sessionmgr4008&vid=7&hid=4212

Masters in Psychology and Counseling Accreditation Council. (2017). *2017 standards*. Retrieved from http://mpcacaccreditation.org/2017-standards/

McGlothlin, J. M., & Davis, T. E. (2004). Perceived benefit of CACREP (2001) core curriculum standards. *Counselor Education and Supervision, 43*(4*),* 274-285.

Mellin, E. A. (2009). Responding to the crisis in children's mental health: Potential roles for the counseling profession. *Journal of Counseling and Development, 87*(4), 501-506. Retrieved from http://web.b.ebscohost.com.lmunet.idm.oclc.org/ehost/pdfviewer/pdfviewer?vid=3&sid=38ea8e1e-9026-4b67-a7d9-b0fcde0b7f86%40sessionmgr104&hid=128

Mellin, E. A., Hunt, B., & Lorenz, D. C. (2009). Rehabilitation counselor preparation for working with youth with psychiatric disabilities. *Rehabilitation Education, 23*(1), 33-42.

Mellin, E. A., & Pertuit, T. L. (2009). Research priorities for mental health counseling with youth: Implications for counselor preparation, professional development, and research. *Counselor Education and Supervision, 49*(2), 137-155. Retrieved from web.b.ebscohost.com.lmunet.idm.oclc.org/ehost/pdfviewer/pdfviewer?vid=3&sid=bfcb6338-995f-4228-a55c-2912361e372d%40sessionmgr101&hid=128

Merikangas, K. R., He, J., Burstein, M., Swanson, S. A., Avenevoli, S., Cui, L., Benjet, C., Georgiades, K., & Swendsen, J. (2010). Lifetime prevalence of mental disorders in US adolescents: Results from the National Comorbidity Study-Adolescent Supplement (NCS-A). *Journal of the American Academy of Child and Adolescent Psychiatry, 49*(10), 980-989.

National Academies of Sciences, Engineering, and Medicine. (2017). *Training the future child health care workforce to improve behavioral health outcomes for children, youth, and families: Proceedings of a workshop – in brief.* Washington, DC: The National Academies Press. https://doi.org/10.17226/24789

National Association of Social Workers. (2003). *NASW standards for the practice of social work with adolescents.* Washington DC: Author. Retrieved from https://www.socialworkers. org/LinkClick.aspx?fileticket=rUt4ybE_GW4%3D&portalid=0

National Institute of Mental Health. (2016). *Child and adolescent mental health*. Retrieved from https://www.nimh.nih.gov/health/topics/child-and-adolescent-mental-health/index.shtml

Pidano, A. E., Kurowski, E. C., & McEvoy, K. M. (2010). The next generation: How are clinical child psychologists being trained? *Training and Education in Professional Psychology, 4*(2), 121-127.

Pidano, A. E., & Whitcomb, J. M. (2012). Training to work with children and families: Results from a survey of psychologists and doctoral students. *Training and Education in Professional Psychology, 6*(1), 8-17.

Ponterotto, J. G., Casas, J. M., Suzuki, L. A., & Alexander, C. M. (Eds.). (2010). *Handbook of multicultural counseling* (3rd ed.). Thousand Oaks, CA: Sage.

Roberts, M. C., Carlson, C. I., Erickson, M. T., Friedman, R. M., La Greca, A. M., Lemanek, K. L., Russ, S. W., Schroeder, C. S., Vargas, L. A., & Wohlford, P. F. (1998). A model for training psychologists to provide services for children and adolescents. *Professional Psychology: Research and Practice, 29*(3), 293-299.

Russ, B. R. (2016). Counselor preparation and adolescent youth: A study of mental health counselors (Unpublished dissertation). Western Michigan University, Kalamazoo, MI.

Schmidt, J. J. (1999). Two decades of CACREP and what do we know? *Counselor Education and Supervision, 39*(1*),* 34-44.

Stanard, R. P. (2000). Assessment and treatment of adolescent depression and suicidality. *Journal of Mental Health Counseling*, *22*(3), 204–217. Retrieved from http://web.b.ebscohost.com.lmunet.idm.oclc.org/ehost/pdfviewer/pdfviewer?vid=5&sid=560a215d-b951-46c4-89cb-54d3ff96d0d3%40sessionmgr104&hid=128

Substance Abuse and Mental Health Services Administration. (2013). *Report to Congress on the nation's substance abuse and mental health workforce issues.* Rockville,

Md. Retrieved from https://store.samhsa.gov/shin/content//PEP13-RTC-BHWORK/PEP13-RTC-BHWORK.pdf

Sue, D. W., Sue, D., Neville, H. A., & Smith, L. (2019). *Counseling the culturally diverse: Theory and practice* (7th ed.). Hoboken, NJ: Wiley.

Vacc, N. A. (1992). An assessment of the perceived relevance of the CACREP standards. *Journal of Counseling and Development, 70,* 685-687.