

Profiles

The American Mental Health Counselors Association: Reflection on 30 Historic Years

James J. Colangelo

The American Mental Health Counselors Association (AMHCA) celebrated its 30th anniversary in May 2006. This article provides a synopsis of AMHCA's illustrious history, from its urgent beginnings in 1976 to its current status as the premier organization attending to the needs and representing the interests of mental health counselors in the United States and elsewhere.

In 2006, the American Mental Health Counselors Association (AMHCA) celebrated its 30th anniversary, presenting an excellent opportunity to reflect on the association's historic beginnings, incredibly rapid growth, developmental milestones, significant successes and its maturation into one of today's premier mental health professional associations. Due in large measure to the tremendous effort on the part of the leadership of AMHCA throughout its 30-year history, mental health counseling is now considered one of the core mental health professions in the United States.

The history of AMHCA and mental health counseling as a profession has been previously covered by Weikel (1985), Smith and Robinson (1995), and Weikel and Palmo (1989). However, it seems appropriate that on the occasion of such a momentous anniversary we take time to reflect on the significant role that AMHCA has played in the development of mental health counseling as an independent mental health profession and its recognition as a core mental health profession along with psychiatry, psychology, social work, and marriage and family therapy.

■ Beginnings

Smith and Robinson (1995) reported that in the 1970s, mental health counselors had no clear identity as a profession and no professional organization to champion their efforts to be recognized as a legitimate distinct profession within the mental health field. The authors indicated that by the mid-1970s, it became clear that there were a large number of individuals who (a) were educationally prepared at either the master's or doctoral level; (b) worked in community agencies, community mental health, or private practice settings; (c) were delivering a wide variety of services very similar to the more established

mental health care provider groups of psychiatry, psychology, and social work; and (d) felt they had no professional home by virtue of their uniqueness (p. 159).

It was in this climate that AMHCA was born in May 1976 when Jim Messina and Nancy Spisso of the Escambia County Mental Health Center took action on the basis of letters written to the American Personnel and Guidance Association's (APGA) *Guidepost* by Ed Anderson and his Wisconsin colleagues and earlier by Gary Seiler of the University of Florida. The correspondence addressed the lack of representation and recognition for non-school counselors within APGA. Messina and Spisso joined with Gary Seiler and Jim Hiatt, also in Florida, in an attempt to establish a new division within APGA. Messina contacted then-APGA President Thelma Daley for information on what needed to be done to establish a new division (Weikel, 1985, 1994).

This core group consisting of mental health professionals from the University of Florida and other mental health practitioners from Wisconsin, a group that included Ed Anderson, formed the American Mental Health Counselors Association. The group quickly expanded to 50 members and they unsuccessfully petitioned the APGA for admittance as a new division in July 1976. Because a moratorium on the establishment of new divisions had been passed by the APGA Board that same month, the AMHCA proposal was not acted upon by APGA and the group established themselves as an independent organization in November 1976. The new organization achieved fairly rapid success because of the early leadership's recognition of the critical need for establishing an identity for the counseling professionals working in various community mental health settings (Weikel & Palmo, 1989).

By the time of its first annual conference, which was held concurrently with the APGA convention in Dallas

James J. Colangelo, Department of Counseling and Development, Long Island University. Correspondence concerning this article should be addressed to James J. Colangelo, Department of Counseling and Development, Long Island University, CW Post Campus, 720 Northern Boulevard, Brookville, NY 11548-1300 (e-mail: james.colangelo@liu.edu).

© 2009 by the American Counseling Association. All rights reserved.

in March 1977, the membership had grown from the original 50 members to almost 500. A Board of Directors for AMHCA was elected and Spisso became president, Messina was president-elect, Rebecca Stall was secretary, David Rouse-Eastin was treasurer, and Don Didier became member-at-large. The AMHCA meeting in Dallas was attended by the then-APGA President-Elect Norm Gysbers; by the end of the APGA convention, the moratorium on new divisions had been lifted. After being notified that APGA had lifted the moratorium, AMHCA called for a vote by its members to determine whether the organization would become affiliated with APGA, an action that was necessary because AMHCA was already incorporated. With strong pro and con sentiments, the AMHCA membership voted 51% to 49% in November 1977 to become a division of the APGA. During this time, Steve Lindenberg was voted the new president-elect of the AMHCA (Weikel, 1985, 1994).

By March 1978, AMHCA membership had grown to almost 1,500, and a second "First Annual AMHCA Conference" was held in Columbia, Maryland, just prior to the APGA convention in Washington, DC. Many workshops were presented and membership and business meetings were conducted. Many of AMHCA's current priorities were initially developed at the Columbia meeting, for example,

licensure laws for mental health counselors in those states that did not yet have them, obtaining third party payments from health insurance plans for services rendered by mental health counselors, defining private practice standards for mental health counselors, obtaining "full parity" for mental health counselors with other "core providers" of mental health services (psychiatrists, clinical psychologists, psychiatric social workers, and psychiatric nurses), provision of treatment to special populations, such as the elderly and mentally retarded. (Hershenson & Power, 1987, p. 51; see also Weikel, 1985)

The AMHCA leadership was informed later that month that the APGA Board had voted to make AMHCA its 13th division, effective July 1, 1978; Jim Messina, who was president of AMHCA at that time became a member of the APGA Board. Although the move to the APGA did not result in all AMHCA members joining the newly formed division, AMHCA's membership quickly rose back to 1,500 and continued to show strong growth in the membership rolls over the next few years (Weikel, 1994).

The growth in AMHCA's membership was a testimony to the organization having filled a void for professional recognition for thousands of mental health practitioners. From an early membership total of 1,500 in the late 1970s, AMHCA experienced a tremendous expansion in membership to 9,669 by July 1985 (AMHCA, 1985) and to more than 12,000 members by 1989, making it the largest division at the time in the American Association for Counseling and Develop-

ment (AACD), previously the APGA (Weikel, 1996). Thus, AMHCA quickly developed into one of the largest divisions within AACD and immediately concentrated its efforts to unite mental health counselors into a professional organization by defining what their role was and the goals of the new organization (Gladding, 2004). Attesting to AMHCA's rapid raise to the forefront of the mental health counseling profession, Herr (1987) stated, "The American Mental Health Counselors Association (AMHCA) has been a major success story as it has intensified the profession's attention to counselors in non-educational settings and to the need for broadening the scope of legislative influence to encompass regulation governing third party payments and definitions of eligible providers" (p. 400).

Independence

Smith and Robinson (1995) reported that from the earliest days of affiliation between AMHCA and ACA (formerly APGA, then AACD), the relationship was difficult and often contentious, as manifested by miscommunication and misunderstanding. AMHCA's agenda, which emphasized professional credentials, recognition, legislative activity, and third-party reimbursement, was a rather extreme departure from the manner in which ACA conducted its business prior to AMHCA's emergence on the scene. The two associations were often at odds in terms of overall purpose. AMHCA exhibited a much clearer focus than ACA on legislative activities affecting mental health counselors' right to practice such as licensure, vendorship, freedom of choice, core provider status and third-party reimbursement. Another factor was AMHCA's ability to focus exclusively on advancing the status of mental health counselors, whereas ACA needed to attend to the overall needs of its many other divisions. This cross purpose in focus was one of the predominant reasons that AMHCA came into existence in 1976. As the years progressed, the distinct differences between the ongoing agendas of the two organizations became more and more of a problem.

In addressing the differences between the two organizations, Smith and Robinson (1995) summarized the respective positions of both AMHCA and ACA at the time:

AMHCA sometimes perceived ACA as being too broadly focused and attempting to treat all divisions the same when AMHCA perceived its own needs to be very specific (e.g., ACA support on AMHCA's efforts to gain recognition as a mental health core provider). ACA sometimes perceived AMHCA as being too narrowly focused, and while they admired AMHCA's quest for quality through the development of credentials (e.g., the National Academy of Certified Clinical Mental Health Counselors in 1979), ACA's support and encouragement was somewhat less than impressive in AMHCA's eyes. (p.159)

The two associations eventually separated in 1998, reflecting on the predominant sentiment that ACA was not meeting the professional needs of AMHCA's membership. At one point, ACA had ceased all public policy efforts. This, coupled with ACA experiencing a series of major financial crises, led many AMHCA members to lose faith in ACA's fiscal management. Despite numerous AMHCA/ACA leadership meetings, separation became reality in 1998 and AMHCA took control of its own financial affairs. However, it should be noted that AMHCA never withdrew as an ACA division and continues to this day as an official division within ACA with the designation of organizational affiliate (V. Moore, personal communication, February 16, 2007). Thus, AMHCA moved out from under the ACA umbrella while remaining as a division within the organization. The separation allowed AMHCA to take the necessary action that would allow it to function in a more collaborative, and less affiliative, relationship with ACA. Both organizations have worked together continuously to address the common needs of the professional counselors they represent (Gerig, 2007).

One of the major ramifications of separation and independence from ACA was a significant drop in membership. In 1989, the AMHCA divisional membership was reported to be more than 12,000 members (Weikel, 1996); AMHCA's current membership just exceeds 6,000 members. The large difference in membership numbers is due to a number of factors: (a) at the time, in 1989, AACD/ACA membership required a divisional membership as well; (b) divisional membership was very inexpensive; and (c) membership records at APGA and AACD were unreliable and ultimately led to great financial turmoil for all entities involved. The major reason that AMHCA membership decreased with independence was that divisional membership was no longer mandatory. In addition, upon separation there was a substantial increase in AMHCA membership dues. Another factor that contributed to a negative political environment between the two organizations was the segment of AMHCA membership who strongly opposed any separation from ACA. However, AMHCA was not the only division within ACA that experienced a drop in membership. Once divisional membership was not required by ACA, all divisions experienced a decline in membership (V. Moore, AMHCA, personal communication, February 16, 2007).

Contributions

Certification

A significant contribution of the neophyte organization that materialized just prior to the 1978 Columbia, Maryland, meeting was the development of the "Blueprint for the Mental Health Counseling Profession" by a special ad hoc committee of AMHCA. The main purpose of the committee was to establish a strong foundation for the mental health counseling profession. The proposal outlined in that historic

document led to the formation of the National Academy of Certified Clinical Mental Health Counselors (NACCMHC) to nationally certify counselors in the new specialty of mental health counseling. The main reason for the formation of the NACCMHC was to address a serious problem existing at that time, which was the lack of counselor licensure. The NACCMHC established criteria for the professional certification of MHCs, specifically the Certified Clinical Mental Health Counselor (Weikel, 1994).

During this same period (1978), AMHCA and the Association for Counselor Education and Supervision (ACES) formed a Joint Committee on Education and Training for Mental Health Counselors. A short time later, in 1979, the NACCMHC appointed a task force for the purpose of developing a competency based system of counselor preparation. A direct outcome of these efforts was the publication in 1981 of the "Ideal Training Standards for Mental Health Counselors" by Messina and Seiler (Seiler, Brooks, & Beck, 1987; Smith & Robinson, 1995). Messina (1985), in discussing the impact of the NACCMHC, indicated that the Academy had met the dreams of AMHCA "to establish mental health counseling as a distinct profession with standards and a code of ethics that made it distinguishable from the other core mental health professions and other counseling specialties" (p. 608).

NACCMHC later affiliated with the National Board of Certified Counselors (NBCC) and the Association for Counselor Education and Supervision in 1993. The first certification examination for the new credential of CCMHC was taken on February 3, 1979, by 50 applicants at Johns Hopkins University in Columbia, Maryland (Gerig, 2007; Weikel, 1994). NACCMHC managed the credentialing of CCMHCs from July 1979 to July 1993 when the CCMHC credential was transferred to NBCC management. In 1993, there were approximately 1,500 CCMHCs nationally. The current number of CCMHCs is 1,173 with the attrition due primarily to retirement (NBCC, 2007).

Accreditation

AMHCA also played a significant role in the formulation of standards for the accreditation of mental health counseling programs, which was eventually adopted by the Council for Accreditation of Counseling and Related Educational Programs (CACREP). CACREP had been established as an independent, freestanding, legally incorporated accreditation body by APGA in 1981 and was charged with the responsibility for accrediting counselor education programs and for revising ongoing training standards (Cowger, Hinkle, DeRidder, & Erk, 1991; Seiler et al., 1987). As mentioned previously in this article, AMHCA's efforts in this area resulted in the publication of *Ideal Training Standards for Mental Health Counselors* (Messina & Seiler, 1981).

In 1982, after his term as president of AMHCA, Seiler drafted official training standards for mental health counselors, which were subsequently adopted by AMHCA. Working with Robert

Stripling of the University of Florida, Seiler further refined the standards to the form adopted by CACREP as "community and other agency counseling programs." This led to an ongoing debate between AMHCA and CACREP, with AMHCA taking the position that the standards developed by Seiler and his collaborators were meant to be freestanding and not incorporated under another category as the action by CACREP had done. AMHCA's argument to CACREP was that although community and other agency counseling was a work environment in which some mental health counselors worked, it certainly did not incorporate all mental health counselors. Furthermore, AMHCA posited that community and other agency counseling was not an appropriate professional identity, whereas mental health counselor was. CACREP responded that community and other agency counseling was a generic category and any new specialties, such as mental health counseling, would have to enter under these standards. Small progress was made when revised standards by CACREP adopted the title "Mental Health Counseling: Community and Other Agency Settings"; however, the professional identity issue was still not resolved (Seiler et al., 1987).

When CACREP undertook a comprehensive process for reviewing training standards in 1986 with revised standards to be effective July 1988, Edward Beck (AMHCA's representative to CACREP and chair of AMHCA's Accreditation and Standards Committee, and past president of AMHCA) began a revision of AMHCA's standards, which followed CACREP's new concept of defining educational experiences by knowledge and skills. Gary Seiler, responding to Beck's request for assistance, designed a comprehensive standards document incorporating the knowledge and skills approach of CACREP that reflected the advancement of mental health counseling during the years since publication of his original training document in 1981. After completion of that monumental task, Beck, Seiler, and then-AMHCA President David Brooks completed a thorough and comprehensive review of both CACREP's most recent draft of revised generic standards and the standards in Seiler's draft of knowledge and skills in mental health counseling (Seiler et al., 1987).

The 1986-1987 AMHCA Board of Directors voted to accept the comprehensive training standards for mental health counselors developed in the 15-page document submitted by Seiler, Beck, and Brooks. The new training standards adopted by the Board required mental health counseling training programs to include at least 60 semester credit hours and a minimum of at least 1,000 hours of *clinical instruction*, the new CACREP terminology for practicums and internships (Smith & Robinson, 1995). AMHCA submitted the revised standards to CACREP and reiterated its position that mental health counseling should be recognized as a distinct discipline rather than as a subspecialty under counseling in community and other agency settings. Support was unanimously received by the AACD Governing Council in April 1987, and in May 1987, CACREP accepted and incorporated, with some modifications, AMHCA's document on standards, thereby

establishing a new and separate mental health counseling track (Seiler et al., 1987).

AMHCA also promoted specialty accreditation for certain areas in the broader mental health counseling area, such as marriage/couples and family counseling. AMHCA's efforts to promote these subspecialty standards within the mental health counseling area were met with initial resistance from other ACA entities with different agendas, such as the International Association for Marriage and Family Counselors (IAMFC) and CACREP. However, CACREP eventually adopted specialty standards for marriage and family counselors that were quite similar to the ones proposed initially by AMHCA in the mid-1980s (Smith & Robinson, 1995). It is clear that AMHCA has had a significant role in championing and persuading CACREP to adopt accreditation standards for mental health counseling programs that helped to establish a clear and distinct professional identity for mental health counselors.

Licensure

From the beginning, obtaining licensure laws for mental health counselors was a major priority for AMHCA. At the time of its incorporation in 1976, only Virginia had passed a counselor licensure law. By 1989, through the continual efforts of AMHCA working in conjunction with the AACD, counselors were licensed in 28 states, were reimbursed for services by the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), and were recognized by the National Institute of Mental Health, other federal agencies, the United States Congress, and several private insurance carriers (Weikel & Palmo, 1989). Fong and Sherrard (1991) stated that after a little more than a decade of growth, the new discipline of mental health counseling was receiving both external recognition and status as a core mental health profession. The authors reported that in the 15 years since the inception of the AMHCA mental health counselor national certification, licensure in 36 states, and standards for accreditation of training programs had been achieved.

AMHCA's (2004) *Advocate* reported that Licensed Mental Health Counselors (LMHCs), also referred to as Licensed Professional Counselors (LPCs), numbered 80,000 strong in the United States and were recognized as licensed practitioners in 48 states, the District of Columbia, and Puerto Rico. At the time, only California and Nevada had yet to pass legislation recognizing mental health counselors as licensed practitioners. In 2007, Nevada successfully passed legislation licensing mental health counselors, leaving California as the only state not providing legal recognition to mental health counselors. It is only a matter of time before California joins the ranks and provides legal recognition to mental health counselors. This surely is the single most significant accomplishment of AMHCA in its 30 year history and the fulfillment of one of its original primary goals.

Publications

The publications developed by AMHCA in late 1978 and early 1979 were another important contribution immediately made

by the new professional organization to establish a distinct identity. The *AMHCA News* was devoted to the communication of professional news, and the *American Mental Health Counselors Association Journal* was committed to supporting the accumulation of scholarly literature for the profession (Gerig, 2007).

The first edition of the *AMHCA News* under the stewardship of Colleen Haffner and Janet (Asher) Anderson was released in April 1978 and soon was expanded to 6 issues per year. In the summer of 1989, the *AMHCA News* was changed to the *AMHCA Advocate* and began being published 10 times yearly. The initial issue of the *AMHCA Journal*, under the editorial leadership of Bill Weikel, was published in January 1979. A balance between theoretical manuscripts and practical articles that were useful to the AMHCA membership was sought by the early editorial board. The journal was a semiannual publication through 1982 and became a quarterly publication in 1983 under the editorship of James Wiggins. During the editorial term of Linda Seligman (1984–1986), the journal continued to gain credibility, thus fulfilling her pledge to guide the journal to a place of esteem, establishment, and entitlement. The *AMHCA Journal* was renamed the *Journal of Mental Health Counseling (JMHC)* during the term of Lawrence Gerstein, who continued the journal's growth by introducing special issues (Weikel, 1994).

Gerstein (1989) reported that *JMHC*'s circulation had grown significantly over the 10 years of its existence under the leadership of its four editors William Weikel, James Wiggins, Linda Seligman, and Lawrence Gerstein. The periodical was received by slightly more than 12,000 persons, making it the second highest circulated counseling journal at the time. Furthermore, *JMHC* had become a rather selective periodical, with only 25% of the over 100 manuscripts submitted yearly being accepted for publication. Today, *JMHC* is considered an influential peer-reviewed journal devoted to addressing and covering issues that are significant and of critical importance in the field of mental health counseling from both the research (experimental) and clinical (practice) perspectives. It has evolved over the years into one of the premier professional journals in the mental health field.

Other Significant Contributions

AMHCA has also made other significant contributions to the profession of mental health counseling and organizationally to its membership since it became an independent association. Organizationally, AMHCA's annual budget now exceeds a record \$1 million, and there is a professional office staff of five with additional outside consultants. AMHCA has recently expanded its office suite with new physical space to better enable its staff to respond to the ongoing needs of its membership. The *Advocate* newsletter is now a monthly, color publication, and the quarterly *JMHC* continues to be published, with an online version now available. AMHCA has launched a national Web site and publishes two monthly

electronic newsletters. After achieving its independence, AMHCA initiated its own yearly national conference in addition to a leadership training meeting; over the years, it has forged several business partner relationships and has become a collaborative member of a variety of national mental health coalitions. There are now over 40 state chapters, many of which have their own newsletters and Web sites. Licensure has been achieved in 48 states, and continual efforts are being made to assist passage of licensure legislation in the remaining two states. The AMHCA Foundation was launched in 2006 with a variety of projects planned that will hopefully have a positive impact on the profession and membership (V. Moore, personal communication, February 16, 2007).

AMHCA has always encouraged and supported legislative activities at the federal, state, and local levels affecting all aspects of the mental health counseling profession. AMHCA continues to recognize that strong support and legislative advocacy can result in the inclusion of mental health counselors in federal health care programs. It actively participates in advocacy efforts through lobbying the United States Congress for recognition of mental health counselors as providers in such federal programs as Medicare and Medicaid (Barstow, 2007). A recent success of such efforts on the part of AMHCA in collaboration with ACA was realized with the passage of federal legislation establishing licensed professional counselors as mental health specialists within the Department of Veterans Affairs (VA) health care system. AMHCA Executive Director and CEO Mark Hamilton said, "The inclusion of licensed mental health counselors by the VA and the quality of services they provide will make it easier for those who served our nation and who are in need of mental health services to get the health care they need. Passage of this legislation could not have been achieved without the longtime collaborative efforts of AMHCA and ACA" (Barstow, 2007, p. 16).

AMHCA Executive Director Mark Hamilton (2006a) recently announced another important contribution of AMHCA in the *Advocate*, the launching of the "National Mental Health Disaster Relief Registry," which will serve as a resource for referrals from disaster relief agencies for disaster survivors and their families. The Registry represents another initiative undertaken by AMHCA in its continuing efforts to provide quality professional mental health care to all populations in need of such services. In addition, Hamilton (2006b) has been appointed to the National Health Council's Board of Directors. The NHC is a Washington, DC-based forum for public policy development that currently has 115 member organizations. This appointment will afford Hamilton and AMHCA the opportunity to provide increased mental health representative on this senior health policymaking body.

Present and Future Goals

AMHCA's ongoing and continuing mission is to promote and enhance the mental health counseling profession

through licensing, advocacy, education, and professional development. The long-term vision statement is "to be the national organization representing licensed mental health counselors and state chapters, with consistent standards of education, training, licensing, practice, advocacy and ethics." This is summed up with the words on the masthead of *The Advocate*, AMHCA's monthly newsletter: "The only organization working exclusively for the mental health counselor" (V. Moore, personal communication, February 16, 2007).

Gail Mears (2006), the current AMHCA president, outlined some of the pressing issues that AMHCA will work to improve in the near future:

continue the advocacy for expanded practice rights and move toward a stronger sense of professional identity; continue the impressive gains that have been made in state and national legislation and achieve licensure in all 50 states, expand state vendorship laws, and obtain recognition for mental health counselors as covered mental health providers in federal legislation regulating provider status for Medicare and other federal programs; continue to be active allies to mental health consumers by working to ensure that mental health services are accessible, affordable, and relevant to the needs of the children, adults, and families in the country by expanding AMHCA's already impressive network of professional partnerships, collaboration with allied mental health professionals, and advocacy for the availability or prevention and wellness programs as well as treatment programs; continue to ensure that mental health counseling students are connected with AMHCA by extensive outreach efforts to clinical graduate programs and close collaboration with counselor educators; continue to maintain and expand AMHCA's ability to promote mental health counseling through strong state chapters connected to, and supported by AMHCA. (p. 2)

Virginia Moore (personal communication, February 12, 2007) of AMHCA's national office states it eloquently when she says,

Our goals are to provide the best services possible to our members, state chapters, and consumers. We support our student members through grants and the funding of a student committee. We work to provide a variety of quality member benefits and services. We will continue our legislative work for licensure in all 50 states and for equality with other professional mental health providers.

As in any historical rendering, there may have been individuals who made significant contributions to the development and growth of AMHCA over the years that I have failed to mention in this article. That oversight, partially due to limited space, is not meant to minimize in any way their

worthy contributions. To such persons, I wish to apologize for any oversights and express the heartfelt gratitude of all those within the mental health counseling profession for their selfless efforts and generous acts of professional responsibility on behalf of all those who followed.

References

- American Mental Health Counselors Association. (1985). *The Advocate*, 9(1), 2.
- American Mental Health Counselors Association. (2004). Hawaii becomes 48th state to license mental health counselors. *The Advocate*, 27(8), 12.
- Barstow, S. (2007). Counselors claim major victory. *Counseling Today*, 49(7), 16.
- Cowger, E. L., Jr., Hinkle, J. S., DeRidder, L. M., & Erk, R. R. (1991). CACREP community counseling programs: Present status and implications for the future. *Journal of Mental Health Counseling*, 13, 172-186.
- Fong, M. L., & Sherrard, P. A. D. (1991). Mental health counselor training: Directions for the 1990s. *Journal of Mental Health Counseling*, 13, 167-171.
- Gerig, M. S. (2007). *Foundations for mental health and community counseling: An introduction to the profession*. Upper Saddle River, NJ: Pearson/Merrill Prentice Hall.
- Gerstein, L. H. (1989). The *Journal of Mental Health Counseling*: A tenth anniversary and a new beginning. *Journal of Mental Health Counseling*, 11, 3-5.
- Gladding, S. T. (2004). *Counseling: A comprehensive profession*. Upper Saddle River, NJ: Pearson/Merrill Prentice Hall.
- Hamilton, W. M. (2006a). Director's cut. *The Advocate*, 29(2), 2.
- Hamilton, W. M. (2006b). Report of AMHCA's executive director and CEO. *The Advocate*, 29(9), 2.
- Herr, E. L. (1987). Another view of AACD and its journals. *Journal of Counseling and Development*, 65, 400-403.
- Hershenson, D. B., & Power, P. W. (1987). *Mental health counseling: Theory and practice*. New York: Pergamon Press.
- Mears, G. (2006). Presidential points. *The Advocate*, 29(7), 2.
- Messina, J. J. (1985). The National Academy of Certified Clinical Mental Health Counselors: Creating a new professional identity. *Journal of Counseling and Development*, 63, 607-608.
- Messina, J. J., & Seiler, G. (1981). *Ideal training standards for mental health counselors*. Tampa, FL: Advanced Development Systems.
- National Board of Certified Counselors. (2007). *Statistics*. Retrieved March, 20, 2007, from <http://www.nbcc.org/stats>
- Seiler, G., Brooks, D. K., & Beck, E. S. (1987). Training standards of the American Mental Health Counselors Association: History, rationale, and implications. *Journal of Mental Health Counseling*, 9, 199-205.
- Smith, H. B., & Robinson, G. P. (1995). Mental health counseling: Past, present, and future. *Journal of Counseling & Development*, 74, 158-161.

-
- Weikel, W. J. (1985). The American Mental Health Counselors Association. *Journal of Counseling and Development, 63*, 457-460.
- Weikel, W. J. (1994). A brief history of the American Mental Health Counselors Association. *AMHCA leader handbook*. Retrieved January 10, 2007, from <http://www.amhca.org>
- Weikel, W. J. (1996). The American mental health counselors association. In W. J. Weikel & A. J. Palmo (Eds.), *Foundations of mental health counseling* (2nd ed., pp. 30-38). Springfield, IL: Charles C Thomas.
- Weikel, W. J., & Palmo, A. J. (1989). The evolution and practice of mental health counseling. *Journal of Mental Health Counseling, 11*, 7-25.