Among the various professionals (e.g., physiatrists, psychologists, social workers, medical case managers) who may provide services to individuals with disabilities during their individual rehabilitation process, the rehabilitation counselor represents a unique professional, who plays a central role in the extramedical phase of the rehabilitation process, for individuals with both acquired and congenital disabilities (G. N. Wright, 1980). Rehabilitation counseling emerged as a full-time occupation over 80 years ago. Unlike the beginnings of other counseling specialties and health-related occupations, rehabilitation counseling was mandated as a specific work role, through federal legislation (Smith-Fess Act in 1920), which established the public or state–federal rehabilitation program in this country. In the years following this landmark legislation, rehabilitation counseling practice in the public and private sectors evolved and expanded to provide a comprehensive array of vocational and independent living services to an everincreasing adult population of persons with a wide range of physical and mental disabilities (Leahy & Szymanski, 1995).

Although the occupational status of rehabilitation counseling was established in the 1920s, it was not until the mid-1950s, with the passage of the 1954 Vocational Rehabilitation (VR) Act Amendments, that the discipline embarked on a series of significant ongoing developments (e.g., preservice education, professional associations, code of ethics, regulation of practice), which have led, over time, to the professionalization of practice in this
country, and to some extent internationally. Although initially a very heterogeneous group of practitioners, in terms of educational background and professional competencies, rehabilitation counselors today, as a result of the professionalization process over the past 45 years, represent a group of professionals with a much higher degree of commonality in preservice preparation, practice, and professional identity than at any previous time in our professional history.

The purpose of this chapter is to review those elements of the profession that serve to uniquely identify and provide the foundation for rehabilitation counseling practice in today’s health and human services environment. Particular attention is devoted to the scope and research-based foundation of practice, and to the definition of qualified providers. In addition, preservice and continuing education, regulation of professional practice (certification and licensure), and the professional associations in rehabilitation counseling are reviewed.

SCOPE OF PRACTICE

Rehabilitation counseling has been described as a process in which the counselor works collaboratively with the consumer to understand existing problems, barriers, and potentials, in order to facilitate the effective use of personal and environmental resources for career, personal, social, and community adjustment following disability (Jaques, 1970). In carrying out this multifaceted process, rehabilitation counselors must be prepared to assist individuals with disabilities in adapting to the environment, to assist environments in accommodating the needs of the individual, and to work toward the full participation of individuals in all aspects of society, with a particular focus on career aspirations (Szymanski, 1985).

Over the years, the fundamental role of the rehabilitation counselor has evolved (Jaques, 1970; Rubin & Roessler, 1995; G. N. Wright, 1980), with the subsequent functions and required knowledge and skill competencies of the rehabilitation counselor expanding as well. Regardless of variations in their employment setting and client population, most rehabilitation counselors (a) assess needs, (b) establish a working alliance with the individual to develop goals and individualized plans to meet identified needs, and (c) provide or arrange for therapeutic services and interventions (e.g., psychological, medical, social, behavioral), including job placement and follow-up services. Throughout this individualized process, counseling skills are considered essential components of all activities. The specialized knowledge of disabilities
and of environmental factors that interact with disabilities, as well as the range of knowledge and skills required in addition to counseling, serves to differentiate the rehabilitation counselor from social workers, other types of counselors (e.g., mental health, school, career) and other rehabilitation practitioners (e.g., vocational evaluators, job placement specialists) in today’s service delivery environments (Jenkins, Patterson, & Szymanski, 1992; Leahy & Szymanski, 1995).

In 1994, utilizing the long-standing tradition in rehabilitation counseling research of studying the role and functions of qualified practitioners, an official scope of practice statement was developed and adopted by the major professional, accreditation, and credentialing organizations. This statement, which is consistent with available empirical research, was required to more explicitly identify the scope of practice for the public, consumers of services, related professional groups, and regulatory bodies. The statement, which was originally constructed by members of the Examination and Research Committee of the Commission on Rehabilitation Counselor Certification (CRCC), also contains major assumptions and underlying values associated with the scope of practice. The statement was formally adopted in the mid-1990s by the following organizations: the American Rehabilitation Counseling Association (ARCA), National Rehabilitation Counseling Association (NRCA), Alliance for Rehabilitation Counseling (ARC), National Council on Rehabilitation Education, CRCC, and the Council on Rehabilitation Education (CORE). The official scope of practice statement for rehabilitation counseling reads as follows:

Rehabilitation counseling is a systematic process which assists persons with physical, mental, developmental, cognitive, and emotional disabilities to achieve their personal, career, and independent living goals in the most integrated setting possible through the application of the counseling process. The counseling process involves communication, goal setting, and beneficial growth or change through self-advocacy, psychological, vocational, social, and behavioral interventions. The specific techniques and modalities utilized within this rehabilitation counseling process may include, but are not limited to:

- assessment and appraisal;
- diagnosis and treatment planning;
- career (vocational) counseling;
- individual and group counseling treatment interventions focused on facilitating adjustments to the medical and psychosocial impact of disability;
- case management, referral, and service coordination;
- program evaluation and research;
- interventions to remove environmental, employment and attitudinal barriers;
- consultation services among multiple parties and regulatory systems;
job analysis, job development, and placement services, including assistance with employment and job accommodations; and the provision of consultation about, and access to, rehabilitation technology (CRCC, 1994, pp. 1–2)

RESEARCH-BASED FOUNDATION OF PRACTICE

Underlying the practice of any profession or professional specialty area is the delineation of specific knowledge and skill competencies required for effective service delivery. Job analysis, role and function, professional competency, critical incident, and knowledge-validation research are all terms that describe a process whereby the professional practice of rehabilitation counseling has been systematically studied, to identify and describe important functions and tasks or knowledge and skills associated with the effective delivery of services to individuals with disabilities.

Over the past 40 years, an extensive body of knowledge has been acquired through these various research methods, which has empirically identified the specific competencies and job functions important to the practice of rehabilitation counseling (e.g., Berven, 1979; Emener & Rubin, 1980; Harrison & Lee, 1979; Jaques, 1959; Leahy, Chan, & Saunders, 2001; Leahy, Shapson & Wright, 1987; Leahy, Szymanski, & Linkowski, 1993; Muthard & Salomone, 1969; Rubin et al., 1984; Wright & Fraser, 1975). This long-standing emphasis on the development and ongoing refinement of a research-based foundation in relation to practice, and the required knowledge and skills, has served to distinguish rehabilitation counseling from other counseling specialties that are also seeking to define and validate their scope of professional practice. These research efforts have also provided the profession with evidence of construct validity of rehabilitation counseling knowledge and skill areas (Szymanski, Linkowski, Leahy, Diamond, & Thoreson, 1993b).

Although role and function approaches generally provide an empirically derived description of the functions and tasks associated with the role, the knowledge required to perform these functions is typically more indirectly assessed and inferred on the basis of the described functions and tasks. Roessler and Rubin (1992), in their review of major studies (Emener & Rubin, 1980; Leahy et al., 1987; Rubin et al., 1984), concluded that rehabilitation counselors have a diverse role requiring many skills, if they are to effectively assist individuals with disabilities improve the quality of their lives. They also concluded that the role of the rehabilitation counselor can be fundamentally described as encompassing the following functions or job task areas: assess-
ment, affective counseling, vocational (career) counseling, case management, and job placement.

Conversely, knowledge validation and professional competency approaches provide an empirically derived description of the knowledge and skills associated with a particular role, but the actual functions and tasks are more indirectly assessed and inferred on the basis of the knowledge and skills needed by an individual to practice. Recent research by Leahy et al. (2001) provided empirical support that the following six knowledge domains represent the core knowledge and skill requirements of rehabilitation counselors: (1) career counseling, assessment, and consultation; (2) counseling theories, techniques, and applications; (3) rehabilitation services and resources; (4) case and caseload management; (5) health care and disability systems; and (6) medical, functional, and environmental implications of disability. A complete listing of the knowledge domains and subdomains from this study, sponsored by the CRCC, is provided in Table 7.1.

In terms of research utilization and applications, these empirically derived descriptions of the rehabilitation counselor’s role, function, and required knowledge and skill competencies have assisted the profession in a number of important ways. First, they have helped define the professional identity of the rehabilitation counselor, by empirically defining the uniqueness of the profession and by providing evidence in support of the construct validity of its knowledge base. Second, the descriptions have been extensively used in the development of preservice educational curricula, in order to provide graduate training in areas of knowledge and skill critical to the practice of rehabilitation counseling across major employment settings. Third, the long-standing emphasis on a research-based foundation to practice has greatly contributed to the rehabilitation counseling profession’s leadership role in the establishment and ongoing refinement of graduate educational program accreditation, through the CORE, and in individual practitioner certification, through the CRCC. Finally, this body of knowledge has also been useful in identifying the common professional ground (shared competency areas) and the uniqueness of rehabilitation counseling among related rehabilitation disciplines (e.g., vocational evaluators, job placement specialists) and other counseling specialties (e.g., career, school, mental health). This process of further definition in the area of occupational competence is a normal sequence in the professionalization process for any occupation seeking public recognition.

**QUALIFIED PROVIDERS**

According to the professional associations (ARCA, NRCA, and ARC), qualified providers of rehabilitation counseling services are those professionals
TABLE 7.1 Rehabilitation Counseling Knowledge Domains and Subdomains

### Domain 1: Career Counseling, Assessment, and Consultation Services

**Subdomain A: Vocational Consultation and Employer Services**
- Employer practices that affect employment or return to work
- Ergonomics
- Job modification and restructuring techniques
- Consultation services available from rehabilitation counselors for employers
- Methods and techniques used to conduct labor market surveys
- Work-conditioning or work-hardening resources and strategies
- Business/corporate terminology
- Accommodation and rehabilitation engineering services
- Marketing strategies and techniques for rehabilitation services
- Workplace culture and environment

**Subdomain B: Job Development and Placement Services**
- Employer development and job placement
- Client job-seeking skills development
- Client job-retention skills
- Job placement strategies
- Job and employer development
- Follow-up/postemployment services
- Occupational and labor market information
- Vocational implications of functional limitations associated with disabilities

**Subdomain C: Career Counseling and Assessment Techniques**
- Tests and evaluation techniques available for assessing client’s needs
- Computer-based counseling tools in rehabilitation counseling
- Computer-based job-matching systems
- Interpretation of assessment results, for rehabilitation planning purposes
- Internet resources for rehabilitation counseling
- Assistive technology
- Theories of career development and work adjustment
- Transferable skills analysis

### Domain 2: Counseling Theories, Techniques, and Applications

**Subdomain A: Mental Health Counseling**
- Mental health and psychiatric disability concepts
- Rehabilitation techniques for individuals with psychological disabilities
- Treatment planning for clinical problems (e.g., depression and anxiety)
- Substance abuse and treatment
- Human sexuality and disability issues
- Wellness and illness prevention concepts and strategies
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<td><strong>Subdomain B: Group and Family Counseling</strong></td>
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<td>Family counseling practices and interventions</td>
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<td>Group counseling practices and interventions</td>
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<td>Group counseling theories</td>
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**Subdomain C: Individual Counseling**

- Individual counseling theories
- Individual counseling practices and interventions
- Behavior and personality theory
- Human growth and development

**Subdomain D: Psychosocial and Cultural Issues in Counseling**

- Psychosocial and cultural impact of disability on the family
- Psychosocial and cultural impact of disability on the individual
- Multicultural counseling issues
- Gender issues
- Societal issues, trends, and developments as they relate to rehabilitation
- Techniques for working with individuals with limited English proficiency

**Subdomain E: Foundations, Ethics, and Professional Issues**

- Design of research projects, program evaluation, and needs assessment
- Basic research methods
- Evaluation procedures for assessing the effectiveness of rehabilitation services and outcomes
- History of rehabilitation
- Philosophical foundations of rehabilitation
- Ethical issues related to online counseling
- Ethical decision-making models and processes
- Theories and techniques of clinical supervision
- Advocacy processes needed to address institutional and societal barriers that impede access, equity, and success for clients
- Legislation or laws affecting individuals with disabilities

**Domain 3: Rehabilitation Services and Resources**

- Supported employment strategies and services
- School-to-work transition for students with disabilities
- Services available for a variety of rehabilitation populations, including persons with multiple disabilities
- Planning provision of independent living services with clients
- Financial resources for rehabilitation services
- Community resources and services for rehabilitation planning
- Social Security programs, benefits, and disincentives
- Organizational structure of the public vocational rehabilitation service delivery system
- Rehabilitation services in diverse settings
- Organizational structure of the not-for-profit service delivery systems
### TABLE 7.1  (continued)

**Domain 4: Case and Caseload Management**

- Case management process and tools
- Case recording and documentation
- Principles of caseload management
- Professional roles, functions, and relationships with other human service providers
- Clinical problem-solving and critical-thinking skills
- Negotiation and conflict resolution strategies
- The case management process, including case finding; service coordination; referral to, and utilization of, other disciplines; and client advocacy
- Techniques for working effectively in teams and across disciplines

**Domain 5: Health Care and Disability Systems**

- Managed care concepts
- Health care delivery systems
- Employer-based disability prevention and management strategies
- Workers’ compensation laws and practices
- Techniques for evaluating earnings capacity and loss
- Expert testimony
- Life care planning
- Organizational structure of the private, for-profit vocational rehabilitation systems
- Health care benefits
- Appropriate medical intervention resources

**Domain 6: Medical, Functional, and Environmental Implications of Disability**

- Environmental barriers for individuals with disabilities
- Physical/functional capacities of individuals with disabilities
- Medical aspects and implications of various disabilities
- Rehabilitation terminology and concepts
- Medical terminology
- Attitudinal barriers for individuals with disabilities

who have completed graduate degree training in rehabilitation counseling or a closely related degree program (e.g., counseling) at the master’s level, have attained national certification as a Certified Rehabilitation Counselor (CRC), and have acquired the appropriate state licensure (e.g., Licensed Professional Counselor), in those states that require this level of credential for counseling practice. As an integral aspect of this professional identity, qualified providers, under this definition, are required to practice rehabilitation counseling within
the guidelines and standards of the Code of Professional Ethics for Rehabilitation Counselors (2002) and to maintain ongoing professional development through relevant continuing education to maintain and upgrade their knowledge and skills related to practice. In addition to these professional requirements and responsibilities, qualified providers are expected to be members of a professional association and contribute, through professional advocacy, to the advancement of the profession.

In recent years, a series of studies were conducted to investigate the relationship between rehabilitation counselor education and service delivery outcomes, which has provided consistent support for the position that rehabilitation counselors, as qualified providers, need to obtain preservice training at the graduate level in rehabilitation counseling or a closely related field, prior to practice. Studies of the New York (Szymanski & Parker, 1989), Wisconsin (Szymanski, 1991), Maryland (Szymanski & Danek, 1991), and Arkansas (Cook & Bolton, 1992) state VR agencies demonstrated that counselors with master’s degrees in rehabilitation counseling achieved better outcomes with clients with severe disabilities than did rehabilitation counselors with unrelated master’s or bachelor’s degrees. In another group of studies, involving rehabilitation counselors from a variety of employment settings, preservice education was linked to the rehabilitation counselors perceived (self-assessed) level of competency. Shapson, Wright, and Leahy (1987), and Szymanski, Leahy, and Linkowski (1993) demonstrated that counselors with master’s degrees in rehabilitation counseling perceived themselves to be more competent or better prepared in critical knowledge and skill areas of rehabilitation counseling than did counselors with unrelated preservice preparation (Leahy & Szymanski, 1995).

During the past 25 years, there has been a growing expectation, among members of the profession, employers, and regulatory bodies, that rehabilitation counselors who provide services to people with disabilities have the appropriate preservice education and credentials (certification and licensure). Even today, however, there are individuals practicing as rehabilitation counselors in both the public and private rehabilitation sectors in this country who do not have this type of preservice preparation or appropriate credentials. Although this heterogeneity in professional background was once thought to be a natural consequence of a quickly expanding field, in more recent years the practice of hiring individuals without appropriate professional training and credentials has been heavily criticized by professional, educational, and regulatory bodies in rehabilitation counseling.

Recently, in probably one of the most substantive policy advances in relation to professionization in the history of the public rehabilitation program,
the Rehabilitation Act Amendments of 1992 provided explicit guidance to state agencies about personnel requirements that may have a significant and long-lasting effect on professionalism at the practitioner level. In 1997, these new regulations regarding qualified providers of rehabilitation counseling services were implemented within the public rehabilitation program. In a commissioners memorandum (CM-98-12), dated May 29, 1998, Fredric Schroeder indicated that:

Section 101(a)(7) of the Rehabilitation Act Amendments of 1992, commonly referred to as the Comprehensive System of Personnel Development (CSPD), requires state VR agencies to establish qualified personnel standards for rehabilitation personnel, including VR counselors, that are consistent with any national or State-approved or recognized certification, licensing, or registration that apply to a particular profession. To the extent that a State’s existing personnel standards are not based on the highest requirements of the State, the State agency is also required to develop a plan to retrain or hire personnel to meet personnel standards that are based on the highest requirements. . . . The purpose of the CSPD provisions is to ensure the quality of personnel who provide VR services and assist individuals with disabilities to achieve employment outcomes through the VR program. (p. 1)

In most situations, state agencies will be required to upgrade and retrain existing personnel to the point at which they would be considered eligible for CRC certification. For new hires, this same standard would be used. What this does not mean is that these personnel would be required to be certified. In addition, only academic criteria will be used by the state agency to determine eligibility—not the typical process of evaluating both academic and work experience, as is the case with CRCC.

On the one hand, this represents a positive step forward in relation to upgrading the educational backgrounds of rehabilitation counselors practicing in state agencies throughout this country. On the other hand, although these provisions are viewed as highly constructive, the current interpretation of the provisions, as relating only to eligibility and not the attainment of the CRC credential, represents some real limitations in relation to individual practitioner accountability. As indicated previously, certification implies that the practitioner not only has appropriate education, but is able to successfully pass a knowledge exam, adhere and be accountable to the profession’s code of ethics in delivering services, and continue the process of professional development, while being certified through continuing education (Leahy, 1999).

One of the key characteristics of any profession is regulation of practice (Rothman, 1987). Individuals who practice rehabilitation counseling outside of the profession are not accountable to, or included in, such regulation of
practice, and are therefore not required to adhere to the profession’s code of ethics or accepted standards of practice. Although this situation has improved over the years, it is still unacceptable. Clearly, however, in the years to come, the trend toward professionalization, and particularly the movement toward state licensure and certification in this country, will make it less likely that an individual will be able to practice as a rehabilitation counselor without appropriate training and credentials.

SPECIALIZATION AND RELATED PROVIDERS

Today, a majority of rehabilitation counselors practice in the public, private, and nonprofit rehabilitation sectors. In recent years, however, rehabilitation counselors have begun to practice in independent living centers, employee assistance programs, hospitals, clinics, mental health organizations, public school transition programs, and employer-based disability prevention and management programs. Although setting-based factors may affect the relative emphasis or importance of various rehabilitation counselor functions or may introduce new specialized knowledge requirements for the rehabilitation counselor, there remains a great deal of communality in the role and function among rehabilitation counselors, regardless of employment setting (Leahy et al., 1987, 1993, 2001). One aspect that is often affected by these various settings is the specific job title—rehabilitation counselor—used in most settings, but one can also find the use of the title rehabilitation consultant or case manager among today’s rehabilitation counselors in practice. In addition, as one advances up the career ladder within these various settings, rehabilitation counselors can assume supervisory, management, and administrative roles.

Although the majority of rehabilitation counselors are viewed as generalists, another aspect of variation among practicing rehabilitation counselors is the degree to which they specialize their practice. One particularly useful model for viewing this issue was developed by DiMichael (1967), who suggested a two-way classification of horizontal and vertical specialization. In DiMichael’s model, horizontal specialization refers to rehabilitation counselors who restrict or specialize their practice with a particular disability group (e.g., deaf, blind, head injury, substance abuse) that requires a significant amount of specialized knowledge or skill, specific to the type of disability. Vertical specialization, on the other hand, occurs when rehabilitation counselors attend to only one function in the rehabilitation process (e.g., assessment or job placement) in their work with consumers. Vocational evaluators and job placement specialists are examples of vertical specialists in this model.
The previous section, on qualified providers, does not imply that only rehabilitation counselors should provide rehabilitation services for persons with disabilities. In fact, there are numerous other related work roles that contribute to the rehabilitation process and complement the role and services provided by the rehabilitation counselor. In addition to vocational evaluators and job placement specialists, who can assist the rehabilitation counselor and client at critical stages in the rehabilitation process (assessment and job placement), other supportive resources could include physicians and physiatrists, physical and occupational therapists, psychologists, work adjustment trainers, job coaches, and various vocational training personnel. Oftentimes, a critical aspect of the rehabilitation counselor’s role is the coordination of services provided by these various professionals within the context of a multidisciplinary team approach, to effectively address the multifaceted needs of the consumer in the rehabilitation process.

PRESERVICE EDUCATION AND PROFESSIONAL DEVELOPMENT

Throughout this chapter, the importance of appropriate preservice education in rehabilitation counseling has been emphasized. By the 1940s, three universities (New York, Ohio State, and Wayne State) had developed graduate training programs in rehabilitation counseling (Jenkins et al., 1992). In 1954, with the passage of the VR Amendments, federal grant support was provided, for the first time, to universities and colleges to develop graduate preservice training programs, to prepare rehabilitation counselors for employment in the public and private nonprofit rehabilitation sectors. This federal training support, which continues to this day, accelerated the design and development of graduate training in rehabilitation counseling, and can be viewed as the beginning of the professionalization process for the formal discipline of rehabilitation counseling (Leahy & Szymanski, 1995).

During this initial period of program development, a conference report by Hall and Warren (1956), which documented the findings of a comprehensive workshop sponsored by the National Rehabilitation Association (NRA) and the National Vocational Guidance Association (now the American Counseling Association [ACA]), provided the initial guidelines for curriculum planning by the new, federally funded rehabilitation counselor education programs (G. N. Wright, 1980). In the years that followed, empirical research, in the form of role and function and professional competency studies (covered earlier in this chapter), helped guide curriculum redesign efforts to ensure that critical
knowledge and skill areas needed in the field were reflected in the preservice training content.

As rehabilitation counselor education programs expanded in colleges and universities, there was a need to devise a mechanism to standardize and accredit these training programs. In 1972, the CORE was established as the national accreditation body for rehabilitation counselor education programs “to promote the effective delivery of rehabilitation services to individuals with disabilities by promoting and fostering continuing review and improvement of master’s degree level programs” (CORE, 1991, p. 2). Research conducted at the University of Wisconsin laid the foundation for a multistakeholder program evaluation process, which was recognized in 1975 by the National Commission on Accrediting, a predecessor of the Council on Postsecondary Accreditation, and, since 1977, the Council for Higher Education Accreditation, and is still in use today (Linkowski & Szymanski, 1993). Currently, there are over 85 accredited master’s degree educational programs in rehabilitation counseling. As the oldest and most-established accreditation body among the counseling professions, the CORE process remains firmly grounded in research and regularly conducts a systematic review of the adequacy and relevancy of its standards.

Following graduate level preservice education, practicing rehabilitation counselors need to continue their professional development, to maintain and upgrade knowledge and skills associated with the delivery of rehabilitation counseling services to persons with disabilities. For example, CRCs are required to obtain a minimum of 100 hr of relevant continuing education, of which a minimum of 10 hr is required in ethics, during their 5-year certification period. With the rapid pace of change in the field and the continual dissemination of new knowledge and expanded skills associated with practice, the rehabilitation counselor needs to be aware of continuing educational opportunities available to them. Although there are numerous organizations and groups that provide this type of training (both face-to-face and distance education opportunities), the primary sources and sponsors of continuing education for the rehabilitation counselor are the professional organizations (e.g., ARCA, NRCA, NRA, ACA), the Regional Rehabilitation Continuing Educational Programs, research and training centers, and university-based outreach educational programs.

REGULATION OF PRACTICE AND CREDENTIALING

Regulation of practice, through professional certification and licensure, is an important characteristic of professions (Rothman, 1987). Rehabilitation
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Counseling has been widely recognized as the leading counseling specialty in the development and pioneering of credentialing mechanisms through national certification and educational program accreditation, which serve as the cornerstones of the general counseling professionalization system (Tarvydas & Leahy, 1993). However, the order of credentialing development in rehabilitation counseling has also been widely observed to be atypical of the expected order of progression seen in other, more-established professions, such as medicine and law. The more-classic evolution of credentials, according to Matkin (1983), has been for the profession to initially achieve state licensure, then move to develop national specialty certifications or endorsements regulated by the professional organizations. In rehabilitation counseling, national certification was established first, followed by a long period of legislative advocacy, in which other counseling specialty groups took the lead role, along with rehabilitation counselors, to establish state counselor licensure laws in individual states (Tarvydas & Leahy, 1993).

In our field, the CRC credentialing process is the oldest and most-established certification process in the counseling and rehabilitation professions. The purpose of certification is to ensure that the professionals engaged in rehabilitation counseling are of good moral character and possess at least an acceptable minimum level of knowledge, as determined by the CRCC, about the practice of their profession. The existence of such standards is considered to be in the best interests of consumers of rehabilitation counseling services and the general public. From a historical perspective, the CRC credentialing program was an outgrowth of the professional concerns of the ARCA and the NRCA.

Since the inception of the credential and the subsequent development of the CRCC in 1973, over 30,000 professionals have participated in the certification process. Today, there are over 15,000 CRCs practicing in the United States and several foreign countries (Leahy & Holt, 1993). Certification standards and examination content for the CRC have been empirically validated through ongoing research efforts throughout the 30-year history of the commission. These standards represent the level of education, experience, and knowledge competencies (see Table 7.1) required of rehabilitation counselors, to provide services to individuals with disabilities (Leahy & Szymanski, 1995).

In terms of regulation of practice, the most powerful credential is licensure. As differentiated from voluntary national certification, licensure regulates the practice of a profession through specific state legislation. Beginning in 1976, with the passage of the first counselor licensure bill in Virginia, there has been a long struggle by advocates of the counselor licensure movement
to enact legislation on a state-by-state basis to protect the title and regulate the practice of counseling. During the past 25 years, 48 states have enacted counselor licensure legislation. The trend has been toward the passage of general practice legislation (which covers various counseling specialty groups), which is consistent with the recommendations of the ACA’s licensure committee in its 1995 model legislation for licensed professional counselors (Bloom et al., 1990; Glosofs, Benshoff, Hosie, & Maki, 1995). Reflecting this trend, the most commonly used title in counselor licensure bills has been that of the Licensed Professional Counselor.

Counselor licensure legislation has been intended to regulate the use of the terms by which the statute officially refers to professional counselors, as well as to protect the practice of professional counseling as set forth in its definition and scope of practice provisions. This combination of title and practice bill is the most stringent form of credentialing and would prohibit anyone from practicing counseling unless fully qualified, regardless of formal title. Title-only legislation, on the other hand, prohibits persons from using the specific titles restricted in the bill to those who have met the specified qualifications established by the bill and who have achieved licensure. It does not, however, restrict persons from providing counseling services, if their job titles avoid restricted language. Most title-only legislation was passed to avoid powerful lobbying efforts that would have been mounted to defeat the more restrictive title and practice bills. Clearly, this type of legislation was seen as a first stage, by counselor licensure advocates, in the overall drive toward eventual regulation of practice through future revisions of the initial legislation (Tarvydas & Leahy, 1993).

Although there are presently three states who have passed licensure laws specifically covering rehabilitation counselors (Texas, Louisiana, and Massachusetts), the majority of states have enacted general practice legislation covering all counselors. The professional associations in rehabilitation counseling (ARCA, NRCA, and the ARC) have taken the position to strongly advocate for the inclusion of rehabilitation counselors within general counselor state licensure, whenever possible. With this in mind, the LPC designation, combined with certification as a CRC, would represent the appropriate credentials for rehabilitation counselors working with individuals with disabilities, in states with general practice legislation.

PROFESSIONAL ASSOCIATIONS

Professional associations provide a forum for the exchange of information and ideas among professionals, reflect the philosophical bases of a profession,
and, as political entities, are concerned with the organization of the profession
and relations with external groups (Rothman, 1987). In rehabilitation counsel-
ing, professional associations also provide an organizational home for individ-
uals with similar professional identities, interests, and backgrounds, who are
committed to the further development and refinement of the profession.

Throughout the modern history of rehabilitation counseling, there have
been two divergent models of the profession that have served to define the
professional associations of the rehabilitation counselor. One model postulates
that rehabilitation counseling should be viewed as a separate and autonomous
profession, organizationally aligned with other related rehabilitation disci-
plines. The other model views the rehabilitation counseling profession as a
specialty area of general counseling, organizationally aligned with related
counseling groups. These early beliefs are presently reflected in the profes-
sion’s two major professional associations, which also represent rehabilitation
counseling’s dual emphasis in counseling and rehabilitation.

The ARCA was founded in 1958 as a professional division of the American
Personnel and Guidance Association (now the ACA). The NRCA was also
founded in 1958 as a professional division of the NRA. The presence of
these two organizations, with similar missions and constituencies, has been
the topic of much discussion and debate over the years. The perplexing aspect
of these discussions is that, depending on individual perspective, one can
rationalize the efficacy of either organizational model. In fact, the argument
can be made that formal organizational relationships, with both the counseling
and rehabilitation communities, has, over time, served to strengthen, align, and
confirm our dual orientations as rehabilitation counselors and has provided the
profession with a unique identity and heritage (Tarvydas & Leahy, 1993).

Through the years, there have been serious discussions of organizational
merger and unification (see Rasch, 1979; Reagles, 1981; Leahy & Tarvydas,
2001) and systems of collaboration (Wright, 1980; Leahy & Tarvydas, 2001),
to repair the fragmentation and professional and public confusion created by
the existence of two such organizations representing rehabilitation counseling
(Leahy & Szymanski, 1995). To address these concerns, the ARCA and
NRCA boards created the Alliance for Rehabilitation Counseling in 1993,
as a formal collaborative structure to marshal the strengths of both organiza-
tions into a unified professional policy and strategic planning voice for rehabil-
itation counseling, while respecting the autonomy, heritage, and value of
each of the individual organizations.

Although this collaborative relationship has only been in existence for 10
years, these two professional organizations have coordinated their respective
strategic planning efforts and developed and approved joint policy statements

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on impending federal legislation, counselor licensure, and scope of practice. In addition, they have developed joint committees, which will meet, under the auspices of the Alliance, in the areas of licensure, standards of practice, and professional development (e.g., Annual Alliance Professional Development Symposium). The Alliance appears to have been a major step forward for the profession in developing comprehensive and coordinated professional advocacy efforts at the national level and in providing a mechanism under which all rehabilitation counselors in this country can unite, as we continue down the path of professionalization.