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A Community Counseling Center Model for Multicultural and Social Justice Counselor Education

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ABSTRACT

The Community Counseling, Education, and Research Center (CCERC) model addresses a critical public health need for accessible, affordable, high-quality mental health services focused on wellness. Within a south-eastern urban community, the multicultural and social justice foundation of the model responds to systemic needs and creates an optimal learning environment for counselor education graduate students, unavailable in traditional health-care and human service systems. A client study is offered to demonstrate the application of the model.

KEYWORDS

Counseling practice;
counselor education;
multicultural issues;
prevention/wellness;
social justice issues

Introduction

Counseling and mental health are usually only covered in the news and become a part of public discourses following reported tragedies, such as school shootings, a wife being killed by her husband, a mother drowning her children, or when a celebrity has a drug overdose or dies by suicide (McGinty, Kennedy-Hendricks, Choksy, & Barry, 2016). Periodically, there are also reports on the increasing utilization of emergency services for individuals experiencing a mental health crisis or the overrepresentation of prisoners with diagnosable mental disorders (Jaffee, 2014). Much less attention is paid, however, to everyday people dealing with the daily stresses of life, without adequate support, that may contribute to such unfortunate events. While the idea of going to counseling for help with personal problems may be initially disconcerting for some, associated costs and health insurance limitations can make counseling unaffordable and inaccessible for many. Any delays or barriers to receiving counseling services act as disincentives that result in disengagement from the help-seeking process and set the stage for crisis.

With an urban North Carolina area as the context, the purpose of this article is to illustrate how counselor education programs can address both counselor training and community mental health needs through community partnerships. First, an overview of the mental health needs of North Carolina and clinical training in counselor education are provided. Next, the process for the development of the Community Counseling, Education, and Research Center (CCERC) and related model are described. Finally, a client study is presented to illustrate application of the CCERC model, followed by implications for implementation and sustainability.

Mental health needs of North Carolina

In the past 20 years, North Carolina has implemented reforms to its public mental health system (Gray, 2009; Rash, 2012). Intended to improve the quality and accessibility of services to the citizens of the state, by-products of these reforms have resulted in the closing of Community Mental Health Centers (CMHCs) in the state and the privatization of services. CMHCs were transformed into organizations that manage behavioral health care by referring clients to private mental health

providers reimbursed by Medicaid. According to Swartz and Morrissey (2012), “one of the unanticipated consequences of this privatization was the increasing fragmentation of services” (p. 180).

The fragmentation has created structural barriers often preventing, delaying, or impeding citizens from receiving critical mental health services. Many North Carolinians who need services are uninformed about who provides these services and do not understand how to access them (North Carolina Institute of Medicine Task Force on Mental Health and Substance Use, 2016). Over half of adults with mental illness in North Carolina went without treatment from 2009 to 2013 (Substance Abuse and Mental Health Services Administration [SAMHSA], 2015). From 2006 to 2013, over 60% of adolescents with depression in the state were not treated (SAMHSA, 2015).

In addition to difficulty navigating the complexity of mental health services in the state, lack of health insurance coverage is another major factor obstructing access to mental health care (Creedon & Le Cook, 2016). Close to 20% of adults under 65 in North Carolina have no health insurance (Cone Health Foundation, 2014). Despite the implementation of the Affordable Care Act in 2014, many adults remain uninsured due to North Carolina’s decision to decline federal funding to expand Medicaid, a key provision of the act (United States Department of Health and Human Services, 2015). Adults who do not have children have been especially hard hit by this decision, as there is no Medicaid coverage available for these individuals in North Carolina (Cone Health Foundation, 2014). The North Carolina Institute of Medicine (NCIOM) Task Force on Mental Health and Substance Use found that “state funding for mental health and substance abuse treatment services is inadequate to meet the mental health and substance use treatment and recovery needs of the uninsured and underinsured” (2016, p. 438).

Lower-income people of color have also been disproportionately impacted by the state’s decision not to expand Medicaid (Creedon & Le Cook, 2016). States that chose not to expand Medicaid have larger populations of racial and ethnic minorities than states that expanded Medicaid (Creedon & Le Cook, 2016). Despite increases in access to mental health treatment for White Americans following the Affordable Care Act in 2014, there were no significant increases for people of color, nor were there any reductions in racial/ethnic disparities in mental health services (Creedon & Le Cook, 2016). According to the 2010 U.S. Census, 21.5% of North Carolinians identify as Black or African American and 8.4% identify as Hispanic or Latino (of any race). Five years later, 22.9% of Black families and 30.5% of Hispanic families were living below the poverty level (United States Census Bureau, 2015).

A lack of sufficient insurance coverage is not the only barrier to mental health treatment for people of color. Other barriers include a shortage of practitioners who are willing and/or trained to provide services to a multicultural population as well as a persistent stigma in many communities around accessing treatment (Creedon & Le Cook, 2016). In addition, preventative, developmental, and wellness components of current mental health care are underemphasized. Individuals experiencing common human issues such as stress, family and relationship challenges, and career difficulties must be given a diagnosis for reimbursement purposes, though they often do not meet diagnostic criteria for a mental disorder (American Psychiatric Association [APA], 2013; Kautz, Mauch, & Smith, 2008). An opportunity to prioritize prevention over treatment is lost due to underfunding for wellness counseling.

Clinical training in counselor education

Creating optimal conditions for the clinical training of counselors has been a pertinent topic among counselor educators since the 1940s (Myers & Smith, 1994). The latest Council for Accreditation of Counseling and Related Educational Programs (CACREP) standards stipulate that “Professional practice, which includes practicum and internship, provides for the application of the theory and the development of counseling skills under supervision” (CACREP, 2016, p. 13). CACREP standards state that professional practice must also include opportunities for counselors-in-training to familiarize themselves with various nonclinical activities of counseling. Counselor education programs are not required to operate clinics, but space must be created for

training, demonstration, and supervision purposes for either prepracticum or for practicum and internships (CACREP, 2016). Some programs opt to create clinics for their students to complete professional practice activities.

Lauka and McCarthy (2013) described Counselor Education and Supervision (CES) training clinics as instructional environments set on university campuses or in the community that provide counseling services, allow for professional development for counselors-in-training, and operate in ways similar to non-university-run clinics. CES clinics are distinct from counseling laboratories, which are used for role-plays or demonstrations but do not provide services to actual clients (2013). Lauka and McCarthy (2013) asserted that CES clinics “are in a unique position to promote social justice within the community” because they fill a gap in the provision of counseling services to marginalized, underinsured, or uninsured clients (p. 111).

Sweeney (2010) discussed the many advantages to developing counselor competence within CES training clinics. Two major such benefits are the opportunity for graduate students to discuss clients directly with faculty members and “deliberate opportunities provided for open dialogue about all issues relevant to the conduct of effective counseling services” (2010, p. 45). Additional benefits include: encouraging counseling research into effective professional practice; increasing program collaboration with local schools, businesses, and agencies; creating an opportunity for doctoral students to practice conducting supervision; and promoting faculty and student community advocacy efforts (Sweeney, 2010).

A review of the literature on CES clinics highlights the delicate balance such clinics must strike in providing high-quality counseling to clients while also developing the skills and capacities of graduate students (Ametrano & Stickel, 1999; Mobley & Myers, 2010; Myers & Smith, 1994, 1995). A potential for conflict exists between the two major objectives of training and service. Mobley and Myers (2010) argued that ethical conflicts arise when clinics try to provide both training and clinical services. Staff coverage during university breaks and summers, criteria for matching clients with counselors-in-training, and requirements for recording counseling sessions are potential areas in which conflict can arise between training and service (Mobley & Myers, 2010; Myers & Smith, 1994).

Hittner and Fawcett (2012) created a CES clinic at Winona State University in Minnesota and argued that, instead of conflicting, the two goals of training and service are complementary. Counseling students at a CES clinic have the opportunity to serve the college and the wider community while also building knowledge, expertise, and skills (Hittner & Fawcett, 2012). Ametrano and Stickel (1999) addressed the ethical issues of conducting training and service and offered an accountability model to enhance evaluation at CES clinics. Their model is derived from the work of Rossi and Freeman (1993) and Hadley and Mitchell (1995) and consists of six categories of accountability measures that CES clinics should meet. The six categories—service delivery, coverage, impact, legal, efficiency, and ethical accountability—cover many facets of clinic operations and interventions (Ametrano & Stickel, 1999). Although the measures are useful for the development of CES clinics, the model is slightly outdated.

In a more recent effort to ensure the ethical and efficient operation of CES clinics, Lauka and McCarthy (2013) advocated for the development of CACREP standards for clinics and proposed guidelines. Building on the work of Myers and Smith (1994, 1995), Ametrano and Stickel (1999), the American Counseling Association (ACA), the Association for Counselor Education and Supervision (ACES), and psychologists regarding training clinics, Lauka and McCarthy (2013) devised guidelines for: (a) clinic mission, (b) clinic director and other staff, (c) clinic operations, and (d) supervision. The aspirational guidelines provide a useful model for operations.

Among recommendations for CES clinics is the standardization of hiring practices for all staff members, including listing specific responsibilities, holding new employee orientation, and conducting continuous evaluation of performance (Lauka & McCarthy, 2013). The guidelines also stipulate that termination and/or referral procedures should be developed if the clinic does not operate year-round and that policies should be created to manage enrollment of new clients and community outreach (Lauka & McCarthy, 2013).

Despite the development of how-to guides for operating CES clinics, a review of the literature reveals that there is limited information available on the number of counselor training clinics that exist and how they are being administered (Mobley & Myers, 2010). While a specific number of functioning clinics could not be found by searching the literature, there is information about the lack of CES in many programs and discussion regarding what hinders the development of clinics (Bobby & Urofsky, 2010; Hittner & Fawcett, 2012). According to Bobby and Urofsky (2010), “CACREP recognizes that, while some programs choose and are able to invest resources in on-campus clinics, many programs do not receive the necessary support from the institution to do so” (p. 37). This may be of particular concern among small, private schools with limited funding. In addition to significant financial costs and university support needed to run a CES, additional barriers to opening a clinic include insufficient space for client services, limited number of qualified supervisors to train master’s students (Hittner & Fawcett, 2012), and a lack of time to market counseling services (Sweeney, 2010). What follows describes the process of developing a counselor education program-based community counseling clinic in spite of these challenges.

Community Counseling, Education, and Research Center (CCERC)

The development of the Community Counseling, Education, and Research Center (CCERC) can be conceptualized in three phases: foundation, refinement, and expansion. Foundational tasks included articulating the mission and vision, acquiring a community space, creating a plan for staffing and supervision of interns, recruiting and assigning clients, and formalizing center structure and procedures including the website and handbook. The name *center* was chosen, instead of *clinic*, which has a negative connotation in some communities and is also closely associated with the medical model (Larson, 1999). *Center* is more reflective of the multidimensional nature of CCERC and aligns better with a wellness model (Myers & Sweeney, 2008). In the refinement phase, the physical space of the center was improved with new furniture and carpet as financial support increased from community and university partners. Additionally, center procedures and processes were more structured and efficient (i.e., supervision, training, client referrals, applying for CCERC internship). Finally, the expansion phase includes plans to transition into a larger space, secure additional funding through the support of the community and university partnerships, and increase the number of students trained and clients served. CCERC is the home base for the application of the corresponding conceptual model (i.e., The CCERC Model).

The CCERC model

The CCERC mission is to provide world-class community counseling and develop counselors and supervisors for multicultural and social justice practice (Grimmett, Lupton-Smith, Beckwith, & Englert, 2016). CCERC defines world-class community counseling as an aspirational ideal to: (1) provide excellent mental health services within communities, informed by: (a) love ethic (Hooks, 2000), (b) wellness focus (Myers & Sweeney, 2008), (c) multiculturalism and social justice (Ratts, Singh, Nassar-McMillan, Butler, & McCullough, 2015), and (d) research and scholarship (CACREP, 2016); and (2) make positive contributions to community mental health models across the world (Stanard, 2013).

The multidimensional, dynamic, and collaborative CCERC model is uniquely valuable to the community when compared to community mental health centers, private practices, and hospitals. Specifically, the CCERC model has three foundations—identity, community, and structure—consisting of 14 synergistic and layered components that operationalize the identity and values of the counselor education program in which it is housed as well as reflect the overarching professional values of counseling and counselor education. The components, defined in Table 1 and discussed within the following three foundations, are not always readily available in traditional health-care and human services systems.

Table 1. CCERC model foundations, components, and description.

Foundation	Component	Description
Identity	World-class Standard	Aspirational community counseling model that informs all others and is among the best in the world.
	Love Ethic	Utilization of all dimensions of love—care, commitment, trust, responsibility, respect, and knowledge— in the everyday work of the center. Presupposes that everyone has the right to be free, to live fully and well.
	Wellness Focus	Attends to the physical, psychological, social, cultural, emotional, relational, and spiritual developmental needs, rather than focus solely on mental illness.
	Multiculturalism and Social Justice	Follows Multicultural and Social Justice Counseling Competencies. Counselors and supervisors trained to work with diverse clients of diverse cultural backgrounds and personal identities.
	Research and Scholarship	Counselor and supervisor training, and counseling services are regularly assessed to enhance quality and effectiveness; Assessment information is used for community engaged scholarship, research, counselor education, advocacy, and innovation.
Community	Community Worldview	Affirming recognition of the interconnection and interdependence between human beings and the environment; collective responsibility.
	Community Partner	Collaborative partnership with local non-profit organization that provides community members with opportunities for achievement, enrichment, and service in preparation for personal and academic success.
	Community Location	Shared, accessible (i.e., bus route, sidewalks, parking, first floor) physical space (i.e., building) with non-profit partner located within community (i.e., not on the university campus).
	Community Outreach	Intentional and standardized community outreach, relationship development, information sharing, and advertising to make public aware of services.
Structure	Public Doctoral University	Affiliated with highest research activity university.
	Counselor Education Program	Operated by CACREP accredited counselor education program for advanced counseling and supervision internship courses.
	Graduate Students	Master's and doctoral student intern counselors, supervisors, coordinators, and research assistants provide all center services under supervision of counselor education faculty.
	Counselor Educators	Faculty direct the center, provide supervision, and work directly with clients, as consultants and co-therapists with counselor interns.
	Sliding Fee Scale	Costs of services match what clients are able to afford, from \$0-\$30 per counseling hour, based on self-reported client income.

Identity

The CCERC model champions accessible, affordable, and high-quality health care as a human right. Following social justice principles, income, class, or background should not restrict access to excellent mental health and career counseling services. In this way, world-class counseling services are provided to uninsured, underinsured, underserved, and marginalized community members.

Both the mission and model address a critical public health need for holistic health care, which includes mental health and counseling services focused on prevention, development, and wellness. A wellness model allows for individuals to participate in counseling to benefit their health, similar to healthy eating and exercise, as well as the opportunity to address mental health issues. Myers and Sweeney (2008) explained that “health in this context is a neutral concept, with wellness defined as a positive state of well-being on a continuum that ranges from illness at one extreme, through health in the middle, to high-level wellness at the other extreme” (p. 482). With a focus on prevention, development, and well-being, counselors at CCERC incorporate holistic approaches that attend to the physical, psychological, social, cultural, emotional, relational, and spiritual needs of clients. The primary goal is to prevent emotional distress and impairment in functioning by engaging in counseling for wellness.

CCERC strives to achieve these objectives through outreach that includes: (a) prevention and early intervention in communities (e.g., information sharing at community events, active referral partnerships with schools and community agencies); (b) accessibility structure and strategies that address barriers to services, which disproportionately affect people of color and lower-income groups (e.g., center location, cost, cultural competence); and (c) a formal,

collaborative partnership with a local nonprofit organization, the Wade Edwards Foundation and Learning Lab (i.e., WELL), which serves high school students and community members and provides opportunities for achievement, enrichment, and service in preparation for personal and academic success.

Research on the CCERC model, including qualitative and outcome measurements is in the implementation stage. Studying the model is required to: (a) understand the quality of services provided by CCERC; (b) measure and follow client progress; and (c) assess, plan, and improve the CCERC model and services for ongoing improvement and continuous development. The *World Health Organization Quality of Life Brief* (WHOQOL-Bref; The WHOQOL group, 1998) will be used to assess and monitor the quality of life and wellness of clients receiving services at CCERC. Client experience and satisfaction will be assessed using the *CCERC Client Questionnaire* (i.e., quantitative, Likert scale; Grimm et al., 2016) and the *CCERC Model Questionnaire 5* (i.e., five qualitative questions; Grimm et al., 2016). Early indicators of effectiveness include: the number of sessions completed per client, steady increase in client revenue, consistent increase in new referrals, and qualitative accounts of positive and helpful client experiences voluntarily self-reported by clients to counselors and reported by community partners. Practicum and internship course evaluations also endorse the multidimensional learning opportunities provided by the model.

Community

The second foundation of the CCERC model is a focus on community. A community worldview recognizes connections, shares resources, and builds collaborative partnerships. The collaboration between CCERC and the WELL, for example, offers students served by the WELL and community clients experiences to grow culturally and holistically, while allowing graduate students opportunities for advanced counselor training.

In efforts to provide needed resources to the community, Constantine, Hage, Kindaichi, and Bryant (2007) discussed the social justice competencies that are essential for counselors to consider when working in community settings. Among the recommendations are the following:

Conceptualize, implement, and evaluate comprehensive preventive and remedial mental health intervention programs that are aimed at addressing the needs of marginalized populations; collaborate with community organizations in democratic partnerships to promote trust, minimize perceived power differentials, and provide culturally relevant services to identified groups. (p. 26)

The WELL provides programming that fulfills a social justice mission, such as free tutoring, college preparation, and community service programs that typically serve underresourced students of color experiencing academic and personal challenges as well as job-training programs for adults. Individual, couples, family, career development, and health and wellness counseling services are provided at CCERC and available to community members who are self-referred or referred by community partners such as schools, university counseling center, private practice, and human services agencies. Clients are also considered partners and are oriented to this worldview during the informed consent process, as their engagement in counseling services makes training counseling students possible.

Structure

Many community mental health agencies depend on third-party reimbursement, which often requires that clients be given a diagnosis for payment of services rendered. With the CCERC model, formal diagnoses are not required and are often unnecessary for people to engage in the counseling process. In lieu of third-party reimbursement, CCERC encourages clients to pay what they choose according to a sliding scale based on income. Fees collected are used to support the operation of the center (e.g., office supplies, marketing, training and research materials). The fees

contribute to long-term sustainability of the center within the college, university, and community and instill in counseling students the notion that counseling services warrant financial compensation (i.e., some students are initially uncomfortable accepting payment for services). At CCERC, the implementation of a sliding scale fee shows respect for the agency of the clients receiving services (i.e., paying for services can help promote a more egalitarian relationship between counselor and client) and also makes explicit the financial value of counseling services (i.e., particularly, when compared to the typical cost of counseling services within the community).

The *process* for receiving counseling services involves the client contacting CCERC by phone or completing an online contact information form. The doctoral student center coordinator contacts the client for a phone interview to determine appropriateness of fit for CCERC services. Individuals with severe and persistent mental illnesses or who pose a threat to safety for self or others would not be appropriate referrals, as CCERC does not provide comprehensive mental health services (e.g., on-call counselor, psychiatry, 24-hour crisis support). Counseling areas include, but are not limited to, work and career, stress, anxiety, depression, family, relationships, trauma, identity, and LGBTQI+ issues.

Practicum and internship at CCERC

The development component of the CCERC mission requires providing an optimal learning environment for counselor education graduate students that is enabled by the service component. Both parts of the mission, together with the components of the CCERC model, support and facilitate multicultural and social justice counseling competency of the graduate students and center operations as a whole (Ratts et al., 2015; Sue, Arredondo, & McDavis, 1992). Master's- and doctoral-level counselor education students, enrolled in counseling practicum, internship, and supervision courses taught by counselor education faculty, provide the counseling services at CCERC. Two program faculty members serve as CCERC codirectors and supervise two doctoral student center coordinators and all center operations (e.g., weekly administrative, clinical and research meetings, trainings, supervision, development). The whole counselor education faculty is involved in major decisions related to CCERC.

A relational-collaborative organizational structure is practiced within CCERC, which follows multicultural and feminist principles of value and equality of all staff members. CCERC responsibilities and tasks are divided flatly according to staff roles (i.e., faculty codirectors, graduate assistants, interns), rather than hierarchically, with the clear expectation that all members are expected to contribute their unique talents to our working community. Finally, all CCERC members are responsible for forming, nurturing, and sustaining community partnerships, which ultimately make services more accessible and provide additional CCERC resources.

As per the recommendations for counselor education and supervision clinics put forth by Lauka and McCarthy (2013), graduate assistants who serve as coordinators are provided with specific job responsibilities and agree to them before accepting their positions. An orientation for interns and/or practicum students is held at the beginning of each academic semester (i.e., Fall, Spring, Summer) to train new students on the mission, vision, policies, and procedures of CCERC. After 1.5 years of operation, six doctoral and nine master's students received one to three semesters of clinical training at CCERC. The following client study illustrates an application of the CCERC model.

CCERC model client study

After CCERC partnered with the WELL, the executive director organized a meeting with student support services at the public high school across the street to provide information about the mental health and career development services of CCERC. The meeting resulted in referrals from the school counselor. *Daniella* (i.e., pseudonym; identifying information and specific details have been changed to ensure confidentiality) is a 15-year-old, Latina, female student athlete. Her mother (Latina, single, employed, another child in college) contacted CCERC to initiate counseling services for her daughter, based on the referral of her school counselor. The *doctoral student center coordinator* (White

American, heterosexual, cisgender, male, 53) conducted an initial client phone interview and assigned Daniella to a *master's student counselor intern* (White American, heterosexual, cisgender, female, 24).

In the first session, the master's student counselor intern (i.e., counselor) met with Daniella and her mother, who reported they were seeking services for Daniella's emotional problems, frequent fighting within the family, and alcohol use. Daniella's mother also reported concerns about self-harming and purging behavior. Once the client informational interview was complete, the counselor asked Daniella's mother if she and Daniella could meet without her for the remainder of the session. During this time alone with the counselor, Daniella disclosed that she had been sexually assaulted the previous year. Daniella explained that she had not told her mother about the experience and that it was playing a major role in her current emotional challenges.

Immediately following the session, the counselor met with one of the *CCERC codirectors* (clinical coordinator, White American, heterosexual, cisgender, female, 50s), who was on-site for coverage and supervision, to discuss Daniella's disclosure and related ethical issues and implications. Within hours of the first session with Daniella, the counselor also had phone consultations with *her doctoral student supervisor* (White American, heterosexual, female, cisgender, 35) and the other *CCERC codirector* (i.e., tenured associate professor, licensed psychologist who specializes in sexual trauma; African American, heterosexual, male/nonbinary, 43) to discuss plans of action.

At the next CCERC staff meeting, before the follow-up session with Daniella, the Frame and Williams (2005) *Multicultural Ethical Decision-Making Model* was employed. Before ethical perspectives and decisions are considered in the model, an assessment of the worldview and identity of Daniella and her family, as well as the counselor (e.g., including White privilege and related cultural expectations) is completed. The counselor also represented the organizational worldview and identity of CCERC. After generating alternative solutions, the team decided to have the counselor and codirector specializing in sexual trauma meet together with Daniella and her mother for the next session. The focus of the follow-up session was to support Daniella in disclosing the sexual assault to her mother and assist the family through the therapeutic process. Given that Daniella is a minor; CCERC staff determined that her mother needed to be informed, which is consistent with the American Counseling Association Code of Ethics, Responsibility to Parents and Legal Guardians (i.e., Section B.5.b.; American Counseling Association [ACA], 2014). Reporting the sexual assault to child protective services was also deliberated by the CCERC staff using the ethical decision making model. State-mandated reporting laws for child abuse only apply when the perpetrator is a parent, guardian, custodian, or caretaker (N.C. G.S. 7B301, 7B101), which was not the case for Daniella.

The counselor met first with Daniella to check in and see how she was feeling about the previous session. The counselor took this opportunity to reintroduce confidentiality and connect the client back to the informed consent process, explaining that Daniella's experience was considered an exception that required CCERC to inform her mother about her disclosure. The counselor asked if it was acceptable to bring in the CCERC codirector (i.e., male) to help facilitate this process, and Daniella agreed. The counselor and codirector met with Daniella to review her disclosure the previous week, validate what she experienced and her feelings, and explore her understanding of the ethical issues at hand. After Daniella agreed to share her experience, we invited her mother into the room and supported Daniella as she disclosed. Following the disclosure, the intern and codirector met with Daniella's mother to help her process and cope with the disclosure, as well as with Daniella alone again to help her process her mother's reaction and prepare for subsequent conversations with her mother. In the same session, reporting the sexual assault to Child Protective Services was also addressed. Given that: (a) mandatory reporting was not required; (b) Daniella no longer had any contact with the perpetrator and felt safe; and (c) neither Daniella nor her mother wanted the assault reported, the final decision was to respect the autonomy of the client and not file a report. The counselors and family agreed to each come weekly for counseling, which continued for several weeks, until Daniella and her family moved to another state.

Application of the CCERC model is evident in the accessibility of high-quality mental health services in the community for Daniella and her mother. The collaborative professional relationship

between the high school, the WELL, and CCERC established a facilitated referral process that seamlessly connected Daniella's mental health needs to service providers, literally across the street. As a single parent, Daniela's mother had to balance financial responsibilities; a sliding scale made counseling services affordable, which removed another barrier to receiving services. Finally, the relational-collaborative organizational structure of CCERC, practiced love ethic, and adherence to multicultural and social justice counseling competencies draws from the professional experiences and resources of all CCERC staff and community partners to provide world-class community counseling to all clients.

Implications

A community counseling center that integrates multicultural and social justice counselor education principles has broad implications for graduate training programs and counseling service delivery to underserved populations. Building on the guidelines that Lauka and McCarthy (2013) developed for counselor education and supervision clinics, CCERC and the CCERC model can offer useful recommendations to other potential counselor education programs seeking to create or enhance a community counseling center. These recommendations are as follows: (a) develop a mission, vision, implementation, and sustainability plan informed by multiculturalism and social justice; (b) acquire university, college, departmental, and program support through authentic professional relationships and systematic information sharing about center plans and services; (c) develop partnerships with community organizations that have similar values and purposes; (d) integrate doctoral and master's students in the operation of the center by cultivating a sense of community and ownership; (e) maintain active faculty engagement through direct involvement in all center operations; and (f) create a research and scholarship agenda and protocol to contribute to the literature, best practices, and community engagement. An intentionally structured, counselor education program-based, community counseling center merges best practices of counselor education, including research on counseling services and graduate student training. Ideally, the vision and mission of the center should represent the counselor education program philosophy and values reflected in the program curriculum and demonstrate congruence between theory, content, practice, and advocacy.

The CCERC model also applies to practitioners who endeavor to integrate multiculturalism, advocacy, and social justice into their work. Constantine et al. (2007) urged community-based counselors to utilize social justice competencies, including implementing preventive interventions, coordinating with community organizations, working to mitigate power differentials, and offering culturally relevant counseling to marginalized clients. Practical considerations for counselors based on the CCERC model include: (a) an accessible and inviting external and internal physical space and location; (b) removal of barriers to services (e.g., response time, impatient responses to service inquiries, affordability, and extraneous steps to begin services); (c) clear explanation and application of a wellness model; (d) outreach (e.g., having an information table at community events, community partnerships, easy-to-understand and -use website); and (e) welcoming attitude and organization that communicates and demonstrates love and respect for all potential clients and community partners.

Conclusion

Counselor education and supervision clinics have traditionally struggled to balance their two major objectives of training counseling students and service delivery to the community (Ametrano & Stickel, 1999; Mobley & Myers, 2010). Hittner and Fawcett (2012) argued that the provision of quality counseling services to the community does not have to conflict with conducting effective training and supervision for graduate students. CCERC exemplifies how the two objectives can coexist successfully. Our hope is that the CCERC model can serve as a framework for training and

service delivery that maintains fidelity to core counseling values of prevention, development, wellness, multiculturalism, social justice, and advocacy.

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