Journal of Counselor Preparation and Supervision

Volume 15 | Number 1 Article 7

2022

Trauma-Informed Child Client Advocacy (TICCA) Plan: Conceptualization and Case Study

Aubrey D. Daniels
Rider University, adaniels@rider.edu

Trauma-Informed Child Client Advocacy (TICCA) Plan: Conceptualization and Case Study

Abstract

The Multicultural and Social Justice Counseling Competencies (MSJCC; Ratts et al., 2016) and the American Counseling Association (ACA) Advocacy Competencies (Lewis et al., 2003; Ratts et al., 2010; Toporek & Daniels, 2018) formalized the advocacy process for counselors. Nevertheless, the literature focused on the advocacy competencies does not provide child client advocacy examples or a concise plan for advocacy efforts for clinical mental health counselors to follow with children. To bridge this gap, this article is in place to describe a new advocacy plan, Trauma-Informed Child Client Advocacy (TICCA), followed by a case study providing context for how this plan can be effectively utilized in a clinical setting with children.

Keywords

advocacy, clinical mental health counseling, counseling children, advocacy competencies, trauma-informed

Author's Notes

Correspondence concerning this article should be addressed to Aubrey D. Daniels, Department of Graduate Education, Leadership, and Counseling Bierenbaum-Fisher Hall 202 2083 Lawrenceville Rd, Lawrenceville NJ 08648, e-mail: adaniels@rider.edu

Advocacy, a term rooted in the identity of Clinical Mental Health Counselors (CMHCs). Advocacy is important as clients are directly impacted by school and community systems. Therefore, CMHCs must construct change in these systems to benefit the mental wellbeing of their clients. CMHCs must also aim to empower clients to advocate for themselves. However, there is a lack of direction in the counseling literature regarding advocacy as a CMHC. Specifically, the literature is scarce regarding research and application of child client advocacy in clinical mental health counseling (Ptakowski, 2010). Field et al., 2019 expanded upon these conclusions as they found counselors were struggling to create advocacy plans. Furthermore, advocacy plans combining the Multicultural and Social Justice Counseling Competencies (MSJCC) and the ACA advocacy competencies is needed in the counseling literature (Ratts, 2011). The present article aims to address these gaps through the explanation of a new plan, Trauma Informed Child Client Advocacy (TICCA), which was cultivated through examination of both competencies, and a trauma-informed approach. Another gap exists in the area of trauma-informed advocacy; however, success was found with college students (Wood et al., 2021). In another study, Welfare et al. (2020) found trauma-informed care would provide further direction for counselors to provide better client services. Therefore, the TICCA plan consists of trauma-informed advocacy examples that can be infused into clinical practice. School counselors have taken efficient steps in the right direction for child-client advocacy via the recent American School Counseling Association (ASCA) National Model (2019). These steps are fueled by the urgency to forge change in the school systems and connected communities (Barrett et al., 2011). CMHCs can learn from school counselors' advocacy strategies to gain more specific direction on how they can advocate for children. Some of the examples provided in the TICCA plan were cultivated from the school counseling literature. The

rationale of this article is to provide CMHCs, clinical supervisors and counselor educators with concrete steps for child client advocacy, as such literature is scarce in the counseling literature.

The Definition of Advocacy for the Clinical Mental Health Counselor

Advocacy is challenging as there are not clear methods regarding steps and effectiveness for children and adolescents (Ptakowski, 2010). Despite this uncertainty, Ptakowski defines advocacy as representing clients who are unable to vouch for themselves or petitioning for various legislation (Ptakowski, 2010). Examples of advocacy are, conversing with those in government positions, organizing a march in the community, writing letters to various magazines and newsletters, speaking on behalf of children at county board meetings, and speaking about a variety of issues that threaten the population a counselor may work with (Ptakowski, 2010). These activities and actions must occur consistently in order to inform communities about change needed for the group a CMHC is advocating for. When advocacy is in the form of educating the general public, CMHCs should use terminology that can be understood by a variety of people despite their age or socioeconomic status as this can lead to more change (Ptakowski, 2010). The American Counseling Association (ACA) recognizes the importance of advocacy as a part of counseling; therefore, competencies were formed to support it (Ratts et al., 2010). Ratts & Hutchins (2009) define advocacy as, the utilization of counseling skills to provide client empowerment, interacting with schools and community to collaborate for the benefit of clients, and advocating for and with clients among a variety of systems.

The History of Advocacy in Counseling and Mental Health Services

The counseling profession has been committed to a holistic, advocacy focused approach for much of its existence. In 1934, Arthur Jones published *Principles of Guidance* where he emphasized that the youth are in need of assistance to make progress and reach their goals (Chang

et al., 2012; Jones, 1934). These sentiments are important, as they show the early existence of an advocacy mindset prior to the official cultivation of the advocacy and social justice competencies. Furthermore, this statement is representative of the identity held by counselors to advocate and assist clients. Through various health policies, greater strides towards advocacy have been made for people with intellectual and mental health concerns (Ptakowski, 2010). The creation of the Professional Personnel Act of 1959 (Ptakowski, 2010) led to trainings for educators, as children with a variety mental health concerns were not typically allowed in the classroom (Ptakowski, 2010). In 1983, the National Institute of Mental Health (NIMH) implemented the Child and Adolescent Service System Program and allotted funds for programs focused on children with serious mental health issues (Ptakowski, 2010). Three years later, the State Comprehensive Mental Health Services Plan Act (CMHSPA) was passed by congress, ordering each state to employ community-based services, leading to the Comprehensive Community Mental Health Services for Children and their Families Program founded in 1992, which remains in effect today (Ptakowski, 2010). In the counseling profession, the call to advocacy began in the 1970s (Field & Baker, 2004; Lee & Walz, 1998). It has also been stated that advocacy is an ethical obligation for counselors (Field & Baker, 2004). Considering advocacy is considered a skill that counselors can learn, CMHCs should aim to be competent and educated in doing so (Hartley et al., 2015; Roysircar, 2009). In 1991, there was a turning point in the history of advocacy, when the Association for Multicultural Counseling and Development (AMCD) crafted the Multicultural Counseling Competencies, which eventually led to the MSJCC (Ratts et al., 2016).

Multicultural and Social Justice Counseling Competencies

The MSJCC provide counselors with a straightforward framework which promotes deeper thinking of the counselor's individual attitudes toward clients of varying levels of power and

privilege. The MSJCC promote counselor awareness regarding the way oppression may impact a client's wellbeing. The MSJCC also promote counselor awareness of the ways diversity and culture impacts the client-counselor relationship (Ratts et al., 2016). Lastly, the MSJCC highlight the importance of advocacy efforts from a social justice perspective (Ratts et al., 2016). Research focused on the practical application of MSJCC is scarce. Rather, MSJCC research focuses on counselors and counselors-in-training's (CIT) ability to comprehend and utilize them. Results demonstrate, CIT and counselors tend to lack confidence and are unaware of how to incorporate advocacy into their work load (Collins et al., 2015; Field et al., 2019; Hipolito-Delgado et al., 2011; Prosek & Michel, 2016).

ACA Advocacy Competencies

Following the MSJCC was the development of the ACA Advocacy Competencies (Lewis et al., 2003; Ratts et al., 2010; Toporek & Daniels, 2018) by the Counselor's for Social Justice, a division of the ACA (Ratts et al., 2016). The ACA Advocacy competencies have moved counselors forward in client advocacy, providing counselors with an understanding of when they should advocate for or alongside a client (Ratts & Hutchins, 2009; Ratts et al., 2010). The ACA advocacy competencies are valuable to the counseling profession due to their focus on the multiple levels counselors may partake in advocacy. These consist of the micro, meso, and macro levels of advocacy (Ratts et al., 2016). The micro level consists of advocating with or on behalf of the actual client. The meso level of advocacy consists of advocating for the greater community. The macro level consists of advocacy at the higher level through policy change (Ratts et al., 2016). As advocates, counselors must be aware of their access to resources and contacts for resources that a client may not have access to, which typically stems from less power and privilege in comparison to their counselor (Toporek et al., 2009). For example, many parents are not informed of their right

to having their child tested for an IEP, especially in underfunded school districts (Reiman et al., 2010; Sacks & Haider, 2017). Therefore, CMHCs working with child populations must be privy to this information, and educate parents or caregivers on their rights.

Empirical Findings: Advocacy and Social Justice

Combined, the MSJCC and the ACA advocacy competencies can be utilized for a systemic focused and holistic approach for child advocacy. The combination of the competencies prompts CMHCs to be aware of their cultural attitudes. Furthermore, CMHCs actively utilizing both competencies lead to greater awareness about CMHCs personal identities in society as well as those held by clients and the ways these identities can impact the counseling relationship. Through this approach, counselors are also set to a standard of higher awareness of their client's experiences in communities outside of the classroom as well (Ratts et al., 2016). When combining both sets of competencies into practice, CMHCs may also find spaces in the community where they can serve clients (Ratts, 2011). It is understandable that the combination of both competencies would decrease the likelihood of counselor biases being reflected onto the clients leading to a safe counseling space for the child. To enhance the child safety in the counseling room, the addition of trauma-informed advocacy provides CMHCs with a more guided approach to advocating for children and families.

Field et al. (2019) examined the ability of CIT to develop competence utilizing the MSJCC and ACA advocacy competencies during their practicum and internship experiences. It was found that the CIT's knowledge of both competencies led to greater understanding of ways clients are impacted by social injustice (Field et al., 2019). This knowledge also increased CIT awareness of the impact politics and funding for mental health can have on clients (Field et al., 2019). A challenge CIT experienced was formulating a conceptual idea of steps toward an advocacy plan

for a client. However, the likelihood of the CIT to create an actual advocacy plan for a client was low (Field et al., 2019). This was due to a lack of time as CIT complete coursework alongside other internship duties such as case notes and supervision. Furthermore, CIT lacked the confidence to advocate for their clients. Low confidence stemmed from CIT beliefs that they did not hold enough power to advocate for clients at the intern level. They were also overwhelmed and described themselves as feeling helpless since their general understanding of social justice and challenging social injustices was low (Field et al., 2019). There were some CIT who did create advocacy plans. They partook in meetings with government representatives, teachers, primary care doctors, school administrators, and school counselors as a means to advocate for their clients. Other forms of advocacy were, assisting clients to find outside social services such as transitional housing for clients who were homeless (Field et al., 2019). Results demonstrated that over time students were more comfortable with the concept of advocacy. This suggests CIT become more confident with advocating as they gain more experience in the profession (Field et al., 2019). It should be noted, all participants had positive attitudes toward both sets of competencies prior to the study (Field et al., 2019). However, there are not many models available in counseling and counselor education which guide the practice of social justice advocacy for clinical mental health counselors Which adds to counselor anxiety surrounding client advocacy in clinical settings (Malott & Knoper, 2012; Ratts & Wood, 2011). Therefore, the TICCA model is in place to provide more direction in the counseling literature.

Another barrier for advocacy efforts of counselors is the misconception that a counselor must achieve perfection regarding their ability to self-reflect and resolve their own internal biases and struggles prior to being a strong advocate for clients (Roysircar, 2009). Considering people are continually evolving, this barrier must be addressed in counselor education and supervision to

promote more client advocacy. Also, counselors tend to have strong interpersonal skills, yet some may struggle with clearly explaining and advocating for equity and social justice matters. This is prompted by self-induced pressure to be an extraordinary advocate or fears and anxiety associated with the injustices in society (Dale & Daniel, 2013; Roysircar, 2009). Regarding direction for CMHCs to follow when advocating for clients, Lopez-Baez & Paylo (2009) addressed a gap for teenage clients and provided examples regarding collaboration with outside systems following the 2003 ACA Advocacy competencies. However, a gap still exists as it was solely focused on the outside systems and for adolescents rather than also working with the client for advocacy, their family, and did not acknowledge the MSJCC and TIC.

Despite these barriers, the school counseling literature contains some examples of advocacy for the child population, such as an emphasis on networking with local community organizations who may have specific expertise such as homelessness, food insecurity, trauma, or gender identity. For example, Coolhart & MacKnight (2015) focused on advocacy for transgender children. Referring the children and their families to local agencies who were experts in working and advocating for transgender children provided children and families with a strong community they could learn from and form relationships with. Furthermore, the school counselor can also network with the agency to learn how to better advocate for transgender children in the school setting. Brown et al. (2019) also highlighted the importance of having a network of professionals and organizations in the school's surrounding community, as advocacy plans can be more efficiently executed when school counselors have community assistance to refer students to outside counseling or social services, mentorship, or legal services. Outside of the community network, school counselors should also form strong working relationships with other professionals in their school so they can better advocate for their students based on shortcomings in their school

system (Brown et al., 2019). Another theme in the school counseling literature is the use of empowerment during role plays as a tool for child advocacy. Empowerment was also utilized with a Latinx, English Language Learners (ELL) child population as school counselors were able to empower students with role plays focused on seeking help from teachers and peers, which empowers the children to feel secure in their learning environment and more satisfied with their school experience (Bessman et al., 2013). Welfare et al. (2020) found the use of role plays with Black boys to express their feelings about discipline practices in the school provided the boys with a sense of validation and empowerment as they were able to share their stories without repercussions. Welfare et al. (2020) suggested the need for trauma-informed practices and restorative circles in schools as a means to truly make schools a safe space for all.

A common shortcoming in school settings are harsh discipline practices which tend to be disproportionately aimed at students of color (Welfare et al., 2020). For example, a student may be startled by a loud noise in the classroom, which leads to a behavioral response such as yelling and tossing papers. In many circumstances, this child may be unjustly suspended. School counselor's knowledge of these incidents allows them to advocate against such practices and inform their colleagues about behavioral trauma responses and more effective ways to intervene, which will be emphasized in the present article more specifically for CMHCs. Trauma-informed counselors are aware that it is typical for children to respond to environments behaviorally when they are exposed to trauma (Anda et al., 2006; Schumm et al., 2006). Trauma exposure during childhood can impact the development of the brain, specifically the amygdala, which leads to children to respond to most scenarios fearfully, they may struggle with interpersonal relationships, feel hopeless, and worthless (Bartlett et al., 2016). Trauma-informed care with children assists with the healthier development of the brain and general human development (Bartlett et al., 2016).

Therefore, TIC should be utilized when advocating considering the emphasis TIC places on the family system rather than placing blame on the child for responding to their environment in the way in which the brain should be responding. The TIC approach is a collaborative effort of teachers, families, others in the community, leading to better treatment outcomes and more secure advocacy efforts. Therefore, the present article will discuss how these trauma-informed concepts can lead to more effective client advocacy for CMHCs. There is no article focused on trauma-informed advocacy with child clients. However, a study with a sample of advocates who assisted college students who survived sexual assault (Wood et al., 2021) uncovered the importance and effectiveness of trauma-informed care combined with student advocacy to assist them in making decisions and finding quality care as they processed through past or ongoing trauma. Wood et al. (2021) recognized there is a need for more direction and future research for those who want to provide trauma-informed advocacy to clients. Also, the Wood et al. (2021) study did not focus on the counseling profession, there is more direction needed for those who hold counselor identities.

Considering most clinical mental health research focused on advocacy is not specific to child advocacy, the school counseling literature is a helpful tool for CMHCs to utilize as they brainstorm ways to be more effective advocates for their child clients. The school counseling literature is also helpful for CMHCs to understand the importance of the counseling relationship and the effectiveness of child empowerment. From the general counselor education literature, leaders of the profession called for more guidance for advocacy, utilizing the MSJCC and advancing the literature in this way (Nassar & Singh, 2020). The infusion of trauma-informed care with the MSJCC and ACA advocacy competencies will assist in counselor educators teaching practical, applicable ways to advocate from a social justice perspective and be in tune with their own biases and beliefs. Singh et al. (2020) mention the MSJCC's should evolve over time. By

combining ACA advocacy competencies and trauma-informed care, adds to the evolvement of advocacy, especially considering the prevalence of trauma amidst the COVID-19 pandemic. In response to the findings that a counselor's likelihood to advocate is lower due to counselor's lack thereof self-efficacy, lack of resources, and lack of time (Field et al., 2019) the advocacy plan in the present article addresses these concerns by placing CMHCs in a position of gaining greater knowledge of the communities they work with to learn more about client needs, and infusing a trauma-informed approach to place CMHCs in a stronger, more self-efficacious role to advocate for child clients.

Trauma-Informed Child Client Advocacy Plan

An approach grounded in trauma-informed care, while also adhering to the MSJCC and ACA Advocacy Competencies can assist CMHCs in a higher likelihood to partake in child client advocacy, as it will be embedded in their overall approach to clinical work. The MSJCC moves counselors to be introspective about their personal beliefs, knowledge, skills, and action (Ratts et al., 2016). Adding the trauma-informed approach will provide counselors with the tools for action, especially considering the lack thereof concrete child examples for clinical mental health counselors. The use of a trauma informed lens while advocating combats the issue of counselors not having enough time to advocate. There are many hands-on trauma-informed interventions that are multiculturally competent, which allows the counselor less time researching which approach to utilize. In comparison to clinical mental health literature, school counseling literature has more concrete examples of child advocacy (Barrett et al., 2011; Evans et al., 2011), some of which was modified for CMHCs in the present advocacy plan. CMHCs can take the following steps in order to do so; (1) trauma-informed care; (2) partake in consistent self-care; (3) practice or involvement in the community; (4) direct client services; (5) collaborating with schools; and (6) assessing

advocacy efforts. This approach allows CMHCs to gain a better understanding about where advocacy efforts must begin, and which of the children they work with are at highest risk of not achieving their counseling goals. This approach also addresses the skepticism some have regarding advocacy being achievable for CMHCs, as these suggestions are organically part of a successful CMHCs role.

Trauma Informed Care. What happened to you? This is a question posed by trauma informed counselors, rather than the medical-model approach of 'what is wrong with you?' (Mirksy, 2010). Trauma-informed care is the lens which assists CMHCs to effectively providing services and understanding how to approach clients about advocacy issues. Trauma-informed counselors seek to understand the traumatic experiences that were formerly or are currently being experienced by clients. Furthermore, CMHCs who utilize a trauma-informed approach aim to understand how trauma impacts a client's biological, psychological, neurological, and social functioning and development (Arnold & Fisch, 2011; Walsh & Benjamin, 2020). Therefore, trauma informed counselors understand impulsive or other undesirable behaviors a client partakes in is a response to traumatic events. Trauma-informed counselors aim to view the situation, signs, symptoms, and behavior first rather than making precipitous assumptions that a client has a particular diagnosis (Powers & Duys, 2020; SAMHSA, 2014; Walsh & Benjamin, 2020). Counselors must treat childhood trauma cases with care and compassion, which is why it is important for counselors to follow a more trauma-informed lens when providing advocacy. When advocating on the behalf of a child, CMHCs should aim to explain the biological and neurological impacts (Bremner, 2006; Jennings, 2004; Mersky et al., 2013). Behaviors as a result of these traumas tend to be labeled as 'bad behavior', and counselors must reframe this, explaining the various impacts trauma has on a child (Jennings, 2004).

CMHCs who provide trauma-informed services cultivate a safe space, empower, and collaborate with clients throughout the counseling relationship (Dass-Brailsford, 2007; Walsh & Benjamin, 2020). Trauma-informed counselors also maintain a positive outlook that clients will recover (Powers & Duys, 2020; SAMHSA, 2014). These aspects of a trauma-informed approach are a means to preventing re-traumatization of clients (Powers & Duys, 2020; SAMHSA, 2014). Furthermore, aesthetics and culture of a clinical setting are also taken into consideration when following trauma-informed care. For example, the wellbeing of the staff is acknowledged in order to provide strong services to clients. Aesthetically, the building where the counseling services occur is inviting to the clients, rather than a more sterile environment (Jennings, 2004).

TICCA is of high importance considering the prevalence of trauma in child populations (Copeland et al., 2007). TICCA alongside the ACA advocacy competencies and the MSJCC also addresses the prevalence of historical, racial trauma, and complex trauma. Historical trauma is trauma impacting various communities, cultural groups, and generations (Heart et al., 2011). Racial trauma, is when discrimination and continued stress related to race negatively impacts a person's health both physically and emotionally (Comas-Díaz et al., 2019; Liu & Modir, 2020). Complex trauma is an ongoing trauma during childhood (Arnold & Fisch, 2011). Examples of complex trauma exposures are community violence, witnessing domestic violence, mental health crises and illness in the family, parent/caregiver with substance use disorder, chronic and terminal illness in the family, divorce or separation of caregivers/parents, child maltreatment, and sexual abuse (Arnold & Fisch, 2011). Furthermore, client advocacy is highly important with child clients regarding college access, preparing children to think about future careers, and possible college attendance. Considering many marginalized populations are not the majority population attending colleges as they typically lack resources for college access (Schaeffer et al., 2010). It is important

to advocate for assemblies and other career presentations for children to cultivate the children's path to college. By utilizing the TICCA plan alongside the MSJCC and ACA advocacy competencies, child clients will experience a safe environment and such modeling will allow their parent/caregiver to replicate the safe environment outside of session. When following the TICCA approach, CMHCs must be open to understanding the client's experiences and culture. CMHCs must not place their own trauma experiences on the child or their caregiver as everyone experiences trauma differently. Regarding culture in the form of spirituality and religion, some clients may use it as a mechanism which boosts their resilience, meanwhile others may have experienced trauma associated with their religion (Gerassi & Nichols, 2018). Therefore, CMHCs should ask questions rather than assume what is helpful for a client's growth. CMHCs should allow children and their caregiver to bring cultural traditions into the counseling space if they would like (i.e., prayer or music) as such practices may enhance safety associated with the counseling process (Gerassi & Nichols, 2018).

Partake in consistent self-care practices. CMHCs must regularly focus on self-care as a means to having the strongest capacity to provide counseling services to clients. Self-care should recharge counselors mentally, emotionally, physically, and spiritually (Coaston, 2017), which is similar to the trauma-informed model (Heramis, 2020). CMHCs should partake in self-care in a consistent manner, as taking care of oneself is the first step to being able to assist others. Similarly, CMHCs should take time off throughout the year, planning ahead, so they have moments to rejuvenate while also being able to allow clients to know ahead of time. Organizations such as the Council for Accreditation of Counseling & Related Education Programs (CACREP; 2016), and the American Counseling Association's (ACA) Code of Ethics (ACA, 2014), highlight the importance of counselor self-care to prevent burnout and inability to care for clients (Coaston,

2017). When counselors partake in self-care, they experience self-compassion which impedes burnout (Barnard & Curry, 2011; Coaston, 2017).

A concrete takeaway from the present article is for CMHCs is creating self-care plans (Coaston, 2017). The CMHC's plan can be as formal or informal as the counselor sees fit. Self-care plans should have a holistic focus with self-compassion in mind (Coaston, 2017). Therefore, self-care plans should consist of time to reflect on the state of their mind, spirit, and body, and the various activities they should add to their schedule to ascertain the wellness of these areas (Coaston, 2017; Myers et al., 2001). There are many challenges to partaking in wellness for counselors such as long hours, a lack of time standing and moving, pressure with timeliness of notes, as well as added pressure to add to their caseload. It has been suggested that a strong wellness plan follows a similar style of a treatment plan counselors would write for their clients (Coaston, 2017; Franco, 2016). This approach to self-care is similar to moments where counselors utilize a narrative therapy approach (Coaston, 2017) and ask clients what they would tell a friend in a situation that the client is currently in, which is what counselors should ask themselves when creating their self-care plan. An exercise such as this will promote self-compassion and assist CMHCs to practice the commitment to self-care they hope clients partake in (Coaston, 2017). This form of self-care will also assist counselors in prolonging their enthusiasm as advocates (Evans et al., 2011).

Example of a self-care plan. If a counselor realizes they struggle with anxious thoughts, their self-care plan could list two goals similar to a treatment plan. For example, the counselor would create goals to reduce their anxious thoughts, such as taking five minutes each morning to journal or meditate. Counselors should also write down signs they are aware that their self-care

goals are working, such as self-rating their anxiety before and after a particular anxiety reducing activity.

Client self-care and safety is important as well considering clients who experience trauma may struggle with feeling safe around others and various environments (Guarino, 2009). As CMHCs begin working with children, they should collaborate with the child and the caregiver to create a self-care plan. CMHC's should ask clients, 'What makes you feel peaceful?' or 'When do you feel safe?'. A list of possible self-care items are; (1) alone time; (2) taking a walk; (3) taking 3 deep breaths; (4) gardening with caregiver; (5) listening to music; (6) coloring; (7) playing on the iPad or watching tv; and (8) playing with my favorite toy. CMHCs should be open to incorporating some of the self-care/safe activities into the counseling sessions. For example, horticulture therapy with child and parent may start in the counseling sessions and be carried out in the child's home with their parent (Guarino, 2009). The CMHC should talk with the child about what may make them feel unsafe, as a way to prepare the child and parent to remember the list of items on the safety plan. Safety plans should be shared with school personnel to provide the child with continuity across settings of community, school, and home. Creating self-care plans with children will provide them with self-efficacy to deregulate their heightened emotions, which will eventually lead to self-efficacy and self-advocacy. When CMHCs share safety plans with school personnel, this is a form of advocating for the child.

Practice or involvement in the community. An effective step toward child client advocacy is simply understanding the community and culture of the children a CMHC is serving. CMHCs should start by holding groups in spaces within the community the practice is housed such as churches or other places of worship. This extension of services provides community accessibility to counseling services (Bryan & Henry, 2003), and assists CMHCs with having a

better understanding about what life is like outside of the counseling room for their clients and client's families. Furthermore, CMHCs can form a greater understanding about the barriers that exist for their clients to achieve optimum mental wellness. This collaboration between CMHCs and community members can also inform CMHCs of areas where the children are facing injustice or inequity (Evans et al., 2011). Once an understanding of what some barriers may be in the community, CMHCs should hold free workshops in places of worship or boys' and girls' clubs which allow community members and clients to gain tools to advocate for themselves.

Another option for community collaboration, consists of working with community members who aim to address an area of social injustice within the community. The collaboration could entail of educating the community, raising money, and hosting awareness events (Toporek et al., 2009). For example, if a CMHC has a variety of child clients who experience food insecurity, they would rally a group from the community who are passionate about the topic to rally together to raise money for the local schools or other organizations to assist children in having the optimal number of meals each week. Furthermore, from a systemic perspective, CMHCs can address local companies (Toporek et al., 2009) about the issue of food insecurity in the community with the aim for companies to donate food to local shelters or provide affordable resources to community members, which directly impacts the child clients.

Similar to what is found in the school counseling literature (Evans et al., 2011), in order to inform community members and school personnel of their advocacy efforts, CMHCs can distribute brochures or newsletters that describe what they are advocating for and what their success has been thus far (Evans et al., 2011). This effort could lead to potential advocacy partnerships, which could assist CMHCs from taking on the majority of the advocacy efforts, which addresses concerns about advocacy being impossible, or too time consuming since counselors would have others to partake

in advocacy projects with. Another option for CMHCs to partner with the community and local schools is volunteering for committees. CMHCs can advocate for their child clients based on any cultural barriers or other community-based issues impacting their client and voice these issues at the committee meetings. They may also learn more about the needs of their child clients at these committee meetings (Evans et al., 2011). More community engagement such as this, can assist CMHCs in understanding which barriers exist for client mental health to in areas such as financial, nutritional, and community violence.

Direct client services; utilize TICCA interventions in session. After spending some time in the community and learning about client needs, CMHCs should take steps toward advocacy in sessions with the client. In most cases, parent(s) or caregiver(s) will be a part of this process considering children may not know what advocacy efforts are needed. The observation of children and their family, listening, and learning more about them as individuals and their past will assist CMHCs in advocating for clients better (Crumb et al., 2019). Once this occurs, counselors should uncover the strengths and growing edges of the client and the caregiver(s), as this assists in understanding where clients may need more guidance in certain areas of the advocacy process (Roysircar, 2009). With parents/caregivers, this portion of advocacy may consist of writing a letter to the child-client's school testing for accommodations in school, or calling a caseworker together in the office. The counselor is encouraged to empower the client by identifying their strengths, aiding clients to understand their lives through a cultural context, helping clients develop skills in self-advocacy, and working with clients to form and apply a self-advocacy plan. Through this, the client is empowered and becomes self-efficacious, leading to further awareness of issues they experience (Ratts & Hutchins, 2009). A conclusion of this process leads the caregiver, and in some cases, the child to conceptualize issues they once internalized as issues caused by the oppression

which exists in society (Ratts & Hutchins, 2009). Utilizing the tool of empowerment with children specifically consists of learning about the areas they need to learn more self-efficacious skills or behaviors, and provide psychoeducation or role play skills in the session for the child to take into society with them. For example, a CMHC may aid a client who experienced abuse to develop the proper communication skills, and feelings identification techniques such as a 'feelings wheel' to express themselves in the event they are feeling uncomfortable in any circumstance, whether it is traumatic or not.

Collaborating with schools. Barrett et al. (2011) suggested school counselors assure students are receiving mental health services. Conversely, CMHCs should collaborate with school counselors to assure the progress in the clinical setting is also carrying over to the school setting to continue the process of aiding the child client's social, emotional, mental development through in school interventions, more resources, and appropriate accommodations (Evans et al., 2011). This collaboration with schools will assist CMHCs with effectively counseling and advocating for their clients. School professionals can share their observations of the children while also discussing with CMHCs which interventions can be practiced in both school and clinical settings as they pertain to the client's treatment plan. As time progresses in the child's counseling process, the CMHC may realize a need to advocate for an Individualized Educational Plan (IEP) (Barrett et al., 2011). This should be considered as trauma can have a negative impact on cognition, which impacts children's learning development (Heramis, 2020). CMHCs should also partner with school counselors (Evans, et al., 2011) to expand the resources that can be shared and distributed to children in their community or shared clientele. This collaboration can assist CMHCs with financially supporting advocacy projects and programming.

Advocating for children to principals and teachers is also important, however this is

missing from both clinical mental health and school counseling research. CMHCs should take the time to call teachers to discuss proper accommodations for the child based on trauma or mental health symptoms the child is experiencing. Regarding advocacy for children to principals, CMHC's should explain the ways trauma manifests in children, and why it is inappropriate to suspend or expel students as they are reacting to trauma rather than being a 'bad child' (Dass-Brailsford, 2007; Heramis, 2020; SAMHSA, 2014). CMHC's can assist teachers and principals by giving them alternative options to harsh punishment such as calling the police when children have a behavioral reaction to an event that happens in schools (Dass-Brailsford, 2007; Heramis, 2020; SAMHSA, 2014). Additionally, CMHC's can collaborate with schools by educating them about cultural barriers that are apparent between clients and school professionals (Evans et al., 2011).

Assessing advocacy efforts. CMHCs should partake in two assessment processes; one through self-reflection, and the second with the client and client's caregiver. Through the process of self-reflection, CMHCs may also discuss their advocacy efforts in clinical supervision. While assessing advocacy efforts with clients, CMHCs should ask clients if they notice any positive or negative changes as a result of the advocacy. CMHCs should then assess what clients have learned about themselves through the advocacy process, and provide affirmations as a form of client-empowerment, which is important in trauma-informed care (Dass-Brailsford, 2007; Powers & Duys, 2020; SAMHSA, 2014; Walsh & Benjamin, 2020). CMHCs should take note of any barriers when advocating with or for the client at this time as this can lead to a shift in the organizations CMHCs choose to partner with, changing referral sources, or learning that a client may need advocacy in a different or additional manner. Counselor educators and supervisors can utilize the Advocacy Competencies Self-Assessment Survey (ACSA; Ratts & Ford, 2010) which measures competence and comfort with advocacy, as a tool to utilize during supervision during the

assessment process. Following the TICCA approach, supervisors and educators should utilize a strengths-based approach when utilizing the ACSA (Ratts & Ford, 2010), highlighting the growth the supervisee has made over time.

Case study

History

A CMHC was working in a community mental health agency with a caseload of families, and identified clients who are children ages four to ten years old. Considering her caseload consisted of children and families who experienced a wide range of trauma, the CMHC made time for self-care throughout the week. One client in particular was a six-year-old, Black boy, who was suspended after throwing a chair when he was frustrated with his peers. The principal and teacher supported this form of punishment, as the student was given warnings for other behaviors such as, difficulties transitioning from one activity to the next, as he showed reluctance via crying or laying on the ground. The student had also been disciplined for pushing other children on the playground when he was overwhelmed by their screaming and changing the rules of the games they played. The client's teacher also let his mother know, the client struggled to focus on tasks at hand, which the parent and teacher viewed as a major flaw. His mother reported feeling 'ashamed'.

The CMHC was discouraged to learn of the disciplinary actions taken considering the child's extensive history of trauma, specifically, community violence, domestic violence between his mother and her partner, and his father's incarceration. The CMHC knew the child's reactions to unexpected in-class transitions and fire alarms was to be expected as children who experience complex trauma experience difficulties with utilizing proper coping skills when they are overwhelmed (Drapkin et al., 2015). Therefore, his response was similar to the way he would

respond at home when violence randomly occurs, periods when he had no contact with his father due to his arrest, or when visits with his father were cut short.

Conceptualization and Advocacy through a Trauma-Informed Lens

The CMHC took time to educate the client's mother about trauma and the impact it has on children. The CMHC allowed the parent to process through the emotions she had regarding her son's trauma response. The CMHC also educated the mother that the child client is not 'flawed', rather, the difficulties concentrating and transitioning from one activity to the next were most likely a side effect of trauma as the child's brain function is not regulated as a result (Walsh & Benjamin, 2020). The CMHC annually attended trainings and other events focused on a trauma-informed perspective in counseling as a means to stay updated and educated on trauma. The CMHC identified the mother's strengths as; (1) determined to provide her child with the resources needed to succeed in school and beyond; (2) caring about her children's emotional wellbeing; and, (3) she is resilient. The CMHC lists the identified client's strengths as; (1) a caring older brother; (2) a bright child who enjoys reading; (3) excited to learn new feeling words in counseling sessions.

Prior to working with this family, the CMHC spent time in the community, hosting a group for parents at the local church. During this, she found many parents did not know which accommodations their children could receive in school. Parents also felt the teachers and administration did not understand the needs of the children since they did not reside in the school's town, and they were more privileged than their children, unaware of the social injustice felt in the school community. The CMHC's time in the community prepared her to effectively assist the families on her caseload, as well as advocate for children in the community. It should be noted that the CMHC also followed a self-care plan to prevent burn out or vicarious traumatization (Barnard & Curry, 2011). The CMHC set goals on her self-care plan; (1) To prevent the physical sensation

of stress in the form of muscle tension, move frequently throughout the day. Specifically, take breaks to walk and stretch between sessions (2) Exercise at the gym Wednesdays and Fridays without phone to prevent burn out and feelings of being overwhelmed. The CMHC also purchased a computer stand, so she was able to stand while writing her case notes between sessions. The CMHC checked to see how realistic this plan was bi-monthly.

The CMHC was able to assist the family by collaborating with the identified client's mother to co-write a brief letter the child's school to consider her son for a 504 plan, in which the teachers and other school personnel would provide special accommodations for the child regarding transitions, fire alarms, and implementing coping skills learned in counseling sessions to the child's in-class routine. Next, the CMHC had all releases of information signed for permission to contact teachers and the principal via phone about the child's progress. A few weeks later, the CMHC made plans to attend a school board meeting to explain the various complex traumas experienced by children in the community, and how those complex traumas impact behavior and learning. The next board meeting the CMHC attends, she will present on historical trauma specific to racism the students of the community face daily, considering the school consists of a mostly Black and Latinx children, which is also a form of advocacy for the other children on her case load. The CMHC set a three-month plan in which she will assess the progress with child and his mother, as well as assess what has worked well versus not from her perspective. Thus far, the CMHC assessed her efforts in the community, and deemed them successful as the experience led her to gaining a better understanding of her clientele and areas in which advocacy was needed.

Summary of Steps towards Advocacy

In the case study, the CMHC took the appropriate steps towards effective child advocacy. The first step; trauma-informed care was infused throughout the approach as the CMHC

continually attended educational events focused on trauma to further her understanding of her client's trauma experiences and how to effectively treat them through a trauma-informed approach. She also focused on client strengths (Jennings, 2004), and shared her knowledge with the community, schools, and families (Powers & Duys, 2020; SAMHSA, 2014; Walsh & Benjamin, 2020). Step two; partaking in consistent self-care practices, was also evident in the case study as the CMHC created a plan with two goals to prevent burn out. Step three; practice or involvement in the community assisted the counselor as she took time to listen to the concerns of parents, and understand the friction between school personnel and parents, which appeared to be a misunderstanding and lack of trauma knowledge. Therefore, the CMHC partook in advocacy efforts to educate the school personnel about trauma reactions and community trauma that is apparent in children's in-school behaviors. Step four; direct client services, was portrayed as the counselor listened to the concerns of the identified client's mother, educated her about trauma, processed through the emotions, and then collaborated on the note to the school regarding testing and accommodations. Step five; collaborating with the schools, was portrayed as the counselor collaborated and educated school professionals through phone calls, letters, and school board meetings. Step six; assessing advocacy efforts, was apparent as the counselor established a plan to assess advocacy efforts individually and with the client's mother in three months, which would predict the next advocacy efforts to be taken. Furthermore, the counselor acknowledged her efforts in the community opened more doors for advocacy opportunities and understanding her client better.

Implications for Clinical Mental Health Counseling

TICCA addresses the call for more child advocacy in the counseling profession (Nassar & Singh, 2020; Singh et al., 2020). Previous literature addressed the need for future advocacy models

to evolve over time as the profession also evolves (Singh et al., 2020). One area in counseling that has rapidly evolved in the counseling literature is trauma-informed care. Considering there has been more trauma focused literature (Chatters & Liu, 2020), there is a need for more advocacy models rooted in trauma-informed care, which the TICCA plan is. Children are a vulnerable population who will most likely need CMHCs to advocate for them. This statement can be supported as, Welfare et al. (2020) found Black children are disciplined at a disproportionally higher rate in comparison Latinx, Asian and White students. Furthermore, Black male students were more likely to be disciplined via multiple day suspensions in comparison to all students (Welfare et al., 2020). Considering Black children are at a higher risk of experiencing trauma outside of school (Henderson, 2019) and the additional racial trauma of unconscious bias as they are unfairly disciplined, it is understandable Black children may respond to insecure school environments via behavioral problems, which is their brain correctly responding to trauma (Gerassi & Nichols, 2018). Therefore, CMHCs utilization of the TICCA will consist of educating the community and schools about trauma disparities based on race so children are fully supported and able to meet counseling goals. TICCA also provides some concrete, explicit examples of how to advocate for children as a CMHC. In the present model TICCA, CMHCs empower children to express themselves through feelings identification. CMHCs must also partner with schools to educate school personnel about how to cultivate safe spaces in school, so the child clients are able to experience safety at home, school, the community, and the counseling room. CMHCs should utilize the child's self-care plan as a tool that can be used at school, home, and counseling to teach clients how to utilize useful coping skills. This can lead to feelings of empowerment for children. When partnering with schools, CMHCs should highlight client strengths while also educating them about trauma responses, which explain why a child may be acting in a way that is seen as 'bad'.

The TICCA plan focuses on understanding what needs are present in the community, which leads to a more culturally responsible mindset for stronger advocacy efforts. By listening to client communities and adhering to trauma-informed principles, CMHCs will cultivate a more positive, empathic mindset where they aim to understand prejudices against students and clients. This shift in mindset should translate to CMHC action against systems such as antiquated teaching models, testing, leadership positions only held by white students, books lacking diverse characters, and behavior requirements normed on white students (Chang et al., 2012; Hale, 2001). CMHCs who are resistant to advocacy and struggle to hold resilience focused mindsets which stem from trauma-informed care, may be less likely to see potential in child clients, and lack awareness of the disparities that exist for clients based on cultural and/or trauma backgrounds (Duan & Brown, 2015). These CMHCs will also be less likely to advocate for children. TICCA is in place to enhance the likelihood that CMHCs will advocate for children since there is a more concrete plan for action. The case study exemplifies the good that can come from listening and advocating for clients in a manner that is realistic and fits into the schedule of a CMHC, rooted in trauma-informed care in alignment with the ACA advocacy competencies and the MSJCC.

Presently in the literature, direction for how to advocate effectively for clients is scarce. Specifically, trauma informed child advocacy in the counseling literature is limited. However, the TICCA plan, adds to such literature. Future research should focus on counselors' experiences advocating for children through a trauma-informed lens. Furthermore, research focused on supervisor's ability to teach or support supervisees with models such as TICCA. Furthermore, it is important for counselor educators to focus on advocacy, examples of advocacy, and various models of advocacy throughout the counseling curriculum to assure counselors in training are

better equipped to safely advocate with and for clients. A trauma-informed approach will assure such safety and self-efficacy.

Conclusion

In conclusion, CMHCs must take more direct action advocating for child clients considering how well equipped they are to do so. CMHCs who do not advocate for their child clients are at risk of providing culturally incompetent services and not upholding the standards of the ACA Code of Ethics (2014). The case study provides a more detailed description of what advocacy looks like when following the six-step plan in this article. Seeing the literature and clinical direction for child advocacy is scarce in mental health counseling, CMHCs can start by discussing the issues to the general public, volunteering in schools and communities, and attending school board meetings as the CMHC did in the case study, which led to an action plan with her caseload as well as the elementary school in her client's community. As time progresses, CMHCs become more confident in advocating which leads to stronger advocacy (Field et al., 2019). Counselor educators should continue to discuss advocacy that child CMHCs partake in, and develop models so there is a more standardized approach to advocating for children.

References

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

American School Counselor Association. (2019). *The ASCA national model: A framework for school counseling programs* (4th ed.). Author.

Arnold, C., & Fisch, R. (2011). *The impact of complex trauma on development*. Rowman & Littlefield.

Barnard, L. K., & Curry, J. F. (2011). Self-compassion: Conceptualizations, correlates, & interventions. *Review of General Psychology, 15*(4), 289-303. https://doi.org/10.1037/a0025754

Barrett, M., Lester, S.V., & Durham, J.C. (2011). Child maltreatment and the advocacy role of professional school counselors. *Journal for Social Action in Counseling and Psychology*. *3*(2). 85-102. https://doi.org/10.33043/jsacp.3.2.86-103.

Bessman, L., Carr, R., & Grimes, L. E. (2013). A Gift for the Gifted: School Counselor Advocacy for Representation of Latino Students in Gifted Education. *Georgia School Counselors Association Journal*, *20*(1).

Bremner J. D. (2006). Traumatic stress: Effects on the brain. *Dialogues in clinical neuroscience*, *8*(4), 445–461.

Brown, M. H., Lenares-Solomon, D., & Deaner, R. G. (2019). Every student succeeds act: A call to action for school counselors. *Journal of Counselor Leadership & Advocacy*, *6*(1), 86 96. https://doi.org/10.1080/2326716X.2018.1557574

Bryan, J., & Henry, L. (2003). A model for building school-family-community partnerships: Principles and process. *Journal of Counseling & Development*, *90*(4), 408–420. https://doi.org/10.1002/j.1556-6676.2012.00052.x

Chang, C., Barrio Minton, C.A., Dixon, A. I., Meyers, J. E., & Sweeney, T.J. (2012). *Professional counseling excellence through leadership and advocacy*. Routledge.

Chatters, S., & Liu, P. (2020). Are Counselors Prepared? : Integrating Trauma Education into Counselor Education Programs. *The Journal of Counselor Preparation and Supervision, 13*(1). 1-23. http://dx.doi.org/10.7729/131.1305

Coaston, S. C. (2017). Self-Care through self-compassion: A balm for burnout. *Professional Counselor*, *7*(3), 285–297.

Collins, S., Arthur, N., Brown, C., & Kennedy, B. (2015). Student perspectives: Graduate education facilitation of multicultural counseling and social justice competency. *Training and Education in Professional Psychology, 9*, 153-160. https://doi.org/10.1037/tep0000070

Comas-Díaz, L., Hall, G. N., & Neville, H. A. (2019). Racial trauma: Theory, research, and healing: Introduction to the special issue. *American Psychologist, 74*, 1–5. https://doi.org/10.1037/amp0000442

Coolhart, D., & MacKnight, V. (2015). Working with transgender youths and their families: Counselors and therapists as advocates for trans-affirmative school environments. *Journal of Counselor Leadership and Advocacy*, *2*(1), 51–64.

Copeland, W. E., Keeler, G., Angold, A., & Costello, E. J. (2007). Traumatic events and posttraumatic stress in childhood. *Archives of General Psychiatry*, *64*(5), 577–584. https://doi.org/10.1001/archpsyc.64.5.577

Council for Accreditation of Counseling and Related Educational Programs. (2015). *2016*

CACREP Standards. http://www.cacrep.org/wp-content/uploads/2018/05/2016-Standards-with-Glossary-5.3.2018.pdf

Crumb, L., Haskins, N., & Brown, S. (2019). Integrating social justice advocacy into mental health counseling in rural, impoverished american communities. *Professional Counselor*, *9*(1), 20–34.

Dale, S. K., & Daniel, J. H. (2013). Talking about the trayvon martin case in psychology and counseling training and psychotherapy. *Journal for Social Action in Counseling & Psychology*, *5*(1), 37–49. https://doi.org/10.33043/jsacp.5.1.37-49

Dass-Brailsford, P. (2007*). A practical approach to trauma: Empowering interventions*. Sage.

Drapkin, M. L., Eddie, D., Buffington, A. J., & McGrady, B. S. (2015). Alcohol-specific coping styles of adult children of individuals with alcohol use disorders and associations with psychosocial functioning. *Alcohol and Alcoholism*, *50*(4), 463-469.

Duan, C., & Brown, C. (2015). *Becoming a Multiculturally Competent Counselor*. Sage.

Bartlett, J. D., Wilson, A., Anderson Moore, L., Redd, Z. (2016, April 19). 5 ways trauma Informed Care supports children's development. Child trends. https://www.childtrends.org/publications/5-ways-trauma-informed-care-supports-childrens-development

Evans, M. P., Zambrano, E., Cook, K., Moyer, M., & Duffey, T. (2011). Enhancing school counselor leadership in multicultural advocacy. *Journal of Professional Counseling, Practice, Theory, & Research*, *38*(2), 52.

Field, J., & Baker, S. (2004). Defining and examining school counselor advocacy. *Professional School Counseling*, *8*(1), 56-63.

Field, T. A., Ghoston, M. R., Grimes, T. O., Sturm, D. C., Kaur, M., Aninditya, A., & Toomey, M. (2019). Trainee counselor development of social justice counseling competencies. *Journal for Social Action in Counseling & Psychology*, *11*(1), 33–50. https://doi.org/10.33043/jsacp.11.1.33-50

Franco, G. E. (2016). Productivity standards: Do they result in less productive and satisfied therapists? *The Psychologist-Manager Journal*, *19*, 91–106. https://doi.org/doi:10.1037/mgr0000041

Gerassi, L.B., Nichols, A.J. (2018). Sex trafficking and commercial sexual exploitation: Prevention, advocacy, and trauma-informed practice. Springer Publishing Company.

Guarino, K., Soares, P., Konnath, K., Clervil, R., & Bassuk, E. (2009). Trauma-informed organizational toolkit . Rockville, MD: Center for Mental Health. Retrieved from http://www.pcamn.org/wp-content/uploads/2014/04/Trauma Informed_Organizational_Toolkit_Homelessness-Services.pdf

Hale, J. E. (2001). *Learning while black: Creating educational excellence for african american children*. Johns Hopkins university Press.

Hartley, M. T., Tarvydas, V. M., & Johnston, S. P. (2015). The ethics and practice of social media advocacy in rehabilitation counseling. *Journal of Rehabilitation*, *81*(1), 42–51.

Heart, M. Y., Chase, J., Elkins, J., & Altschul, D.B. (2011). Historical trauma among indigenous peoples of the americas: concepts, research, and clinical considerations. *Journal of Psychoactive Drugs*, *43*(4), 282-292. https://doi.org/10.1080/02791072.2011.628913

Henderson, Z. (2019). In their own words: How black teens define trauma. *Journal of Child & Adolescent Trauma*, *12*(1), 141–151. https://doi.org/10.1007/s40653-017-0168-6

Heramis, L. (2020) Developing a trauma-informed perspective in school communities: An introduction for educators, school counselors, and administrators. Cognella.

Hipolito-Delgado, C. P., Cook, J. M., Avrus, E. M., & Bonham, E. J. (2011). Developing counseling students' multicultural competence through the multicultural action project. *Counselor Education and Supervision*, *50*, 402-421. https://doi.org/10.1002/j.1556-6978.2011.tb01924.x

Jennings, A. (2004). Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services.

Jones, A. J. (1934). *Principles of guidance.* McGraw Hill.

Lee, C., Walz, G., R. (1998). *Social action: A mandate for counselors*. American Counseling Association

Lewis, J. A., Arnold, M. S., House, R., & Toporek, R. L. (2003). ACA advocacy competencies. *Journal of Counseling and Development*, *87*, 260-268.

Liu, S. R., & Modir, S. (2020). The outbreak that was always here: Racial trauma in the context of COVID-19 and implications for mental health providers. *Psychological Trauma: Theory, Research, Practice, and Policy*, *12*(5), 439–442. https://doi.org/10.1037/tra0000784

Lopez-Baez, S. I., & Paylo, M. J. (2009). Social justice advocacy: Community collaboration and systems advocacy. *Journal of Counseling & Development*, *87*, 276–283. https://doi.org/10.1002/j.1556-6678.2009.tb00107.x

Malott, K. M., & Knoper, T. (2012). Social Justice in Application: Counselor Training in a Legal Context. *Journal for Social Action in Counseling & Psychology*, *4*(2), 23–40. https://doi.org/10.33043/JSACP.4.2.23-40

Mersky, J. P., Topitzes, J., & Reynolds, A. J. (2013). Impacts of adverse childhood experiences on health, mental health, and substance use in early adulthood: A cohort study of an urban, minority sample in the U.S. *Child Abuse & Neglect*, *37*(11), 917-925 https://doi.org/10.1016/j.chiabu.2013.07.011

Mirksy, L. (2010) The sanctuary model: A restorative approach for human services organizations, March. EForum. International Institute for Restorative Practice.

Myers, J. E., Sweeney, T. J., & Witmer, J. M. (2001). Optimization of behavior: Promotion of wellness. In D. C. Locke, J. E. Myers, & E. L. Herr (Eds.), *The handbook of counseling* (pp. 641–652). Thousand Oaks, CA: Sage.

Nassar, S. C., & Singh, A. A. (2020). Embodying the multicultural and social justice counseling competency movement: Voices from the field. Journal of Counseling & Development, 98(3), 253–260. https://doi.org/10.1002/jcad.12320

Powers, J. J., & Duys, D. (2020). Toward trauma-informed career counseling. *Career Development Quarterly*, *68*(2), 173–185.

Prosek, E. A., & Michel, R. E. (2016). Transformative learning for counselor trainees: Implementation of the multicultural immersion experience model. *International Journal for the Advancement of Counselling*, *38*(1), 61-76. https://doi.org/10.1007/s10447-015 9256-1

Ptakowski, K.K (2010). Advocating for children and adolescents with mental illnesses. *Child and Adolescent Psychiatric Clinics of North America*, *19*(1), 131-138. https://doi.org/10.1016/j.chc.2009.08.003

Ratts, M. J. (2011). Multiculturalism and Social Justice: Two Sides of the Same Coin. *Journal of Multicultural Counseling & Development*, *39*(1), 24–37. https://doi.org/10.1002/j.2161-1912.2011.tb00137.x

Ratts, M. J., & Ford, A. (2010). *Advocacy Competencies Self-Assessment (ACSA) Survey©: A tool for measuring advocacy competence.* In M. J. Ratts, R. L. Toporek, & J. A. Lewis (Eds.), *ACA advocacy competencies: A social justice framework for counselors* (p. 21–26). American Counseling Association.

Ratts, M. J., & Hutchins, A. M. (2009). ACA advocacy competencies: Social justice advocacy at the Client/Student level. *Journal of Counseling & Development*, *87*(3), 269-275. https://doi.org/10.1002/j.1556-6678.2009.tb00106.x

Ratts, M. J., Singh, A. A., Nassar-McMillan, S., Butler, S. K., & McCullough, J. R. (2016). Multicultural and social justice counseling competencies: Guidelines for the counseling profession. *Journal of Multicultural Counseling and Development*, *44*(1), 28-48. https://doi.org/ 10.1002/jmcd.12035

Ratts, M. J., Toporek, R., Lewis, J. A., & American Counseling Association. (2010). *ACA advocacy competencies: A social justice framework for counselors*. American Counseling Association.

Ratts, M. J., & Wood, C. (2011). The fierce urgency of now: Diffusion of innovation as a mechanism to integrate social justice in counselor education. *Counselor Education & Supervision*, *50*, 207-223. https://doi.org/10.1002/j.1556-6978.2011.tb00120.x

Reiman, J. W., Beck, L., Coppola, T., Engiles, A., & Center for Appropriate Dispute Resolution in Special Education (CADRE). (2010). Parents' Experiences with the IEP Process: Considerations for Improving Practice. In *Center for Appropriate Dispute Resolution in Special Education (CADRE)*.

Roysircar, G. (2009). The big picture of advocacy: Counselor, heal society and thyself. *Journal of Counseling & Development*, *67*, 288-294. https://doi.org/10.1002/j. 1556-6678.2009.tb00109.x

Sacks, L. H., & Haider, S. (2017). Challenges in implementation of individualized educational plan (IEPs): Perspectives from India and the United States of America. *Indian Journal of Health & Wellbeing*, *8*(9), 958–965.

Singh, A. A., Nassar, S. C., Arredondo, P., & Toporek, R. (2020). The past guides the future: Implementing the multicultural and social justice counseling competencies. *Journal of Counseling & Development*, *98*(3), 238–252. https://doi-org.rider.idm.oclc.org/10.1002/jcad.12319

Substance Abuse and Mental Health Services Administration. (2014). *SAMHSA's concept of trauma and guidance for a trauma-informed approach*. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Schaeffer, K., Akos, P., & Barrow, J. (2010). A phenomenological study of high school counselor advocacy as it relates to the college access of underrepresented students. *Journal of School Counseling*, *8*(2) 1-35.

Toporek, R. L., & Daniels, J. (2018). *American Counseling Association advocacy competencies: Updated*. https://www.counsel-ing.org/docs/default-source/competencies/aca-advocacy-compe-tencies-updated-may-2020.pdf?sfvrsn=f410212c_4

Toporek, R. L., Lewis, J. A., & Crethar, H. C. (2009). Promoting systemic change through the ACA advocacy competencies. *Journal of Counseling & Development, 87*(3), 260–268. https://doi.org/10.1002/j.1556-6678.2009.tb00105.x

Walsh, K., & Benjamin R. (2020). Using participatory methods to engage multidisciplinary clinical staff in the embedding of trauma-informed care and practice principles in a sub-acute mental health inpatient unit. *Journal of Multidisciplinary Healthcare*, *ume*

13, 485–494.
Welfare, L.E., Grimes, T.O., Lawson, G., Hori, K., & Asadi, G. (2020). The school to prison pipeline: quantitative evidence to guide school counselor advocacy. *Journal of Counselor Leadership and Advocacy. 8*(1), 1-14. https://doi.org/10.1080/2326716X.2020.1861490
Wood, L., Voth Schrag, R., Hairston, D., & Jones, C. (2021). Exploring advocacy practices for interpersonal violence survivors on college campuses: Approaches and key factors. *Psychology of Violence*, *11*(1), 28–39. https://doi.org/10.1037/vio0000343