Mental Health Counseling: Past, Present, and Future

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This article examines the significant events in the history of mental health care that have contributed to the development of a specialty within the counseling profession referred to as mental health counseling. The development of credentials for the specialty and the issues currently facing mental health counseling are discussed, and a perspective on directions for the future is offered.

Mental health counseling brings a unique approach to the mental health care professions in that it offers a broader response to the definition of care than the traditional fields of psychiatry and clinical psychology. Historically, people who could benefit from mental health services were viewed as distinctly different from those who would be considered "healthy" (i.e., there is something "wrong" with them, or they are "ill" and therefore in need of treatment). If one considers mental health care to be a continuum based on needs of society with high-level wellness being on one end of the continuum and severe and persistent mental illness being on the other, virtually every person can improve their respective quality of life through the use of mental health services. Simply stated, mental health counseling believes that a person does not have to be sick to get better.

Seiler (1990) noted that mental health counseling emphasizes the developmental, preventive, and educational as well as the traditional remedial aspects of mental health care. Weikel and Palmo (1989) called mental health counseling a "hybrid" and suggested that it was "born from an uneasy relationship between psychology and educational counseling, but with family ties to all of the core mental health care disciplines" (p. 7). Hershenson and Power (1987) used words like "enabling," "asset oriented," and "skill based" (p. 18). They advocated assisting clients to help themselves by identifying and mobilizing the clients' strengths and developing the skills within the client that will carry them beyond the resolution of any immediate issue as opposed to simply "curing the patient" (p. 18). This article provides a brief outline of the history of mental health counseling as a counseling specialty, a snapshot of the present, and some speculation about the future.

These statements appear to be fairly simple and straightforward; however, they are not as simple as they first appear. They set the stage for a profound effect on mental health care both philosophically and in the way it is delivered. Consider the mental health continuum mentioned earlier. Mental health counselors, with their definition, expand the range of treatment to include the concept of professionals delivering preventive services. This represents a fundamentally different concept of health care. It is truly health care rather than treatment of disorders, abnormalities, or disease amelioration. The health care industry of today is only beginning to consider the possibility of *health* care, having been obsessed with *illness* care since the beginning of time. With this as a backdrop, let us consider a brief history.

OVERVIEW OF HISTORICAL DEVELOPMENT

Brooks and Weikel (1986) traced the historical roots of mental health counseling back to the "moral treatment" of the mentally ill that was started by Philippe Pinel, director of the Bicetre (the largest mental hospital in Paris) in 1793. Pinel expanded the definition of mental health care to include the principles of "liberty, equality, and fraternity." Brooks and Weikel explained that Pinel forbade corporal punishment and demanded that the "inmates" be released from their chains. Pinel introduced the idea that individuals who were mentally ill had a level of competence and confidence that precluded the necessity of physical restraint unless, of course, they were a danger to themselves or others. He refused to assume that the "best" treatment was the most conservative, restrictive, and protective. Rather, he felt that a level of normalcy should be maintained or introduced into the clients' lives. About this same time, other reformers were beginning to introduce other more humane expansions to traditional forms of treatment (e.g., William Tuke of England and Dorthea Dix of the United States).

As history unfolded, there was not a straight-line development that led from the traditional, dichotomous thinking (i.e., healthy or sick) to where we are today. Instead, it followed a random and sporadic pattern through the late 1800s during which time there was a reversal from this gravitation toward humanitarian ideals back to a more conservative mentality. A decline in funding from both private and public sources undoubtedly played a role in this shift in that it is less costly to warehouse problematic individuals than to help them attain their potential.

As Brooks and Weikel (1986, p. 7) pointed out, the pendulum of change began to swing toward a broader, more humane position once again, with the publication in 1908 of Clifford W. Beers's autobiographical account of his experience as a patient in mental institutions. Public interest in the area of mental health care was heightened once again, and an organization which later became the National Mental Health Association was formed.

Other expansionist contributions led to the inclusion of occupational or vocational concerns to the definition of mental health, the development of the ability to estimate human abilities, and the measuring of differences between individuals through standardized tests. This was due in no small part to world events such as World Wars I and II, which created an interest in human aptitudes and abilities. This interest later was expanded to include personalities, for example, the publication of the Minnesota Multiphasic Personality Inventory by McKinley and Hathaway in 1940.

Again, Brooks and Weikel (1986, p. 10) pointed to the development of "nonmedical approaches" to psychotherapy being very significant in the continued evolution of this expanded definition of mental health care. Carl Rogers and Fritz Perls, for example, emphasized a client-centered theory, which had at its core the belief that the *client* is a partner in the healing process rather than a *patient* on which a cure is imposed by the professional.

Concurrent with this continuous refinement of the whole concept of mental health care and services were other significant events. Graduates of counselor education programs, who were primarily prepared to work in elementary and secondary education settings, were not able to find employment in those schools as the market was reaching a saturation point. Federal dollars for human services programs such as the Secondary Education Act of 1965 were being redirected into supporting the Vietnam war efforts. The effect of this was twofold. First, it meant less federal money for counseling services in school settings. Second, graduates from counselor education programs, especially those with doctorates, were beginning to find employment (often as licensed psychologists) in university counseling centers or in the Veterans Administration.

The latter was to be short-lived relief, however, as the psychology profession began to block the entrance of these mental health counselors into their "professional turf." The law of supply and demand dictated that the market for these educated and skilled professionals was drying up.

Brooks (1991) noted a number of other forces coming into focus at the same time. Some of these forces had positive effects on mental health counseling, such as the Community Mental Health Centers Act of 1963, which created employment opportunities. There were also increasing numbers of doctoral level counselors, which increased their viability as health care professionals.

STATEMENT OF NEED

According to Seiler (1990), mental health counselors "did not work exclusively with mental illness; we did not work solely through the social service system; nor was our clinical work mainly with marriages or families in trouble. Their roots had been influenced by developmental and prevention services and mental health education" (p. 7). In essence, by the 1970s, mental health counselors found themselves a loosely defined profession without a clear identity or a professional organization around which to rally or form the nucleus of an organizational structure for support or networking capabilities.

By the mid-1970s, it was clear that there was a critical mass of these individuals who (a) were educationally prepared at either master's or doctoral level; (b) worked in community agencies, community mental health, or private practice settings; (c) were delivering a wide variety of services very similar to the more established mental health care provider groups (psychiatry, psychology, social work, etc.); and (d) felt they had no professional home by virtue of their uniqueness (Seiler, Brooks, & Beck, 1987). Thus, the American Mental Health Counselors Association (AMHCA) was formed in 1976 around those things these individuals had in common. However, the central group of members soon discovered that they needed a larger identity or professional family to be able to move their agenda forward. They approached the American Personnel and Guidance Association, which is now the American Counseling Association (ACA), and eventually found, in 1976, a larger professional family with which to associate. By 1989, Ivey concluded, "it is clear that mental health counseling has reached the point at which it has become a heavyweight contender on the national scene" (p. 26).

RELATIONSHIPS WITH OTHER ASPECTS OF ACA

The early years of the relationship between AMHCA and ACA were often stormy and fraught with miscommunication and misunderstanding. It seemed that the AMHCA agenda (i.e., professional credentials, recognition, legislative activity, and third-party reimbursement) represented such a radical departure from the "business as usual" of pre-AMHCA days for ACA that the relationship would surely be strained beyond repair if not broken completely.

ACA had organizational maturity and strength of numbers and AMHCA had a youthful exuberance and had learned how to move swiftly and effectively in the public policy arena. Unfortunately, these respective descriptors occasionally led the two associations to be at cross-purposes. AMHCA sometimes perceived ACA as being too broadly focused and attempting to treat all divisions the same when AMHCA perceived its own needs to be very specific (e.g., ACA support in AMHCA's efforts to gain recognition as a mental health care provider). ACA sometimes perceived AMHCA as being too narrowly focused, and while they admired AMHCA's quest for quality through the development of credentials (e.g., the National Academy of Certified Clinical Mental Health Counselors in 1979), ACA's support and encouragement was somewhat less than impressive in AMHCA's eyes. However, 3 years after the Academy was established, ACA established its own credential, the National Board for Certified Counselors (NBCC). AMHCA continues to be more clearly focused than ACA on legislative activities that affect mental health counselors' right to practice, such as licensure, vendorship, freedom of choice, core-provider status, and third-party reimbursement. ACA, by definition and function, must respond to the legislative needs of the other 15 divisions that represent counselors in other work settings in addition to AMHCA.

AMHCA's relationship with the other divisions of ACA has been cordial and cooperative for the most part. Rarely has it been adversarial, even when the agenda of mental health counseling and other ACA divisions has been at cross-purposes. Over the years, the clear movement has been one of assuming an increasing leadership role within the ACA family. AMHCA, as a division of ACA, has moved from being the "new kid on the block" to being one of the largest divisions whose counsel is sought by other divisions and ACA itself. The emphasis of all of the divisions within ACA has shifted away from emphasizing their uniqueness and professional diversity toward emphasizing cooperation and professional unity. However, from time to time, the unique needs of ACA division members have resulted in dissatisfaction with the overall organization as not responsive and helpful. In a rare instance, this resulted in disaffiliation based on divergent goals. In most instances, the commonalities among counselors have led to problem resolution and a continued desire to maintain ACA's common professional identity, as is the case of the 1993 referendum initiated by the AMHCA Board of Directors.

SPECIALTY TRAINING STANDARDS

AMHCA and the Association for Counselor Education and Supervision (ACES) formed a Joint Committee on Education and Training for Mental Health Counselors in 1978. This was followed shortly in 1979 by the National Academy of Certified Clinical Mental Health Counselors appointing a task force to develop a system of counselor preparation that was competency based. The outcome of this effort came in 1981 when Messina and Seiler (1981) published the *Ideal Training Standards for Mental Health Counselors.*

By the mid-1980s, it had become obvious that if mental health counselors were to work in the health care system, new and more rigorous standards were going to have to be established. The marketplace demanded proof of clinical skills if mental health counselors were to be taken seriously as qualified providers. This meant including issues such as the nomenclature of psychopathology, diagnosis,

and treatment planning if mental health counselors were to be viable vendors of quality care as defined in the marketplace.

The 1986–1987 AMHCA Board of Directors adopted a set of comprehensive training standards for mental health counselors. These training standards required at least 60 semester credit hours and a minimum of 1,000 clock hours of clinical supervision. These standards were finally adopted, with some modifications, by the Council for Accreditation of Counseling and Related Educational Programs (CACREP) in July 1988.

SPECIALTY ACCREDITATION

Also in the mid-1980s, AMHCA began to promote specialty accreditation for certain areas within the broader mental health counseling area, such as marriage/couples and family counseling. In keeping with the strong emphasis on competency-based programs, it was the considered opinion of AMHCA that programs preparing mental health counselors to enter certain areas of specialty in practice should also guarantee skill and provide for supervised clinical instruction for these specialty designations. These special competencies were to be added to the common core and the environmental curriculum as specialized studies designed to "give the trainee a foundation and overview of this field of study," which would "provide an adequate basis for the mental health counselor to begin to utilize the knowledge and skills in practice" (Seiler, 1990, p. 85).

AMHCA's efforts to promote these subspecialty standards within the mental health counseling area (e.g., marriage/couples and family counseling) met with resistance partially from other ACA entities with differing agendas (i.e., the International Association for Marriage and Family Counselors and CACREP) and from other internal circumstances such as not having the energy and resources to address AMHCA's full agenda. CACREP now has adopted specialty standards for marriage and family counselors that are quite similar to those initially proposed by AMHCA.

SPECIALTY LICENSURE

A major focus for mental health counselors has been to gain licensure. Licensure laws differ from state to state. For example, counselor licensure laws have resulted in the use of at least 16 different titles and a different definition of counseling in virtually every state. In most cases, licensure laws were written to cover a broad spectrum of counseling services. Several states have chosen to license counselors only at the clinical level. These laws specify that diagnosis and treatment of mental and emotional disorders are appropriate practices for qualified counselors. Still other states have provisions for recognizing clinical and other counselor specialties within their laws.

Licensure laws may be either *title* acts, which protect the use of particular titles such as Licensed Professional Counselor, or *practice* acts, which require the practitioner to hold a license in order to practice. In cases in which a generic counselor license provides the right to practice but does not provide a clear scope of practice, the counselor may be able to establish competence through specialty certification or by meeting national standards for clinical mental health counseling.

NATIONAL STANDARDS

By the late 1980s, it had become obvious that mental health counselors would not be recognized for reimbursement by third-party payors without standards of preparation and practice. Preparation standards for the specialty of mental health counseling were established by CACREP in 1988. ACA had adopted a policy statement on advocacy for counselors. In 1993, using the CACREP standards and ACA policy as starting points, AMHCA adopted a comprehensive set of national standards for mental health counselors who deliver clinical services.

These national standards were designed to enable the mental health counselor to satisfy requirements of third-party payors, particularly multistate insurance companies, and to pave the way for greater reciprocity among state regulatory bodies. A mental health counselor can achieve a Certified Clinical Mental Health Counselor (CCMHC) credential or meet the categories of criteria of the AMHCA National Standards for Mental Health Counselors, which include the following:

1. Education: completion of a CACREP-approved program in Mental Health Counseling or the equivalent (see Appendix A);
2. Experience: completion of at least 3,000 hours of clinical experience;
3. Supervision: completion of at least 100 hours of face-to-face supervision by a qualified supervisor;
4. Standards of practice: adherence to the AMHCA Standards of Clinical Practice;
5. Ethical standards: adherence to appropriate statutory or certifying body or professional association code of ethics;
6. National clinical examination: achievement of a passing score on clinical exam;
7. Competency-based criterion (work sample): submission of a satisfactory sample of counseling session on audio or video tape; and
8. Statutory regulation: appropriately licensed where available.

Many practicing mental health counselors received their training long before these standards were in place. They have wanted to establish their professional viability as providers but have not been able to return to school full time, perhaps enter a new degree program, in order to keep up with current education and training requirements. Now the mental health counselor may attain national standards by taking one of several paths that have been designed to guide them toward meeting the standards (see Table 1). Again, one of the paths (often referred to as the "path of choice"), is to become a Certified Clinical Mental Health Counselor (CCMHC) through the NBCC.

The CCMHC was created by AMHCA in 1979 when it established the National Academy of Certified Clinical Mental Health Counselors. Soon after, the NBCC was founded. In 1993, the National Academy and NBCC merged to provide a unified certification program.

The most critical piece of the comprehensive national standards that was missing was the standards of clinical practice. Mental health counseling is practiced all along the continuum of mental health as mentioned above, and the diagnosis and treatment of mental and emotional disorders are necessary practices on part of that continuum. Consequently, AMHCA adopted national standards to serve as guidelines for the "best practice" of clinical mental health counseling. The standards of clinical practice will help ensure the delivery of high-quality clinical services to clients.

FUTURE TRENDS AND ISSUES

On the basis of changes in the health care marketplace, we believe that the term *mental health counseling* will come to mean the delivery of counseling services along the full continuum of mental health ser-

TABLE 1

Uniform National Clinical Standards for Mental Health Counselors

Component	CCMHC	Board Eligible	CACREP-Approved Program in Mental Health Counseling	Equivalent Education
Education	60 semester hours	60 semester hours	60 semester hours	60 semester hours
Experience	3,000 hours of clinical experience	3,000 hours of clinical experience	3,000 hours of clinical experience	3,000 hours of clinical experience
Supervision	100 hours of face-to-face	100 hours of face-to-face	100 hours of face-to-face	100 hours of face-to-face
Standards of practice	Clinical standards of practice	Clinical standards of practice	Clinical standards of practice	Clinical standards of practice
Ethics	NBCC Code of Ethics AMHCA Code of Ethics	NBCC Code of Ethics AMHCA Code of Ethics	NBCC Code of Ethics AMHCA Code of Ethics	NBCC Code of Ethics AMHCA Code of Ethics
Examination	National Clinical Mental Health Counselor Exam	National Clinical Mental Health Counselor Exam	National Clinical Mental Health Counselor Exam	National Clinical Mental Health Counselor Exam
Competency-based work sample	Work product sample	Work product sample	Work product sample	Work product sample
Statutory regulation	1. Clinical license 2. Clinical license beyond general license 3. Clinical designation	1. Clinical license 2. Clinical license beyond general license 3. Clinical designation	1. Clinical license 2. Clinical license beyond general license 3. Clinical designation	1. Clinical license 2. Clinical license beyond general license 3. Clinical designation

Note. CCMHC = Certified Clinical Mental Health Counselor; CACREP = Council for Accreditation of Counseling and Related Educational Programs; NBCC = National Board for Certified Counselors; AMHCA = American Mental Health Counselors Association.

vices. If the reimbursement climate remains as it is today, a specialty in the clinical practice of mental health counseling may continue to be necessary. We also believe that all counselors will find it necessary to have at least entry-level education and experience along the full continuum of services. The identification of mental and emotional disorder is essential to proper treatment, referral, or both.

At the same time, mental health counselors will be articulating a diagnostic system based on developmental theories and determining appropriate intervention or treatment (D'Andrea, 1994). We hope that, through these efforts, preventive counseling will become respected as cost saving and effective as the practice of preventive medicine.

National standards for counselor preparation will continue to evolve to acknowledge a profession truly worthy of the status afforded other mental health care providers. We anticipate that all practicing mental health counselors will have basic knowledge and skills in the diagnosis and treatment of mental disorders as a part of their core coursework. This, in addition to the preventive, developmental, holistic, and multidisciplinary emphasis, will remain unchanged as mental health counselors continue to broaden the continuum of care.

We hold out much hope for the counseling profession to seek unity to maximize its impact on the field of mental health. The concepts of "continuum of care," "continuum of mental health services," and "multidisciplinary" will take precedence over special interests that cordon off specific parts of the continuum. The uniqueness that counselors offer is the application of counseling processes all along the continuum.

We anticipate that specific techniques, special populations, or work settings will become subsumed under the identity of being mental health practitioners. If counselors really want to be viewed as members of a mental health profession, then they must truly become mental health counselors qualified to practice on the continuum of mental health services.

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APPENDIX A
CURRICULAR EXPERIENCES FOR MENTAL HEALTH COUNSELING PROGRAMS

In addition to the common core curricular experiences found in Section II.J of the *CACREP Accreditation Standards and Procedures Manual* (Council for Accreditation of Counseling and Related Educational Programs, 1994. pp. 73–74), curricular experiences and demonstrated knowledge and skill in each of the following areas are required of all students in the program.

A. Foundations of Mental Health Counseling

Studies in this area include, but are not limited to, the following:

1. Historical, philosophical, societal, cultural, economic, and political dimensions of mental health counseling;
2. Roles, functions, and professional identity of mental health counselors;
3. Structures and operations of professional organizations, training standards credentialing bodies, and ethical codes pertaining to the practice of mental health counseling;
4. Implications of professional issues unique to mental health counseling, but not limited to recognition, reimbursement, right to practice, core provider status, access to and practice privileges with managed-care systems, and expert witness status; and
5. Implications of sociocultural, demographic, and lifestyle diversity relevant to mental health counseling.

B. Contextual Dimensions of Mental Health Counseling

Studies in this area include, but are not limited to, the following:

1. Assumptions and roles of mental health counseling within the context of the health and human services systems, including functions and relationships among interdisciplinary treatment teams, and the historical, organizational, legal, and fiscal dimensions of the public and private mental health care systems;
2. Theories and techniques of community needs assessment to design, implement, and evaluate mental health care programs and systems;
3. Principles, theories, and practices of community intervention, including programs and facilities for inpatient, outpatient, partial treatment, and aftercare, and the human services network in local communities; and
4. Theoretical and applied approaches to administration, finance, and budgeting; management of mental health services and programs in the public and private sectors; principles and practices for establishing and maintaining both solo and group private practice; and concepts and procedures for determining accountability and cost containment.

C. Knowledge and Skills for the Practice of Mental Health Counseling

Studies in this area include, but are not limited to, the following:

1. General principles of etiology, diagnosis, treatment, and prevention of mental and emotional disorders and dysfunctional behavior, and general principles and practices for the promotion of optimal mental health;
2. Specific models and methods for assessing mental status; identification of abnormal, deviant, or psychopathological behavior; and the interpretation of findings in current diagnostic categories (e.g., *Diagnostic and Statistical Manual of Mental Disorders* [4th ed., DSM–IV; American Psychiatric Association, 1994]);
3. Application of modalities for maintaining and terminating counseling and psychotherapy with mentally and emotionally impaired clients, including crisis intervention, brief, intermediate, and long-term approaches;
4. Basic classifications, indications, and contraindications of commonly prescribed psychopharmacological medications for the purpose of identifying effects and side effects of such medications;
5. Principles of conducting an intake interview and mental health history for planning and managing client caseload;
6. Specialized consultation skills for effecting living and work environments to improve relationships, communications, and productivity and for working with counselors of different specializations and with other mental health professionals in areas related to collaborative treatment strategies;
7. The application of concepts of mental health education, consultation, outreach, and prevention strategies, and of community health promotion and advocacy; and
8. Effective strategies for influencing public policy and government relations on local, state, and national levels to enhance funding and programs affecting mental health services in general and the practice of mental health counseling in particular.

D. Clinical Instruction

For the Mental Health Counseling program, the following standard should be applied in addition to Section III, Standard I of the *CACREP Accreditation Standards* (Council for Accreditation of Counseling and Related Educational Programs, 1994):

A minimum of 300 clock hours of supervised experience must be completed in an appropriate setting under the direct supervision of a qualified mental health professional (e.g., CCMHC). The total internship experience will, therefore, consist of a minimum of 900 clock hours.

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