Mental Health Counseling in the 90's

A Research Report for Training and Practice

Michael K. Altekruse, Ed.D.
Thomas L. Sexton, Ph.D.
University of Nevada, Las Vegas

An Orlando Model Series Monograph
National Commission for Mental Health Counseling

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Orlando Model Series Monographs
Editors:
Jim Messina, Executive Director NCMHC
Michael Altekruse, Senior Editor of Series
Thomas Sexton, Research Editor
Beverly Mustaine, NCMHC Media Committee Chair
Ann Lynch, Research Associate of NCMHC

National Commission for Mental Health Counseling
7405-D Temple Terrace Highway
Tampa, Florida 33637

For information on how to get a monograph included in the Orlando Model Series contact:

National Commission for Mental Health Counseling
7405-D Temple Terrace Highway
Tampa, FL 33637
(813) 988-0623 or FAX (813) 980-3413

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Introduction to the Orlando Model Series Monographs

In June 1994, the American Mental Health Counselors Association (AMHCA) approved the formation of the National Commission for Mental Health Counseling. In November 1994, the Commission established a Board of Governors and appointed its first twelve members. The Commission is now a free standing independent non-profit corporation which has become the "Guardian of the Orlando Model."

The mission of the National Commission for Mental Health Counseling is to improve the quality of the clinical services provided by Mental Health Counselors through the promotion of competency based standards for pre-professional graduate school, pre-graduation internship, post-graduation residency, and practitioner training and practice, with strong encouragement to utilize the Orlando Model of competency based standards of training, supervision and clinical practice. The objectives of NCMHC are:

1. To provide a system of information sharing and networking between training programs for trainees and practicing mental health counselors.
2. To publish a professional semi-annual journal/newsletter to encourage the sharing of innovation, research and new developments in mental health counseling.
3. To conduct an annual conference on mental health counselor competency at the time of the AMHCA/ACA annual convention to promote the expansion of knowledge and information transfer in the field.
4. To encourage the development of curriculum guides and textbooks in Mental Health Counselor training which are consistent with the intent of the Orlando Model.
5. To provide a forum for information sharing among the graduate programs, internship supervisors, residency supervisors, continuing education providers, employers of mental health counselors, and mental health counselor practitioners in the private and public sector.
6. To promote new competency based standards for the training and practice of Mental Health Counseling which are based on the ongoing needs and changes in the Mental Health field.
7. To maintain an active two way liaison with CACREP, the Academy of Clinical Mental Health Counseling and the American Association of State Boards of Counseling to insure that all standards for Mental Health Counseling are in tune with the changing needs of the mental health counseling field.
8. To work with employer groups nationally to implement subsidized internship and

residency programs for Mental Health Counselors in training.

9. To work with graduate programs, free standing internships, and residency supervisors to insure that standardized competency based, clinically sound supervision is provided Mental Health Counselors in training.

10. To develop Research and Development Projects which can be supported by federal or private foundation funding to expand the implementation of the Orlando Model Competency Based Standards for Mental Health Counseling.

11. To promote the development of regional Centers for Excellence in Mental Health Counselor Training which drive the movement to improve the quality of clinical training and clinical practices for the profession.

12. To maintain open dialogue with the professional associations (AMHCA, ACES and ACA); State Boards of Counselor Licensure; CACREP; NBCC-The Academy; and other entities which influence the setting of standards for the counseling profession, to insure that the Orlando Model competency based system for Mental Health Counselors is recognized and implemented universally.

13. To promote the Orlando Model competency based standards of training and clinical practice to groups who hire Mental Health Counselors including: managed care companies, large group practices, public mental health agencies, psychiatric hospitals, general hospitals, prisons, court systems, churches, university and college counseling centers, public and private schools, geriatric service centers and non-profit, semi-public mental health agencies.

14. To govern itself by a voluntary Board of Governors whose makeup is representative of the constituent groups involved in the Mental Health Counseling field.

In order to achieve its mission and objectives the NCMHC has begun the publishing of the Orlando Model Series Monographs with this first monograph. The monographs will cover a variety of topics:

1. Reports on research and development efforts of the research associates of the Commission.
2. Proceedings of the Commission's Annual Conference.
3. Curriculum Guides based on outcomes research and empirical studies.
4. Conceptual works by authors pertinent to the Orlando Model of competency based standards of training and clinical practice.

The commission hopes that by its efforts in publishing and distributing these monographs that the field of mental health counseling will be advanced so that it gains the national recognition is deserves as a core profession in the mental health service delivery system.

James J. Messina, Ph.D., CCMHC, NCC
Executive Director NCMHC
April 1995

Preface

In the past, talk of mental health care was limited to those intimate conversations among close friends. Working with a mental health practitioner was considered by many to be a sign of weakness. However, the world of mental health care is quickly changing. Celebrities are beginning to talk about their own therapy and promoting the value of counseling in today's world. The Vice President's wife, Tipper Gore, has become a strong and vocal advocate for mental health services. Even the popular press is featuring mental health. *U.S. News and World Report* (1993) highlighted an article on the effectiveness of psychotherapy, and the *Parade Magazine* (1994) featured a story on Tipper Gore and her ideas on mental health. National health care reform has also brought mental health care into the spotlight.

Along with this increased attention have come many questions. Who will provide mental health services? What type of services should and will be covered? What is "good" mental health care? What is the efficacy of mental health care service? These are issues of critical importance for the future of mental health counseling. Within the American Counseling Association (ACA), it is the American Mental Health Counselors Association (AMHCA) that is the standard bearer of such issues. AMHCA started the Orlando Model Project to examine competencies that effective mental health counselors possess so that trainers could instill such competencies in future mental health counselors. The energy and impetus of the Orlando Model Project lies with Jim Messina and Roberta Driscoll, the co-chairs of the Project. They initiated the project and have been instrumental in keeping it alive.

The Orlando Model Project was an evolving project involving various teams working on issues related to the future of mental health. This volume is the beginning of a systematic search by AMHCA and its newly spun off free standing National Commission for Mental Health Counseling (NCMHC), to identify and understand the practice of mental health counseling in our country today. This preliminary report outlines the first results of the effort to develop a set of competencies that can be used as the standard for mental health care in the future. This volume represents the first of many efforts to understand what practicing mental health counselors do, what they believe to be important, and how and from what source they have learned what they know and do. This report is a first glimpse at where we stand today.

This volume represents the work of Team 1 of the Orlando Model Project, chaired by Michael K. Altekruse. Team 1 used multiple perspectives in an attempt to identify a set of competencies that may serve as the basis of identifying what mental health counseling is. This

monograph is divided into seven chapters:

Chapter 1 is a historical perspective on the Project and the creation of the NCMHC. Jim Messina covers the 18 year history of the evolution of the mental health counseling profession which brought us to this current effort.

Chapter 2 describes the Orlando Model Project and the AMHCA Competency Survey of 1992 which serves as the data base for this report.

Chapter 3 is a report of the demographic profile of the respondents to this nationwide survey of mental health counselors. It provides a glimpse into what mental health counselors actually do in their daily practice.

Chapter 4 contains the results of the competency survey. Here respondents indicated what they believe to be the important knowledge, skills, attitudes and traits of mental health counseling and sources of these competencies.

Chapter 5 contains Harold Hackney's survey of trainers and their perceptions on what mental health counselors do in the 1990's.

Chapter 6 uses a generic model of the counseling process to briefly outline the status of counseling outcome research and identify areas in which these empirical findings overlap with those areas rated as most important by respondents of the survey.

Chapter 7 ties together these diverse perspectives in order to identify the major question: What is mental health counseling and where does it need to go?

Michael K. Altekruse, Ed.D. and Thomas L. Sexton, Ph.D.
University of Nevada, Las Vegas
April 1995

Chapter 1

The Historical Context of the Orlando Model Project and the NCMHC

James J. Messina, Ph.D.
Executive Director NCMHC

In 1976, the American Mental Health Counselors Association (AMHCA) was founded by Nancy Spisso and Jim Messina as a voice for counselors who were employed in mental health settings (Weikel, 1985). One of its early goals was to identify competencies of successful mental health counselors. The Orlando Model Project was founded in 1992 by AMHCA to complete this 1976 task and to develop a working relationship with the trainers of counselors.

AMHCA's goal is and has been to establish Mental Health Counseling as a core profession in the mental health field (Messina, et. al., 1978). The other core professions were also subspecialties of larger professions, i.e.: Psychiatry, a subspeciality of Medicine, Clinical and Counseling Psychology of Psychology, Clinical Social Work of Social Work and Psychiatric Nursing of Nursing. Mental health counselor training in the original plans of AMHCA's founders was modeled after the National Association of Social Work (NASW) recommended training. The graduate of a 60-hour program was supposed to be a terminal degree recipient who would have had a clinical internship and been recognized as being as competent as other professionals in mental health (AMHCA Certification Committee, 1979). This meant the creation of a completely new breed of counselor (Seiler & Messina, 1979). It meant that the Ph.D. would not be the pinnacle degree in the Mental Health Counseling field. Perhaps the Ph.D. would be retained for those who wanted either to do research or to train mental health counselors like the Doctorate in Social Work (DSW). However, the early planners envisioned a well trained mental health counselor who could be a very appropriate trainer of entry level students in the field.

Messina (1979) suggested that the goals of AMHCA should focus on the efforts to establish the new profession of Mental Health Counseling, more specifically: 1. A national voluntary membership association (AMHCA). 2. A national standard for recognition of competent members in the profession through national certification by the Academy of Clinical Mental Health Counselors (ACMHC) earlier known as the National Academy of Certified

Clinical Mental Health Counselors (NACCMHC) and now known as "The Academy." 3. A national accreditation standard for the educational programs which train members of the profession (Training Program Accreditation, CACREP, which currently has only accredited three Mental Health Counselor Education Programs). 4. A uniform standard of licensure in all 50 states for the members of the profession (forty-one states and the District of Columbia currently license professional counselors). Only three states license Mental Health Counselors (Florida, Iowa & Massachusetts); one state licenses Professional Counselors of Mental Health (Delaware); one state licenses Licensed Professional Clinical Mental Health Counselors (New Mexico); two states certify Certified Mental Health Counselors (New Hampshire and Washington); one state certifies Certified Clinical Mental Health Counselors (Vermont); one state certifies Certified Counselors in Mental Health (Rhode Island); and four states license Clinical Counselors (Illinois, Maine, Montana, Ohio) (Covin, 1994). 5. A national standard of professional competencies (knowledge, skills and abilities) which is the foundation for the profession's certification, accreditation, licensure and clinical standards. 6. A body of knowledge, research and theory which distinguishes this profession from other professions which are engaged in similar work efforts. The Orlando Model Project addressed item #5, the national standard of professional competence, and item #3, the national standard for training in the mental health counseling profession. These efforts will have impact on all aspects of the ongoing professional development of Mental Health Counseling.

In reviewing what is needed for Mental Health Counseling to be fully recognized as a profession, one can see that in the last 19 years since AMHCA was conceived that much was accomplished but much still needs to be done. AMHCA lost its vision of creating the Mental Health Counseling profession at some point in its history. Many of its leaders believed that over time they were already members of such a profession even though the fundamental foundation was lacking. Also, impairing AMHCA's efforts at "profession creation" was the disarray in the larger profession of counseling which was seeking its own professional identity. Simultaneously with AMHCA's emergence the professional association of counseling was having its own identity problem. The professional association of counseling was called the American Personnel and Guidance Association (APGA) when AMHCA became a division within it in 1977. APGA struggled to establish a national certification process resulting in success in 1982. Jim Messina became a founding board member of the National Board of Certified Counselors (NBCC) with the goal of incorporating the Academy within it. When he represented NBCC to establish a joint effort, Messina's offer was declined by the Academy. The Academy decided to remain independent at that time. This, despite the fact that the NBCC utilized the procedures of the Academy in its own development, in part due to Messina's presence on the board. APGA also was finally successful in establishing a national accreditation process for counselor education programs in the early 1980's: the Council for Accreditation of Counseling and Related Educational Programs (CACREP). AMHCA has representation on the CACREP Board but has not pursued the concept of competency based training standards as part of the Mental Health Counseling Accreditation, since CACREP's focus is on educational standards not training standards (Seiler, et. a.l, 1990). Unfortunately, only three programs have been accredited under CACREP's Mental Health Counseling designation.

The professional association for counselors started with APGA and has changed its name twice in the past 19 years from the American Association of Counseling and Development (AACD) to the American Counseling Association (ACA). The name change clarifies that the profession of counseling is served by ACA and that AMHCA serves Mental Health Counseling which is a subspecialty of the counseling profession. In July 1993, the Academy became the Clinical Academy of NBCC thus clarifying that the Certified Clinical Mental Health Counselor (CCMHC) is the subspecialty and designated clinical professional of the larger, generalists, National Certified Counselor (NCC) designation. The merger of the Academy with NBCC accomplishes a goal eleven years in the making.

An inhibiting factor, preventing the Mental Health Counseling profession's development in the past 19 years, stems from the historical legacy of guidance and school counseling within the professional association. There has been disagreement over the theoretical model of mental health counseling since the majority of mental health counselors are trained in Colleges of Education and not Psychology or Social Work. Should the model for mental health counseling be based on pathology and the medical model or should it be based on the prevention model of teaching clients to be more skillful and effective in coping and applying new skills? In the first theoretical article, espousing the recognition of mental health counselors (Seiler & Messina, 1979), the emphasis was on such counselors being prevention and developmentally oriented. Since then the pressures of the health care market have pushed the profession to become more focused on the diagnosis and treatment of mental health disorders. The current definitions of mental health counseling, by the Academy and state licensing boards, emphasize the diagnosis and treatment of mental health disorders. The dynamic tension of the pressure for counselors to be educational and developmental rather than treatment oriented still exists in the political atmosphere in the larger counseling profession and very well might continue to inhibit the growth and clarity of identity of the Mental Health Counseling profession. The work to identify competency based standards for mental health counselors was intended to clarify what distinguished them from other mental health professionals and if it was the prevention, educational and developmental orientation which was the differential competencies.

The effort to establish a national standard of professional competence was begun when the Academy was founded by AMHCA in 1977 (Messina, 1985). When Messina became the first Chair of the Academy, the board's mission was to identify a means to establish a list of "in the field" validated performance competencies which could become minimal standards required of all counselors who wanted the designation of Certified Clinical Mental Health Counselor (CCMHC). During his three year term, Messina compiled a data base of competencies (knowledge, skills and abilities) through his work with the National Institute of Mental Health's (NIMH) Office of Paraprofessional Training and the National Center for Professional Competence and from three different doctoral dissertations sponsored by the Academy. This data base was to accomplish two major tasks of professional development: 1. Create a competency based assessment process for national certification, and 2. Establish a minimal standard of competencies which a counselor needed to master prior to graduation from a Mental Health Counselor Training Program. This second task led Messina, as the Academy Chair, in 1980 to create a Task Force to identify national training standards for Mental Health Counselor Training Programs which

would be competency based and performance assessed (AMHCA/NACCMHC Blue Ribbon Task Force, 1980). Messina was requested to discontinue the Training Standards Task Force by Tom Sweeney, then President of APGA, who spearheaded the effort to establish what became to be known as CACREP. Tom Sweeney hoped to spare the field confusion from an AMHCA/ACADEMY effort to establish it's own training standards when APGA was in the process of developing its accreditation program. Messina agreed and tabled the training standards efforts. Unfortunately, the competency based standards identification effort got lost or was ignored by the Academy Chairs and AMHCA presidents over the years, even after it was resurrected again by Messina in 1987 at an AMHCA Think-Tank (McCormick & Messina, 1987).

Since its inception in 1976 and its formal recognition as a Division of ACA (APGA/AACD), AMHCA has grown to close to 12,000 members, with over 4,600 in private practice, over 1,800 in public mental health agencies, close to 1,000 in universities, colleges, and community colleges, and over 600 in school settings. Since the Academy began certifying Clinical Mental Health Counselors, close to 2,000 have become certified CCMHC's. There have been a number of arenas in which the Certified Clinical Mental Health Counselor has been recognized as a professional designation, but it has not as yet been recognized as a core profession in the mental health field by an amendment of the Public Health Services Act. The efforts to establish Mental Health Counseling as a core profession was seriously inhibited by the 1980 decision to table the AMHCA/ACADEMY effort to establish competency based standards for the field.

How the Orlando Model Project Came to be

One way to assist AMHCA in its efforts to gain core provider status for Mental Health Counseling was to complete the task begun in 1979 - to establish a competency based standard for training and the clinical practice of mental health counselors. In the February of 1991 in a meeting of the regional representatives in Orlando, Florida, Gail Robinson (who had just received word that she was elected AMHCA President for 1992-93), Roberta Driscoll (who was to be elected AMHCA President for 1993-94 and is the 1995 Chair of the NCMHC), Bill King (a recent member of the Academy Board) and Ralph Carlino met with Gary Seiler and Jim Messina. The two past-presidents of AMHCA gave these board members a historical perspective as to where AMHCA was and its vision. It was at this meeting, that Robinson chose to resurrect the competency study begun in 1979. She took the data base, gathering dust in Messina's archives and published them in the *AMHCA Advocate* in Spring of 1991. The response to this listing with additions and clarifications was then compiled into a questionnaire for priority rating and sent out to all CCMHC's (n=1500) by Robinson. Close to 400 responses were then put into a fortran data base by Robinson. The task of analyzing the data hung for awhile. It was at Driscoll's hearing of her election, as President-Elect of AMHCA, in spring of 1992 that she announced that she wanted to complete the task of identifying competency based training standards for the profession. Messina and Driscoll prepared a proposal for the Orlando Model Project which they presented formally at the AMHCA Leadership Conference held in Orlando, Florida in May, 1992. The Orlando Model Project name comes from the fact that it took two meetings in Orlando to put back on track an effort which had begun 15 years previously and was sidetracked 12 years

ago. The AMHCA leadership are committed to finalizing the work needed to make the profession of Mental Health Counseling a recognized core profession in the mental health field. They recognized that the Mental Health Counseling profession is still in its nascent stage until further refinements are completed. The Orlando Model Project is a major piece in the refining of the profession.

The Orlando Model Competency Based Standards Characteristics

In June 1994, the AMHCA Board of Directors approved a plan to initiate a free standing national organization to be guardian of the Orlando Model competency based standards. The new organization is the National Commission for Mental Health Counseling (NCMHC). The Commission has as its mission the promotion of the competency standards for training and clinical practice originated by the Orlando Model Project and the competency study covered in this book. The competency based standards of the National Commission for Mental Health Counseling for the pre-professional graduate education, internship, residency, and practitioner continuing education levels will have the following characteristics:

1. Competency based standards not educational accreditation standards.
2. Standards will be based on empirical study and be practical in nature.
3. Standards will be voluntary in nature.
4. Standards will address four levels of training:
   (1). Pre-professional graduate education - 60 graduate hours as prescribed by the CACREP Standards for Mental Health Counseling programs
   (2). Internship - 1000 hours of supervised counseling as prescribed by CACREP
   (3).Residency - 2 full years (2000 hours a year) of post-graduate supervised experience as required by most State Licensing Boards and the Academy
   (4). Continuing Education (20 hours of CEU's a year) as required by the Academy and most State Licensing Boards
5. Standards will be responsive to the "real world" of mental health counseling and not rooted in theoretical or idealistic models.
6. Standards will be practical, applied and practitioner oriented with an emphasis on trainees and practitioners at all levels having "hands on" experiences to reach the competencies identified.
7. Standards will be flexible and responsive to the market demand to insure that Mental Health Counseling is responsive to its constituents.
8. Standards will be easily adapted by non-traditional training programs which work with "adult learners" who come from lower socio-economic status, single parent families or from a diversity of ethnic, racial or national heritages.
9. Standards which insure that Mental Health Counselor training programs are not too expensive, complicated or unattractive to new candidates for training.
10. Standards which monitor the employment potential for mental health counselors and are responsive to the needs of the employers of these counselors.
11. Standards will cover specialty niches in Mental Health counseling such as: children with ADHD; multi-ethnic services; bi-lingual services; personality disorders; eating

disorders; substance abuse; geriatric services; chronic psychiatric services; people infected and affected with HIV and AIDS; survivors of sexual abuse; victims of crimes; victims of domestic violence; step-families and divorce issues, and the severely depressed.

Future Employment Sites for Mental Health Counselors

The Orlando Model Project in setting competency standards for Mental Health Counselors also designated where these newly trained counselors would fit into the mental health scene now that the era of the "solo practitioner" is coming to a close. What is replacing it is the HMO, managed care centers and managed care networks of clinicians who maintain private offices or who are part of a large interdisciplinary group practice. This new model will lower the anticipated income for clinicians and the Orlando Model Project was committed to establishing training and clinical practice standards which were responsive and reflective of the changing employment scene in the mental health field. For this reason the Orlando Model Project members believed that the Mental Health Counselors, who will complete the pre-professional graduate training, internship and residency outlined in its competency standards, will most probably be employed in the following settings:

1. HMO or managed mental health care centers
2. Large multi-disciplinary group practices
3. Public mental health Agencies
4. Psychiatric hospitals' inpatient or outpatient services
5. General hospitals' mental health clinical services
6. Prisons or other units of the correctional system at the local, state or national level
7. Court systems(Family Court, Divorce Services, Victim's Assistance etc.)
8. Churches or pastoral counseling centers
9. University or college counseling centers
10. Public and private schools(pre-school, elementary, middle and high schools)
11. Senior care and elderly service centers
12. Non-profit semi-public mental health agencies

The Orlando Model Project was a step in promoting a renewed vigor and enthusiasm for an 19 year old effort to establish quality competency based standards for mental health counselors' training and clinical practice.

Chapter 2

Mental Health Counseling in the 90's

Michael K. Altekruse
Thomas L. Sexton
University of Nevada, Las Vegas

Today there seems little doubt that counseling is successful in helping clients make the lasting personal changes they seek. The evidence accumulated over the last 40 years suggests that approximately 65% of clients make positive improvements as a result of the counseling process (Lambent & Bergin, 1993; Lambert, Shapiro, & Bergin, 1986; Whiston & Sexton, 1993). In addition, the research suggests that these changes are enduring (Bergin, 1971, Bergin & Garfield, 1994; Lambent, 1991). One of the primary aspects of counseling that can be attributed to these changes is the quality of the counseling relationship (Rogers, 1957; Orlinsky & Howard, 1986; Sexton & Whiston, 1994).

However, like most other aspects of culture, much of what we know about the process of counseling is changing. As a result, many of our cherished beliefs regarding what makes up effective counseling are being questioned. Consider a few examples. Many of us were trained to believe that to be understanding, genuine listeners in order to provide a nurturing environment was the quintessential picture of good counseling. Unfortunately, the present outcome research does not support the importance of these conditions, particularly when compared to others aspects of the counseling process (Beutler, Crago, & Arizmedi, 1986). Many of us also believe that more counseling is usually better. However, the research literature seems to suggest that our effectiveness is greatest around the eighth session, and that after six months almost seventy five percent of change has occurred (Orlinsky & Howard, 1986). Finally, many believe that the theoretical models from which we operate are an essential aspect of effective practice. Once again, there seems to be a substantial body of evidence that suggests that there is very little difference between approaches in terms of counseling outcome (Garfield & Bergin, 1986; Lambent, 1991; Whiston & Sexton, 1993). Instead it may be a set of "common factors" shared by all approaches that is the active ingredient in successful counseling. Unfortunately, as of yet

we do not know what those factors may be.

These sometimes confusing and certainly divergent reports have, if nothing else, placed the practice of mental health counseling under the microscope. It seems as if we can no longer assume that what we were taught in our graduate training programs necessarily leads to successful counseling. In addition, it seems that, considering the price of mental health care, our society may no longer be willing to accept rather vague claims regarding the success of counseling.

These trends pose an important challenge to the practice of mental health counseling. The future of the counseling profession may rest on an analysis of our practice and the development of training consistent with that analysis. The future of mental health counseling may very well be directly tied to an understanding of what comprises effective practice, what methods of practice fit into the changing landscape of our health care picture, and what models of intervention are consistent with these trends.

The Orlando Project

In 1991, a group of regional leaders of the American Mental Health Counselors Association (AMHCA) met to discuss the direction that AMHCA needs to take in order to meet the challenges of the future of counseling. From that meeting came the vision of a multi-faceted researched effort to identify these directions. This effort came to be known as the Orlando Project. This group formulated the Orlando Project with Jim Messina and Roberta Driscoll as co-chairs. The project was intended to focus on competency based training standards as an alternative to the educational standards promoted by such groups as CACREP. It was hoped that the findings of the Orlando effort would supplement the CACREP standards and encourage more mental health programs to seek CACREP accreditation.

Eight teams were selected to compose this multi-faceted research effort. The teams and titles of their tasks were:

Team 1: Competency Study
Team 2: Curriculum Design
Team 3: Managed Care Impact
Team 4: Credentialing Impact
Team 5: Trainer Attributes
Team 6: Political Realities
Team 7: Sub-specialty Standards
Team 8: Non-traditional Programs

The AMHCA Competency Survey

The first step in the Orlando project was the resurrection of a national survey to identify competencies necessary and important for the practice of mental health counseling. This survey was to become the primary focus of Team 1. This report is the preliminary analysis of a national survey of practicing mental health counselors. Surveys are the most common form of research to the general public. Surveys are commissioned by government, are carried out by business,

churches, professional organizations, schools, by anyone who wants to collect information. The major goal of a survey is to learn about the ideas, knowledge, feelings, opinions, attitudes, characteristics, and self reported skills of a defined population of people by directly asking them. In this case AMHCA asked the entire population of CCMHCs some questions to find out about them and their thoughts about what constitutes successful counseling.

Acceptable sample size varies greatly depending on the design of the survey and the population studied. The degree of homogeneity of the population studied greatly affects the acceptable rate of return. A homogeneous population is one where the members are similar to one another. In general, the greater the homogeneity, the smaller the return needed (Rossi, Wright. and Anderson, 1983). CCMHC's are considered a very homogeneous group. An examination of the respondents of this survey of the general CCMHC population shows very similar breakdowns in respect to age, sex, education, and employment.

There are a great number of reasons that people may not respond to a survey. Rosenthal and Rosnow's (1975) review of the literature shows that volunteers tend to be better educated, have higher social status, are more intelligent, have a greater need for social approval, and are more social than nonrespondents. We do not see these characteristics as being applicable other than being more social and having a higher need for social approval which can not be proven.

Is a 19% return good enough to generalize to the CCMHC population? Given the homogeneity of the population and the compared characteristics of the respondents, it probably is. However, CCMHC's may or may not be characteristic of the entire mental health counselor population or even of members of AMHCA. We caution the reader throughout the monograph concerning the sample size and the population studied. However, we also point out that other studies on the mental health population have similar results in some of the areas surveyed which would indicate that the results of this study may be pretty close to reality. This survey also allows us to gain a preliminary report on what it is that practicing mental health counselors actually do, what they believe is important, the degree to which they believe themselves competent in various areas of practice, and the source from which they may have gained those skills. In the final analysis, what practitioners believe to be important must be combined with other perspectives (the empirical research) in order to identify a core set of competencies.

Instruments: The AMHCA Competency Survey

In 1992, the President of AMHCA mailed a survey to 1500 Certified Clinical Mental Health Counselors from across the country. The survey took more than an hour to complete. The survey was constructed from three smaller surveys previously used by AMHCA and was compiled by a small group of AMHCA leaders. From the initial mailing, 284 completed returned surveys were collected (19%). From follow-up conversations with respondents, the length and cumbersome nature of the instrument were factors in the return rate.

The survey is composed of 316 questions regarding the perceived knowledge, skill, attitudes and trait competencies required of practicing mental health counselors. For each competency question, the respondent was asked the following: 1) Rate the importance of the

competency for mental health counselors, 2) Rate whether you believe that you have reached a desired level of competency, 3) What is the source of your competence?

Responses to these questions were made according to both Likert and forced choice scales. The importance question was rated according to a five point Likert scale: 0 (no importance), 1 (somewhat important), 2 (important), 3 (very important) to 4 (essential). If respondents believed they had not reached the desired level of competence in an area, they indicated that and did not rate a source for that competency. If the respondent believed they had reached a desired level of competency, they were asked to identify the source of their level of competency from among the following choices:

1. Formal education (a degree program)
2. Formal education (post degree program)
3. Continuing education (conferences, workshops)
4. Continuing education (institutes)
5. On the job experience
6. Supervision
7. Study groups
8. Independent study
9. Other

The questions contained in the AMHCA competency survey were divided into four main areas: 1. knowledge, 2. skill and abilities, 3. attitudes and styles, and 4. traits that are necessary for the mental health counselor. The questions were grouped into these categories by the survey authors. A review of the questions reveals that, at least on a surface level, the questions seem to have some degree of face validity. In the discussion section, we will provide a further analysis of the validity of the questions and survey categories.

The knowledge competency questions required the respondent to indicate the degree of knowledge needed by a mental health counselor in various areas. The survey was composed of 226 knowledge competency questions. The knowledge questions were further divided into 16 sub-areas that represented various distinct areas of mental health counselor knowledge. Each sub-area had varying numbers of questions.

Knowledge sub-areas	*# of questions*
1. Mental health counseling profession	5
2. Mental health care system	5
3. Clinical services	7
4. Theories in mental health counseling	23
5. Understanding abnormal behavior	14
6. Understanding models of intervention with individuals	31
7. Therapeutic and mood altering chemicals	15
8. Behavior medicine approaches	12

9. Small group interventions	18
10. Evaluation and research techniques	16
11. Assessment and appraisal processes	10
12. Community interventions	23
13. Identity, function and ethics	11
14. Mental health counseling in the larger context of human services	10
15. Supervision and management	12
16. Understanding theories of mental health intervention	15

The mental health counselor skill competencies required the respondent to indicate the level of **importance** of demonstrating acceptable levels of performance in various skill areas. There were fifty skill-related competency questions on the survey. The skill questions were divided into four sub-areas, each with varying numbers of questions.

Skill sub-area	*# of questions*
1. General skills and abilities	33
2. Skills and abilities related to the counseling profession	5
3. Skills and abilities related to the mental health care system	5
4. Skills and abilities related to clinical services	7

Both the attitude and style and trait competencies questions required the respondent to indicate the degree to which a mental health counselor should be able to demonstrate various traits. The survey was composed of 23 trait related questions. This area was not sub-divided. The attitude and style competencies area was composed of 16 different questions. Like the trait area, it was not subdivided. All of the questions, along with the average importance scores and sources, are contained in the Appendix .

Survey Respondents

The subjects for this study were Certified Clinical Mental Health Counselors. Certified Clinical Mental Health Counselors is a national certification granted by the Academy of Clinical Mental Health Counselors (the Academy), an independent non-profit corporation, which is now incorporated into the National Board for Certified Counselors (NBCC). The purpose of the Academy is to maintain a credentialing program for counselors who are specialists in the diagnosis, treatment, and prevention of mental and emotional disorders and in the promotion of optimal mental health.

To become certified by the Academy, a person, at the time of the study must have had:

1. A doctorate or masters degree in an allied mental health field from a regionally

accredited institution with at least two academic years and 45 semester hours of graduate work, or a doctorate or masters degree from a program approved by the Council for Accreditation of Counseling and Related Educational Programs (CACREP).

2. A minimum of two years post-masters experience in which there has been a minimum of 3000 hours of supervised clinical experience and 100 hours of face-to face supervision from a qualified clinical supervisor.
3. Demonstrate minimal clinical competence through Board approval of an audio or video tape sample and the applicant's critique of the sample.
4. A qualifying score on the Academy's certification examination, which is designed to assess knowledge of clinical mental health counseling