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Implementation of the 2009 CACREP Standards Addiction Competencies

Tiffany K. Lee
Western Michigan University

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IMPLEMENTATION OF THE 2009 CACREP STANDARDS
ADDICTION COMPETENCIES

by

Tiffany K. Lee

A Dissertation
Submitted to the
Faculty of The Graduate College
in partial fulfillment of the
requirements for the
Degree of Doctor of Philosophy
Department of Counselor Education and Counseling Psychology
Advisor: Gary Bischof, Ph.D.

Western Michigan University
Kalamazoo, Michigan
April 2011
Addiction issues have been and continue to be significant problems affecting the United States. Over the past few decades, substantial scholarly attention has been paid to the lack of addictions training in the counseling profession. The purposes of this mixed-method study were to examine the current status of addiction training among institutions that offer counselor education programs accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP) and determine how institutions plan to integrate the addiction-related competencies outlined in the 2009 CACREP standards.

The quantitative data were obtained from a 15-item online survey completed by 74 CACREP liaisons nationwide. The results indicate addiction training is taking place in the majority of CACREP programs. Over 70% of institutions offering CACREP programs are teaching content related to screening, diagnosis, counseling strategies, and prevention. This investigation also determined the perceived importance of addiction-related content areas by counseling program option. Twenty-eight percent of institutions in the sample require a course and 39% infuse the instruction in core courses. Almost 90% of institutions have at least one faculty member with addiction expertise, and 92% of addiction courses offered at these institutions are taught by an instructor with addiction expertise.
expertise. Moreover, despite the financial downturn in the economy and budget cuts within universities, many institutions have plans to add addiction courses, faculty with expertise, and the new Addiction Counseling program.

The qualitative findings resulted from phone interviews with five counselor educators who are also addictions experts. Five themes emerged from the interviews, including (1) the need for addiction training, (2) significant changes occurring in the field, (3) a critique of the 2009 CACREP standards, (4) best practice versus reality, and (5) further changes needed in the counseling profession. This investigation identified best practices related to (a) implementing the new addictions-related competencies, (b) the specific addictions content that should be taught to trainees, (c) course design, and (d) addictions course instructor qualifications. The qualitative findings are compared to the survey results. Implications for counselor training are offered and recommendations are made for the counselor education profession, as well as the addictions field.
ACKNOWLEDGMENTS

Several slogans used in addiction recovery were on my mind during the last four years. For instance, when I felt overwhelmed I found myself saying, “One day at a time,” “First things first,” “This too shall pass,” and “Progress, not perfection.” Also, the acronym related to self-care was one I had to take heed to frequently: “HALT- do not get too Hungry, Angry, Lonely, and Tired.” While the process was indeed stressful at times, the support I received from faculty, colleagues, family, and friends was undeniably the driving force for my ability to continue with, and be successful in, this program.

I would like to start by thanking the Counselor Education and Counseling Psychology Department faculty members for their guidance, instruction, and wisdom. In particular, thank you to Dr. Gary Bischof, my chair, for everything. Yes, everything. I would not be the person I am today without your unyielding support and devotion to my success as your advisee. Your honest, open, and prompt feedback for my professional work, as well as my personal concerns is so greatly treasured. Thank you for your kind words and humor (I will never look at Special K cereal the same way). I would like to thank Dr. Suzanne Hedstrom for her mentorship. Thank you for the invaluable knowledge gained in your College Teaching class and the wonderful co-teaching opportunity last year in Grand Rapids, as your teaching style is one I will continue to model in the future. (I am up to about 40 magazine pictures now by the way). Your smile is infectious, and I appreciate seeing it every time I see you. Thank you for always being
positive and uplifting. Students know you love what you do, and we love you for it.

Dr. C. Dennis Simpson, I have started and then erased five or so sentences thus far. I cannot find the words to express my gratitude. You have been a father to me over the past three years. So how would one begin to thank a father for being there for her? You believed in me, when I doubted myself. You go out of your way to say and do things that show you care about me, your students, your staff, your instructors, and this University. Thank you—for “THAT!”

My mother, Dalle, is the reason for my success in any endeavor. She has instilled in me the values of hard work, dedication, open-mindedness, and honesty. I can only hope to be the kind of mother, friend, and PERSON she is. You are amazing. In reference to your favorite poem, I cannot “count the ways” because I am sure there is a page limit here and I cannot count that high. So, simply put, I love you.

I would like to say thank you to my father, Jim, who passed away four years ago. He was a man who loved his children, family, and life. He had surgery for cancer on and off for almost thirty years, and he was the epitome of strength. I want to say thank you to him for vehemently and persistently trying to recover from both of his diseases. He was the best father he could be, with what he had, where he was. Miss you and love you dad.

Thank you to my other family members including my brother, two wonderful grandmothers, twenty-plus aunts and uncles, and thirty-plus cousins. Yes, I am FINALLY done with the “book,” and yes, I am FINALLY done with school.
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Last, but not least, Dr. Simpson recently reminded me to also “thank the trees.”

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CHAPTER I

INTRODUCTION

Addiction issues associated with substance use and other behaviors (e.g., gambling, sex, eating, shopping) have been and continue to be significant problems affecting the United States (Hagedorn, 2009; Harwood, Kowalski, & Ameen, 2004). The consequences resulting from drug and alcohol use, for example, have contributed to the societal cost of an estimated half a trillion dollars each year (National Institute for Drug Abuse [NIDA], 2008). The cost is not only to the nation, but communities, families, and the individual.

The Substance Abuse and Mental Health Services Administration (SAMHSA, 2008) found many Americans consume alcohol and illicit drugs on a regular basis. For example, 6.9% of Americans (aged 12 or older), or 17.3 million people, are considered heavy drinkers. According to SAMHSA, heavy drinking is defined as five or more alcoholic drinks on the same occasion on five or more days in the past month. In addition to alcohol consumption, 20 million Americans (aged 12 or older) used illicit drugs in the past month and this estimate represents 8% of the population. These statistics only indicate the frequency of alcohol or illicit drug use; albeit millions of these Americans could be also diagnosed as abusing or dependent on drugs or alcohol.

Behavioral addictions, or process addictions, are still being debated in the counseling field (Veatch & Hollander, 2008). Despite the differing opinions, researchers have found a high percentage of Americans are struggling with the harmful consequences
from continued engagement in these behaviors (Carnes, 2001; Hagedorn, 2009). For instance, 3 to 6 percent of the United States population has a sexual addiction (Carnes, 2001), and according to the *Diagnostic and Statistical Manual of Mental Disorders* (*4th* ed., text rev.; *DSM-IV-TR*), up to 3.4% of adults are pathological gamblers (American Psychiatric Association [APA], 2000).

Many factors are correlated with the misuse of chemicals and continued engagement in addictive behaviors despite the negative consequences. One of the main reasons Americans do so is to alleviate unpleasant emotional states including stress, conflict, fear, anxiety, depression, and boredom (Fields, 2010). According to Fields, these emotional states are frequently caused by the experience of traumatic events in the past. Chemicals and addictive behaviors are used to escape or “numb out” negative feelings (Hagedorn & Juhnke, 2005; Thombs, 2006).

People who self-medicate with chemicals due to mental health issues have the potential to develop a substance use problem, otherwise known as a co-occurring disorder. Conversely, substance use disorders have the potential to directly cause a co-occurring mental health condition, such as anxiety or depression (Merikangas et al., 1998). The propensity for self-medication to be linked to co-occurring disorders has been well-established (RachBeisal, Scott, & Dixon, 1999). Individuals who have any form of mental illness are 270% more likely to develop a substance abuse disorder than someone who does not have a mental illness (Doweiko, 2009). In fact, approximately five million people in the United States have a serious mental illness and a co-occurring substance use disorder (Center for Substance Abuse Treatment [CSAT], 2007). In addition, process
addictions are also reportedly correlated with chemical addictions (Hagedorn & Juhnke, 2005).

Each year millions of Americans seek treatment for mental health, substance use, and addictive disorders. In 2008, 30 million adults (aged 18 years or older), or 13.4% of the population, received mental health services (SAMHSA, 2008). SAMHSA found drug and alcohol use rates are higher among people who experience a serious mental illness, major depressive episode, and serious psychological distress. However, in regards to substance abuse treatment, services are not being provided to these populations. For example, among the 2.5 million adults with both a serious mental illness and a substance dependence or abuse (i.e., a co-occurring disorder) in 2008, 45.2% received only mental health care and 3.7 percent received only specialty substance use treatment (SAMHSA, 2008). Moreover, SAMHSA (2007) indicated that large national epidemiologic studies may not accurately reflect what is going on within the specific population. Due to the documented prevalence of co-occurring disorders, it is likely many of the 30 million individuals who were provided mental health services also had an undiagnosed co-occurring substance abuse disorder.

Currently, mental health services are provided by a variety of professionals. However, professional counselors (excluding addictions counselors) have the highest proportion of clients with a primary substance abuse diagnosis (20%) as compared to other helpers such as social workers (7%), psychologists (6%), and psychiatrists (3%) (Harwood, Kowalski, & Ameen, 2004). Another study conducted in mental health settings substantiates the notion that counselors are encountering a high number of clients
with co-occurring disorders. Sacks, Sacks, De Leon, Bernhardt, and Staines (1997) determined 20 to 50 percent of clients had a lifetime co-occurring substance use disorder, while 50 to 75 percent of clients in substance abuse treatment agencies had a lifetime co-occurring mental health disorder.

**Statement of Problem**

The pervasiveness of addiction issues in the mental health arena has caused several professions, such as psychiatry, nursing, social work, and psychology, to make recent advancements toward addressing the deficiency in addiction education in their respective fields (Keller & Dermatis, 1999). Over the past few decades, substantial scholarly attention has also been given to the lack of addictions training in the counseling profession. It has been strongly suggested counselor educators integrate this type of instruction and training into the curriculum for school counselors (Burrow-Sanchez, Lopez, & Slagle, 2008; Lambie & Rokutani, 2002), marriage and family therapists (Crespi & Rueckert, 2006), rehabilitation counselors (Ong, Lee, Cha, & Arokiasamy, 2008), and clinical mental health counselors (Glenn, 1999). In fact, faculty from counselor education programs accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP) propose addiction education is necessary for all counselors-in-training, regardless of their program specialty or area of concentration (Morgan, Toloczko, & Comly, 1997). Ninety-seven percent of faculty in the Morgan et al. study reported the need for preparation in this area. Yet for many years, it has been asserted that addiction instruction and training have been inadequate (McDermott, Tricker, & Farha, 1991; Morgan et al., 1997; Salyers, Ritchie, Luellen, &
Roseman, 2005; Toloczko, Morgan, Hall, Bruch, Mullane, & Walck, 1998; Whittinghill, Carroll, & Morgan, 2004).

Research completed in 1997 determined 30% of the counselor education programs required a course in addiction and 77% of the programs offered an elective course (Morgan et al., 1997). Thirty-one percent of the respondents stated their program had plans at that time to provide systematic, substance abuse training to all students, regardless of their specialty area. However, when the study was replicated in 2004, seven years later, there was no increase in the percentage of counselor education programs requiring an addiction course (i.e., remained at 30%) and only 50% of programs offered an elective course, which was a 27% decrease from the previous study (Whittinghill et al., 2004).

A study of institutions offering CACREP-accredited counselor education programs completed by Salyers et al. (2005) revealed more optimistic results for the inclusion of addiction training in two specializations, Mental Health Counseling and Community Counseling. Ninety-two percent of Mental Health Counseling programs and 83% of Community Counseling programs incorporated training into their instruction either as a separate, required addiction course or the training was infused into other courses. When respondents were asked whether addiction counseling should be strictly a specialty area, 61% indicated it should not be limited to a specialty area and all counselors-in-training should be educated on substance abuse and addiction-related issues. Since there was evidence supporting the idea all students should receive training, Salyers et al. presented two methods in which to accomplish this task. One
recommendation was to either establish a new core curricular area to the existing eight (e.g., Human Growth and Development, Group Work) and the other suggestion was to include substance abuse and addictions standards in all of the current eight common core areas. Ultimately, this relatively recent study revealed there is no consensus among counselor education program faculty in regards to how addictions training should be implemented (Salyers et al.).

Although there was no agreement as to how to implement addiction education, Salyers et al. (2005) still submitted a proposal as to when in students’ programs the training should be provided. These authors found a high percentage of students in both practicum and internship were providing services to clients with substance abuse issues. For instance, 71% of respondents reported between 11% and 50% of the practicum students’ clients had substance abuse problems and 18% of respondents indicated more than half of the practicum students’ clients faced these concerns. Since practicum students were in frequent contact with clients presenting with substance abuse problems, it was important to determine when addiction instruction was taking place. Salyers et al. discovered out of more than 25 counselor education courses which were listed, practicum and internship were the top two courses where substance abuse was most frequently addressed in counselor education curricula. This is clear evidence that while training may be occurring, it is not timely and it must be completed prior to providing services to clients.

**CACREP Standards and Addiction Competencies**

Since the 2001 CACREP standards, there has been a movement in counselor
education toward developing counselor competency to address clients' substance abuse and addiction issues. After extensive research in this field and substantial advocacy for change, CACREP released the new 2009 standards (CACREP, 2009a) and there were a multitude of additions and changes associated with substance abuse and addictive behavior training. The 2009 CACREP standards require all students, regardless of program option, to know the "theories and etiology of addictions and addictive behaviors, including strategies for prevention, intervention, and treatment" (CACREP, 2009a, p.10). In addition to having all counseling students gain knowledge about addiction and addictive behaviors, there is now a specialty program option called "Addiction Counseling," which has a separate set of competencies for counselors who wish to work with people engaging in substance abuse or process addictions. According to the 2009 CACREP glossary, process addictions are behaviors or activities which can be addictive, such as gambling, sex, and shopping.

Another significant addition in the 2009 CACREP standards related more specifically to drug and alcohol training, as opposed to all addictive behaviors, is the new program option called Clinical Mental Health Counseling (CMHC). The CMHC program is replacing two existing CACREP program options, Community Counseling and Mental Health Counseling. Clinical Mental Health (CMH) counselors have more expansive addiction training requirements than other CACREP program options, such as Career Counseling, School Counseling, and Marriage, Couple and Family counseling. A student who wishes to complete the CMHC program is expected to have competency in several areas of addiction knowledge and skills. The 2009 CACREP standards call for
CMHC programs to demonstrate evidence that student learning has occurred in six domains: (1) Foundations; (2) Counseling, Prevention, and Intervention; (3) Diversity and Advocacy; (4) Assessment; (5) Research and Evaluation; and (6) Diagnosis. This author noted four of the six domains directly acknowledge addictions-related competencies (see Table 1).

Table 1

*The CMHC Addiction-Related Competencies in the 2009 CACREP Standards*

<table>
<thead>
<tr>
<th>Domain</th>
<th>Standard</th>
<th>Competency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foundations</td>
<td>A.6</td>
<td>&quot;Recognizes the potential for substance use disorders to mimic and coexist with a variety of medical and psychological disorders&quot; (p. 29).</td>
</tr>
<tr>
<td>Counseling, Prevention, and Intervention</td>
<td>C.2</td>
<td>&quot;Knows the disease concept and etiology of addiction and co-occurring disorders&quot; (p. 30).</td>
</tr>
<tr>
<td></td>
<td>D.8</td>
<td>&quot;Provides appropriate counseling strategies when working with clients with addiction and co-occurring disorders&quot; (p. 31).</td>
</tr>
<tr>
<td>Assessments</td>
<td>G.4</td>
<td>&quot;Identifies standard screening and assessment instruments for substance use disorders and process addictions&quot; (p. 32).</td>
</tr>
<tr>
<td></td>
<td>H.3</td>
<td>&quot;Screens for addiction, aggression, and danger to self and/or others, as well as co-occurring mental disorders&quot; (p. 33).</td>
</tr>
<tr>
<td></td>
<td>K.2</td>
<td>&quot;Applies the assessment of a client’s stage of dependence, change, or recovery to determine the appropriate treatment modality and placement criteria within the continuum of care” (p. 33).</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>K.3</td>
<td>&quot;Knows the impact of co-occurring substance use disorders on medical and psychological disorders” (p. 34).</td>
</tr>
</tbody>
</table>
For years, Certified Clinical Mental Health Counselors, endorsed by the National Board of Certified Counselors (NBCC), have recognized the importance of obtaining competency in regards to addressing addiction concerns (Glenn, 1999). Although the 2009 CACREP standards for the CMHC program option indicate progress in the area of substance abuse and addictions training, there remains uncertainty regarding the non-prescriptive nature of these new competencies and how they may be implemented or integrated into existing curricula. The introduction section of the 2009 CACREP standards state the standards are not intended to discourage program innovation and programs can institute variations in how the standards can be met (CACREP, 2009a). In essence, accreditation standards are often descriptive enough to provide direction, but sufficiently vague to allow for creativity. However, this is based on the assumption that CMHC program faculty will have adequate expertise in a given area in order to integrate accreditation standards into curricula. Unfortunately, many institutions offering counselor education programs have a limited number of full-time faculty who have formal addiction training (Morgan et al, 1997; Toloczko, et al., 1998). Moreover, Toloczko et al. also noted that even fewer faculty hold substance abuse or addiction-related credentials or have membership in addiction affiliated organizations.

A review of the CACREP directory indicates over 200 institutions offer CACREP-accredited counselor education programs in Community Counseling and Mental Health Counseling exist nationwide (CACREP, 2009b). These institutions applying for accreditation as CACREP-accredited CMHC programs will need to require at least 60 credit hours by July 1st, 2013 (CACREP, 2009a). The transition to the 60-
credit hour CMHC program option may require significant curriculum changes, most notably for the 48-credit hour Community Counseling option. Due to the lack of faculty expertise in addiction counseling, integrating these new 2009 competencies into a CMHC program could potentially be difficult for some CACREP counselor education programs. Moreover, in the past, there has been a lack of consistency pertaining to the methods in which addiction education has been delivered to counselors-in-training (Salyers et al., 2005). For instance, some institutions have required students to complete an addictions course, while other institutions have addressed substance abuse and addictive behaviors in the core counseling courses (e.g., Human Growth and Development) or during practicum or internship. Previous research has also shown through analyses of course syllabi there were not only different methods of integrating it into the curriculum, but the addiction concepts being taught varied greatly among CACREP-accredited counselor education programs (Morgan et al., 1997).

Counselor education program faculty who wish to offer the new CMHC program option and seek CACREP accreditation must determine how to train and educate their students in the required addiction competencies identified in the 2009 CACREP standards. Problems may arise when attempting to integrate these new competencies into CMHC program curricula since there is no outline or framework from CACREP for faculty to follow and the area of training may be unfamiliar to faculty due to a lack of expertise in addiction counseling.

Another problem for counselor educators is the lack of research currently available examining the implementation of the CACREP standards. Taking into account
that now all students must be knowledgeable about the theories and etiology of addictions and addictive behaviors (CACREP, 2009a) and the Addiction Counseling and CMHC program options are also new to CACREP in 2009, research regarding the integration of addictions-related competencies into curricula has not yet been conducted. Information has yet to be obtained pertaining to how institutions offering CACREP-accredited, counselor education programs are implementing the CACREP standard changes, and the rationale for choosing the method(s) selected. For instance, if faculty choose to require a separate addiction course (in lieu of, or in addition to, integrating into existing curricula), research is needed to ascertain the following: (a) if the course had to be created or whether the course was already offered at the university, (b) course design, (c) curriculum components of the course, and (d) course goals and objectives. Due to the numerous addiction-related competencies in the new 2009 CACREP CMHC program standards, research would also be helpful to address the decision-making process of implementing these competencies. Investigating what would be considered "best practices" by counselor educators, especially those who have expertise in substance abuse and other addiction counseling, would provide valuable training information to other CACREP program faculty.

**Purpose of the Study**

The purposes of the study were to examine the current status of addiction training among institutions that offer CACREP-accredited counselor education programs and determine how these institutions will integrate the addiction-related competencies outlined in the 2009 CACREP standards. In addition, this study also obtained the
viewpoints of experts and other counselor educators in an effort to determine best practices in addiction training. The following are the research questions which guided the study:

(1) How is addiction training currently being taught in CACREP-accredited, counselor education programs?

   i. What specific aspects of addiction training are being taught in CACREP-accredited programs (e.g., etiologies, co-occurring disorders, psychopharmacology, prevention, intervention, treatment)?

   ii. Is completion of an addiction course required or is the training infused into one or more core courses?

   iii. Are the addiction courses offered as part of the counselor education department curricula or curricula of other university departments?

Determining how addiction is currently being taught helped ascertain what common practice is among the CACREP-accredited programs. This research updated statistics found in the past (e.g., Morgan et al., 1997; Salyers et al., 2005; Whittinghill et al., 2004) related to how addiction instruction is implemented (e.g., requiring a course or infusing into courses). In addition, research has shown curriculum components among addiction courses in CACREP programs differ greatly (Dawes-Diaz, 2007; Morgan et al., 1997). Due to the vagueness of the 2009 CACREP standards, continued program variation is inevitable. This research question helped discover the content areas of substance abuse
and addictive behavior education that are being taught to students in CACREP-accredited programs.

(2) How many CACREP-accredited program faculty have expertise in substance abuse/addictions counseling (e.g., experience in the field, completed research, hold credentials)?

i. Who is teaching addiction-related courses currently? (e.g., adjunct with expertise)

This question updated statistics obtained from past research (e.g., Toloczko, et al., 1998) that investigated the number of faculty members with expertise in addictions.

(3) How will programs change due to the 2009 CACREP standards?

i. Add new faculty with expertise in addictions?

ii. Add a required addictions course?

iii. Offer the Addiction Counseling program option?

This investigation will be the first to be identified which has ascertained the future program planning of CACREP-accredited programs as a response to the 2009 addiction-related standards.

(4) What do counselor educators view as “best practice” in the training of counselors?

i. What do CACREP-liaisons perceive as best practice? (e.g., methods of implementing the 2009 CACREP addiction competencies, necessary addiction-related content)

ii. What do counselor educators who are also experts in the
field of addictions view as best practice? (e.g., requiring a course or infusion, instructor qualifications, and pedagogical methods)

The 2009 CACREP standards not only address addiction training in one of the core competencies (e.g., Human Growth and Development core area) and in the CMHC program option, but an Addiction Counseling program option now exists. The purpose of obtaining expert opinions related to the 2009 CACREP standard changes regarding addiction instruction was three-fold. First, the interviewees provided an informal evaluation of the 2009 addiction-related standards. Second, the perspectives given by these experts may offer guidance in the implementation of the standards to institutions lacking faculty expertise. Third, the researcher was interested in determining if and how the opinions related to best practice in addictions instruction and education differ between experts and CACREP liaisons

Significance of the Study

In 2008, approximately 665,500 counselors were employed in the United States and 113,300 were mental health counselors (Bureau of Labor Statistics, 2008). Mental health counselors comprised the third largest specialty area after educational, vocational, and school counselors (i.e., 275,800 total) and rehabilitation counselors (i.e., 129,500 total). Counselor employment, including all counseling specialty areas, is projected to increase by 18% between 2008 and 2018. However, mental health counselors have a projected employment increase of 24%, which is the highest percentage among the counseling specialties. Substance abuse and behavioral disorder counselors rank second
with a projected 21% increase. According to the Bureau of Labor Statistics, the mental health counseling profession is growing at a much faster than average rate compared to other professions. Due to this expected employment increase, continued research in the professional preparation and training of counselors, in particular Clinical Mental Health (CMH) counselors, is needed in order to maintain accountability and promote excellence in the counseling discipline.

Prior research suggests CMH counselors should have substance abuse education and instruction as part of their training (Glenn, 1999). Over the last twenty years, specific addiction concepts have been identified as critical components to be included in the curriculum of master's level addiction counselors (Hosie, West, & Mackey, 1990; Klutschkowski & Troth, 1995; Page, Bailey, Barker, & Clawson, 1995; Von Steen, Vacc, & Strickland, 2002; Whittinghill, 2006). Recently, in 2009, CACREP released standards which now identify the specific addiction-related knowledge and skill student outcomes required for students who wish to pursue the CACREP-accredited Clinical Mental Health Counseling program option.

Existing CMHC programs are encouraged to move toward compliance with the most current criteria outlined in the 2009 CACREP standards (CACREP, 2009c). According to CACREP policy, the programs will be accountable for these required changes in their submission of a mid-cycle report due at the end of the fourth year of the accreditation cycle. The compliance requirements for CMHC programs, new or existing, include integrating the new addiction competencies into curricula.

The timeliness of this study is significant because the information gained will
provide guidance to CACREP-accredited programs, in particular at institutions that offer the CMHC program option. This research investigation determined the methods by which institutions that offer CACREP-accredited counselor education programs choose to integrate the new 2009 CACREP competencies and the curriculum components currently implemented. These findings can have significant implications for any future implementation of CACREP standards that require curricular changes in counselor education programs.

Another reason for completing this investigation is to provide new, up-to-date information to faculty of CACREP-accredited counselor education programs related to course design. A comprehensive review of the existing literature has not identified any studies that have been conducted in the past five years addressing the addiction-related curriculum components taught in CACREP programs and course design. Therefore, if faculty wish to integrate the new competencies by adding a stand-alone course, there is not an abundance of current literature to provide guidance for creating such a course.

Last, this study would be a contribution to the profession because of the proposed mixed-method design. No identified studies have been published as of yet which surveyed institutions offering CACREP-accredited programs to find how many institutions are currently offering or planning on offering the new Addiction Counseling and CMHC program options. No research in the last five years has been identified how many institutions offering CACREP-accredited programs (a) are offering or requiring one or more addiction course(s) and (b) have faculty with expertise, research interests, or membership in organizations related to addictions. The research will also include
questions regarding the level of importance for addictions-related training for different specialty options (e.g., School Counseling, Career Counseling, and Clinical Mental Health Counseling). No study has been identified in the literature which investigated faculty perceptions on the importance of this type of instruction by program option. In addition, the quantitative data will provide information on the specific addictions-related curriculum components (e.g., drug pharmacology, etiology, assessment, and treatment) taught to all students. Furthermore, it will be beneficial to determine how addiction course design and curricula have changed since the Morgan et al. (1997) study. This analysis will also provide guidance to counselor education programs that are in the process of implementing the 2009 CACREP competency requirements. Faculty from institutions lacking a high level of addiction expertise may benefit from learning how other counselor education programs are implementing the standards into syllabi.

A few studies have surveyed counselor educators’ perspectives related to substance abuse and addictions-related education (e.g., Morgan et al., 1997 and Salyers et al., 2005); however, there is an absence of literature which qualitatively explores the opinions of experts in the field of addictions who are also counselor educators. This study will be the first to be identified which has obtained qualitative data related to (a) the decision-making process for implementing the 2009 CACREP standards, (b) how experts view the new addiction competencies (e.g., necessary, insufficient, excessive), and (c) what these experts consider “best practice” for the addiction instruction of all counselors-in-training.
Definition of Terms

Addictive Behaviors - Impulsive and compulsive behaviors (e.g., gambling, shopping, eating, and substance use) which involve a lack of control, tolerance, and/or withdrawal. There is usually an increasing sense of tension or arousal before committing the act, often followed by gratification, pleasure, relief, and then remorse and guilt over the consequences of the behavior (Inaba & Cohen, 2007).

CACREP - The Council for Accreditation of Counseling and Related Educational Programs. An independent agency recognized by the Council for Higher Education Accreditation to accredit master's and doctoral degree programs in various counseling programs (e.g. career, clinical mental health, school). (www.cacrep.org)

Co-Occurring Disorder - A disorder involving one or more substance use disorder(s) and one or more mental health disorder(s), as defined by the Diagnostic and Statistical Manual of Mental Disorders-IV-TR (DSM IV-TR, American Psychiatric Association, 2000) (CSAT, 2007). Also referred to as “dual diagnosis” or “co-morbidity.”

Heavy Drinking - Consuming five or more alcoholic drinks on the same occasion on five or more days in the past month (SAMHSA, 2008).

Institution – A university or college offering one or more accredited CACREP program options. There can be more than one program option offered at an institution.

Process Addictions - Addictions to behaviors or actions, such as gambling, shopping, eating, or sexual activities (CACREP, 2009a).

Program – A counselor education program accredited by CACREP (e.g., School
Counseling, Addiction Counseling, Career Counseling, etc.). Also referred to as a program option, specialization or specialization option.

Substance Abuse - A maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to repeated use, such as failure to fulfill major role obligations at work, school, or home; legal problems; or social or interpersonal problems (DSM IV-TR, APA, 2000). No universal definition of substance abuse exists. For this study, the term “substance abuse” encompasses the DSM IV-TR definitions of abuse and dependency and should not be considered a synonym for the terms “use” or “misuse.”

Substance Dependence - A maladaptive pattern of substance use leading to clinically significant impairment or distress, including tolerance, withdrawal, and/or compulsive drug taking behavior (DSM IV-TR, APA, 2000). In this study, substance dependence and addiction will be used interchangeably.
CHAPTER II

LITERATURE REVIEW

The incidence of addiction in the United States has been noted and countless attempts have been made by the government to address this issue within the last century. The 18th amendment, or the prohibition of alcohol, in 1920 and the Marijuana Tax Act of 1937 are just two examples of laws passed with the intention of decreasing the negative effects of chemical dependency in this country. Substance use disorders have been linked to health problems, such as Hepatitis and Acquired Immune Deficiency Syndrome (AIDS); decreased productivity in the workplace; emergency room visits; criminal activity, including domestic violence, sexual assault, theft, and murder; homelessness; and mental health concerns, both pre-existing and substance-induced (Hart, Ksir, & Ray, 2009; Lowinson, Ruiz, Millman & Langrod, 2005).

Addictive behaviors (e.g., gambling, sex, eating, and shopping) have also come to the forefront of our society and counselors have seen an increase of these issues in their clients (Hagedorn, 2009). A relationship is shown between the prevalence of substance abuse and other addictive behaviors (e.g., sexual compulsivity and pathological gambling) (Grant & Potenza, 2005; Griffin-Shelley, Sandler, & Lees, 1992). Chemical dependency and addictive disorders are personal, familial, social, and cultural problems which affect millions of Americans. The counseling field has recognized these issues and the 2009 CACREP standards are a reflection of this acknowledgement. In this chapter, literature will be presented pertaining to the following areas: (a) addiction-related
competencies in counselor education, (b) the current state of addictions training in counselor education, (c) the 2009 Clinical Mental Health Counseling program addiction competencies, (d) the implementation options of the 2009 CACREP standards related to addiction, and (e) curriculum design for addictions training.

**Addiction Competencies in Counselor Education**

CACREP-accredited counselor education programs indicate to the public at large they have accepted and are fulfilling a commitment to educational quality (CACREP, 2009a). The accreditation process determines if and how well the standards are being met in program curricula. These standards are written to ensure students who graduate from CACREP programs develop a professional identity and master the knowledge and skills to practice effectively (CACREP). Since its inception in 1981, CACREP has created and revised standards that “reflect the needs of society, respect the diversity of instructional approaches and strategies, and encourage program improvement and best practices” (CACREP, 2008, Core values, para. 2). The most recent standards were released in July 2008 (CACREP, 2009a) and have some vast differences between the previous 2001 standards (CACREP, 2001). These differences included changes to entire programs, as well variations and additions to the student learning outcomes (i.e., competencies) within these programs. In the next section, an overview of the 2001 CACREP standards will be provided, followed by a synopsis of the new 2009 CACREP standards changes. Highlighted throughout these two sections will be the addiction-related competencies within the standards related to student learning outcomes.
2001 CACREP Standards

In 2001, there were eight master's-level counseling program options for which CACREP rendered accreditation based on demonstrated compliance with the CACREP standards (CACREP, 2001). These program options were: (1) Career; (2) College; (3) Community; (4) Gerontological; (5) Marital, Couple, and Family; (6) Mental Health; (7) School; and (8) Student Affairs. The Mental Health Counseling and Marital, Couple, and Family Counseling programs required a minimum of 60-semester credit hours and the other six programs were comprised of a minimum of two full academic years, defined as four semesters of at least 48-semester credit hours.

**Addictions in the core areas.** All students enrolled in these CACREP programs must have curricular experiences and demonstrated knowledge in eight common core areas (Professional Orientation and Ethical Practice, Social and Cultural Diversity, Human Growth and Development, Career Development, Helping Relationships, Group Work, Assessment, and Research and Program Evaluation). Each of the core areas lists required curricular components that CACREP programs are to teach all students, regardless of their program option. For example, all students are to learn about the “history and philosophy of the counseling profession, including significant factors and events” (CACREP, 2001, Standard K.1.a, p. 11).

Upon examination of the 2001 standards, it was found the term “substance abuse” was not mentioned in any of the curricular components within the eight core areas. However, in the Human Growth and Development Core Area of the standards, it indicates all students must have knowledge of “human behavior including an
understanding of developmental crises, disability, exceptional behavior, addictive behavior, psychopathology, and situational and environmental factors that affect both normal and abnormal behavior” (CACREP, 2001, Standard K.3.c, p. 12). Addictive behavior, by definition, encompasses drug and alcohol use (Hagedorn, 2009). Therefore, the assumption is all students are learning about addictive behaviors, with the possibility of substance abuse issues being addressed in the counselor education curriculum.

Although the standards included training in addictive behaviors, training in substance abuse may have been inadequate due to shortcomings with how it was denoted in the standards. First, the Human Growth and Development competency indicated above was the only place in the core area standards that addressed addictive behaviors. Moreover, in the one place it was listed, the term “addictive behavior” was one of six listed content areas of instruction (e.g., developmental crises, disability, exceptional behavior, and psychopathology). This lends itself to the decreased likelihood substance abuse training, in particular, was being provided to students.

Another potential weakness was simply the vagueness of language in the CACREP standards. Due to the debate surrounding the etiologies of addiction (e.g., moral, environmental, biological) and the criteria needed for a diagnosis of dependency, there has been controversy in how the term “addictive behaviors” is defined (Thombs, 2006). It is noted by the author of this study the 2001 and 2009 CACREP standards do not define the term in either Glossary section. This author found many working definitions for addictive behavior and research is contradictory in relation to what constitutes an addiction. For example, some authors state only chemical substances can
be categorized as addictive and the diagnosis for dependency cannot be applied to other behaviors. Schneider and Irons (2001) addressed this issue in detail by removing the physiological aspects of addiction (i.e., tolerance and withdrawal), and focusing on the behavioral components of dependency defined by the Diagnostic and Statistical Manual, fourth edition, text-revised ([DSM-IV-TR], American Psychological Association, 2000). Addictive behaviors include compulsivity, continuation despite adverse consequences, and obsession or preoccupation with the activity. Addictive behaviors, often called process addictions, can include gambling, sex, eating, shopping, television, exercise, the Internet, and video games (Hagedorn & Juhnke, 2005). This broad definition yields a wide range of curriculum content areas for counselor educators to have chosen from and substance abuse instruction may not have been one of them. According to the 2001 CACREP standards, counselor educators needed to train students on potentially numerous addictive behaviors. However, there was a lack of emphasis specifically devoted to substance abuse training. As research has indicated, instruction in this area has been inadequate in the past (Salyers et al., 2005; Toloczko et al., 1998; Whittinghill et al., 2004), and the problems identified above can be some of the reasons for the insufficient education.

**Addictions in program options.** In addition to the absence of the term “substance abuse” in the eight common core areas, another identified deficiency in the 2001 CACREP standards is the dearth of substance abuse competencies listed within the specialty program options. Of the eight CACREP-accredited program options, half of the programs listed a competency with the term “substance abuse” and these programs were:
(1) School Counseling, (2) Gerontological Counseling, (3) College Counseling, and (4) Student Affairs. The researcher took note that three of the four program options prepare counselors to serve a student population.

The School Counseling program was the only specialty option in the 2001 CACREP standards that specifically indicated a requirement for substance abuse training. Graduates from a CACREP-accredited School Counseling program are to know the “approaches to recognizing and assisting children and adolescents who may use alcohol or other drugs or who may reside in a home where substance abuse occurs” (CACREP, 2001, p. 51). This competency is unlike any other listed in the 2001 CACREP standards for a couple reasons. First, this competency is specifically related to substance abuse instruction (i.e., not encompassed under addictive behaviors). The standard is a stand-alone competency related to this area of training and it is not listed among numerous other curricular components (e.g., developmental crises, disability, exceptional behavior, and psychopathology). Secondly, it identifies the terms “alcohol” and “drugs.” These terms are not found anywhere else in the 2001 standards.

The Gerontological Counseling program option listed substance abuse directly in one of its competencies. However, it was not a stand-alone competency and it was listed among several other curricular components. Counselors trained to work with older persons were to have knowledge of conditions including “acute, chronic, and terminal illness; organic brain syndromes, including Alzheimer’s disease and related disorders; substance use and abuse; depression; suicide; and prescription medications and complications with polypharmacy” (CACREP, 2001, p. 39). Even though it was listed
among other curricular components, substance use and abuse instruction was to occur at some point during the preparation of gerontological counselors.

Substance abuse was also listed once in the College Counseling and Student Affairs program standards. It is noted the same CACREP (2001) competency was listed for both programs and it states that students must have:

knowledge of issues that may affect the development and functioning of college students (e.g., attention deficit hyperactivity disorder, sexual assault, various disabilities, eating disorders, substance abuse, stress) and the methods and procedures for coping with an/or deterring them and promoting healthful living (p. 34).

In the above competency, the term “substance abuse” was listed as one example among six other issues which college counselors and student affairs personnel may encounter with their students. Again, unlike in the School Counseling program, the College Counseling and Student Affairs programs did not list substance abuse as a stand-alone competency. Moreover, because substance abuse was listed as an example of the issues that could potentially affect their clients, this type of training may not have been addressed in the professional preparation of college counselors or student affairs personnel.

Of the eight program options CACREP provided accreditation to in 2001, two programs, Mental Health Counseling and Marital, Couple, and Family Counseling/Therapy, had one competency each addressing addictive behaviors. Mental Health Counseling students are to gain knowledge relative to the “general principles and practices of etiology, diagnosis, treatment, referral, and prevention of mental health and emotional disorders and dysfunctional behavior, including addictive behaviors”
(CACREP, 2001, p. 47). The competency in the Marital, Couple, and Family Counseling/Therapy program states students are to be able to identify "specific problems that impede family functioning, including issues related to socioeconomic disadvantage, discrimination and bias, addictive behaviors, person abuse, and interventions for their resolution" (CACREP, 2001, p. 43).

The remaining two specialty programs, Community Counseling and Career Counseling, had no established 2001 CACREP competencies citing "substance abuse" or "addictive behaviors." In summary, the School Counseling and Gerontological Counseling programs are the only specialty options that specifically indicate a requirement for substance abuse training. Consequently, there may have been a discrepancy in the extent of addiction training among students depending on their program of study.

The vague nature of the language in the 2001 CACREP standards and the absence of an addiction counseling specialty resulted in vast differences in how programs have taught substance abuse and addiction-related curricula (Morgan et al., 1997; Toloczko et al., 1998; Whittinghill et al., 2004). In light of these differences, several notable studies have been conducted in order to determine the necessary curriculum components in the preparation of master's level addiction counselors (Hosie, West, & Mackey, 1990; Klutschkowsi & Troth, 1995; Page et al., 1995; Von Steen et al., 2002; Whittinghill, 2006). Research has also been done to determine curriculum requirements for all counselors-in-training (Lawson & Lawson, 1990) due to the high probability they will come into contact with clients that have substance abuse disorders (Harwood et al.,
After extensive research in this field and the substantial advocacy for change, CACREP released the new 2009 standards in July 2008 and there were a multitude of additions and changes associated with addictions training in counselor education. The following section includes an overview of these changes.

2009 CACREP Standards

New Addiction Counseling program. The most significant change in the 2009 CACREP standards relative to addictions is the creation of the new Addiction Counseling program option. This 60-credit hour program will prepare students to work with persons who have addictive behaviors (CACREP, 2009a), which includes substance abuse and dependency. In addition to the counselor education students sharing in the required eight common core curricular experiences, which are outlined in Section II.G (CACREP, 2009a), faculty instructing in this specialty program must demonstrate student learning occurs in the following six domains: (1) Foundations; (2) Counseling, Prevention, and Intervention; (3) Diversity and Advocacy; (4) Assessment; (5) Research and Evaluation; and (6) Diagnosis.

Other program options. For those students who do not wish to work specifically with persons who have addictions, there are other program options to choose from: (1) Career; (2) Clinical Mental Health; (3) Marriage, Couple, and Family; (4) School; and (5) Student Affairs and College Counseling. The student learning outcomes for each of these program options also fall under one of the six domains which were listed above. Several notable changes were identified in the 2009 CACREP standards in regards to the program options offered for accreditation. These changes are worth mentioning. First, there is no
longer a Gerontological Counseling or a Community Counseling specialty option. Second, there is a new program option called Clinical Mental Health Counseling, which combined the previously offered Community and Mental Health Counseling programs. Third, the Student Affairs and College Counseling program options merged into one.

**Addictions as a stand-alone competency.** As in the 2001 CACREP standards, the 2009 CACREP Human Growth and Development common core curricular area lists a competency including the term “addictive behaviors.” However, in the new 2009 CACREP standards, “addictive behaviors” is no longer listed among numerous other curricular components (e.g., developmental crises, disabilities, and psychopathology). Instead, it is a stand-alone competency which requires all students, regardless of program, to know the “theories and etiology of addictions and addictive behaviors, including strategies for prevention, intervention, and treatment” (CACREP, 2009a, p.10). Again, substance abuse is not identified specifically as an area of instruction, but it is assumed that it falls under the umbrella of the term “addictions.”

**CMHC competencies.** The 2001 CACREP standards had no substance abuse-related competencies listed for the Community Counseling program option, and the Mental Health Counseling program option had one competency listing addictive behaviors, but not substance abuse. The new Clinical Mental Health Counseling (CMHC) program, which is replacing the two previously mentioned specialty options, has more expansive requirements in regards to substance abuse and addictions training. As stated earlier, the 2009 CACREP standards call for all specialty program options to demonstrate evidence that student learning has occurred in six domains: (1) Foundations;
(2) Counseling, Prevention, and Intervention; (3) Diversity and Advocacy; (4) Assessment; (5) Research and Evaluation; and (6) Diagnosis. In the CMHC program, addiction-related competencies are directly acknowledged in four of the six domains (see Table 1). Moreover, several of these competencies are skill-based (e.g., applies, provides, and screens) versus knowledge-based (e.g., knows or understands). One of the focal points of this study is on the integration of the addiction competencies listed in Table 1. Therefore, an in-depth overview of these seven CMHC program competencies will be provided in a later section of this literature review.

**Competencies in other programs.** In 2009, School Counseling is the only other program, besides the CMHC and Addiction Counseling program options, which identifies substance abuse directly in its competencies and it is virtually identical as the one listed in 2001. The competency is listed under the Assessment Domain and it states that students are to know “the signs and symptoms of substance abuse in children and adolescents, as well as the signs and symptoms of living in a home where substance abuse occurs” (CACREP, 2009a, p. 42).

Two other program options, Marriage, Couple and Family Counseling and Student Affairs and College Counseling, mention addictive behaviors, but they do not mention substance abuse directly. The Marriage, Couple and Family Counseling program has two competencies which list addictive behaviors among other curricular components (e.g., domestic violence, suicide risk, immigration, and trauma) and they are not stand-alone competencies (CACREP, 2009a). The Student Affairs and College Counseling program does identify addiction training in a stand-alone competency under
the Counseling, Prevention, and Intervention Domain. It states students in this particular program option are to know the “principles of addiction intervention, consultation, education, and outreach for students in postsecondary education” (CACREP, 2009a, p. 47).

There were two final observations noted among the 2009 CACREP standards related to substance abuse and addictions training. First, there is no mention of the terms “alcohol” and “drugs” throughout the standards. Addictive behaviors, or process addictions, are being recognized in the standards and students are to also learn about other addictions, besides chemical addiction. Second, the Career Counseling program option does not have any competencies specifically related to substance abuse, addictions, or addictive behavior. Therefore, besides the addiction-related content addressed in the Human Growth and Development core area, Career Counseling students are not required by CACREP to be provided any other addiction-related instruction during their program of study.

Definitions in the 2009 standards. In the previous section addressing the 2001 CACREP standards, the researcher noted the term “addictive behaviors” was not defined in either of the standards' glossaries. Moreover, the terms “substance abuse” or “addiction” are also not defined. The 2009 CACREP standards do, however, provide a definition for process addiction, which has been used when referring to addictive behaviors. CACREP defines a process addiction as an “addiction to a behavior or action, such as gambling, shopping, eating, or sexual activities” (CACREP, 2009a, p. 62). Faculty who are to integrate the instruction of addictive behaviors into their curricula, as
required by CACREP, can now use this definition to determine what to include in the training of addictive behaviors.

The differences between the 2001 and 2009 CACREP standards in relation to addiction instruction are evidence of the shift in counselor education. The need for substance abuse and addictive disorders training is being recognized due to the likelihood that counselors will encounter clients with these issues (Harwood et al., 2004).

Excluding the Addiction Counseling program option, out of the five remaining program options for which CACREP provides accreditation, the Clinical Mental Health Counseling program has the most student learning outcomes. These seven identified student competencies (listed in Table 1) can require major changes among some CACREP counseling programs nationwide.

**CMHC competencies and expected program changes.** A review of the CACREP directory indicates over 200 CACREP-accredited counselor education programs in Community Counseling and Mental Health Counseling currently exist nationwide (CACREP, 2009b). Provided they wish to continue their accreditation status, these programs will have to move to the new CMHC program by 2013. The transition to the 60-credit hour CMHC program may require significant curriculum changes, most notably for the 48-credit hour Community Counseling option. Due to the lack of faculty expertise in addiction counseling, integrating these new addiction-related competencies into a CMHC program could potentially be difficult for faculty at some institutions. Moreover, in the past, there has been a lack of consistency pertaining to the methods by which substance abuse and addictions education has been delivered to counselors-in-
training (Salyers et al., 2005).

To obtain an understanding of the current state of addiction training in counselor education, the next section will present information pertaining to the number of institutions offering or requiring addiction courses, and it will describe the perceptions of faculty and graduates related to this instruction. The data presented reflects the status of training among institutions before the new, 2009 edition of the CACREP standards was released.

**The State of Addictions Training in Counselor Education**

Researchers have investigated the presence of substance abuse and addiction-related instruction among counselor education programs for decades (Hosie, West, & Mackey, 1990; Klutschkowski & Troth, 1995; Whittinghill, 2006). The current state of addictions training will be reviewed and presented as follows: (1) addiction course offerings and requirements, (2) faculty expertise and perceptions pertaining to addiction-related instruction, and (3) the perceptions of current students and graduates regarding their addictions training.

**Addiction Course Offerings and Requirements**

Over the years, there has been a variation in the number of CACREP-accredited counselor education programs offering an addiction course as an elective; however, the number of programs requiring a course has remained approximately the same. In 1997, 21 out of 70 institutions offering CACREP-accredited programs (30%) were found to require one or more addiction courses (Morgan et al., 1997). More specifically, 19 of the 21 institutions required one course, one institution required two courses, and one
institution required three courses. Seventy-seven percent of institutions offered an elective in substance abuse/addictions and 73% of respondents stated they offer other required courses that cover some general issues of substance abuse/addictions. When asked about future plans for addiction training, 31% of program faculty intended to provide systematic, addictions-related training to all students, regardless of their specialty area (Morgan et al.). However, when the study was replicated seven years later, there was no increase in the percentage of counselor education programs requiring an addiction course (i.e., remained at 30%) and only 50% of institutions offered an elective course, which was a 27% decrease from the previous study (Whittinghill et al., 2004). However, a study completed one year later determined 84.5% of institutions that have CACREP-accredited programs offer an addiction course (Salyers et al., 2005), which is a 7.5% increase from the 1997 study (Morgan et al.). It is worth noting four studies, conducted over a ten year period, consistently found 30% of institutions that have counselor education programs require completion of an addiction course (Dawes-Diaz, 2007; Morgan et al.; Salyers et al.; Whittinghill et al.).

When looking at the various CACREP-accredited counselor education programs individually, some program options include more addiction training than others. For instance, a study by Salyers et al. (2005) found 92% of Mental Health Counseling programs and 83% of Community Counseling programs incorporated training into their instruction either as a separate addiction course or the training was infused into other courses. Even though there were no CACREP competencies addressing substance abuse or addictive behaviors in the Community Counseling program, faculty in 83% of these
programs still incorporated it into their curricula.

Substance abuse and addiction-related training in CACREP-accredited programs has also been offered as a specialty degree. In 2004, 25 out of 89 CACREP-accredited program liaisons indicated they offered a master’s degree in substance abuse/addictions counseling even though there were no standards established at that time (Whittinghill et al., 2004). When asked if their program faculty would consider adding a substance abuse program if CACREP created standards, the majority of those indicating interest in obtaining accreditation for a substance abuse counseling program were participants from institutions which currently provide a master’s degree in substance abuse. According to Whittinghill et al., it is presumed by faculty that by gaining accreditation, it would add credibility and visibility to their programs. In 2009, the CACREP board created student learning outcomes (i.e., competencies) for a new specialty program option, Addiction Counseling. There is yet to be research identified by this author indicating how many institutions will offer, or have plans to offer, this Addiction Counseling program in the future. In order to create such a program option, institutions would need faculty with expertise and hold a positive perception of implementing such a specialization option.

**Expertise and Perceptions of Faculty**

In 1997, 58% of respondents from a study of CACREP-accredited programs reported having faculty with prior formal addiction education, and 11% of faculty had membership in an addictions-affiliated organization (Morgan et al., 1997). The survey data provided by the Morgan et al. (1997) also indicated 20% of institutions used part-time faculty to teach their addiction courses.
While institutions may not have an overabundance of faculty with expertise in addiction counseling, counselor educators hold the opinion that addiction training is important. In fact, 97% of faculty from institutions that offer CACREP-accredited counselor education programs indicated substance abuse and addictions training were necessary (Morgan et al., 1997). Thirty-one percent of respondents in the Salyers et al. (2005) study reported more than half of their graduates work with clients presenting with substance abuse issues and therefore, it must be integrated into the curricula. Due to the prevalence of clients presenting with addiction issues within this profession, it has been strongly suggested CACREP adopt specific competencies regarding addiction knowledge and skills within the standards (Salyers et al.; Whittinghill et al., 2004). Even though faculty perceive a necessity for CACREP to adopt addiction competencies, there has been shown to be a lack of consensus among counselor education program faculty in regards to how this training should be implemented (Salyers et al.).

According to faculty, a high percentage of students in both practicum and internship are providing services to clients with addiction issues. For instance, 71% of faculty report between 11% and 50% of the practicum students' clients had substance abuse problems and 18% of respondents indicated more than half of the practicum students' clients faced these concerns (Salyers et al., 2005). Since students are in frequent contact with clients presenting with substance abuse problems, the need for addiction instruction to take place before students are providing services is warranted. Out of more than 25 counselor education courses which were listed in the Salyers et al. study, practicum and internship were the top two courses where addiction was most frequently
addressed in counselor education curricula. This is clear evidence that while training may be occurring, it is not timely and it must be completed prior to providing services to clients.

Another aspect of the Salyers et al. (2005) study worth noting is even though 97% of faculty indicated addiction instruction was necessary, most respondents identified substance abuse counseling as a specialty within mental health counseling (73.6%). Moreover, some faculty indicated it is a separate profession overlapping with mental health counseling (21.8%) (Salyers et al.). The 2009 CACREP standards reflect this faculty opinion. For example, there is a difference in the number of competencies addressing addiction among the various specialty program options. Excluding the new Addiction Counseling specialty, the Clinical Mental Health program option has the highest number of counselor competencies referring to substance abuse and addictive behaviors.

Perceptions of Graduates

Graduates of counselor education programs are not satisfied with the addiction training they received in their master’s program (Dawes-Diaz, 2007). Almost 24% of graduates indicated their institution did not offer an addictions course and 14% denoted substance abuse and addiction-related instruction was not addressed at all during their training. When asked what specific addiction concepts were addressed, many students did not receive training in several areas. For example, between 23% and 31% of graduates specified they had no training in areas such as pharmacology (30.5%), etiologies (29.5%), criteria for referral (26.5%), screening (25.5%), and assessment and
diagnosis (23.6%). Moreover, 33.2% of students in this study reported 40% or more of their clients presented with these types of issues during their practicum and internship experiences. Not only does research indicate counselors-in-training need more education in substance abuse and addictions while enrolled in counselor education programs, but 81% of graduates highly recommend one or more required addiction courses (Dawes-Diaz, 2007).

One last aspect worth mentioning regarding addiction training is the continued education after the master’s degree. Professional counselors, who hold membership in various counseling organizations (i.e., American Counseling Association, National Board of Certified Counselors, and American Mental Health Counselors Association), were asked about their training during and after their graduate degree education. Forty-nine percent of professional counselors had some type of formal substance abuse training in their coursework (Harwood et al., 2004). However, continuing education/professional development, including seminars and workshops, was shown to be the primary method by which these practitioners received substance abuse training. For example, in the past year, 27% of professional counselors had 1-9 hours of continuing education/professional development in substance abuse, 23% had 10-29 hours, and 24% had 30 or more hours. In summary, three-fourths of respondents participated in seminars and workshops during the past year, while 26% of professional counselors had no continuing education related to substance abuse. These numbers indicate counselor interest for post-master’s addiction education and suggest a deficiency in addiction training in the past.

While professional counselors are obtaining continuing education in addictions,
researchers suggest Clinical Mental Health counselors should have addictions-related education and instruction as part of their training (Glenn, 1999). As noted above, CACREP released standards in 2009 that now identify the specific substance abuse and addictive disorder knowledge and skill student outcomes required for students who wish to pursue the Clinical Mental Health Counseling program option (see Table 1). The next section provides information related to these new standards.

**The 2009 Clinical Mental Health Counseling Addiction Competencies**

The compliance requirements for CMHC programs include integrating the new addiction competencies into curricula. The main addiction-related content areas embedded within the Human Growth and Development core area standard and the CMHC addiction competencies were identified by this author. The content areas are: theories, etiology, the disease concept, prevention, intervention, screening and assessment, co-occurring disorders, treatment modalities, continuum of care, and counseling strategies. These areas are to be part of the knowledge and skills CMHC students are to obtain during their training and, therefore, will become necessary topics of instruction in the curricula of CMHC programs. The subsequent sections briefly describe and summarize each of the main content areas according to research in the addictions field.

**Theories, Etiology and the Disease Concept**

CMHC faculty must provide instruction pertaining to the causes of addiction and co-occurring disorders, as outlined in the Counseling, Prevention, and Intervention domain (CACREP, 2009b). All etiologic theories attempt to identify and explain factors
that classify persons and populations at risk for addiction (Fisher & Harrison, 2000).

Diverse strategies for prevention and intervention exist due to the various philosophical underpinnings of the theories. The main etiological schools of thought are the moral model, social and psychological models, family and genetic models, and the disease concept (Capuzzi & Stauffer, 2008). A brief synopsis of the disease concept is provided because (a) it is a widely accepted model (Fisher & Harrison, 2000), and (b) the 2009 standards specifically call for knowledge of this theory (CACREP, 2009b).

The disease concept follows the medical model and posits addiction as an inherited disease that chemically alters the body in such a way that the individual is permanently ill at a genetic level (Jellinek, 1960). According to Jellinek, this disease is progressive and maturates in a manner that cannot be reversed. As a result, an individual cannot go from the middle stage (e.g., a loss of control) to the early stage (e.g., an increased tolerance). The disease concept views addiction as a primary, permanent, predictable, and progressive illness that can be prevented and treated (Jellinek, 1960).

Symptoms related to these aspects are delineated in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; DSM-IV-TR; American Psychiatric Association [APA], 2000) criteria to diagnose addiction. If a client who meets or has met the *DSM-IV-TR* (APA, 2000) criteria for dependence and has no symptoms “present for at least one month” (p.195), then he or she is not cured but “in remission.” Thus, it appears the *DSM-IV-TR* (APA, 2000) supports the use of the medical model, or the disease concept put forth by Jellinek (1960).

Critics of the disease concept highlight several flaws including how “disease” is
defined, Jellinek's weak research design, the lack of attention to environmental factors, and the absence of a genetic link to addiction (Doweiko, 2009). Additionally, fundamental aspects of this model (e.g., loss of control, permanence, and progression) have been called into question over the years (Dowiko, 2009). In response, multicausal models are emerging and gaining attention because they acknowledge the interaction of the drug, person, and environment (Capuzzi & Stauffer, 2008).

**Prevention and Intervention**

Prevention strategies can target (a) an entire population (i.e., universal prevention), (b) a subset of the population at risk for addiction (i.e., selected prevention), or (c) individuals who have behaviorally demonstrated the potential for addiction (i.e., indicated prevention) (Fisher & Harrison, 2000). These strategies assist in avoiding the initiation of use (i.e., primary prevention) as well as stopping the use of substances or addictive behavior before dependency starts (i.e., secondary prevention). Court-diversion programs and addictions treatment programs are examples of the last type of strategy, otherwise known as relapse prevention or tertiary prevention (Finn, 2008). These strategies correspond with the different prevention classifications that exist in the United States. Examples of the classifications include: educational methods in schools; the development of alternative activities; problem identification and referral; and environmental approaches that address the laws, codes, and attitudes for the distribution and consumption of substances (Finn, 2008).

Many mental health programs apply the Risk and Protective Factor model developed by Hawkins, Catalano, and Miller (1992) as a means of prevention. The
model addresses the social and cultural factors (e.g., laws, normative expectations) and individual/interpersonal factors (e.g., physiology, family, behavior) which are correlated with addiction. If students learn how to identify risk factors, enhance protective factors, and implement appropriate prevention strategies, the need for intensive counseling interventions may be reduced.

Intervention approaches vary from court-mandated treatment to motivational interventions (Fisher & Harrison, 2000). Fisher and Harrison (2000) outline the effectiveness of coercive and confrontational models, as well as approaches that work through client ambivalence and resistance. If intervention is deemed necessary, client variables will dictate which specific approach to employ. These variables are discussed later in the counseling strategies section.

Screening and Assessment

The 2009 CACREP standards require CMHC students to identify screening and assessment instruments for substance use disorders and process addictions. Exposure to the DSM-IV-TR (APA, 2000) criteria for substance use is fundamental, but trainees should also identify instruments frequently used by addictions counselors such as the: (1) Substance Abuse Subtle Screening Inventory (SASSI), (2) Michigan Alcoholism Screening Test (MAST), (3) Beck Depression Inventory (BDI), (4) Minnesota Multiphasic Personality Inventory-2 (MMPI-2), and (5) Addiction Severity Index (ASI) (Juhnke, Vacc, Curtis, Coll, & Paredes, 2003).

Screening and assessment methods for addictive behaviors are emerging in the helping professions (Donovan & Marlatt, 2005). Researchers propose the application of
the *DSM-IV-TR* (APA, 2000) chemical dependency criteria to addictive behavior and some counselor educators suggest a new *DSM* diagnosis for addictive behaviors with various subtypes (Hagedorn, 2009). Whether for substance use or behavioral addictions, screening and assessment can potentially oversimplify clients' presenting concerns and fall short in understanding addiction as a complex problem. Therefore, trainees are encouraged to approach these processes from a holistic perspective considering the clients' worldview (Lewis, Dana, & Blevins, 2002).

**Co-Occurring Disorders**

CMHC programs must provide instruction on co-occurring disorders (CODs), also referred to as dual diagnosis or co-morbidity. Trainees are to “[recognize] the potential for substance use disorders to mimic and coexist with a variety of medical and psychological disorders” (CACREP, 2009b, p. 29) and “[know] the impact of co-occurring substance use disorders on medical and psychological disorders” (CACREP, p. 34). Clients are considered to have CODs if they have one or more substance use disorder(s) with one or more mental health disorder(s). According to Inaba and Cohen (2007), the mental health conditions most often diagnosed as part of CODs fall into two categories: pre-existing and substance-induced. Examples of pre-existing mental disorders are thought disorders (e.g., schizophrenia), mood disorders (e.g., bipolar disorder), and anxiety disorders (e.g., obsessive-compulsive disorder). Unlike pre-existing disorders, substance-induced disorders result from chemical use and usually disappear after a period of abstinence, while the damages can last for a lifetime (Inaba & Cohen, 2007).
Due to the prevalence of CODs, all individuals presenting for treatment should be screened for CODs (Sacks, 2008). The screening process for CODs attempts to answer the question: "Does the client with a substance abuse [or mental] disorder show signs of a possible mental [or substance abuse disorder]?" (Sacks, 2008, p. 9). The main screening instruments for CODs are the Global Appraisal of Individual Needs (GAIN), Psychiatric Diagnostic Screening Questionnaire (PDSQ), Behavior and Symptom Identification Scale (BASIS-24), and Centre for Addiction and Mental Health-Concurrent Disorders Screener (CAMH-CDS) (Peters, Bartoi, & Sherman, 2008; Sacks, 2008). Last, research has shown a relationship between the prevalence of substance abuse and other addictive behaviors as well (e.g., sexual compulsivity, pathological gambling) (Grant & Potenza, 2005; Griffin-Shelley, Sandler, & Lees, 1992). Therefore, counselors commonly discover clients have multiple addictions and/or maladaptive behavioral patterns even though they may not be classified as having a COD.

**Treatment Modalities and the Continuum of Care**

After screening and assessment, CMHC trainees are expected to "[apply] the assessment of a client's stage of dependence, change, or recovery to determine the appropriate treatment modality" (CACREP, 2009b, p. 33). Identifying the treatment modality suitable for a client along the continuum of care is based on criteria gathered during the assessment process. Assessment criteria developed by the American Society of Addiction Medicine (ASAM) are widely used today (Mee-Lee, Shulman, Fishman, Gastfriend, & Griffith, 2001). The assessment dimensions are: (1) acute intoxication-withdrawal potential (i.e., whether medical detoxification is necessary), (2) biomedical...
conditions and complications, (3) emotional and behavioral conditions and complications, (4) treatment acceptance and resistance, (5) relapse-continued use potential, and (6) recovery environment (Mee-Lee et al., 2001). Trainees must also know the available community resources so they can refer a client to the appropriate treatment modality along the continuum of care based on the ASAM criteria (Johnson, 2003).

The continuum of care offers the greatest likelihood of engaging people at different points in their lives depending on their needs, their resources, and the severity of their addiction problem (Deitch, Koutsenok, & Marsolais, 2005). For clients experiencing withdrawal from drugs such as alcohol and benzodiazepines, detoxification may be appropriate. Detoxification is a medically monitored, intensive, inpatient program for clients whose physical functioning is compromised due to the toxicity of the withdrawals, and requires 24-hour skilled observation (Fisher & Harrison, 2000).

Residential treatment programs are highly structured and can be short-term (3-6 weeks) or long-term (6-18 months) (Deitch et al., 2005). Halfway houses provide a transitional living facility for clients lacking a stable, social support system and for those needing an intermediate step between inpatient treatment and independent living (Doweiko, 2009).

Outpatient modalities tend to be short-term (up to 6 months) and consist of one or two weekly group therapy sessions. Intensive outpatient programs (IOP) meet more frequently (2-6 days weekly) and have no time limit. Day care treatment is a “9 to 5” program, meets up to six days weekly, and is the step down from inpatient or residential treatment (Deitch et al., 2005). Finally, aftercare programs are for clients who have completed an inpatient, IOP, or outpatient program and consist of group counseling once
per week or 12-step meetings (Fisher & Harrison, 2000).

**Counseling Strategies**

CMHC students will “[provide] appropriate counseling strategies when working with clients with addiction and co-occurring disorders” (CACREP, 2009b, p. 31). Empirically supported therapies for addiction include contingency management, cognitive-behavioral approaches, family counseling, twelve-step facilitation treatment, and community reinforcement approaches (Carroll, 2005; Fiellin, Reid, & O’Connor, 2000; Moos, 2007).

Up to 50-60% of clients are unaware of their addiction problems when they enter counseling (Prochaska & Norcross, 2001). Action-oriented counseling strategies are premature if clients are not motivated or committed to change (Miller & Rollnick, 2002). Thus, motivational strategies, such as Motivational Enhancement Therapy (MET; Miller, 1995), are found to be effective when treating addictions (Burke, Arkowitz, & Dunn, 2002).

MET is based on the Stages of Change Model (Prochaska & Norcross, 2001) and grounded in Motivational Interviewing (MI; Miller & Rollnick, 2002). MI is a “method of communication rather than a set of techniques” (Miller & Rollnick, 2002, p. 25). Instead of telling clients how to change or prescribing skills, MI evokes ideas from them as to how change might occur. Counselors “roll with the resistance” and view ambivalence as normal, not pathological. MI was originally used in treatment preparation because of its effective strategies for managing the resistance and ambivalence in clients presenting in the precontemplation or contemplation stages.
However, MI is also helpful as an adjunct or integrated strategy (Miller & Rollnick, 2002).

Counselors use a variety of approaches to treat addiction problems and divergent opinions exist regarding the best strategies to employ (Lewis et al., 2002). Regardless of the treatment strategy, Lewis et al. suggest counselors (1) use a respectful and positive approach, (2) view addiction on a continuum from non-problematic to problematic, (3) provide individualized treatment, (4) provide multi-dimensional treatment focusing on social and environmental aspects, (5) remain open to new methods and goals as research findings become available, and (6) use a multicultural perspective to meet the needs of diverse populations.

The addiction concepts embedded within the Human Growth and Development core standard and the CMHC program competencies indicate the depth and breadth of knowledge and skill that CMHC students will obtain during their training. The next section presents an overview of three methods that can be used when implementing the addictions-related competencies into curricula.

**Implementation Options of the CACREP Standards Related to Addiction**

Counselor education faculty have been asked whether substance abuse or addiction counseling should be strictly a specialty area. In the Salyers et al. (2005) study, 61% of faculty indicated it should not be limited to a specialty program option and all counselors-in-training should be educated on substance abuse issues. The 2009 CACREP standards reflect both sentiments. There is not only a new Addiction Counseling specialty program option available, but there is also a required addiction-related
competency listed under the Human Growth and Development Core. All counselor education students are to gain knowledge about the theories and etiology of addictions and addictive behaviors as well as prevention, intervention and treatment strategies (CACREP, 2009a). In addition to this competency, CMHC students are to gain more knowledge and skills regarding addictions education than their peers enrolled in other CACREP-accredited counseling programs. Program faculty must ensure that all curricular changes designed to meet accreditation standards are required coursework for all CMHC students. Otherwise, there is a potential that some CMHC students may not be exposed to all relevant accreditation standards. Essentially, there are three methods of implementing the addiction-related competencies into the CMHC program curriculum: (1) infusion, (2) stand-alone course(s), and (3) combined.

**Infusion**

The infusion method involves faculty incorporating relevant addictions standards into existing curricula required of all CMHC students. In other words, rather than creating new courses, faculty may decide to revise current courses to reflect the new standards. For example, CMHC programs that choose to *infuse* standard A.6 of the CMHC program standards (see Table 1) may add a course objective, weekly reading, and course assignment (e.g. field trip to a local clinical mental health agency) to their Foundations of Clinical Mental Health Counseling course. This method is particularly appealing for programs already requiring 60 credit hours and programs that already have coursework in addictions. Fortunately, such changes rarely require programs to undergo the often rigorous review of curriculum revisions at the department, college, and
university levels. On the other hand, program faculty must be intentional in selecting which courses will cover specific standards in the most effective way. This process requires building faculty consensus, and thus, brings its own set of challenges.

There is a dearth of literature regarding the methods for implementing new substance abuse competencies into counselor education curricula. As a result, this author reviewed research pertaining to other areas of instruction where CACREP-accreditation standards have been met through the infusion method. Briggs and Rayle (2005) suggested incorporating instruction on spirituality as part of the core counseling courses and provided a framework to demonstrate where and how to do so. The authors outlined how faculty can infuse spirituality into the curricula of the various core counseling areas (e.g., Social and Cultural Diversity, Helping Relationships, etc). This was based on the 2001 CACREP standards which identified one student outcome in the Foundations domain (CACREP, 2001). The student outcome listed “religious and spiritual beliefs” among many other issues and this outcome was identified in many of the counseling program options (e.g., Career, College, Community, Student Affairs, etc.). It is worth noting the 2001 standards did not list any competencies specific to, or solely addressing, spirituality and/or religious issues in counselor education.

The infusion method has also been proposed for the 2009 CACREP standards which relate to disaster, trauma, and crisis counseling. Webber and Mascari (2009) outlined the new competencies identified in the core curricular areas (e.g., Professional Orientation and Ethical Practice, Helping Relationships), as well as the competencies identified by program option (e.g., Addiction Counseling, Career Counseling, Clinical
Mental Health Counseling). These authors discussed the implications for these new standards due to the likelihood that counselor educators and professionals may be unfamiliar with this growing specialty. Thus, counselor educators will need to become well-versed in the theory and practice of traumatology, crisis intervention, and emergency preparedness in an effort to infuse the new standards into program objectives and syllabi.

If choosing the infusion method, Webber and Mascari (2009) provided six guidelines to assist with infusing standards and these can be applied to the new addiction competencies. For instance, faculty should (1) know the organizations and government agencies and their purposes, (2) understand the major principles of this area, (3) insure that students understand their ethical responsibility to practice this type of counseling only to the extent of their competence, (4) develop knowledge and practice competencies in this area if faculty plan to teach this specialty in classes, (5) establish relationships with credentialed specialists with field experience who are willing to be guest trainers for specialized course components, and (6) recognize this is a growing specialty that needs research to ensure outcome based practices.

**Stand-Alone Course(s)**

The stand-alone course(s) method permits faculty to meet accreditation standards by creating a new course or partnering with other university departments already offering addictions coursework. The stand-alone course(s) method may be appealing to 48-credit hour Community Counseling programs transitioning to the new 60-credit hour CMHC program. Such programs have some flexibility with the courses they wish to require as
part of the new program. This method does not always entail the creation of a new course. In some cases, programs may develop partnerships with other university departments that already offer addictions coursework. These partnerships require counselor education faculty to communicate the relevant CACREP standards that are expected to be met through stand-alone courses.

**Combined**

The combined method involves some elements of the infusion and stand-alone course(s) methods. Program faculty who choose this method are likely to create at least one stand-alone addictions course, while also integrating some standards into existing courses.

Researchers have addressed the multiplicity of methods CACREP programs use to implement the standards. For example, Pieterse, Evans, Risner-Butner, Collins and Mason (2009) discuss how faculty incorporate multicultural competencies into counselor training. Infusion has been described as the most effective method; however, the stand-alone course approach remains the dominant approach (Pieterse et al., 2009). Time, cost, and feasibility are aspects that make infusion very practical for many programs. On the other hand, some empirical support exists for the stand-alone course(s) method related to addiction training. Carroll (2000) found completion of at least a three credit-hour addiction course increases the likelihood counseling students can appropriately screen, assess, treat, and refer out according to clients’ needs. Moreover, 70% of these students were more inclined to identify the addiction as the principle issue and more likely to treat the addiction problem or refer out for addiction counseling (Caroll, 2000).
Some critics may suggest that addictions training can be adequately addressed through conference workshops or continuing education, thereby negating the importance of a stand-alone course. A study by McDermott, Tricker, and Farha (1991) indicated otherwise. McDermott et al. (1991) found limited exposure to addiction training, such as a three-hour workshop, does not significantly improve students' ability to address addiction and suggested at least the completion of one semester-long course. However, a study conducted 13 years later (Harwood et al., 2004) found the majority of professional counselors actually attend more than three hours of continuing education related to addictions. Three-fourths of the professional counselors in the study participated in addiction-related seminars and workshops during the past year. Almost half had more than 10 hours of continuing education. In fact, 27% of respondents had 1-9 hours; 23% had 10-29 hours; and 24% had 30 or more hours (Harwood et al., 2004). While the Harwood et al. study does not advocate for a particular implementation method, it indicates counselor interest for post-master's addiction education and suggests a deficiency in addiction training in the past.

In summary, there are pros and cons to any one of the three aforementioned methods. CACREP does not prescribe how programs implement the standards. Therefore, factors such as time, cost, available resources, and faculty expertise, agreement, and perceptions will inevitably influence faculty decisions when attempting to meet the requirements of the 2009 standards. Regardless of which method programs choose, specific curriculum components and course designs have been shown to be most effective. The next section will outline the addiction-related curriculum components that
have been recommended in training and the assignments that have been beneficial to students, as well as instructors.

**Curriculum Design for Addiction Training**

**Curriculum Components**

Five years before the 2009 CACREP standards were released that includes an established Addiction Counseling specialty program option (CACREP, 2009a), an investigation of addiction training was completed to determine the curricular experiences of substance abuse counselors (Whittinghill et al., 2004). Out of 89 CACREP liaisons who participated in the study, 25 respondents reported that their counselor education department offered a master's degree in addiction counseling (Whittinghill et al.). In other words, at least 25 institutions were preparing future addiction counselors without the guidance or requirements of CACREP accreditation standards.

As a result of the lack of CACREP standards, scholars have attempted to establish a consensus, using the Delphi Method, regarding the knowledge and skill competencies necessary in the training of addiction counselors (Klutschkowski & Troth, 1995; Whittinghill, 2006). Whittinghill used a panel of 28 experts and identified 89 graduate-level addiction counseling curriculum components which are "most important" to the training of addiction counselors. Klutschukowski and Troth also formulated a list of 28 essential curriculum components based on the opinions of 33 expert panelists (see Appendix A). The difference between these two studies is the list generated by Klutschukowski and Troth is specific to substance abuse instruction and the list in the Whittinghill (2006) study relates to addictions counseling instruction. In the past,
identifying these curriculum components may have been helpful to counselor education faculty because they may have used these lists for guidance when creating addiction courses or adapting curricula of courses which were already offered.

Addiction course designs, as well as curriculum components, have varied considerably among counseling programs (Morgan et al., 1997). Morgan et al. surveyed institutions that have CACREP-accredited programs to determine how the courses were structured and reviewed 98 course syllabi. The majority (57%) of courses focused on counseling skills including assessment, diagnosis, case management, treatment, relapse prevention, and tools of recovery. The second highest percentage of courses (28%) focused on a basic overview of substance abuse including types of drugs and pharmacology, models of addiction, etiology, epidemiology, community resources, and intervention. The authors found most courses used typical academic methods of evaluation such as tests (63%), research papers (66%), report writing (41%), and oral presentations (21%). The largest percentage of programs (33%) used supplemental readings, as opposed to one textbook, as their main source of addiction information (Morgan et al.).

**Instructional Strategies**

Scholars suggest counselor preparation in the area of substance abuse and addictive behaviors should incorporate both reflective and experiential learning activities (MacMaster & Holleran, 2005; McDermott et al., 1991; Osborn & Lewis, 2004; Sias & Goodwin, 2007). Sias and Goodwin analyzed reflective journals kept by counselors-in-training and found 96% of their students believed attending a 12-step meeting was a
positive learning experience. They further reported that hearing firsthand, personal accounts concerning the impact of addiction and recovery, as well as interacting with the members at the meeting, challenged students’ stereotypical views of addiction.

Although scholars and students alike have noted the perceived benefits of both reflective and experiential learning activities, few studies have revealed their widespread application. For instance, Morgan et al. (1997) identified only 34% of course syllabi required personal assignments (i.e., weekly logs, drinking diaries, abstinence agreements, personal philosophy papers, and a family-of-origin/substance abuse history). Other experiential methods employed were attendance at 12-step or other recovery meetings (23%), treatment center visits or interviews with counselors (11%), and role plays (8%). Another influential course component is the use of a “recovery panel” consisting of 12-step community members who are presently in recovery (Carroll & Bazan, 2001; Sias & Goodwin, 2007). These panels are designed to deconstruct myths that students may have regarding people with addiction problems.

Summary

A review of the literature revealed important information relevant to this proposed investigation. For instance, an examination of the 2009 CACREP standards indicate CMHC programs are to facilitate numerous student learning outcomes related to addiction, many of which are skill-based. The areas of instruction for CMHC students should include the following: theories, etiology, disease concept, prevention, intervention, screening and assessment instruments, co-occurring disorders, treatment modalities, continuum of care, and counseling strategies (CACREP, 2009a). With the
inclusion of these new addiction-related competencies, CMHC program faculty can infuse these competencies into existing courses, create a stand-alone course(s), or do a combination of both methods. Historically, if addiction education has been integrated into coursework, it has been offered as an elective or a required course, or it has been infused into other required courses. The number of institutions that have CACREP-accredited counseling programs which require an addiction course has remained at 30% over the past decade (Dawes-Diaz, 2007; Morgan et al., 1997; Salyers et al., 2005). It would be of interest to determine: (a) if the percentage of institutions (that have CACREP-accredited programs) requiring an addiction course has changed after the release of the 2009 CACREP standard requirements, (b) which implementation method faculty choose in their efforts to comply with the 2009 CACREP standards, and (c) how many institutions will implement the new Addiction Counseling program since past research has indicated faculty interest in offering such a program if one existed.

In 1997, 58% of institutions offering CACREP-accredited programs reported having faculty with prior formal addiction education, and 11% of faculty had membership in an addictions-affiliated organization (Morgan et al., 1997). Moreover, 20% of institutions used part-time faculty to teach their addiction courses. While institutions may not have an overabundance of faculty with expertise in addiction counseling, counselor educators hold the opinion that addiction training is important (Morgan et al., 1997). Over ten years later, it would be of interest to determine: (a) the current percentage of counselor educators with addiction expertise (b) who is teaching addictions courses (e.g., full-time faculty with expertise), and (c) the opinions of
counselor educators regarding the new addiction-related standards.

This author also reviewed studies which found that the curricular components and course designs of addiction courses have varied among counselor education programs (Dawes-Diaz, 2007; Morgan et al., 1997). With addictions-related curriculum components now identified in the CACREP standards, it would be important to ascertain if there is more consistency among the curricula of counselor education programs. Moreover, this review of the relevant literature identified the most beneficial instructional strategies related to substance abuse and addictive disorder instruction. Even though research has acknowledged these instructional strategies as being favorable to others, programs may not be employing them in the classroom. This proposed study of CACREP-accredited programs will attempt to update and inform the counselor education field in regards to addiction training by investigating the implementation of the 2009 addictions-related competencies. Next, in chapter three, the methodology will be presented.
CHAPTER III

METHODOLOGY

This chapter provides a detailed description of the methodology employed in this study and it is divided into two sections. After a brief introduction, the first section explains the methods used for obtaining the quantitative data, and the qualitative methodology is addressed in the second section. Within each of these sections, the details about the design, sampling, data collection, and data analysis are provided.

According to Heppner, Kivlighan, and Wampold (2008), the usefulness of a particular research design is a function of (1) the existing knowledge bases pertaining to the specific research question, (2) the types of research designs used and inferences made to develop the existing knowledge bases, and (3) the resources available to the researcher. In other words, there must be a match or fit between the design being considered, one's own resources, and knowledge of previous research. Based on these three aspects of usefulness, the investigation into the implementation of the addiction-related CACREP standards was completed using a mixed-method research design.

In order to be in compliance with accreditation requirements, the 2009 CACREP standards are currently being implemented into counselor education programs nationwide. As a result, changes (such as those detailed in chapter two) are being made related to addictions training. A survey was selected for this part of the study because it yielded the desired data pertaining to the methods institutions chose (or will choose) in their efforts to comply with the required addictions-related training competencies listed in
the new standards. In addition, the information provided by the survey updated previous research completed by survey methodology regarding the number of master’s-level counselor education programs in the country which require and/or offer courses in this area (Dawes-Diaz, 2007; Morgan et al., 1997; Salyers et al., 2005). A survey was also an efficient and effective way to examine the other research questions related to the specific aspects of addictions education. For example, the survey addressed the various curriculum components taught to students and the participants’ opinions on best practices for the implementation of the 2009 addiction-related competencies. The questionnaire also was used to investigate the number counselor education faculty members which have expertise in the addictions field.

Quantitative Methodology

Research Design and Instrumentation

A descriptive design was chosen because this research strategy allowed the investigator to describe the occurrence of, the underlying dimensions in, and the relationship between or among variables (Heppner et al., 2008). Three of the four research questions were fully addressed through the use of the survey questionnaire and they are: (1) How is addiction training currently being taught in CACREP-accredited, counselor education programs (e.g., required course or infusion)? (2) How many CACREP-accredited program faculty have expertise in substance abuse/addictions counseling (e.g., experience in the field, hold credentials, etc.)? (3) How will programs change due to the 2009 CACREP standards (e.g., add a required addictions course or offer the Addiction Counseling program option)? The fourth research question inquires
as to the perceived best practices related to addiction instruction. The survey obtained data to partially answer this question, and the qualitative findings were used to augment (as well as contrast) the survey results.

A 15-item questionnaire (Appendix B) was developed by the researcher based on a review of previous research on substance abuse and addictions-related training in counselor education (e.g., Dawes-Diaz, 2007; Morgan et al., 1997; Salyers et al., 2005; Whittinghill et al., 2004) and the 2009 CACREP standards (CACREP, 2009a). The questionnaire was sent to CACREP liaisons or counselor education unit directors, as explained in greater detail below. The first survey question asked the participant to identify the various master's-level, CACREP-accredited counselor education programs offered at his or her location. Questions 2 through 5 inquired about the current and future substance abuse training of all students. More specifically, these questions attempted to determine if institutions are (1) infusing the training into core courses, (2) requiring a separate addictions course(s), (3) using a combination of both methods, and/or (4) offering an elective addictions course(s). Question 3 asked respondents to indicate which master's-level program options (e.g., Career Counseling; Marriage, Couple, and Family Counseling; etc.) require completion of an addictions course, if any. This question had a follow up question. If an addictions course is required by any program option, the respondent was asked if this course is part of the counselor education curriculum or if it is offered by another department of the university (e.g., sociology, psychology, or specialty program in addictions). This information provided the researcher an understanding as to whether the course is comprised mostly of counselors-in-training. If so, the course likely
focuses on the counseling profession versus other helping professionals. If counselor education programs offer addictions courses through other departments, collaboration is needed in order to satisfy the CACREP accreditation requirements.

Question 4 inquired about plans for requiring an addictions course in the next two years, and it had four sub-questions which were contingent on the answers of the participant. Some participants provided only one answer (i.e., to Question 4) and others had the potential, with follow up items, to answer five questions (i.e., Questions 4, 4.a., 4.b., 4.c., and 4.d.). Questions 6 through 10 were designed to investigate the participants' opinions regarding addictions training. These questions include asking for their perspectives about the overall importance of addictions instruction in counselor education, as well as their opinions of the 2009 CACREP standard requirements related to addictions training. Respondents were also asked about the perceived necessity of educating students on certain addictions-related curricular components (e.g., screening, assessment tools, diagnosis, and pharmacology) based on the program option (e.g., Clinical Mental Health Counseling, Career Counseling, etc.). To follow up, Question 11 asked respondents to provide information regarding the current status of these curricular components in their respective CACREP-accredited programs.

The evaluation of counselor education faculty expertise in relation to addictions counseling was through the use of Questions 12 and 13. Question 12 asked for the number of full-time counselor education faculty members at the respondents' institutions and Question 13 followed up to ask for the number of those faculty members who have expertise in the addictions counseling field. Expertise was not defined by a set of criteria.
Instead, examples were provided at the end of the question, such as "experience in the field, completed research, hold credentials." Question 14 was a two-part question related to the Addiction Counseling program option now listed in the 2009 CACREP standards. The first part of Question 14 asked if the respondents' institutions plan to offer, or do offer, the Addiction Counseling program option. If the respondents answered "no," they were then asked the primary reason for not offering the option. If the respondents answered "yes," they were directed to another question which asked for the primary reason for implementing this new program option. Question 15 was an invitation for the CACREP liaison to "provide any additional comments regarding substance abuse education and training needs that should be considered by CACREP-accredited counselor education programs." Information obtained from this open-ended question was analyzed for common themes in order to add to the quantitative data obtained regarding addictions training.

The researcher estimated it would take approximately 10 minutes to complete the survey. For the purposes of efficiency and convenience, an online survey program called QuestionPro was used for this investigation. The survey was available on the World Wide Web at http://substanceabusecompetency.questionpro.com.

Participation in this study (or access to the survey) was voluntary and was granted only if the CACREP liaisons electronically indicated they read the consent document (Appendix C). and were willing to complete the survey. The consent document explained confidentiality, the purposes of the research, and how the data will be used. The electronic indication of consent was obtained when the potential participant clicked
the "Continue" button on the consent page of the website.

**Sampling, Subjects, Access, and Setting**

Participants for this study were chosen by criterion sampling. Respondents were to be the designated CACREP liaison at their institution. If an institution did not have a designated liaison, then the Counselor Education unit or training director was also an approved participant for the purposes of this study. In June 2010, a copy of the CACREP directory of accredited master's-level, counselor education programs was obtained online (www.cacrep.org). According to CACREP, there was no hard-copy list of the CACREP liaisons. Each counselor education program had information available including the mailing address, website link, and the CACREP liaison’s name. This researcher was advised by CACREP staff to obtain the programs' information from the website and then find the CACREP liaisons’ contact information by searching each of the programs’ websites. According to the website, there were 518 CACREP-accredited counselor education program options available at this time. Some institutions had more than one accredited program option. For example, Western Michigan University’s Counselor Education Department had three accredited master's-level program options (i.e., Community, School, and College Counseling) at that time. A total of 218 institutions were found to have accredited programs and the contact person at each institution was obtained by the researcher. It was assumed the contact person listed in the CACREP directory was the CACREP liaison. The total number of institutions ($N = 218$) included institutions that had various locations. For instance, Argosy University had five locations nationwide which offered CACREP-accredited program options and each had a different
contact person.

Based on the program listing provided on the CACREP website, 218 CACREP liaisons were contacted. A total of 101 liaisons viewed the consent document page; 20 did not continue past the consent page; and seven dropped out after starting the survey. Seventy-four participants ($N = 74$) completed the questionnaire, for a 33.9% response rate. The average time to complete the survey was nine minutes.

The use of online surveys has grown in popularity in the field of counselor education because of the advantages such as the reduced response time, lower cost, ease of data entry, advances in technology, and acceptance of the format by recipients (Granello & Wheaton, 2004). Although there has been an increase in Web-based surveys, researchers have indicated this type of method has lower response rates than pencil-and-paper questionnaires (Porter, 2004). This can be due to the negative attitudes toward unsolicited e-mails, a lack of interest in the research topic, and the length of the survey. Response rates can vary dramatically by discipline and survey to survey. It has been noted the rates have dropped to around 20% in higher education (Porter, 2004). This investigation sought out a 25% response rate from the institutions that have CACREP-accredited programs, or approximately 55 participants. Researchers have recommended several strategies to improve the quality and response rates of online surveys such as multiple contacts with potential participants, including statements which “ask for help” from the respondents, and the use of advanced letters (Bourque & Fielder, 2003; Porter, 2004). Therefore, an informational postcard (Appendix D) was sent by the United States Postal Service to each contact person listed in the directory. The main purpose of the
postcard was to give advanced notification of an upcoming e-mail which was sent to the contact person requesting his or her help in the research regarding addictions training in counselor education. The postcard briefly explained the overall focus of the study, and the potential participants were directed to the survey website link if they wished to gain more information and/or complete the survey prior to the invitation e-mail.

Another recommendation by Bourque and Fielder (2003) is the use of incentives. In an effort to complete quality research with a satisfactory response rate, potential participants were informed on the postcard and in the e-mail invitations of the opportunity to enter a random drawing to receive one of four, $50 VISA cards.

**Data Collection Methods**

Seven days after the invitation postcards were sent out by mail, the electronic version of the invitation letter (Appendix E) was be sent by e-mail through QuestionPro. The potential participants’ e-mails were a part of an e-mail address group listing. The survey link provided in each of the e-mails was specific to that particular e-mail. Therefore, once the survey was completed by the participant, his or her e-mail address was taken off the e-mail listing. The first of three reminder e-mails (Appendix F) was sent to the CACREP contact person one week after the invitation e-mail was sent out. The last two reminder e-mails were also sent one week apart.

There were no survey questions specifically asking participants for any identifying or demographic information. Question 15, however, was open-ended and allowed for a participant to provide information which could lead to identification. In an effort to ensure the privacy and protection of the respondents’ identities, the researcher
and her doctoral chair, Dr. Gary Bischof, were the only people who had access to the data from the website. The data collection process for the survey took approximately five weeks.

Respondents who desired to enter the drawing for the VISA cards had the option of providing their e-mail address, which was not associated with their survey responses. On the “Thank you” page, after the participant submitted the survey, a webpage link to the drawing was provided. The participant clicked on the link and a pop up window appeared with a space for the participant to enter his or her e-mail address. This data was entered and stored by QuestionPro in a file separate from the survey responses. A total of 27 participants entered their e-mail addresses. Four numbers were randomly drawn from a grouping of 27 numbers on pieces of paper. The four participants’ were contacted via e-mail (Appendix G) and the researcher requested their mailing addresses. The $50 VISA gift cards were sent by mail in October 2010.

Data Analysis

All questionnaire responses were entered directly into QuestionPro. The program allowed the researcher to run a series of analyses in order to find descriptive statistics (e.g., mean, total number, etc.) for each of the survey questions.

In summary, the survey method was the best approach to employ in an effort to answer three of the four research questions and partially answer the last research question. The data determined (a) the percentage of institutions that have master’s-level, CACREP-accredited counselor education programs which offer and require an addictions course(s), (b) the addictions-related curriculum components most frequently taught
among these institutions, and (c) the opinions and addictions expertise of counselor education faculty. The survey also provided the data necessary to ascertain if institutions that have counselor education programs are changing their curricula in regards to the new addictions-related competencies listed in the 2009 CACREP standards. Last, an online survey was the most cost effective and time efficient research method. The next section provides an overview of the qualitative methodology of this mixed-method research design.

**Qualitative Methodology**

In the past, the perceptions of counselor education faculty members regarding addiction education have been investigated primarily by quantitative measures. However, information obtained by interviewing counselor educators, specifically those who are experts in the area of addiction and addictive behaviors, is crucial in the attempt to determine best practices. Marshall and Rossman (2006) state qualitative methodology is an effective approach to use when there is “little-known . . . [about] the informal and unstructured linkages and processes in organizations” (p. 53) and when a researcher “seeks to explore where and why policy and local knowledge and practice are at odds” (p. 53). This study will be the first to be identified which has obtained qualitative data related to the decision-making process for the implementation of the 2009 CACREP standards, how expert faculty members view these competencies (e.g., sufficient, insufficient, excessive, etc.), and what would be considered “best practice.”

**Research Design**

Researchers cite the “interviewing of elites” as a dialogue with individuals who
are considered to be “influential, prominent, and/or well-informed in an organization or community [and] they are selected for interviews on the basis of their expertise” (Marshall & Rossman, 2006, p. 105). The research design for this study was constructed based on elite interviewing of counselor educators who are also experts in the addiction field. There were no other units of analysis (e.g., documents, field observations, focus groups, etc.). The researcher was attempting to find within-case and cross-case themes to assist in answering research question four (i.e., what do counselor educators view as “best practice” in the training of counselors?). The researcher was not attempting to perform multi-site case study, phenomenology, or grounded theory (Patton, 2002). The responses of the interviewees provided data for thematic analysis and the creation of thematic networks (Attride-Stirling, 2001). Thematic analysis was considered the best approach to examine and compare the opinions of faculty in CACREP-accredited programs, who are also addiction experts. This process will be described in-depth in the analysis section below.

Two purposes of this part of the study are: (1) to gather data from expert faculty members describing the implementation of the addiction-related competencies into curricula, and (2) to provide an in-depth understanding of what is considered “best practice” related to addictions training in counselor education. It was the intent of the researcher to determine if counselor educators from different institutions (who were also addiction experts) have similar or differing perspectives on addictions training, and obtaining data for thematic analysis was the most effective method in order to do so.
Sampling, Subjects, Access, and Setting

Purposive criterion sampling was used because the participants had to meet several pre-determined criterion (Patton, 2002). The participants for the qualitative part of the study were considered an “expert” in the field of addictions, and they were selected based on two criteria. In order to be considered an expert, the participant must have:

1. Been employed full-time as a counselor educator (i.e., not an adjunct faculty member) at a CACREP-accredited program at the time of the interview
   and-

2. Completed three or more of the following tasks:
   a. Published one or more journal articles related to substance abuse/addiction
   b. Carried out research related to substance abuse/addiction
   c. Presented information on substance abuse/addiction at a conference
   d. Provided five or more years of substance abuse/addictions counseling
   e. Obtained credentials in the substance abuse/addictions field
   f. Taught at least one substance abuse/addictions course
   g. Provided professional service in this area for a year or longer (e.g., committee or board member, editor, etc.)

Since the researcher was focusing on the implementation of the 2009 CACREP standards, these experts also had to be faculty at an institution that has a CACREP program which will be deciding (or has decided) on whether or not to implement, as well as how to implement, the addiction competencies into curricula. The researcher
ascertained the participants' opinions on best practices related to (1) the necessary curriculum components, (2) course design, and (3) implementing the standards by infusion, stand-alone course, or combined methods. In addition, these experts were asked for their perception of the 2009 CACREP standards related to substance abuse and addictions training.

The sample of experts was selected from the following purposeful sampling methods: (1) the researcher’s prior knowledge of experts in the addictions field, and (2) snowball sampling. The researcher had previous knowledge of specific counselor educators who have published on the topic of substance abuse and other addiction-related education, taught coursework in the area, presented addiction information at conferences, and provided service to the profession such as serving as an editor of a professional journal related to addictions. The counselor educators were contacted by the researcher via telephone to determine if they qualified as experts for the purposes of this study and if they were willing to participate in the research interview. The protocol used for this telephone call is outlined in Appendix H.

Only one participant was obtained by snowball sampling. This method identifies cases of interest from people who know which specific cases are information rich (Miles & Huberman, 1994). Since the researcher had four experts which agreed to participate after the first contact, the fourth participant was asked to provide names of counselor educators who may be potential participants. The fourth expert provided three other names to the researcher. The fifth participant, a female, was selected to be contacted first because the researcher had a sample of three males and one female at that time. The fifth
participant agreed to the interview, and therefore the researcher did not contact the other
counselor educators referenced by the fourth participant. In an effort to protect the
experts' identity, provide confidentiality, and promote candid responses from the
interviewees, the researcher gave each of the participants a number code for the purpose
of data keeping and analyses (Feola, Malu, & Brause, 2003).

**Basic information.** The sample included five Caucasian counselor educators
who at the time of the study were employed full-time as faculty members at CACREP-
accredited programs. Three interviewees are male and two are female. Two of the five
participants were employed at institutions in the Midwest, two in the Southeast, and one
in the South-central part of the United States. Each counselor educator qualified as being
an expert in the addiction field by the pre-determined set of criteria outlined in chapter
three.

**Expertise.** To protect the identity of the participants, the experts’ information
provided in this section will be broad in nature and limited to aspects which will maintain
anonymity. The clinical experience (with a focus on addictions) of the participants
ranges from 2 to 24 years and averages approximately 12 years. All have taught addiction
courses at the graduate level, and all have published and presented on addiction-related
issues. One participant indicated publishing approximately 45 articles and another
reported presenting approximately 75 times at various conferences. One expert
reportedly provides addiction-related trainings to front-line clinicians. Four of the five
interviewees have been involved with the International Association of Addictions and
Offender Counselors (IAAOC) in some capacity; two have been involved with CACREP
standard revisions related to addictions; and one has been involved with the creation of the Master Addictions Counselor examination for the National Board for Certified Counselors.

**Data Collection Methods**

Prior to collecting data, the researcher sent two copies of the consent document (Appendix I) by mail to the potential participants. The potential participants were asked to sign one copy, keep the other for their records, and send the signed copy back to the researcher in the pre-stamped envelope which was sent with the documents. In addition, two other documents were also sent at the same time as the consent documents. One document was the list of substance abuse/addictions curriculum components (Appendix J) and the second document was an inventory of the 2009 CACREP competencies that include training on substance abuse and addictive behaviors (Appendix K). The participants were asked to review these prior to the interview because they would be referenced during the interview. Two participants requested that the researcher send them questions prior to the interview. Therefore, the researcher sent the Interview Guide Sheet (Appendix L) via e-mail to these interviewees. This guide sheet is described in more detail below.

After receiving the signed consent forms, the researcher arranged and conducted one-on-one interviews over the telephone. Two interviews took place privately at the researcher’s home and three were conducted privately in a faculty office in Sangren Hall at Western Michigan University, with the door closed to ensure confidentiality. All interviewees were asked verbally before the interview proceeded if they understand they
would be audio-taped with a digital recorder attached through the telephone. Once confirmed, the interviews began.

To provide some organization for each interview, the researcher developed a semi-structured Interview Guide Sheet (Appendix L) beforehand. The semi-structured guide was chosen in an effort to further clarify the central domains, factors, and sub-factors; operationalize factors into variables; and develop preliminary hypotheses (Schensul, Schensul, & LeCompte, 1999). To gain the data needed to answer the fourth research question regarding best practices in addiction education and training, particular types of interview questions were created. According to Patton (2002), the first question on the interview guide sheet is categorized as a background type of interview question and the remaining inquiries are of the opinion, or belief, style of questioning. Due to the emergent quality of these questions, the researcher followed up with sub-questions which were not outlined on the guide. The researcher took extreme caution in providing a neutral stance so she did not show either approval or disapproval of responses. The purpose was to gain valuable, rich information from these experts. In order to do so, open-ended, probing questions were asked to gain a more complete description from the participants. However, this researcher was mindful not to shape the responses of the interviewees by covertly reinforcing some statements with the use of follow up questions (Heppner et al., 2008).

The interviews averaged 53 minutes in duration and ranged from 40 minutes to 65 minutes. The interviews were recorded on separate audio tapes. These five tapes were stored in a locked filing cabinet in the primary researcher's office. Once the interviews
Data Analysis

Braun and Clarke (2006) argue thematic analysis should be seen as a methodology and systematic approach in its own right, rather than simply a tool used across different qualitative methodology. Thematic analysis has been outlined into a clearly defined, rigorous process, and this researcher adhered to this framework (Attride-Stirling, 2001). There are three broad stages: (a) the breakdown of the text, (b) the exploration of the text, and (c) the integration of the exploration. Within each of these three stages are specific steps of analysis. The first identified step in thematic analysis is coding the material.

Coding the material. Each of the five interviews was transcribed by the researcher on the same day as the interview took place. Next, the data were organized and the researcher became immersed in the data. Marshall and Rossman (2006) urge researchers to read, reread, and then read the data once more in order to become intimately familiar with it. Therefore, the researcher read each transcription twice and then over a period of two days, the researcher listened to the interviews again while cross-checking the transcription data for accuracy. While listening to each interview for the second time, the researcher began making notes for each interview and coding salient issues that arose in the text. In addition, the researcher also took note to possible cross-case similarities and differences. The text which represented salient issues was separated into manageable chunks of data, such as a passage, quote, or single words (Attride-
Stirling, 2001). Next, summaries were created for each of the transcriptions which highlighted significant aspects of the interviews. These summaries were read again to note repeated patterns within each interview and between interviews.

The type of thematic analysis, inductive versus theoretical, is imperative to determine, as it drives the researcher’s coding of the data (Braun & Clarke, 2006). Theoretical thematic analysis tends to provide less of a rich description of the data overall, and more of a detailed analysis of some aspect of the data. Inductive analysis can produce research questions through the coding process and this approach attempts to code the data without trying to fit into the researcher’s interest or area of topic (Braun & Clarke, 2006). The researcher was coding basic themes according to research question four regarding the expert’s opinions on best practices in addiction training; therefore, theoretical analysis was chosen as the means to code the data.

Identifying themes. A theme “captures something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set” (Braun & Clarke, 2006, p. 82). The researcher used this definition in terms of coding data as a theme. At times, themes were identified due to the prevalence of a repeated pattern of data across interviewees, and at other times it was due to the perceived crucial nature of the data by one or two interviewees.

An important decision for the researcher is to determine if themes will be identified as latent or semantic themes (Braun & Clarke, 2006). The analysis looked for semantic themes and not latent themes. The researcher was not looking for anything beyond what the participants said; the data were organized to show patterns in semantic
content, then summarized, and interpreted. This interpretation involved theorizing the significance of the patterns and their implications, particularly in relation to previous research. For instance, the interviewees indicated which of the addiction-related curricular components were necessary in the instruction of all counselors in training. The researcher did not simply use the questions to create themes, but looked for patterns across and within the interviews. Then interpretations were made related to the findings, which formed the implications for course design and curricular content for faculty.

**Constructing the networks.** The themes were arranged into groupings according to their relevance. Next, “basic themes” were selected. Basic themes are the lowest-order themes which emerge from the text and separately do not have much meaning (Attride-Stirling, 2001). These basic themes were then grouped together to create the “organizing themes.” Organizing themes are the middle-order themes. They are clusters of significance and are more abstract relative to the basic themes. Global themes were then deduced in light of these organizing themes. The global themes encapsulate the main points in the text and are considered the final tenets (Attride-Stirling, 2001).

At this point, the researcher created thematic networks based on the three levels of themes. Thematic networks are web-like illustrations of the themes that “aim to facilitate the structuring and depiction of these themes” (Attride-Stirling, 2001, p. 387). Five global themes emerged and therefore, five thematic networks were generated in an effort to assist in the presentation of the findings in chapter four.

**Describe and explore the thematic networks.** The next step involved exploration of the emergent themes. The researcher returned to the original text and
interpreted it with the aid of the networks (Attride-Stirling, 2001). The researcher took each of the networks and supported each part of its contents with text segments. At the same time, the researcher explored and took note of underlying patterns that began to appear. This part of the process brought together the data and the interpretation for the researcher.

**Summarize networks and interpret patterns.** The researcher then presented summaries of each network in order to conceptualize the findings in a succinct manner. The next step was to return to research question four and address the question with arguments grounded in the data. The purpose was to pool together the network summarizes to create a cohesive story relating back to the research question (Attride-Stirling, 2001). This resulted in the researcher’s ability to make general statements about the perceived best practices related to addiction training in CACREP-accredited, counselor education programs.

**Validity Procedures**

Researchers using qualitative methodology employ a lens established through the viewpoints of the people who (1) conduct, (2) participate in, and (3) review the study (Creswell & Miller, 2000). Qualitative inquirers need to demonstrate the credibility of this lens and there are a vast number of procedures available to address validity concerns. Therefore, this researcher attempted to establish credibility by outlining the procedures which were used to attend to each of three viewpoints listed above.

**The lens of the researcher.** The researcher is the instrument in qualitative inquiry and to ensure researcher credibility, clarifying the researcher’s assumptions,
beliefs, values, and biases from the onset of the study is imperative (Creswell, 2007; Creswell & Miller, 2000; Patton, 2002). Therefore, this section will explicate the “self as the researcher” in an effort to display the viewpoint as seen through my lens.

My interest in addiction counseling began after working at the national organization, Treatment Alternatives for Safer Communities (TASC). I was a court advocate for defendants involved in felony court cases in Jefferson County, Alabama. Clients’ drug use was monitored as their case was pending and I referred them to substance abuse services, as applicable. A high percentage of the people on my caseload were sent to prison due to drug-related offenses and/or continuing to use illicit drugs while their case was pending. After a year-and-a-half at TASC, my passion shifted away from providing advocacy in the courtroom to providing the counseling services.

While employed with TASC, I was also in a master’s program for Agency Counseling. While in the program, I found that addiction-related education and training was lacking in my program and this became apparent to me while completing the practicum and internship experiences. My supervisors would rely on me to answer the questions regarding substance use and addiction that were posed by my peers. As a result of the lack of training and faculty expertise seen at my master’s program, my interest in addiction education increased.

I have approximately six years of clinical experience with individual and group substance abuse counseling and personally believed that prior to the 2009 CACREP standards, there was a need for more addiction-related training requirements for counselor education programs. In addition, I believed there was a necessity for specific
training for persons who wish to become an addictions counselor.

During my doctoral program at Western Michigan University, I have taught, and currently teach, undergraduate substance abuse courses. This experience has affected my opinion on the level of importance of specific addiction-related curricular components (e.g., more time should be spent on teaching screening than etiological theories). In regards to implementing the addiction-related competencies listed in the 2009 CACREP standards for the Clinical Mental Health Counseling program, I believe that requiring a course would be the most efficient and effective way to ensure the implementation of these competencies into the curriculum. I do not believe a separate addictions course is a necessity for all counselors-in-training, although I do believe that training has been lacking and program faculty should teach all students certain curriculum components (i.e., screening, co-occurring disorders, treatment options, pharmacology) prior to the practicum experience. Due to the fact that there is now an addiction-related competency in the core 2009 CACREP standards which includes etiological theories, prevention, intervention, and treatment and is required for all counselors, I reflected on the necessity of these curriculum components. It is my opinion that these are important to know because of the prevalence of clients with problems stemming from addiction who present for counseling services, but not all counselors-in-training need to be competent in knowing prevention, intervention, and treatment methods. I have a strong belief in the necessity for all counselors to have the ability to effectively screen for addictive behaviors, more specifically substance abuse problems, above all the other identified substance abuse curriculum components (e.g., assessment, prevention, and treatment) in
the 2009 CACREP standards.

I also have an opinion on course design. If a course is required for or offered to counselors-in-training, there are significant benefits of employing activities which generate students’ reflection regarding their opinions on substance use and abuse. I have used experiential activities in my classes and think students benefit from activities such as attending an open 12-step meeting, role playing an assessment interview, hearing guest speakers, attempting to quit using a substance of their choice, visiting a treatment facility, and interviewing an addictions counselor.

Last, I had a close family member who was addicted to drugs, including alcohol. He was addicted for over 40 years and never maintained recovery. His addictions influenced my beliefs on substance use, misuse, abuse, and dependency. Creswell and Miller (2000) referred to the influence of the researcher’s lens and I understand that this lens is affected by my historical, social, and cultural context in which I have lived and currently live. I took great care throughout the study to ensure that the beliefs which impact my lens would not have an effect on the credibility of this investigation. Although value-free interpretive research is impossible, Patton (2002) urges researchers to be empathetic, neutral inquirers. In other words, I care about and I am interested in the people being studied, but neutral about the content of what they reveal.

The lens of the participants. The validity procedure here shifts from the researchers to the participants with member checking (Creswell & Miller, 2000). Researchers who choose to use member checking are urged to share the preliminary analysis of descriptions and themes and the drafts of the final report with the research
participants, rather than solely the transcripts or the raw data (Creswell, 2007). Therefore, each participant was sent by e-mail a copy of his or her transcript for review. The researcher asked participants to provide written and/or verbal feedback. Of the five interviewees, one provided feedback. The feedback was comprised of word corrections and additions to the interview transcription. Approximately a month later, the researcher e-mailed all participants a draft of the qualitative findings section of chapter four. Again, they were asked to review the document and provide feedback. Two of the five interviewees specifically indicated no changes were needed to the draft. One of the interviewees sent a reply e-mail and requested instructions on the particular feedback that was desired. The researcher provided some criteria in an e-mail response, but never received any follow up response. The other two interviewees sent e-mail responses that included “well wishes” and support for the study. By engaging in member checking, the researcher attempted to add to the credibility and accuracy of the information provided and the narrative account of the data.

The lens of the reviewer. In an effort to add another layer of credibility to the investigation, this researcher used someone external to the study, otherwise known as a peer review or debriefing (Creswell, 2007). Creswell equated this process to inter-rater reliability in quantitative research and identified this external reviewer’s role as a “devil’s advocate.” This investigator requested assistance from another doctoral student in the Department of Counselor Education and Counseling Psychology at Western Michigan University. This student had previous experience with qualitative research both in her master’s and doctoral programs. Once the researcher completed the written analysis of
the data, the reviewer was brought into the investigation. The reviewer was provided a copy of the five transcripts and a separate document which outlined the within-case and cross-case analyses, including the global, organizing, and basic themes. In addition, a print out of the five thematic network illustrations and a rough draft of the qualitative findings were provided for her evaluation. This reviewer was to challenge the researcher’s assumptions and ask questions about the methods, meanings, and interpretations (Creswell, 2007; Creswell & Miller, 2000).

The reviewer and researcher met on one occasion for three hours and discussed the reviewer’s assessment of the findings. She provided written feedback for the researcher, including her own thematic analysis which she derived from the data. The researcher and reviewer discussed reasons for choosing the basic, organizing, and global themes, and the researcher clarified questions the reviewer had regarding CACREP standards, program options, implementation methods, etc. Based on the reviewer’s comments, the researcher implemented several of these changes accordingly. For example, the reviewer suggested reordering some of the presentation of the results based on the perceived importance of the theme or how many of the experts indicated the basic theme. She also suggested adding the basic theme, “Clinical Mental Health Counseling Program,” under the “Practicality” organizing theme. Another example of implementation is when the researcher added the term “Public” to the basic theme entitled, “Major Public Health Crisis.” Not only did the reviewer provide critique of the researcher’s thematic analysis, but she also gave ample written feedback on the first draft of the qualitative section. The reviewer indicated areas that needed further support and
areas which were repetitive or had too long of quotes. In addition, she assisted with the organization of the basic themes into the final draft.

**Human Subjects Review**

The researcher attempted to obtain approval by the Western Michigan University Human Subjects Institutional Review Board (HSIRB). HSIRB reviewed the study in July 2010 and determined that approval was not needed. A copy of the Institutional Review Board’s letter is in Appendix M.
CHAPTER IV

RESULTS AND FINDINGS

In this chapter, the four main research questions of this study are answered. The organization of the results is as follows. First, the quantitative data collected from the survey is discussed. Next, the qualitative findings obtained from the five interviews are presented.

Quantitative Results

The quantitative data answered the first three research questions and supplied part of the data to satisfy the fourth research question. The results are separated into six sections and introduced in the following manner. The first section provides some information related to the number of available CACREP-accredited program options and counselor education faculty members. The next four sections are organized by each research question and will address (1) the current status of addiction training in CACREP-accredited, counselor education programs, (2) the available faculty with expertise in addictions counseling, (3) the future program changes resulting from the 2009 CACREP standards, and (4) the perceived best practices related to addiction instruction. Last, the findings gained from the open-ended survey question are shared. The order of this chapter is organized by the four research questions and not by the survey question sequence; although, the researcher references the specific question number when reporting the quantitative results.
Programs

Question 1 on the survey asked for the liaisons to report the type of CACREP-accredited counselor education program options that are available at their institutions. The 74 liaisons reported a total of 154 program options offered. Fifty-five liaisons (74.3%) report having a School Counseling track; 34 of the sample (45.9%) have a Community Counseling track; 20 (27.0%) have a Mental Health Counseling track; 19 (25.7%) have a Clinical Mental Health Counseling track; 11 (14.9%) have a Marriage, Couple, and Family Counseling track; six (8.1%) have a Student Affairs and College Counseling track; and five (6.8%) have a Non-accredited Substance Abuse Counseling program track. Three liaisons (4.0%) selected “Other” and indicated their institutions offer non-accredited program tracks. The three open-ended responses include the following: “Non-accredited school counseling and marriage and family,” “Rehabilitation Counseling,” and “Several non-accredited specializations.” One institution (1.3%) has a Career Counseling track and no institutions (0%) have the Addiction Counseling option (see Figure 1).

Faculty

Participants were asked to indicate the number of current, full-time counselor education program faculty members employed at their institutions (Question 12). In the 74 institutions, there are reportedly 443.5 faculty members total. The range is 2 to 12 faculty members and the mean is 6 faculty members per institution. One participant indicated “4.5.”
Research Question 1: The Current State of Addiction Training

The first research question was regarding the present state of addiction training and was as follows:

(1) How is addiction training currently being taught in CACREP-accredited, counselor education programs?

i. What specific aspects of addiction training are being taught in CACREP-accredited programs (e.g., etiologies, co-occurring disorders, pharmacology, prevention, intervention, treatment)?

ii. Is completion of an addiction course required or is the training infused into one or more core courses?
Three aspects of current addiction training are addressed in this section. Participants were asked explicitly about the kind of addiction-related content which is taught at some point in the curricula of all students. The details about the addiction-specific curricular components are given first. Second, the researcher provides the results of how the content is being taught to all students, such as the infusion method or a stand-alone course method. In addition, statistics are provided regarding institutions that integrate more than one method or require a course only for specific program options. The third aspect presented on the current state of addiction training is whether the addiction courses offered are part of the counselor education department.

**Addiction-related curriculum components.** A list of 11 addiction-related components that can be or should be taught in CACREP-accredited counselor education program curricula was created by the researcher (see Appendix K). The listing was based on a review of prior research that investigated the importance of specific addiction-related curriculum components (Dawes-Diaz, 2007; Hosie et al., 1990; Klutschkowski & Troth, 1995; Morgan et al., 1997; Page et al., 1995; Von Steen et al., 2002; Whittinghill, 2006; Whittinghill et al., 2004) and a review of the 2009 CACREP standards. The focus of the analysis of the 2009 CACREP standards was on the addiction-related competencies, excluding the Addiction Counseling program standards.

Question 11 asked participants to indicate which of the 11 components are currently taught to all students at some point in the counselor education curricula. Fifty percent or more of the liaisons in the sample reported their institutions provided addiction-related instruction covering the content of each of the components (see Table
2). Of the 11 components, the researcher found addiction screening content is covered by the majority of institutions (78.4%) and the content least likely to be covered is process addictions (50%). More specifically, "Screening" is taught in 58 of the 74 institutions (78.4%); "Diagnosis" in 57 institutions (77.0%); "Counseling Strategies" in 54 institutions (73.0%); "Prevention" in 53 institutions (71.6%); "Intervention" in 52 institutions (70.3%); "Assessment Tools" in 51 institutions (68.9%); "Etiological Theories" in 50 institutions (67.6%); "Co-occurring Disorders" in 49 institutions (66.2%); "Treatment Options (on the Continuum of Care)" in 47 institutions (63.5%); "Pharmacology" in 39 institutions (52.7%); "Process Addictions or Addictive Behaviors (e.g., gambling, shopping, Internet, sex)" in 37 institutions (50%); and "None of the above" in 6 institutions (8.1%).

Table 2

*Total Number and Percent of Sample Teaching Specific Addiction Curriculum Components*

<table>
<thead>
<tr>
<th>Curriculum Component</th>
<th>Count</th>
<th>Percent of Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening</td>
<td>58</td>
<td>78.4%</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>57</td>
<td>77.0%</td>
</tr>
<tr>
<td>Counseling Strategies</td>
<td>54</td>
<td>73.0%</td>
</tr>
<tr>
<td>Prevention</td>
<td>53</td>
<td>71.6%</td>
</tr>
<tr>
<td>Intervention</td>
<td>52</td>
<td>70.3%</td>
</tr>
<tr>
<td>Assessment Tools</td>
<td>51</td>
<td>68.9%</td>
</tr>
<tr>
<td>Etiological Theories</td>
<td>50</td>
<td>67.6%</td>
</tr>
<tr>
<td>Co-occurring Disorders</td>
<td>49</td>
<td>66.2%</td>
</tr>
<tr>
<td>Treatment Options</td>
<td>47</td>
<td>63.5%</td>
</tr>
<tr>
<td>Pharmacology</td>
<td>39</td>
<td>52.7%</td>
</tr>
<tr>
<td>Process Addictions</td>
<td>37</td>
<td>50.0%</td>
</tr>
<tr>
<td>None of the Above</td>
<td>6</td>
<td>8.1%</td>
</tr>
</tbody>
</table>
Implementation method. The CACREP liaisons were also asked how addiction training is currently implemented at their institutions, specific to all counseling students (Question 2). Of the 74 institutions, 37 institutions (50%) offer one or more elective substance abuse courses, 34 institutions (45.9%) require a substance abuse course, 29 institutions (39.2%) infuse substance abuse training into the content of one or more core courses, two institutions (2.7%) indicate no training is provided, and no institutions (0%) require two or more substance abuse courses (see Figure 2).

Figure 2. Method of addiction-related training among CACREP-accredited programs. This figure illustrates how addiction instruction is implemented at the institutions of the sample.
More than one method. The CACREP liaisons had an option to indicate more than one choice related to their institutions' implementation methods for addiction training. Twelve of the 74 liaisons (16.2%) reported their institutions do not require a course, but they infuse the content into one or more core courses and also offer one or more elective courses. Seven liaisons (9.4%) indicated addiction content is infused into one or more core courses for all students and also students in specific program options are required to take a course. Five liaisons (6.7%) report their institutions offer one or more elective courses, infuse the content into one or more core courses for all students, and also require a substance abuse course for some students. Two liaisons (2.7%) report their institutions do not infuse the content into core courses for all students, but offer one or more elective courses and require students in specific program options to complete a course.

Institutions requiring a course. Of the total sample, 26 participants (35.1%) indicate their institutions do not require a course for any of their students, while 21 institutions (28.4%) require an addiction course for all students, regardless of the program option or specialization (see Figure 3).

Some institutions require the completion of an addiction course only for students enrolled in a specific program option (see Figure 4). In this study, 27 of the 74 institutions (36.5%) require a course only for students in certain specializations. Question 3 asked the liaisons to indicate for which students the course(s) is required.
Figure 3. Institutions requiring an addictions course. This figure illustrates the percentage of the sample that indicated an addiction-related course was required for all counseling students, not required for any students, or only required for students in a specific program option.

Nine of the 19 CMHC programs (47%) in the sample require an addictions course; 8 of the 20 Mental Health Counseling programs (40%) in the sample require a course; 4 of the 11 Marriage, Couple, and Family Counseling programs (36.4%) in the sample require a course; 7 of the 34 Community Counseling programs (20.6%) in the sample require a course; and 4 of the 55 School Counseling programs (7.3%) in the sample require a course. When looking at the total sample, 9 of the 74 institutions (12.2%) require a course for students in the Clinical Mental Health Counseling program option; 8 institutions (10.8%) require a course for Mental Health Counseling students; 7 institutions (9.4%) require a course for Community Counseling students; 4 institutions
(5.4%) require a course for Marriage, Couple, and Family Counseling students; 4 institutions (5.4%) require a course for School Counseling students; and 2 institutions (2.7%) require a course if students are enrolled in an addictions specialization or certificate program. None of the 27 institutions (0.0%) require a course for Career Counseling students or Student Affairs and College Counseling students.

Figure 4. Addiction course requirement by specialization. This figure represents the percent of the sample \((N = 74)\) requiring an addiction course by program option.

Addiction course in counselor education department. Forty-eight liaisons (64.9%) indicated their institutions offer or require an addiction course. These participants were asked in Question 3(a) if the courses are offered by or a part of the counselor education department curriculum or if the courses are offered by another department of the institution (e.g., sociology, psychology, or specialty certificate program...
Almost all, or 46 out of the 48 liaisons (95.8%), report the courses are a part of the counselor education department curriculum and 2 liaisons (4.2%) indicate the courses are not part of the counselor education program curriculum.

**Research Question 2: Faculty Expertise**

The second inquiry of this study pertained to the available faculty with expertise in the area of addictions. Two survey questions provided the data to answer following research question:

(2) How many CACREP-accredited program faculty have expertise in substance abuse/addictions counseling (e.g., experience in the field, completed research, hold credentials)?

i. Who is teaching addiction-related courses currently (e.g., full-time faculty with addictions expertise)?

**Number of faculty.** Question 13 on the survey asked the participant, “How many of the faculty members identified in the previous question have expertise in substance abuse counseling (e.g., experience in the field, completed research, hold credentials)?” Of the 443.5 full-time faculty members reported by the liaisons, there are reportedly 142 members (32.0%) who have addiction-related expertise. The mean per institution is 1.9 counselor education faculty members with expertise and the range is 0 to 6 faculty members (see Figure 5). Eight liaisons (10.8%) indicated there are no faculty members with addiction-related expertise. Twenty-four institutions (32.4%) have 1 faculty member, 25 institutions (33.8%) have 2 members, 7 institutions (9.5%) have 3 members, 6 institutions (8.1%) have 4 members, 1 institution (1.3%) has 5 members, and 3
institutions (4.0%) have 6 members.

![Reported Number of Faculty Members with Addiction Expertise](image)

**Figure 5.** Reported number of faculty members with addiction expertise. This figure illustrates the total number of faculty with expertise at the institutions of the sample.

**Addiction course instructor status.** The liaisons were asked in Question 3(b) to provide information about the instructor of the addiction course which was offered or required at their counselor education program. The participants were to indicate if the instructor is an adjunct or a full-time faculty member and whether the instructor has addiction-related expertise. The majority, or 64.6% of the 48 liaisons, reported a full-time faculty member with addiction expertise teaches the course, 27.1% (n = 13) reported an adjunct faculty instructor with expertise teaches the course, 6.2% (n = 3) reported a full-time faculty member without expertise in addictions teaches the course, and 2.1% (n = 1) indicated an adjunct faculty instructor without expertise in addictions teaches the
course (see Figure 6).

![Addiction Course Instructors](image)

**Figure 6.** Addiction course instructors. This figure illustrates the percent of addiction courses that are taught by full-time faculty, with or without expertise and the percent of courses that are taught by adjunct instructors with or without addiction expertise.

**Research Question 3: Future Plans in Addiction Training**

The survey included questions related to the institutions’ future plans in addiction education and instruction. The following section is divided into four topic areas which answer research question three, which is:

(3) How will programs change due to the 2009 CACREP standards?

i. Add new faculty with expertise in addictions?

ii. Add a required addictions course?

iii. Offer the Addiction Counseling program option?
**Plans to add faculty.** CACREP liaisons were asked in Question 13(a) if there are plans to add faculty with addiction expertise at their institutions in the next two years. Of the 74 participants, 45 liaisons (60.8%) reported their institutions have no plans, 22 (29.7%) indicated "I don't know," and 7 (9.5%) indicated their institutions have plans to add faculty with expertise within two years. Of the 7 institutions which are planning on adding faculty, 3 institutions currently have one faculty member with expertise; 2 institutions have 2 faculty members with expertise; and 2 institutions have 3 members with expertise. Moreover, the researcher noted that 4 of the 7 institutions planning on adding faculty (57.1%) are also planning on offering the Addictions Counseling program as well.

**Plans to require a course.** The CACREP liaisons were also asked if their institutions have plans to require one or more addiction-related courses in the next two years (Question 4). There were three answer choices, "yes," "no," or "n/a, required already." Forty-two (56.7%) of the 74 liaisons reported their institutions already require a course. Thirty-two institutions (43.2%) do not currently require a course. Of the 32 institutions, 24 liaisons (75.0%) indicated there are no plans to require a course for any of their students in the next two years. However, 8 of these 32 institutions, or 25%, reportedly have plans to require a course in the next two years. In regards to the total sample of 74 institutions, 10.8% intend on requiring an addiction course in the near future.

Of the 8 participants indicating a future addiction course requirement, 6 liaisons (75%) reported in Question 4(a) that this new requirement decision was made primarily
to fulfill the 2009 CACREP standards related to addictions. In addition, all 8 liaisons (100%) indicated in Question 4(b) that this new course will be created by the counselor education department and will not be a course already developed from another department at the university (e.g., sociology, psychology, or a specialty certificate program in addictions). The 8 liaisons were then asked in Question 4(c) if completion of this course will be a requirement for all students. Six of the liaisons (75.0%) indicated the addiction course will be for all students and 2 liaisons (25.0%) indicated the course will be required only for students in the Community Counseling (n = 1) and Addiction Counseling (n = 1) programs.

**Plans to offer a course.** Question 5 asked participants if their institutions had plans to offer one or more addiction courses in the next two years. One of the options was “N/A, offered already.” Fifty-six of the 74 liaisons (75.7%) reported their institutions offered an addiction course at this time. The data obtained from Question 5 does not match the data obtained from Question 2. Question 2 asked about “all students” and it was found 37 institutions offer an elective to all counseling students. Question 5 determined 56 institutions offer a course, but maybe the course is only offered (or made available) to students in a specific program option. Eighteen of the 74 liaisons (24.3%) indicated their institutions do not currently offer an elective course in addictions. Of those 18 institutions, 11 liaisons (61.1%) reported no plans to offer a course in the next two years and 7 of the 18 liaisons (38.8%) reported there are plans to offer such a course in the next two years. In other words, 9.4% of the 74 institutions in this study intend on offering an addiction course in the near future.
Plans to offer the addiction counseling program option. In regards to future planning, the last inquiry asked participants whether their institutions offer, or have plans to offer, the new Addiction Counseling program option (Question 14). Sixty-two of the 74 liaisons (83.8%) reported their institutions do not plan on offering the program (see Figure 7).

![Addiction Counseling Option: Programs Planning to Obtain Accreditation](image)

*Figure 7. Addiction counseling option: Programs planning to obtain accreditation. This figure illustrates the number of institutions in the sample (N = 74) that have current plans to offer the addiction counseling program option.*

Question 14(a) followed up to ask the 62 liaisons for the primary reason why they will not offer the Addiction Counseling program option at their institutions. There were five choices, including four pre-determined answers and “other” which allowed for an open-ended response. Thirty-three of the 62 liaisons (53.2%) chose one of the four pre-determined answers. More specifically, 20 liaisons (32.3%) indicated the “department
did not have a substance abuse program option already available and it would cost too much time/money to obtain accreditation;” 12 (19.3%) reported “there is not a demand by students for this program option;” 1 (1.6%) indicated “addictions is not a specialty field and there is no need to have this program available.” None of the liaisons chose the answer which stated, “There is not a demand or need by the counseling profession to have this option available for students.”

Twenty-nine of the 62 liaisons (46.8%) provided open-ended responses to indicate why their institutions will not offer the Addiction Counseling option. These responses were analyzed and grouped together according to theme. Eight liaisons (12.9%) reported their institutions already offer an addiction certification or concentration; 8 (12.9%) cited limited resources, including faculty; 4 (6.4%) reported the current focus is on adding/changing other program options; 3 (4.8%) cited state addictions licensing/certification issues; 2 (3.2%) reported that more faculty discussion is needed; 1 participant (1.6%) indicated addictions “can be covered in other specialties;” 1 participant (1.6%) stated the program “sees this area as one of specialization post master’s;” and 1 participant (1.6%) indicated “I don’t know.” The last answer (1.6%) was “offered.” This response did not fit with the respondent’s other survey answers. When looking back at this participant’s questionnaire, he or she did not indicate his or her institution offered a non-accredited addiction counseling program or addictions specialization/concentration, and indicated the institution had no plans to offer the Addiction Counseling program option.

Of the 74 institutions, 12 liaisons (16.2%) reported their institutions did have
plans to offer the Addiction Counseling program in the future (Refer to Figure 7).

Question 14(b) followed up to ask for the primary reason why the Addiction Counseling program accreditation will be pursued. Seven of the 12 participants (58.3%) indicated “addictions is a specialty field and there needs to be a program option available which is devoted to teaching students how to work with populations who have addictions.” Two liaisons (16.7%) reported “there is a demand by students for this program option.” Two (16.7%) cite “there is a demand or need by the counseling profession to have this option available for students.” One liaison (8.3%) reported his or her department already has an addiction program available.

The survey responses of the 12 liaisons that indicated plans to adopt the new program option were reviewed for further analysis. The researcher was interested in determining if any of the 12 institutions currently have a non-accredited addiction program option. Only two institutions (16.7%) currently have such a program.

In addition, the researcher reviewed the survey data collected related to institutions that presently require or offer one or more addiction courses. Of the 12 institutions planning on adopting the new option, 8 (66.7%) already require an addiction course for their students, and 1 of the 12 institutions (8.3%) offer one or more elective courses at this time.

When focusing on the responses related to participant opinions, 8 of the 12 liaisons (66.7%) report addiction training is perceived as “crucial” and the remaining 4 liaisons (33.3%) perceive the training as “very important.” The researcher also looked at the faculty information provided by these 12 institutions. These institutions have an
average of 6.8 faculty members total and an average of 2.2 faculty members with addiction expertise. With the plans to add the new counseling program option, the researcher was interested to ascertain if these 12 institutions had plans for adding faculty expertise. Six of the 12 liaisons (50.0%) report no plans to add faculty with addictions expertise, 4 liaisons (33.3%) report their institutions plan to add faculty with addictions expertise, and 2 participants (16.7%) reported “I don’t know.”

**Research Question 4: Opinions Regarding Best Practices in Addiction Training**

Five survey questions (Questions 6-10) asked the CACREP liaisons’ to provide their opinions on several aspects of addiction training. The first question was general in nature, while the next three questions were more specific and detailed. The last question investigating the participants’ perspectives was conceivably the most time consuming inquiry of the 15-item survey. These inquiries answered the first part of the fourth research question:

(4) What do counselor educators view as “best practice” in the training of counselors?

i. What do CACREP-liaisons perceive as best practice? (e.g., methods of implementing the 2009 CACREP addiction competencies, necessary addiction-related content)

**Perspectives on the level of importance.** First, the liaisons were asked how important substance abuse training is in counselor preparation programs (Question 6). Thirty-six of the 74 respondents (48.6%) indicated this type of training was “Crucial,” 31 (41.9%) indicated it was “Very Important,” 6 (8.1%) indicated it was “Important,” 1 (1.4%) indicated it was “Somewhat Important,” and none of the liaisons (0.0%) indicated
it was "Not Important" (Refer to Figure 8).

**Figure 8.** Importance of addiction-related training in counselor education programs. This figure illustrates the CACREP liaisons’ opinions regarding the importance of addiction training.

<table>
<thead>
<tr>
<th>Importance</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crucial</td>
<td>48.6%</td>
</tr>
<tr>
<td>Very Important</td>
<td>41.9%</td>
</tr>
<tr>
<td>Important</td>
<td>8.1%</td>
</tr>
<tr>
<td>Somewhat Important</td>
<td>1.4%</td>
</tr>
<tr>
<td>Not Important</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

**Perspectives on the core area competency addressing addiction.** The 2009 CACREP standards require all students, regardless of program option, to know the "theories and etiology of addictions and addictive behaviors, including strategies for prevention, intervention, and treatment" (CACREP, 2009b, p. 10). This competency is listed in the Human Growth and Development Core Area of the standards. In Question 7, participants were asked their opinions about this new addiction-related requirement. Almost all the liaisons, or 91.9% (n = 68), reported it is "sufficient," 5.4% (n = 4) reported it is "excessive," and 2.7% (n = 2) indicated it is "insufficient."

Question 8 followed up to ask the CACREP liaisons their opinions about the best
implementation method that should be used to address the core competency. The three main choices were infusion, stand-alone course, or a combination of both. Thirty of the 74 liaisons (40.5%) indicated counselor education programs should require a stand-alone addiction course; 17 participants (22.9%) indicated programs should implement a combined method, and require an addiction course and infuse it into at least one core course; 16 respondents (21.6%) reported it should be infused into two or more core courses; 9 participants (12.2%) reported the training should be infused into one core course; 2 participants (2.7%) indicated it should be infused into every course; and no participant (0.0%) selected the two course requirement choice. Refer to Figure 9 below.

Figure 9. Suggested implementation method to address 2009 CACREP core competency. This figure illustrates the CACREP liaisons’ opinions regarding the best method to use when providing addiction-related training to all counseling students.
Perspectives on the CMHC competencies addressing addiction. The researcher identified seven addiction-related competencies in the 2009 Clinical Mental Health Counseling program option (Refer to Table 1). These student learning outcome requirements are more than any other CACREP-accredited program option and the competencies are noted to be more skill-based than knowledge-based. Question 9 asked participants how they think institutions with accredited counselor education programs should implement the 2009 CACREP addiction-related standards for the CMHC program option. Thirty-three of the 74 liaisons (44.6%) indicated students should be required to complete an addiction course (i.e., stand-alone method), 22 (29.7%) indicated students should be required to complete a course and the training should be infused into at least one core course (i.e., combined method), 8 (10.8%) reported the training should be infused into two or more core courses (i.e., infusion method), 5 (6.8%) reported the training should be infused into one core course (i.e., infusion method), 3 (4.0%) indicated it should be infused into every course (i.e., infusion method), and 3 (4.0%) reported students should be required to complete two or more addiction courses (i.e., stand-alone method). In other words, 78.4% of the liaisons (n = 58) think CMHC students should have at least one stand-alone course, while 21.6% (n = 16) think a form of the infusion method is best (Refer to Figure 10).

Perspectives on addiction-related curriculum components. As discussed earlier, the participants indicated which of the 11 addiction-related components are currently taught at some point in the curriculum of all students. Another inquiry, Question 10, was also related to these 11 addiction-related curriculum components.
Figure 10. Suggested implementation method for CMHC programs. This figure illustrates the CACREP liaisons' opinions regarding the best method to use when providing addiction-related training to CMHC students.

Regardless of whether the addiction components are presently being taught, the liaisons were asked to indicate if these various components are viewed as necessary in counselor education training.

The CACREP liaisons were provided a six by eleven matrix (see Question 10). On the matrix, a box represented a combination of a specific curriculum component (e.g., screening) and counseling program option (e.g., Career Counseling). Six columns across the top were labeled with the following: “Clinical Mental Health Counseling;” “Career Counseling;” “Marriage, Couple, and Family Counseling;” “School Counseling;” “Student Affairs and College Counseling;” and “None of these program options.” On the left of the matrix, there were eleven rows labeled “Screening,” Assessment Tools,”

![Suggested Implementation Method for CMHC Programs](chart.png)
“Diagnosis,” “Pharmacology,” “Prevention,” “Intervention,” “Treatment Options,” “Counseling Strategies,” “Co-occurring Disorders,” “Etiological Theories (i.e., causes of substance abuse),” and “Process Addictions (e.g., gambling, shopping, Internet, sex).”

Participants were asked to put a check mark in the box if they agreed to the necessity of the addiction component in the training of students in that particular master’s-level, counselor education program option.

Question 10 was created because the researcher recognized a significant difference in the number of competencies listed by program option in the 2009 CACREP standards. For example, Career Counseling has no addiction-related competencies listed, while Clinical Mental Health Counseling has seven. The researcher wanted to investigate if counselor education faculty perceived a difference in the need for training by counseling program option and by curriculum component.

The results for Question 10 are displayed in Table 3. The total number of times the box was checked by the participants (N) is listed for each combination. The total number was divided by 74 in order to obtain the percentage for each combination. The maximum number for each combination of component and counseling program option is N = 74 and the highest possible percentage is 100%. Only two combinations of the 66 total combinations in the matrix received the maximum number of N = 74, or 100%, and they are (1) “Diagnosis” for “Clinical Mental Health Counseling” students and (2) “Etiological Theories” for “Clinical Mental Health Counseling.” The lowest total number in the matrix (n = 7) is “Pharmacology” for “Career Counseling” students. Four participants (5.4%) indicated “Pharmacology” does not need to be taught to any students.
in the program options provided in the matrix. The option “None of these program options” was selected by one participant for five of the 11 components: “Screening,” “Assessment Tools,” “Prevention,” “Intervention,” and “Process Addictions.”

Table 3

Percent of Participants Indicating Necessity of Curriculum Component by Program Option

<table>
<thead>
<tr>
<th>Curriculum Component</th>
<th>CMHC</th>
<th>Career</th>
<th>Marriage, Couple, and Family</th>
<th>School</th>
<th>Student Affairs and College</th>
<th>No Programs</th>
<th>Sum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening</td>
<td>98.6% (n = 73)</td>
<td>50.0% (n = 37)</td>
<td>77.0% (n = 57)</td>
<td>91.9% (n = 68)</td>
<td>73.0% (n = 54)</td>
<td>1.3% (n = 1)</td>
<td>n = 288</td>
</tr>
<tr>
<td>Prevention</td>
<td>97.3% (n = 72)</td>
<td>29.7% (n = 22)</td>
<td>66.2% (n = 49)</td>
<td>86.5% (n = 64)</td>
<td>64.9% (n = 48)</td>
<td>1.3% (n = 1)</td>
<td>n = 254</td>
</tr>
<tr>
<td>Assessment Tools</td>
<td>97.3% (n = 72)</td>
<td>29.7% (n = 22)</td>
<td>70.3% (n = 52)</td>
<td>73.0% (n = 54)</td>
<td>64.9% (n = 48)</td>
<td>1.3% (n = 1)</td>
<td>n = 247</td>
</tr>
<tr>
<td>Treatment Options</td>
<td>97.3% (n = 72)</td>
<td>27.0% (n = 20)</td>
<td>66.2% (n = 49)</td>
<td>68.9% (n = 51)</td>
<td>55.4% (n = 41)</td>
<td>0.0% (n = 0)</td>
<td>n = 233</td>
</tr>
<tr>
<td>Etiological Theories</td>
<td>100.0% (n = 74)</td>
<td>25.7% (n = 19)</td>
<td>64.9% (n = 48)</td>
<td>68.9% (n = 51)</td>
<td>50.0% (n = 37)</td>
<td>0.0% (n = 0)</td>
<td>n = 229</td>
</tr>
<tr>
<td>Intervention</td>
<td>97.3% (n = 72)</td>
<td>21.6% (n = 16)</td>
<td>66.2% (n = 49)</td>
<td>64.9% (n = 48)</td>
<td>52.7% (n = 39)</td>
<td>1.3% (n = 1)</td>
<td>n = 223</td>
</tr>
<tr>
<td>Counseling Strategies</td>
<td>98.6% (n = 73)</td>
<td>13.5% (n = 10)</td>
<td>68.9% (n = 51)</td>
<td>66.2% (n = 49)</td>
<td>51.3% (n = 38)</td>
<td>0.0% (n = 0)</td>
<td>n = 221</td>
</tr>
<tr>
<td>Process Addictions</td>
<td>95.9% (n = 71)</td>
<td>25.7% (n = 19)</td>
<td>67.6% (n = 50)</td>
<td>62.2% (n = 46)</td>
<td>48.6% (n = 36)</td>
<td>1.3% (n = 1)</td>
<td>n = 221</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>100.0% (n = 74)</td>
<td>24.3% (n = 18)</td>
<td>59.5% (n = 44)</td>
<td>54.0% (n = 40)</td>
<td>50.0% (n = 37)</td>
<td>0.0% (n = 0)</td>
<td>n = 213</td>
</tr>
<tr>
<td>Co-occurring Disorders</td>
<td>98.6% (n = 73)</td>
<td>16.2% (n = 12)</td>
<td>62.2% (n = 46)</td>
<td>54.0% (n = 40)</td>
<td>43.2% (n = 32)</td>
<td>0.0% (n = 0)</td>
<td>n = 203</td>
</tr>
<tr>
<td>Pharmacology</td>
<td>91.9% (n = 68)</td>
<td>9.5% (n = 7)</td>
<td>51.3% (n = 38)</td>
<td>37.8% (n = 28)</td>
<td>39.2% (n = 29)</td>
<td>5.4% (n = 4)</td>
<td>n = 166</td>
</tr>
<tr>
<td>Program Option Average</td>
<td>97.5% (n = 72)</td>
<td>24.8% (n = 49)</td>
<td>65.5% (n = 48)</td>
<td>66.2% (n = 40)</td>
<td>53.9% (n = 18)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
In Table 3, the researcher created a column titled, "Sum," and a row titled, "Program Option Average." For each curriculum component (or each row) the \( n \) for all five program options were added together and the responses indicating "None of these program options" were subtracted to obtain the total in the "Sum" column. For example, the "Sum" column for "Screening" which indicates \( n = 288 \) was obtained by adding 73, 37, 57, 68, and 54 together, then subtracting 1. The highest possible "Sum" is \( n = 370 \). This would have occurred if all 74 participants indicated a curriculum component should be included in each of the five programs. The following is the order from largest curriculum component "Sum" to the smallest: (1) "Screening" \( (n = 288) \), (2) "Prevention" \( (n = 254) \), (3) "Assessment Tools" \( (n = 247) \), (4) "Treatment Options" \( (n = 233) \), (5) "Etiological Theories" \( (n = 229) \), (6) "Intervention" \( (n = 223) \), (7) "Counseling Strategies" and "Process Addictions \( (n = 221) \), (8) "Diagnosis" \( (n = 213) \), (9) "Co-occurring Disorders" \( (n = 203) \), and (10) "Pharmacology" \( (n = 166) \) (see Table 3). Overall, screening, prevention, and assessment tools are perceived as the three most important to include in curricula, and diagnosis, co-occurring disorders, and pharmacology are perceived as the three least important to include.

To determine if the program options differed in regards to perceived necessity in curriculum components, two averages were calculated. For each program option (or each column), the percentages of all 11 curriculum components were averaged and the \( n \) for all 11 components were averaged. The results of these two calculations were placed in the "Program Option Average" row at the bottom of Table 3. The following is a list of the program options from highest average percentage to lowest average percentage: (1)
"Clinical Mental Health Counseling" (97.5%); (2) "School Counseling" (66.2%); (3) "Marriage, Couple, and Family Counseling" (65.5%); (4) Student Affairs and College Counseling" (53.9%); and "Career Counseling" (24.8%). In other words, on average, 97.5% of the liaisons perceived the 11 curriculum components as necessary in the training of Clinical Mental Health Counseling students. In regards to Career Counseling students, the 11 components were perceived as necessary by 24.8% of the sample, on average. See Figure 11 for an illustration of the total mean $n$ for each program. On average, 72 liaisons perceived the 11 curriculum components as necessary for the training of students in the CMHC program option. The second highest average was School Counseling with $n = 49$, a mean of 23 participants less than CMHC.

Figure 11. Average number of liaisons perceiving necessity of addiction-related content. This figure illustrates the average number of participants that viewed the 11 addiction-related curriculum components as necessary for each of the program options.
Summary

Over 90% of the CACREP liaisons indicated addiction training is considered crucial or very important and the majority of institutions are currently providing addictions-related instruction in some form. In regards to all students, 50% of the institutions offer an elective course, 28.4% require a course, 39.2% infuse the training, and 2.7% indicate no training is provided. Thirty-six percent of the sample \((n = 27)\) require a course for students enrolled in a specific program option. Of all the program options requiring their students to complete an addictions course, the CMHC programs had the highest percentage (47%). On the other hand, none of the 27 institutions (0.0%) require a course for Career Counseling students or Student Affairs and College Counseling students.

Many institutions offering CACREP-accredited counselor education programs have plans for change related to addictions education. This investigation found an average of two counselor educators per institution with expertise in addictions. Sixty-six percent of the institutions have 1 or 2 faculty members, 23% have 3 to 6 members, and almost 11% have no members with expertise. Seven liaisons, or 9.5% of the sample, reported their institutions have plans to add more faculty members with expertise within the next two years. In addition, 25% of institutions that do not currently require a course, or 10.8% of the sample, have plans to require a course in the next two years. Also, 38.8% of institutions that do not currently offer a course, or 9.4% of the sample, have plans to offer a course in the next two years. According to many of the liaisons, even more substantial changes within programs may occur in the future. Twelve participants
(16.2%) reported their institutions plan on implementing the Addictions Counseling program option and it was determined that 10 of the 12 institutions do not currently have a non-accredited substance abuse or addictions specialization.

The liaisons held opinions regarding how to implement addiction training. In order to address the new Human Growth and Development core competency related to addictions, over 64% of participants believe all students should have a required course and roughly 36% believe the training should be infused into curricula. Fifty-eight of the 74 liaisons, or 78.4%, indicated CMHC students should have at least one stand-alone course, if not two or more courses, and a little over 21% think a form of infusion is the best method.

In terms of current addiction-related education, the top four content areas which are presently taught most often are screening (78.4%), diagnosis (77.0), counseling strategies (73.0) and prevention (71.6%). The four addiction-related training components which are taught least often are co-occurring disorders (66.2%), treatment options (63.5%), pharmacology (52.7%), and process addictions (50.0%). Six institutions, or 8.1% of the sample, reportedly do not teach on any of the addiction-related content listed above. This study also found that while pharmacology may be taught in almost 53% of the institutions, 4 participants believe this component is not necessary in the training of any counselor education program options. On the other hand, all 74 participants indicated addiction diagnosis and etiological theories are necessary in the training of CMHC students. In general, the CACREP liaisons perceived addiction-related education to be more important in the training of CMHC students than the other options. For
example, the "program option average" was 97.5% for the CMHC option, while the second highest was 31% lower at 66.2% for School Counseling. The next program option average was 65.5% for Marriage, Couple, and Family Counseling, followed by Student Affairs and College Counseling at 53.9%. The program option average for Career Counseling was the lowest at 24.8%, almost 73% less than the CMHC program.

Themes from Open-Ended Comments

The last question on the survey was optional. Question 15 was an opportunity for participants to provide any additional comments regarding addiction education and training needs that should be considered by CACREP-accredited counselor education programs. There were 15 participants that contributed open-ended responses (see Appendix N for verbatim responses), and these statements were analyzed for common themes by the researcher. The following five broad themes emerged from the data: (1) Addiction training is important in counselor education, (2) CACREP requirements are excessive, (3) CACREP must allow for flexibility, (4) Program limitations impact implementation methods, and (5) Addiction counseling is perceived as a specialization. The themes are addressed individually in the next five sections and they are in order from the most prominent theme to those of less prominence.

**Addiction training is important in counselor education.** Several of the respondents made reference to the importance and prevalence of addiction-related issues, and called for this type of instruction in counselor education. For example, respondents indicated, "Substance abuse education for counselors is vitally important" and "It is irresponsible to train counselors, especially CMHC and [marriage and family therapists]
as well as college counselors without providing a minimum of one required course in [substance abuse]. This issue impacts the majority of clients, especially in internship settings.” Others included statements that recommended specific training components such as, “The more emphasis on process addictions across the curriculum, the better;” “ALL counselors should have some competency in assessment of substance abuse/addictions;” “content on substance abuse (screening, prevention, interventions, etc.) should be included in CACREP accredited program curricula;” and “including substance abuse background either in required courses or through infusion strategies ... as long as it is covered.” One respondent stated the National Board for Certified Counselors (NBCC) needs to recognize the importance of addiction training and reported, “Since substance abuse education is required by CACREP, there should be a corresponding effort by NBCC to include this area in the [National Counselor Exam].”

**CACREP requirements are excessive.** Participants shared their views pertaining to CACREP and the current standards which mandate substance abuse competencies. One respondent stated that while, “training in substance abuse is important ... I think the counseling field is starting to go too far with its emphasis on competencies. Substance abuse competencies ... multicultural competencies ... spiritual competencies ... how many more competencies will be required to insert into counseling programs over the next 10 years?” Another respondent stated that, “CACREP is throwing on too many requirements for all the degrees, watering down the importance of some areas; they should be focusing more on important areas - not just everything they can think of requiring.” Another respondent commented on the decreased number of
specialty programs due to increased number of standards and stated, “As the credit hour requirements for graduate counseling degrees have steadily increased (by CACREP), so too have the standards. As a result, many institutions have been forced to require more courses and limit the number of elective, specialty options.” One liaison recommended the dissolution of the organization and stated, “CACREP should not exist as it is no longer an independent accrediting body as [shown] by the 2009 standards. It is controlled by universities and counselor educators have no input.”

Program limitations impact implementation methods. Restrictions exist at institutions and several aspects impact how CACREP standards are implemented, such as resource availability, curriculum flexibility, faculty expertise, and faculty and administration perceptions. One respondent indicated that his or her program is “maxed out at 63 semester hours for a Master's degree . . . [and the] dean will not permit [the program] to require any more courses.” One participant simply stated it is “difficult to [keep] adding required courses.” One institution will “for the first time . . . devote nine class hours, in [the] new Advanced Counseling course, to substance abuse and addictions . . . This seems to be the best way . . . in a 48-hour, full-time, two-year school-counseling program to incorporate this emphasis.”

CACREP must allow for flexibility. Several liaisons believed there is an overabundance of CACREP standard requirements and there are limitations within their programs which impact how they can implement the standards. Therefore, variation among programs will exist. Some participants shared their opinion on the necessity of having the flexibility to implement the requirements as needed. For example, one liaison
stated, “The ideas of competencies is fine as long as individual counseling programs have the option of determining whether such competencies are appropriate given their particular circumstances.” One respondent thought “many programs have been forced to require more courses” and that the freedom for flexibility has not been given. On the other hand, another liaison indicated that faculty members are implementing the standards which work best for them and reported that “substance abuse is required for CMH; optional for others.”

**Addiction counseling is perceived as a specialization.** The last theme was only indicated by one liaison, although the theme is relevant. The discussion of addiction counseling as a specialization is one which impacts the CACREP standards, as well as how standards are implemented within institutions. This liaison pointed out that due to the increase in course requirements at his or her institution, and possibly other counselor education programs, it “limit[s] the number of elective, specialty options. Although this may ensure that all counselors have a baseline level of training in 'core' areas, it limits the number of counselors who may have designated specialties to serve specific populations” and it was the participant’s “opinion that substance abuse/addictions should remain a specialized part of counseling practice.”

**Qualitative Findings**

The qualitative data answered part of the last research question of this mixed-method study. The fourth and final question was:

(4) What do counselor educators view as “best practice” in the training of counselors?
More specifically, the findings from the interviews addressed the second half of the fourth research question.

ii. What do counselor educators who are also experts in the field of addictions view as best practice? (e.g., requiring a course or infusion, instructor qualifications, and pedagogical methods)

The 2009 CACREP standards not only address addiction training in the Human Growth and Development core area and the CMHC program option, but an Addiction Counseling program option now exists. The purpose of obtaining expert opinions regarding the new CACREP standards changes related to addiction instruction is three-fold. First, the results of the interviews provide an informal evaluation of the new 2009 standard additions and changes. Second, the opinions offer some guidance in the implementation of the standards, especially for institutions lacking faculty with expertise in this area. Last, the purpose was to gain the perspectives of experts on the “best practices” in addictions training of master’s-level counselors, such as necessary curriculum components and effective pedagogical methods.

The presentation of the qualitative results is as follows. The findings from the thematic analysis are organized by the main, or global, themes. Last, a summary is given which highlights the significant outcomes from the qualitative inquiry.

**Findings from Thematic Analysis**

Five global themes were found after completion of the thematic analysis. Each global theme contains organizing themes, which are made up of basic themes. In the next five sections, the data will address all three levels. The five main themes are: (1) Need
for Addictions Training, (2) Significant Changes in Profession within the Last Decade, (3) Critique of the 2009 CACREP Standards, (4) Best Practice/Ideal versus Practicality/Reality, and (5) Further Changes Need to be Made in the Field (see Figure 12).

![Diagram](image)

**Figure 12.** Qualitative findings from expert interviews. This figure is an illustration of the five global themes that were found in the qualitative data.

**Theme One: Need for Addictions Training**

Cross-case analysis of the five interviews yielded repeated patterns of meaning related to the necessity for education and instruction in addiction-related issues. The middle-order themes, or organizing themes, represent the cluster of basic themes found in the data. The two organizing themes that emerged were “Prevalence” and “Call for Specialty Program Option.” Refer to Figure 13 for the Thematic Network of Theme One.
Figure 13. Thematic network for global theme one, "Need for addictions training."

Prevalence. Five basic themes were categorized together to create this organizing theme. By mentioning the prevalence of addictions within the United States, the participants spoke to the necessity for counselor education students to have this type of training.

The number of people in general populations with addictions. The first basic theme identified by participant responses indicated the widespread nature of substance abuse and other addictions. For example, one interviewee stated, "Substance use disorders are not exclusive to a specific population . . . those who are affected span the range of demographics . . . no one is immune." Another participant reported that it is "such a pervasive problem . . . and given the prevalence of this problem it just makes sense to me that we also train people . . . in at least some basic knowledge of addiction."
When discussing the training needs of all counselors, one respondent discussed how graduates over the years have told him that addiction instruction was one of the areas they felt most lacking. He stated, “Whether it’s a school counselor, a community counselor, or a student affairs counselor . . . you run across clients with these problems in so many different settings. It’s very generalized. So it’s not just for community counselors.”

*Vicarious connections.* The second basic theme emerged due to several statements relating to the impact that addiction has on other people, not just the person with the addiction. Therefore, training in this area is crucial for counselors. For instance, one of the counselor educators stated he can enter any classroom he wants, whether it is a “counseling class or an undergraduate biology class . . . and ask them how many people have been affected by somebody that they know and their drug or alcohol use . . . the vast majority of people are going to raise their hands.” Another respondent reported that counselors will work with “persons who are directly affected by substance use disorders . . . themselves, family members, other people, so I think it is very important that students have training” in addictions. One stated, “I think it runs the entire gamut [of counseling issues], whether it’s personal or vicarious connections to addictive disorders” and he thought all counselors should have “at least a working knowledge of prevention, assessment, and treatment” due to these connections. Another expert concluded, “Everyone is impacted by addictions in some form or fashion . . . and I think all counselors should be prepared for it.”
Co-morbidity with mental health. The third basic theme under “Prevalence” is the tendency for addiction to co-exist with other mental health issues. One counselor educator indicated that due to the incidence of co-occurring disorders, “no counseling student can say I don’t want to work with quote, those people.” Another expert recommended more instruction on the spectrum of Axis I disorders as it relates to addictions. He stated that frequently clients will present as depressed or anxious and instead of assessing further they will “just go with the DSM Axis I related to anxiety but fail to understand that anxiety only [results from] someone’s substance abuse or their depression is post cannabis abuse.”

Co-relational with other issues in life. The fourth basic theme is the tendency for addiction to be related to other aspects of a client’s life. Therefore, this type of education is necessary due to the impact substance use and addictive disorders have on the various life areas. One participant stated this instruction is of the “utmost importance given the co-relation of addictive disorders with the realm of client presenting issues.” He went on to say, addiction can be related to problems when “a client, couple, or family is presenting with communication concerns, an individual is presenting with low self-esteem . . . career indecisions, difficulty in study skills in schools,” etc. Another interviewee discussed how the instruction should be implemented and stated, there should be a “stand-alone course like . . . diversity and ethics, but then [addiction-related] content is also infused in every other course because it impacts every other part of the client’s life.”
**Major public health crisis.** The fifth and final basic theme in the Prevalence area was reported explicitly by one of the experts who stated addiction is “very prevalent, and it is one of our top national health crises.” Due to the nature of addiction, another participant indicated the need for counselors to take a “public health perspective” and “not only view ourselves as interventionists, but as public health professionals.”

**Call for specialty program option.** Under the global theme related to the need for addiction training is the organizing theme pertaining to the demand for an addictions specialty program option. Three basic themes emerged from the data which comprise this organizing theme.

**Student interest.** First, students reportedly have an interest in addictions counseling. One counselor educator reported at the last two institutions of his employment “the vast majority of [students] have an interest in substance abuse counseling.” Likewise, another participant stated a similar sentiment and reported at her university “there are several students who have an interest in addictions and I see them as having good prospects for employment in CACREP-accredited programs.” The reason students may be attracted to the specialization is because it will “help students develop a niche. So when they go out there, they have some additional coursework in a specialty area that they [will] be spending most of their time.”

**State licensure requirements.** Several of the experts mentioned how a specialty program will assist in acquiring an addictions license, and therefore there is a need for this training. The experts also discussed the appeal of a counselor education program that prepares students for licensure. For instance, departments will adopt this specialty option
because CACREP “programs [are looking] to differentiate themselves from others within their state [and] the state licensing boards are moving from a certified addictions professional to a licensed addictions professional.” He went on to say that adopting the Addiction Counseling option will “bring some credibility and some legitimacy to a CACREP-accredited program.” One of the participants stated his institution is going to offer the option because it is “specifically designed for students who [want] to work in this treatment area and want to get the state license as a chemical addictions specialist.” Another stated, “As state certification and licensing boards catch on to this, then there may be more programs [offering the Addiction Counseling option] to help counselors meet those requirements.”

*Addiction counseling is still perceived as a specialty within the mental health field.* Previously, the perception has been that addictions should be treated by a specialist and addiction education has not been viewed as necessary for all students. In fact, according to one expert it was considered the “ugly step-child in most counselor education programs.” Two participants stated addiction training has been seen as “an elective.” One of them reported it is still considered an “optional specialization . . . an aside perhaps . . . something [a student is] welcome to identify as a specialty, but [in-depth training] is not something that we as a program provide [students] with” at this time. Therefore, there is a call for an Addictions Counseling specialty option due to the continued existence of the perception that counselors need expertise to provide addiction services. Addictions counseling has been considered an aside in the past, and some counselor educators may still have this belief; although, due to the previously stated
themes, the experts also recommend this training should be infused for all students regardless of specialization area. This belief will be discussed in greater detail later in this chapter.

**Theme Two: Significant Changes in Profession within the Last Decade**

The experts were asked about the current state of addictions training in CACREP-accredited programs. While discussing this aspect of education, the second global theme emerged and it is comprised of two organizing themes (see Figure 14). The considerable changes within the counselor education profession related to addictions are associated with acknowledging the need for education and instruction, resulting in the reduction of stigma, and the increase of acceptance.

*Figure 14. Thematic network for global theme two, “Significant changes in profession within the last decade.”*
**Answering the call for needed training.** Over the years, the counseling profession has "come a long way" in addiction-related education, according to one counselor educator. The CACREP standards particularly have "brought a whole lot more attention to addiction as a counselor training area than I think has been there in the past."

Another participant indicated "compared with what [counselors] have now to what we were doing five or ten years ago. Significant difference. Light years ahead."

All of the respondents made reference to the progress made in addictions instruction over the years, and five basic themes emerged from the data related to this organizing theme. Four of the five correspond to the 2009 CACREP standards and the other relates to changes at the state and national levels.

**Core competency.** A few of the experts discussed the new addiction-related competency listed in the Human Growth and Development Core Area (CACREP, 2009b) as a significant move in the counseling profession. One participant stated "we have come light years ahead . . . I think now [addiction training] has really come to the forefront. Especially now with CACREP saying addictions is to be integrated throughout the curriculum" of all students. Another counselor educator addressed the depth and breadth of the core competency stating, "theories and etiology of addiction and addictive behaviors could be a class in itself, or it can be infused into each class."

He went on to discuss the second half of the competency and stated "strategies for prevention, intervention, and treatment. Again, there is a lot packed in there." The expert thought this competency was succinct, yet the content to be taught is expansive. He indicated counselor education programs will probably have to shift the curricula of courses that
have traditionally not had any addiction-related content. He referenced the core competency again and reportedly was “satisfied that [addition training] is in the core curriculum” and that it was “a big step forward.”

**CMHC competencies.** The second basic theme found was related to the larger number of competencies necessary for CMHC students to obtain during their graduate studies relative to students in other counselor education program options. One participant went into detail about the required student learning outcomes for program areas. He explained how there is a difference in knowledge-based and skill-based outcomes. The respondent stated the CMHC program option requires more outcomes that are a demonstration of skill versus a demonstration of knowledge related to addiction training. For instance, the Marriage, Couple, and Family specialty standards do not have “a lot of skills and practices related to addictions. Most of those are found under the Clinical Mental Health [Counseling] program.” More specifically, the Marriage, Couple, and Family Counseling competencies include verbs such as “recognizes” and “understands” (i.e., knowledge-based outcomes) and the CMHC program competencies include verbs such as “applies,” “provides,” and “screens for” (i.e., skill-based outcomes). Another participant indicated that the CMHC competency requiring students to demonstrate appropriate counseling strategies when working with clients having addiction problems is one that cannot be covered by infusion and recommends a stand-alone course. This recommendation signifies the shift in training requirements for current CMHC students compared to students in the past Mental Health Counseling and Community Counseling program options. One participant specifically mentioned the 2001 standards and how
addiction training was lacking in the Community Counseling program. Currently, addiction training in the Community Counseling track “is sorely underrepresented in the CACREP programs.” The 2009 CMHC standards symbolize a recognition that addiction training has been lacking in the past and an increase in education is now required.

**Addiction counseling program option.** The third basic theme under “Answering the Call for Needed Training” is acknowledgement of the new specialization program in addictions counseling. A few of the participants mentioned that the call for a specialty program has been answered, and this new addition is a significant change in counselor education. One of the experts addressed the significance of CACREP creating this specialization and stated, “The fact that counselor education is running accreditation standards for one of the major helping professions is a huge jump forward in our profession.”

**Addressing addictive behaviors in the 2009 standards.** The fourth basic theme is related to the identified competencies that include instruction on addictive disorders. Several of the counselor educators discussed the increase in recognition of these disorders, which are separate from chemical use, and include gambling, shopping, sex, etc. One expert stated, “It’s about time. I think it’s wonderful because the process for [addictive behaviors] and substance abuse addictions is exactly the same . . . we needed to include [those addictions].” A couple participants noted the transition in the titles of addiction-related courses even before 2009 standards were released. One stated that he thinks the change in wording “emphasizes the range of addictive disorders that are no longer relegated to alcohol and drugs.” He went on to say that counseling is the “first
helping profession to officially recognize that there are such disorders, whether [the American Psychological Association] or the *DSM*, they do not recognize them as addictive disorders." Another expert indicated "when [he] started out [in the field] it was about alcohol and other drugs, but overlooked all the process addictions" and over the years he has witnessed a significant change in the profession since the beginning of his counseling career.

*State and national level changes.* The last basic theme is comprised of data related to the modifications in state and national organizations, excluding the CACREP standards. For example, two of the experts discussed the shift in requirements for licensing and credentialing by states. One counselor educator asserted, "The field needs . . . to continue advancing the professional training of counselors so that we increase our education level." He reportedly would like to see a continued nationwide shift and have states "move toward more master’s-level training, regardless of whether or not you are in recovery." Another respondent referenced the standards set forth by the National Association for Alcoholism and Drug Abuse Counselors (NAADAC). He indicated progression in the counseling profession because of these standards created for associates, bachelor’s, master’s, and doctoral-level addiction counselors. Moreover, this participant stated, "License sometimes implies master’s degree . . . Treatment should be done by master’s-level clinicians" and the profession should continue to move forward with this requirement. When one of the experts discussed her appreciation of the recognition of ethical and legal standards related to addiction counseling, she referenced the various codes of ethics to which clinicians must adhere for state licensure as a
chemical dependency or addiction counselor. In particular, she pointed out the federal confidentiality law 42CFR (part II), which relates specifically to persons with chemical dependency issues.

Reducing stigma and gaining acceptance. Participants discussed perceptions of addiction and how the counseling profession has attempted to reduce the stigma held by students, faculty, administrators, and society. One respondent stated, “When you start talking about addictions, people freak out” and some faculty and students say, “Well, I’m not trained in addictions” and “Those people are different.” Another participant asserted “certainly there is still stigma, but I’d like to think we are making positive directions in that area of stigma.”

Terminology changes. The first basic theme associated with making attempts to reduce stigma and gain acceptance was related to the alterations in terminology seen within the profession. Participants conveyed to the researcher that modifications to certain words are noteworthy. For instance, the change from using the terms “alcohol,” “drugs,” and “substance abuse” to the term “addictions” is an acknowledgement of other addictive disorders besides chemical dependency. When referencing the increase in acceptance of process addictions, one participant commented, “Let’s start with the title [of the Addiction Counseling program]. Just using the word addiction I think is a huge step forward from calling it substance abuse.” A couple participants also noticed the name conversions in addiction courses prior to the CACREP standard revisions which demonstrated the increase in acceptance of the terminology. One interviewee went on to say, “[changing the course titles] emphasizes the range of addictive disorders that are no
longer relegated to alcohol and drugs... even the language used within the Addiction Counseling standards... has moved away from substance use and misuse and is using addictive disorders.

**Experiential activities versus knowledge-based course design.** In an effort to reduce the students' stigma associated with addictive behaviors and with addicted clients, the experts reportedly incorporate specific methods or activities in the classroom. In addition to the traditional, knowledge-based assignments, the respondents described various types of experiential and reflective activities both in and out of the classroom. These assignments will be discussed in more detail later when outlining best practices.

The basic theme pertained to how counselor educators are attempting to challenge students' beliefs regarding addiction and people with addictions by implementing assignments which are not based on assessing how much information a student has retained. One participant reported using an abstinence contract in which students abstain from something of their choosing such as a beverage, food item, or behavior for an entire semester. She stated this exercise will help them gain a "first-hand experience of what it's like not to have. To simulate what it's like for clients when told to do without the substance they have become dependent on." The respondent hopes engaging in these experiential activities increases students' empathic skills. Another interviewee stated that by interviewing clients struggling with addictions, students "get to see real people with real problems and see the human side of addiction." He stated that exposure to these types of assignments will deconstruct the "myths or concern about drug and alcohol clients" because "at the root of this is a person [and] being able to see who the person is
and meeting the person” is important in order to “[separate] the person from the addiction.” Another participant discussed perceptions of who attends 12-step meetings. By having students observe meetings in the community, they will find variation in the demographics of attendees. For example, some programs “are comprised of little old men who are 85 years old versus other programs that are comprised of stay-at-home, affluent moms.”

More instruction provided to students. Stigma connected to addictions is not restricted to the counseling students. As a few of the experts pointed out during their interviews, faculty and administrators also have perceptions that influence decisions about instruction on this topic. Acceptance is increasing and stigma is decreasing because of additional instruction provided to counselor education students over the years. This final basic theme emerged due to statements such as, “There are a lot of negative connotations that [are] often put with addictions counseling and some faculty don’t want to be [connected to it].” Referencing a past interaction with a colleague, one counselor educator stated:

I spoke to one faculty member who did not want to teach any addictions programming because he didn’t want to be associated with it. The person was in fear that if they are affiliated with that program, people are going to think I’m in recovery and the literal fear that they would be identified as someone in recovery. The social, negative perceptions that still remain related to addictions can have an impact on whether departments [adopt the Addiction Counseling program].

Participants indicated the additional training that has been devoted to addictions over the last decade has decreased some of the existing stigma. Moreover, the potential increase in training that will take place in CACREP programs in the coming years will continue to change perceptions surrounding this area of instruction. One counselor educator
described how this can occur and thought “if multiple courses speak to [addictions]... [such as] an assessment course... human development course... and a family class...
Then it becomes more of a common topic and a common conversation point with counselors.” In short, to decrease stigma, faculty must make addiction-related instruction “a significant part of the counseling climate.”

**Process addiction defined in standards glossary.** The last basic theme related to the evidence of stigma reduction and gaining acceptance was directly referenced by one participant. The interviewee shared his excitement pertaining to the “shift toward accepting the terminology of addictive disorders and even having a glossary definition of process addictions in the 2009 standards... just blows me away.” He indicated CACREP took a “stand” in this regard and “it is an exciting time personally and professionally to see this [shift] happening.”

**Theme Three: Critique of the 2009 CACREP Standards**

The revised standards include more addiction-related content than previous editions. During the interviews, each of the experts provided their opinions regarding these new standards. One organizing theme emerged from the data and five basic themes comprise the organizing theme. Refer to Figure 15 for the Thematic Network of Global Theme Three.

**Positive overall and a good start.** Each of the five experts critiqued several aspects of the 2009 standards. The identified organizing theme was that all participants perceived the latest edition of the CACREP standards to be a positive step forward and a good starting point. Every respondent had an opinion on specific pieces of the standards
and these five facets became basic themes.

**Core competency.** First, the participants pointed out the addiction-related competency in the Human Growth and Development core area was a good start, and they all perceived its inclusion in the new standards as positive. One counselor educator stated, “I’m satisfied that it’s in the core curriculum. I think that’s a big step forward.” He also described the core competency as expansive and the content within it was substantial. For example, he asserted “there’s a lot to pack into” the instruction of theories and etiology in his opinion. Another participant indicated the competency was “nice and succinct” and a “summative statement.” One expert stated she appreciated the use of the plural term “theories,” which acknowledged the variety of ways to view and
treat addiction. One of the interviewees worked closely with the revision committee, and he reportedly received feedback in regards to incorporating addiction training in the core. He stated the inclusion of addiction training in the core standards was highly recommended. Therefore, he stated “the end result has been very favorable.” A final participant described the impact of the core requirement and how addiction-related instruction is coming to the forefront:

Especially now with CACREP saying addictions is to be integrated throughout the curriculum and that those who graduate from CACREP-accredited programs need to demonstrate addictions competencies. So, from that I think it is outstanding because it is really bringing addictions forward.

**Specialty program options.** Most of the specialty program options have competency requirements regarding substance abuse and addictive disorders. The researcher provided the participants an outline of these standards prior to the interview (Appendix K). Each of the participants discussed his or her opinion associated with the specialization areas, and some participants were more detailed in their critiques. Three of the five experts reported their contentment with the current standard revisions pertaining to the specialization areas. The other two participants believed the new standards in the program options represented movement in the field, but they were not fully satisfied with the outcome. One counselor educator stated it was a “great start” but she didn’t “think that [the specialty program standards are] comprehensive enough.” The two interviewees gave feedback related to the perceived lack of addiction content in several options such as the School Counseling, Career Counseling, CMHC, and Marriage, Couple, and Family Counseling programs. These identified deficiencies will be described in detail later under Global Theme Five which relates to recommended changes for the future.
**Addiction counseling program option.** As seen in the specialty program option critique, the five participants shared an overall positive reaction to the Addiction Counseling standards. One stated he was “very pleased with it. So if folks who want to have a specialization in addictions, they have an option of which way to go. I think that’s wonderful.” Almost all of the counselor educators commented on the title and expressed appreciation for it. They indicated the title is an accurate representation of the range of addictions, not just substance abuse. Three experts found these particular standards to be “comprehensive.” One respondent stated the program is “very thorough and very consistent” and could not identify any areas for change. Another participant shared the understanding that the program “is the first installment of such a program area for CACREP [and] . . . it represents a very good start.” This counselor educator went on to give positive feedback on specific competencies that were seen as valuable (i.e., A5, A8, D2, G4, K1, and B1) due to the inclusion of the following concepts: theories, resilience, individualized strategies, prescribed medications, differential diagnosis, and ethical and legal standards. The participant’s critical feedback is discussed in detail later under Global Theme Five.

**Terminology and glossary basic themes.** The researcher found two of the basic themes, “Terminology Changes” and “Process Addictions Defined in Standards Glossary,” to emerge and correspond with two different global themes. As stated above in Global Theme Two, the participants discussed the terminology changes and the presence of the process addiction definition as representations of how addiction-related content is gaining acceptance in counselor education. The researcher determined these
two aspects of the 2009 CACREP standards also correspond with the participants' critiques (i.e., Global Theme Three). The respondents were very pleased to see the inclusion, and use of, the terms "addiction," "addictions" and "addictive disorders." In addition, the new glossary definition provided by CACREP for process addictions was viewed by one counselor educator as exciting and it "just blows [him] away."

**Theme Four: Best Practice/Ideal versus Practicality/Reality**

During the discussion of the implementation of the 2009 CACREP standards and the preferred methods for addictions training, the Global Theme Four emerged. Each participant acknowledged a difference between reality and the ideal. The researcher will present the "Best Practice" organizing theme first and then the "Practicality" organizing theme will be presented.

![Thematic network for theme four, "Best practice/ideal versus practicality/realities."](image-url)
Best practice. Six basic themes comprise the organizing theme related to best practices in addiction-related training within counselor education. The researcher will outline what the experts believed to be the model or exemplar approach regarding (1) the implementation of addiction training for all students, regardless of program option; (2) the curricular components which should be taught to all students; (3) the implementation method for the core competency; (4) the implementation method for the CMHC competencies; (5) course design; and (6) the qualifications of an instructor of an additions-related course.

Implementation of addiction training for all students, regardless of program option. The counselor educators were directly asked about the ideal method for providing addiction instruction to counseling students. All five experts indicated a combination of requiring an addiction course and infusing the instruction into core courses would be best practice.

Two experts compared addiction training to diversity training and stated instruction should be implemented by the same methods. When asked directly about whether training should be infused into curricula, provided in a stand-alone course, or a combination of the two methods, one participant stated:

What you are describing is a discussion that has been going on awhile around multicultural counseling. It’s very hard, if not impossible, to separate cultural diversity from anything we talk about related to counseling. Well, given the prevalence of [addiction], and the prevalence of the clients we are dealing with that have this problem as either as a primary or secondary issue or family member, it seems like it should be taught on both those levels, where it is both an infusion and stand alone . . . most programs have stand alone courses in multicultural counseling and so I see it as a very similar level of significance.
Another respondent also provided similar sentiments. She asserted, "[students should] have a stand-alone course like [they] have in diversity and ethics, but then that content is also infused in every other course because it impacts every other part of the client’s life."

Most of the experts recommended completion of more than one addiction course and two respondents identified the specific types of courses which should be required. For instance, one expert described potential courses that relate to "addictions theory," "counseling the addicted client," "assessments and case management," and "working with families." He indicated past experience teaching a stand-alone course and stated:

In that type of course [an instructor] must do a broad brush review of theoretical approaches to working with clients . . . beyond the 12-step approach, which is not a theory. So, what are the theoretical approaches to working with clients? What are the counseling issues that you are going to have to deal with? How are you going to assess these clients and determine . . . the level of their addiction problem? Ideally, it would be nice to talk about process addictions and also family stuff. But family can be a whole other class. Process addictions can be a whole other class. You can do a broad survey class, one class, but it’s not going to be enough.

Another expert recommended three courses as well. He described a "broad spectrum" addictions course which includes instruction on the continuum of care, the differences between substance abuse and substance dependence, routes of administration, and the various substances and behaviors to which one can be addicted. The second course would be a psychopharmacology course that would incorporate education on addiction to prescribed medications. He stated, "It’s really imperative . . . all counselors should have such course. So if they encounter someone who is depressed they can say, medications may very well be warranted. But I find a lot of counselors try to move away from medications." The third course proposed would be a family course. This expert
suggested "instead of calling it family and addiction, or a family addictions course, I think [it may be called] a family dysfunctional course or family pathology course."

Curricular components to be taught to all students. The five participants were asked about the list of curriculum components identified on the document sent to them prior to the interview (Appendix J). All five indicated the 11 components should be taught at some point to all counselors-in-training. The researcher noted that at one point in the interviews, all respondents discussed the need for screening, assessment, and diagnosis in particular. Some participants went into detail about specific aspects of these components which should be addressed. For instance, certain screening and assessment tools should be taught to counselors-in-training, such as the CAGE, the Substance Abuse Subtle Screening Instrument (SASSI) and the MacAndrew Alcoholism Scale (MAC) in the Minnesota Multiphasic Personality Inventory-2 (MMPI-2). According to one participant, students should also be able to distinguish between substance abuse and substance dependence and be able to identify treatment options on the continuum of care. He specified a few treatment approaches or strategies that are also important to know, including Motivational Interviewing, Brief Strategic Therapy, and Cognitive Behavioral Therapy.

One participant was hesitant to require instruction on pharmacology at first. She stated that counselors "are not medically trained or medical professionals, and I certainly wouldn't want counseling students or counseling graduates to start acting like medical doctors or medical professionals . . . or practicing beyond their scope of practice." The participant was leery of counselors "recommending certain medications [to clients] or
informing them about symptoms where [they are] not the professional on those side
effects.” After further discussion regarding the term “pharmacology” and the
participant’s belief that students should be taught the classification of drugs and the
physical, psychological, and behavioral effects of chemicals, she stated:

You are making me think about what I said earlier. On the list of components that
you listed, I put pharmacology at the bottom of my list, but you are making me
think so what is meant by pharmacology. By pharmacology, I’m thinking of
prescribed medication and side effects that physicians would have the purview,
where as non-prescribed [chemicals] . . . students should have an understanding
[of those misused drugs] . . . you know alcohol, cannabis . . .

If the term pharmacology was restricted to prescribed medication, this expert would place
that component on the bottom of the list in terms of importance. She believes counselor
educators should be careful not to promote counselors to work outside of the scope of
their competence. Another expert had a differing opinion. He stated:

Psychotropic medication has gotten so sophisticated these days. In fact, one of
the things that I believe very strongly in, in the addiction field, is the use of . . .
SSRIs with addicted clients. I think there is such an absolute line in thinking in
the treatment community about any kind of mood altering substances. I agree with
that, but I also struggle with the idea of absolute thinking. So what I would say is,
is there a lot of reasons to train drug and alcohol counselors in medicines as
much as we can. Because if we teach them in that absolute line of thinking, then
they are not going to be open to thinking about meds for these clients, and I think
a lot of these clients need the antidepressants because of the alteration of their
brain chemistry that has occurred through addiction. Plus there are all sorts of
drug interaction effects, so the more you know about meds the better.

Ideally, exposure to all of the 11 curriculum components (i.e., screening, assessment
tools, diagnosis, pharmacology, prevention, intervention, treatment options on the
continuum of care, counseling strategies, co-occurring disorders, etiological theories, and
process addictions) should occur to some degree over the course of counselor education
training according to the experts. In regards to all students, the participants believed
these components would be best integrated through the combined method of infusion and at least one stand alone course.

Core competency. Faculty most likely will integrate the Human Growth and Development core competency into curriculum either by infusion, a stand-alone course, or a combined method. The experts were asked what the ideal method would be to address the “theories and etiology of addictions and addictive behaviors, including strategies for prevention, intervention, and treatment” (CACREP, 2009a, p. 11). Most of the participants stated infusion would be adequate as long as programs are demonstrating instruction on the addiction-related content identified in that particular competency. One expert explained:

[Programs are required] to demonstrate the necessary breadth and depth of content. This can be met in a single course or demonstrated throughout . . . as a site team member, we look at how is a program demonstrating this, not necessarily in a single course, although they could do that, but how do they provide these opportunities for students across the curriculum. So just looking at those words, ‘theories and etiology of addiction and addictive behaviors,’ that could be a class in itself or it can be infused into each class. And then ‘strategies for prevention, intervention, and treatment,’ again there’s a lot packed in there. So that’s going to involve a shift in courses that traditionally did not have any addiction-related content.

The participant went on to say “the nice thing about CACREP is that it doesn’t prescribe how programs need to address this, but they just need to demonstrate that they are providing the opportunities for students to get the content.” He stated the core curriculum area is a knowledge-based form of outcome demonstration; the specialty areas are more skill-based, student learning outcomes. For the specialty program standards in particular, he reported:
[Faculty] are looking at knowledge, skills, and practice . . . [faculty] are looking for where students [are] doing these things. So if it's listed in the core curriculum, it keeps . . . school counseling students [for example, from] demonstrating how are they doing strategies for prevention, intervention and treatment; they just need to learn [the strategies].

Another expert expressed his opinion related to how many institutions will attempt to integrate the addiction content found in the core competency. Ideally, infusion and a stand-alone course would be the method chosen by counselor education programs; however, it depends on the institution. He stated:

If I take a minimalist approach, I think [faculty] will try to infuse some pieces here and there. And we do that [at my program] with a number of parts of it. So it's hard to say. Given that there is going to be an increase in the number of hours required for counselors, I think we may see some programs go ahead and add a course . . . We'll have to watch and see.

**CMHC program.** The experts gave their opinions on the ideal implementation method for the CMHC competencies related to addictions, and this was the third basic theme identified. The competencies listed in Table 1 may also be integrated into a curriculum by infusion, stand-alone course(s), or a combination of the two methods. Participants identified the ideal method would be infusion and a stand-alone course method; but at the minimum, training would have to be in one course. The researcher will address this further in the next section regarding the practicality of infusing and requiring a stand-alone course. The experts stated the combined method would be best practice; although, it may not be practical.

CMHC students must demonstrate competencies related to skill and practice, as well as knowledge. Due to the CMHC program competencies requiring skill-based outcomes, faculty must figure out how to demonstrate these outcomes in and out of the
classroom. Because many institutions may not require an addiction course and these skill-based outcomes must occur, institutions must demonstrate how students are gaining these competencies in other counseling courses or during practicum or internship. One participant discussed the CMHC competencies in detail and stated the difference in outcome demonstration. For instance, the Counseling, Prevention and Intervention domain includes the competency, “Knows the disease concept and etiology of addiction and co-occurring disorders” (CACREP, 2009a, p. 30). This is a knowledge-based competency. Another CMHC competency, “Provides appropriate counseling strategies when working with clients with addiction and co-occurring disorders” (CACREP, p. 31) is skill or practice based. The counselor educator indicated that the faculty members at his institution reviewed the standards and identified which of their courses have traditionally addressed the addiction-related content. He stated students typically have been doing the content in practicum and internship. Therefore, faculty:

Had to revise [their] internship site supervisor evaluation forms to be much more specific to having the site supervisors looking for when these [competencies] are done . . . a real practical way . . . because in terms of the classroom [faculty] wouldn’t see [students] demonstrate these skills . . . sometimes until they are in practicum or internship. So bear in mind some of the challenge too is that the assessment of some of these domains that has to do with skills and practices are left up to site supervisors.

These competencies, the expert reported, are not usually demonstrated in the classroom unless programs have a practicum component in each class. One way of demonstrating these competencies could be video or audio recording of students working with a client or a fellow student in the classroom. Best practice may be viewed as infusion and a stand-alone course requirement; although, regardless of how institutions integrate the CMHC
competencies, the participant pointed out the need for institutions to focus on how they will demonstrate these skill-based learning outcomes.

Course design. The experts provided their opinions on the best practices related to course design, or the fourth basic theme. One counselor educator stated ideally a course should include “a mixture of didactic [lecture] and experiential [activities] and writing.” Five pedagogical methods emerged from the data provided by the participants, and these methods are: (1) Didactic instruction, (2) Research-based projects, (3) Application assignments, (4) Reflective assignments, and (5) Experiential activities.

The didactic instruction may include various addiction-related curriculum components, such as the 11 content areas listed in Appendix J. For example, one participant stated the instruction “has to cover each of those curricular components identified in . . . the Clinical Mental Health [Counseling program]” standards. Another expert recommended instructors lecture on addiction theories, assessment, case management, process addictions, and family issues. Addiction-related research was also cited as necessary didactic material to present to counselors-in-training.

Instructors can educate students on the pertinent research through lecture, but a couple of the participants also mentioned having students do their own research-based projects. Students are required to write a paper and present on their literature review as part of their coursework. One expert recommended that students examine research related to the connection between addiction and a topic of interest. For instance, students can investigate the relationship between “addiction and veterans, addiction and crime, or [Fetal Alcohol Syndrome] babies, or how [addiction] affects couples’ relationships.”
Two experts detailed assignments in which students apply knowledge gained in class to a specific client case. One of the counselor educators requires students to create a treatment plan based on a character in a film or novel. The other application assignment cited was a group activity in the classroom. The following excerpt is how the expert described the application:

Each student [is] on a four person roundtable [and] each student has a different theory of addiction that they are representing . . . They all [discuss] a shared client case . . . [and] how they would conceptualize a case based on the different theories . . . [The purpose is to have] students be exposed to a range of conceptualizations of addictions and not just one.

The fourth aspect of course design, reflective assignments, was mentioned by several of the experts and can be used in conjunction with the experiential activities specified below. Examples of reflective coursework include journaling and keeping a log. One expert stated the students are required to write their reflections or reactions to an experience and then write a summary paper as well. In the next section below, the experiential activities that would initiate the student reactions, and be the basis for the reflective assignments, will be presented.

All of the experts recommended the use of experiential activities as part of course design when training counselors about addictions and addiction-related issues. The researcher will cite each of the mentioned activities and provide some details given by the participants. One of the experts shared two experiential activities that he implements into the coursework of an advanced family addictions course. One activity he mentioned was to have students ride in a patrol car on two to three weekends, from 11pm to 3am. He stated:
The purpose of that activity is we have a lot of people who come into counseling who have not seen or experienced folks from lower SES backgrounds and experienced folks who are violent or under the influence, [or] who are exceptionally violent. I think that is a good experience for them, especially related to families.

This expert also described another activity he incorporates into addiction training. He reportedly has students visit a domestic violence shelter and attend at least one meeting at a shelter. The purpose is two-fold. First, the students will hopefully gain a better understanding of both perpetrators and survivors of domestic violence. Second, the activity will help counselors-in-training recognize the overlap between addictions and violent behaviors.

One counselor educator recommended student exposure to clients in recovery or who are recovering. He suggested two different assignments, one in the classroom and one out of the classroom. Instructors can bring clients to class who are in a treatment program and who “they have developed a relationship with and [have the students get] in small groups . . . [and] interview those clients so they can see real people with real problems and see the human side of addiction.” The other valuable course assignment cited by this expert that involves exposure to clients is coordinating an addiction treatment center visit. Student observation of treatment groups, possibly through a one-way mirror, was a recommended part of the visit. The purpose of these two aforementioned activities was described by the expert:

There are a number of myths or concern about drug and alcohol clients and I don’t care how significant the problem is, at the root of this is a person. So being able to see who the person is and meeting the person and working on separating the person from the addiction I think is [important] . . . whatever kind of activity you can set up to allow that is a big, big plus.
According to the experts, the kind of activity that may assist in deconstructing myths or concerns about clients with addictions is requiring attendance at support meetings. All five participants described how they implement this pedagogical method. The counselor educators varied in the type of meetings required. For instance, one requires attendance only at 12-step, self-help groups related to substance dependency.

One of the experts indicated:

[Students attend] open Alcoholic Anonymous or open Narcotic Anonymous meetings, but not self help groups for process addictions or addictive behaviors, such as Gambler’s Anonymous [or] Overeater’s Anonymous. They have to be struggling with chemicals. Ideally they will go to four different meetings, so they have an exposure to the breadth of the diversity of meetings that are available.

Three of the experts reported their students can attend other kinds of meetings, such as Al-Anon, Rational Recovery, and self-help groups related to process addictions. One counselor educator stated observation of online groups was an option as well.

All participants agreed that students should go to more than one meeting, if not up to four or five meetings. Four reasons were stated for requiring more than one meeting. The reasons are to have students experience the (1) various viewpoints on recovery between meeting types, (2) variety that exists among the same type of 12-step meetings, (3) different programs which are available within their community, and (4) diversity of people attending the different meeting locations within their community. One of the participants suggested faculty should be cognizant of the size of the city and the number of available meetings in the area. He stated, “We don’t want [group members] to be inundated by students.” Therefore, while three to five meetings may be considered ideal, the availability of the open meetings in their community may limit attendance to only one
or two meetings.

Counselor educators should not only inform students how to find an open meeting and require their attendance, but faculty should sufficiently prepare them for the assignment. One counselor educator stressed the importance of teaching students how to dialogue with members at the meetings and how to conduct themselves at the meetings beforehand. He stated:

I think having students understand and attending 12-step programs is really important and that means prepping them prior to [attending] those programs. [They need to] know what to say and how to respond. [They should not say] they are . . . a student from XYZ University [just] here to observe . . . but to say 'I'm here to learn more about Al-Anon or [Narcotics Anonymous] or [Sexual Addiction]' [Students should] understand how people utilize those 12 steps in their recovery [before attending].

Experiential activities in the classroom that do not involve exposure to clients or to a different environment yet provide a new learning experience are role plays. One expert described how to use role plays as a means to demonstrate the addiction assessment process and to involve students in the learning activity. Doctoral students come to the classroom and play the role of a client coming in for an assessment. The instructor performs a full assessment interview and has the actor take the assessment instrument or pretend to complete it. Next, the class discusses the interview afterwards and the students write up the assessment report.

The last experiential activity to be outlined in this section was described by three of the five experts in the study. The assignment involves students participating in a project requiring them to abstain from a substance, food item, beverage, or specific behavior. One expert stated the change project could also include adding a behavior,
such as working out three times a week. In addition, students were to find a “sponsor in the class, or peer support.” According to one participant, the purpose is to help them understand relapse and relapse prevention. The behavior or substance (which the student abstains from) must be important to the student, stated an expert, in order to “gain a first hand experience of what it’s like to not have. To simulate what it’s like for clients when told to do without the substance they have become dependent on or attached to.” The expert went on to indicate it was her hope that engaging in an abstinence agreement or “abstinence contract” would increase students’ empathic skills. Two of the three experts that cited this exercise during their interviews specifically indicated the concurrent requirement of a reflective journaling assignment which included the students’ reactions to the experience during the semester.

Addictions course instructor qualifications. The researcher investigated the ideal expertise or qualifications of an instructor who would teach a stand-alone addictions course. Many of the experts cited similar sentiments. Ideally, the instructor would have a doctoral degree and have addictions specific training as part of his or her graduate counseling studies. All the participants indicated the instructor should have counseling experience; although their opinions differed in the ideal length of clinical experience and the whether the experience had to be specific to delivering services to addicted clients. One expert stated the experience could be limited to services provided to clients during the person’s internship, another reported two years experience, while another participant cited five to seven years as ideal. Some of the experts thought the experience should be specific to addictions, and one expert stated teaching addiction-related material is
"similar to what we have with the School [Counseling] track or the Clinical Mental Health track [and] that we have people who have worked in that area." He went on to state how his clinical experience has significantly influenced his teaching of addictions.

The expert reported:

[By] having had work experience [with this population], it informs so much of my teaching. It’s hard to even say how much it informs it . . . it’s such a foundation level . . . so I think that it is very, very important for people who are training substance abuse counselors to have worked with substance abuse clients.

In contrast, one expert stated, “I don’t think you need to be [working] in a drug and alcohol program for experience. I think every professional counselor encounters it.”

A couple of the experts also stressed the importance of the instructor possessing knowledge of addiction-related literature in order to provide up-to-date, pertinent information to counselors-in-training. One counselor educator stated the ideal instructor’s “professional work as a faculty member [would include] a focus on addictions, whether that be presentations, publications, consultations [and] the person [would] be familiar with salient research in the field of addictions.” In addition, a couple of the participants reportedly also viewed credentialing as an ideal qualification for an instructor. One participant asserted that the counselor educators teaching these courses would also “have a credential in addiction, such as a licensed chemical dependency counselor or a certification in addictions.”

The sections above denoted what would be considered best practices in regards to the training of addictions. All of the counselor educators identified the differences between what is perceived as ideal, and what is the reality of many institutions. The next section will address the practicality of implementing addiction-related training.
Practicality. There are four basic themes that emerged from the data and comprise the organizing theme of “Practicality.” The three themes are outlined in the next section and are as follows: (1) Influences on Implementing Best Practice; (2) All Students, Regardless of Program Option; (3) CMHC program; and (4) Threshold versus Perfection.

Influences on implementing best practice. Each expert described various reasons why the ideal methods for addiction-related training might not occur in counselor education programs. There were five reasons identified during the interviews: (1) Financial status, (2) Faculty expertise, (3) Faculty perceptions, (4) National and state standards, and (5) Counselor education program credit hour requirements.

One of the most frequently stated reasons was the state of the economy in the United States at this time. The financial status of many CACREP-accredited programs limits resources and does not allow institutions the opportunity to add more courses, additional faculty, or the Addiction Counseling program option. One participant stated:

I think we’ve come a long way because of the CACREP standards that [have] recently been implemented, but I don’t think that it’s trickled down into the universities yet . . . the guidelines in 2009 happened at the same time as the financial meltdown in our country for budget cuts and really impacted our ability to provide additional courses. I know at my university, there is no money for adjuncts, so asking for additional courses right now is unheard of.

An expert described budget issues as the basis for why institutions may or may not add courses to address the new addiction-related competencies in the Human Growth and Development Core area and the CMHC program. He also cited financial status as the primary reason why institutions may or may not adopt the Addiction Counseling program. Another counselor educator reported the same sentiment:
There will [not] be a wide adoption [of the Addiction Counseling program] at this point. Hopefully in the future. As we come out of the recession, there will be more flexibility. I just don’t see a lot of specialization programs period right now.

Most of the interviewees mentioned the lack of counselor educators with addictions expertise and this lack of expertise will impact the implementation of best practice. They stated faculty expertise can influence how addiction material is taught, whether addiction training is infused or stand-alone courses are offered, and whether institutions adopt the Addiction Counseling program option. For instance, one participant stated, “Professors themselves may not have that training or know how to address issues of addictions in the different courses they teach, such as a basic interviewing course, or in career development.” One of the interviewees discussed ideal instructor qualifications versus the reality of many institutions. He stated:

Given the constraints of department faculty, I think we have to have faith in the department that they will hire the right person for the course. That is not the answer that people are going to want, but I would like to say that I’d like to have someone with 5 to 7 years of experience, licensed as an addictions specialist in that state, and would have a doctorate. But the reality is, you might want that, but you might not have the option for that in many programs.

Therefore, faculty may have to look for the assistance from others who have expertise in this area. One of the interviewees discussed this issue in-depth:

Best practice is that ideally . . . the [instructor] would have an expertise in the area, but practically speaking that isn’t always the case. You have new faculty coming in or even faculty [who have] been here for a while and they have a course developed, or someone’s moved on and the course is open and you need someone to teach it. Sometimes you are staying a week ahead of the students in a content area that you are not as familiar with. But at the minimum, you have at least had a course yourself, but practically it doesn’t always work that way. I can imagine that might be particularly challenging for the non-clinically based specialty areas. Someone may not have had this content in their master’s or doctoral studies, because it was never required before. So a real practical way of [addressing addictions in the classroom] would be to bring in a content expert, whether it [is] a clinician in the community to come in and talk about how these
disorders affect those seeking career counseling or school counseling. [Another option is to] have another faculty member who has expertise in that area to come in and lead discussions or do an activity related to the core curricular content. That may be better way to address the best practices if the faculty member does not have expertise her or himself. Bring in someone who does.

Another influence faculty members have on best practice is their perceptions of addictions. One participant referred to the area of addictions as the “ugly step-child in most counselor education programs.” If faculty members or administrators perceive the area as a separate entity or a specialization, the methods for training and the depth and breadth of training will be affected. For instance, one of the experts stated some faculty members “say ‘counseling isn’t about addictions . . . we are not training addictions counselors. If they want to be an addictions counselor, they need to go through the local community college and get their training there.’” He went on to report:

I think there [are] still some negative perceptions of addictions by faculty and administrators . . . When you start talking about addictions people freak out . . . and some faculty don’t want to be associated with addictions counseling. I spoke to one faculty member who did not want to teach any addictions programming because he didn’t want to be associated with it. The person was in fear that if they are affiliated with that program, people are going to think [he was] in recovery and the literal fear that [he] would be identified as someone in recovery. The social, negative perceptions that still remain related to addictions can have an impact on whether departments [adopt the Addiction Counseling program].

Another participant referred to the negative perceptions among faculty; although, she was optimistic about changing these attitudes or beliefs. She reported, “Certainly there is still stigma, of course, but I’d like to think we are making positive directions in that area of stigma.” Having these perceptions may be one of the reasons why addictions is “treated as an elective, as an optional specialization.” One expert reported that many counselor education programs “welcome [their students] to identify [addictions] as a specialty, but
[in-depth training] is not something that [the faculty] provide.” Another participant stated training has varied among programs, such as offering an elective addictions core or instructing on addictions during one period. He went on to suggest that “there are some programs where it is not taught at all and [students] just kind of have to figure it out.” This participant believed there “has not been any kind of large scale effort to unify the training process of counselors in [the addictions] area and [he thinks] that it is definitely needed.” In conclusion, faculty perceptions could have influenced the lack of unity in addictions training and why this area has been treated as a specialization in counselor education programs.

National and state standards were cited as the fourth influence on best practices. Credentialing requirements impact if and how addiction training is implemented. Therefore, this type of instruction can vary between institutions nationwide depending on state requirements. One participant referenced professional counseling licensing requirements and stated, “Here in [my state] in the scope of practice for our professional counselors, substance abuse counseling is within that scope of practice. And I do not know how anyone can provide substance abuse counseling services without having had that training.”

When participants were asked about institutions’ decisions to add addiction courses and the Addiction Counseling program, the experts reported that state licensure requirements will affect the choice to do so. For instance, one counselor educator discussed the Addiction Counseling program and reported in the “initial rush” there may be a dozen institutions that adopt the new option “and then afterwards, as state
certification and licensing boards catch on to this, then there may be more institutions coming up with a program in addictions to help meet those requirements.” Similarly, another expert stated, “as the state licensing boards are moving from a certified addictions professional to a licensed addictions professional, I think that will bring some credibility and some legitimacy to a CACREP-accredited [Addiction Counseling] program.”

Another participant spoke to the national requirements of CACREP and the difference in state requirements for obtaining a license in addictions as influencing best practice:

Each state has different standards and required training and practice related to licensure as an addictions counselor. So for example, I believe in the state of Colorado you need to have a course on domestic violence and in Florida you need to have courses related to AIDS and HIV. So there’s the issue . . . you’ve got national standards [from CACREP] and there is no way that national standards can match all the state standards for a licensed addictions or dependency counselor.

This participant went on to discuss the concern about scope of practice for both the Licensed Professional Counselor (LPC) and Licensed Chemical Dependency Counselor (LCDC) credentials. Ideally, counselor education programs could address these requirements during training and the CACREP standards could align with state license requirements as well. This is not practical for the following reasons:

[In] many states when you get an LPC or CMHC license, they allow you to treat folks who are presenting with Axis I disorders related to addictions and substance use. Some states, however, say that they don’t address that within the scope of practice for licensure in that state as an LPC. So you’ve got a whole different license [i.e., a LCDC] that isn’t related to counseling per se, that one is required to obtain and many times it is at a high school, an associates degree level, or a bachelor’s degree level. [One issue is] you’ve got two sets of licensure in some states; one won’t allow LPCs or CMHCs to practice anything related to substance abuse and therefore require people to have a LCDC . . . [The other issue is
CACREP tries] to establish national standards for many states who have different requirements. So there’s not a broad brush that you can use that is going to satisfy everybody.

Furthermore, two participants referenced the influence of state requirements for obtaining an addiction credential. Acquiring the credential may be easier and more cost-effective than completing a graduate degree. In turn, addiction training among CACREP-accredited programs may be affected. One participant addressed this and reported students can obtain a “less expensive, less rigorous state license in addictions counseling and say . . . ‘if that license provides reimbursement at this state level, why would I go on for a master’s degree and have to pay for more education?’” Therefore, those persons interested in working with addicted clients do not have to acquire a master’s degree and thus, counselor education programs are less likely to implement the ideal training in this area.

The addiction profession is moving from certification to licensure. One of the participants was a “part of the [National Association for Alcoholism and Drug Abuse Counselors] educational standards committee which is a cross-discipline, ad-hoc committee that . . . put together . . . curricular components for those at the associate, bachelors, master’s and doctoral level.” He discussed the shift in credentialing and the increase in education requirements. The participant stated that “license sometimes implied master’s degree [and] I think . . . treatment should be done by master’s level clinicians.” He went on to assert that it will be “left up to the [counselor education] programs to try to match what the state is requiring.” This statement is reflective of the best practice versus reality global theme that emerged from the data. Counselor education
programs will provide training in order to match what the state is requiring for licensure. The state may or may not require standards which are considered ideal. For instance, the participant above believes treatment should be completed by a counselor who holds a graduate degree, although the state may offer a certification at the associate or bachelor's level and not require the counselor to have a graduate degree education.

The fifth and last influence on best practice is the credit-hour requirements of a counseling degree. The experts asserted that the ideal method for training would be completion of at least one separate addictions course as part of counseling coursework. In addition, training would also be infused into the curriculum. The participants indicated that this may not occur in reality because of the credit-hour constraints of programs. One expert reportedly recognized:

There is only so much room for the amount of content that a master's-level counselor needs to be prepared for. And I know that, I'm trying to think of the practicality. I know a lot of programs are maxed out in the number of courses they can offer. It can very quickly go from a master's degree into even a specialist's degree.

Another expert also provided a statement of recognition for credit-hour requirements. The participant acknowledged, “I'm also aware that we only have X number of hours in a day, unless we want to develop a 24-hour training program, but I don't think that will fly.”

Some counselor education programs can be maxed out on the number of credits, and therefore faculty will not add courses. One expert discussed another issue influencing the addition of course requirements. The participant cited competition for students among university programs as another reason. Therefore, counselor education
program faculty and administrators may not increase the credit-hour requirement because it can influence the attractiveness of the program. Thus, student enrollment may be affected.

**All students, regardless of program option.** The previous section outlined the reasons why best practice may not occur in counselor education programs (e.g., budget cuts and lack of faculty expertise). This section will focus on the basic theme which emerged regarding the practicality of implementing the ideal training for all students.

As stated before, the experts cited the best practice for implementing the addiction-related content (listed in Appendix J) and the CACREP addiction-related competencies for all students would be a combined method (i.e., infusion and at least one stand alone course). The participants asserted that while the combined method may be ideal, it is not practical. One expert stated that he “would be fine with infusion, at least that would get the content into each course or at least the courses that are clinical in nature, but ideally you would have both.”

Despite the cited concerns associated with financial status and credit-hour constraints, three of the five participants stated CACREP-accredited programs will most likely add one addiction course to the curriculum of all students. An interviewee reported institutions will “probably go with the one course. It would be the easiest. Thinking that, yes, we will just take care of it with one course, instead of all [faculty members] teaching all of the courses needing to address addictions.”

In contrast, another expert asserted the position that the combined method is best practice, although not practical because of the economic status of many institutions. She
stated:

I think there is definitely some programs out there right now that combine, but in terms of additional courses, which I think we do need to cover the standards, I don’t think that is a possibility right now…to have an additional course. So in order to cover everything, it has to be infused . . . Best practice would be two or three [courses]. But in reality, you know, one is what we are dealing with.

One of the counselor educators described the issue further in relation to credit-hour requirements by states. If there is flexibility in the credit-hour requirements, additional courses can be added, which would be ideal. He detailed the situation as follows:

In certain states, [counselors] are required . . . to only have a 45-hour . . . or a 48-hour program . . . [and faculty] don’t want their folks to . . . take more graduate credit hours than they have to. Other states . . . can bump it up to 60 or 68-[hours] . . . So I think it’s going to be up to individual department faculty to figure out how to [implement the standards for all students]. And again, we are trying to make a national statement over places that each state is so different . . . An easy thing to do would be to say well let’s integrate it and let’s add at least three courses. That is what I would probably favor . . . [Although,] the [participant’s state] Board of Education regents, really don’t want to force people to take more graduate level courses. So it is a really big issue, how do we handle this? So the way we will probably end up handling it is infusion and adding some additional courses for faculty.

Adding more courses may be ideal; however, this participant went on to assert that when looking at the majority of counselor education programs, the “reality is you are looking at one course, one broad spectrum basic course.”

**CMHC program.** Students in the CMHC program option have more addiction-related competency requirements compared to other students. The experts report the combined method would be the best implementation method; although, again it may not occur. A couple of the participants stated at minimum, a stand-alone course requirement would have to be implemented. One expert stated:
I don’t see [integrating the CMHC competencies] as being infusion only. If for no other standard than the third one, ‘provides appropriate counseling strategies when working with clients with addiction and co-occurring disorders.’ That’s teaching the treatment of, so just doing one day or two days in a course is not going to do it. I would say [the] stand alone [method].

Another interviewee hypothesized that institutions will “probably go with [adding] the one course. It would be the easiest. [Faculty will think] that, ‘yes, we will just take care of it with one course, instead of all of us faculty teaching all of the courses needing to address addictions in our course.’”

Threshold versus perfection. Two of the experts mentioned the reality of education and the limitations of teaching. These participants held the belief that CACREP and counselor education program faculty need be cognizant of identifying a “threshold” for addiction training, instead of creating standards or implementing instruction which strives for perfection. These counselor educators explained the importance of having students attain necessary addiction knowledge and skills during their coursework. On the other hand, they stressed the value of clinical experience and continued education, which will provide the opportunities for counselors to gain the competency not obtained during their graduate studies. When discussing the new addiction-related standards, one participant stated:

I think [they are] sufficient given the amount of content that students are given, as well as trying to absorb. They have the rest of their careers to continue to address client [issues and gain the competency] they need to do their jobs.

Another expert expressed his views regarding the CACREP standards and issues that are seen associated with state licensing requirements. In particular, when referencing the CMHC program addiction-related competencies, he stated:
I have a hard time with [taking] a national standard and [applying] it to all programs. I am not in favor of that. I think you have a threshold that you say people have to get up to but . . . I think what we have to look at is a threshold rather than perfection. And I think when they put [the CMHC program] together they put everything they possibly could, which isn’t wrong, but I think the reality is . . . what people need is a threshold to meet related to basic training and then they need to get out in the field and gain experience.

The participant went on to describe an example in an effort to depict the importance of practical experience or skill as opposed to knowledge gained through coursework. He said:

Comparing it to a neurosurgeon, they have plenty of training programs. They have to get all these courses, but even there it’s really once they get out and get the experience of doing surgery under supervision . . . I think that is what is going to make a difference for [counselors]. I think we have excellent standards . . . so now let’s get [counselors] out and have them learn how to [provide services] under excellent supervision and gain the hours that way.

**Theme Five: Further Changes Need to be Made in the Field**

Throughout the interviews, participants made reference to areas in the counseling profession that need additional modifications. Global Theme Five had two organizing themes that emerged, and each organizing theme has four to five basic themes (see Figure 17). Participants were directly asked to provide their critiques of the CACREP addiction-related standards such as the Addiction Counseling program, the core competency citing addiction training, and the CMHC addiction competencies. In addition, at the end of the interview the experts were explicitly asked to give their opinion about “specific changes that still need to be made in the area of addiction, such as the profession, the standards, faculty, students,” etc.
Changes specific to the 2009 CACREP standards. Four basic themes comprise this organizing theme. While providing their critiques of the new standard revisions regarding addiction training, the experts offered suggestions for change. These changes related to the core competency, the Addiction Counseling program option, other counseling program options, and specific curriculum components.

Core competency. The first basic theme was associated with the Human Growth and Development Core addiction-related competency. The competency states all counseling students are to know the “theories and etiology of addictions and addictive behaviors, including strategies for prevention, intervention, and treatment” (CACREP, 2009b, p.10). Overall, the new competency is well received by all of the experts; however, two of the five experts detailed information about possible future modifications.
One participant stated, “It doesn’t [list] screening and assessment. I don’t know if that would go under an umbrella for intervention perhaps. I would probably want to add screening and assessment to [this competency].” The other counselor educator indicated the competency was insufficient because it did not include “diagnosis,” “assessment tools,” and “screening.” She specifically reported, “We’ve got etiology, which partly covers [diagnosis], but not fully. Assessment tools, you don’t see anything about that. Screening, well a little bit about that for prevention. I mean [the competency] is nice and succinct but I don’t think that it’s comprehensive enough.”

The participant went on to discuss the absence of “relapse prevention.” When confirming the expert’s statement, the researcher asked about relapse prevention as differing from prevention. The expert reported the following:

I would think that [relapse prevention] would come at the end [of the competency] because first you are trying to prevent it from happening, then [you] intervene, and then you provide treatment. But you also want to keep it from happening again. And that is very different than prevention with people who haven’t started using.

In summary, both of the experts reported the desire to see addiction screening, assessment, and diagnosis in the core competency requirement for all students. Moreover, one of the two counselor educators also cited relapse prevention as another content area missing from the core competency.

**Addiction counseling program option.** All participants critiqued the new program option, and all five of the global themes included this basic theme in some capacity. In the previous global themes, the experts conveyed their appreciation for the creation and inclusion of this program option in the 2009 CACREP standards. In this
section, the basic theme is associated with further modifications to the specialization program.

Almost all of the counselor educators commented on the title and expressed approval. They indicated the title is an accurate representation of the range of addictions, not just substance abuse. One participant appreciated the shift seen in the profession; however, this expert also stated the Addiction Counseling program title should not be singular. The concern was when the public at large, students, or lay persons see the title of the program, Addiction Counseling, they would assume “that there is only one way to understand it, one addiction, one model, one theory.”

In addition to the title, feedback was also provided related to various competencies included within the program option. For example, one counselor educator commented on standard A.9 listed under the Foundations Domain which states Addiction Counseling students are to know “the impact of crises, disasters, and other trauma-causing events on persons with addictions” (CACREP, 2009b, p. 18). The respondent reportedly desired to see “how these crises increase the propensity for people to use substances, as opposed to persons who already have addictions.” Another critique was related to standard D.5 listed under the Counseling, Prevention, and Intervention Domain, which indicates students are to have “the ability to provide counseling and education about addictive disorders to families and others who are affected by clients with addictions” (CACREP, 2009b, p. 20). The counselor educator believes students should be able to demonstrate “the ability to provide counseling and education to not only families who are affected by addictions but the community. [Addiction counselors
should educate the community or provide preventative measures.” The last comments made regarding the new program option were associated with “systemic or contextual factors related to addictions, such as socioeconomic variables.” The expert continued to describe the critique in the following manner:

I guess when we talk about policies, I mean political inclinations. How the delivery of services, or even views of addiction, can change dramatically based on who is elected as the president of the United States. This has been true throughout our history . . . this may come from my recent reading of the history of addictions in the US . . . In [standard] A.1, ‘understands the history in addiction counseling.’ I might even say the history of addictions in the United States . . . [including] that aspect of systemic or contextual factors.

In summary, the majority of the participants described the Addiction Counseling program standards as comprehensive and all of the experts viewed the creation of the program option as a positive step forward for the field of addictions. Although considered comprehensive, the 2009 standards is the first edition of these competencies outlined for such a program. Therefore, counselor education faculty will most likely have recommended changes for future editions.

**Specialty program options.** Two of the five interviewees mentioned deficiencies within the CACREP standards of the other CACREP program options. These experts specifically cited the competencies within the CMHC, School Counseling, and Career Counseling program options. One of the participants identified the CMHC Foundations Domain and the Counseling, Prevention, and Intervention Domain as insufficient. The expert went on to say other program options were deficient because the “disease concept . . . isn’t mentioned anywhere else [besides the CMHC program option]. And there are many theories or models of addictions beyond the disease concept.”
When discussing the CMHC option, the other expert cited shortcomings including "treatment." The participant stated, "If you look at the Addictions standards, or the Addictions track, it seems like more [treatment-related content] would be in the Clinical Mental Health [Counseling track] as well." Moreover, the faculty member reported the need for "crisis counseling" content and training on providing services to "special populations." For example, "when [a counselor provides] mental health counseling with offenders, how is that different than working with the mainstream population?"

In addition to the CMHC program standards, the expert continued to discuss the perceived need for additional education and instruction in other specialization areas. When asked directly to look over the handout listing the addiction-related competencies (Appendix K) in an effort to critique the program options, the expert referenced School Counseling and Career Counseling in particular. The participant stated, "School Counseling doesn't even mention prevention. Of course it's in the core competency for everybody, but that seems like a primary role of a school counselor. I would like to see it there again." Later in the interview, the researcher asked about the increased attention and recognition of process addictions. The participant then stated, "That brings up another point about School Counseling, because you don't see anything about process addictions." In essence, since addictive behavior was not mentioned in the School Counseling standards, "we [may not be] doing any prevention for gambling, sex addiction, or internet addiction in general with kids who are spending more and more time online."

The Career Counseling option standards are also insufficient at this time
according to one expert. The participant asserted, “Career Counseling doesn’t even have anything [related to addictions in the standards]. That’s definitely lacking.” The interviewee described career assistance as most beneficial, “particularly for people who are coming out of a recovery program. It’s a really difficult time for people to get reestablished, either in the career that they were in or to begin a career for the first time.” Therefore, in this counselor educator’s opinion, the career counseling standards need to have additional addiction-related education.

Curriculum components. The experts were asked directly about the necessity of the 11 curriculum components listed on a document sent to the participants (Appendix J). Four of the five participants mentioned addiction-related content that they believed should be included in counselor training that was not identified on the sheet provided. Specifically, four of the interviewees stated family issues were important to address; two experts cited pharmacological medication; and one described how drug classification and non-prescribed medication were both missing elements either in the 2009 CACREP standards or in the training of counselors. The last part of this section will mention a few addiction-related content areas, or curriculum components, which were discussed at some point in the interviews of two participants and comprise this basic theme.

Four of the five counselor educators expressed the importance of training counselors about the influence addiction has on family and significant others. Two educators proposed offering an addiction course focusing on family or including addiction content into a family course. One of participants also reported use of experiential activities in his family course to teach students how addiction can affect
other family members (e.g., domestic violence shelter visits and riding in a patrol car).

Information pertaining to prescribed medications was also cited as an important curriculum component to teach counselors-in-training. On the list of curriculum components given to the participants, the researcher listed the term “pharmacology” based on previous research (e.g., Dawes-Diaz, 2007; Whittinghill, 2006) and there were discussions with two experts about the definition of this term. “Pharmacology” is not included in the 2009 standards; although, other related terms were identified by the researcher and the participants. To provide some context for the reader, the researcher will mention the three competencies in the 2009 CACREP standards that include the term “psychopharmacological” medications or “psychopharmacology” when explaining the experts’ opinions related to this topic.

One of the counselor educators referenced a competency included in the Addiction Counseling program standards (Standard G4., CACREP, 2009b). This competency was noted by the researcher to also be in the CMHC program standards (Standard G3., CACREP, 2009b). The interviewee believed the content to be important, and it should be included in the standards of other program options. The competency states students should understand the “basic classifications, indications, and contraindications of commonly prescribed psychopharmacological medications so that appropriate referrals can be made for medication evaluations and so that the side effects of such medications can be identified” (CACREP, 2009b, p. 21). The expert stated:

One note that I made as I was reviewing . . . your handout [was] I couldn’t find anywhere that identified the importance of students being exposed to or learning about classification of substances that are typically misused. I noted that under the Addiction Counseling program under Assessment, or G4., it does include that students are to understand basic classifications indications and contraindications
of commonly prescribed psychopharmacological medications . . . but I couldn’t find anywhere else in [the 2009 standards] where students are to have knowledge about substances that are typically misused, [such as] depressants, stimulants, hallucinogens, cannabis. So we may be talking about chemical addictions or chemical misuse, but . . . we don’t have to inform students what those specific substances are [or] their medical effects, [or] their subjective effects.

In essence, this counselor educator defined pharmacology and classification as two separate content areas and classification should include “street drugs” and “alcohol,” as well as prescription medication. In addition, this expert believed students should also understand the indications and contraindications of these non-prescribed chemicals.

As a side note, a review of the 2009 standards revealed one other competency citing “psychopharmacology.” Participants did not specifically identify this competency, although, its inclusion in the Marriage, Couple, and Family Counseling option should be noted. Students in the program are to understand “the impact of addiction, trauma, psychopharmacology, physical and mental health, wellness, and illness on marriage, couple, and family functioning” (Standard G3., CACREP, 2009b, p. 38). This competency cites “addiction” and “psychopharmacology;” however, in this case psychopharmacology is not associated with abusing medications or non-prescribed chemicals.

The last part of this section will identify three areas of addiction-related content that were perceived as important to include in curricula; however, they may not be widely implemented in the training of all counselors at this time. One participant recommended all students, not only students in the Addiction Counseling program option, have instruction on crisis counseling and working with special populations. Researchers indicate the need for counselors to have awareness and to be sensitive to the diversity and
culture of their clients who abuse substances (Brooks & McHenry, 2009). For example, the worldviews, values, and environments will vary for women, adolescents, college students, older persons, persons of color, spiritual or religious persons, incarcerated persons, and gay, lesbian, bisexual persons (Brooks & McHenry, 2009; Loue, 2002).

Another content area worth mentioning under this basic theme is a comment by an expert that addressed her definition of etiological theories. The Human Growth and Development core area competency cites etiological theories and all counselors-in-training are to have instruction on the causes of addiction. This particular counselor educator expressed her concern about whether students will get exposure to instruction that not only addresses how “addiction begins or originates, but also how it is maintained.”

In summary, the experts discussed the necessity of the 11 curriculum components listed in Appendix J, but also shared their opinions on other imperative addiction-related content (see Table 4 for details). This content included family issues, pharmacological medications, drug classification, and the effects and indications of alcohol and other drugs which are not prescribed. Moreover, this basic theme also was comprised of statements related to the importance of educating counseling students on crisis counseling associated with addictions, working with special populations, and the aspects which maintain and perpetuate addictions.

**Changes specific to other areas.** All five counselor educators also suggested further improvement in other areas that are not associated with the CACREP standards. This organizing theme emerged due to the question that directly asked the experts to give
Table 4

Recommendations for Curriculum Components Related to Addiction Training

<table>
<thead>
<tr>
<th>Addiction-Related Curriculum Component</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Issues</td>
<td>Provide education pertaining to family issues associated with addiction.</td>
</tr>
<tr>
<td>Pharmacological Medications</td>
<td>Provide education on pharmacological medications.</td>
</tr>
<tr>
<td>Drug Classification</td>
<td>Provide education pertaining to the classification of drugs (e.g., stimulants, depressants, hallucinogens). Standard G.4., under Addiction Counseling, was specifically referenced.</td>
</tr>
<tr>
<td>Effects and Indications of Non-Prescribed Medications</td>
<td>Provide education pertaining to effects and indications of alcohol and other drugs (e.g., cannabis, cocaine, MDMA). Standard G.4., under Addiction Counseling, was specifically referenced.</td>
</tr>
<tr>
<td>Crisis Counseling</td>
<td>This type of instruction should be expanded to include how crises can “increase the propensity for people to use substances as opposed to persons who already have addictions.” Standard A.9., under Addiction Counseling, was specifically referenced.</td>
</tr>
<tr>
<td>Special Populations</td>
<td>Provide education pertaining to special populations (e.g., those involved in the criminal justice system). Three competencies were included in the Addiction Counseling program related to special/diverse populations. This type of instruction should be added in the CMHC program as well.</td>
</tr>
<tr>
<td>Aspects Maintaining and Perpetuating Addictions</td>
<td>This type of instruction should be expanded to include how addictions not only originate, but how they are maintained and perpetuated. Human Growth and Development Core competency was referenced.</td>
</tr>
</tbody>
</table>

their opinion about “specific changes that still need to be made in the area of addiction, such as the profession, the standards, faculty, students,” etc. Five basic themes that were identified as current issues of concern are outlined below: (1) Research, (2) Paraprofessionals, (3) Public Health Model, (4) Diagnostic and Statistical Manual, and
(5) Professional Recovery Issues. These themes are connected to the fourth research question because they help ascertain what the experts believe still needs to occur in order to provide best practices related to addiction training.

**Research.** Continued investigations related to ascertaining the most effective treatment strategies when providing addiction services is an area that still needs attention, according to two experts. For instance, one participant reported “more studies of treatment outcomes need to be done looking at different treatment approaches . . . [in an effort to determine if one] theoretical approach works better than [another].” Moreover, another interviewee expressed the belief that the counseling profession needs “to have more understanding about what works for people and if we have different professional organizations or agencies working together, then we are more apt to come up with some of the best practices or effective strategies.” In other words, to meet the needs of persons with addiction issues, further research in this area must be completed, and the results must be communicated to local, state, and national organizations.

**Paraprofessionals.** Two of the experts indicated the desire to see the addiction field continue to move toward requiring licensure, which includes obtainment of a graduate degree. For instance, one counselor educator reported, “there continues to be a significant portion of addiction treatment provided by paraprofessionals at the associates and bachelors level” and this is a result of “a holdover to when addiction counseling used to be the realm of those who had been to treatment themselves.” He continued:

I think the move toward licensed addiction professionals is a good move . . . It’s very rarely that [addiction clinicians] are providing just addictions counseling, given how infused it is through many other issues . . . I think counseling is the way to go, or social work, or psychology. License sometimes implied master’s degree, so I think . . . treatment should be done by master’s-level clinicians.
Another one of the interviewees provided the same sentiment. He discussed future changes which need to be made in the field related to addiction clinicians having a master’s degree. The expert stated, “Another area that I think the field needs is . . . to continue advancing the professional training of counselors so that we increase our education level.” The participant went on to describe how in his state they “have master’s level trained counselors who are working alongside recovering counselors. And while [he thinks] recovering counselors add a good bit to the treatment process, oftentimes it is considered an equal credential and it is really not.” He compared addiction counselors to counselors who specialize in treating persons with eating disorders and said:

We don’t see people going out and being counselors for eating disorders simply because they had an eating disorder. So I would like to see us move toward more master’s-level training, regardless of whether or not you are in recovery. That may bring in more recovering counselors, or students into the program, but [being in recovery should] not be a primary credential that allows someone to work.

**Public health model.** This basic theme emerged from two experts directly acknowledging the need for addiction counselors to learn about and view addiction through a public health model. One interviewee suggested, “on more a professional level, I think there needs to be more collaboration amongst professional agencies that deal with addictions in terms of helping with policy, and mental health parity . . . We have that now, but it still has to be implemented.”

Another participant went more in-depth regarding this issue and described her viewpoint concerning the use of a public health model. She has become “more appreciative of a public health model or public health perspective and how [counselors
should not only be viewed] as interventionists, but as public health professionals.” The
counselor educator acknowledged that public health “is a separate discipline, but . . .
[she] would like for [the counseling] profession, specifically those in addictions
counseling, to be exposed more to that public health model.” In addition, counselors
should learn how to “address the community, a neighborhood, a city, or a jurisdiction . . .
and [learn how to address] . . . policies that affect a community, not just policies that
affect an individual client.” Examples of addressing these policies would be working
with “members of the liquor control board, bar owners, owners of other types of shops or
downtown areas, . . . [and] university officials or college administrators, [and] taking
more of a landscape approach, or panoramic perspective, rather than [an] individual client
perspective.” The expert suggested addictions counselors should be prepared to work
with “not just other behavioral health professionals, i.e., psychiatrists, nurses, mental
health counselors, but other professionals such as those in public administration within a
community or city, or criminal justice or legal profession.” In essence, the question
proposed by this participant is, “How can students who graduate from Addiction
Counseling programs know how to work with . . . local, state-level [personnel] in terms
of policy or policy prevention issues?”

**Diagnostic and statistical manual.** One of the experts identified the need for
future modifications to the *DSM-IV* (APA, 2000). This counselor educator reported the
desire to see diagnostic classifications or criteria for “process addictions.” A process
addiction has been defined in the CACREP glossary as “an addiction to a behavior or
action, such as gambling, shopping, eating, or sexual activities” (CACREP, 2009b, p. 62).
It is assumed the interviewee was referring to having a separate diagnosis for each addictive behavior; although this was not clearly stated, and the researcher did not directly ask for further explanation during the interview.

Another participant mentioned the lack of diagnostic criteria for addictive behaviors in the *DSM-IV*, and how this affects the allocation of services. The counselor educator, however, did not dictate a precise statement about the need for this classification in the future. He asserted:

> We are the first profession, in the helping profession, to officially recognize that there are [addictive] disorders. Whether [the] APA or the *DSM*, they do not recognize them . . . As you know, [addictive behaviors] are usually put into [the category of] Impulse Control Disorders or qualifying for an NOS qualification. I know in providing services in the past to my sexually addicted clients, I could no longer use insurance to work with them . . . [This] causes a problem because only those who can afford treatment can obtain it.

*Professional recovery issues.* The last basic theme was presented by one expert, and it was related to the monitoring of professionals in recovery and the consequences of relapse. The participant discussed this deficiency in the counseling field and stated, “I think one area that really needs to be addressed that I don’t see a lot in regard to, within any of the [CACREP] standards mentioned, are issues related to persons who are currently in recovery.” This counselor educator pointed out that this issue can be connected to faculty members or students. He went on to question “how to monitor, how to engage, [and] how to remediate.” Although, remediation should “not [be] in a punitive way. But in a way where we can keep people who are in recovery in the system and understand . . . relapse is a part of that whole process.” Guidelines should be set to determine “how [to] reach out to them, let them do their own recovery, but also have
stringent enough standards that say if [a person does] slip . . . this isn’t the end of the world, but part of the process.” The expert discussed the biases and intolerance that are present within the counseling profession:

[Counselors] accept . . . clients who make a slip but with students and faculty I think there is different mentality, like they should never have a slip . . . I’m aware of faculty members who go for 5 or 7 years and do exceptionally well and then relapse. They don’t want anyone to know of their relapse because this is their profession [and] they are scared of losing their faculty position . . . [On the other hand], nurses and physicians . . . have monitoring programs set up that they pay for and they are monitored; they do urinalysis, hair screens, and they have to work a recovery program that is established. So it is a helpful, not a punitive model. I don’t think we have addressed that within counselor education [yet].

Summary of Qualitative Findings

Five global themes became apparent in the analysis of the qualitative data. The main themes are: (1) Need for Addictions Training, (2) Significant Changes in Profession within the Last Decade, (3) Critique of the 2009 CACREP Standards, (4) Best Practice/Ideal versus Practicality/Reality, and (5) Further Changes Need to be Made in the Field.

Need for addictions training. The first major finding from the expert interviews was the need for addictions education and instruction in counselor education. In particular, there was a need for a CACREP-accredited program option available for students who wish to specialize in providing services with persons struggling with these issues. The need for instruction was reportedly due to the high incidence of addiction issues in the United States, its impact on others, the co-morbidity with mental health, the co-relation with other life areas, and the fact that addiction is considered a major health crisis in the United States.
Significant changes in profession within the last decade. Transformations have occurred within the counseling field in the last ten years related to addictions. CACREP has answered the call for necessary training in addiction and addictive disorders with the 2009 edition of the CACREP standards. First, a competency in the Human Growth and Development core area requires all counseling students, regardless of program option, to learn about etiological theories, prevention, intervention, and treatment strategies for both chemical and behavioral addictions. Also, the Clinical Mental Health Counseling program option requires even more competency requirements and many of these competencies are skill-based, versus knowledge-based. Probably the most obvious and significant change in the new edition of the CACREP standards was the creation of the 60 credit-hour, Addiction Counseling program option. Another transformation identified was the recognition and inclusion of addictive behaviors in the 2009 standards, not only in the core but throughout the program options. Even more changes took place within the addictions field and these were at the state and national levels. More specifically, there has been a shift in requirements for licensing and credentialing, and standards have been created for addiction counselors with varying amounts of education.

Over the last ten years, attempts have been made to reduce the stigma associated with addictions, and thus increasing acceptance for this area in counselor education. These have been identified as significant changes in the profession as well. By including more instruction to students, in particular experiential activities, the effort has been seen to reduce biases and gain tolerance. In addition, there have been terminology changes, such as the use of the term addiction, in lieu of the term substance abuse. Last,
instruction related to addictive behavior, or addictive disorders, is included in the 2009 CACREP standards, and the term "process addiction" is defined in the standards' glossary now.

Critique of the 2009 CACREP standards. The third major finding of this investigation is the inclusion of various addiction-related competencies in the 2009 CACREP standards represents a good start in regards to addressing addiction instruction in counselor education. The critique of the new edition of the standards was positive overall, and little feedback was given to improve the standards in this area. For instance, there is appreciation for training associated with addictive behaviors and the introduction of process addictions in the glossary. Moreover, the required training for all students, regardless of program, was also appreciated. Counselor preparation now must include etiological theories and prevention, intervention, and treatment strategies. This content listed in the Human Growth and Development core competency is considered expansive, summative, and succinct.

The addiction-related CMHC program competencies, many of which are skill-based, demonstrate a big shift when compared to the 2001 CACREP standards in Community Counseling and Mental Health Counseling. Therefore, the addiction instruction required for students in this program option is viewed as much more comprehensive. Deficiencies still exist in the CMHC Counseling program, as well as the School Counseling, Career Counseling, and Marriage, Couple, and Family Counseling programs; however, the program options are considered in good shape overall at this time.
Furthermore, there is a positive reaction to the CACREP standards created for the Addiction Counseling program option. The standards are deemed comprehensive and a good start considering it is the first edition of such standards. In addition, there is appreciation for the title as “Addiction” Counseling and not “Substance Abuse” Counseling; although, one participant would prefer the title to be in plural form as to represent all addictions.

**Best practice/ideal versus practicality/reality.** The fourth finding of the analysis is a concept related to best practice versus reality. There is considered the exemplar approach regarding several areas of addiction training in counselor education. Best practice would include the following aspects: (a) all counseling students would complete at least one addiction course and addiction content would be infused into their other courses as well; (b) all students should have exposure to the curriculum components listed in Appendix J (e.g., screening, diagnosis, process addictions, etc.); (c) course design would include didactic instruction, research-based projects, application assignments, reflective assignments, and experiential activities; and (d) the instructor would have a doctorate, an addictions credential, clinical experience, addiction training during their graduate studies, addiction-related professional work as a faculty member, and knowledge of salient research.

The reality for many counselor education programs is different than the ideal. Influences on implementing the best practices for addiction instruction are (a) financial status of the programs/institutions, (b) lack of faculty expertise, (c) faculty perceptions about addictions and the importance of addiction training, (d) national and state standards
that differ from licensure requirements, and (e) counselor education program credit-hour requirements. The reality of implementing the core competency is most programs will probably add a course, in lieu of requiring one or more courses and infusing the addiction content into core courses. Also, the reality is there should be a threshold for instruction, and CACREP and counselor educators should not expect perfection. Students should be allowed the opportunity to gain the necessary knowledge and skill during their graduate studies, but also should be expected to continue to obtain competency while practicing in the field.

Further changes need to be made in the field. The last major finding addresses continued changes called for in the area of addictions. The CACREP standards, in particular, need modifications. For instance, the core competency is lacking instruction on screening, diagnosis, assessment, and relapse prevention. Moreover, the Addiction Counseling program option needs changes related to the title and some of the existing competencies. Adjustments were also called for in the competencies of the School Counseling, Career Counseling, and CMHC program options. For instance, there are no competencies in the Career Counseling option which require students to gain addiction-related knowledge or skill. In addition, there were areas of addiction-related curriculum content which was identified as missing in the standards. Absent from the list of curriculum components (i.e., Appendix J) was content related to: (a) family issues, (b) pharmacological medications, (c) drug classification, (d) the side effects and interactions of commonly abused chemicals, (e) crisis counseling, (f) special populations, and (g) the aspects that maintain and perpetuate addictions.
Five other areas, not related to the 2009 CACREP standards, were also specified as needing modifications. First, the profession should continue to investigate the most effective treatment strategies and complete more outcome research. Second, national and state standards should continue to be created for addiction professionals, and addiction licensure should be required to practice. Furthermore, licensure should necessitate a graduate degree. In other words, those providing addiction services should have a master's degree. Third, addiction counselors should be taught how to interact and collaborate with various other professionals and take a community, or "landscape," approach. Specifically, counselors should not only be viewed as interventionists, but also as public health professionals. Fourth, diagnostic criteria for process addictions should be included in future editions of the DSM. The last area for change identified was related to professional recovery issues. Guidelines should be put in place, and continued discussion should occur related to professionals in recovery. These guidelines must include methods for monitoring and engaging faculty and students, as well as inclusion of a helpful, not punitive, model when these professionals relapse.

In conclusion, this chapter reported the quantitative results and qualitative findings of this investigation examining addiction training in CACREP-accredited counselor education programs. Four research questions were answered by obtaining data through the use of a nationwide survey and five telephone interviews. In the next chapter, the researcher will compare and contrast the key findings of this study to previous research and present implications and recommendations based on these key findings.
CHAPTER V

DISCUSSION

Chapter five is organized into four sections. A summary of the study is presented first, including the limitations. Next, the results of past research are compared and contrasted to the findings of this investigation. The following section communicates the similarities and differences noted in the data obtained by the two methodologies used in this research, the quantitative survey and qualitative interviews. The last section of this chapter outlines the implications for the Counselor Education profession and the training of master’s-level counselor education students, and recommendations for future areas of research are also mentioned.

Summary of Study

The purposes of the study were to examine the current status of addiction training among CACREP-accredited counselor education programs and determine how these programs will integrate the addiction-related competencies outlined in the 2009 CACREP standards. In addition, this study also obtained the viewpoints of experts and other counselor educators in an effort to determine best practices in addiction training. The following are the research questions which guided the study:

(1) How is addiction training currently being taught in CACREP-accredited, counselor education programs?

i. What specific aspects of addiction training are being taught in CACREP-accredited programs (e.g., etiologies, co-occurring...
disorders, psychopharmacology, prevention, intervention, treatment)?

ii. Is completion of an addiction course required or is the training infused into one or more core courses?

iii. Are the addiction courses offered as part of the counselor education department curricula or curricula of other university departments?

Determining how addiction instruction is presently taking place helped ascertain what common practice is among the CACREP-accredited programs. This research updated statistics found in the past (e.g., Morgan et al., 1997; Salyers et al., 2005; Whittinghill et al., 2004) related to the implementation methods of addiction education (e.g., requiring a course or infusing into courses). In addition, research has shown curriculum components among addiction courses in CACREP program differ greatly (Dawes-Diaz, 2007; Morgan et al., 1997). Due to the vagueness of the 2009 CACREP standards, continued program variation is inevitable. This research question helped discover the content areas of substance abuse and addiction education that are being taught to students in CACREP-accredited programs.

(2) How many CACREP-accredited program faculty have expertise in substance abuse/addictions counseling (e.g., experience in the field, completed research, hold credentials)?

i. Who is teaching addiction-related courses currently? (e.g., adjunct with expertise)
This question updated statistics obtained from past research (e.g., Morgan et al., 1997) that investigated the number of faculty members with expertise in addictions.

(3) How will programs change due to the 2009 CACREP standards?
   i. Add new faculty with expertise in addictions?
   ii. Add a required addictions course?
   iii. Offer the Addiction Counseling program option?

This investigation will be the first to be identified which has ascertained the future program planning of CACREP-accredited programs in response to the 2009 addiction-related standards.

(4) What do counselor educators view as “best practice” in the training of counselors?
   i. What do CACREP-liaisons perceive as best practice (e.g., methods of implementing the 2009 CACREP addiction competencies and necessary addiction-related content)?
   ii. What do counselor educators who are also experts in the field of addictions view as best practice (e.g., requiring a course or infusion, instructor qualifications, and pedagogical methods)?

The 2009 CACREP standards not only address addiction training in one of the core competencies (e.g., Human Growth and Development core area) and in the CMHC program option, but an Addiction Counseling program option now exists. The purpose of obtaining expert opinions related to the 2009 CACREP standard changes regarding
addiction instruction was three-fold. First, the interviewees provided an informal evaluation of the 2009 addiction-related standards. Second, the perspectives given by these experts may offer guidance in the implementation of the standards to programs lacking faculty expertise. Third, the researcher was interested in determining if and how the opinions related to best practice in addictions instruction and education differ between experts and CACREP liaisons.

Methodology

The researcher used a mixed-methodology for this investigation. A 15-item survey was created and accessed online through QuestionPro. An introductory postcard was sent out to all 218 CACREP liaisons for advanced notification, and then a week later an invitation e-mail was sent to all liaisons. Three reminder e-mails were sent to invite participation to those liaisons that had not completed the questionnaire. Seventy-four surveys were completed, which was a 33.9% response rate. In the end, four participants were randomly chosen and mailed a $50 VISA gift card. An analysis of the data was conducted through the use of QuestionPro, and descriptive statistics were presented for the quantitative part of the study.

After an extensive review of the relevant literature and an examination of the 2009 CACREP standards, the researcher created a few documents for the qualitative methodology. A semi-structured interview guide sheet, a list of 11 curriculum components, and an inventory of the addiction-related competencies in the 2009 standards were constructed. The sample consisted of five counselor educators who met the pre-determined criteria to be deemed an expert in addictions. The researcher
followed the guide sheet and asked questions regarding the perceived best practices in addiction training in counselor education. The data were examined using thematic analysis (Attride-Stirling, 2001). Thematic networks were created to assist in data analysis and provided a visual representation of the findings (Attride-Stirling, 2001). Member checking and peer review were two procedures used to ensure the validity of the study. These procedures provided a more rigorous design and allowed the researcher to incorporate the feedback into the analysis of the data and presentation of the findings.

The design of this study yielded the answers to the four research questions. The mixed methodology determined the following aspects related to counselor education: (1) the current state of addiction training, (2) the percentage of faculty with addiction expertise, (3) how programs will change due to the 2009 CACREP standards, and (4) the perceived best practices regarding addiction instruction and education in counselor preparation programs. This investigation produced the data needed to answer the research questions; although, there were limitations to this study.

**Limitations and Delimitations**

Limitations of this mixed-method study should be taken into consideration when relaying the findings and discussing the implications for counselor education. All of the information received from the counselor educators was self-report, based on memory, and subjective. For instance, the CACREP liaisons were asked on the survey to provide answers based on their knowledge of what is occurring in their counselor education programs. If a syllabus indicates addiction education is part of the curriculum of a course, the liaison will assume it is taking place, even though it may not be an accurate
representation of what actually transpires in the classroom due to time constraints or other factors. Also, the depth of addiction-related education is a difficult variable to measure. The amount of time an instructor devotes to this type of training can vary drastically. This research investigation did not evaluate this variable. Therefore, training may be found to be happening, but to what extent is unknown.

Another limitation, specifically in the quantitative investigation, is the CACREP liaison may be spearheading the curriculum changes, yet may not have clinical experience in the field of addictions, substantial knowledge of addictions, or an interest in addictions research or training. The level of knowledge in this area (e.g., expert or novice) may impact the participants’ answers on the questionnaire. Moreover, the findings could reflect a self-selection bias. Counselor educators who felt confident in this area or had a personal interest in addictions-related education may have been more likely to participate in the survey. Also, if the faculty members at the liaisons’ counselor education programs are presently discussing how to integrate addiction training into curricula or if faculty are adopting the Addiction Counseling option, these liaisons may have been more apt to participate in the study. On the other hand, if potential participants had a negative view or bias toward this area of training or if their programs are not making significant changes in curricula related to addictions, these liaisons may have opted not to participate.

The contact list from the CACREP website was considered outdated as soon as it was printed. Due to the changes in accreditation status as well as faculty responsibilities, this researcher is unaware if the CACREP liaison was the one who was contacted or if he
or she is the one who completed the survey. Moreover, the consent document indicated the participant must be the liaison or unit director. In several instances this researcher was notified that the contact person listed in the directory was not the CACREP liaison. In essence, even if the participant was willing to complete the survey, after reading the consent form, he or she may not have met this criterion for participation.

Delimitations of the study are also identified, in particular with the qualitative methodology. With qualitative research, transferability or generalizability to other settings may be problematic (Marshall & Rossman, 2006). To address this, only those who were employed full-time as counselor educators at CACREP-accredited programs were eligible to be interviewed. Since only five experts were included, it is possible the findings might have been different had other or additional experts been interviewed.

The next section will provide an overview of previous research in the field of addictions as it relates to counselor education. The results and findings from this investigation will be compared and contrasted with this previous literature.

**Discussion of Past Research**

Past research has been crucial in advocating for change in the CACREP standards, and the information provided has offered training-related guidance to faculty in CACREP-accredited programs. This section addresses the variations and similarities found between previous research outcomes and the results of this study. The section is outlined according to the following areas of interest: (1) the number of program options offered in the past, (2) the implementation method used for addiction training (e.g., infusion or stand-alone course), (3) the number of faculty with addiction expertise, (4)
non-accredited addiction program options available in the past and current programs adopting the Addiction Counseling option, (5) various aspects related to curriculum components, and (6) course design.

**Program Options Offered**

The number of CACREP-accredited program options may vary each year. Additionally, some specializations may be more popular than others depending on the profession and the increased need of certain services in society. Two previous studies surveyed CACREP-accredited programs, and the results were compared to the present investigation. One 1997 study (Morgan et al.) found (1) 75.7% of the 70 institutions offering CACREP-accredited programs had an accredited School Counseling option, (2) 62.8% offered a Community Counseling option, (3) 17.1% offered a Mental Health Counseling option, and (4) 8.5% offered a Marriage and Family Counseling option. Eight years later, another study surveyed participants from 111 institutions with CACREP programs and determined: (1) 93.6% offered a School Counseling option, (2) 76.4% offered a Community Counseling option, and (3) 21.8% offered a Mental Health Counseling option (Salyers et al., 2005). This 2010 investigation surveyed 74 liaisons and they reported a total of 154 available specialization options. In fact, the top three most frequently offered programs in this study were the same as in the two studies cited previously; although, the percentages were quite different. The percentages found from the survey are as follows: (1) 74.3% of the sample reported having a School Counseling track; (2) 45.9% have a Community Counseling track; and (3) 27.0% have a Mental Health Counseling track. The fourth ranked option was Clinical Mental Health...
Counseling track at 25.7% and Marriage, Couple, and Family Counseling track came in fifth at 14.9%. Almost 7% of the institutions in the present study offered a non-accredited Substance Abuse Counseling program track, and only one of the 74 institutions offered a Career Counseling track. Figure 18 illustrates the variation in the number of CACREP-accredited program options available over the years.

![Top Three Program Options, 1997-2010](image)

*Figure 18. Top three program options, 1997-2010. This figure illustrates the three most popular program options available according to the results of three studies conducted over a 13 year period.*

Figure 18 shows School Counseling has been the most widely offered program option among CACREP-accredited programs, with Community Counseling track being second, and Mental Health Counseling consistently being third. Mental Health Counseling has increased ten percent from 1997 to 2010. In 2009, CACREP released the new standards and the Board no longer provides accreditation to Community Counseling programs or Mental Health Counseling programs; however, accreditation for the CMHC option is available instead. Therefore, in the coming years these numbers will change.
For instance, this study found over one-fourth of the programs in the sample currently offers a CMHC option at this time.

**Implementation Method**

A few researchers have investigated addiction training in CACREP-accredited programs and, two studies in particular will be referenced frequently in this section (i.e., Morgan et al., 1997; Whittinghill et al., 2004). Before comparing the results, the variation in response rates should be noted. In the Morgan et al. (1997) study, 70 liaisons from the available 86 institutions which offered CACREP-accredited programs completed the survey (or an 81% response rate). The Whittinghill et al. (2004) study sample was composed of 89 CACREP liaisons, out of a possible 163 participants (i.e., 55% response rate). Approximately one-third of the potential 218 liaisons participated in this current 2010 study. The next three sections will review the results related to the implementation method used over the past decade (see Table 5 for an illustration).

### Table 5

**Comparison of Four Studies Examining Addiction Training Methods**

<table>
<thead>
<tr>
<th>Training Method</th>
<th>Morgan et al. (1997)&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Whittinghill et al. (2004)&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Dawes-Diaz (2007)&lt;sup&gt;c&lt;/sup&gt;</th>
<th>Lee (2010)&lt;sup&gt;d&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Require a Course</td>
<td>30%</td>
<td>30%</td>
<td>33%</td>
<td>28%</td>
</tr>
<tr>
<td>Offer a Course</td>
<td>77%</td>
<td>50%</td>
<td>30%</td>
<td>50%</td>
</tr>
<tr>
<td>Infusion</td>
<td>73%</td>
<td>33%</td>
<td>23%</td>
<td>39%</td>
</tr>
</tbody>
</table>

**Note.** The four studies had varying response rates.

<sup>a</sup> N= 70; of possible 86 liaisons

<sup>b</sup> N= 89; of possible 163 liaisons

<sup>c</sup> N= 304; of possible 1734 graduates; included graduates from non-accredited programs

<sup>d</sup> N=74; of possible 218 liaisons
Require a course. Researchers have found the percentage of institutions requiring an addiction course to be fairly consistent over the years. For example, two previous studies found 30% of institutions offering CACREP programs have a course requirement (Morgan et al., 1997; Whittinghill et al., 2004) and the current study found over 28% of institutions with CACREP programs require a course for all students. A recent study by Dawes-Diaz (2007) found 33% of programs required a course. Although, it should be noted the respondents were graduates, not liaisons, and the graduates were from both accredited and non-accredited counselor education programs.

Furthermore, a study completed over ten years ago found one institution required two courses, and another institution required three courses (Morgan et al., 1997). This investigation, however, determined none of the 74 CACREP liaisons indicated a requirement for all students to complete two or more addiction courses. It is possible that some institutions requiring more than one addiction course did not respond to the survey in this current study.

Past research supports the completion of one or more addiction course as a requirement for counseling students. Carroll (2000) claims students are more likely to appropriately screen, assess, treat, and refer out when they have completed a 3 credit-hour course. Moreover, an overwhelming majority of graduates (81%) highly recommend one or more required addiction courses (Dawes-Diaz, 2007). Limited exposure to addiction training, such as a 3-hour continuing education session, will not improve students’ ability to address addiction (McDermott et al., 1991). Therefore, a required course or the equivalent in continuing education hours may be appropriate. In
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this study, both participants of the survey and the expert interviewees were asked their
opinions regarding the best methods to implement the Human Growth and Development
core area competency. Over 63% of the survey respondents indicated a form of stand-
alone course requirement would be the most appropriate method and the remaining 36%
identified infusion as best practice. More specifically, 40% suggested a stand-alone
course, and 23% recommended a stand-alone course and infusion into one or more core
courses. Furthermore, close to 22% suggested infusing the training into two or more core
courses, 12% suggested infusing into one core course, and 3% indicated infusing the
training into every course. No survey respondents recommended completion of two or
more courses. During the interviews, all of the experts stated the best method would be a
combination of infusion and a stand-alone course. The best practice, in fact, would
include more than one stand-alone course, if not up to three courses. Furthermore, the
experts asserted infusing the required addiction training into more than one course could
be possible, but one course would not be viable or effective.

Participants of the survey and interviews were also asked their opinions about the
best method for implementing the 2009 CACREP addiction competencies which are now
required for students in the CMHC program option. Again, the experts indicated the best
method would be a combination of infusion and a stand-alone course. Similarly, the
majority of survey respondents, over 78%, suggested some form of stand-alone course
requirement, with 30% recommending the combined method and 4% recommending two
or more courses. On the other hand, 22% of the survey participants suggested some form
of infusion. For instance, 11% indicated infusion into 2 or more courses, 7%
recommended infusion into one core course, and 4% recommended infusion into every
course. One expert interviewee stated directly that infusion of the CMHC competencies
into one course would not be possible.

In conclusion, previous research supports the method of a stand-alone course,
both by researchers and graduates of counselor education programs (e.g., Carroll, 2000
and Dawes-Diaz, 2007). This study found the participants in both the survey and
interviews recommend the use of some form of a stand-alone course. The interviewees
did indicate while the combined method may be best practice, it may not be feasible due
to various influences such as funding, faculty expertise and perceptions, and credit hour
requirement constraints.

**Offer a course.** The percentage of CACREP-accredited programs offering an
elective course is less than it was over a decade ago. In 1997, 77% of institutions with
CACREP-accredited programs offered an elective course (Morgan et al., 1997); however,
in 2004, 50% of institutions offered an elective course (Whittinghill et al., 2004).
Currently, in 2010, the percentage has remained stable and 50% of institutions currently
offer such a course.

**Infusion.** Many institutions infuse addiction training into curricula. In 1997,
73% of the institutions offering CACREP programs infused addiction training into other
required courses (Morgan et al., 1997). At that time, 6% of respondents indicated their
institutions infused the training only and did not require or offer an addictions course. In
2004, 33% of respondents stated that substance abuse training was infused into other
courses and offered as a separate course (Whittinghill et al., 2004). Moreover, practicum
and internship were identified as the top two courses where training was infused at that time. The current investigation found 39% of institutions with CACREP-accredited programs infuse addiction training into one or more core courses.

As noted above, the number of institutions requiring a course (i.e., approximately 30%) has been consistent over these three studies; however, there appears to be a decline in programs implementing the infusion method. Therefore, this researcher cannot necessarily conclude this decline is due to an increase in required addiction courses.

Moreover, from 1997 to 2010 there has been a 27% decrease in institutions offering an addictions course (i.e., from 77% to 50%). Some may suggest this decrease can be due to how survey questions were asked, which program liaisons participated in the studies, or other limitations. Another possibility is over time many programs did not provide addiction education in other core courses because students were required to take a stand-alone course. In 2001, the CACREP standards were revised and released, and requirements were changed or added. The amount and frequency of addiction instruction possibly decreased due to an increase in required counselor education in other areas.

None of the previous research reviewed by this author directly addressed the absence of addiction instruction in CACREP-accredited counselor education programs. One study surveyed graduates of accredited and non-accredited programs and found 14% of respondents had no instruction related to addictions during their program of study (Dawes-Diaz, 2007). In the current investigation, participants were asked about the implementation method used, such as requiring a course, offering a course, and infusing addiction training into core courses. If none of those options were applicable, the
participants could specify if no training is currently provided to students. Close to 3% of the liaisons in this study reported their programs provided no training at the time of this study.

**Faculty Expertise**

Over a decade ago, Morgan et al. (1997) investigated the number of faculty who had expertise in the area of addictions. The current study followed up to determine the status of faculty expertise. In 1997, there was an average of 7 faculty members per institution with CACREP-accredited programs (Morgan et al., 1997). At that time, each institution reportedly averaged 1.4 full-time faculty with formal education. The CACREP liaisons in this 2010 study reported a total of 443 full-time faculty members and an average of 6 faculty members per institution with CACREP-accredited programs. Of the 443 faculty members, 32% are considered to have addiction expertise, with an average of 2 members per institution. Over 66% of institutions had 1 or 2 faculty with expertise and 23% had 3 to 6 faculty. In summary, 89% of institutions had at least 1 member; although, almost 11%, or 8 institutions, had no full-time faculty with addiction expertise.

If addiction courses are offered, researchers have attempted to determine who is teaching these courses. Morgan et al. (1997) found 20% of the CACREP programs in their study used part-time faculty to teach addiction courses. This study attempted to follow up on this data, but instead of asking the CACREP liaisons to report if they use part-time faculty to teach addiction courses, the survey asked participants to identify if the instructor was a part-time or full-time faculty member and whether the instructor had
expertise in addiction. Currently, 29% of addiction courses are taught by a part-time instructor, with only 2% having no addiction expertise. Moreover, almost two-thirds of courses (almost 65%) are taught by a full-time faculty member with addiction expertise. Regardless of part-time or full-time status, this study showed that almost 92% of courses are taught by an instructor with expertise in addictions. Table 6 illustrates the differences between the current study and the Morgan et al. (1997) study.

Table 6

*Comparison of Two Studies Examining Faculty Expertise in the Area of Addictions*

<table>
<thead>
<tr>
<th>Results</th>
<th>Morgan et al. (1997)</th>
<th>Lee (2010)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Number of Faculty</td>
<td>7 faculty per institution</td>
<td>6 faculty per institution</td>
</tr>
<tr>
<td>Average Number of Faculty with Expertise</td>
<td>1.4 faculty with &quot;formal education&quot;</td>
<td>2 faculty with expertise</td>
</tr>
<tr>
<td>Percent of the Total Number of Faculty Having Expertise</td>
<td>Unknown</td>
<td>32% of the total number of full-time faculty</td>
</tr>
<tr>
<td>Addiction Course Instructor Expertise</td>
<td>20% of institutions used part-time faculty</td>
<td>65% of courses have full-time faculty with expertise</td>
</tr>
<tr>
<td></td>
<td></td>
<td>27% of courses have part-time faculty with expertise</td>
</tr>
</tbody>
</table>
Addiction Counseling Option

Prior to 2009, CACREP did not offer standards for a substance abuse or addictions option, nor did the CACREP Board provide accreditation to any such programs. In 2004, 25 out of 89 institutions (28%) offered a master’s in substance abuse counseling and 23 institutions (26%) suggested their faculty would consider adding an addiction program if CACREP offered such an option (Whittinghill et al., 2004). The majority of those indicating interest came from institutions which currently offer a master’s degree in substance abuse counseling and would adopt the program option “presumably to add credibility and visibility to their programs” (Whittinghill et al., 2004, p. 72). The experts in this study also supported this assumption. Many of the experts believed institutions with CACREP programs would adopt the Addiction Counseling program if they already offered a similar counseling track and the reasons for doing so would be to add credibility and distinguish themselves from other institutions offering CACREP-accredited programs.

The current study followed up on the Whittinghill et al. (2004) results and investigated if institutions with CACREP-accredited programs had plans to adopt the Addiction Counseling program now that the 2009 CACREP standards were released. See Table 7 for a visual comparison between these two studies. Of the 74 liaisons who participated in the study, five liaisons (6.8%) reported their institutions currently have a non-accredited Substance Abuse Counseling program track and none indicated the Addiction Counseling track. Twelve of the 74 liaisons (16%) reported their faculty have plans to add the Addiction Counseling program, or about half of the number found in the
Whittinghill et al. (2004) study. The assumption was that institutions already offering a substance abuse or addiction-related track would be the ones adopting the new specialization. The results of this investigation did not support that assumption. In fact, only two institutions currently have a non-accredited addiction/substance abuse track. In other words, 10 of the 12 institutions may have significant curricular changes if they wish to adopt the program. This researcher noted these 12 institutions have an average of 7 counselor education faculty currently and an average of 2 members with addiction expertise. In addition, one-third of these 12 institutions have plans to add more counselor education faculty with addiction expertise in the next two years.

Table 7

*Comparison of Two Studies Examining Plans to Implement the Addiction Counseling Program Option*

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Currently Offer a Substance Abuse Counseling Degree</td>
<td>25 of 89 institutions</td>
<td>5 of 74 institutions</td>
</tr>
<tr>
<td></td>
<td>28% of sample</td>
<td>7% of sample</td>
</tr>
<tr>
<td>Plans to Add an Accredited Addiction Program</td>
<td>23 of 89 institutions</td>
<td>12 of 74 institutions</td>
</tr>
<tr>
<td></td>
<td>26% of sample</td>
<td>16% of sample</td>
</tr>
<tr>
<td>Currently Offer Non-Accredited Track and Plans to Add New Program</td>
<td>No specific number indicated</td>
<td>2 of the 12 institutions</td>
</tr>
</tbody>
</table>
Curriculum Components

Previous research has investigated the curricular components that are considered imperative to the training of addiction counselors (e.g., Page et al., 1995; Whittinghill, 2006). Among the top twenty components listed in the Whittinghill (2006) study were components associated with screening, assessment and diagnosis, crisis intervention, treatment planning, and relapse prevention. The implications for counselor education generated by these studies were specific to addiction counselor training, not students in other program options such as Career Counseling or School Counseling. No prior research was identified by this author that addresses the importance or necessity of curricular components by program option and therefore one of the purposes of this study was to find out the opinions of counselor educators who are CACREP liaisons or unit directors related to various curricular components.

The assumption by this researcher is counselor educators believe certain counseling specializations need more addiction-related training than others. This assumption is based on the variation in the number of addiction-related competencies listed in the 2001 and 2009 standards. Refer to Appendix K for a listing of the 2009 addiction-related competencies by program option. One study by Salyers et al. (2005) did not investigate perceived importance, but the researchers found variation in the amount of addictions training by program option. For example, 92% of Mental Health Counseling programs reportedly offered substance abuse coursework, while 83% of Community Counseling programs did, and 56% of School Counseling programs offered coursework in addictions (Salyers et al., 2005).
A dissertation by Dawes-Diaz (2007) did not investigate training by program option, but was the only study found by the researcher that examined the specific addiction-related curricular components offered to students during their program of study. It should be noted that this study also included graduates of non-accredited counselor education programs. Dawes-Diaz (2007) found many curricular components were not taught to approximately one-third of counselor education students, even though they were perceived as very important content by the majority of graduates. For instance, 30.5% of respondents did not get training in pharmacology, but 61.5% believed the training was very important; 29.5% had no training in etiological theories, although 61.5% stated it was very important; 27.6% had no training in prevention, yet 72.7% of graduates reportedly believed it was very important; 25.5% had no training in screening, but 72.4% believed it was very important; and 23.6% had no training in assessment and diagnosis, yet 76.7% indicated it was very important content.

Some of the curricular components in the Dawes-Diaz (2007) study were included in the listing of curricular components created for this current study (e.g., pharmacology, etiological theories, screening, intervention, etc.). This researcher wanted to expand the previous investigation by Dawes-Diaz (2007) and (1) examine the specific curricular components presently taught to students in CACREP-accredited programs, and (2) find if these components are perceived as necessary for the training of all students. Therefore, the researcher asked the experts interviewees about the importance of the 11 curricular components listed in Appendix J. All five experts reportedly found value in each component and some more than others. The survey participants also were asked about
the importance of each and the researcher found that screening, prevention, assessment tools, treatment options, and etiological theories were ranked in the top five and pharmacology was ranked last in necessity.

The Human Growth and Development core competency addresses curricular components such as theories, etiology, addictive behaviors, prevention, intervention, and treatment (CACREP, 2009a). Therefore, all students are to have exposure to these content areas while in their counselor preparation programs. Some program options have more expansive requirements. For instance, this author reviewed the 2009 CACREP standards and identified seven competencies related to addiction in the CMHC program, yet identified no competencies in the Career Counseling program option.

This investigation attempted to find if counselor educators perceived addiction training as more important for certain program options over others. By doing so, the researcher could examine if their opinions matched the differences found in the number of addiction-related competencies in the various CACREP standard program options. The results showed counselor educators think students in the CMHC program option need more addiction training than students in another program of study. This opinion corresponds with the disparity in competencies between program options found in the 2009 CACREP standards. More specifically, CMHC program ranked the highest, second was School Counseling, and then Marriage, Couple, and Family Counseling, followed by Student Affairs and College Counseling, and last was Career Counseling. Moreover, when viewing curricular components by program option, differences were found. For instance, 100% of the survey participants indicated CMHC counselors are to have
training in addiction diagnosis and etiological theories and only 9.5% of participants believed Career Counselors should be trained on pharmacology. In fact, four survey participants reported that no counselors should be required to have pharmacology instruction.

As stated above, the Dawes-Diaz (2007) study determined student instruction varied among institutions offering counselor education programs, and approximately one-third of students did not get any training on some content areas such as pharmacology, etiological theories, and prevention. This study also investigated whether specific curricular components were currently being taught, but this survey only included CACREP-accredited programs. The results were similar to the Dawes-Diaz study in that this researcher also found variation among institutions. Overall, 50% or more of the CACREP liaisons indicated their programs were covering the 11 addiction-related content areas. Not all programs taught the same type of content in their curricula. At least three-fourths of institutions offering CACREP-accredited programs teach their students on screening (78%) and diagnosis (77%). At least half to three-fourths of the programs teach content related to addiction counseling strategies (73%), prevention (71%), intervention (70.3%), assessment tools (68.9%), etiological theories (67.6%), co-occurring disorders (66.2%), treatment options (63.5%), pharmacology (52.7%), and process addictions or addictive behaviors (50%). The greatest variation in addiction education among the sample would be noted in six programs (8%) that reported none of the 11 curricular components were currently taught in their CACREP-accredited programs.
Course Design

Researchers have found that addiction courses vary in regards to the type of content taught, as well as how the content is delivered in and out of the classroom (Morgan et al., 1997). The inclusion of specific assignments or activities (e.g., attendance at 12-step meetings and engagement in abstinence agreements) has been suggested in addiction education coursework (MacMaster & Holleran, 2005; McDermott et al., 1991; Osborn & Lewis, 2004; Sias & Goodwin, 2007). In 1997, researchers determined these reflective and experiential activities were not widely used at the time (Morgan et al., 1997). More specifically, 34% of the course syllabi examined required personal assignments (i.e., weekly logs, drinking diaries, abstinence agreements, personal philosophy papers, and a family-of-origin/substance abuse history). Twenty-three percent of the courses required attendance at 12-step or other recovery meetings, 11% incorporated treatment center visits or interviews with counselors, and 8% used role plays. Another influential course component is the use of a “recovery panel” consisting of 12-step community members who are presently in recovery (Carroll & Bazan, 2001; Sias & Goodwin, 2007). These panels are designed to deconstruct myths that students may have regarding people with addiction problems.

This researcher also found similar results in the qualitative findings related to experiential and reflective activities. The addiction experts were asked directly about course design. The researcher asked, “What have you found to be the most valuable course assignments or learning experiences that help students gain competence in this area?” Didactic instruction, research-based projects, application assignments, reflective
assignments, and experiential activities were identified as important assignments to include into the coursework of addiction training. The following experiential activities were specifically acknowledged: (1) self-help meeting attendance, both chemical and process addictions; (2) domestic violence shelter visits; (3) riding in a police car; (4) abstinence agreements; (5) treatment center visits; (6) visitors in the classroom who are in recovery; and (7) assessment role plays.

In summary, previous research has been crucial in advocating for changes in counselor education specific to addiction training (e.g., Hagedorn, 2009; Salyers et al., 2005; Whittinghill, 2006). These results have assisted in determining the best methods for implementing addiction instruction in the classroom and clarifying the addiction-related content to include in the 2009 CACREP standards. This section outlined how the current findings update prior studies on addictions education and advance the field by examining areas absent from older studies.

This investigation determined the popularity of program options has been consistent over the past decade, with School Counseling being the most frequently offered. With the dissolution of the Community Counseling and Mental Health Counseling options and the newly accredited Addiction Counseling option, these numbers may change over the next five to ten years. For instance, twelve liaisons in this study indicated their faculty had plans to implement the Addiction Counseling program in the future. Almost all of the institutions planning on offering the Addiction Counseling option did not currently offer a non-accredited substance abuse counseling option, which was an unexpected finding. Based on the data, one can assume the statistics related to
The data obtained regarding requiring students to complete an addiction course were similar to the results from previous studies. Approximately 28% of institutions require a course currently, as compared to 30% of institutions in the Morgan et al. (1997) and Whittinghill et al. (2004) studies. This investigation also found 50% of institutions offer an addictions course, which is the same data found in the research completed by Whittinghill et al. (2004), but 27% less than the percentage found in a study conducted over a decade ago (Morgan et al., 1997). Approximately 4 out of 10 institutions infuse the training currently; however, in 1997, training was infused in approximately 7 out of 10 institutions (Morgan et al., 1997).

Faculty expertise was also examined and compared to one previous study. Counselor education programs currently have, on average, approximately two faculty members with expertise in addictions, or approximately one-third of the sample. As compared to a study in 1997, this percentage is 26% less than found in the Morgan et al. (1997) research. While the overall percentage may be less in regards to faculty with expertise represented in counselor education programs, 92% of addiction courses are taught by an instructor with expertise. In fact, 65% of courses are taught by full-time faculty with expertise and 27% by part-time faculty with expertise. Moreover, if addiction courses are provided, this study found the preferred course design. The experts indicated faculty should include didactic instruction, research-based projects, application assignments, reflective assignments, and experiential activities.

While addiction content is currently being taught to many counseling trainees
through infusion or a stand-alone course, this investigation also determined some students are still not provided any education or instruction. In fact, 8% of the liaisons reported no training on the 11 curriculum components included on the survey. Of the 11 components, CACREP liaisons believe screening, prevention, and assessment tools are the three most important areas of instruction. Moreover, compared to all program options, liaisons indicated students in the CMHC program should have the most training. This supports the disparity in competencies noted in the 2009 CACREP standard program options (e.g., CMHC has seven listed and Career Counseling has none listed).

The two methodologies used in this research obtained data which yielded results that supplemented, as well as contrasted with, one another. The next section will describe the comparisons made between the quantitative results and the qualitative findings.

**Data Comparison between the Two Methodologies**

The results from the survey were compared to the interview findings, and some noteworthy observations that were made are discussed in this section of chapter five. The first part outlines some of the similarities and differences in the themes discovered in the open-ended survey question data and the interview data. Next, future plans related to the addition of (a) faculty, (b) addiction courses, and (c) the Addiction Counseling option are addressed. The third portion focuses on the survey and interview participants’ perceptions associated with the 2009 addiction-related, Human Growth and Development core competency requirement. Last, the participants in both methodologies had opinions regarding the methods for implementing addiction training, and these opinions are
compared to the current state of training.

**Themes Found in Open-Ended Survey Question and Interviews**

Some of the themes that emerged from the qualitative interview data were similar to the themes found from the open-ended, survey question data. For instance, addiction training is perceived as important in counselor education, especially due to the prevalence of addictions in society and for those who seek counseling. Also, participants in both samples acknowledged that limitations exist in counselor education programs, and these limitations impact best practice. The survey respondents and the addiction experts cite poor resource availability and credit-hour restraints as barriers for implementing additional courses and more standard requirements. In the same vein, some survey respondents found the CACREP requirements to be excessive, and one survey participant recommended the dissolution of CACREP. In contrast, the experts found the 2009 standards to be sufficient at this time and did not find them to be extraneous. One expert, however, urged the counselor education profession to seek a threshold for training, and not strive for perfection. Moreover, he suggested counselors are like surgeons; they must gain competency by performing services and cannot learn everything they need to know during their graduate studies.

**Future Program Planning**

The release of the 2009 CACREP standards will inevitably cause changes among many counselor education programs nationwide. The researcher reviewed the qualitative findings related to program planning modifications and compared them to the survey results associated with anticipated changes in counselor education programs. For
instance, the interviewees discussed reasons why institutions with CACREP programs may or may not adopt the Addiction Counseling option. Many of the experts believed due to the state of the economy and budget constraints, a widespread adoption of the new specialization program will not occur in the near future. One expert speculated that at first there may be a “dozen” institutions that seek accreditation for this option. Moreover, the institutions that will seek accreditation more than likely already have a non-accredited substance abuse specialization track. In fact, 12 of the 74 liaisons (16%) reported their faculty had plans to adopt the Addiction Counseling option; although, only two of the 12 liaisons reported their institutions currently have an addictions-related track available. The primary reason cited by the experts why institutions will not adopt the program was due to budget limitations. The survey data supported this assumption. Over 45% of the institutions that do not have plans to adopt the Addiction Counseling option reported it was due to funding issues and limited resources.

Despite the budget restraints cited by the participants in both methodologies, many institutions with CACREP-accredited programs have plans to add faculty, courses, and the Addiction Counseling track. For instance, over 9% of institutions with CACREP programs are planning to add faculty with addiction expertise within the next two years. All of these institutions reportedly have members with expertise currently, and four of the seven institutions also plan to adopt the Addiction Counseling option. Moreover, almost 11% of institutions with CACREP-accredited programs are planning to add a required addictions course in the next two years and 75% of institutions adding a course are doing so to fulfill the 2009 CACREP addiction-related standard requirements. All of the new
courses will be taught in counselor education programs versus courses in another university department. In addition, of the institutions not currently offering an elective addictions course in counselor education, 39% are planning on offering an elective course in the next two years. More specifically, 9% of the total sample intend on offering a course in the future. If this were to occur, hypothetically 85% of the current sample would then offer an addictions course.

**Perceptions of the Core Competency**

The participants in both methodologies addressed their perceptions of the competency listed in the 2009 Human Growth and Development core area. In essence, the participants were asked if they viewed the competency as excessive, sufficient, or deficient. Five percent of the CACREP liaisons found the competency to be excessive. Almost 92% of the survey respondents and three of the five experts, however, declared the content to be sufficient. In contrast, two of the five experts and 3% of the survey respondents perceived the competency as deficient. The two expert interviewees were asked to specifically identify the necessary addiction-related content that was missing. The content areas cited were screening, assessment, diagnosis, and relapse prevention.

**Implementation Method**

The experts cited the best implementation method for addiction training in the curricula of all students would be a combination of a stand-alone course and infusing the instruction into core courses. Only 23% of the survey participants agree with this opinion. On the other hand, close to 22% of the CACREP liaisons recommended infusing the content into two or more courses. While all of the experts stated a combined
method would be ideal, a few of them stated realistically many institutions will opt to add a course instead. The survey data supported this statement. In fact, over 40% of the respondents indicated a stand-alone course would be the best method for training all students.

Specifically for CMHC students, almost 45% of survey respondents recommended a stand-alone course and almost 30% suggested the combined method. Moreover, three of the 74 participants cited completion of two or more courses would be ideal. In other words, 78% of survey participants reported the best method for the addiction training of CMHC students would be some form of stand-alone course method. Only 11%, however, recommended infusion into two or more courses. The idea of infusing addiction instruction into two or more courses was possible according to the experts, although not considered ideal. The survey data substantiated this opinion. Again, over three-fourths of survey participants perceived the stand-alone course(s) or combined method would be ideal.

In summary, the data found in both methodologies supported the use of some form of stand-alone course implementation. Although, when investigating the current state of training the survey results indicated the majority of institutions are implementing infusion instead of a stand-alone course method. The survey found 39% of institutions with CACREP programs infuse addiction education into one or more core courses, 28% currently require a course for all students, 9% implement the combined method, and 3% do not provide any training. When reviewing the individual program options, however, the percentage of institutions requiring a course was higher. For instance, almost half of
CMHC programs (47%) require their students to complete an addictions course, 40% of Mental Health Counseling programs require a course, and 36% of Marriage, Couple, and Family programs do as well.

This section outlined the similarities and differences found between the two methodologies used in this study. In summary, the number of institutions planning on adopting the Addiction Counseling program was anticipated by the experts; although, most of these institutions do not have an existing addictions track which was cited by the experts as the main reason institutions would seek accreditation. Budget constraints are the reasons why counselor education programs are not adopting the new program option and the experts reported this in their interviews. Despite the financial strain, institutions with CACREP programs are planning on adding faculty with expertise and adding addictions courses (both required and elective courses) in the next two years. Also, the study found similarities in perceptions of the core competency. Both the experts and CACREP liaisons think it is sufficient. Last, there were differences found between the current state of training and what participants believed to be the ideal training method.

The next section is a discussion of the implications for counselor education and the addiction profession, as well as recommendations for future research.

**Implications and Recommendations**

Addiction issues associated with substance use and other addictive behaviors (e.g., gambling, sex, eating, and shopping) have been and continue to be significant problems affecting the United States (Hagedorn, 2009). Each year millions of Americans seek services to assist in reducing and eliminating problems associated with addictions
Currently, mental health services are provided by a variety of professionals. However, professional counselors (excluding addictions counselors) have the highest proportion of clients with a primary substance abuse diagnosis as compared to social workers, psychologists, and psychiatrists (Harwood et al., 2004).

The addiction-related competencies in the 2009 CACREP standards acknowledge the importance of this type of training, and many counselor education programs may have to undergo curricular changes in order to align with the new standards. The introduction section of the 2009 CACREP standards indicates the standards are not intended to discourage program innovation, and programs can institute variations in how the standards can be met (CACREP, 2009a). In essence, accreditation standards are often descriptive enough to provide direction, but sufficiently vague to allow for creativity. However, the assumption is faculty will have adequate expertise in addictions in order to integrate these accreditation standards into curricula. This investigation examined the current state of addiction training, future program plans, faculty expertise, and perceived best practices. The addiction-training information acquired from the present study is valuable to counselor educators and the counseling profession. The implications discussed in this section are related to (a) the current state of training, (b) the necessity of various curricular components, and (c) faculty. Last, recommendations for implementing addiction training and future research will be provided.

**The Current State of Training**

Addiction training may not be as deficient today as researchers have found in the past (e.g., Dawes-Diaz, 2007; Harwood et al., 2004; Salyers et al., 2005). According to
the results of this study, many CACREP-accredited programs are providing instruction on
the various addiction-related curriculum components which are considered important in
counselor preparation. Content areas such as screening, diagnosis, counseling strategies,
prevention, and intervention are being taught by over 70% of institutions with CACREP-
accredited programs. These findings are noteworthy because it demonstrates that most
programs are already educating their students on some of the content areas listed in the
2009 Human Growth and Development core competency. This standard requires
programs to teach all students about etiological theories, addictive behaviors, prevention,
intervention, and treatment. In other words, based on the data found in this investigation,
less than one-third of counselor education programs may have to incorporate new
addiction-related content into curricula due to the new core standard requirement.

While the results indicate addictions training is occurring in most CACREP-
accredited counselor education programs, the required areas of training may not be
considered important. Certain addiction-related content that is not required for all
counseling students was perceived as more important than the required addiction-related
content in the core competency. Moreover, some of the required content was also found
not to be taught currently by 30% or more of CACREP-accredited programs. Therefore,
the core competency may require training on various content areas, but the content may
not be perceived as necessary nor is it currently taught by a large percent of programs.
For instance, etiological theory content is now required training for all students, yet it was
ranked fifth in perceived importance among the eleven curricular components listed, and
it is not currently taught by 33% of institutions with counselor education programs.
Moreover, instruction on process addictions content, also now required for all counseling students, was ranked seventh out of the 11 curricular component and half of institutions in this study do not provide education related to process addictions presently. The research also found screening to be the most frequently taught component by institutions with CACREP programs (78%) and it was also ranked highest in perceived importance; however, screening is not required training for all counselors as it is not included in the core competency.

Another significant finding was 8% of institutions with CACREP-accredited programs do not teach their students on any of the 11 addiction-related curricular components. According to the CACREP website, over 200 institutions have CACREP-accredited programs in existence at this time. Potentially, at least 16 of available counselor education programs would now have to incorporate instruction on etiological theories, addictive behaviors, prevention, intervention, and treatment into their curricula for all students in order to be in compliance with the Human Growth and Development core competency.

These findings are significant because it means many faculty members have to find some way to now integrate this content into curricula. Curricular changes can take considerable time and effort, especially if there are considerable changes in the CACREP standards (e.g., CMHC program option replacing Community and Mental Health Counseling programs). The core competency lists several content areas which can be perceived as expansive. Thus, a substantial increase in the amount of class time or reading assignments devoted to these content areas may have to be provided to students.
Although the content listed in the competency may be viewed as expansive by many CACREP-liaisons, the competency is a knowledge-based competency and may not require as much change in curricula as skill-based competencies. Therefore, it does not require demonstration of skill outcomes and as a result, the instruction and evaluation methods can be less intensive than a skill-based competency.

**Necessity of Various Curricular Components**

The current state of addiction training may be influenced by the opinions of counselor educators. For example, the 2001 standards did not include a requirement for instruction on a number of addiction-related content areas (e.g., etiological theories and intervention) and therefore, the amount of addiction content has varied among programs in the past depending on the level of perceived importance by faculty. The 2009 standards, however, now include various aspects of addiction education which were not required in the past. Thus, regardless of opinion, the content must be addressed in the curricula for all students if programs wish to obtain or maintain accreditation.

As stated in the previous section, addiction-related content required in counselor preparation is not perceived as necessary for all counselors-in-training. For instance, the Human Growth and Development core competency requires training in process addictions. Although instruction on addictive behaviors is required, it is not viewed by many of the liaisons in this study as necessary training for all students. This investigation examined the opinions of faculty related to the new standard requirements, and the results have several implications for addiction training in CACREP-accredited programs. These findings and implications are discussed below.
The Human Growth and Development core competency related to addiction training is perceived as sufficient by participants in both of this study’s methodologies. In fact, an overwhelming majority, or 92% of survey respondents, found this competency to be appropriate as stated. Counselor educators were then asked to rank 11 addiction-related curricular components in order of importance, and these components included content areas listed in the core competency (e.g., addictive behaviors and intervention). Interestingly, some of the curricular components specified in the core competency are considered less important than other components not specified in the competency. For example, the participants ranked process addictions seventh out of 11 content areas; counseling strategies was tied and also ranked seventh out of 11; and intervention was ranked sixth out of 11. On the other hand, screening was considered the most important component to teach all students, yet the core competency does not specifically address screening. This deficiency was also noted by two of the five experts during their interviews. Additionally, assessment tools was ranked third, and assessment is not included in the core competency either. Not only did the survey results indicate the need for assessment tools to be included in the core area, but the experts also addressed this deficiency during their interviews. Therefore, the qualitative findings support the results of the survey in regards to the absence of required training in addiction screening and assessment tools. In essence, all counseling students in CACREP-accredited programs will be trained on addiction-related content which is considered important, although other curricular components (e.g., screening and assessment) may be perceived as more crucial.

As stated in the previous section, specific addiction-related content areas are
appraised as important in the training of all counselors, and the majority of counselor educators perceive the 2009 CACREP core competency as sufficient. However, when evaluated by program option, certain curricular components are perceived as unnecessary for some counselor specializations. For instance, each of the 11 curricular components was viewed as more appropriate content for the training of CMHC students versus Career Counseling students. Moreover, every one of the 74 CACREP liaisons in the sample indicated addiction diagnosis training was necessary for CMHC students; although, out of the 11 components, diagnosis was ranked ninth overall. In contrast, only 24% of participants believed diagnosis was appropriate instruction content for Career Counseling students.

These results reflect the disparity in the number of competencies required for students in the various program options, as noted in the 2001 and 2009 CACREP standards. For instance, there were no addiction-related competency requirements in the 2001 or the 2009 standards for the Career Counseling program option. In contrast, the 2009 standards list seven competency requirements for students graduating from a CMHC program. Moreover, these CMHC addiction-related competencies are more skill-based versus knowledge-based. Therefore, faculty may have to change their methods for instruction, as well as evaluation processes. In this study, one expert stated the faculty at his institution had to adapt an evaluation form which internship supervisors complete. The form now requests supervisors to note whether students are demonstrating the necessary skill-based addiction competencies required by the 2009 CACREP standards.

When examining the individual curricular components listed in the core
competency (e.g., prevention, intervention, etiological theories, and addictive behaviors),
this researcher noted these various aspects are not perceived as crucially important in the
education of any students other than CMHC students. For instance, 73% of the CACREP
liaisons believe instruction on process addictions is not necessary for Career Counseling
students, and one-third of liaisons believe this content is also not essential for the training
of students in the Marriage, Couple, and Family Counseling option. Also, 50% of
counselor educators indicated content related to etiological theories does not need to be part of the curricula for Student Affairs and College Counseling. Similarly, 47% of counselor educators think instruction on intervention is also not necessary for Student Affairs and College Counseling students. In other words, due to the 2009 Human Growth and Development core competency requirements, all students in CACREP-accredited programs are supposed to be educated on addiction-related content during their programs; however, this content (e.g., addictive behaviors, prevention, intervention, etiological theories) may be considered as excessive by many faculty members.

Faculty Implications

The number of faculty members with expertise in addictions has increased over the years. In fact, close to 90% of institutions have at least one full-time counselor educator with addictions expertise, and some have up to six members. Moreover, despite the economic downturn the nation is experiencing at this time, 9% of institutions with CACREP programs are planning to add faculty with addiction expertise within the next two years, and all of these institutions reportedly have members with expertise currently. This investigation also found the majority of addiction courses available are taught by
full-time faculty members with expertise.

The implications of having the input of faculty with knowledge, clinical experience, and research interests pertaining to addictions are significant, particularly with the release of the 2009 CACREP standards. If 16% of institutions with counselor education programs are planning on implementing the new Addiction Counseling option, expertise would assist in the process of obtaining accreditation. Moreover, many counselor education programs are also changing the Community Counseling and Mental Health Counseling program curricula to align with the new CMHC program option standards. More than likely, this transition includes incorporating more addiction-related content into courses than in the past and possibly even creating new addiction courses. This investigation found almost 11% of institutions with CACREP-accredited programs are planning to add a required addictions course in the counselor education department in the next two years, and 75% of institutions adding a course are doing so to fulfill the 2009 CACREP addiction-related standard requirements. In addition, of the institutions not currently offering an elective addictions course, 39% of institutions not offering an elective addictions course have plans to do so in the next two years. These various curricular changes would be more efficient transitions if institutions had faculty with addiction expertise, and this study determined almost all institutions do have someone who with such expertise.

On the other hand, over 10% of institutions with CACREP-accredited programs have no full-time faculty with expertise, and therefore one in ten institutions may have to seek out guidance from faculty in other university departments or other counselor
educators in CACREP-accredited programs. Communication among counselor educators is vital during this time of transition. Journal publications, conference presentations, CACREP training sessions, the ACA-ACES syllabus clearinghouse, and discussions on list-serves (e.g., CES-net) provide opportunities for consultation and the exchange of ideas within the counselor education profession.

When institutions lack the faculty expertise and choose to infuse addiction training into existing courses (in lieu of adding a course), there are methods to aid counselor educators in aligning coursework and instruction with the CACREP standards. For instance, one of the experts in this study explained a couple options. One possibility is the use of a guest lecturer who is an expert in addictions. This expert can be another faculty member or a community service provider who can come into the classroom and teach the necessary content. Another option is to develop creative ways to infuse the standards and demonstrate student competency outcomes for CACREP. If a competency is skill-based, students may not demonstrate their abilities in the classroom. One of the CMHC program competencies, for example, requires that a student “provides appropriate counseling strategies when working with clients with addiction and co-occurring disorders” (CACREP, 2009a, p. 31). Counselor education programs must provide CMHC students the opportunity to demonstrate the ability to provide counseling strategies to addicted clients if presented with such a population. One addiction expert in this study described the process of adapting curricula at his institution to align with the new standards. He stated the faculty made adjustments to an evaluation form for internship supervisors. Instead of having the students demonstrate the necessary
addiction-related competencies in the classroom, the internship supervisor will now indicate whether students have gained the appropriate addiction-related skills.

The implications for this study are important to the counselor education profession. No previous investigation has examined the implementation or the perception of the addiction-related competencies in the 2009 CACREP standards. Due to the recent release of the CACREP standards, curricular changes are being made nationwide in an effort to align with the competency requirements. With the increase in the number of addiction-related competencies, in particular with the addiction content cited in the Human Growth and Development core competency, significant modifications may be necessary in some programs. The majority of CACREP-accredited programs are training their students currently on addiction content. However, it may be addiction content not listed in the core competency. In fact, one-third of institutions are not educating their students on this content, and almost 8% of institutions have to integrate all of the new addiction-related content. While most institutions have faculty with addiction expertise available to assist in this process, one in ten institutions with CACREP-accredited programs do not have any faculty members. These counselor education programs may have to seek out guidance from faculty in other university departments or other counselor educators in CACREP-accredited programs. Due to this deficiency in expertise, communication among counselor educators is vital at this time. Based on the survey results and interview findings of this research, recommendations will be presented in the next section related to the implementation of addiction training and future research needed in this area.
Recommendations for Implementation of Addiction Training

The field of counseling is constantly changing and CACREP values the continued revision of counselor competency requirements in order to keep abreast of these transformations in the profession. The CACREP Board of Directors believe in “creating and strengthening standards that reflect the needs of society, respect the diversity of instructional approaches and strategies, and encourage program improvement and best practices” (CACREP, 2008, Core values, para. 2). Regardless of the method counselor education programs choose to implement the new 2009 standards, CACREP has acknowledged the need for all counselor trainees to gain more addiction-related knowledge and skill. This next section provides recommendations specific to (a) implementation methods, (b) curricular components, (c) course design, (d) instructor qualifications, (e) further changes in the field, and (f) future research.

Implementation methods. The recommended implementation method for addictions training is a combination of infusion and a stand-alone course requirement. Regardless of specialty program, all students should have exposure to addiction education in core courses such as an assessment course or a psychopathology course and also complete a course specifically devoted to addictions. This suggested course would cover the following addiction-related content: etiologies and theories, various substances and behaviors to which one can be addicted, routes of administration, screening and assessment, treatment approaches, continuum of care, co-occurring disorders, and family issues. The content listed above will cover the necessary instructional content cited within the several CMHC addiction-related competencies (see Table 1) and the Human
Growth and Development core competency. In other words, programs will be able to address the expansive addiction content that is required by CACREP if the students are provided (a) instruction on the content identified above and (b) given the opportunities to demonstrate the knowledge and skill competencies related to this content.

Some counselor education programs may choose to meet the new accreditation standards by either requiring a course or infusing the instruction into one or more core courses. If programs choose to infuse addiction training, there are a couple recommendations. While not considered ideal, faculty may be able to modify the instruction and coursework of two or three existing courses to align curricula with the addiction-related competency requirements. In the past, addiction training has been deficient and not timely (Salyers et al., 2005). Practicum and internship may be the appropriate stages in training where the skill-based addiction competencies can be demonstrated; however, the knowledge-based training requirements should occur before the clinical parts of counseling programs. For instance, a CMHC student can demonstrate he or she has learned “the disease concept and etiology of addiction and co-occurring disorders” (CACREP, 2009a, p. 30) in a Foundations of Clinical Mental Health Counseling course and then can demonstrate he or she “provides appropriate counseling strategies when working with clients with addiction and co-occurring disorders” (CACREP, 2009a, p. 31) during internship.

Curricular components. This researcher suggests that while the Human Growth and Development core competency may be sufficient, some content may be more appropriate for the training of CMHC students than for students in program options such
as Career Counseling. This researcher does suggest that graduates from Student Affairs and College Counseling programs should also be trained in more addiction-related content (e.g., screening, assessment) due to the prevalence of alcohol and drug use on college campuses (Maggs, Williams, & Lee, 2011; Seigers & Carey, 2010). In addition, the inclusion of addiction-related content pertaining to screening may be very appropriate for the training of all counselors and should be added to the core competency in future revisions. Education on various addiction assessment tools was found to be important for the training of all counselors, except Career Counselors. Currently, the 2009 CACREP standards require assessment instruction for students in the CMHC program, but this type of education may be included in the other specializations in the future (e.g., Marriage, Couple, and Family and School Counseling programs). Finally, teaching students how to diagnosis addictions was recommended for all students by a couple of the experts; however, the CACREP liaisons believe that particular content is important for CMHC students and does not need to be included in the core area for all students. Therefore, addiction diagnosis is not recommended training for any other counseling program options.

The CACREP standards may need modifications. For instance, the core competency is lacking instruction on screening, assessment, and relapse prevention. In addition, the following areas of addiction-related curriculum content may be considered for inclusion in future CACREP standard revisions: (a) drug classification, (b) the side effects and interactions of commonly abused chemicals, (c) family issues, (d) crisis counseling, and (e) special populations.
Moreover, several of the program options may be re-evaluated and competencies modified in the future. For instance, the Addiction Counseling program option may be missing some content or existing content can be amended in the future (e.g., systemic and cultural factors). The researcher also found that adjustments were suggested for the School Counseling, Career Counseling, and CMHC program options. For instance, there are no additional competencies in the Career Counseling option related to addiction knowledge or skill.

**Course design.** Five pedagogical methods are recommended when integrating addiction training in the classroom. Course syllabi should include didactic instruction, research-based projects, application assignments, reflective assignments, and experiential activities. If faculty are infusing addiction-related content into one or more core classes, any of these pedagogical methods can be used. The choice made more than likely will depend on a few factors. Time constraints and available resources will more than likely influence the implementation of specific assignments. Also, if an instructor wishes to have students learn foundational knowledge, didactic instruction may be more fitting. If the goal is to increase students' empathetic skills and possibly explore their attitudes and beliefs, experiential activities may be more appealing. Based on prior research (e.g., Osborn & Lewis, 2004; Sias & Goodwin, 2007) and the experts' opinions expressed in this study, the use of experiential activities is highly recommended, especially in a stand-alone addiction course. Another recommendation is if an instructor chooses to require attendance at a self-help group, a couple necessary steps need to be taken. First, the instructor should have knowledge about the type and number of meetings offered in the
community. Also, the students must be fully prepared in regards to what to expect, how to act, and what to communicate to these community members. One final suggestion would be to pair a reflection assignment with the engagement of any experiential activity chosen.

**Instructor qualifications.** Integration of the addiction-related competencies can be completed by using infusion, a stand-alone course, or a combination of the two approaches. If faculty members choose to infuse the training into core courses, they may need some assistance by counselor educators who are also experts in the addictions field. An instructor of the core course does not need to have expertise in addictions to teach the content required by CACREP. There are, however, qualifications cited for an ideal instructor who teaches a stand-alone course in addictions. The ideal experience, education, and credentials have been identified by experts and these instructors may be more available in counselor education departments nationwide than in the past.

Ideally, an addictions course instructor would have a doctorate and have addictions specific training as part of his or her graduate counseling studies. He or she would also have counseling experience, preferably at least two years of general practice. Ideally, the person would have provided counseling services for several years and specifically with addicted clients. The instructor would hopefully possess a significant amount of knowledge related to addiction literature in order to provide up-to-date, pertinent information to counselors-in-training. Also, the faculty member would have an addictions focus in their professional work with presentations, publications, and consultations. Last, it is recommended the instructor hold a credential as a licensed
chemical dependency counselor or a certification in addictions.

**Further changes in the field.** Several recommendations for change are suggested for counselor educators and clinicians in the field. First, in an effort to continue to reduce stigma and gain acceptance, counselor educators can maintain their engagement in activities supporting the significant transformations taken by CACREP and the counseling field. For instance, faculty can support and use the terms “addiction(s)” in lieu of “substance abuse.” Already, there have been changes demonstrated related to this shift in terminology. The proposed *DSM-V* may no longer use the term “dependence” and the category “Substance-Related Disorders” may be renamed “Addiction and Related Disorders” (APA, 2010). Moreover, the titles of certain academic journals (e.g., Addictive Behaviors), credentials (e.g., Master Addictions Counselor), organizations (e.g., International Association of Addictions and Offender Counselors), counseling courses (e.g., Addiction and the Addiction Process), and conferences (e.g., National Conference on Addictive Disorders) reflect the acknowledgement of process addictions. The title and creation of the Addiction Counseling program option are clear indications that the counselor education profession is supporting this transition. The title, however, may be re-evaluated and changed to a plural term in an effort to include the range of various addictive behaviors that exist. Counselor educators should also provide instruction on addictive behavior in coursework and advocate for changing course titles. Efforts to reduce stigma can also be made by implementing experiential activities, educating colleagues, providing colloquia, and advocating for addiction content into curricula.
Another recommendation for the counseling field is to continue to advocate for the creation of national and state standards for addiction professionals. Many states are shifting to addiction licensure requirements in order to practice, and most of the time it requires a master's degree. Counselor educators should support this transition and advocate for graduate training for addiction counselors.

Third, addiction counselors, more specifically in the Addiction Counseling program option, should be taught how to interact and collaborate with various other professionals. Addiction professionals should take a community, or landscape, approach. Specifically, counselors should not only be viewed as interventionists, but also as public health professionals.

Fourth, the creation of diagnostic criteria for various process addictions is recommended and should be included in future editions of the DSM. For years, researchers (e.g., Block, 2008; Manley & Koehler, 2001; Hagedorn, 2009) have advocated for specific addictive behaviors to be in the diagnostic manual. With the upcoming release of the DSM-V in 2013, there have been discussions related to the inclusion of behavioral addictions. According to the American Psychiatric Association website (http://www.dsm5.org/Pages/Default.aspx), “disordered gambling” may be considered an addiction in the new edition of the DSM (APA, 2010). Also, hypersexual disorder is a proposed diagnosis; although still not considered an addiction, this addictive behavior more than likely will be recognized in the “Sexual and Gender Identity Disorders” category.

The last area for suggested change is related to recovery issues for professionals.
Guidelines should be put in place, and continued discussion should occur related to professionals in recovery. These guidelines must include methods for monitoring and engaging faculty and students, as well as inclusion of a helpful, not punitive, model when these professionals relapse.

**Recommendations for Future Research**

The counseling profession has made significant changes over the past decade and previous research has provided support for these transformations. Areas for further investigation became apparent for this researcher during the completion of this study. Therefore, this last section will outline recommendations for future research in addictions and counselor training.

The researcher examined how CACREP-accredited programs are currently training their students with regards to addiction-related content. Since the revised edition of the CACREP standards were released over one year ago, future studies can determine how training is being implemented and if it differs greatly from the results of this study. The researcher assumes many programs are in transition with regard to curricular changes, particularly in addictions training content. Therefore, researchers can survey institutions a couple years from now to find out how many institutions adopted the Addiction Counseling program option and if the number of programs requiring or offering an addictions course has changed.

One aspect of addictions training not researched in this study is when the instruction takes place. If addiction content is infused into counseling courses, in which courses is the training most often taught? Over five years ago, Salyers et al. (2005) found
that practicum and internship are commonly the courses where the instruction is occurring. Researchers can determine since the release of the new CACREP standards, if the content is now infused into other courses more frequently.

This investigation also did not address how much time is involved or the extent of training. Is the duration of training devoted to a course (e.g., 45 hours), one class period (e.g., 3 hours), or one hour of a class period? How many addiction-related assignments are required? Are the CACREP competencies addressed mostly through didactic lecture and examined through the use of an exam? How often are experiential activities being used? To address these questions, follow up research can update the data found in the Morgan et al. (1997) and Whittinghill et al. (2004) studies. Researchers could examine the syllabi of addiction courses and course design can be investigated. By doing so, researchers can determine if instructors are using didactic lecture, research-based projects, application assignments, reflective assignments, and experiential activities, and identify what specific assignments or activities are being used.

One facet of counselor education that appears to be less researched is the policies to follow or procedures to engage in when faculty members or counselors-in-training are in recovery. The researcher did not perform an exhaustive search, but attempted to gain a sense of available literature regarding this topic. There seems to be a gap in the research related specifically to faculty and students, particularly in counselor education. One search under the ERIC Database with the key words “counselor education” and “relapse” yielded one article related to recovering addicts working in the field (Doukas & Cullen, 2010); however, no articles pertained to faculty or counseling students. The following
keywords were used and obtained very limited results: "counselor education," "impaired," "students," "faculty," "addiction," "substance abuse," "recovery," and "rehabilitation." A Google Internet search found more results for other helping professionals. For instance, programs have been set up for physicians, pharmacists, and nurses who are in recovery or suspected of being addicted. In summary, this area is virtually absent in the literature, and researchers and counselor educators need to address this dearth in research.

This investigation examined faculty members perceptions and opinions related to addiction training. A few years ago, Dawes-Diaz (2007) asked graduates about their satisfaction with the addiction instruction they received and determined what addiction content was taught at that time. The sample included graduates from non-accredited CACREP programs. Future research could replicate the Dawes-Diaz study and focus on graduates from CACREP-accredited programs. The 2009 standards will more than likely change the data obtained in the previous study. Due to the new requirements pertaining to addictions, it is assumed the data obtained from graduates of CACREP programs would differ from graduates of programs which may not adhere to the CACREP standards.

Of the 218 institutions offering CACREP-accredited programs, liaisons from 74 institutions completed the survey. Thus, the response rate for this study was approximately 34%. The implications and recommendations made by this researcher are based on data collected from approximately one-third of the institutions which have accredited counseling programs. Therefore, this author suggests CACREP facilitate
further data gathering and assessment in an effort to gain a larger sample size and reinvestigate the research questions posed in this study.

Outside of counselor education, research is needed as well. Continued investigations are imperative in order to determine the most effective treatment strategies for working with addicted clients. A couple of the experts in this study stated the importance of more outcome research, and researchers have been working on finding the treatment modalities which are most efficacious with this population. Up to 50-60% of clients are unaware of their addiction problems when they enter counseling (Prochaska & Norcross, 2001). Action-oriented counseling strategies are premature if clients are not motivated or committed to change (Miller & Rollnick, 2002). Thus, motivational strategies, such as Motivational Enhancement Therapy (Miller, 1995), are found to be effective when treating clients who are not prepared to take action (Burke, Arkowitz, & Dunn, 2002). Some other effective counseling strategies commonly used are cognitive-behavioral therapies, trauma work with women, and contingency management (Carroll, 2005; Fiellin et al., 2000; Hien, Cohen, Miele, Litt, & Capstick, 2004; Moos, 2007). Further research is imperative in order to empirically validate what modality is most appropriate to use, at what time, and with what type of client population.

**Conclusion**

In conclusion, the 2009 CACREP standards symbolize a recognition that addiction instruction has been lacking in the past, and now there is an increase in educational requirements for all counselors-in-training. In the next few years, curricula will be changing nationwide among the counselor education programs in an effort to
align with the newest edition of the standards. This mixed-method study found that addiction training in CACREP-accredited programs may not be as limited in curricula as found in the past, and most of the addiction content required in the new standards are currently being taught in the majority of institutions. Moreover, the Addiction Counseling program option appears to be a well-received specialty, and approximately a dozen institutions will seek accreditation. Despite the economic downturn, counselor education programs still have plans to add faculty with addiction expertise in the next two years. Also, addiction courses, both required and elective, most likely will be added as well. Implementation methods will continue to vary among programs, although the best practice would be infusion and a stand-alone course in addictions. Moreover, in the classroom, addiction training should include a combination of didactic lecture, experiential and reflective activities, and writing assignments. This study provided a formal evaluation of the 2009 CACREP standards by interviewing addiction experts and surveying CACREP liaisons within counselor education programs. Overall, the 2009 addiction-related standards are sufficient and perceived in a positive light. CACREP and the counseling field have advanced substantially over the years, particularly with addiction training, and the new standards reflect the significant progression in this area.
REFERENCES


Appendix A

The Ideal Substance Abuse Training Components
The Ideal Substance Abuse Training Components

(Klutschkowski & Troth, 1995)

<table>
<thead>
<tr>
<th>Training Components</th>
<th>Expert Panel Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol abuse and related medical problems</td>
<td>1</td>
</tr>
<tr>
<td>Alcohol and drug education</td>
<td>1</td>
</tr>
<tr>
<td>Counseling, group</td>
<td>1</td>
</tr>
<tr>
<td>Counseling, individual</td>
<td>1</td>
</tr>
<tr>
<td>Counseling, techniques</td>
<td>1</td>
</tr>
<tr>
<td>Ethics</td>
<td>1</td>
</tr>
<tr>
<td>12 core areas</td>
<td>1</td>
</tr>
<tr>
<td>12-step program of AA or NA</td>
<td>1</td>
</tr>
<tr>
<td>Addiction issues</td>
<td>2</td>
</tr>
<tr>
<td>Counseling theories</td>
<td>2</td>
</tr>
<tr>
<td>Treatment planning, approaches, management, evaluation</td>
<td>2</td>
</tr>
<tr>
<td>No different training for counselors who have never been addicted</td>
<td>2</td>
</tr>
<tr>
<td>Intrapersonal relationship skills</td>
<td>3</td>
</tr>
<tr>
<td>No different training for recovering counselors</td>
<td>3</td>
</tr>
<tr>
<td>Communication skills</td>
<td>4</td>
</tr>
<tr>
<td>Family dynamics</td>
<td>5</td>
</tr>
<tr>
<td>Relapse</td>
<td>5</td>
</tr>
<tr>
<td>Self-help groups</td>
<td>5</td>
</tr>
<tr>
<td>AIDS education</td>
<td>6</td>
</tr>
<tr>
<td>Legal aspects (federal, state, local)</td>
<td>6</td>
</tr>
<tr>
<td>High school graduate</td>
<td>7</td>
</tr>
<tr>
<td>Pharmacology</td>
<td>7</td>
</tr>
<tr>
<td>Client treatment-matching</td>
<td>8</td>
</tr>
<tr>
<td>Needs of specific populations</td>
<td>8</td>
</tr>
<tr>
<td>Referral networks</td>
<td>8</td>
</tr>
<tr>
<td>Support systems</td>
<td>8</td>
</tr>
<tr>
<td>Etiology of substance abuse</td>
<td>9</td>
</tr>
<tr>
<td>Multicultural counseling</td>
<td>9</td>
</tr>
</tbody>
</table>
Appendix B

Addictions Training Questionnaire
Addictions Training Questionnaire

1. What type of master’s-level, CACREP-accredited counselor education program options do you offer currently? (Check all that apply)

☐ Community Counseling
☐ Mental Health Counseling
☐ Clinical Mental Health Counseling
☐ Career Counseling
☐ Marriage, Couple, and Family Counseling
☐ School Counseling
☐ Student Affairs and College Counseling
☐ Addiction Counseling
☐ Non-accredited Substance Abuse Counseling program option
☐ Other: ______________________________

2. In regards to ALL students, your masters-level counselor education program: (Check all that apply)

☐ Requires a substance abuse course
☐ Requires two or more substance abuse courses
☐ Offers one or more elective substance abuse courses
☐ Infuses substance abuse training into the content of one or more core courses
☐ No training is provided

3. If your program REQUIRES completion of one or more substance abuse courses, indicate for which students it is required: (Note: if not a or b, check all that apply)

☐ a) N/A, no course required for any students
☐ b) All students, regardless of program option / specialization
☐ c) Community Counseling students
☐ d) Mental Health Counseling students
☐ e) Clinical Mental Health Counseling students
☐ f) Career Counseling students
☐ g) Marriage, Couple, and Family Counseling students
☐ h) School Counseling students
☐ i) Student Affairs and College Counseling students
☐ Other ______________________________

3.a. The course is (or these courses are) offered by and/or a part of:

☐ the counselor education department curriculum
☐ another department of the university (e.g., sociology, psychology, specialty certificate program in substance abuse)
3.b. The substance abuse course(s) is currently taught by:

- [ ] an adjunct faculty instructor WITHOUT expertise in substance abuse counseling
- [ ] an adjunct faculty instructor WITH expertise in substance abuse counseling
- [ ] a full-time faculty member WITHOUT expertise in substance abuse counseling
- [ ] a full-time faculty member WITH expertise in substance abuse counseling
- [ ] I don’t know

4. If your program *DOES NOT REQUIRE* a substance abuse course currently, are there plans to require one or more courses in the next two years?

- [ ] Yes
- [ ] No
- [ ] N/A, required already

4.a. Is this new requirement decision primarily made in order to fulfill the 2009 CACREP standards related to substance abuse/addictions?

- [ ] Yes
- [ ] No

4.b. The course to be required in the future will be:

- [ ] created by the counselor education department
- [ ] already developed from another department at the university (e.g., sociology, psychology, specialty certificate program in substance abuse)

4.c. Will this be a requirement for ALL students?

- [ ] Yes
- [ ] No

4.d. If it won’t be a requirement for all students, for which program(s) will it be a requirement? (Check all that apply)

- [ ] Community Counseling
- [ ] Mental Health Counseling
- [ ] Clinical Mental Health Counseling
- [ ] Career Counseling
- [ ] Marriage, Couple, and Family Counseling
- [ ] School Counseling
- [ ] Student Affairs and College Counseling
- [ ] Other: ____________________________________________
5. If your program **DOES NOT OFFER** a substance abuse course currently, are there plans to offer one or more courses in the next two years?

- Yes
- No
- N/A, offered already

6. In your opinion, how important is substance abuse training for counselors-in-training?

- Crucial
- Very Important
- Important
- Somewhat Important
- Not Important

7. The 2009 CACREP standards require **ALL** students, regardless of program option, to know the “theories and etiology of addictions and addictive behaviors, including strategies for prevention, intervention, and treatment” (CACREP, 2009, p.10). In your opinion, this requirement is:

- excessive
- sufficient
- insufficient

8. Specifically in relation to the training of **ALL** students, in your opinion, how should counselor education programs implement the 2009 CACREP substance abuse education and training requirements? (Check only one)

- Infuse into one core course
- Infuse into two or more core courses
- Infuse into every course
- Require a substance abuse course
- Require two substance abuse courses
- Infuse into at least one core course and require a substance abuse course

9. Specifically in relation to the new **Clinical Mental Health Counseling** program option, in your opinion, how should counselor education programs implement the 2009 CACREP substance abuse education and training requirements? (Check only one)

- Infuse into one core course
- Infuse into two or more core courses
- Infuse into every course
- Require a substance abuse course
- Require two substance abuse courses
- Infuse into at least one core course and require a substance abuse course

10. Indicate which master’s-level counselor education program options *should* include each of the following substance abuse components into the training of their students.

<table>
<thead>
<tr>
<th>Substance Abuse Component</th>
<th>Clinical Mental Health Counseling</th>
<th>Career Counseling</th>
<th>Marriage, Couple, and Family Counseling</th>
<th>School Counseling</th>
<th>Student Affairs and College Counseling</th>
<th>None of these program options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
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<td>[ ]</td>
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<tr>
<td>Assessment Tools</td>
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<td>[ ]</td>
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<tr>
<td>Diagnosis</td>
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<tr>
<td>Pharmacology</td>
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<tr>
<td>Prevention</td>
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<tr>
<td>Intervention</td>
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<tr>
<td>Treatment Options</td>
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<td>[ ]</td>
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<td>[ ]</td>
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<tr>
<td>Counseling Strategies</td>
<td>[ ]</td>
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<tr>
<td>Co-occurring Disorders</td>
<td>[ ]</td>
<td>[ ]</td>
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<tr>
<td>Etiological Theories (i.e., causes of substance abuse)</td>
<td>[ ]</td>
<td>[ ]</td>
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<td>[ ]</td>
</tr>
<tr>
<td>Process Addictions (e.g., gambling, shopping, Internet, sex)</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
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<td>[ ]</td>
</tr>
</tbody>
</table>
11. Please indicate the following substance abuse components which are currently taught at some point in the curricula of ALL the counselor education students in your programs.

☐ Screening
☐ Assessment Tools
☐ Diagnosis
☐ Pharmacology
☐ Prevention
☐ Intervention
☐ Treatment Options (on the Continuum of Care)
☐ Counseling Strategies
☐ Co-occurring Disorders
☐ Etiological Theories
☐ Process Addictions or Addictive Behaviors (e.g., gambling, shopping, Internet, sex)

12. How many full-time Counselor Education faculty members does your program have at this time? (Type in a number)


13. How many of the faculty members identified in the previous question have expertise in substance abuse counseling (e.g., experience in the field, completed research, hold credentials)? (Type in a number)


13.a. Are there plans to add faculty with expertise in substance abuse counseling in the next two years?

☐ Yes
☐ No
☐ I don’t know

14. Does your program offer, or have plans to offer, the new Addiction Counseling program option?

☐ Yes
☐ No
14.a. The PRIMARY reason for offering the Addiction Counseling program option is:

☐ There is a demand by students for this program option.
☐ There is a demand or need by the counseling profession to have this option available for students.
☐ Addictions is a specialty field and there needs to be a program option available which is devoted to teaching students how to work with populations who have addictions.
☐ Our department had a substance abuse program option already available and wanted to obtain accreditation.
☐ Other: ________________________________

14.b. The PRIMARY reason for not offering the Addiction Counseling program option is:

☐ There is not a demand by students for this program option.
☐ There is not a demand or need by the counseling profession to have this option available for students.
☐ Addictions is not a specialty field and there is no need to have this program available.
☐ Our department did not have a substance abuse program option already available and it would cost too much time/money to obtain accreditation.
☐ Other: ________________________________

15. OPTIONAL: Please provide any additional comments regarding substance abuse education and training needs that should be considered by CACREP-accredited counselor education programs.

________________________________________________________________________
Appendix C

Consent Document – Quantitative Version
You are invited to participate in a research project titled "Implementation of the 2009 CACREP Standards Substance Abuse Competencies." This project will serve as Tiffany K. Lee's dissertation for the requirements of the Doctor of Philosophy in Counselor Education. This consent document will explain the purpose of this research project and will go over all of the time commitments, the procedures used in the study, and the risks and benefits of participating in this research project. Please read this consent form carefully and completely and contact the student or principal investigator if you have any questions.

The purpose of this study is to investigate the current state of substance abuse training in master's-level, CACREP-accredited programs, more specifically in relation to the new 2009 CACREP standard requirements.

There is one requirement for participation in the study. The participants must be the identified CACREP liaison or unit/training director.

The anonymous, 15-item survey is hosted on QuestionPro, an Internet-based research site. Your participation in this study should take approximately 10 minutes.

If you choose to participate in this study, you will be asked to provide information pertaining to the substance abuse training taking place in your master's-level counselor education programs, as well as your opinion regarding curriculum changes resulting from the 2009 CACREP standards. If you so choose, you can be entered in a random drawing for one of four $50 VISA cards. In order to be entered into the drawing, you must provide your e-mail address. Your e-mail address will not be associated with your survey responses. The four recipients of the VISA cards will be randomly selected once data collection has been completed. If you are selected as a winner, you will be contacted by the student researcher and asked to provide your mailing address. The VISA card will then be mailed to you through the United States Postal Service.

Time spent on completing these surveys may result in equivalent time lost to spend on other activities. Participating in this research provides the opportunity to think about your attitudes toward an important topic in our profession, which may be a potential benefit to you. There are no costs associated with participating in this study.

All information entered by researchers and participants into QuestionPro's site is kept in a secure data facility that is monitored for operational security. The surveys are protected
by Check Point FireWall-1, decreasing the chances the survey information can be intercepted or manipulated by a third party during transmission. All of the information collected from you is anonymous. Your name is not recorded on any of the information collected.

You can choose to stop participating in the study at anytime for any reason. You will not suffer any prejudice or penalty by your decision to stop your participation. You will experience no consequences if you choose to withdraw from this study. Should you have any questions prior to or during the study, you can contact the primary investigator, Gary H. Bischof at 269-387-5108 or gary.bischof@wmich.edu, or Tiffany K. Lee at 269-387-7321 or tiffany.k.lee@wmich.edu.

You may also contact the Chair, Human Subjects Institutional Review Board at 269-387-8293 or the Vice President for Research at 269-387-8298 if questions arise during the course of the study.
This research study and consent document have been reviewed by the Human Subjects Institutional Review Board (HSIRB) of Western Michigan University.

I have read this consent document. The risks and benefits have been explained to me. If you would like to participate, please click on the "Continue" button below to indicate your consent to participate in this study.
Appendix D

Advanced Notification of Invitation to Participate in the Survey
Research Opportunity Coming Soon!

In a few days you will receive an e-mail invitation to participate in a study titled:

Implementation of the 2009 CACREP Standards Substance Abuse Competencies

Your contribution will be so valuable to this initiative and I thank you in advance for your participation.

Research participants will have the option to enter a drawing for

ONE OF FOUR $50 VISA CARDS

Watch for the e-mail coming soon!

For more information on this study and/or to participate in the 15-item survey, please visit the following link:

HTTP://SUBSTANCEABUSECOMPETENCY.QUESTIONPRO.COM

Front of the Postcard
Appendix E

Invitation E-mail for Survey
Sent September 20, 2010

Subject: 2009 CACREP Standards-Substance Abuse/Addictions Competencies

Dear Dr. {LAST_NAME},

I hope this e-mail finds you well. My name is Tiffany K. Lee and I am a doctoral candidate in the Counselor Education program at Western Michigan University. Approximately one week ago, I mailed out an informational postcard about your potential participation in my study.

My research is investigating the current state of substance abuse training in master's-level, CACREP-accredited programs, specifically in relation to the implementation of the new 2009 CACREP standards. It is my intent to determine how programs are responding to the new standards. This research is being supervised by my faculty mentor and chair, Gary H. Bischof, Ph.D., and it has been reviewed by the Human Subjects Institutional Review Board at Western Michigan University.

This survey is being sent to you because I obtained your contact information from the CACREP directory and your expertise is greatly needed to complete this research. I know your time is valuable and I truly appreciate your consideration in submitting the survey.

This anonymous, online questionnaire has 15 items and will take approximately 10 minutes to complete. Research participants will have the option to ENTER A DRAWING FOR ONE OF FOUR $50 VISA CARDS!

If you would like to learn more about the study, the consent information and survey are available and can be accessed by clicking on the following link:

http://substanceabusecompetency.questionpro.com/

If you are not the CACREP liaison, I would ask that you please forward this e-mail to the appropriate faculty member. If there is no designated CACREP-liaison, the unit/training director is invited to complete this survey. Again, thank you for your time.

Sincerely,

Tiffany Lee, MA, NCC
Endorsed by Stephen Craig, PhD, CACREP Liaison
Counselor Education and Supervision
Specialty Program in Alcohol and Drug Abuse
Western Michigan University
E-mail: tiffany.k.lee@wmich.edu
Appendix F

Reminder E-mails for Survey
First e-mail reminder:

Sent September 26, 2010

Subject: Current State of Substance Abuse/Addictions Training

Hello {FIRST_NAME} {LAST_NAME},

I hope you had an enjoyable weekend. Approximately one week ago, I sent an e-mail requesting participation in an online, anonymous questionnaire.

My research is investigating the current state of substance abuse/addictions training in master’s-level, CACREP-accredited programs. Further, I am interested in determining the opinions and actions of faculty in response to the new 2009 CACREP standards related to addictions.

The survey is comprised of 15 questions and it will take approximately 10 minutes to complete. Your input is invaluable to this investigation. Research participants will have the option to enter a drawing for one of four $50 VISA cards! (Your survey is not associated with your contact information.)

The consent form and survey are available at

<SURVEY_LINK>

(http://substanceabusecompetency.questionpro.com/)

I greatly appreciate your time and consideration in completing the survey or forwarding this e-mail to the CACREP liaison in your counselor education program.

Please contact me if you have any questions and thank you again.

Sincerely,

Tiffany Lee, MA, NCC
Counselor Education and Supervision
Specialty Program in Alcohol and Drug Abuse
Western Michigan University
E-mail: tiffany.k.lee@wmich.edu
Second e-mail reminder:

Sent October 3, 2010

Subject: Re: Addictions Training

Good afternoon Dr. {LAST_NAME},

I am contacting you to follow up on my invitations sent over the past two weeks. Your input is so valuable to this investigation Dr. {LAST_NAME}. Please consider contributing to my dissertation research surveying CACREP-accredited counselor education programs. I am interested in determining the current state of addictions training in your program, as well as the opinions and actions of your faculty in response to the new 2009 CACREP standards.

The survey will take approximately 10 minutes to complete and you will have the option to enter a drawing for one of four $50 VISA cards! (Your survey is not associated with your contact information.)

The consent form and survey are available at

<SURVEY_LINK>

(http://substanceabusecompetency.questionpro.com/)

I greatly appreciate your time and consideration in completing the survey or forwarding this e-mail to the CACREP liaison in your program.

Please contact me if you have any questions and thank you again Dr. {LAST_NAME}.

Sincerely,

Tiffany Lee, MA, NCC
Counselor Education and Supervision
Specialty Program in Alcohol and Drug Abuse
Western Michigan University
E-mail: tiffany.k.lee@wmich.edu
Final e-mail reminder

Sent October 10, 2010

Subject: Last E-mail Request: Addictions Training

Hello Dr. {LAST_NAME},

I hope this e-mail finds you well. My name is Tiffany Lee and I am a doctoral candidate at Western Michigan University. This will be my last request asking for your participation in my dissertation research. Your input is so valuable to my investigation Dr. {LAST_NAME}.

I am surveying CACREP program liaisons/unit directors in an effort to determine the current state of addictions training, as well as the opinions and actions of faculty in response to the new 2009 CACREP standards.

So far, the survey has taken participants an average of 8 minutes to complete. The survey is anonymous and has 15 items. At the end you will have the option to enter a drawing for one of four $50 VISA cards. (Your survey is not associated with your contact information.)

The consent form and survey are available at

<SURVEY_LINK>

(http://substanceabusecompetency.questionpro.com/)

I greatly appreciate your time and consideration in completing the survey or forwarding this e-mail to the CACREP liaison/unit director in your program.

Please contact me if you have any questions and thank you again Dr. {LAST_NAME}.

Best Wishes,

Tiffany Lee, MA, NCC
Counselor Education and Supervision
Specialty Program in Alcohol and Drug Abuse
Western Michigan University
E-mail: tiffany.k.lee@wmich.edu
Appendix G

E-mail Contact Regarding the VISA Card Drawing
On Oct 18, 2010, at 9:00 AM, Tiffany Kay Lee wrote:

Subject: Survey Drawing Winner

Good afternoon,

You recently completed a survey regarding addictions training in CACREP-accredited programs. You are one of four randomly selected participants who won a $50 VISA gift card!! Congratulations! Please provide me your mailing address and I can send it out tomorrow. I am placing the receipt in with the gift card as proof of payment. Thank you again for your input. I greatly appreciate your time and consideration!

Take care,

Tiffany

Tiffany Lee, MA, NCC
Specialty Program in Alcohol and Drug Abuse
Doctoral Candidate, Counselor Education
Western Michigan University
Appendix H

Telephone Script for Qualifying Potential Expert Participants
Telephone Script for Qualifying Potential Expert Participants

"Hello. My name is Tiffany Lee and I am a doctoral candidate in Counselor Education at Western Michigan University. I am conducting research for my dissertation, which is investigating the current state of addictions training in CACREP-accredited counselor education programs. As you know, the 2009 CACREP standards were released and there are several changes and additions related to addiction training, including the new Addiction Counseling program option. I am trying to determine what may be considered ‘best practices’ related to the addiction education of counselors-in-training, as well as what may be regarded as ‘best practices’ when faculty attempt to implement the standard requirements related to addictions training. In order to do this, I need to interview counselor educators who are also ‘experts’ in substance abuse and addictions counseling. Participation would involve a semi-structured, tape-recorded, telephone interview and it will take approximately 45-60 minutes to complete. I am contacting you because I am familiar with some of your work in addictions (or because someone referred me to you). I was hoping to have the opportunity to discuss my research with you and see if you would be interested in possibly becoming a participant in this study.”

<Potential participant indicates his or her interest or lack of interest. Also, I will answer any questions the potential participant may have at this time>

“If you are interested in participating, I must determine first if you are considered an “expert” based on some pre-determined criteria I have set. I need to confirm that you are employed full-time as a counselor educator at a CACREP-accredited program and you have completed three or more of the following tasks:
(a) Published one or more journal articles related to substance abuse/addiction

(b) Carried out research related to substance abuse/addiction

(c) Presented information on substance abuse/addiction at a conference

(d) Provided five or more years of substance abuse/addictions counseling

(e) Obtained credentials in the substance abuse/addictions field

(f) Taught at least one substance abuse/addictions course

(g) Provided professional service in this area for a year or longer (e.g., committee or board member, editor, etc.)

Which of the tasks have you completed?"

<Potential participant will answer>

<If the potential participant is interested and considered an “expert,” I will proceed to the next paragraph. If not interested or not considered an expert, I will skip down to the paragraph with the two asterisks>

“I would like to discuss a little further what is requested of a participant. After the interview is transcribed and I have typed up the analysis of your interview, and findings from the cross-case analyses, I would like to provide you with those documents to review. The amount of time spent on this will vary based upon how closely you choose to review the findings. Would you be willing to provide me with comments and feedback about the accuracy of my analysis?

<If yes, continue with script below. If no, discuss the lack of interest in participating with potential participant. If they still do not want to be involved
with the study, then I would skip down to the paragraph with the two asterisks>

"Great. So I will be sending 2 copies of a consent document by mail with a pre-stamped envelope. Please review it, sign one copy, and keep the other for your records. I will also be sending two other documents with the consent form which I need you to review before the telephone interview. One is a listing of 11 substance abuse/addictions curriculum components and the other is a summary of the addiction competencies which are identified in the 2009 CACREP standards. It is not all of the 2009 CACREP standards, only the substance abuse and addictions-related competencies listed by program option. Again, please review these documents before the interview; it may take approximately 15-20 minutes of your time. Once I have received the consent document, I will contact you by telephone or e-mail in order to set up the interview. Do you have any questions at this time?"

<Answer any questions>

"I would like to get all your contact information, including an address to send the consent document. Is that ok?"

<Obtain the contact information and also provide my contact information to the participant>

"Great. I am looking forward to the interview and appreciate your time. Your input will be essential to this investigation. I have one other question for you. Would you know of any other counselor educators with expertise in this area who may qualify for this study?"

<Yes or No; Obtain potential participant’s contact name/information, if possible>

"Ok. Thank you again. I will be putting the documents in the mail tomorrow. Please
contact me if you have any questions in the meantime. Goodbye.”

** <If unwilling/unable to participate>

“Thank you so much for your time today. I appreciate it. I was hoping you may know of any other counselor educators with expertise in this area who may be potential participants for the study. Do you know of anyone you could refer me to at this time?”

<Yes or No; Obtain potential participant’s contact name/information, if possible>

“Thank you again. Have a great afternoon/evening.”
Appendix I

Consent Document – Qualitative Version
You are invited to participate in a research project titled "Implementation of the 2009 CACREP Standards Substance Abuse Competencies." This project will serve as Tiffany K. Lee’s dissertation for the requirements of the Doctor of Philosophy in Counselor Education. This consent document will explain the purpose of this research project and will go over all of the time commitments, the procedures used in the study, and the risks and benefits of participating in the qualitative part of this research project. Please read this consent form carefully and completely and contact the student or principal investigator if you have any questions.

The purpose of this study is to investigate the current state of substance abuse training in master’s-level, CACREP-accredited programs, more specifically in relation to the new 2009 CACREP standard requirements. It is the researcher’s intent to determine what may be considered “best practices” related to the substance abuse education of counselors-in-training, as well as what may be regarded as best practices when faculty attempt to implement the standard requirements related to substance abuse competencies.

In order to participate in the interview portion of this study, the participants must be a full time counselor educator and must be considered an expert by the researcher based on predetermined criteria. Your participation in this portion of the study should take approximately 45-60 minutes.

The semi-structured interview questions are focused on three main areas and you will be asked your expert opinion about:

(1) The current status of substance abuse training at CACREP-accredited programs.
(2) The importance of substance abuse training.
(3) What would be considered “best practice” in the training of master’s level counselors.

There are two documents sent with this consent form which should be reviewed prior to the interview. This review will take approximately 10 minutes. After your participation in the interview, a copy of the findings will be sent to you for your review and your feedback on the findings will be requested. The time commitment for this portion of study will vary based upon how closely you choose to review the findings.
Time spent on completing this interview may result in equivalent time lost to spend on other activities. Participating in this research provides the opportunity to think about your attitudes toward an important topic in our profession, which may be a potential benefit to you. There are no costs associated with participating in this study.

If you choose to participate in this study, your interview will be confidential and coded with a number and transcribed verbatim by the researcher. You may request a copy of your transcribed interview at any time. The tapes will be held in a locked cabinet and erased once the transcripts are transcribed and verified. No identifying information will appear in the write-up of the findings. There are no other potential risks known for participating in this study.

You can choose to stop participating in the study at anytime for any reason. You will not suffer any prejudice or penalty by your decision to stop your participation. You will experience no consequences if you choose to withdraw from this study. Should you have any questions prior to or during the study, you can contact the primary investigator, Gary H. Bischof at 269-387-5108 or gary.bischof@wmich.edu, or Tiffany K. Lee at 269-387-7321 or tiffany.k.lee@wmich.edu.

You may also contact the Chair of the Human Subjects Institutional Review Board at 269-387-8293 or the Vice President for Research at 269-387-8298 if questions arise during the course of the study. This research study and consent document have been reviewed by the Human Subjects Institutional Review Board (HSIRB) of Western Michigan University.

I have read this consent document. The risks and benefits have been explained to me. I agree to take part in this study. Please return a signed copy in the envelope provided; the other copy is for your records.

Please print your name

Participant’s Signature

Date
Appendix J

List of Substance Abuse/Addictions Curriculum Components
List of Substance Abuse/Addictions Curriculum Components

Screening
Assessment Tools
Diagnosis
Pharmacology
Prevention
Intervention
Treatment Options (on the Continuum of Care)
Counseling Strategies
Co-occurring Disorders
Etiological Theories
Process Addictions or Addictive Behaviors (e.g., gambling, shopping, Internet, sex)
Appendix K

The 2009 CACREP Standards: Addiction-Related Competencies
The 2009 CACREP Standards:  
Addictions Competencies

The competencies below were extracted from the 2009 CACREP standards. These competencies relate to the terms “substance abuse,” “addiction(s),” and “addictive behavior.” No competencies in the 2009 standards include the terms “drug” or “alcohol.”

Please review these standards prior to the interview.

COMPETENCY LISTED IN CORE AREA FOR ALL STUDENTS

Under “HUMAN GROWTH AND DEVELOPMENT” Core Area

“theories and etiology of addictions and addictive behaviors, including strategies for prevention, intervention, and treatment” (p. 11).

THE FOLLOWING COMPETENCIES ARE LISTED BY PROGRAM OPTION

ADDITION COUNSELING

Students who are preparing to work as addiction counselors will demonstrate the professional knowledge, skills, and practices necessary to work in a wide range of addiction counseling, treatment, and prevention programs, as well as in a mental health counseling context. In addition to the common core curricular experiences outlined in Section II.G, programs must provide evidence that student learning has occurred in the following domains.

FOUNDATIONS

A. Knowledge

1. Understands the history, philosophy, and trends in addiction counseling.

2. Understands ethical and legal considerations specifically related to the practice of addiction counseling.

3. Knows the roles, functions, and settings of addiction counselors, as well as the relationship between addiction counselors and other mental health professionals.

4. Knows the professional organizations, competencies, preparation standards, and state credentials relevant to the practice of addiction counseling.

5. Understands a variety of models and theories of addiction related to substance use and other addictions.
6. Knows the behavioral, psychological, physical health, and social effects of psychoactive substances and addictive disorders on the user and significant others.

7. Recognizes the potential for addictive disorders to mimic a variety of medical and psychological disorders and the potential for medical and psychological disorders to coexist with addiction and substance abuse.

8. Understands factors that increase the likelihood for a person, community, or group to be at risk for or resilient to psychoactive substance use disorders.

9. Understands the impact of crises, disasters, and other trauma-causing events on persons with addictions.

10. Understands the operation of an emergency management system within addiction agencies and in the community.

B. Skills and Practice

1. Demonstrates the ability to apply and adhere to ethical and legal standards in addiction counseling.

2. Applies knowledge of substance abuse policy, financing, and regulatory processes to improve service delivery opportunities in addictions counseling.

COUNSELING, PREVENTION, AND INTERVENTION

C. Knowledge

1. Knows the principles of addiction education, prevention, intervention, and consultation.

2. Knows the models of treatment, prevention, recovery, relapse prevention, and continuing care for addictive disorders and related problems.

3. Recognizes the importance of family, social networks, and community systems in the treatment and recovery process.

4. Understands the role of spirituality in the addiction recovery process.

5. Knows a variety of helping strategies for reducing the negative effects of substance use, abuse, dependence, and addictive disorders.

6. Understands the principles and philosophies of addiction-related self-help programs.

7. Understands professional issues relevant to the practice of addiction counseling,
including recognition, reimbursement, and right to practice.

8. Understands the principles of intervention for persons with addictions during times of crises, disasters, and other trauma-causing events.

D. Skills and Practices

1. Uses principles and practices of diagnosis, treatment, and referral of addiction and other mental and emotional disorders to initiate, maintain, and terminate counseling.

2. Individualizes helping strategies and treatment modalities to each client’s stage of dependence, change, or recovery.

3. Provides appropriate counseling strategies when working with clients with addiction and co-occurring disorders.

4. Demonstrates the ability to use procedures for assessing and managing suicide risk.

5. Demonstrates the ability to provide counseling and education about addictive disorders to families and others who are affected by clients with addictions.

6. Demonstrates the ability to provide referral to self-help and other support groups when appropriate.

7. Demonstrates the ability to provide culturally relevant education programs that raise awareness and support addiction and substance abuse prevention and the recovery process.

8. Applies current record-keeping standards related to addiction counseling.

9. Demonstrates the ability to recognize his or her own limitations as an addiction counselor and to seek supervision or refer clients when appropriate.

DIVERSITY AND ADVOCACY

E. Knowledge

1. Understands how living in a multicultural society affects clients with addictions.

2. Understands current literature that outlines theories, approaches, strategies, and techniques shown to be effective when working with specific populations of clients with addictions.

3. Knows public policies on local, state, and national levels that affect the quality and accessibility of addiction services.
4. Understands effective strategies that support client advocacy and influence public policy and government relations on local, state, and national levels to enhance equity, increase funding, and promote programs that affect the practice of addiction counseling.

F. Skills and Practices

1. Maintains information regarding community resources to make appropriate referrals for clients with addictions.

2. Advocates for policies, programs, and/or services that are equitable and responsive to the unique needs of clients with addictions.

3. Demonstrates the ability to modify counseling systems, theories, techniques, and interventions to make them culturally appropriate for diverse populations of addiction clients.

ASSESSMENT

G. Knowledge

1. Understands various models and approaches to clinical evaluation for addictive disorders and their appropriate uses, including screening and assessment for addiction, diagnostic interviews, mental status examination, symptom inventories, and psychoeducational and personality assessments.

2. Knows specific assessment approaches for determining the appropriate level of care for addictive disorders and related problems.

3. Understands the assessment of biopsychosocial and spiritual history.

4. Understands basic classifications, indications, and contraindications of commonly prescribed psychopharmacological medications so that appropriate referrals can be made for medication evaluations and so that the side effects of such medications can be identified.

H. Skills and Practices

1. Selects appropriate comprehensive assessment interventions to assist in diagnosis and treatment planning, with an awareness of cultural bias in the implementation and interpretation of assessment protocols.

2. Demonstrates skill in conducting an intake interview, a mental status evaluation, a biopsychosocial history, a mental health history, and a psychological assessment for treatment planning and case management.
3. Screens for psychoactive substance toxicity, intoxication, and withdrawal symptoms; aggression or danger to others; potential for self-inflicted harm or suicide; and co-occurring mental and/or addictive disorders.

4. Helps clients identify the effects of addiction on life problems and the effects of continued harmful use or abuse.

5. Applies assessment of clients’ addictive disorders to the stages of dependence, change, or recovery to determine the appropriate treatment modality and placement criteria in the continuum of care.

RESEARCH AND EVALUATION

I. Knowledge

1. Understands how to critically evaluate research relevant to the practice of addiction counseling.
2. Knows models of program evaluation for addiction counseling treatment and prevention programs.
3. Knows evidence-based treatments and basic strategies for evaluating counseling outcomes in addiction counseling.

J. Skills and Practice

1. Applies relevant research findings to inform the practice of addiction counseling.
2. Develops measurable outcomes for addiction counseling programs, interventions, and treatments.
3. Analyzes and uses data to increase the effectiveness of addiction counseling programs.

DIAGNOSIS

K. Knowledge

1. Knows the principles of the diagnostic process, including differential diagnosis, and the use of current diagnostic tools, such as the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).
2. Knows the impact of co-occurring addictive disorders on medical and psychological disorders.
3. Understands the established diagnostic and clinical criteria for addictive disorders and
describes treatment modalities and placement criteria within the continuum of care.

4. Understands the relevance and potential cultural biases of commonly used diagnostic tools as related to clients with addictive disorders in multicultural populations.

**CAREER COUNSELING**

No competencies which relate to the terms “substance abuse,” “addiction(s),” or “addictive behavior.”

**CLINICAL MENTAL HEALTH COUNSELING**

*Under “FOUNDATIONS” Domain*

“Recognizes the potential for substance use disorders to mimic and coexist with a variety of medical and psychological disorders” (p. 29).

*Under “COUNSELING, PREVENTION AND INTERVENTION” Domain*

“Knows the disease concept and etiology of addiction and co-occurring disorders” (p. 30).

“Provides appropriate counseling strategies when working with clients with addiction and co-occurring disorders” (p. 31).

*Under “ASSESSMENTS” Domain*

“Identifies standard screening and assessment instruments for substance use disorders and process addictions” (p. 32).

“Screens for addiction, aggression, and danger to self and/or others, as well as co-occurring mental disorders” (p. 33).

“Applies the assessment of a client’s stage of dependence, change, or recovery to determine the appropriate treatment modality and placement criteria within the continuum of care” (p. 33).

*Under “DIAGNOSIS” Domain*

“Knows the impact of co-occurring substance use disorders on medical and psychological disorders” (p. 34).
MARRIAGE, COUPLE, AND FAMILY COUNSELING

Under “COUNSELING, PREVENTION, AND INTERVENTION” Domain

“Recognizes specific problems (e.g., addictive behaviors, domestic violence, suicide risk, immigration) and interventions that can enhance family functioning” (p. 37).

Under “ASSESSMENT” Domain

“Understands the impact of addiction, trauma, psychopharmacology, physical and mental health, wellness, and illness on marriage, couple, and family functioning” (p. 38).

SCHOOL COUNSELING

Under “ASSESSMENT” Domain

“Knows the signs and symptoms of substance abuse in children and adolescents, as well as the signs and symptoms of living in a home where substance abuse occurs” (p. 42).

STUDENT AFFAIRS AND COLLEGE COUNSELING

Under “COUNSELING, PREVENTION, AND INTERVENTION” Domain

“Knows principles of addiction intervention, consultation, education, and outreach for students in postsecondary education” (p.48).

Notes: The 2009 Glossary defines “process addictions,” but not “substance abuse,” “addiction” or “addictive behavior(s).”
Appendix L

Interview Guide Sheet
Interview Guide Sheet

Title of Study: Implementation of the 2009 CACREP Standards Addiction Competencies

Time of interview: ____________________________

Date of interview: ____________________________

Location: ____________________________________

Interviewer: _________________________________

Interviewee: _________________________________

Thank you for consenting to participate in this study. I would like to record the interview so the study can be as accurate as possible.

Questions:

1. Can you please start by describing your professional expertise related to substance abuse and addictions?

2. In your opinion, how important is addictions training in counselor education and why?

3. In your opinion, what is the current state of substance abuse and addictions training in master’s-level, CACREP-accredited programs?

4. How should addiction instruction be taught? In other words, what would be considered best practice?

   Note: Be sure each of these sub-questions are answered

   (a) Is the best practice of implementing the CACREP standards by infusion, stand-alone course, or combined methods?

   (b) Which students should be exposed to addiction training (e.g., Career, CMHC, Marriage, Couple, and Family, School, etc.) and why?

   (c) What should be the qualifications of an instructor who teaches this content?

   (d) In respect to course design, what have you found to be the most valuable course assignments or learning experiences that help students gain competence in this area (e.g., testing; reflection papers based on 12-step meetings, interviewing a counselor; visiting a treatment center)?
5. *[Ask participant to refer to the curriculum component list sent by researcher prior to the interview]*

What specific curricular components should be taught to ALL counselor education students related to substance abuse and addictions (e.g., etiologies, prevention, treatment strategies, and pharmacology), if any?

Which components should be taught only to students in specific program options?

6. The 2009 CACREP standards have some changes related to substance abuse and other addictions. I want to discuss some of these changes in particular. Refer to “The 2009 CACREP Standards” document (Appendix J) which was mailed to you.

   (a) What is your opinion of the 2009 CACREP standards related to addictions?

   (b) What is your opinion in regards to the number of CACREP competencies related to substance abuse and addiction education in the Clinical Mental Health Counseling program option (e.g., excessive, sufficient, insufficient)?

   (c) What is your opinion in regards to the competencies related to addictions-related education in the other program options (e.g., Career; Marriage, Couple, and Family)?

   (d) In regards to best practice, what method should be used to implement these competencies into CMHC programs (e.g., infusion, stand-alone, combined)?

   (e) What method do you think most programs will use to implement these competencies?

   (f) What is your opinion of the new Addiction Counseling program option?

       i. The program’s standards
       ii. The title
       iii. The content covered
       iv. The program option, in the general sense

   (g) What percentage of counselor education programs do you think will adopt this accredited program option? Why?

7. Based on your expertise, can you identify any specific changes that still need to be made in this area? (e.g., related to the profession, the CACREP standards, CACREP-accredited programs, or students and faculty)

Closing comments; thank the participant
Appendix M

Human Subjects Institutional Review Board Letter
Date: July 19, 2010

To: Gary Bischoff, Principal Investigator
    Tiffany Lee, Student Investigator for dissertation
    James Jobe, Student Investigator

From: Amy Naugle, Ph.D., Chair

Re: Approval not needed for HSIRB protocol 10-07-17

This letter will serve as confirmation that your project “Implementation of the 2009 CACREP Standards Substance Abuse Competencies” has been reviewed by the Human Subjects Institutional Review Board (HSIRB). Based on that review, the HSIRB has determined that approval is not required for you to conduct this project because you are studying programs and are not collecting private information about individuals. Thank you for your concerns about protecting the rights and welfare of human subjects.

A copy of your protocol and a copy of this letter will be maintained in the HSIRB files.
Appendix N

Open-Ended Responses to Survey Question 15
Open-Ended Responses to Survey Question 15

1. "The more emphasis on process addictions across the curriculum, the better."

2. "A very important component that students should know about"

3. "Since substance abuse education is required by CACREP there should be a corresponding effort by NBCC to include this area in the NCE."

4. "Many of these questions do not include options for our programs. Substance abuse is required for CMH; optional for others. It is taught by a part-time faculty member who has expertise in addictions. Some of the questions are unknown at this time, yet there was not an option for that answer."

5. "We are maxed out at 63 semester hours for a Master's degree. Our dean will not permit us to require any more courses."

6. "Training in substance abuse is important, but I think the counseling field is starting to go too far with its emphasis on competencies. Substance abuse competencies . . . multicultural competencies . . . spiritual competencies . . . how many more competencies will be required to insert into counseling programs over the next 10 years. The ideas of competencies is fine as long as individual counseling programs have the option of determining whether such competencies are appropriate given their particular circumstances. Just my two cents (I'll get off my soap box now)."

7. "Substance abuse education for counselors is vitally important."

8. "Within survey . . . you did not give an option for including substance abuse background either in required courses or through infusion strategies . . . as long as it is covered . . . both are viable options."
9. “Difficult to keeping adding required courses.”

10. “As the credit hour requirements for graduate counseling degrees have steadily increased (by CACREP), so too have the standards. As a result, many programs have been forced to require more courses and limit the number of elective, specialty options. Although this may ensure that all counselors have a baseline level of training in 'core' areas, it limits the number of counselors who may have designated specialties to serve specific populations. In my opinion, ALL counselors should have some competency in assessment of substance abuse/addictions. However, it is my opinion that substance abuse/addictions should remain a specialized part of counseling practice.”

11. “In view of the prevalence of substance abuse in our society, content on substance abuse (screening, prevention, interventions, etc) should be included in CACREP accredited program curricula.”

12. “For the first time, next spring, we will devote 9 class hours, in our new Advanced Counseling course, to substance abuse and addictions. I responded to pertinent questions here with those course plans in mind. A counseling psych adjunct, with long experience in community practice (currently in a community agency), will teach the course, and I will be quite involved in a service-learning component of it (and in planning the course). I had coursework in this area and spent 5 part-time years in subst-abuse treatment work in two states. This seems to be the best way for us, in a 48-hour, full-time, two-year school-counseling program to incorporate this emphasis. The new course is being created because we are redistributing the content of 2
courses after the retirement of a long-time faculty member with special expertise in another area.”

13. “CACREP should not exist as it is no longer an independent accrediting body as should by the 2009 standards. It is controlled by universities and counselor educators have no input.”

14. “It is irresponsible to train counselors, especially CMHC and MFT as well as college counselors without providing a minimum of 1 required course in SA. This issue impacts the majority of clients, especially in internship settings.”

15. “CACREP is throwing on to many requirements for all the degrees, watering down the importance of some areas, they should be focusing more on important areas - not just everything they can think of requiring.”