Considerations for Preparing Prospective Alcohol and Drug Counselors

Introduction

The Substance Abuse and Mental Health Services Administration’s (SAMHSA) National Survey on Drug Use and Health estimates that 23.5 million individuals age 12 years or older require treatment for an alcohol or a drug abuse problem [1]. It is further estimated that an additional 11 million individuals meet the criteria for alcohol and drug treatment under the new provisions of the Affordable Health Care Act [2]. However, of these individuals, only 11% will receive specialized treatment for an addictive disorder [1]. The demand for alcohol and drug treatment has contributed to the need for professionals who specialize in alcohol and drug counseling. In fact, employment rates for alcohol and drug counselors are expected to increase 27% by 2018 [3]. This employment trend has led to discussions about the preparedness of alcohol and drug counselors among behavioral health providers [4]. The purpose of this brief report is to make recommendations for preparing prospective alcohol and drug counselors.

The perceived recovery status is unique to the alcohol and drug profession, because many counselors are themselves in recovery from substance abuse [5,6]. The few studies conducted on this area of research have assessed perceived recovery status impacts on supervisory relationships [7,8], evidence-based practices [9], and competence [10,11]. Simons et al. [9] surveyed emerging counselors and found that 53% of them were in recovery from substance abuse. Findings from this study suggest that recovering counselors were more resistant to using evidence-based practices in alcohol and drug treatment compared to their counterparts [9]. Subsequent studies indicate that less than one-third of alcohol and drug professionals identify themselves as in recovery [6,11,12]. A recent study detected that professionals with a recovery identity were not as comfortable working with consumers diagnosed with depression, anxiety, and eating disorders, and were more likely to use twelve-step and faith-based approaches in treatment compared to those professionals without a recovery identity [11]. Taken together, these findings indicate that professionals entering the alcohol and drug counseling field are less likely to identify as in recovery and those professionals who do identify as in recovery are more likely to use self-help approaches in treatment. Cross-training for professionals who do and do not identify as in recovery may be necessary to provide effective counseling for individuals diagnosed with an addictive disorder.

Training for alcohol and drug counselors has evolved from a professional model of recovery rooted in personal experience to a professional model of continuing care derived from treatment research [13]. Although recovery models for alcohol and drug use have advanced, there is a great deal of variability in state staffing requirements and standards for certification/licensure as an alcohol and drug counselor [2,14,15]. West et al. [16] Studied state standards for staffing regulations governing substance abuse treatment programs and found that few of them require a graduate degree to provide counseling or supervision. Kerwin et al. [17] Similarly detected that education, supervision, and training requirements for certification vary from state to state. Addiction knowledge and clinical supervision also varies in graduate counseling programs [4,18]. The inconsistent training in counseling programs and addiction education may contribute to students being less prepared to enter the alcohol and drug workforce upon graduation. This discrepancy has contributed to concerns about the preparedness of alcohol and drug counselors [16,19].

A national addiction counseling curriculum would address the concerns raised about inconsistencies in education, supervision and training. National and state boards, educators, and healthcare providers may want to consider developing an addiction counseling curriculum. Interdisciplinary or cross-disciplinary training should be provided so that alcohol and drug counselors are comfortable and competent to work with different populations (i.e., adolescents) with varying problems (i.e., mental health issues). Alcohol and drug counselors should also be trained to integrate techniques derived from both evidence-based treatment models (i.e., Medication Assisted Therapy) and twelve-step approaches. Evidence-based practices, as well as basic and advanced counseling models should be disseminated in undergraduate and graduate studies, continuing education training programs, and clinical supervision. It is reasonable to expect that professionals with a recovery identity may strongly identify with their work as an alcohol and drug counselor; therefore, recovering perspectives should be incorporated into addiction education and clinical supervision. Simulation exercises and other experiential learning activities (i.e., attend a twelve-step meeting) could be infused to expand counselors’ perspective taking skills. Supervisors could also work with professionals who do and do not identify as in recovery so that they use blended or integrated counseling approaches in practice. Supervisors should assess how personal recovery experiences impact counseling. If these suggestions were to be utilized, then alcohol and drug counselors with and without a recovery identity may be more prepared to practice.
Considerations for Preparing Prospective Alcohol and Drug Counselors

References