2004

# Implications of Personal Recovery History for Training and Development of Addiction Treatment Workers

Bruce K. Barnard
*Eastern Illinois University*

# THESIS REPRODUCTION CERTIFICATE

TO: Graduate Degree Candidates (who have written formal theses)

SUBJECT: Permission to Reproduce Theses

The University Library is receiving a number of request from other institutions asking permission to reproduce dissertations for inclusion in their library holdings. Although no copyright laws are involved, we feel that professional courtesy demands that permission be obtained from the author before we allow these to be copied.

PLEASE SIGN ONE OF THE FOLLOWING STATEMENTS:

Booth Library of Eastern Illinois University has my permission to lend my thesis to a reputable college or university for the purpose of copying it for inclusion in that institution's library or research holdings.

4-13-04

Date

I respectfully request Booth Library of Eastern Illinois University **NOT** allow my thesis to be reproduced because:

_____

_____

_____

_____ _____

Author's Signature Date

**This form must be submitted in duplicate.**

# Implications of Personal Recovery History for Training and Development of Addiction Treatment Workers

BY

Bruce K. Barnard

**THESIS**

SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE OF

Master of Science in Technology

IN THE GRADUATE SCHOOL, EASTERN ILLINOIS UNIVERSITY
CHARLESTON, ILLINOIS

2004

I HEREBY RECOMMEND THAT THIS THESIS BE ACCEPTED AS
FULFILLING THIS PART OF THE GRADUATE DEGREE CITED ABOVE

4/15/04
DATE

April 15, 2004
DATE

Running head: IMPLICATIONS OF PERSONAL RECOVERY HISTORY

THESIS COMMITTEE

4/12/04
DATE

4/12/04
DATE

4/12/04
DATE

## Abstract

The purpose of the study was to identify and compare competencies perceived as most important by addiction treatment workers with, and without, a personal history of recovery. A survey was developed and administered to 94 workers in three community-based addiction treatment agencies. The study found broad support for the competencies published by the Addiction Technology Transfer Center, National Curriculum Committee (1998). There were no significant differences in perceptions of competencies by workers with a personal recovery history and those without such history. Results indicate that factors such as workplace culture may be more powerful than recovery history in influencing worker perceptions. Areas for improved training, such as utilization of research, outcome studies, and applying systems theory, are discussed.

Acknowledgements

This study would not have been possible without the assistance of the Central East Alcohol and Drug Council in Charleston, Illinois; Triangle Center in Springfield, Illinois; and Prairie Center Health Systems in Urbana, Illinois. These agencies generously opened their doors and allowed distribution of surveys during their staff meetings. The following individuals offered assistance and support.

| | |
|---|---|
| Pam Irwin, Executive Director | CEAD Council |
| Deb Brisino, Program Director | CEAD Council |
| Steve Knox, Executive Director | Triangle Center |
| Jamie Shawgo, Clinical Director | Triangle Center |
| Patrick Leary, Executive Director | Prairie Center |
| Betty Seidel, Associate Director for Vermilion County | Prairie Center |

Table of Contents

List of Tables

# Chapter 1

## Introduction

Addiction treatment workers in community-based addiction treatment agencies respond to requests for services from clients with multiple treatment needs. To respond effectively, community-based agencies seek to maintain a multi-disciplinary staff of workers to provide services in a number of treatment settings. Supervisors and administrators in community-based agencies are challenged to recruit, train, and develop effective workers who enter the workforce from diverse cultural, educational, and employment backgrounds, including many who have a personal history of addiction and recovery. Effective training and development of professional staff is necessary to refine and develop clinical skills that support and sustain quality services (Leukefeld, Pickens, & Schuster, 1991).

Professional addiction treatment began in the 1940s (White, 1998). When compared to psychology or sociology, addiction treatment is a relatively new discipline (Ward & Thorp, 1996). The developing professional treatment field was influenced by the parallel emergence of personal recovery movements such as Alcoholics Anonymous and Narcotics Anonymous (White, 1998). Agencies and practitioners often use treatment models designed to incorporate principles and steps of personal recovery movements with professional counseling techniques based on research and science. A number of these models, including the Minnesota Model, are common today (Boren, Carroll, & Onken, 2000). However, there is a natural tension that develops between these two approaches to addiction. White (1998) states:

> Where the scientist is searching for empirical truth, the alcoholic and addict are searching for a workable answer to their painful entrapment. The objectivity and detachment of the scientist stand in stark contrast to the passionate belief and commitment that marks most avenues of addiction recovery. (p. 329)

To be effective, agencies must be able to tap the knowledge and energy of both research-based interventions and the personal recovery movement.

Addiction treatment agencies typically respond to client needs by offering integrated services in a number of settings. Addiction treatment workers include professional counselors, nurses, and physicians who provide outpatient services, home-based services, or work in structured residential settings. The educational backgrounds vary from highly trained and licensed counselors and physicians to workers with no professional training beyond what is offered by their employer. In Illinois, licensure of addiction treatment facilities authorizes the use of counselors, with minimal formal education, who obtain certification by demonstrating a combination of experience and competencies (State of Illinois, 2001, Illinois Alcoholism and Other Drug Professional Counselors Association, n.d.).

Efforts to measure and predict present and future job performance often use competency-based assessment methods. Such competency-based assessments can be especially helpful when designing training and development plans to assist workers in moving from entry-level to senior positions (Gupta, 1999). Similarly, credentialing bodies attempt to define and measure competencies in order to categorize workers from entry-level performance to senior or master's levels of performance.

*Need for the Study*

Training specialists in addiction treatment agencies develop training programs designed to improve the effectiveness of addiction treatment workers and assist them in attaining their career goals. Certain aspects of training, (i.e. confidentiality, blood-borne pathogens, clinical documentation, and licensure rules), are defined by licensing bodies (State of Illinois, 2001). Certification also requires demonstrated competency in assessment, individual and group facilitation, treatment planning, education, referral, and clinical documentation (Illinois Alcoholism and Other Drug Professional Counselors Association, n.d.). However, largely undefined by certification and licensure bodies is the critical area of philosophy and practice models in service delivery to clients.

To be effective, training programs must assist workers in integrating prior education and experiences with new learning to develop a coherent philosophy and practice model. It is important to investigate training and development needs of addiction treatment workers from differing recovery and educational backgrounds. Building a competency dictionary based on exemplary performance can assist trainers in preparing workers for a variety of roles (Gupta, 1999, Robinson & Robinson, 1995). Understanding a worker's perceptions of competencies necessary to provide clinical services and identifying those competencies that define exemplary performance is required to design effective training programs and professional development plans that foster excellence.

*Purpose of the Study*

The purpose of the study was to identify and compare competencies perceived as most important by addiction treatment workers with a personal history of recovery and competencies perceived as most important by workers with no personal history of recovery

*Hypothesis*

Perceptions of competencies by workers with a personal history of recovery differ from perceptions of competencies by workers with no personal history of recovery.

*Research Questions*

1. What core competencies have professional certification bodies, licensure bodies, and the profession identified?

2. What competencies do addiction treatment workers, not eligible for licensure, who have a personal history of recovery perceive as most important?

3. What competencies do addiction treatment workers, eligible for licensure, who have a personal history of recovery perceive as most important?

4. What competencies do addiction treatment workers, not eligible for licensure, who have no personal history of recovery perceive as most important?

5. What competencies do addiction treatment workers, eligible for licensure, who have no personal history of recovery perceive as most important?

6. Do the perceptions of competencies by addiction treatment workers with a personal history of recovery differ from those of addiction treatment workers with no such history?

7. What are the implications of any differences or similarities for training and professional development of workers?

*Definitions*

Addiction treatment - client services offered by a licensed agency to treat a substance abuse problem.

Addiction treatment worker - a person whose primary job duties involve professional services for clients with a substance abuse diagnosis.

Community-based addiction treatment facility - an agency that receives public funding to provide addiction treatment services in a community setting.

Competencies – knowledge, skills, and attitudes considered necessary for professional practice in the field of addiction treatment.

Eligible for licensure – having met educational requirements necessary to attain licensure as a Licensed Professional Counselor, Licensed Clinical Professional Counselor, Licensed Social Worker, or Licensed Clinical Social Worker in Illinois.

Recovery - the process of resolving substance abuse related issues and arresting the symptoms of substance abuse through professional treatment or involvement with a self-help organization.

*Assumptions*

1. For the purposes of this study, it was assumed that participants would respond honestly to questions regarding their personal history, eligibility for licensure, and perceptions of competencies.

*Limitations*

1. The study compared intact groups in multiple agencies.

2. The demographics of addiction treatment workers in agencies selected for study may be different from those found in the population.

3. There are a number of demographic factors that affect an individual's perceptions of competencies such as professional experience, age, race, culture, and gender.

4. The work culture, training programs, and employee selection practices workers are exposed to in agencies selected for the study may differ from those in the population.

5. The research design lacks the controls necessary to demonstrate a causal relationship between personal recovery history and perceptions of competencies.

*Delimitations*

1. The study was conducted in community-based agencies in central Illinois.

2. The study was limited to an analysis based on eligibility for licensure and personal recovery history.

# Chapter 2

## Related Literature

Modern addiction treatment in the United States has been subject to a number of historical influences including the development of science-based treatment approaches and the emergence of the self-help recovery movement (White, 1998). The field has become a significant provider of specialized behavioral health services. Today, there are over 11,000 providers of addiction treatment services in the United States listed by the Substance Abuse and Mental Health Services Administration (2001). Treatment for addiction to alcohol and other drugs is offered primarily in two settings, substance abuse treatment agencies and community multi-service mental health centers (Von Steen, Vacc, & Strickland, 2002). Of those settings, community-based addiction treatment settings provide services to the majority of clients seeking publicly and privately funded service options (Duggar, 1991).

According to the National Survey on Drug Use and Health (SAMHSA, 2001) over 7% of Illinois residents and over 18% of the18 to 25 year olds reported using illegal drugs within the last month, while over 42% of 18 to 25 year olds in Illinois report binge drinking. Nationally, over 7% of the population has a drug or alcohol problem that requires treatment. In Illinois, 2% of the population needed treatment services that were not available. Given the prevalence of addiction and drug abuse problems nationally and in Illinois, the demand for skilled workers competent to practice in the addictions field seems likely to increase.

Within community-based organizations, workers from a number of professional disciplines and diverse backgrounds provide treatment services. Through comprehensive needs assessment, training and development programs can improve effectiveness of all workers in community-based agencies and improve the quality and outcome of addiction services (Gupta, 1999, Leukefeld, Pickens, & Schuster, 1991). A competency-based model is effective in identifying knowledge, skills, and attitudes that exemplify professional practice and developing action plans to address gaps between actual and desired performance on an individual or organizational level (Gupta, 1999). It is useful to conduct needs assessment within the context of historical influences on the field, current best practices, education, and the personal experience of workers.

*Early History of Addiction Treatment*

Society's response to consequences of misuse of alcohol and other drugs has been varied. In the United States, "willingness to invest resources in the addiction treatment enterprise has been extended and withdrawn in cyclical patterns of moralization, criminalization, medicalization, and demedicalization" (White, 1998, p. 331). Today, our response remains conflicted. We simultaneously establish social policies that treat addiction as a medical and psychosocial problem and as willful criminal behavior (Heymann & Brownsberger, 2001).

Before the 1920s, what is now called alcoholism or addiction was known as inebriety or dipsomania. The most common approach was confinement in inebriate asylums with a range of controversial approaches and treatments. Practitioners experimented with psychoanalytic approaches and treatment of one drug with

another, most notably treatment of morphine addiction with cocaine advocated by Freud (White 1998). In an effort to reduce crime and solve social problems alcohol was prohibited in the United States from 1920 to 1933. While consumption of alcohol fell in the early years of prohibition, it subsequently increased (Thornton, 1991). Alcoholics Anonymous (AA) emerged from the moral climate that produced prohibition, to become the largest self-help organization in the world (White, 1998).

*Self-Help Recovery Movement*

Alcoholics Anonymous (AA) was formed in 1935 when its founders began to recruit members for a group of alcoholics to work together towards a goal of abstinence from alcohol (White, 1998). With the publication of the original "big book," AA established the formal 12-step recovery process for alcoholism which involves turning one's will over to a higher power, working the 12 steps, mutual aid, voluntary meetings, and service work (Alcoholics Anonymous, 1976). By the early 1950s its membership had grown to 90,000 while both the American Psychiatric Association and the American Public Health Association publicly recognized its success (White, 1998).

AA has spawned a number of groups that adapted the 12-step approach to similar problems, most notably Narcotics Anonymous (NA), a 12-step recovery group for drug dependence (White, 1998). AA presently has over 2 million members worldwide (Alcoholics Anonymous, 1998). NA has grown from 200 registered groups in three countries in 1978 to 20,000 registered groups in over 100 countries in 2002 (Narcotics Anonymous, 2002). Both AA and NA are voluntary associations maintaining their independence by declining to take positions on social, political, or

religious issues and declining formal associations and endorsements (Alcoholics Anonymous, 1998, Narcotics Anonymous, 2002).

*Science-Based Treatment*

In the 1940s, Jellinek (1960) began work on a system of classifying alcoholics. With the publication of The Disease Concept of Alcoholism, Jellinek reduced the classifications to five "species" of alcoholics. A number of researchers followed Jellinek in identifying the symptomology, progression, and proposed treatments for addiction. However, "many of the field's core concepts have emerged, not through the articulation and testing of theory, but by proclamation" (White, 1998, p. 329). Proponents of the 12-step recovery processes continue to profoundly influence addiction counseling approaches and philosophy today (Polcin, 2000).

Physicians have been influential in the development of the treatment field. By 1987 the American Medical Association had ratified resolutions accepting both alcohol and drug addiction as diseases. The treatment of addiction as a disease led to the organization of the American Society for Addiction Medicine and the certification of physicians as addiction specialists ( Haynes, 1988). Today, the Patient Placement Criteria developed by the American Society for Addiction Medicine (1996) are widely accepted as the basis for determining treatment setting and intensity of services for individual patients. Illinois licensure regulations require agencies to adopt the placement criteria (State of Illinois, 2001).

White (1998) defines modern treatment as follows; "alcoholism/addiction treatment is the delivery of professionally directed services to the alcoholic or addict, with the primary goal of altering his or her problematic relationship with alcohol

and/or drugs" (p. 334). Today, there are a number of approaches that integrate theory and research into practical models of treatment. Many of these models incorporate the 12-step recovery process of AA and NA as part of the professional treatment process (Boren, Onken, Carroll, 2000). However, the gap between research and clinical practice remains in addiction treatment. The future of the field lies in its ability to define and disseminate its core technologies and its ability to deliver effective services within the client's social environment (White, 1998).

*Counselors with a Personal Recovery History*

Persons with a personal history of addiction and recovery have had a profound effect on the field. White (2000) reports a "strain between an avocation (calling) to work with the addicted and the more formal demands of vocation – the use of one's addiction and personal recovery experience as a credential for professional employment (p. 13). Many, like Marty Mann who served as Director of the National Council on Alcoholism for 24 years, have openly shared their experiences with addiction and recovery and used those experiences to assist clients and shape the field (Brown, 1998).

In the 1970s a growing number of persons working in "street drug" programs and alcoholism halfway houses claimed personal experience with drugs or alcohol as a primary qualification (White, 2000). In many settings and communities "street" credentials were considered necessary to reach and work with clients. Organization of communities to offer alternatives to drugs and advocacy for clients was considered as important as counseling and treatment (Gemini Foundation, 1978).

The demands of coping as counselors in agency practice with little or no professional training has been cited as a factor in the relapses of early contributors to the field. Education and training requirements have varied widely. In the 1980s, the struggle to integrate drug and alcohol treatment services and meet demands for payment by health insurers brought increased attention to preparation and training of workers, credentialing, and licensure (White, 1998, 2000). However, credentialing of addiction counselors was not a licensure requirement in the State of Illinois until 1996 (State of Illinois, 2001).

White (2000) reports that the percentage of recovered people working as professional counselors varies depending on the setting; with over half of addictions counselors surveyed nationally acknowledging a personal recovery background. The percentage is highest in dedicated addiction treatment settings and lowest in integrated behavioral health settings. The presence or lack of personal recovery has not been demonstrated to predict counseling effectiveness. White (2000) writes, "the best addiction counselors are often described by a constellation of traits – compassion, empathy, respect, genuineness, emotional courage – that cannot be easily reduced to categories of life experience or formal education" (p. 20).

*Credentialing*

Page & Bailey (1995) identify four certifying organizations offering professional credentials for addictions counseling; the National Board of Certified Counselors (NBCC); the National Association of Alcohol and Drug Abuse Counselors (NAADAC); the International Certification Reciprocity Consortium (ICRC); and the International Association of Addictions and Offender Counselors (IAAOC). Each

recognizes levels of qualification and requires a combination of education or instruction, experience, examination, and adherence to a code of ethics.

Illinois requires that licensed agencies employ counselors who are licensed, certified, or eligible for licensure or certification within two years of employment. Counselors may be licensed as Professional Counselors, Clinical Professional Counselors, Social Workers, or Clinical Social Workers (State of Illinois, 2001). The Illinois Department of Professional Regulation (2003) issues licenses and regulates social workers and professional counselors. The Illinois Alcohol and Other Drug Abuse Professional Counselor Association (IAODAPCA), affiliated with the ICRC, offers the only addiction treatment certifications recognized by the State of Illinois.

The trend in the field is toward more stringent educational requirements for addiction counselors. Insurance and managed care requirements are forcing agencies and credentialing organizations to review requirements for addiction counselors (Juhnke, 2000). NAADAC, ICRC, and IAODAPCA accept the addiction counseling competencies established by the Addiction Technology Transfer Centers, National Curriculum Committee as the foundation of professional practice ("Alcoholism & Drug Abuse Weekly," 1998).

*Implications of Competencies for Training and Development*

A competency model focuses on human competencies necessary to operate successfully in a particular job or function. Analyzing the performance of exemplary performers can help in identifying necessary competencies. The model uses a detailed list of competencies, or competency dictionary, and identifies a general competency profile that leads to success in each job (Gupta, 1999, Robinson &

Robinson, 1995). Training and development plans are designed to close the gap between competencies evident in each worker and those evident in exemplary performers. Identifying support and resources necessary to sustain performance is essential to using a competency model (Gupta, 1999).

A competency model can be useful in developing an organization that values learning and draws upon its diversity to improve outcomes and work climate (Arredondo & Aciniega, 2001). It follows that a competency model can assist agencies in building a diverse staff and preparing addictions counselors from varying backgrounds for professional practice.

A sense of personal mission and passion for the work can be a powerful force in an addiction treatment milieu (White, 2000). Bednar (2003) suggests that in child welfare "staff should be hired who express a strong sense of personal or professional mission in connection with their work, and they should be carefully matched to positions for which they have been adequately prepared through education and training" (p. 11). Given similarities of roles between child welfare and addiction treatment workers, it follows that this recommendation applies equally to addiction treatment workers.

Training to refine clinical skills and sensitivity, coupled with an organizational commitment to excellence, can have a profound effect on competencies demonstrated by individual workers (Leukefeld, Pickens & Schuster, 1991, Manese, 2001). Designing and implementing an individual training and development plan requires an understanding of competencies, existing skills, and attitudes demonstrated by workers (Gupta, 1999). Sue & Sue (1990) view multicultural counseling competency as a

process that occurs throughout a counselor's professional career. It follows that treating the development of addiction counseling competencies as an on-going process, is a useful training and development model.

*Competencies in the Addiction Treatment Field*

The most comprehensive and widely accepted work published regarding addiction counseling competencies was completed by the Addiction Technology Transfer Centers, National Curriculum Committee (1998). In *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice* the committee organizes and outlines competencies in two broad categories and 12 areas. Transdisciplinary foundations are knowledge, skills, and attitudes required for addiction specialists in a number of disciplines. They include understanding addiction; treatment knowledge; application to practice; and professional readiness. Additional competencies required for the practice of addiction counseling include; clinical evaluation; treatment planning; referral; service coordination; counseling; client, family, and community education; documentation; and professional and ethical responsibilities. Each area includes general categories and detailed outlines of the related knowledge and skills.

*Measuring Perceptions of Competencies*

A number of studies have developed instruments and methods to measure beliefs, perceptions of competencies, and training needs among counseling professionals. The studies have used a variety of methods and instruments.

Chan, Leahy, Saunders et al. (2003) modified a Knowledge Validation Inventory developed by Leahy to determine training needs of rehabilitation counselors in three

settings. Respondents were asked to rate the importance of each knowledge item and levels of perceived preparedness using a 5-point Likert scale from "not important" to "very important" or "not prepared" to "very prepared." The authors ranked the reported training needs according to frequency of response. They identified the need for coordinated education and training programs, and an acknowledgment of constant change by professionals as implications of the study.

Hosie, West, & Mackey (1990) surveyed executives and clinical directors to determine competencies expected of master's level clinicians in substance abuse centers. The survey, developed by the authors, consisted of sections related to required knowledge, therapeutic skills, and administrative tasks. Respondents were asked to indicate "yes", "no", or "not applicable" regarding the need for each competency at their center. Respondents then rated the competency of their counselors using a 7-point Likert scale from "very low" to "very high". Competencies were selected based on a prior survey. The authors conclude that supervisors are generally satisfied with the ability of master's level clinicians.

Meza & Cunningham (2001) surveyed physician and non-physician substance abuse practitioners to determine beliefs and attitudes regarding treatment modalities. The survey used a 7-point Likert scale from "detrimental" to "essential" or "strongly disagree" to "strongly agree". The authors used factor analysis to identify sets of data that represented underlying constructs. Major differences were identified in the respondents' views of the disease concept of addictions and the role of medications in treatment. The authors recommend expanded involvement of physicians in

community-based programs, dissemination of pharmacology research, and improved inter-disciplinary communication.

Drake (1996) conducted nine focus groups with consumers and client service workers focusing on the skills, attitudes, and competencies necessary for child welfare workers. The purpose of the study was to identify key competency themes as communicated by consumers. The author reports general agreement between worker and consumer groups on key competencies with the worker-consumer relationship as critical.

Manese (2001) evaluated the effect of training on multicultural competencies. A 7-point Likert scale questionnaire was administered to 24 counseling interns to determine if self-rating of multicultural counseling scores would increase after an internship experience with a multicultural training component. The questionnaire included 14 awareness items, 28 knowledge or skill items, and 3 social desirability items. Paired t-tests on matched pretest and posttest scores were evaluated along with pretest correlation of variables. The researcher concludes training can increase multicultural competency but acknowledges limits due to self-selection, small sample size, and limited demographic data.

The literature does not discuss instruments designed specifically to measure addiction counselor perceptions of competencies. Geron (2002) discusses the challenges in measurement issues in cultural competency. Uncertain definitions of competency, instrument validity, and bias are key concerns. Respondents may provide the "socially desirable" but inaccurate response. Developers of any instrument to measure competencies should seek to minimize these problems.

*Summary*

Science-based treatment models and the 12-step recovery movement influence the delivery of professional addiction treatment. While combined models exist, the two views of treatment and recovery are often divergent. Addiction counselors are challenged to incorporate medical models, practice models, and a recovery culture into a coherent philosophy and personal counseling style. Workers with a personal history of recovery often bring a sense of personal mission and dedication to the field. They have made significant contributions to the field and can serve as a bridge between the divergent worlds of the 12-step recovery movement and professional practice.

Competency models are effective in designing and implementing training and development programs. Such programs use detailed lists of competencies and competency profiles to improve outcomes and quality in professional organizations. Understanding the perceptions of competencies by workers can provide a basis for implementing effective training and development programs. A comprehensive set of competencies for addiction treatment has been published by the Addiction Technology Transfer Centers, National Curriculum Committee and accepted by national counselor certification bodies as the foundation of professional practice.

A number of researchers have developed instruments to measure attitudes, knowledge, and skills of counselors. The literature does not discuss measures designed to evaluate perceptions of competencies by addiction counselors.

The next chapter will discuss the research methods selected for this study. Information concerning development of the instrument, the research subjects, and data analysis is presented.

# Chapter 3

## Research Method

This chapter describes the methods and procedures used in the study including development of the survey instrument. Information regarding the research subjects and data analysis process is presented.

### *Method*

A survey was administered to addiction treatment workers practicing in community-based agencies in central Illinois regarding their perceptions of counseling competencies. The data was analyzed to test the hypothesis that, perceptions of competencies by workers with a personal history of recovery differ from perceptions of competencies by workers with no personal history of recovery. The data was further analyzed to answer the research questions and determine what competencies are considered most important by: addiction treatment workers, not eligible for licensure, who have a personal history of recovery; those eligible for licensure who have a personal history of recovery; those not eligible for licensure with no personal history of recovery; and those eligible for licensure with no personal history of recovery.

### *Subjects*

According to the Illinois Department of Human Services, Office of Alcoholism and Substance Abuse (2003), there are six agencies that meet the definition of community-based addiction treatment facilities in central Illinois. The agencies have home offices in Bloomington, Charleston, Decatur, Peoria, Springfield, and Urbana.

Agencies in Charleston, Springfield, and Urbana were contacted requesting permission to distribute surveys during staff meetings, agency in-services, or other times when workers are gathered. The three agencies agreed to allow access to distribute the survey and assist in contacting all clinical staff working at the agency. In order to maximize response rate, participants were asked to complete the survey on-site and return it to the researcher. However, a mailing option was provided for those who chose to respond at a later time and for participants not present when the survey was administered. Surveys were distributed to all workers who were identified by their agency as meeting the definition of addiction treatment worker.

The response rate for each of the three agencies was between 94% and 95%. Overall, 94 surveys were distributed with 89 surveys returned for a response rate of 94.6%. The agencies are located in metropolitan areas with populations from 39,000 to 112,000, but also serve multiple counties with significant rural populations. The percentage of the population reported as Caucasian in these counties varies from 71% to 94% (Northern Illinois University, 2000).

Of all respondents, 41 or 46% of valid responses indicated they were licensed as a Professional Counselor, Clinical Professional Counselor, Social Worker, Clinical Social Worker, Psychologist, Physician, or will obtain licensure within two years. One respondent did not answer the question. Of all respondents, 66 or 74% of valid responses, indicated they were certified as an Alcohol and Drug Counselor, Assessment and Referral Specialist, or will be certified within two years. One respondent did not answer the question. Twenty-four or 27% reported they are eligible for licensure and hold certification as an addictions counselor. A total of 6

respondents or 7% of valid responses indicated they were a Registered Nurse, a Licensed Practical Nurse, or on Emergency Medical Technician. Of all respondents, 29 or 32% of valid responses indicated they had a personal history of recovery. Two respondents did not answer the question.

In order to answer the research questions, responses were divided into four groups based on licensure and recovery status. Group A includes responses from 11 addiction treatment workers, eligible for licensure, who have a personal history of recovery from alcohol or drug abuse. Group B includes responses from 18 addiction treatment workers, not eligible for licensure, who have a personal history of recovery. Group C includes responses from 30 addiction treatment workers, eligible for licensure, who have no personal history of recovery. Group D includes responses from 28 addiction treatment workers, not eligible for licensure, who have no personal history of recovery. Two respondents could not be classified because they did not respond to the criteria questions.

*Development of the Instrument*

The survey instrument (Appendix A) was developed to measure perceived importance of competencies. Competencies were selected and organized based on those published in *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice*, Addiction Technology Transfer Centers National Curriculum Committee (1998). The competencies developed by the national committee were validated in a national survey indicating, "broad support for virtually all of the competencies as essential to the practice of addiction counseling" (p. 3). The survey instrument uses a five-point Likert scale to rate relative importance of

each competency and also asks which of the competencies is believed to be most important, second most important, and third most important. An additional question asks which of several approaches to drug treatment most closely represent the respondent's personal treatment philosophy.

In order to assess validity, the survey was distributed to selected experts (Appendix B) in the addiction treatment field for comment. The expert panel was comprised of a physician certified by the American Society of Addiction Medicine, a Professor who teaches substance abuse in a master's level counseling program, and a Licensed Clinical Social Worker in private practice. After incorporating comments from the expert panel, the survey was pre-tested on a group of six addiction treatment workers who would not be participating in the study. They completed the survey, reported the time required for completion, and provided feedback regarding clarity of instruction, construction of the survey, and the formulation of the questions. Comments from the pre-test group were incorporated into the final instrument.

A cover letter (Appendix C) was attached to each survey. The letter contains instructions, a brief explanation of the research, assures information will be maintained in confidence and that responses will be reported as aggregate data only. Modifications to the letter (Appendix D) were made at the request of a participating agency. The modified letter was used at one of three agencies participating in the study.

*Scaling of Competencies*

Respondents reported the relative importance of competencies as "Very High, "High", "Neither High Nor Low", "Low", or "Very Low". Numeric scores were

assigned to the responses as follows: a response of "Very Low" received a score of one; "Low" received a score of two; "Neither High Nor Low" received a score of three; "High" received a score of four; and "Very High" received a score of five. Summary data was reported according to the validity scale presented in Table 1. The frequency of response, mean scores, and standard deviation were calculated for each of the items for the entire sample as well as each of the four groups.

Table 1

*Validity Scale*

| Numerical Scale | Description | Average |
|---|---|---|
| 1 | Very Low | 1 to 1.50 |
| 2 | Low | 1.51 to 2.50 |
| 3 | Neither High Nor Low | 2.51 to 3.50 |
| 4 | High | 3.51 to 4.50 |
| 5 | Very High | 4.51 to 5.00 |

*Ranking of Competencies*

Respondents identified which of the cluster of competencies they believed to be "most important", "second most important", and if the question included five or more items, "third most important". Responses to questions regarding the most important competency were weighted as follows: the competency identified as "most important" received three points, "second most important" two points, and "third most important" one point. The competency with the highest weighted score was reported as most important. If weighted scores were identical, the competency with the highest mode in the most important category was reported.

*Statistical Tests*

A Chi Square analysis was used to test the hypothesis on the competencies determined, by weighted score, to represent those rated as most important, second most important, and third most important by each of the four groups. Significance data was reported.

A multivariate analysis of variance (MANOVA) was used to test the hypothesis on the competencies that were interval rated by respondents. A multivariate F value, or Wilkes Lambda test, was calculated for all interval data. Data for specific dependent variables indicating statistical significance between perceptions of the four groups was reported.

*Summary*

Addiction treatment workers in three community-based agencies were surveyed regarding their perception of counseling competencies. The survey instrument was based on competencies in *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice* (Addiction Technology Transfer Centers, National Curriculum Committee (1998). A multivariate analysis of variance and a Chi Square analysis was used to test the hypothesis that, perceptions of competencies by workers with a personal history of recovery differ from perceptions of competencies by workers with no personal history of recovery. A weighted score was used for ranking and a mean score for each variable was calculated to answer research questions regarding which competencies are considered most important by addiction treatment workers. The following section will describe the results of the research.

# Chapter 4

## Results

With few exceptions, addiction treatment workers perceived the importance of skills and competencies included in the instrument to be "High" or "Very High". While differences in the group's perceptions appear to emerge from the data, these are largely not statistically significant. Unless otherwise noted, all skills and knowledge areas are identified in *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice* (Addiction Technology Transfer Centers, National Curriculum Committee (1998). Because they are used for establishing certification requirements, these competencies are the most widely accepted in Illinois.

### *Hypothesis*

A Chi Square analysis was applied to test the hypothesis that, perceptions of competencies by workers with a personal history of recovery differ from perceptions of competencies by workers with no personal history of recovery. The test was applied to those competencies determined, by weighted score, to represent the competencies rated as "most important", "second most important", and "third most important" by each of the four groups. Responses to certain questions regarding which competencies are most important, and in preferred treatment philosophy, appear to be different among the four groups. However, the differences were not statistically significant according to the Chi Square analysis.

A multivariate analysis of variance (MANOVA) was used to test the hypothesis on competencies rated by respondents. A multivariate F value, or Wilkes Lambda test, was calculated for all interval data. The differences in perception of competencies by workers with a personal history of recovery and those of workers with no personal history of recovery were not statistically significant. The data does not support the hypothesis.

*Research Questions*

In order to answer the research questions, the mean score for each competency was calculated from the interval data and the validity scale was applied to determine if the importance of the competency was rated as "Very High", "High", or "Neither High Nor Low". The data is reported for each of the four groups; addiction treatment workers eligible for licensure, who have a personal history of recovery (Group A); workers not eligible for licensure who have a personal history of recovery (Group B); workers eligible for licensure who have no personal history of recovery (Group C); and workers not eligible for licensure with no personal history of recovery (Group D).

The skills identified in Q-1 represent transdisciplinary foundations related to understanding addiction and are considered to underlie the work, not just of counselors, but all addictions professionals. Table 2 summarizes the responses for all groups.

Table 2

*Mean Scores for All Groups, Questions 1.1 to 1.4*

| No. | Abbreviated Name | Mean Overall | Mean A | Mean B | Mean C | Mean D | S.D. |
|---|---|---|---|---|---|---|---|
| 1.1 | Models and Theories | 4.29 H | 4.17 H | 4.13 H | 4.57 VH | 4.14 H | .627 |
| 1.2 | Social Context | 4.38 H | 4.33 H | 4.62 VH | 4.24 H | 4.32 H | .576 |
| 1.3 | Effects of Substances | 4.48 H | 4.50 H | 4.50 H | 4.43 H | 4.50 H | .561 |
| 1.4 | Discrimination | 4.44 H | 3.83 H | 4.56 VH | 4.57 VH | 4.36 H | .682 |

Note. H represents "High"; VH, "Very High"; and NH, "Neither High Nor Low". Group A; eligible for licensure with a personal history of recovery; Group B eligible for licensure with no personal history of recovery; Group C not eligible for licensure with a personal history of recovery; Group D not eligible for licensure with no personal history of recovery

An ability to describe the behavioral, psychological, health, and social effects of psychoactive substances was considered the most important skill by the group of all addiction treatment workers surveyed. Groups A and B were identical to the total sample, while Group C rated an understanding of the models and theories of addiction as most important. Group D rated the ability to recognize the cultural context of substance abuse as most important.

The skills identified in Q-3 also represent transdisciplinary foundations related to treatment knowledge. Table 3 summarizes the responses for all groups.

Table 3

*Mean Scores for All Groups, Questions 3.1 to 3.4*

| No. | Abbreviated Name | Mean Overall | Mean A | Mean B | Mean C | Mean D | S.D. |
|---|---|---|---|---|---|---|---|
| 3.1 | Philosophy and Practice | 4.00 H | 4.17 H | 4.00 H | 4.00 H | 4.05 H | .627 |
| 3.2 | Family and Social | 4.62 VH | 4.67 VH | 4.56 VH | 4.71 VH | 4.59 VH | .576 |
| 3.3 | Research and Outcomes | 3.68 H | 3.83 H | 3.69 H | 3.81 H | 3.59 H | .561 |
| 3.4 | Inter-Disciplinary | 4.18 H | 4.00 H | 4.06 H | 4.43 H | 4.09 H | .682 |

Note. H represents "High"; VH, "Very High"; and NH, "Neither High Nor Low". Group A; eligible for licensure with a personal history of recovery; Group B eligible for licensure with no personal history of recovery; Group C not eligible for licensure with a personal history of recovery; Group D not eligible for licensure with no personal history of recovery

An ability to recognize the importance of family, social networks, and community systems in the recovery process was considered the most important skill by the group of all addiction treatment workers surveyed and for all groups.

The skills identified in Q-5 represent transdisciplinary foundations applied to practice. Table 4 summarizes the responses for all subgroups.

Table 4

*Mean Scores for All Groups, Questions 5.1 to 5.8*

| No. | Abbreviated Name | Mean Overall | Mean A | Mean B | Mean C | Mean D | S.D. |
|---|---|---|---|---|---|---|---|
| 5.1 | Diagnostic Criteria | 4.46 H | 3.88 H | 4.44 H | 4.61 VH | 4.50 H | .688 |
| 5.2 | Helping Strategies | 4.35 H | 4.13 H | 4.33 H | 4.29 H | 4.62 VH | .760 |
| 5.3 | Tailor to Stage | 4.61 H | 4.63 VH | 4.50 H | 4.71 VH | 4.62 VH | .539 |
| 5.4 | Adapt to Setting | 4.09 H | 3.75 H | 4.11 H | 4.07 H | 4.23 H | .711 |
| 5.5 | Medical Resources | 3.64 H | 3.63 H | 3.59 H | 3.71 H | 3.62 H | .811 |
| 5.6 | Insurance and HMO | 3.35 NH | 3.13 NH | 3.39 NH | 3.43 NH | 3.35 NH | .820 |
| 5.7 | Opportunity in Crisis | 4.28 H | 4.13 H | 4.50 H | 4.29 H | 4.15 H | .614 |
| 5.8 | Measuring Treatment Outcomes | 3.79 H | 3.50 NH | 3.61 H | 4.07 H | 3.77 H | .857 |

Note. H represents "High"; VH, "Very High"; and NH, "Neither High Nor Low". Group A; eligible for licensure with a personal history of recovery; Group B eligible for licensure with no personal history of recovery; Group C not eligible for licensure with a personal history of recovery; Group D not eligible for licensure with no personal history of recovery

The ability to tailor helping strategies to the client's stage of dependence and recovery was considered most important by the group of all workers surveyed and also by Groups A and B. Groups C and D rated the ability to understand diagnostic criterion as most important.

The skills identified in Q-7 represent specific skills related to one aspect of individual counseling. Table 5 summarizes the responses for all groups.

Table 5

*Mean Scores for All Groups, Questions 7.1 to 7.5*

| No. | Abbreviated Name | Mean Overall | Mean A | Mean B | Mean C | Mean D | S.D. |
|---|---|---|---|---|---|---|---|
| 7.1 | Monitor Behavior | 4.01 H | 3.73 H | 3.89 H | 4.07 H | 4.11 H | .731 |
| 7.2 | Confront Inconsistency | 4.29 H | 4.55 VH | 4.11 H | 4.23 H | 4.36 H | .678 |
| 7.3 | Re-frame Re-Direct | 4.52 VH | 4.55 VH | 4.61 VH | 4.43 H | 4.50 H | .624 |
| 7.4 | Problem Solving | 4.62 VH | 4.36 H | 4.72 VH | 4.63 VH | 4.61 VH | .554 |
| 7.5 | Recognize Underlying Issues | 4.75 VH | 4.65 VH | 4.67 VH | 4.83 VH | 4.75 VH | .459 |

Note. H represents "High"; VH, "Very High"; and NH, "Neither High Nor Low". Group A; eligible for licensure with a personal history of recovery; Group B eligible for licensure with no personal history of recovery; Group C not eligible for licensure with a personal history of recovery; Group D not eligible for licensure with no personal history of recovery

The ability to identify underlying client issues that may impede client progress was considered most important by the group of all workers surveyed, as well as groups C and D. Groups A and B considered abilities in conflict resolution, decision-making, and problem solving skills most important.

The skills identified in Q-9 represent transdiscipinary foundations related to professional readiness. Table 6 summarizes the responses for all groups.

Table 6

*Mean Scores for All Groups, Questions 9.1 to 9.6*

| No. | Abbreviated Name | Mean Overall | Mean A | Mean B | Mean C | Mean D | S.D. |
|---|---|---|---|---|---|---|---|
| 9.1 | Cultural Awareness | 4.26 H | 4.27 H | 4.33 H | 4.23 H | 4.32 H | .699 |
| 9.2 | Self Awareness | 4.44 H | 4.45 H | 4.50 H | 4.57 VH | 4.25 H | .673 |
| 9.3 | Ethics | 4.74 VH | 4.82 VH | 4.61 VH | 4.80 VH | 4.71 VH | .512 |
| 9.4 | Supervision and Training | 4.49 H | 4.45 H | 4.59 VH | 4.50 H | 4.39 H | .625 |
| 9.5 | Prevention | 4.04 H | 3.73 H | 4.11 H | 3.93 H | 4.29 H | .752 |
| 9.6 | Safety | 4.43 H | 4.18 H | 4.33 H | 4.55 VH | 4.43 H | .724 |

Note. H represents "High"; VH, "Very High"; and NH, "Neither High Nor Low". Group A; eligible for licensure with a personal history of recovery; Group B eligible for licensure with no personal history of recovery; Group C not eligible for licensure with a personal history of recovery; Group D not eligible for licensure with no personal history of recovery

Understanding the addiction professional's obligation to adhere to ethical and behavioral standards was rated most important by the group of all counselors surveyed, as well as Groups A, C, and D. Group B rated understanding the importance of self-awareness in one's own personal, professional, and cultural life as most important.

The areas of knowledge identified in Q-11 represent generally accepted models, knowledge of which is considered important as a transdiscipinary foundation. Table 7 summarizes the responses for all groups.

Table 7

*Mean Scores for All Groups, Questions 11.1 to 11.8*

| No. | Abbreviated Name | Mean Overall | Mean A | Mean B | Mean C | Mean D | S.D. |
|---|---|---|---|---|---|---|---|
| 11.1 | Pharma-cotherapy | 3.63 H | 3.64 H | 3.72 H | 3.62 H | 3.50 NH | .862 |
| 11.2 | AA/NA | 4.44 H | 4.18 H | 4.67 VH | 4.38 H | 4.43 H | .771 |
| 11.3 | Behavioral Training | 4.02 H | 3.82 H | 3.94 H | 4.07 H | 4.04 H | .826 |
| 11.4 | Mental Health | 4.38 H | 4.55 VH | 4.33 H | 4.48 H | 4.19 H | .703 |
| 11.5 | Psycho-therapeutic | 3.92 H | 3.73 H | 4.06 H | 3.93 H | 3.89 H | .755 |
| 11.6 | Therapeutic Community | 3.96 H | 4.27 H | 3.53 H | 4.21 H | 3.86 H | .808 |
| 11.7 | Relapse Prevention | 4.76 VH | 4.73 VH | 4.83 VH | 4.79 VH | 4.71 VH | .455 |
| 11.8 | Multimodality | 4.24 H | 4.36 H | 4.25 H | 4.38 H | 4.07 H | .750 |

Note. H represents "High"; VH, "Very High"; and NH, "Neither High Nor Low". Group A; eligible for licensure with a personal history of recovery; Group B eligible for licensure with no personal history of recovery; Group C not eligible for licensure with a personal history of recovery; Group D not eligible for licensure with no personal history of recovery

Knowledge of relapse prevention was rated as most important by the group of all counselors surveyed, as well as groups A and C. Groups B and D rated mutual and self help (AA, NA, and Alanon) as most important.

The skills identified in Q-13 represent general areas related to clinical evaluation, service coordination, counseling, education, documentation, and ethical obligations. Table 8 summarizes the responses for all groups.

Table 8

*Mean Scores for All Groups, Questions 13.1 to 13.11*

| No. | Abbreviated Name | Mean Overall | Mean A | Mean B | Mean C | Mean D | S.D. |
|---|---|---|---|---|---|---|---|
| 13.1 | Screening | 4.49 H | 4.18 H | 4.44 H | 4.60 VH | 4.54 VH | .659 |
| 13.2 | Assessment | 4.78 VH | 4.64 VH | 4.83 VH | 4.83 VH | 4.75 VH | .446 |
| 13.3 | Implementing Treatment plan | 4.44 H | 4.30 H | 4.39 H | 4.48 H | 4.46 H | .642 |
| 13.4 | Case Presentation | 4.23 H | 4.27 H | 4.28 H | 4.17 H | 4.22 H | .659 |
| 13.5 | Continuing Assessment | 4.62 VH | 4.64 VH | 4.61 VH | 4.67 VH | 4.54 VH | .511 |
| 13.6 | Individual Counseling | 4.74 VH | 4.64 VH | 4.67 VH | 4.83 VH | 4.75 VH | .465 |
| 13.7 | Group Counseling | 4.66 VH | 4.55 VH | 4.50 H | 4.73 VH | 4.71 VH | .542 |
| 13.8 | Family Counseling | 4.42 H | 4.18 H | 4.39 H | 4.63 VH | 4.32 H | .688 |
| 13.9 | Client and Community Education | 4.19 H | 4.00 H | 4.24 H | 4.30 H | 4.18 H | .641 |
| 13.10 | Documentation | 4.30 H | 4.00 H | 4.28 H | 4.17 H | 4.54 VH | .805 |
| 13.11 | Ethics | 4.75 VH | 4.80 VH | 4.72 VH | 4.66 VH | 4.75 VH | .564 |

Note. H represents "High"; VH, "Very High"; and NH, "Neither High Nor Low". Group A; eligible for licensure with a personal history of recovery; Group B eligible for licensure with no personal history of recovery; Group C not eligible for licensure with a personal history of recovery; Group D not eligible for licensure with no personal history of recovery

Assessment, the on-going process through which the counselor collaborates with the client and others to gather and interpret information necessary for treatment planning and evaluating client progress was rated most important by all groups.

The skills identified in Q-15 relate to counseling of individuals. Table 9 summarizes the data for all groups.

Table 9

*Mean Scores for All Groups, Questions 15.1 to 15.13*

| No. | Abbreviated Name | Mean Overall | Mean A | Mean B | Mean C | Mean D | S.D. |
|---|---|---|---|---|---|---|---|
| 15.1 | Warmth and Respect | 4.62 VH | 4.55 VH | 4.71 VH | 4.66 VH | 4.57 VH | .511 |
| 15.2 | Engagement in Recovery Process | 4.49 H | 4.45 H | 4.50 H | 4.55 VH | 4.39 H | .606 |
| 15.3 | Establish Goals | 4.69 VH | 4.55 VH | 4.72 VH | 4.72 VH | 4.71 VH | .464 |
| 15.4 | Promote Knowledge | 4.58 VH | 4.73 VH | 4.56 VH | 4.59 VH | 4.54 VH | .601 |
| 15.5 | Reinforce Beneficial Actions | 4.52 VH | 4.73 VH | 4.50 H | 4.41 H | 4.57 VH | .606 |
| 15.6 | Discourage Actions | 4.34 H | 4.18 H | 4.22 H | 4.38 H | 4.43 H | .759 |
| 15.7 | Involve Significant Others | 4.14 H | 3.91 H | 4.00 H | 4.17 H | 4.29 H | .746 |
| 15.8 | HIV/AIDS Awareness | 4.01 H | 3.82 H | 4.17 H | 3.83 H | 4.18 H | .750 |
| 15.9 | Basic Life Skills | 4.44 H | 4.55 VH | 4.56 VH | 4.34 H | 4.37 H | .623 |
| 15.10 | Adapt Counseling Strategies | 4.65 VH | 4.73 VH | 4.67 VH | 4.62 VH | 4.61 VH | .548 |
| 15.11 | Confront Inconsistencies | 4.49 H | 4.18 H | 4.39 H | 4.55 VH | 4.57 VH | .557 |
| 15.12 | Crisis Management | 4.51 VH | 4.27 H | 4.78 VH | 4.48 H | 4.43 H | .547 |
| 15.13 | Relapse Prevention | 4.51 VH | 4.50 H | 4.41 H | 4.55 VH | 4.50 H | .682 |

Note. H represents "High"; VH, "Very High"; and NH, "Neither High Nor Low". Group A; eligible for licensure with a personal history of recovery; Group B eligible for licensure with no personal history of recovery; Group C not eligible for licensure with a personal history of recovery; Group D not eligible for licensure with no personal history of recovery

Of the skills identified in Q-15, all groups considered the ability to establish a helping relationship characterized by warmth respect, genuineness, concreteness, and empathy most important.

The skills identified in Q-17 relate to group counseling. Table 10 summarizes the data for all groups.

Table 10

*Mean Scores for All Groups, Questions 17.1 to 17.6*

| No. | Abbreviated Name | Mean Overall | Mean A | Mean B | Mean C | Mean D | S.D. |
|---|---|---|---|---|---|---|---|
| 17.1 | Group Counseling Strategies | 4.17 H | 4.36 H | 4.22 H | 4.10 H | 4.11 H | .727 |
| 17.2 | Forming Group | 4.27 H | 4.40 H | 4.28 H | 4.23 H | 4.25 H | .784 |
| 17.3 | Entry of New Members | 4.15 H | 4.27 H | 4.22 H | 4.17 H | 4.04 H | .762 |
| 17.4 | Rules and Goals | 4.35 H | 4.27 H | 4.44 H | 4.37 H | 4.25 H | .623 |
| 17.5 | Process and Content | 4.55 VH | 4.64 VH | 4.56 VH | 4.53 VH | 4.50 H | .584 |
| 17.6 | Documentation of Group | 4.44 H | 4.36 H | 4.44 H | 4.50 H | 4.39 H | .690 |

Note. H represents "High"; VH, "Very High"; and NH, "Neither High Nor Low". Group A; eligible for licensure with a personal history of recovery; Group B eligible for licensure with no personal history of recovery; Group C not eligible for licensure with a personal history of recovery; Group D not eligible for licensure with no personal history of recovery

The ability to carry out actions necessary to form a group (i.e. determining, size and leadership, recruitment, establishing goals etc.) was considered most important by the group of all workers surveyed and by groups A, C, and D. Group B rated understanding process and content and the ability to shift the focus of a group to help the group move toward its goals as most important.

Q-19 includes brief descriptions, developed by the researcher, of common practice approaches. Table 11 summarizes the results of weighted scores for all groups.

Table 11

*Ranking by Weighted Scores for Preferred Treatment Approach, All Groups*

| No. | Overall | Group A | Group B | Group C | Group D |
|---|---|---|---|---|---|
| 1 | Eclectic | Strength Based | Harm Reduction | Strength Based | Eclectic |
| 2 | Strength Based | Eclectic | Strength Based | Eclectic | Strength Based |
| 3 | Cognitive | Cognitive | Eclectic | Harm Reduction | Therapeutic Community |
| 4 | Harm Reduction | Harm Reduction | Cognitive | Cognitive | Cognitive |
| 5 | Therapeutic Community | Therapeutic Community | Therapeutic Community | Therapeutic Community | 12-Step AA/NA |
| 6 | 12-Step AA/NA | 12-Step AA/NA | 12-Step AA/NA | Systems Theory | Systems Theory |
| 7 | Systems Theory | Systems Theory | Systems Theory | 12-Step AA/NA | Harm Reduction |

Note. Group A; eligible for licensure with a personal history of recovery; Group B eligible for licensure with no personal history of recovery; Group C not eligible for licensure with a personal history of recovery; Group D not eligible for licensure with no personal history of recovery

An eclectic approach to counseling was favored by the group of all workers surveyed and also by group D. Group A and C favored a strength-based approach, while Group B favored a harm reduction approach.

*Summary*

Workers generally considered the importance of all competencies to be "High" or "Very High". The data did not support the hypothesis that, perceptions of competencies by workers with a personal history of recovery differ from perceptions of competencies by workers with no personal history of recovery.

*Research question 1.*

Competencies published in *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice* (Addiction Technology Transfer Centers, National Curriculum Committee (1998), are the most widely accepted by national certification bodies. These competencies are used in the certification process for addiction counselors in Illinois.

*Research question 2.*

The following competencies are considered most important by workers, not eligible for licensure, who have a personal history of recovery; understanding of the models and theories of addiction; an ability to recognize the family, social networks, and community systems in the recovery process; an ability to understand diagnostic criterion, an ability to identify underlying client issues that may impede client progress; understanding an addiction professional's obligation to adhere to ethical and behavioral standards, knowledge of relapse prevention; skills in assessment; the

ability to establish a helping relationship characterized by warmth and respect; and the ability to carry out actions necessary to form a group.

*Research question 3.*

The following competencies are considered most important by workers, eligible for licensure, who have a personal history of recovery; an ability to describe the behavioral, psychological, health, and social effects of psychoactive substances, an ability to recognize the family, social networks, and community systems in the recovery process; an ability to tailor helping strategies to the client's stage of dependence and recovery; abilities in conflict resolution, decision-making, and problem solving; understanding an addiction professional's obligation to adhere to ethical and behavioral standards, knowledge of relapse prevention, skills in assessment, the ability to establish a helping relationship characterized by warmth and respect, and the ability to carry out actions necessary to form a group.

*Research question 4.*

The following competencies are considered most important by workers, not eligible for licensure, who have no personal history of recovery; an ability to recognize the cultural context of addiction, an ability to recognize the family, social networks, and community systems in the recovery process; an ability to understand diagnostic criterion; the ability to identify underlying issues that may impede client progress; understanding an addiction professional's obligation to adhere to ethical and behavioral standards, knowledge of mutual and self help (AA, NA, Alanon), skills in assessment, the ability to establish a helping relationship characterized by warmth and respect, and the ability to carry out actions necessary to form a group.

*Research question 5.*

The following competencies are considered most important by workers, eligible for licensure, who have no personal history of recovery; an ability to describe the behavioral, psychological, health, and social effects of psychoactive substances; an ability to recognize the family, social networks, and community systems in the recovery process; an ability to tailor helping strategies to the client's stage of dependence and recovery; abilities in conflict resolution, decision-making, and problem solving; understanding the importance of self-awareness in one's own personal, professional, and cultural life; knowledge of mutual and self help (AA, NA, Alanon); skills in assessment, the ability to establish a helping relationship characterized by warmth and respect, and understanding process and content and the ability to shift the focus of a group to help move the group toward its goals.

*Research question 6.*

The data identified no statistical differences in perceptions of competencies by workers with, or without, a personal history of recovery.

*Research question 7.*

A discussion of the implications of the data for training and development follows in the next chapter.

# Chapter 5

# Discussion

This chapter will discuss the implications of the research method, the recovery status and education of workers in the study, and the findings. Implications of the findings are presented as relating primarily to training, organizational development, or future research.

## *Research Method*

The data collection techniques selected for the research were very successful. Over 94% of the addiction treatment workers contacted returned a survey. Each of the three agencies selected for the study cooperated fully. The data provides an accurate picture of the perceptions of competencies by addiction treatment workers in three community-based agencies in central Illinois. Caution should be used when generalizing results to all community-based agencies in central Illinois, although the fact that agencies selected represent half of the population is one argument for generalizibility. The similarity in funding and licensing requirements among agencies in the population is another argument for generalizibility. However, other factors including agency culture produce significantly different perceptions of competencies among workers and may vary widely within the population of agencies.

Distributing surveys to workers in staff meetings clearly contributed to the high response rate. However, this method has the potential to amplify any influence from peer relationships or workplace environment on responses. This researcher believes that the professional training and education of the subjects served to minimize this potential problem.

In reviewing the data, competencies rated as most important also received a high mean score on the interval data; an indication the data is reliable. Because the importance of essentially all competencies were considered "High" or "Very High", the data is truncated. While there were no significant differences in worker perception of competencies in workers with, or without, a history of recovery, it is possible that differences exist that the instrument was not sensitive enough to detect.

*Profile of Workers*

Approximately one-third of the workers surveyed indicated they had a personal history of recovery. White (2000) reports that over half of addiction counselors surveyed nationally acknowledged a personal recovery background. While the percentage varies depending on setting, one would anticipate the percentage of recovering workers to be highest in facilities with a primary focus on addictions, such as those in the study. If the data represents an actual reduction in the number of workers with a personal history of recovery, it could be due to changing requirements in the field including State of Illinois licensure mandates that all workers be certified or licensed. While certification requirements permit certification without a college education, documentation standards, certification exams, and training and supervision requirements may be responsible for changing the composition of workers in the field. In addition, managed care and accrediting bodies are placing increased emphasis on advanced degrees and licensure among treatment workers, even in community-based agencies (Juhnke, 2000).

Over 74% of workers were certified as addictions counselors, or will be certified in two years. Over 46% were licensed or will obtain licensure within 2 years. There

are a significant number, approximately 27% of workers sampled, who are certified and also licensed or pursuing licensure. The percentage of workers in this study with a master's degree is approaching 50%. Since certification is the only credential required for practice in Illinois, the number of master's level clinicians would seem to be due to increased emphasis on educational credentials from managed care, funding sources, accrediting bodies, or agency policy.

*Implications for Training*

There seems to be broad agreement among workers regarding the importance of competencies identified in the *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice*, Addiction Technology Transfer Centers, National Curriculum Committee (1998). The emphasis on certification mandated by agency licensure is likely to be responsible for infusing the field with these competencies. As noted above, 75% of workers are certified or will be certified within two years. If we accept these competencies as a profile of an exemplary worker, the data indicates a need to focus training in a number of areas, six of which are discussed here.

1. Workers reported that skills related to engagement, assessment, identifying underlying issues that may impede progress, and relapse prevention were the most important clinical skills. As might be expected, workers seemed to rate competencies as important in those areas where they are likely to spend a significant amount of their time and effort. However, understanding ethical obligations was rated as more important than activities where counselors spend significant time such as supervision and training. This may point to a belief among workers that ethics represent broad

guidelines that become a part of everything they do. Trainers may wish to incorporate ethical implications into training in all areas rather than, or in addition to, conducting specific ethics training.

2. The mean score identified the importance of the majority of competencies as "Very High" or "High", with a few exceptions including an understanding of the various insurance and health maintenance options available to patients, which was rated as "Neither High Nor Low" by all groups. This rating is not surprising given the high percentage of clients in community-based agencies receiving services funded by Medicaid, the Illinois Department of Human Services, or other grants. However, agencies wishing to reduce dependence on public funding may need to improve understanding of the importance of third party reimbursement among workers.

3. Workers rate the importance of understanding family, social networks, and community in the treatment process as most important. However, competencies necessary to put that knowledge into practice such as client and community education and family counseling received relatively low scores. Further, only two workers selected systems theory, a cornerstone of family counseling, as their preferred treatment approach. Clearly there is a need to expand awareness of competencies necessary to work effectively with family and community systems in order to support workers' perceptions of the family and community's role in addiction treatment.

4. A number of competencies and knowledge areas related to current research and emerging practices in the field received relatively low scores. Familiarity with medical and pharmacological resources and pharmacotherapy received low scores. A lack of acceptance of pharmacological interventions is likely due to the historically

strong emphasis on abstinence approaches in the field. However, recent research is focusing increasingly on the role of brain chemistry in the development and resolution of addiction. The development of drugs specifically to alter cravings and reverse the changes to brain chemistry brought on by addiction is clearly on the horizon (NIDA, 1996). These approaches are likely to play an important role in the future of addiction treatment. Incorporating information about research and emerging trends into training and development activities, and tying them to competencies highly valued such as ethics and relapse prevention, will help prepare workers for the future of the field.

5. Workers indicated a relatively strong preference for the statement summarizing a harm reduction philosophy and strength-based approaches, rather than the traditional approaches of therapeutic community and 12-step recovery. Given the controversial nature of harm reduction approaches such as methadone and needle exchange programs in the addiction field, workers may benefit from an in depth dialog of how a harm reduction approach would effect treatment activities and how it relates to each worker's individual philosophy. Licensure requirements essentially impose a problem focus on workers by requiring problem oriented treatment goals. It may be possible for training and development programs to assist workers in aligning their personal philosophy with their work and incorporate a strengths approach in more settings.

6. In some cases apparent contradictions between public policy and worker perceptions will identify areas for training and development. Workers in the study identified therapeutic community as one of their least preferred treatment approaches.

At a recent symposium outlining contracting options for community-based agencies, Howell (2004) reported on the Sheridan Prison project where 1300 designated drug treatment beds will be operated, making it the largest modified therapeutic community in the country and possibly in the world. Community-based treatment programs will be asked to work with the Department of Corrections to provide services to these offenders upon their release. Training and development specialists will need to prepare workers in community agencies to meet the needs of these clients and build on the progress they have made in the therapeutic community.

7. Training and development specialists will need to monitor the continued recognition of competencies specific to the addiction treatment field in their organizations. Workers receive most of their addiction-specific training in agencies. With the increased emphasis on licensure and a multi-disciplinary approach brought on by managed care and designated programs for patients with co-occurring mental illness, workers will be entering the field with diverse academic and professional backgrounds. While the skills they bring will enhance the breadth of competencies in the field, they will need training specific to addiction counseling competencies. While a history of recovery may not be an accurate predictor of perceptions of competencies, such workers bring a wealth of experience to their organizations. Diversity in backgrounds, including a personal history of recovery, can and should be used in training and development to improve the competency of all workers.

*Recommendations for Organizational Development*

Training in isolation is ineffective. The data reveals a number of issues to be addressed in organizational development processes. Four specific recommendations are presented here.

1. Strong support for all competencies among workers with, and without, a personal history of recovery may be due to the evolution of the field. While early treatment programs focused almost exclusively on 12-step recovery, most treatment programs now use a multidisciplinary approach and offer multiple treatment modalities in various settings (White, 1998). Evidence to support this evolution can be found in the data. While workers rated the importance of knowledge of AA and 12-step recovery relatively high, they ranked it low as a preferred treatment approach. Workers apparently distinguish between professional treatment approaches and 12-step recovery. Organizations should explore their treatment philosophy and relationship to AA, NA, and Alanon in their mission, values, and strategic planning process.

2. Training and development specialists may take comfort in the fact that there is broad support among workers for competencies validated and accepted nationally. Such support is likely to result in an interest in training and technology transfer in those areas. However, rating a competency as important does not indicate that the worker has the attitudes, skills, knowledge, and agency supports necessary to perform the competency adequately. Agencies should develop processes to measure performance and provide the support and resources necessary to promote and sustain exemplary performance.

3. When a multiple analysis of variance was applied to data sorted by agency, a statistically significant difference in the interval data reported by workers was observed. Furthermore, statistically significant differences were also observed when a Chi Square analysis was applied to responses from workers in each agency regarding preferred treatment philosophy. Because there were no significant differences detected when comparing the groups based on recovery status or licensure status, it seems likely employee selection, environmental factors, and workplace culture are more powerful than recovery history in influencing worker perceptions.

As noted earlier, one approach to using the data for training and development is to accept the competencies as defined by the Addiction Technology Transfer Center as a competency profile of an exemplary worker. Training should then be directed to competency areas where workers indicated relatively low importance. However, it may be more effective to use a process, such as appreciative inquiry, to identify organizational strengths and uncover the history of organizational accomplishments (Barrett & Fry, 2002). This approach is consistent with the strong support for strength-based client interventions among workers surveyed. Using a strength-based approach in organizational interventions will promote acceptance and synergy between the individual's work and agency goals. This process can be used to develop complementary competency profiles for the organization and for exemplary employees. Training for targeted competencies can then be accomplished within the framework of a shared vision for the future of the organization.

4. Indications that organizational environment and culture play a more important role than history of recovery in shaping perceptions of competencies have a number

of implications for training and development specialists. White (1997) points out "the workplace can be seen as an organizational family system" (p.xiii). Organizations in distress can damage workers and clients. Maintaining a healthy organizational climate should be a central concern for all organizations. Competencies generally associated with a "learning organization" appear to be undervalued by addiction treatment workers. Understanding the importance of a systems approach and effectively utilizing research and outcome data are critical to developing fluid and responsive organizations (Bandenburg & Binder, 1999). Training and development specialists must be aware of the overall health of the organization and prepare workers to play an active role in moving the organization in a direction consistent with its mission and values.

*Suggestions for Future Research*

In reviewing the results of this research, there are a number of areas worthy of further investigation. Three suggestions for future research are presented here.

1. There is a strong sense among workers in community-based addiction treatment agencies that perceptions of what it takes to succeed with clients is markedly different among staff with a personal history of recovery and those with no such history. The data does not support this belief. Future researchers may wish to modify the instrument by expanding the Likert scale. An expanded scale may be more sensitive to any differences among the groups. It may also be useful to verify the presence of this perception among workers and study its nature and origins.

2. It may be useful for future researchers to explore a possible link between external credentialing requirements, the percentage of recovering workers in the field,

and their educational credentials. The data suggests that there may be a reduction in the percentage of recovering workers among addiction treatment workers practicing in Illinois.

3. The data provides a profile of competencies and practice philosophy perceived to be most important by workers. However, treatment occurs in a relationship between worker and client. Research into client perceptions of competencies may improve our ability to use competency training to improve client service and outcomes.

*Conclusions*

Given the significant unmet need for addiction treatment (SAMHSA, 2001) the demand for trained workers competent in addiction treatment is likely to increase. Alcohol and drug problems carry huge costs for society in many areas including crime and public safety, health care, and child welfare. Dramatic benefits are possible through the use of effective and timely treatment for addiction problems (Heymann & Brownberger, 2001). Properly prepared and trained addiction treatment workers can play a key role in society's efforts to minimize the detrimental effects of drug and alcohol abuse.

This study found broad support among addiction treatment workers in community-based agencies for counseling competencies identified in *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice*, Addiction Technology Transfer Centers, National Curriculum Committee (1998). Worker support can be used to improve the effectiveness of treatment by

implementing a competency-based model to guide training and development of workers.

This study did not find a statistically significant difference in perceptions of the relative importance of competencies among workers with a personal history of recovery and those with no such history. Workplace culture and environmental factors seem to play a more significant role in molding perceptions than recovery history. Consequently, efforts to improve addiction treatment competency through training should simultaneously address organizational development issues.

Chapter 6

References

Addiction Technology Transfer Centers, National Curriculum Committee (1998). *Addiction counseling competencies: the knowledge, skills, and attitudes of professional practice.* (DHHS Publication No. 98-3171) Washington D.C. U.S. Department of Health and Human Services.

Alcoholics Anonymous (1976). *Alcoholics anonymous: the story of how many thousands of men and women have recovered from alcoholism, third edition.* New York, NY: Alcoholics Anonymous World Services, Inc.

Alcoholics Anonymous (2003). *A.A. fact file.* Retrieved March 30, 2003 from http://www.alcoholics-anonymous.org/default/en_about_aa.cfm?pageid-24

Alcoholism & drug abuse weekly. (1998, April 13), copy editor, 10 (15) p. 4.

American Society of Addiction Medicine, Inc. (1996). *Patient placement criteria for the treatment of substance-related disorders* (2nd ed.). Chevy Chase, Maryland: Author.

Arredondo P. & Arciniega G. M. (2001). Strategies and techniques for counselor training based on the multicultural counseling competencies *Multicultural Counseling and Development* 29, 263-273.

Barrett, F. & Fry R. (2002). Appreciative inquiry in action: the unfolding of a provocative invitation. In R. Fry, F. Barrett, J. Selling. D. Whitney (Eds.), *Appreciative inquiry and organizational transformation* (pp. 1-23). Westport, Connecticut: Quorum.

Bednar S. G. (2003). Elements of satisfying organizational climates in child welfare agencies *Families in Society: The Journal of Contemporary Human Services* 84 (1) 7-12.

Boren, J. J., Carroll, K. M., Onken, L. S. (Eds.). (2000). *Approaches to drug abuse counseling* (NIH Publication No. 00-4151) Bethesda, Maryland: National Institute on Drug Abuse.

Brandenburg, D. C. & Binder C. V. (1999). Emerging trends in human performance interventions. In H. D. Stolovitch & E. J. Keeps (Eds.), *Handbook of human performance technology* (pp. 843-866). San Francisco: Jossey-Bass Pfeiffer

Brown, S. (1998). Marty Mann and the evolution of alcoholics anonymous. *Paradigm* 3 (4) Retrieved April 3, 2003 from http://www.addictionrecov.org/parchive.htm

Chan F., Leahy M. J., Saunders J. L., Tarvydas V. M., Ferrin J. M., & Lee G. (2003). Training needs of certified rehabilitation counselors for contemporary practice. *Rehabilitation Counseling Bulletin* 46(2) 82-91. Manuscript retrieved March 10, 2003 from EBSCO Publishing database.

Drake B. (1994). Relationship competencies in child welfare services. *Social Work* 39(5) 595-603.

Duggar, B. C. (1991). Community-based drug treatment reimbursement: progress and barriers. In W. S. Cartwright & J. M. Kaple (Eds.) *Economic costs, cost-effectiveness, financing, and community-based drug treatment* (HHS Publication No. 91-1823. pp. 148-164). Washington, D.C. U.S. Department of Health and Human Services.

Gemini Collective (1978). *The Gemini house manual, a comprehensive primer of drug and life information* (2nd Ed.). Chicago: Salsedo Press.

Geron S. M. (2002). Cultural competency: How is it measured? Does it make a difference? *Generations* Fall 39-45 Manuscript retrieved March 10, 2003 from EBSCO Publishing database.

Gupta, K. (1999). *A practical guide to needs assessment.* San Francisco: Jossey-Bass Pfeiffer.

Haynes T. L. (1988). *The changing role of the physician in the treatment of chemical dependence.* Retrieved March 30, 2003 from http://www.wemac.com/adm-hist.html

Heymann P. B. & Brownsberger W. N. (Eds.) (2001). *Drug addiction and drug policy: the struggle to control dependence.* Cambridge: Harvard University Press.

Hosie T. W., West J. D., & Mackey J. A. (1990). Perceptions of counselor performance in substance abuse centers. *Journal of Mental Health Counseling* 12 (2) 199-207.

Howell, D. (2004, March) *Drug treatment initiatives at Sheridan.* Symposium presented by the Illinois Department of Corrections & the Illinois Division of Alcoholism & Substance Abuse, Charleston, Illinois.

Illinois Administrative Code Title 77: Public Health Chapter X: Department of Human Services Subchapter d: Licensure Part 2060 Alcoholism and Substance Abuse Treatment and Intervention Licenses (August 14, 2001). Retrieved February 15, 2003, from http://163.191.134.21/docs/rules/dir/77-2060.pdf

Illinois Alcoholism and Other Drug Professional Certification Association, Inc. (n.d.). *Credential information.* Retrieved February 15, 2003, from http://www.iaodapca.org/certifications/counselor/

Illinois Department of Human Services, Office of Alcoholism and Substance Abuse (2003). *OASA licensed sites.* Retrieved April 3, 2003, from http://www.state.il.us/oasa/sscct.pdf

Jellinek E. M. (1960). *The disease concept of alcoholism.* New Haven: Hillhouse Press.

Juhnke, G.E. (2000). An interview with Thomas W. Clawson *Journal of Addictions and Offender Counseling* 20 (2), 50-56.

Leukefeld, C. G., Pickens, R. W., & Schuster C. R. (1991). Improving drug abuse treatment: recommendations for research and practice. In R.W. Pickens, C. G. Leukefeld & C. R. Schuster (Eds.), *Improving drug abuse treatment* (HHS Publication No. 91-1754. pp. 394-406). Washington, D.C. U.S. Department of Health and Human Services.

Manese, J. E. (2001). The effect of training on multicultural counseling competencies: An exploratory study. *Journal of Multicultural Counseling* 29 (1), 31-41.

Meza, E. C. & Cunningham E. E. (2001). Alcoholism: beliefs and attitudes among Canadian alcoholism treatment practitioners *Canadian Journal of Psychiatry* 46(2),167-172 Manuscript retrieved January 20, 2002 from Academic Search Elite database.

Narcotics Anonymous (2002). *Information about NA.* Retrieved March 30, 2003 from http://www.na.org/berlbull.htm

National Institute on Drug Abuse (1996). NIDA supported researchers use brain imaging to deepen understanding of addiction. *NIDA Notes* 11 (5), Retrieved March 14, 2004 from http://www.drugabuse.gov/NIDA_Notes/NNVol11N5/Deepen.html

Northern Illinois University, Center for Government Studies (2000). *Census 2000 redistricting data.* Retrieved March 7, 2004 from http://www.illinoisdata.com/census2000/pl94171/pdf/il_ci_race.pdf

Page R. C. & Bailey J. B. (1995). Addiction counseling certification: an emerging counseling specialty *Journal of Counseling & Development* 74, 167-170.

Polcin D. L. (2000). Professional counseling versus specialized programs for alcohol and drug abuse treatment. *Journal of Addictions and Professional Counseling* 21, 2-12.

Robinson D. G., & Robinson J.C. (1995). *Performance consulting: moving beyond training.* San Francisco: Berrett-Koehler.

Substance Abuse and Mental Health Services Administration (2001). *Substance abuse treatment facility locator.* Retrieved March 29, 2003 from http://findtreatment.samhsa.gov/

Substance Abuse and Mental Health Services Administration (2001). *National survey on drug use and health.* Retrieved March 19, 2004 from http://www.samhsa.gov/oas/whsda.htm

Sue D. W. & Sue D. (1990). *Counseling the culturally different: theory and practice.* New York: Wiley.

Thornton, M. (1991). Policy analysis: alcohol prohibition was a failure. Retrieved March 30, 2003 from http://www.cato.org/cgi-bin/scripts/printtech.cgi/pubs/pas/pa-157.html

Von Steen P. G., Vacc, N. & Strickland, I. M. (2002). The treatment of substance-abusing clients in multi-service mental health agencies: a practice analysis. *Journal of Addictions & Offender Counseling,* 22, 61-71.

Ward L. & Throop R. (1996). *Timetable of significant events in psychology.* Retrieved March 27, 2004 from http://spartan.ac.brocku.ca/~lward/Mead/time/TIME_PSY.HTML

White W. L. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America.* Bloomington, Illinois: Chestnut Health Systems/Lighthouse Institute

White W. L. (2000). The history of recovered people as wounded healers: II. The era of professionalization and specialization. *Alcoholism Treatment Quarterly,* 18(2), 1-25.

White W. L. (1997). *The incestuous workplace: stress and distress in the organizational family.* Center City, Minnesota: Hazeldon.

# Appendix A
# Survey Instrument

**Q-1** Listed below are some skills demonstrated by addiction treatment workers. Please indicate how you rate the importance of each skill: VERY LOW, LOW, NEITHER HIGH NOR LOW, HIGH, or VERY HIGH.

| Skill No. | _____ Description of Skill_____ | VERY LOW | LOW | NEITHER HIGH NOR LOW | HIGH | VERY HIGH |
|---|---|---|---|---|---|---|
| 1 | Understand a variety of models and theories of addiction and other problems related to substance use. | | | | | |
| 2 | Able to recognize the social political, economic, and cultural context within which addiction and substance abuse exist, including risk and resiliency factors that characterize individuals and groups and their living environments. | | | | | |
| 3 | Able to describe the behavioral, psychological, physical health, and social effects of psychoactive substances on the user and significant others. | | | | | |
| 4 | Able to recognize the potential for substance use disorders to mimic a variety of medical and psychological disorders and the potential for medical and psychological disorders to co-exist with addiction and substance abuse. | | | | | |

**Q-2** Of the skills listed in Q-1 which do you believe is most important for addiction treatment workers? Please write the skill number in the appropriate area. **Most important** _____ **Second most important** _____

**Q-3** Listed below are some skills demonstrated by addiction treatment workers. Please indicate how you rate the importance of each skill: VERY LOW, LOW, NEITHER HIGH NOR LOW, HIGH, or VERY HIGH.

| Skill No. | _____ Description of Skill_____ | VERY LOW | LOW | NEITHER HIGH NOR LOW | HIGH | VERY HIGH |
|---|---|---|---|---|---|---|
| 1 | Able to describe the philosophies, practices, policies, and outcomes of the most generally accepted and scientifically supported models of treatment, recovery, relapse prevention, and continuing care for addiction and other substance-related disorders. | | | | | |
| 2 | Able to recognize the importance of family, social networks, and community systems in the treatment and recovery process. | | | | | |
| 3 | Understand the importance of research and outcome data and their application in clinical practice. | | | | | |
| 4 | Understand the value of an interdisciplinary approach to addiction treatment. | | | | | |

**Q-4** Of the skills listed in Q-3 which do you believe is most important for addiction treatment workers? Please write the skill number in the appropriate area. **Most important.** _____ **Second most important** _____

**Q-5** Listed below are some skills demonstrated by addiction treatment workers. Please indicate how you rate the importance of each skill: VERY LOW, LOW, NEITHER HIGH NOR LOW, HIGH, or VERY HIGH.

| Skill No. | _____ Description of Skill_____ | VERY LOW | LOW | NEITHER HIGH NOR LOW | HIGH | VERY HIGH |
|---|---|---|---|---|---|---|
| 1 | Understand the established diagnostic criteria for substance abuse disorders and describe treatment modalities and placement criteria within the continuum of care. | | | | | |
| 2 | Able to describe a variety of helping strategies for reducing the negative effects of substance use, abuse, and dependence. | | | | | |
| 3 | Able to tailor helping strategies and treatment modalities to the client's stage of dependence, change, or recovery. | | | | | |
| 4 | Able to adapt practice to the range of treatment settings and modalities. | | | | | |
| 5 | Familiarity with medical and pharmacological resources in the treatment of substance use disorders. | | | | | |
| 6 | Understand the variety of insurance and health maintenance options available and the importance of helping clients access those benefits. | | | | | |
| 7 | Able to recognize that crisis may indicate an underlying substance use disorder and may be a window of opportunity for change. | | | | | |
| 8 | Understand the need for and the use of methods for measuring treatment outcome. | | | | | |

**Q-6** Of the skills listed in Q-5 which do you believe is most important for addiction treatment workers? Please write the skill number in the appropriate area.

**Most important** _____ **Second most important** _____ **Third most important** _____

**Q-7** Listed below are some skills demonstrated by addiction treatment workers. Please indicate how you rate the importance of each skill: VERY LOW, LOW, NEITHER HIGH NOR LOW, HIGH, or VERY HIGH.

| Skill No. | _____ Description of Skill_____ | VERY LOW | LOW | NEITHER HIGH NOR LOW | HIGH | VERY HIGH |
|---|---|---|---|---|---|---|
| 1 | Able to monitor the client's behavior for consistency with preferred treatment outcomes. | | | | | |
| 2 | Able to present inconsistencies between client behaviors and goals. | | | | | |
| 3 | Able to re-frame and redirect negative behaviors. | | | | | |
| 4 | Abilities in conflict resolution, decision making, and problem solving skills. | | | | | |
| 5 | Able to recognize and address underlying client issues that may impede treatment progress. | | | | | |

**Q-8** Of the skills listed in Q-7 which do you believe is most important for addiction treatment workers? Please write the skill number in the appropriate area.
**Most important** _____ **Second most important** _____ **Third most important** _____

**Q-9** Listed below are some skills demonstrated by addiction treatment workers. Please indicate how you rate the importance of each skill: VERY LOW, LOW, NEITHER HIGH NOR LOW, HIGH, or VERY HIGH.

| Skill No. | _____ Description of Skill_____ | VERY LOW | LOW | NEITHER HIGH NOR LOW | HIGH | VERY HIGH |
|---|---|---|---|---|---|---|
| 1 | Understand diverse cultures and incorporate the relevant needs of culturally diverse groups, as well as people with disabilities, into clinical practice. | | | | | |
| 2 | Understand the importance of self-awareness in one's own personal, professional, and cultural life. | | | | | |
| 3 | Understand the addiction professional's obligations to adhere to ethical and behavioral standards of conduct in the helping relationship. | | | | | |
| 4 | Understand the importance of ongoing supervision and continuing education in the delivery of client services. | | | | | |
| 5 | Understand the obligation of the addiction professional to participate in prevention as well as treatment. | | | | | |
| 6 | Understand and apply setting-specific policies and procedures for handling crisis or dangerous situations, including safety measures for clinical staff. | | | | | |

**Q-10** Of the skills listed in Q-9 which do you believe is most important for addiction treatment workers? Please write the skill number in the appropriate area.
**Most important** _____ **Second most important** _____ **Third most important** _____

**Q-11** Listed below are some areas of knowledge that have been identified in addiction treatment workers. Please indicate how you rate the importance of knowledge in each area: VERY LOW, LOW, NEITHER HIGH NOR LOW, HIGH, or VERY HIGH.

| Skill No. | _____ Description of Knowledge_____ | VERY LOW | LOW | NEITHER HIGH NOR LOW | HIGH | VERY HIGH |
|---|---|---|---|---|---|---|
| 1 | Pharmacotherapy (combining medical and pharmacological interventions with counseling) | | | | | |
| 2 | Mutual help and self-help. (AA, NA, Alanon) | | | | | |
| 3 | Behavioral self-control training | | | | | |
| 4 | Mental health | | | | | |
| 5 | Self-regulation community (therapeutic community) | | | | | |
| 6 | Psychotherapeutic | | | | | |
| 7 | Relapse prevention | | | | | |
| 8 | Multimodality | | | | | |

**Q-12** Of the knowledge areas listed in Q-11 which do you believe is most important for addiction treatment workers? Please write the knowledge number in the appropriate area.
**Most important** _____ **Second most important** _____ **Third most important** _____

**Q-13** Listed below are some clusters of skills demonstrated by addiction treatment workers. Please indicate how you rate the importance of each cluster of skills: VERY LOW, LOW, NEITHER HIGH NOR LOW, HIGH, or VERY HIGH.

| Skill No. | _____ Description of Skills_____ | VERY LOW | LOW | NEITHER HIGH NOR LOW | HIGH | VERY HIGH |
|---|---|---|---|---|---|---|
| 1 | Screening, the process through which a counselor, client and available significant others determine the most appropriate initial course of action, given the clients needs and characteristics, and the available resources within the community. | | | | | |
| 2 | Assessment, an on-going process through which the counselor collaborates with the client and others to gather and interpret information necessary for planning treatment and evaluating client progress | | | | | |
| 3 | Implementing the treatment plan. | | | | | |
| 4 | Consulting (case presentation and staffing). | | | | | |
| 5 | Continuing assessment and treatment planning | | | | | |
| 6 | Individual counseling | | | | | |
| 7 | Group Counseling | | | | | |
| 8 | Counseling families, couples, and significant others | | | | | |
| 9 | Client, Family, and Community Education | | | | | |
| 10 | Documentation. The recording of the screening and intake process, assessment, treatment plan, clinical reports, clinical progress notes, discharge summaries, and other client-related data | | | | | |
| 11 | Professional and Ethical Responsibilities | | | | | |

**Q-14** Of the skill areas listed in Q-13 which do you believe is most important for addiction treatment workers? Please write the skill number in the appropriate area.

**Most important. _____ Second most important _____ Third most important _____**

**Q-15** Listed below are some clusters of skills demonstrated by addiction treatment workers. Please indicate how you rate the importance of each cluster of skills: VERY LOW, LOW, NEITHER HIGH NOR LOW, HIGH, or VERY HIGH.

| Skill No. | _____ Description of Skills_____ | VERY LOW | LOW | NEITHER HIGH NOR LOW | HIGH | VERY HIGH |
|---|---|---|---|---|---|---|
| 1 | Able to establish a helping relationship with the client characterized by warmth, respect, genuineness, concreteness, and empathy. | | | | | |
| 2 | Able to facilitate the client's engagement in the treatment and recovery process. | | | | | |
| 3 | Able to work with the client to establish realistic, achievable, goals consistent with achieving and maintaining recovery. | | | | | |
| 4 | Able to promote client knowledge, skills, and attitudes that contribute to a positive change in substance abuse behaviors. | | | | | |
| 5 | Able to encourage and reinforce client actions determined to be beneficial in progressing toward treatment goals. | | | | | |
| 6 | Able to work appropriately with the client to recognize and discourage all behaviors inconsistent with progress toward treatment goals. | | | | | |
| 7 | Able to recognize how, when, and why to involve the client's significant others in enhancing or supporting the treatment plan. | | | | | |
| 8 | Able to promote client knowledge, skills, and attitudes consistent with the maintenance of health and prevention of HIV, TB, STDs, and other infectious diseases. | | | | | |
| 9 | Able to facilitate the development of basic and life skills associated with recovery. | | | | | |
| 10 | Able to adapt counseling strategies to the individual. | | | | | |
| 11 | Able to make constructive therapeutic responses when the client's behavior is inconsistent with stated recovery goals. | | | | | |
| 12 | Able to apply crisis management skills. | | | | | |
| 13 | Able to facilitate the client's identification, selection, and practice of strategies that help sustain the knowledge, skills, and attitudes needed for maintaining treatment progress and preventing relapse. | | | | | |

**Q-16** Of the skill areas listed in Q-15 which do you believe is most important for addiction treatment workers? Please write the skill number in the appropriate area.

**Most important. _____ Second most important _____ Third most important _____**

**Q-17** Listed below are some clusters of skills demonstrated by addiction treatment workers. Please indicate how you rate the importance of each cluster of skills: VERY LOW, LOW, NEITHER HIGH NOR LOW, HIGH, or VERY HIGH.

| Skill No. | _____ Description of Skills_____ | VERY LOW | LOW | NEITHER HIGH NOR LOW | HIGH | VERY HIGH |
|---|---|---|---|---|---|---|
| 1 | Able to describe, select, and appropriately use strategies from accepted and culturally appropriate models for group counseling with clients with substance abuse disorders. | | | | | |
| 2 | Able to carry out actions necessary to form a group, including, but not limited to: determining group type, purpose, size, and leadership; recruiting and selecting members; establishing group goals and clarifying behavioral ground rules for participating; identifying outcomes; and determining criteria and methods for termination or graduation form the group. | | | | | |
| 3 | Able to facilitate the entry of new members and the transition of exiting members. | | | | | |
| 4 | Able to facilitate group growth within the established ground rules and movement toward group and individual goals by using methods consistent with group type. | | | | | |
| 5 | Understand the concepts of process and content, and shift the focus of the group when such an intervention will help the group move towards its goals. | | | | | |
| 6 | Able to describe and summarize client behavior within the group for the purpose of documenting the client's progress and identifying needs and issues that may require a modification in the treatment plan. | | | | | |

**Q-18** Of the skill areas listed in Q-17 which do you believe is most important for addiction treatment workers? Please write the skill number in the appropriate area.

**Most important. _____ Second most important _____ Third most important _____**

**Q-19** Below are brief descriptions of some addiction treatment philosophies and approaches. Please identify those statements that most closely resemble your personal treatment philosophy.

(1) Successful treatment of addiction requires an understanding of and working with the social systems within which the client operates.

(2) Successful treatment of addiction requires engaging the client wherever he or she is and embracing any change that reduces the harm caused by addiction.

(3) Successful treatment of addiction requires following a 12-step program and bonding to a recovery community.

(4) Successful treatment of addiction requires helping the client identify destructive thinking and emotional patterns and working with the client to change those patterns.

(5) Successful treatment of addiction is based on the belief that each client has the strength, skills, and resources necessary to overcome addiction. Treatment involves helping the client identify his or her own strengths, skills, and resources and use them to create a successful recovery plan.

(6) Successful treatment of addiction requires educating the client as to the nature of addiction and providing him or her with a toolbox of skills including, but not limited to, problem solving, anger management, relapse prevention, and relaxation.

(7) Successful treatment of addiction requires the client to make a long-term commitment to change. Treatment involves providing a supportive drug-free community where the client can develop new skills and coping strategies in real world situations.

**Most closely represents my philosophy** _____
**Second most closely** _____
**Third most closely** _____

**Q-20** Are you licensed as a Professional Counselor (LPC), Clinical Professional Counselor (LCPC), Social Worker (LSW), Clinical Social Worker (LCSW), Psychologist, Physician, or will you be licensed within two years?
**YES** **NO**

**Q-21** Are you a Registered Nurse (RN), a Licensed Practical Nurse (LPN), or Emergency Medical Technician (EMT). **YES** **NO**

**Q-22** Are you certified as an Alcohol and Drug Counselor (CADC) or Assessment and Referral Specialist (CARS), or will you be certified within two years. **YES** **NO**

**Q-23** Do you consider yourself to be recovered or recovering from alcohol or substance abuse? **YES** **NO**

**Thank You!**

# Appendix B
## Expert Panel

Susan G. Bednar, MSW
Licensed Clinical Social Worker
Certified Domestic Violence Counselor
Private Practice

French Fraker, Ph.D.
Professor
Counseling and Student Development
Eastern Illinois University

Narain Mandhan, M.D.
A.S.A.M. Certified Addictionologist
Kirby Hospital
Teaching Faculty, University of Illinois School of Medicine

Appendix C
Cover Letter

Mailing Address

July 15, 2003

As a professional in the field of addiction treatment, you are aware of the importance of training and professional development in improving clinical services. The purpose of this survey is to identify the perceptions of treatment professionals regarding skills and competencies most important to addictions professionals. The survey will be conducted in community-based addiction treatment programs in central Illinois and used to improve training and development programs.

All information will be kept in the strictest confidence. There is no identifying information on the survey. Information from the surveys will be distributed only as aggregate data.

Completing the survey takes an average of 15 minutes. The information you provide will help improve training and development of addiction treatment professionals.

When finished, please return the survey to the researcher. Your response is important in understanding the perceptions of all addictions professionals. If you prefer, you may return it by mail to the above address. Please return the survey by December 1, 2003 to allow adequate time to enter the results. As the findings become available, they will be posted on a website located at http://www.sundaylake.com/research/. You may also request a summary of the findings by contacting me at the above address.

Please feel free to contact me if you have any questions about the study. Thank you very much for your assistance.

Sincerely,

Bruce Barnard
School of Technology
Eastern Illinois University

Appendix D
Cover Letter, Revised

Mailing Address

January 2, 2004

As a professional in the field of addiction treatment, you are aware of the importance of training and professional development in improving clinical services. The purpose of this survey is to identify the perceptions of treatment professionals regarding skills and competencies most important to addictions professionals. The survey will be conducted in community-based addiction treatment programs in central Illinois and used to improve training and development programs.

All information will be kept in the strictest confidence. There is no identifying information on the survey. Information from the surveys will be distributed only as aggregate data. However, some participants may feel uncomfortable sharing perceptions or personal information in this setting or manner. Please feel free to decline to participate by not returning a survey, returning a blank survey, or marking n/a on any or all questions.

Completing the survey takes about 15 to 20 minutes. The information you provide will help improve training and development of addiction treatment professionals.

When finished, please return the survey to the researcher. Your response is important in understanding the perceptions of all addictions professionals. If you prefer, you may return it by mail to the above address. Please return the survey by February 1, 2004 to allow adequate time to enter the results. As the findings become available, they will be posted on a website located at http://www.sundaylake.com/research/. You may also request a summary of the findings by contacting me at the above address.

Please feel free to contact me if you have any questions about the study. Thank you very much for your assistance.

Sincerely,

Bruce Barnard
School of Technology
Eastern Illinois University