

Regular articles

Comparative analysis of state requirements for the training of substance abuse and mental health counselors

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Abstract

Data on minimum state requirements for drug and alcohol counselors and mental health counselors in all 50 states and Washington, DC, suggest that training as a mental health counselor is primarily structured through formal education, whereas training as a substance abuse counselor resembles an apprentice model. Fewer states offer or require certification or licensure of substance abuse counselors, compared to mental health counselors. States that do offer such credentials for substance abuse counselors generally require more hours of supervised work experience and continuing education, but fewer hours of formal coursework and practicum courses, and a lower level of formal education. Although these different models for training are valid, they each have different implications for clinical practice, dissemination of research findings to practice, and management within the service delivery model. © 2006 Elsevier Inc. All rights reserved.

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1. Introduction

In response to the increasing identification of individuals with dual diagnoses (one or more substance abuse diagnoses combined with one or more mental health diagnoses) within substance abuse and mental health treatment systems (Timko, Lesar, Calvi, & Moos, 2003), the report from the President's New Freedom Commission on Mental Health (2003) recommended that screening for both types of problems should be often performed in practice. The report also suggested that this screening should be linked to treatment strategies that integrate substance abuse and

mental health treatments. Therefore, successful assessment and treatment of dual diagnoses increasingly require cross-fertilization across substance abuse and mental health fields and may even suggest eventual integration of such fields.

There is reason to believe that substance abuse and mental health treatment professionals may be very different in their approach to the respective problems that they treat. Historically, training in the two fields has evolved separately, probably because health care professionals often were not interested in treating addiction problems (Primm, 1992). As such, recovering alcoholics and substance abusers themselves often became addiction treatment providers (Keller & Dermatis, 1999). Through years of experience, these addiction treatment providers acquired substantial clinical knowledge and skills in substance abuse treatment based largely on 12 Steps or other self-help principles. In contrast, training for mental health counseling developed within mainstream educational pathways for health care professionals (Keller & Dermatis, 1999). In the past

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several decades, however, marketplace trends caused primarily by managed care have resulted in a reported increase in the didactic and formal training of addiction counselors (Mulvey, Hubbard, & Hayashi, 2003).

One such marketplace trend involves managed care's increasing interest in supporting empirically based practices. This has resulted in the proliferation of treatments that have been identified as meeting the strict methodological criteria required to be considered empirically supported (e.g., Task Force on the Promotion and Dissemination of Psychological Procedures, 1995) and the development of evidence-based practice guidelines that integrate research evidence with clinical expertise and patient values (Institute of Medicine, 1998, 2001). There is growing concern about the lack of dissemination of research findings to practice in community settings (Institute of Medicine, 2001), especially in the addiction field (Rawson, Marinelli-Casey, & Ling, 2002). In comparison to substance abuse treatment, the mental health field, through the efforts of psychology and psychiatry, has led the way in identifying empirically supported treatments and in requiring the training of evidence-based practice in clinical academic and training programs (Hoge, Tondora, & Stuart, 2003). Although these methods of integrating research findings into practice are common to many health care fields, research has demonstrated that the majority of substance abuse treatment programs continue to offer interventions with little empirical support (Brown, 2000; Chiauuzzi & Liljegen, 1993; Thomas, Wallack, Lee, McCarty, & Swift, 2003).

Successful dissemination of research findings to practice depends upon the practitioner's knowledge, skills, and abilities to understand and critically evaluate disseminated information and, when appropriate, incorporate the new methods into practice (Corrigan, Steiner, McCracken, Blaser, & Barr, 2001). Preliminary evidence suggests that differences in researcher and practitioner training and in treatment philosophies might be among the obstacles to technology transfer in the addiction field (Dansereau & Dees, 2002; Morgenstern, Morgan, McCrady, Keller, & Carroll, 2001). As a result, some researchers have postulated that counselor preparation influences counselor attitudes toward empirically supported treatment (Fals-Stewart & Birchler, 2001), and that more formal education is needed within the addiction field (Rawson et al., 2002). Drug abuse counselors appear to agree. Although the majority of certified drug and alcohol counselors in the state of Wisconsin endorsed favorable attitudes toward incorporating research findings into practice, 82% of them reported that they agreed (or strongly agreed) with the statement that they needed more training in integrating research and practice (Campbell, Catlin, & Melchert, 2003). Furthermore, the writing style and content of research publications were ranked second to time constraints as a significant barrier to integrating research into practice (Campbell et al., 2003). Interestingly, 72% reported that they apply research findings to develop treatment plans, but only 44% reported that their

coworkers apply research findings to develop their treatment plans. Examining the states' minimum requirements for substance abuse counselors compared to those for mental health counselors may provide a window on how counselor training and preparation might influence dissemination problems that beleaguer the addiction field more acutely than the mental health field.

In the United States, each state accepts some responsibility for the protection of consumers by legally mandating a minimum level of qualifications to practice within the substance abuse and mental health systems of care. A review of the state regulations of substance abuse treatment facilities demonstrated wide variability regarding academic preparation and relevant work experience necessary to qualify as a certified addiction counselor (West, Mustaine, & Wyrick, 1999). In an analysis of the minimum professional training requirements of 32 state-certifying bodies for substance abuse counselors, Mustaine, West, and Wyrick (2003) reported a lack of education and training in the *Council for the Accreditation of Counseling and Related Educational Programs'* core knowledge area components for certified addictions counselors. Given the emerging trends in the substance abuse and mental health fields, it is unclear how state requirements for substance abuse counselors compare to state requirements for mental health counselors.

The purpose of this article is to review and compare the minimum state requirements for drug and alcohol counselors and mental health counselors. We had two main research questions about states' counselor requirements. First, does the state government offer a license or a certification for substance abuse counselors and/or mental health counselors, and, if so, is the license or certification required to practice in the state? Second, for states offering a license or a certification, what are the respective educational degrees, coursework, supervised hours or experiences, and continuing education requirements that must be met by the counselor to obtain and retain the license or the certification?

2. Materials and methods

We searched the Internet for state government requirements (i.e., laws, codes, rules, and regulations) for substance abuse and mental health counselor licensure and certification in all 50 states and Washington, DC. For states where pertinent information could not be found on the Internet, we called or e-mailed the relevant state government agencies, divisions, or boards. Additionally, because some states' laws and regulations were undergoing changes, we included the most recent state requirements. A few states had recently passed laws initiating counselor credentials and were grandfathering current counselors, but had not yet approved the final requirements. These states were counted in the number of states offering credentials; however, these states were excluded from analyses of the requirements for credentials

because of incomplete data. After the state requirements had been obtained, the requirements were coded into the following categories: necessity of credentialing for practice, minimum degree, course hours and content, practicum or training hours, supervised work experience hours, examinations, and continuing education hours and content. Because states had diverse ways of presenting their requirements, we composed a set of operational definitions to guide the way information was coded.

2.1. Necessity of credentialing for practice

When a state offered multiple levels of credentialing, we used the minimum credentials required for practice, which is defined as being authorized to lead group or individual counseling sessions without being expected to pursue further credentials and without requiring direct supervision (e.g., practitioners are not labeled “assistant counselors” or “interns,” and they may renew their credentials). If no credential was required for practice, we used the minimum renewable credential that did not imply that the counselor was undergoing training. For states that offered both licenses and certifications, we focused on the requirements for whichever credential was required for practice. If neither credential was required for practice, we focused on the requirements for the license to more evenly compare mental health and substance abuse credentials because the majority of mental health credentials were licenses. In addition, requirements for licensure tended to be more stringent than requirements for certification.

2.2. Degree

Some states allowed counselors to meet the degree requirements for credentialing in a variety of ways. For instance, a state could require either a bachelor’s degree with a small number of supervised experience hours, or a high school diploma with more supervised experience hours. In such cases, we coded degree as the lowest degree necessary for the credential (e.g., a high school diploma). The remaining requirements, therefore, were based on what an applicant would need to fulfill if she/he had that minimum degree. Because the level of degree usually corresponded with the number of supervised experience hours required, we also noted whether the applicant could pursue less supervised experience hours if she/he had a more advanced degree.

2.3. Course hours and content

The number of course hours required by each state for the minimum level of practice was clearly stated for all drug and alcohol counseling requirements; however, some state regulations for mental health counseling would enumerate their requirements for related courses, but would not specify how many hours were required for those courses. The regulations would, however, specify that the applicant would

need a master’s degree in the field pursuing those related courses. In such cases, we substituted hours based on the minimum required by the Council for Accreditation of Counseling and Related Educational Programs (CACREP) for the requirements. We made this substitution because the state requirements for mental health credentials almost always reflected CACREP requirements. Therefore, we substituted 720 clock hours (48 semester hours) for the number of related course hours required in a master’s degree—the minimum that CACREP allows for its accredited master’s programs. This substitution was made in 13.7% of mental health credentials (7 of 51 credentials).

When we researched the types of courses required for applicants, we found a variety of courses that the states considered to be related to the profession of counseling. However, in general, we identified 13 categories of courses: (1) drug- and alcohol-related; (2) counseling, treatment, and client education; (3) professional ethics, responsibilities, and preparation; (4) screening, assessment, and appraisal; (5) case management; (6) social/cultural foundations and diversity; (7) health issues, diseases, and sexually transmitted diseases; (8) crisis management or intervention; (9) human growth and development; (10) family and couples therapy; (11) abnormal behavior/psychopathology; (12) measurement, research, and evaluation; and (13) career and lifestyle development. Each state’s requirements were coded into one of these categories.

2.4. Practicum and/or supervised work hours

When states required a practicum, the regulations often specified the number of supervised hours necessary for each of these requirements; however, some states would occasionally require a practicum or an internship as part of the minimum degree, but would not specify the number of hours for that practicum or internship. These cases only occurred for mental health credentials. When a state specified that a practicum was required but did not specify the number of clock hours, we substituted 100 clock hours for each practicum or for each 3 semester hours of practicum required by the state (based on CACREP’s standards). When a state specified that an internship was required, we used CACREP’s minimum of 600 clock hours for that internship. We made this substitution in 33.3% of mental health credentials (17 of 51 credentials).

2.5. Examination and continuing education hours and content

Each state’s requirements for oral and/or written examination were clearly stated and coded as such. In addition, the following information was coded about continuing education: whether it was required by the state, the number of hours required for the typical renewal certification–license cycle (i.e., 2 years), and the content that was required by the state for continuing education. Some states had optional/

suggested courses for continuing education; these were not included in these data.

2.6. Reliability of classification

To assess the reliability of the collected data, two research assistants were each assigned to look up the requirements of a random selection of 16 of 51 states (including Washington, DC). Using interobserver agreement calculations of the number of agreements divided by the combined number of agreements and disagreements multiplied by 100%, the average interrater agreement between observers from the random selection of 16 states was 95.0% (range, 75.0–100.0%). Only 2 of 37 categories fell below 80% reliability: practicum/training hours (75%) and supervised work experience hours (78.1%).

2.7. Data analyses

To determine differences in the education and training of substance abuse and mental health counselors, independent *t* tests were performed on continuous outcome measures (course hours required, practicum hours, supervised work experience hours, and continuing education hours required), and chi-square analyses were performed on categorical outcome measures (credential required, credential offered, minimum degree required, course requirements, examination required, and content areas required for continuing education). Although the dependent variables in various analyses are independent of each other, we have chosen to use an α level of .01 because multiple statistical analyses were conducted.

3. Results

3.1. State requirements

3.1.1. Licensure vs. certification by field

There was a statistically significant difference between drug and alcohol and mental health counseling certifications vs. licenses, $\chi^2(1) = 28.45, p < .001$. Over half of substance abuse counselor credentials were labeled certifications, although only one mental health counselor credential was labeled as certification (substance abuse certification, 18; substance abuse license, 17; mental health certification, 1; mental health license, 48). However, when we compared the requirements for substance abuse counselor certifications to those for licenses, we found no significant differences. Thus, in presenting our results, we do not differentiate between state government certifications and licenses.

3.1.2. State governments offering and/or requiring credentials

Table 1 depicts the number of states requiring counselor certification or license in each field. Almost twice as many

Table 1
Percentage (number) of state governments offering or requiring counseling credentials

Counseling credential	Substance abuse [% (n)]	Mental health [% (n)]	χ^2
State government credential required	49.02 (25) ^a	86.27 (44) ^b	16.17***
State government credential available	68.63 (35) ^c	96.08 (49) ^b	13.22***
No credential available or required	21.57 (11)	3.92 (2)	7.14**

^a This number includes Louisiana, Massachusetts, and Oklahoma, which have passed laws requiring substance abuse counselor credentials.

^b This number includes New York, which has passed a law instituting and requiring a mental health credential.

^c This number includes Delaware, Louisiana, Massachusetts, and Oklahoma, which have passed laws instituting substance abuse counselor credentials.

** $p < .01$.

*** $p < .001$.

states *require* state government credentials for mental health counselors than for substance abuse counselors. Additionally, significantly more states *offer* a state government credential for mental health counselors than for substance abuse counselors. Finally, significantly more states have no substance abuse counseling credential available or required.

There is some indication that states are increasingly offering and/or requiring credentials for substance abuse counselors. For example, the New Jersey state government began issuing credentials for substance abuse counselors in January 2004 and now requires that all practicing substance abuse counselors be certified by the state. The Massachusetts government is currently implementing a program to license substance abuse counselors; the state is now in the process of grandfathering counselors who had previously been certified by a private organization.

3.2. Credential requirements

When looking at the requirements for state government credentials, we included only the states for which full details of the requirements were available. Because the regulations for the Delaware, Louisiana, Massachusetts, and Oklahoma substance abuse counselor credentials and the New York mental health counselor credentials were not yet fully developed at the time of data collection, these states were excluded from all further analyses. In addition, because we are focusing on state government regulations, we did not include the requirements for any private organization certification, although five states (Florida, Georgia, Illinois, South Carolina, and Wisconsin) required substance abuse counselors to be certified by a private organization. In total, we examined 31 states' requirements for substance abuse counselor credentials and 48 states' requirements for mental health credentials.

Table 2
Percentage (number) of states with minimum degree requirements

Degree requirement	Substance abuse counselor (31 states ^a) [% (n)]	Mental health counselor ^{***} (48 states ^b) [% (n)]
No degree required	12.90 (4)	0.00 (0)
High school diploma or general education development	32.26 (10)	0.00 (0)
Associate's degree	19.35 (6)	0.00 (0)
Bachelor's degree	25.81 (8)	2.08 (1)
Master's degree	9.68 (3)	97.92 (47)

^a This number does not include Delaware, Louisiana, Massachusetts, or Oklahoma; the full details of requirements are not yet available.

^b This number does not include New York; the full details of requirements were not available during the preparation of this article.

*** $p < .001$.

3.2.1. Minimum degree

As illustrated in Table 2, advanced degrees were more frequently required for mental health counselor credentials than for substance abuse counselor credentials, $\chi^2(4) = 63.44, p < .001$. All but one state required a master's degree for mental health counselor credentials, whereas the majority of states required a minimum of a bachelor's degree or lower for substance abuse counselor credentials.

3.2.2. Courses

The minimum number of course hours and course content requirements are presented in Table 3. Although among states requiring a credential to practice, there was no statistical difference in the number of states that require coursework; mental health counselor credentials require significantly more hours of related courses than do substance abuse counselor credentials, $t(77) = -14.72, p < .001$. The results

are similar when we exclude states that do not require related course hours, $t(76) = -14.68, p < .001$.

Table 3 also presents the 13 course content requirement categories in order of decreasing prevalence in states' requirements for substance abuse counselor credentials. A large number of significant differences exist between the courses required for substance abuse counselor credentials and those required for mental health counselor credentials. Drug- and alcohol-related courses, and courses that dealt with case management were more often required for substance abuse counselor credentials. Course requirements for mental health counselor credentials more often included courses on counseling, treatment, and client education; professional ethics, responsibilities, and preparation; screening, assessment, and appraisal; social/cultural foundations and diversity; human growth and development; abnormal behavior and psychopathology; measurement, research, and evaluation; and career and lifestyle development.

3.2.3. Practicum or training

As shown in Table 4, practicum or training hours were required significantly more for mental health counselor credentials than for substance abuse counselor credentials. Although differences in the number of required hours of practicum did not reach statistical significance at the .01 level, the mean difference of approximately 200 hours ($SD = 330.4$ for substance abuse; $SD = 341.7$ for mental health) favors substance abuse counseling credentials over mental health counseling credentials.

3.2.4. Supervised work experience

Table 4 details the number of hours required for work experience. Although an equal proportion of states required

Table 3
Percentage (number) of states with minimum course requirements, by type of counselor

Requirement	Substance abuse (31 states ^a) [% (n)]	Mental health (48 states ^b) [% (n)]	Test statistic
Related courses required	96.77 (30)	100.00 (48)	1.57
Content requirements			
Drug- and alcohol-related	87.10 (27)	18.75 (9)	35.5***
Counseling, treatment, and client education	70.97 (22)	97.92 (47)	12.4***
Professional ethics, responsibilities, and preparation	70.97 (22)	97.92 (47)	12.4***
Screening, assessment, and appraisal	58.06 (18)	95.83 (46)	17.5***
Case management	38.71 (12)	2.08 (1)	18.4***
Social/cultural foundations and diversity	29.03 (9)	85.42 (41)	25.8***
Health issues and diseases	29.03 (9)	4.17 (2)	9.7
Crisis management or intervention	22.58 (7)	4.17 (2)	6.3
Human growth and development	19.35 (6)	95.83 (46)	49.0***
Family and couples therapy	9.68 (3)	18.75 (9)	1.2
Abnormal behavior/psychopathology	6.45 (2)	64.58 (31)	26.2***
Measurement, research, and evaluation	3.23 (1)	95.83 (46)	67.0***
Career and lifestyle development	3.23 (1)	70.83 (34)	34.9***
Hour requirements (15 clock hours = 1 semester hour)			
Mean hours required, all states	317.87	789.38	14.7***

Note. *T* test was used when comparing mean hours required, and chi-square analysis was used when comparing content requirements.

^a This number does not include Delaware, Louisiana, Massachusetts, or Oklahoma; the full details of requirements are not yet available.

^b This number does not include New York; the full details of requirements were not available during the preparation of this article.

*** $p < .001$.

Table 4
Minimum practicum/training hours and supervised work experience requirements, by type of counselor

Parameter	Substance abuse (31 states ^a)	Mental health (48 states ^b)	Statistic
States requiring practicum/training hours [% (<i>n</i>)]	58.06 (18)	91.67 (44)	12.6***
Mean number of hours required	242.26	425.21	2.4*
States requiring supervised work experience [% (<i>n</i>)]	90.32 (28)	97.92 (47)	2.3
Mean number of hours required	3,819.35	2,801.25	2.7**

Note. *T* test was used when comparing mean hours required, and chi-square analysis was used when comparing content requirements.

^a This number does not include Delaware, Louisiana, Massachusetts, or Oklahoma; the full details of requirements are not yet available.

^b This number does not include New York; the full details of requirements were not available during the preparation of this article.

* $p < .05$.

** $p < .01$.

*** $p < .001$.

supervised work experience for substance abuse and mental health credentials, state government substance abuse counselor credentials require significantly more time spent doing supervised work experience than do mental health counselor credentials.

3.2.5. Examinations

Most substance abuse (93.6%)—and all mental health—counselor credentials require candidates to pass an examination. Of those states that require some sort of examination, all require a written examination. However, only two mental health counselor credentials require an oral exam or a case presentation, whereas 61.3% of substance abuse counselor credentials require this type of examination, $\chi^2(1) = 31.49, p < .001$.

3.2.6. Continuing education

Most states require both substance abuse counselors (90.3%) and mental health counselors (85.4%) to take continuing education courses between credential renewal periods. Among states that require continuing education, there is a tendency for substance abuse counselor credentials, compared to mental health counselor credentials, to require slightly more continuing education hours ($M = 27.7$ and $M = 30.8$, respectively), although this difference does not reach the prespecified .01 level of significance. For credentials in both fields, the content of continuing education courses is largely unspecified; however, substance abuse counselor credentials are significantly more likely to require drug- and alcohol-related continuing education courses (16.1% vs. 0.0%). Of the 28 states requiring continuing education for substance abuse counselors, 12 required

professional ethics, 5 required drug- and alcohol-related content, and 2 required social/cultural diversity and health issues. Of the 41 states requiring continuing education for mental health counselors, 17 required professional ethics, 2 required counseling and treatment content, and 1 each required social/cultural diversity, health issues, and screening and assessment content.

4. Discussion

The minimum state requirements to qualify as a substance abuse counselor are quite different from the requirements to qualify as a mental health counselor. For example, 45% of states do not require a college degree to qualify as a substance abuse counselor, whereas 98% of states require a minimum of a master's degree to qualify as a mental health counselor. Furthermore, only half of the states require a credential to qualify as a substance abuse counselor compared to 86% of the states requiring a credential to qualify as a mental health counselor. States required fewer hours of formal classroom education for substance abuse counselors than for mental health counselors; additionally, coursework requirements for mental health counseling were more consistent across states. With respect to supervised clinical experience, states appear to emphasize different types of experience within each field; mental health counselors tend to be required to complete more practicum hours (prior to completion of their degree), whereas substance abuse counselors are required to complete more supervised hours during postdegree work experience. More states require an oral examination of substance abuse counselors compared to mental health counselors. Finally, slightly more hours of continuing education are required for substance abuse counselors than for mental health counselors in those states requiring continuing education.

Differences in the minimum qualifications required by the states for practice in each field appear to reflect their historical contexts. Specifically, addiction counseling can best be categorized as having an apprentice model of training in which the majority of knowledge, skills, and abilities needed to practice are acquired on the job under the supervision of a mentor or a supervisor. The data presented in this article suggest that substance abuse counselors are required to have a mean of approximately 1,000 more supervised work hours than mental health counselors.

In contrast to the addiction field, training in mental health counseling more closely resembles professional training models in the medical and allied health fields. These training models place relatively more emphasis on didactic formal classroom instruction combined with formal structured clinical experiences coordinated by the educational program. Placement of students by educational program directors into supervised clinical experiences creates more opportunities for quality assurance; the quality of placement

experience is at least theoretically monitored by the educational program director.

Both models of training depend on the skills and qualifications of the teachers, mentors, or supervisors. However, in the mental health field, there is greater specification as to what academic or experiential preparation qualifies an individual as a mentor or as a supervisor (West et al., 1999). In the West et al. study of 34 states, 24% made no reference to a requirement for clinical supervision, 38% required clinical supervision but provided no minimum qualification standards for supervisors, 3% required experience, and 3% required both experience and academic preparation without specifying the nature of the experience or the field of academic preparation. Although not systematized, recent evidence suggests that drug and alcohol counselors tend to seek out other more educated and experienced counselors for advice (Moore et al., 2004).

Although there are no empirical data to suggest that one of these models for training is superior to the other, differences in training may have implications for professional development, clinical practice, dissemination of research findings to practice, and management within the service delivery model. These data suggest that most drug and alcohol counselors are not formally trained in the diagnostic criteria for mental health problems; only two states required abnormal psychology as a course, and nine states did not require classes on general counseling, treatment, or client education. Conversely, mental health regulations do not require training in drug and alcohol problems; only nine states require mental health counselors to have a drug/alcohol course. Although 46 states require mental health counselors to have at least one course in screening, assessment, and appraisal, only 18 states require this course of drug and alcohol counselors. Interestingly, drug and alcohol counselors report a need for training in specialized areas such as marriage and family therapy, dual diagnoses, counseling special populations, treatment process variables, and training that leads to credentials (Hall, Shaffer, & Bilt, 1997). Furthermore, these different training models may also result in the use of different terminologies and languages that may in turn create a barrier to integrating these two service delivery systems and to disseminating research findings. At face value, it appears that mental health counselors are closer to being able to address dual diagnoses than are drug abuse counselors. This has implications for the future of the substance abuse treatment field, especially if the move toward integrating substance abuse and mental health services continues.

A second implication of these results is the dissemination of research findings to practice. The traditional method of disseminating research findings comes from the medical and allied health fields; research findings are reported in peer-reviewed journals. Professionals are typically taught how to critically read these journal articles in graduate school. Without graduate school or similar-type courses or experiences, individuals may have greater difficulty deciphering

and appreciating these research findings. Most drug and alcohol counselors have not had the necessary coursework to facilitate a deep understanding of research articles, and results from at least one study suggest that drug and alcohol counselors would agree (Campbell et al., 2003). Dissemination efforts in the addiction field may continue to fail if these differences in training are not acknowledged and addressed. These data highlight the need to not simply assume a “one-size-fits-all” dissemination model, but rather to develop and evaluate different methods of dissemination of research findings for the addiction field. An interesting future direction of research would address what forms of dissemination are effective for the clients, acceptable to the counselors, and useful for administrators.

Once an individual has completed the formal training for the profession and begins practicing within the field, continuing education becomes the only regulation that requires counselors to be formally exposed to new findings and treatments. Although a similar number of states require approximately the same number of hours of continuing education for certification renewal, the content of continuing education hours is largely unspecified. This has implications for practice in both fields. The findings from this study suggest that counselors in both fields are given latitude in deciding what type of information would best inform their practice. In the context of increased caseloads and potential for high burnout, many counselors may opt for home study or workshops that are convenient in time and location, rather than workshops that contribute new knowledge and skills. Therefore, future policy and regulation in both fields suggest careful consideration and possible specification of both the format (e.g., workshops, conferences, and reading articles or books) and the content of these continuing education requirements.

The final implication of these differences in training occurs at the level of the organization and management of health care delivery. Specifically, the organizational culture within drug treatment programs may not adequately support dissemination efforts. In a recent study, only 66% of drug treatment counselors agreed or strongly agreed that administrators support the integration of research and practice (Campbell et al., 2003). Administrators of Veterans Administration substance abuse treatment programs also believe that empirically supported interventions should be implemented, but demonstrate inconsistent knowledge about evidence-based practice (i.e., reported knowledge about some efficacious treatments but not others; Willenbring et al., 2004). In a similar study, McGovern, Fox, Xie, and Drake (2004) found that evidence-based practices were not consistently implemented in substance abuse programs; however, counselors, compared to administrators, appeared more interested in implementing these interventions. Although drug and alcohol counselors are interested in evidence-based practice, they reported time constraints as the most highly ranked barrier to integrating research into practice (Campbell et al., 2003).

If empirically supported treatments are to become commonplace in substance abuse and mental health treatments programs, both counselors and treatment programs will need to change. Because the customary method for disseminating research findings is technical report in peer-reviewed literature, future counselors will need to learn how to critically read and evaluate the findings reported in the literature. On one hand, it is possible that mental health counselors, because of their academic training with required research methods courses, will be prepared for this task. On the other hand, because there are many substance abuse counselors well into their careers who have not had this training, current dissemination efforts must be written and delivered in the appropriate manner so that these counselors can read the material and learn from it. Concurrently, drug treatment programs will need to build professional development time into normal work schedules. However, neither increased dissemination nor additional time for professional development will result in any discernable change or use of empirically supported treatment if programs are not organized and managed to allow counselors to practice newly learned skills and to have professional development be rewarded.

Although these data suggest differences in minimum state requirements for substance abuse and mental health counseling, there are several limitations to the interpretation of these differences. The data reported in this article apply to state regulations only and, therefore, may not reflect the actual credentials and experience of practicing counselors within each field. For example, a 2003 survey of 3,267 substance abuse treatment providers revealed that substance abuse counselors are now more educated and have more certifications and licenses specific to substance use (Mulvey et al., 2003).

In summary, these data suggest vast differences between the minimum required credentials to qualify as a substance abuse counselor and the minimum required credentials to qualify as a mental health counselor at the state level. For substance abuse counselors, compared to mental health counselors, fewer states require certification or licensure; in addition, the states require fewer hours of formal coursework, fewer hours of practicum courses, and more hours of supervised work experience. Whereas 47 states require a master's degree to qualify as a mental health counselor, only 3 require such to qualify as a substance abuse counselor. In essence, training as a mental health counselor reflects an allied health professional model, whereas training as a substance abuse counselor resembles an apprentice model of training. Although there are no data to suggest that one of these models for training is superior to the other, different models may have different implications for professional development, clinical practice, dissemination of research findings to practice, and management within the service delivery model. Future research should focus on how these training models impact various aspects of health service delivery.

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