Addiction Counseling Licensure Issues for Licensed Professional Counselors

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This article addresses the obstacles of effectively integrating addiction counseling into a nationwide definition of professional counseling scope of practice. The article covers an overview of issues, specific licensure and credentialing frameworks (LPC, CADC, LCADC) in two U.S. states, and recommendations to effectively bridge the gap between professional and addiction counseling. Historical origins and an overview of addiction counseling are presented.

Keywords: addiction, licensure, credentialing, LPC, CADC, LCADC

The question of professional identity within the counseling profession, first considered during the founding of the American Personnel and Guidance Association (Sweeney, 1995), still exists today (Calley & Hawley, 2008; Cashwell, Kleist, & Schofield, 2009; Mellin, Hunt, & Nichols, 2011; Myers, Sweeney, & White, 2002; Nassar-McMillan & Niles, 2011; Remley & Herlihy, 2009). One possible reason for the continual debate around professional identity may lie in the multitude of specialty fields (e.g., addiction, career, and school) within counseling (Gale & Austin, 2003; Myers, 1995; O'Brien, 2010). Remley (1995) underscores that unlike psychology, psychiatry and social work, counseling is the only mental health profession that licenses specialty areas. Specialty areas such as career and school counseling only denote a practice area or population; whereas addiction counseling actually entails a DSM-IV-TR Axis I disorder (i.e., Substance Use Disorders; American Psychiatric Association, 2000). No other Axis I or Axis II disorder receives such attention.

Addiction is considered a part of professional counseling as implied by the latest CACREP standards (2009). However, a separate licensure track exists for the profession of addiction counseling. If the practice of addiction counseling really is a part of counseling (as implied by the latest 2009 CACREP standards), then the time has come to *recalibrate* the rest of the counseling profession to better fit an inclusive and unifying professional counseling identity that *includes addiction counseling*. Thus, the purpose of this paper is to start the dialogue regarding the mixed messages on the issue of counselor identity and specialization for addiction counseling (Morgen, Miller, Culbreth, & Juhnke, 2011; Tabor, Camisa, Yu, & Doncheski, 2011). The article is divided into an overview of issues, specific licensure and credentialing frameworks in two sample states (New Jersey and North Carolina), and recommendations in response to the concerns discussed.

Overview of Issues

Henriksen, Nelson, and Watts (2010) criticize the counseling specialty system by arguing that counseling specialties do not define counseling but merely denote a practice area, and that counseling specialty licensure/credentialing implies that only a small proportion of the counseling profession is qualified to work with this population. The addiction area is one such area of specialization that comes with a separate licensure/credentialing process. The authors believe that in regard to addiction counseling, the additional supervisory and training hours required for addiction licensure/credentialing (in addition to the supervisory and training hours required for licensure as a professional counselor) *implies* that addiction

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content falls *outside* the professional counseling scope of practice.

For instance, if the graduate counseling program does not possess an addiction track, a cursory review of curriculum at CACREP and non-CACREP programs found the typical option of *one* addiction course as an elective. However, curricular reviews of numerous programs find few to no electives on other DSM-IV-TR disorders (e.g., mood, anxiety). Thus, the authors argue this produces a confusing mixed message in that licensure as a professional counselor covers practice areas that typically receive minimal *exclusive* attention (e.g., one-week discussion on anxiety disorders in a maladaptive behavior course), yet an area where one (or more) electives are typically offered for in-depth study of a disorder (such as addiction) comes with an entirely unique and separate licensure process.

The presence of a separate licensure/credentialing process for addiction counseling seems antiquated considering the extensive training required for a graduate counseling degree. Furthermore, most states consider addiction work within the professional counselor scope of practice (Tabor et al., 2011). Thus, the pioneering issue this paper addresses is whether it is time to thoughtfully reconsider how addiction is conceptualized in professional counseling (beyond the inclusion in the most recent CACREP standards) and *recalibrate* the education and licensure processes accordingly. In order to begin this dialogue a brief review of the history of the licensure/credentialing process of addiction counselors needs to be provided.

Historical Origins of the Issue

Historically across most states, the advent of addiction counseling licensure/credentialing standards occurred parallel with the professionalization of the counseling field (i.e., the master's-level state licensure laws). States mandated that graduate school-level professionals conduct counseling, leaving many long-time and effective addiction counselors (many of whom possessed only a high school diploma or GED) out of the counseling mainstream. Consequently, addiction licensure/credentialing boards were established to achieve two goals. The first goal was to professionalize the addiction counseling field in a manner similar to professional counseling via mandated supervised practice hours and education across a subscribed addiction curriculum. The second goal was to provide a mechanism to grandfather into the profession those addiction counselors who had long worked in the field and provided outstanding services. Without the grandfather clause, many of these addiction counselors would have lost their profession or would have needed to put their career on pause as they obtained the required education and/or training.

The professionalization of addiction counseling, including licensure and credentialing, strengthened the field and provided a higher quality of care to those struggling with addiction. Unfortunately, a system also was established that over 30 years reinforced the notion that addiction falls outside the scope of practice for professional counseling (i.e., the presence of a separate licensure and certification processes focused on *addiction* counseling). While the addiction counseling field did need professionalization, perhaps the original high standards (e.g. upwards of 3,000 hours of clinical practice with supervision) now require *recalibration* that takes into account a new era where counselor training for those engaged in addiction work extends far beyond a high school diploma or GED.

Professionalization or Deterrent?

The authors' perspective in this paper is that imbedded in the current licensure and credentialing process for addiction counseling is the message that LPCs cannot or should not do addiction work. The message comes from a confusing mixed array of information. Using the graduate trainee (the next generation of counseling professional) as an example, it becomes clear as to how future LPCs may shy away from addiction work. For instance, in the classroom graduate students read about how counseling includes working in the addiction area (as per the latest CACREP standards). Graduate students are trained in a graduate counseling curriculum that offers advanced addiction course electives and the possibility of doing practicums or internships at an addiction facility. Many of these graduate students may even attend school in a state where addiction work is covered in the professional counseling scope of practice. But, these students also see professional counselors with separate addiction licenses (e.g., LPC *and* LCADC) and employment announcements requesting/requiring an addiction license. Even the National Board of Certified Counselors (NBCC) Master Addiction Counselor Credential (MAC) focused on this one DSM-IV-TR disorder class (with no other NBCC credential so narrowly focused on one DSM-IV-TR disorder). Because the student does not see an NBCC credential for mood disorders or sees a licensure for anxiety disorders, the imbedded message is strengthened.

The mixed messages coupled with the burdensome task of meeting the mandates for two professional bodies (professional counseling and addiction) may drive some new counselors from the addiction field. For example, at the end of a panel discussion on this topic at the 2011 American Counseling Association Conference (Morgen et al., 2011), a new graduate of a professional counseling master's program said she would like to start accruing practice hours in a substance use disorders clinic as she had completed some internship hours there and took a course on substance use disorders. However, the facility where she wanted to work required her to obtain an addiction license in addition to her professional counseling license. She subsequently indicated that she did not have the time, money, or the energy to do both and was thus looking outside the substance use disorders field for employment. This anecdote clearly demonstrates how newly graduated counseling professionals (especially those working in the provisional licensure period) may be inhibited from entering the addiction counseling field.

How many qualified, talented and motivated students are we turning away from the addiction counseling field due to these extra training requirements unique to working with the specific DSM-IV-TR Axis I Substance Use Disorder diagnosis at a time when there is an ever-growing need for services (e.g., addiction in returning veterans or the chronically unemployed)? Effective training of LPCs who work with addiction requires coordination between educational training institutions and actual practice that reflects *reasonable* experienced-based requirements for working in the area of addiction as well as *respect* for the graduate-level degree (e.g., master's or doctorate) and training the counselor has already received. Such coordination varies from state to state and without a guarantee of such coordination the danger is that well-intentioned, well-trained counselors will enter the field *technically* qualified to counsel individuals, but *philosophically* lacking the integration of theory and practice necessary for treating addiction. This could mean, for example, that the counselor is more vulnerable to enabling the active addictive process and thereby not providing counseling in the best interest of the client.

In an effort to initiate the dialogue on how to perhaps *recalibrate* the system, it first seems warranted to review the professional and addiction counseling licensure laws and policies within two states. The authors intend to (over the next few years) review the state laws and policies for all 50 states. However, for the purposes of this initial paper, New Jersey and North Carolina will be discussed below.

Specific State Issues

New Jersey

New Jersey operates a professional counseling license (LPC) with a minimum education of a graduate counseling degree, a certified alcohol and drug abuse counselor credential (CADC) requiring a minimum education of bachelor's degree, associate degree, high school diploma or GED, and a licensed clinical and alcohol and drug abuse counselor (LCADC) with a minimum education of a graduate counseling degree and qualification for the CADC. The LPC is governed by the Professional Counselor Examiners Committee (imbedded within the Marriage and Family Therapy Board), whereas the CADC/LCADC is governed by the Alcohol and Drug Counselor Committee.

According to the regulations for professional counseling, New Jersey defines counseling in part as "using currently accepted diagnostic classifications including, but not limited to the DSM-IV" (NJ Board of Marriage and Family Therapy Examiners, 2009, 13:34-10.2, p. 34-22). Substance use disorders fall within Axis I of the DSM-IV-TR, thus work with substance use disorders seems in line with the professional regulations of the LPC. Further evidence of this fact exists within the LCADC regulations (NJ Alcohol and Drug Counselor Committee, 13:34C-2.6, p. 34C-10) that states the following individuals are *exempt* from the LCADC licensure requirement:

> A person doing work of an alcohol or drug counseling nature, or advertising those services, when acting within the scope of the person's profession or occupation and doing work consistent with the person's training, including physicians, clinical social workers, professional counselors, marriage and family therapists, psychologists, nurses or any other profession or occupation licensed by the State, or students within accredited programs of these professions, if the person does not hold oneself out to the public as possessing a license or certification issued pursuant to the Act or this chapter.

As long as an LPC does not advertise oneself as an addiction or substance abuse counselor, they are completely free to practice counseling with individuals presenting with addiction.

However, new counselors and LPCs who wish to accrue hours toward addiction licensure/credentialing face obstacles within the hiring process for addiction-focused positions. For example, despite the clear language in the LPC and CADC/LCADC regulations, advertised positions in the addiction counseling field in New Jersey typically include language stating "actively pursuing CADC/LCADC" or "must hold a New Jersey CADC/LCADC." These requirements (which again, contradict the language of the New Jersey LPC and LCADC regulations) are typically in place due to a mandate of the program funding source (e.g., state or federal). Private practice counselors (who do not operate any funded programs with the above-mentioned requirements) are free to practice addiction work if qualified. However, most (if not all) of the addiction counseling positions where a new professional counseling graduate can accrue hours are housed in some type of treatment facility that very likely must adhere to the LCADC mandate, thereby limiting access to positions for those seeking to accrue LPC hours within the addiction counseling field.

In New Jersey, the typical master's student who wants to accrue hours for licensure as an LPC must produce approximately 4,500 supervised counseling hours. This process comes immediately after the challenging two to three years of graduate study and passing the National Counselor Exam (NCE). However, to obtain the LCADC these students must complete an additional and separate 3,000 supervised addiction counseling hours, 270 clock hours of education focused on counseling and addiction, and 300 hours of supervised practical training in core counseling areas such as screening, intake, assessment, etc. The primary and most time-consuming problem lies in the need to accrue the supervised addiction counseling hours. Since the supervised counseling hours cannot be combined (e.g., there is no language in either the LPC or LCADC regulations permitting *or* denying the "double-dipping" of an hour for inclusion in both the LPC and LCADC hours accrual for licensure; this alone is confusing and indicates a need for clarification), the trainee working towards licensure who wishes to work in an addiction facility must accrue thousands of extra hours or opt to only work towards the LCADC. No other DSM-IV-TR disorder class comes with this burdensome extra mandated training requirement.

Recent efforts to integrate the mental health and addiction licensure processes in New Jersey are in motion, but still in an early phase. Much of this work is coming from a project sponsored by the New Jersey Division of Mental Health and Addiction Services designed to train the next generation of dual-licensed and trained (mental health and addiction) practitioners. However, this need to streamline the process is only present because of the dual licenses already in place. Furthermore, the premise of the program (though an excellent contribution) still propels the notion that addiction falls outside the scope of LPC practice and there needs to be a process to merge the two together. Despite the benefits of this new initiative, the end result is still the same: two different licenses. Again, this is the only DSM-IV-TR disorder that receives this treatment.

North Carolina

North Carolina has a well-coordinated system for addiction counselors. All professionals who want to be licensed to work in the addiction counseling field need to go through the same board, the NC Substance Abuse Professional Practice Board (the Board), which is "recognized as the registering, certifying, and licensing authority for substance abuse professionals" (Practice Act, 2005, Senate Bill 705, North Carolina General Assembly, **§** 90 113.32). One board eliminates competition between boards and the related issues that arise. In fact, the Licensed Professional Counselors Act (LPC law) specifically exempts substance abuse counselors from the counseling law by declaring that nothing in the LPC law "shall prevent a person from performing substance abuse counseling or substance abuse prevention consulting" (NC Board of Licensed Professional Counselors, 2009, § 90-332.1.d). Having one board brings together individuals from various professions in a concerted effort to address the issues related to addiction counseling and to advocate for the field at a state level. This framework has the strength of cooperation between different professional groups and the absence of competition within a state.

This cooperation is enhanced by a *tiered system* (licensure and credentialing). Individuals may apply for licensure as a Licensed Clinical Addictions Specialist. With regard to entry at the licensure level, there are *four main routes or criteria* (Criteria A, Criteria B, Criteria C, and Criteria D). Although initially the system may be confusing to determine the criteria under which one fits, the advantage is that there is greater flexibility for the individual applying for licensure. This

flexibility is the result of minimum requirement variation in the areas of *education*, *training*, *experience*, and *supervision* (Criteria A, B, & C), as well as *professional discipline* (e.g., psychology, social work, counseling—Criteria D). For specific guidelines and clarification of this summary, the reader is referred to: http://www.ncleg.net/EnactedLegislation/Statutes/HTML/ByArticle/Chapter_90/Article_5C.html.

In terms of similarities for the individual applying for licensure, there are *two aspects that remain the same* under *Criteria A, B,* and *C*: the submission of three letters of reference (there is some variation allowed for the individuals who can write these letters) and a passing score on a master's level written examination administered by the Board. The variations under these criteria are as follows. In the area of *education, Criteria A* and *B* require a minimum of a master's degree with a clinical application in a human services field from a regionally accredited college or university. In addition, in terms of *training*, *Criteria A* requires 180 hours of substance abuse specific training from either a regionally accredited college or university, which may include unlimited independent study or from training events of which no more than fifty percent (50%) shall be in independent study. *Criteria C* combines the *education and training* requirement in the minimum requirement of a master's degree in a human services field with both a clinical application and a substance abuse specialty from a regionally accredited college or university that includes 180 hours of substance abuse specific education and training. In the area of *experience*, *Criteria A* requires two years postgraduate supervised substance abuse counseling experience, while *Criteria B* requires the applicant to be certified as a substance abuse counselor. Finally, regarding *supervision*, *Criteria A* requires documentation of a minimum of 300 hours of supervised practical training and provision of a board-approved supervision contract between the applicant and an applicant supervisor, while *Criteria C* requires one year of postgraduate supervised substance abuse counseling experience. *Criteria D* simply requires that the applicant has a substance abuse certification from a professional discipline that has been granted deemed status by the Board (i.e., possession of a certification to practice addictions work under another discipline, such as social work, and that certification is recognized by the counseling board).

Note that the Board also offers numerous credentials through certification for non-master's-level professionals. These include the Certified Substance Abuse Counselor (CSAC), Certified Substance Abuse Prevention Consultant (CSAPC), Certified Criminal Justice Addictions Professional (CCJP) and the Substance Abuse Residential Facility Director (CSARFD) credentials. In terms of the CSAC and the CSAPC, the applicant needs to be of good moral character, not be (or have been) engaged in any practice or conduct that would be grounds for disciplinary action, have a minimum of a high school diploma or a high school equivalency certificate, sign a form attesting to the intention to adhere fully to the Board's ethical standards, and submit a complete criminal history record check.

Additionally, a CSAC who completes a clinical master's degree program in a human services field can seek the LCAS via *Criteria B* as outlined above. This criterion recognizes the fact that the CSAC has already completed a 300-hour supervised clinical practicum and has substance abuse specific work experience. In addition to submitting proof of one's master's degree, all one has to do to obtain the LCAS via this criteria is to submit three letters of reference from LCAS's and/or master's level CSAC's and pass the LCAS examination.

This tiered system allows the counselor to enter the field with or without a masters' degree and allows the master's=level counselor to have an accelerated process if they acquire clinical application experience enhancing the possibility they are both technically and philosophically prepared to work in the addiction counseling field. The requirement of the clinical application experience may be a barrier for some counselors, but the intent is to serve the best interests of the public.

Finally, there is collaboration between the Board and specific university degree programs regarding the type and quality of the courses, thus increasing the chance that counselors are effectively trained to work in the addiction counseling field. While there is not "board approval" on the content areas, programs are approved for addiction counseling. Students who graduate from these master's degree programs may seek the LCAS license via *Criteria C* (outlined above). The Board maintains a current list of school programs approved for application under *Criteria C* on its website: http://www.ncsappb.org/certificationssteve/criteriaschools2.htm.

While North Carolina's tiered system of licensure and credentialing allows for greater flexibility for the individual applying to work in the addiction counseling field, the system can be overwhelming and does contribute to the perception

that addiction counseling is a separate profession with separate education, training, supervision and practice. Kaplan and Gladding (2011), King (2011), and Gladding, Kaplan, Linde, Mascari, and Tarvydas (2011) have advocated along with others about the importance of a unified counseling identity with common skills, training and practice (particularly among counseling specialties).

Recommendations

Overall, there appears to be a need for a *recalibration* of the experienced-based training required for LPCs at a national level that will enhance their entrance into the field of addiction counseling. Currently, states that do not allow for multiple entries into the field have a tiered system of entry, or an approval mandate of the type or quality of the addiction training program, that may inhibit LPCs from practicing in the addiction counseling field. In states where there are significant barriers, professional counselors (fully licensed or in-training) entering the addiction counseling profession with a graduate degree may be required to complete additional training requirements that were created during a time when the addiction counseling professional possibly possessed no more than a high school diploma or GED, and such credentialing requirements (e.g., thousands of supervised hours) were imposed as a mechanism to professionalize the field. Considering the graduate counseling degree (and associated supervised counseling hours) held by a LPC or counselor-in-training accruing licensure hours, these mandates currently seem excessive and possibly even redundant. Presently, the North Carolina system may be one of the few in the United States that provides the fewest barriers for LPCs entering the addiction counseling field.

In the following section, two remedies for the licensure/credentialing problems are presented. Although myriad issues complicate the process (e.g., counselors are called different titles in different states and different state requirements are present for licensure/credentialing as an addiction counselor), the following suggestions in some conceptualization may spur more tangible action. Any formal action should likely come from a national committee set up through the American Counseling Association (ACA) and in conjunction with the ACA addiction division, The International Association of Addictions and Offender Counselors (IAAOC), as well as CACREP, and national bodies such as the National Association of Alcoholism and Drug Abuse Counselors (NAADAC) and the International Certification and Reciprocity Consortium (IC&RC). Committee representatives from these parties could examine the coordination of experience and training. Such a committee could develop guidelines for balancing these concerns for states to use in their individual *recalibration* of requirements.

Possible Solution #1: Nationally Recognized Tiered System of Addiction Counselor Credentialing

One of the difficulties in terms of the current state of addiction credentialing in the U.S. is the absence of uniform national curriculum training standards in the addiction field. Also, there are two main national credentialing groups: NAADAC and the IC&RC. Issues arise because affiliation with one of the two main credentialing groups and credentialing variations between these organizations can result in issues in terms of competition and the nature of the boards and exams required for credentialing. Miller, Scarborough, Clark, Leonard, and Keziah (2010) recommend the following with regard to addiction counseling: (a) portability of credentials, (b) competition reduction between credentialing groups and state boards, (c) national standards for addiction education and training, and (d) a standardized national licensure/credentialing process. Unfortunately, these recommendations have not yet been fully implemented.

One possible solution is to develop a tiered system of addiction counseling credentials at a national level that takes into account professional experience as well as educational training. There needs to be a balance between the idea that anyone with a general counseling degree can do addiction counseling and the idea that only a few select counselors can do the work. Furthermore, this balance should be firmly based upon the ACA Ethical Code that indicates that counselors only practice within their area(s) of competence (2005).

For example, graduates of professional counseling programs (e.g., those working towards LPC status) who have taken a nationally-approved addiction counseling curriculum and have completed practicum/internship experiences could be designated as having addiction credentials in addition to the LPC (i.e., a nationally approved addiction concentration). Therefore, graduate counseling coursework that includes addiction counseling education and practical experiences would enable new graduates to move seamlessly into the addiction counseling profession without the need for additional supervision hours or educational components (i.e., beyond the required supervised counseling hours and educational

components required for the LPC). The system would eliminate the need for a professional counselor to acquire an additional and separate addiction license/certification. In addition, the national standards could promote portability of credentials. This compromise works to maintain the licensed/certified addiction counseling credentials in each state while also providing the LPC with the documented expertise required for many addiction facility positions. This tiered system also could facilitate enhanced training during the process of accruing hours for licensure by better focusing the training hours upon the *interface* between addiction and other mental health issues as opposed to the current parallel and disparate relationship between addiction and other mental health issues.

Possible Solution #2: Nationally Recognized Addiction Counseling Concentration Curriculum

There are issues regarding standardization of training that need to be addressed within the context of academia. In essence, what are the theoretical and practical skills required of an addiction counselor nationwide? There are numerous initial places to look into the process of establishing a nationally recognized addiction counseling concentration, such as the 2009 CACREP standards for addiction counseling and the Center for Substance Abuse Treatment's (2006) *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice.* By using these (and other) standards, all counseling programs (regardless of CACREP accreditation) can follow a standard recommended education experience for students who desire the addiction credential discussed in the first possible solution. Curricular issues would likely include standalone addiction courses, infusion of addiction content into other courses, faculty expertise in the addiction area and practicum and internship hours focused on addiction counseling practice.

In addition, the NCE and National Clinical Mental Health Counselor Examination (NCMHCE) would require some *recalibration* to take into account the curricular changes to a professional counseling education that includes the addiction counseling concentration. One caution is that any discussion of these and other training issues may produce opposing forces within academia, the counseling profession, the addiction counseling profession, state licensing/credentialing boards (both professional counseling and addiction) and individual counselor education professors and college/university departments. Again, that is why a national committee comprised of all involved parties is necessary to navigate this challenging process.

Concluding Comments

Two students graduate with a master's degree in counseling. Both took elective courses in their area of interest; one in mood disorders, the other in addiction, and both did an internship in a counseling setting focused on their interest area. Upon graduation, the student with an interest in mood disorders can easily be brought onto the clinical roster of a mood disorders clinic and immediately start accruing hours towards licensure. Their provisional license is all that is required during the training period. Unfortunately, the graduate with an interest in addiction may face competing licensure and/or credentialing requirements between professional and addiction counseling, mandated extra training coupled with thousands of extra supervised hours, and/or the possibility of a denial of employment without the appropriate addiction credential.

The purpose of this article is to start the dialogue on how to effectively incorporate addiction counseling into the scope of practice and accepted role of the professional counselor. We firmly believe that effective counseling focused on addiction issues requires specific and rigorous counselor training. However, we also believe the current national practice of training and credentialing for addiction counseling must change. State-by-state, burdensome (and in some instances outdated) rules and regulations are keeping countless qualified, capable, and motivated counselors from entering the addiction field. The time has come to recalibrate the rest of the counseling profession to better fit an inclusive and unifying professional counseling identity that includes addiction counseling.

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