

Addiction Counseling Accreditation: CACREP's Role in Solidifying the Counseling Profession



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In this article, the authors discuss the Council for Accreditation of Counseling and Related Educational Programs' (CACREP) role in furthering the specialty of addiction counseling. After sharing a brief history and the role of counselor certification and licensure, the authors share the process whereby CACREP developed the first set of accreditation and educational standards specific to addiction counseling. The impact of CACREP on the practice of addiction counseling, quality control, and implications for the future are provided.

Keywords: addiction counseling, educational standards, CACREP accreditation, certification

Whereas counseling as a profession is relatively new (compared with the other helping professions of psychology, psychiatry, and social work), it has made great strides in a relatively short time. With the adoption of the 2009 Council for Accreditation of Counseling and Related Educational Programs (CACREP) Standards, changes in professional identity, specialty areas of practice, core curricular standards, clinical field experiences and measures of student learning outcomes likely will have long-reaching impacts on promoting the development of the counseling profession. One significant change in the 2009 CACREP Standards was the creation and inclusion of a set of specialty standards related to addiction counseling. Whereas individual standards related to the *practice* of addiction counseling have been around for many years (e.g., those of the National Board for Certified Counselors' [NBCC] Master Addictions Counselor [MAC] certification), this is the first time that an accrediting body of the helping professions has both legitimized and standardized the preparation of counselors to work with clients struggling with addictive disorders. In this article, we explore the history of addiction counseling, as well as the development of the credentialing and certification processes related to addiction counseling. Next, we examine the need for educational standards related to addiction counseling and CACREP's role in the development of these standards. Finally, we will conclude with potential implications and directions for future research.

A Brief History of Addiction Counseling

The prevalence and impacts of addictive disorders are well documented and provide a context for the rationale for the creation of an addiction counseling specialty. In terms of those affected by addiction, 22.6 million individuals struggle with chemical abuse or dependency (Substance Abuse and Mental Health Services Administration [SAMHSA], 2007), 14 to 26 million individuals suffer from an eating disorder (also known as food addiction) (APA, 2000; Hudson, Hiripi, & Pope, 2007), 6 to 9 million struggle with compulsive gambling (also known as gambling addiction) (APA, 2000), 17 to 37 million Americans meet criteria for sexual addiction (Carnes, 2001; Cooper, Delmonico, & Burg, 2000), and 17 to 41 million people are addicted to the Internet (Kaltiala-Heino, Lintonen, & Rimpelä, 2004). In considering the lower end of each range of these disorders, it becomes apparent that approximately one in four Americans struggle with some kind of addictive disorder; this number fails to account for those impacted vicariously (i.e., through the addiction of a family member or close friend). Given the noted prevalence figures, it should come as no surprise that research has shown that addictive disorders, and complications related to these disorders, have devastating impacts on individuals, families, and society (French, Roebuck, McLellan, & Sindelar, 2000; Goodman, 2001; National Institute on Drug Abuse [NIDA], 2004;

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National Opinion Research Council [NORC], 1999; Young, 1999). In fact, when one tallies the estimated costs and losses attributed to addictive disorders in the form of health care costs, job productivity losses, crime and punishment, mental health care, impacts on the children and partners of addicts, and monies spent on the pursuit of drugs, alcohol, and other behaviors, one conservative estimate puts the annual total at \$1.1 trillion dollars (Juhnke & Hagedorn, 2006). Without a group of specially trained counselors, untreated addictive disorders will continue to perpetuate costs that many are unable to pay.

Those individuals who emerged to address the aforementioned concerns did not initially matriculate from graduate programs in the helping professions. In fact, no other counseling specialty has been more closely associated with its “recovering” clients than has the addiction field. The origins of addiction treatment come straight from what is referred to as the “lay therapy” movement of the early 1900s (White, 1999). Courtenay Baylor is considered by many to be the first lay therapist to be hired at the treatment clinic in which he was originally a client. His approach to developing a cadre of addiction treatment providers from individuals who had participated in the treatment process became the norm well into the 20th century and laid the groundwork for the concept of *wounded healers* (Jung, 1993; White 2000b). The wounded healer approach became a much stronger influence with the development of Alcoholics Anonymous in the 1930s. Many members of AA began developing clubhouses, “retreats” (known as halfway houses today), and treatment centers (White & Kurtz, 2008). Much of the motivation of AA members providing such services for alcoholics resulted from a general negligence toward these individuals by the medical and mental health communities (AA, 1976).

By 1950, paraprofessional helpers/lay therapists were firmly entrenched in the community of addiction treatment, with the pre-eminent model of treatment, the Minnesota Model, drawing heavily on professionals with no formal training in the helping professions (Fisher & Harrison, 2009; Libretto, Weil, Nemes, Copland-Linger, & Johansson, 2004). Following the adoption of the American Medical Association’s disease concept of addiction in 1967 (Merta, 2001), the latter half of the 20th century produced several additional steps in the treatment process for addicted clients. Formalized training programs were created by both the National Institute for Alcoholism and Alcohol Abuse (NIAAA) and the National Institute for Drug Abuse (NIDA) in the 1970s to create a group of professionals to work with addicted clients using the disease concept, in conjunction with the Minnesota Model, as the primary treatment approach (White, 2000a). Then, during the 1980s, a shift occurred where formally educated and trained professionals began entering the treatment realm, especially from the field of counseling. These individuals stood by their education and training, rather than their recovery status, as the basis for legitimately providing treatment (Hosie, West, & Mackey, 1988). What emerged was a blending of three distinct groups: minimally-educated paraprofessional helpers (with recovery as their entry point into the treatment community), master’s level counselors (without recovery status as their entry point), and a hybrid of the two: master’s level recovering counselors (Culbreth, 2000). The intersection of helpers entering the treatment arena from these three different perspectives, each with varying levels of experiences related to addiction, led to debates regarding what type of helper was best suited to work effectively with addicted clients—lay or professional helpers.

More recently, important developments in addiction treatment have evolved. For example, new treatment paradigms such as *harm reduction* and *relapse prevention* examine addiction from perspectives different from those perpetuated by earlier models (e.g., reducing negative impacts rather than solely focusing on abstinence) (Fisher & Harrison, 2009). Similarly, considering the challenges involved with the change process, Prochaska, DiClemente, and Norcross (1992) developed a stage model (the transtheoretical model of change) to examine the processes that occur in clients’ behaviors as they enter recovery while offering suggested strategies aimed at counseling them within and through each stage. Then, *motivational interviewing* was developed to help explore and resolve the ambivalence and resistance experienced by those entering recovery (Miller & Rollnick, 2002). Another major development, that of viewing addiction through the lens of dual diagnosis (or co-occurring disorders) has been a significant step in addressing clients with multiple mental health issues and needs. More recently, the recognition of a variety of process addictions (addictions to such things as sex, gambling, the Internet and gaming) has taken the concept of addiction to a different level, beyond the traditional scope of chemicals. Finally, there have been significant advances in psychopharmacological approaches to addiction, along with manualized treatment approaches from specific theoretical perspectives, such as Project MATCH (Merta, 2001).

All of the aforementioned developments have led to the need for a much higher level of training and education for professionals intent on working with addicted individuals. Relying solely on one’s recovery status can no longer adequately prepare a counselor to address the myriad of complex issues brought forward by today’s clients. More

sophisticated and in-depth education and clinical training is needed to insure that addicted clients receive the most efficacious treatment possible—hence the purpose for the creation of addiction counseling accreditation standards. On the road toward the creation of such educational standards, the helping professions began seeking standardization through the establishment of formal credentials and licensing.

History of Addictions Credentialing

As noted earlier, addiction counselors traditionally entered the field from a great diversity of backgrounds. As a result, debates ensued as to what best qualified one to be an addiction counselor. White (1999) stated: “Because so many of the grass roots treatment models utilized people in recovery who often had more prior contact with penal institutions than educational institutions, the challenge was how to prepare and professionalize this indigenous workforce while blending it with a growing array of other professionals entering the field...” (p. 25). At that point in time, many addiction counselors had only their own sobriety as a qualification to provide treatment. Unfortunately, the term “counselor” often was used to refer to these paraprofessionals to distinguish them from trained and licensed mental health professionals (i.e., psychiatrists, psychologists, and social workers).

It was in this historical context that a small group founded the National Association of Alcoholism Counselors and Trainers (NAACT) in 1972. This group later evolved into the National Association of Alcoholism and Drug Abuse Counselors (NAADAC) (White, 2005). NAADAC enhanced the professionalism of addiction counselors by establishing ethical standards for addiction counselors, disseminating information via professional publications, and providing ongoing training and credentialing activities (White, 1999). At about the same time that NAADAC was moving forward, two events were unfolding that would further shape credentialing and training efforts. First, the Association for Counselor Education and Supervision introduced the first set of counselor preparation standards (Association for Counselor Education and Supervision, 1973). Ultimately, this led to the establishment of CACREP in 1981 to promote quality counselor preparation at the graduate level. Second, privatized certification boards began emerging at the state level (Mustaine, West, & Wyrick, 2003). A dynamic tension manifested within these state certification boards in regards to reluctance among some within the field to require formal graduate training. Into this mix, the National Board for Certified Counselors (NBCC), NAADAC, and the Commission for Rehabilitation Counselor Certification (CRCC) worked together to establish the Master Addictions Counselor (MAC) credential, a credential that provided addiction counselors with a uniform credential regardless of their original discipline (Juhnke, 2000).

Several rationales exist for the continued shift toward credentialing graduate-level clinicians. First, and most pointedly, researchers have found that effective counseling with addicted clients requires specialized training and that professional counselors trained in academic graduate programs are more effective than their less educated counterparts (Carroll, 2000). Whereas many clinicians have sought to fulfill state certification requirements through workshops or seminars, the certification requirements offered therein are typically based on the number of attendance hours and have little to no assessment of content knowledge or mastery (Mustaine, West, & Myrick, 2003). Another reason for credentialing master’s-level clinicians is that they are better prepared than their lay counterparts to meet the multiple needs of addicted clients (Sias, 2002). Lay practitioners are often solely trained to address issues of chemical abuse and dependence (Banken & McGovern, 1992; Taleff & Martin, 1996), and thus lack the fundamental knowledge and skills required of professional counselors to address concomitant needs beyond chemical abuse. With the growing recognition of the prevalence of co-occurring disorders among clients with addictive disorders, as well as the familial impacts of addiction, the need for trained mental health professionals to treat these concerns has become increasingly important (Merta, 2001; Schulte, Meier, Sterling, & Berry, 2010).

Third-party reimbursement requirements add a third reason for the lean toward graduate-level addiction counselors. Whereas state-based addiction counseling certification boards do not require a graduate degree, insurance companies *have* moved to such a requirement in order to receive reimbursement (Mustaine et al., 2003). A final reason for graduate-level counselors is provided by Mustaine et al., who noted that state-based addiction counseling certification boards have traditionally required no direct observation of addiction counselors by their supervisors (e.g., through audiotape, videotape, transcript, or live observation). Accordingly, it is possible that all supervision can, in theory, be based upon supervisee self-report, a process known to be particularly problematic with novice supervisees (Campbell, 1994;

Holloway, 1988; Muslin, Thurnblad, & Meschel, 1981). Given the potential for problems evolving from inadequately trained and supervised addiction paraprofessionals, the rationale for graduate training is clear.

Given the call by national certifying bodies (e.g., NBCC, NAADAC, CRCC) for more adequately prepared clinicians, individuals were faced with the choice between seeking such training through educational institutions or continuing to rely upon the seminar or self-education model. Unfortunately, many who sought such initial training through a graduate program in the helping professions found that the majority of such programs were woefully unprepared to deliver the necessary addiction-related content they required (Whittinghill, Carroll, & Morgan, 2004).

Establishing a Need for Educational Standards Related to Addiction Counseling

The need for a set of standardized educational requirements for addiction counseling is evident in light of the societal impacts of addictive disorders, the treatment complications engendered by co-occurring disorders, and the lack of standardized preparation standards for addiction counselors. There has been ongoing recognition within the counseling field of just such a need. For example, Morgan and Toloczko (1997) noted more than 14 years ago that trained and educated addiction professionals were needed to help combat the problems created by untreated addictions. Other studies have investigated the perceived need for training standards in addiction counseling among counselor educators (Whittinghill, Carroll, & Morgan, 2004), have identified curriculum components for graduate-level training of addiction counselors (Whittinghill, 2006), have examined the relationship between addiction training in counselor education programs and state licensure requirements (Mustaine, West, & Wyrick, 2003; Salyers, Ritchie, Cochrane, & Roseman, 2006), and have directly called for the inclusion of addiction counseling standards to meet the multiple needs of addicted clients (Hagedorn, 2006; 2007). Many authors have followed suit (Hagedorn & Young, 2011; Hagedorn, 2007; Horvatic & Wergin, 1998; Merta, 2001; Miller, Scarborough, Clark, Leonard, & Keziah, 2010; Robertson, 2006; Whittinghill, Carroll, & Morgan, 2004), noting the need for specialized educational standards not only for those who counsel addicted clients, but for all counselors regardless of their area of specialization.

Given the aforementioned needs, it is somewhat surprising how the helping professions have answered the call. In reviewing the professional preparation standards of the various accrediting bodies, it becomes apparent that standards specific to training students to work with addictive disorders have not been a focus. For example, the Council for Social Work Education (CSWE) does not have any specific accreditation standards for training social workers to address problems related to addiction (CSWE, 2010). Similarly, the standards of the American Psychological Association's Commission on Accreditation (CoA) for professional psychology specifically states that program objectives for professional psychology should be "broad and general" (CoA, 2007, p. 2) in nature. To wit, practice areas described for professional psychologists include clinical psychology, counseling psychology, school psychology, and other areas of professional psychology, with no mention of an addiction practice area, nor any standards specified to psychological work with addicted clients (CoA, 2007). Whereas the Accreditation Council for Graduate Medical Education (ACGME) *does* have specific training standards for psychiatrists working with addicted patients, (a) *all* of those standards are specific to those programs that train addiction *specialists* (i.e., they are not for the general training of psychiatrists who see addicted clients in a variety of treatment settings) and (b) no standards include any reference to process addictions (ACGME, 2003).

Given the lack of other professions' preparation standards specific to working with addicted clients, how has counseling fared? CACREP has made efforts at establishing minimal educational standards related to addiction counseling (such as those found in the 2001 CACREP Standards), yet these were traditionally relegated to those graduate programs with a more clinical focus (e.g., mental health counselors). Thus, students matriculating from other specialties (e.g., school counseling, marriage and family counseling, etc.) have continued to be unprepared. Even when research and clinical practice have indicated the treatment complications produced by the co-morbidity and coincidence of addiction with just about every other presenting concern (e.g., relational difficulties, depression and anxiety, unemployment, school truancy and behavioral problems, impacts of abuse/neglect, domestic violence, low self-esteem, career indecision, legal concerns) (Burrow-Sanchez, Lopez, & Slagle, 2008; Davis, Flett, & Besser, 2002; Fergusson & Boden, 2008; Florida Council on Compulsive Gambling, 2004; Hussong, Galloway, & Feagans, 2005; Ohlmeier, et al., 2008), there has continued to be a lack of training *across* the helping disciplines (e.g., social work and psychology) and *across* specialty

areas within counseling itself (e.g., school counseling, marriage and family counseling, student affairs and college counseling, career counseling).

There may be several reasons why those entities that set the educational standards for their professions have been reluctant to create a set of specialty standards and/or to mandate the inclusion of core curricular experiences related to addictions. Whereas a full discussion of these reasons is beyond the scope of this article (for a detailed description, see Hagedorn, 2009c), some reasons may include (a) the lack of established diagnostic criteria for disorders related to behaviors or processes (e.g., sex, the Internet, gaming); (b) the lack of consensus as to the interconnectedness of addiction and other presenting concerns; and/or (c) the belief that addictions, and the problems they cause, are the treatment responsibility of those who have traditionally been prepared to address them. In response to these areas of potential “push back” from some in the field, there is evidence in the professional literature that (a) diagnostic criteria for process addictions are on their way into the treatment community, (b) the research shows a clear connection between addiction and other concerns, and (c) addiction, and its associated problems, will impact all clinicians regardless of their scope of practice (Hagedorn, 2009c; Kafka, 2010; Robertson, 2006).

Potentially, an additional reason why accrediting bodies may have steered clear of establishing addiction-related standards across the curriculum may be the belief that those who work with addicted clients (and/or those affected by addicted individuals) will obtain the necessary competencies through on-the-job training or through training seminars, workshops, and professional conferences. As noted earlier, the problem with such expectations is that (a) this necessitates that counselors be proactive and motivated to seek out such opportunities, (b) credit for such endeavors is granted by simple *attendance* at such events (rather than as a result of a formal evaluation of knowledge and/or skills as would be found in an educational institution), (c) there is no way to determine the accuracy, timeliness, or quality of the content presented by such delivery methods, and (d) not all counselors will attend the same seminar, resulting in a variety of competency levels (Hagedorn, 2009b; Mustaine, West, & Wyrick, 2003). Clearly, a more standardized delivery method will result in more comparably trained counselors to work with those people impacted by addictive disorders.

Having set the stage for the historical need for educational standards related to counseling those impacted by addictive disorders, we now turn to the direct impact that CACREP has had on the emergence of such standards. Beginning with an introduction to the atmosphere that precipitated the creation of these standards, we will follow with a description of the procedures undertaken by CACREP to ensure the integrity and quality of the creation and revision processes. We then conclude with a brief review of the implications of these standards for the counseling profession and a call for empirical research to substantiate the impacts of a trained and prepared cadre of professional counselors on the lives of addicted clients and their families.

The Impact of CACREP on the Practice of Addiction Counseling

In moving forward with the development of the 2009 CACREP Standards, the CACREP Board (“the Board”) and the CACREP Standards Revision Committee (SRC; a committee external to the Board, charged with overseeing the revision process and presenting standards for consideration and adoption by the Board) were very intentional about maintaining those procedures dedicated to the highest quality of output while remaining open to its constituents. Preserving a transparent agenda, the SRC and the Board began the revision process with a scan of the counselor education horizon as it related specifically to the addiction counseling standards.

Watching the Horizon

Four factors helped trigger the decision to proceed with the drafting of a specific set of addiction counseling standards. First, as noted earlier, there had been a consistent call from the counseling literature for CACREP to establish a set of standards related to addiction counseling (Diaz, 2008; Hagedorn, 2009c; Morgan & Toloczko, 1997; Salyers, Ritchie, Cochrane, & Roseman, 2006; Whittinghill, 2006; Whittinghill, Carroll, & Morgan, 2004). Second, on a national scope, two events were occurring: (a) states continued to move toward the mandate of a master’s degree for addiction counselors and (b) there were a number of non-accredited addiction counseling programs that existed alongside CACREP-accredited programs in community or mental health counseling (Hagedorn, 2006; Salyers, et al., 2006). Third, the International

Association of Addiction and Offender Counselors (IAAOC) had commissioned an Addiction Standards Committee (ASC) with the task of drafting a set of addiction counseling standards. Members of the ARC included David Whittinghill, Gerald Juhnke, and Kenneth Coll, the three of whom drafted the initial set of addiction counseling standards. These were later reviewed and modified by ARC members Rick Gressard and W. Bryce Hagedorn. Finally, the CACREP standards themselves were poised for their regular seven-year revision process. Given the confluence of these events, the time seemed ripe to determine if the Standards accurately reflected the current type of work done by counselors in all realms of practice, as well as for the inclusion of content specifically related to addiction counseling.

Quality Control

Since an exploration of all aspects related to the development of the 2009 CACREP Standards is beyond the scope of this article, our focus will be on a quick review of the processes that occurred related to the *addiction* counseling standards. Activities to solicit feedback, including solicitations via the Internet (cacrep.org, acesonline.net), in print (e.g., the *CACREP Connection, Counseling Today*), and in person (e.g., the American Counseling Association [ACA] National Conference, the Association for Counselor Education and Supervision [ACES] National Conference, and the regional ACES conferences, among others) occurred following the national distribution of each of the three drafts of the proposed 2009 Standards. The initial call for input from the field, particularly as it related to the area of addiction counseling, was answered by the IAAOC Board in January of 2006, who presented the work of the Addiction Standards Committee to the CACREP Board and the SRC for consideration.

Formal work by the SRC began earlier the preceding year, with focus given to the writing of addiction counseling standards beginning in 2006 (after receiving the suggested IAAOC standards). Based upon the CACREP Board's review of the counseling literature and the initial input of constituents, the Board charged the SRC with two related responsibilities: create a set of addiction counseling specialty standards *and* infuse content related to addiction into the core curricular standards (thus introducing such content into the preparation of all counseling students). Pending feedback received from the various drafts disseminated to the public, the SRC adjusted this charge as it deemed necessary.

In the drafting of the CACREP standards related to addiction counseling, the SRC gathered the timeliest, most relevant, and most well-documented sources available. These sources included (a) the IAAOC Addiction Standards; (b) the 1998/2005 Technical Assistance Publication (TAP) Series #21 titled *Addiction counseling competencies: The knowledge, skills, and attitudes of professional practice* (Center for Substance Abuse Treatment, 2006); (c) standards related to NAADAC's National Certified Addictions Counselor credential; and, (d) standards related to NBCC's Master Addictions Counselor credential. In the first disseminated revision of the 2009 Standards, the SRC initially integrated addiction content into the CACREP standards for the new and soon-to-be designated *Clinical Mental Health Counseling* specialty. In receiving feedback from the counseling field, the SRC returned to work and redesigned a specialty area dedicated specifically to addiction counseling. During the gathering of feedback based upon the second and final drafts of the Standards, CACREP's constituents provided only favorable comments about the new specialty area. Then, as a response both to the literature (e.g., Armstrong, Phillips, & Saling, 2000; Hagedorn, 2009c; Goodman, 2001; Merta, 2001; Potenza, Fiellin, Heninger, Rounsaville, & Mazure, 2002; Young, 1999) and the field calling for more inclusive terminology to describe the complex nature of addiction counseling, language found in the Standards related to *substance use disorders* (SUDs) and/or *chemical abuse/dependence* was broadened and substituted with the term "addictive disorder," as this was determined to be the most encompassing designation.

The final set of events germane to the current discussion involved the infusion of content related to addiction counseling into the core curricular standards. The SRC (and the resulting feedback from constituents) agreed that the most obvious fit would be in the curricular standards related to human growth and development (Standard II.G.3.g.). This resulted in required curricular experiences related to the "theories and etiology of addictions and addictive behaviors, including strategies for prevention, intervention, and treatment" (CACREP, 2008, p. 11). Whereas this may seem like a minor adjustment to the core curriculum, the fact that all future CACREP-educated counselors would be exposed to information regarding the impacts of addictions and addictive behaviors, as well as the necessary prevention, intervention, and treatment methods, may well have long standing and positive impacts on the counseling profession. We explore additional potential implications below.

Implications and Directions for Future Research

Whereas it may be too early to measure the direct implications of the aforementioned processes on the delivery of counselor education (and the resulting influence on those affected by addictive disorders), it is important to note here that three important and interrelated elements occurred in the adoption of the 2009 CACREP Standards. First, among the helping professions, CACREP became the first accrediting body to formally establish a set of national educational standards related to addiction counseling. Whereas psychiatry may have a specialty in addiction medicine, the fact that social work and psychology have no such specialty puts counseling at the forefront of providing direct care to the millions impacted by addictive disorders. Future research that investigates such things as the impact of the counseling profession itself (e.g., in comparison with other professions) on the provision of therapeutic services for addicted clients would thus be in order.

Second, in noting the interconnectedness of addictions with other client concerns, CACREP became the first accrediting organization that strongly advocated for the inclusion of addiction-related content knowledge for *all* students, regardless of their scope of practice. The importance of this change cannot be understated: the fact that all future counselors will be at least minimally prepared to recognize the origins of addictive disorders (i.e. etiology) as well as be able to implement prevention, intervention, and treatment strategies is significant. The counseling profession is poised to deliver the crucial front-line interventions to struggling clients in all arenas.

CACREP took a bold professional stance by recognizing that addictions occur outside the context of chemical dependency: this is the final paradigm shift ushered in by the 2009 standards. By (a) broadening the terminology used in the 2001 Standards (which was specific to *substance abuse*) and including language related to *addictive disorders*, *addictive behaviors*, and *process addictions*, as well as (b) providing glossary definitions for *process addictions* (those related to addictions like gambling, shopping, eating, and sex), the counseling profession is potentially the forerunner of a new form of treatment delivery. This truly represents a monumental step toward preparing competent clinicians to work with those impacted by disorders that other accrediting bodies and even the medical community have been slow (some may say “careful”) to officially recognize. As future clients make decisions about from whom they will seek treatment, they will choose the most qualified clinicians; changes such as those mentioned here only solidify their choice of a *counselor*.

In noting the aforementioned decisions induced by the adoption of the 2009 Standards, several implications for future research become evident. First, it will be important to investigate the various impacts of the creation of specialty standards related to addiction counseling on students, graduates, clients, client families, addiction counseling delivery systems, third party reimbursement strategies, and even policy development. Second, similar systems could be evaluated (e.g., students, clients, policy development) following the establishment of a counseling workforce that has been adequately prepared to prevent, intervene and treat addiction-related problems wherever they arise, be it in schools, hospitals, clinics, vocational settings, families or universities.

A final implication of the 2009 standards is best framed as a question: What might occur as a result of a profession officially recognizing and advocating for clients whose struggles and concerns have traditionally been left outside of the treatment realm (e.g., sexual addiction, gaming addiction, etc.)? The *potential* implications on a societal level could be quite remarkable. For example, studies could compare the effectiveness of those clinical mental health counselors trained to recognize the impacts of sexual addiction with those without such training; this may have the potential of lowering sex-related offenses if clients are identified and treated earlier in their addictive cycle before they offend. Marriage and family counselors also could be investigated related to how well they identify family dysfunction and debt-related concerns as a result of addressing a member’s spending addiction. Finally, studies might pursue the impact of school counselors prepared to identify and address gaming addiction on their students’ academic achievement and lowered behavioral referrals.

To conclude, the authors contend that the shared focus, determination and alliance among the CACREP Board, the SRC members, and the involved constituents will help strengthen the counseling profession and help it to forge ahead into the 21st century. More specifically, we believe that the work accomplished by the standard revision process related

specifically to addiction counseling will help place counseling at the pinnacle of the helping professions and look forward to witnessing its impacts on future students and the clients they serve.

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