Welcome to the Addiction Educator!
The publication for Addiction Professionals who teach in academia.

Submission Guidelines

Author Guidelines For Addiction Educator*
Articles submitted to Addiction Educator should focus on teaching in the addiction studies. Therefore, articles can address teaching methods, techniques, strategies, approaches, systems, etc.

Articles selected for publication will be posted on the Addiction Educator website. The article then becomes property of INCASE (International Coalition of Addiction Studies Education). Authors will be asked to sign a release verifying that their article is now property of INCASE.

Manuscript Preparation
Feature article submissions generally range from about 1,200 to about 2,000 words in length, with column submissions, teaching tips and updates generally ranging from 700 to 1,200 words. Letters to the editor should be no longer than 300 words. Please do NOT imbed tables, figures, or other illustrations within the text of your article (see “Graphic Elements” guidelines below).

News and faculty updates will be edited and published as space allows.

Manuscript Submission
Submit articles electronically to mgtasmith@gmail.com, raven8moon@yahoo.com and acavaiol@monmouth.edu. Please send files as attachments saved in Microsoft Word. Include at the bottom of the article file a “bio” of two to three sentences for each author, along with the e-mail address of the lead author. We publish the e-mail addresses of our authors so that readers may have the opportunity to offer authors direct feedback on the article.

In your e-mail message with the article attachment, be sure to include your mailing address, phone and fax numbers, and e-mail address so that we may contact you during the editing process.

Graphic Elements
If photos, tables, or other graphics are sent electronically, each should be sent as a separate file from the article file. Figures and photos MUST be saved in a high-resolution (minimum 300 DPI) TIFF or EPS format to ensure publication-quality images.

If you cannot send your graphics electronically, you may send hard copies suitable for scanning, such as original photographs, photograph-quality prints (especially for color illustrations) and high-resolution computer printouts (for black and white figures and graphs only).

All photographs should be identified with a suggested caption. The captions should include the names of people shown and the location of the shot, if pertinent. If a photograph is copyrighted, the photographer or photography firm’s name also must be included so that we can give proper credit. It is the author’s responsibility to secure appropriate consents from people shown in photographs, and permission to reprint copyrighted photos. If you wish to have photographs returned, request this in your cover letter and include the proper return address.

Tables should be double-spaced and numbered consecutively in the order in which they are mentioned in the text of the article. Provide a brief title for each. Figures or graphs also should be numbered consecutively in the order in which they are mentioned in the article.

References
A list of references or a bibliography may be included, using standard APA.

Where to Submit
Electronic submissions should be e-mailed mgtasmith@gmail.com, raven8moon@yahoo.com and acavaiol@monmouth.edu

*Article guidelines are borrowed and revised from the ADDICTION PROFESSIONAL.
Dear INCASE members,

Once again, a very busy and productive year with INCASE! INCASE did celebrate its 25th anniversary at the NAADAC conference in Washington, D.C., on October 9-13, 2015. INCASE received a special award from NAADAC in honor of its 25th anniversary, and we had several successful presentations at the conference.

We are in the planning stages for an international conference in August of 2017, more information will be forthcoming as plans are firmed up. Please contact Joan Standora for more information. The NAADAC/INCASE 2016 conference will be held in downtown Minneapolis, Minnesota at the Hyatt Regency Minneapolis. The dates are October 7-11, 2016, with the INCASE board meeting on Thursday October 6th prior to the conference.

My priority during this final year as president of INCASE will be the connection of the SAMHSA career ladder to NASAC accreditation and nationwide licensure. One might ask how this is part of what we do as education professionals within INCASE as a whole. The connection is that our students are released to a crazy patchwork quilt of licensure (and certification) standards when they leave our educational programs. Should we move forward with this process, my ultimate goal is that students, upon graduating from our programs will have no trouble becoming licensed in any state in the U.S. (perhaps someday even internationally).

The NAADAC magazine published an article from me concerning this vital topic, a topic that if it is not addressed soon, could lead to the dismantling of our profession in the 23 states which do not have an addiction specific licensure. The lack of a unified national standard (here I am submitting a proposal that the TAP 21 competencies become the guiding force, layered within the SAMHSA career ladder) that retains regional flexibility, but ease of reciprocity, is holding us back as a profession. INCASE educators are uniquely positioned to assist states in setting appropriate educational standards within this type of highly flexible framework.

I am convinced that we will indeed move forward in lockstep with our counselors, accrediting bodies, educational institutions and licensure boards into a highly professionalized future for the Addiction Profession. Thanks and have a great Summer!

Sincerely,

John Korkow, LAC, SAP, Ph.D.
President of INCASE
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Interventions and Their Role in Addiction Treatment

Addictions treatment has come a long way since Vern Johnson (1973) published his classic, I’ll Quit Tomorrow. In that tome, chapter 5 “The Dynamics of Intervention,” to be precise, he outlines how to conduct what he refers to as an intervention. His thoughts on facilitating change—and this is admittedly a brief, almost passing overview—was that someone with alcoholism did not usually “quit” as the result of a single, large, life-threatening event. Rather, it is numerous smaller confrontations or “untoward consequences” resulting from continued use, often involving family and significant others that result in reaching a point where it becomes clear that, paraphrasing Fr. Joseph Martin (1989), what causes a problem is a problem when it causes problems.

Johnson advocated conducting interventions were family and significant others would gather, unbeknownst to the addicted individual, to present their concerns about the individual’s use behavior, albeit in a supportive and caring way, and then ask that the addicted love one go to treatment. Proposing what could be characterized as a “carefrontation,” chapter 5 suggests preparing these interveners to read, from prepared letters, their concerns for the addicted individual as well as the consequences if he or she was unwilling to pursue sobriety. Unfortunately, such interventions were as likely to end in a cursory commitment to change or, worse, anger and resentment depending on where on the continuum of readiness to change the addicted individual might be at the time of the intervention. However, the purpose of this essay is not to critique Johnson’s approach to conducting family interventions; it is to focus the discussion on a different question -- are practitioner-facilitated interventions with individuals or families, consistent with contemporary best practices in the treatment of substance-use disorders?

Turning to the popular culture, cable TV programs such as Intervention and Celebrity Rehab with Dr. Drew further shape our understanding of interventions, suggesting they are appropriate arrows for the practitioner’s treatment quiver. Such programs provide a skewed view of addictions and how best to approach those who have a substance use disorders (SUD). Unfortunately, with audience ratings an issue of primacy for the channel hosting these programs, when intervening with someone in a pre-contemplative stage of readiness to change, there will be ample drama and tension generated by these programs to hold audience interest. Unfortunately, viewers come away believing that addiction treatment is a one-size-fits-all proposition, but interventions are not the panacea of effective addictions treatment and they are not exemplary of best practices in the 21st-Century, especially in one-on-one and group counseling.

The study of addiction and addictive disorders, addictionology, has come a long way in last 50 years. A traditional view of addiction characterized it is a disease of denial. To gain any traction in its treatment, one had to first “break through” that denial in order to affect any meaningful progress towards recovery. It is this belief that prompts interventions, either through a formally orchestrated and professionally facilitated family interaction with an addicted person or when conducted by the individual counselor in individual or group sessions. William Miller, the father of Motivational Interviewing, argues that clients perceive such interventions as attack therapy (White, 2012). Miller further submits that practitioners can either wrestle with their clients or dance with them, and submits that dancing is far more conducive to change. By dancing, motivational enhancement therapists are more focused on what is done “with” individuals when assessing and treating SUDs than they are about what we do “to” them. For this reason, it may be time to revisit the appropriateness of conducting interventions, in particular as part of individual or group counseling sessions and to a lesser degree, as a formal family intervention as proposed by Johnson (1973).
Do We Intervene or Intercede?

The point of this essay is that if addiction educators teach about interventions, this is done from a purely historical perspective and that they refrain from presenting interventions as a best practice. Instead, it is advised that educators instruct students—and that clinical supervisors advise their supervisees—to conduct "intercessions" instead. The rationale for this argument is based on the fact that "to intervene" is a more "reactive" verb and therefore consistent with—not to mention proliferates—aggressive confrontation as the means of interacting with whomever the intervention is conducted.

"To intercede," on the other hand, is more consistent with what contemporary practitioners do when employing brief motivational techniques and is therefore more of a "proactive verb," one associated with "entreating on one's behalf." When practitioners "intervene," they attempt to do something to the individual thus facilitating what Miller refers to as "wrestling." When practitioners "intercede," they insert themselves between the client and the SUD in order to facilitate increasing awareness on the part of the individual regarding the disorder. This facilitates movement through the stages of readiness to change, thereby resulting in more of a "dance" between the individual with a SUD and the practitioner.

By way of fleshing out the merits of this suggestion further, what follow are several points supportive of its adoption:

- To "intercede" is to act as a mediator in a dispute whereas to "intervene" is to involve oneself in a situation so as to alter, hinder, if not stop an action’s continuance. These are very different activities and suggest very different courses of action, particularly in the addictions treatment field;

- The practitioner who intercedes mediates between the individual with the SUD and the SUD itself...it is an experience indicative of enhancing self-awareness and discovery rather than a confrontation as a means of imposed awareness;

- As the professional treatment of SUDs moves farther away from its traditional confrontational style, it increasingly embraces the principles of brief motivational interventions. Evidence-informed practitioners pursue an active role of "involving oneself" in a clinical relationship with an individual or family dealing with a SUD so as to "insert themselves between the client and the SUD in order to facilitate increasing awareness on the part of the individual regarding the disorder";

- The intent of Motivational Interviewing is to elicit from an individual personal insight that permits movement through the progressive stages of readiness to change until reaching the point of "taking action." It is more about "drawing something unrealized out" from the individual rather than "forcing something external in";

- "Intervention" is what physicians do when employing the medical model; this may work wonders when treating strep throat or appendicitis, but "intercession" is what practitioners do when employing the behavioral health model that facilitates movement through the stages of readiness to change;

- Intervention is about doing something TO the individual with a SUD in hopes of changing SUD-related behaviors and therefore is invasive, whereas intercession is about doing something WITH him or her in order to facilitate the same result.
To intervene is all too often an approach that prompts those with a SUD to become intractable in their denial and display what social psychologists call "reactance." Carl Jung is purported to have once said, that which you resist, persists. Its corollary could well be, what you accept, changes. Intercessions are far more likely to yield acceptance than are interventions, and is that not the issue of primacy for the practitioner working with someone with a SUD?

Conclusion

Interventions pit practitioner against individuals with SUDs in a "tug-of-war" where for one to win, the other must lose. This is what Miller meant by referring to it as "wrestling" with a client. Intercessions pursue a more collegial—although at times nonetheless blunt—relationship, one built on mutual trust and respect; what Miller meant when suggesting "dancing" with a client. As any accomplished ballroom dance team will report, "someone leads while the other follows," but the team does not win the competition until and unless "its members" enter a state of symbiosis. In essence, as the practitioner guides more than directs or leads in this dance, the partners, together, constitute an intercession in action. When practitioners intercede as opposed to intervene, they appeal on behalf of the individual with an SUD, essentially countering the rhetoric if not polemic historically delivered, non-stop, by none other than—and please pardon the allegory—Al K. Hall, Mary Juana, Herr O’Wynn, Toby Acco, or any of A. Dictionary's other minions who continually shout in addicted individual’s ears.

References


NOTES

Miller & Rollnick’s (2013) understanding of "denial" differed from Johnson’s (1973) in that Johnson viewed denial as resulting from the addicted individual’s (1) blackouts, (2) repression, and, in what he referred to as (3) euphoric recall or the propensity to remember the “good things” associated with use while minimizing if not overlooking the “less good.” This distinction is significant when considering that Miller & Rollinic viewed denial as not so much indicative of “avoidance” as suggestive of one’s “ambivalence” regarding change. This distinction can have a profound impact on not only a practitioner’s understanding of a client’s behavior, that is, denial, but more importantly, how best to address that denial so as to facilitate “change talk.”

This is not to suggest that a formal intervention, conducted by a trained interventionist, be eliminated. Rather, educators are advised that such interventions not be suggested as a “first” course of action when working with the family. Further, before conducting such interventions, even if appropriate for the family seeking treatment, the interventionist should have some sense that the object of the intervention is at least in the preparation stage of readiness to change.

The reader may find Community Reinforcement Approach and Family Train (CRAFT) a strategy for working with families of interest. This approach to working with families stresses avoiding enabling behaviors and permitting the natural consequences of addiction to occur and then proactively addressing them within the family system. For more on CRAFT consider viewing the segment on CRAFT from the HBO series, Addiction - https://www.hbo.com/addiction/treatment/371_alternative_to_intervention.html

If interested, a video of Fr. Martin delivering this “Chalk Talk” can be viewed at https://vimeo.com/10503911

NAADAC Conference Update

This year’s conference will be held in Minneapolis, MN. The theme of this year’s conference is: Embracing Today, Empowering Tomorrow. Whether you attend for the CEUs and great workshops, or to meet some of your fellow INCASE members, the conference experience is an excellent networking venue. Come out, come out, wherever you are!
The Policy for Alcohol and Drug Abuse Prevention in Iceland

Iceland is looking at the alcohol and drug problems as a health care problem which leads to social consequences. Beer was banned in Iceland for most of the twentieth century, from 1915 to 1989. In 1989 it was once again made legal to sell beer and the consumption of alcohol increased especially among young people. Unfortunately there is now a proposal being put before the Icelandic Parliament where a few members of Parliament propose that liquor may be legally sold in supermarkets. Most of the Icelandic population is against this according to the social media and the Department of Health. According to the Director of the Health Department in Iceland, Icelanders now consume about 6.5 to 7.0 liters of alcohol per person per year. The welfare policy on alcohol and drug abuse prevention was made in December 2013 continuing until 2020. The objectives of the government are characterized as being a healthy environment where people are not in danger from the use or abuse of alcohol or other intoxicants. There are six goals all focusing on improving health.

1. To restrict access to alcohol and other drugs.
2. To protect groups at risk from the damaging effects of alcohol and other drugs.
3. To prevent young people from starting to consume alcohol or other drugs.
4. To reduce the numbers of people who develop dangerous habits regarding the consumption of alcohol or other drugs.
5. To ensure that those who have abuse or addiction problems have access to continuous and coordinated services based on the best available knowledge and quality standards.
6. To reduce health damage and the number of deaths related to consumption of alcohol, or other drugs, consumed by the individuals involved, or by others (Ministry of Welfare, n.d.).

Prevention is in the hands of the government: Steps and measures are being made to reduce the harmful effects of alcohol and other drugs. Limit the availability of alcohol and other drugs. Strict measures concerning alcohol sales arrangement, effective monitoring of the use of prescription drugs, law enforcement is a powerful and effective customs control.

- Price and taxation of alcohol, the alcohol age limit
- Controlled access to alcohol - state monopolies, restrictions on the sale times and days
- Provision of restaurants - the rules to acquire a liquor license
- Efforts against drunken driving under the influence – It is illegal to drive with any blood alcohol level
- Control of alcohol advertising - alcohol advertising is banned in the media and elsewhere
- Prevention information given to students in elementary and secondary schools of the hazards of alcohol and drugs
- Preventative treatment for those who are becoming involved before the problem gets worse and reduces the number who develop problems
- Early intervention and counseling on health and social services
- Reducing the damage and the number of deaths due to personal consumption or other alcohol or other drugs
- Protecting vulnerable groups such as children of parents with substance abuse disorder, pregnant women with active substance abuse disorder and youth (Ministry of Welfare, n.d.).

Society is urgent in addition to strengthening social and health care measures to tackle the problem of hard drug users in society (Helgi Gunlaugsson, 2013).
Public attitude surveys show that most believe drug use to be the most serious crime problem in Iceland and alcohol and drug use the most important cause of why some people end up committing crime. Cannabis use, the most frequent drug, has regularly been measured among students but studies among adults have been examined to a lesser extent. As a result, not much is known about how consumption starting among youth develops into adulthood, if it increases, stays the same or decreases. Furthermore, not much is known about the social characteristics of those who abuse hard drugs in Icelandic society (Helgi Gunnlaugsson, 2013).

Research has investigated cannabis use among adults in Iceland. The questions were- How many have tried cannabis during their lifetime, how many have used it more than ten times, and how many during the last six months before the survey took place? The position of intravenous drug users is examined and what risk factors are associated with this use. Public perceptions of which crime type is the most serious in society and why some people commit crimes is explored. The main findings show that the number of those who have used cannabis in Iceland has increased in the past few years but regular use of cannabis among adults is insignificant. Those who use hard drugs are in a weak social position and face various problems. A social policy sensitive to different levels of drug use in society is urgent in addition to strengthening social and health care measures to tackle the problem of hard drug users in society (Helgi Gunnlaugsson, 2013).

Treatment and services in Iceland

Iceland has a population of only 329,000 people and yet provides a wide variety of services for both alcohol and drug user and victim of domestic violence. The largest being the organization SAA – the National Center of Addiction Medicine which was founded in 1977. SAA runs a hospital and a detoxification clinic, two outpatient units, two treatment clinics, three recovery houses and a social center. Each year approximately two thousand individuals enter the detoxification program and eight hundred of those patients then continue in the treatment program. Women make up approximately 30% of these figures. The National University Hospital of Iceland serves patients with dual diagnosis. There are approximately 450 patients who seek treatment each year. At the National University Hospital of Iceland there is an emergency unit for women and men who have been raped or suffered from another abuse such as domestic violence.

In 2012 the police in the capital area received about 900 reports of domestic violence. In about a quarter of the cases violence was used, sometimes in a very rough and reckless way. The number of sexual offenses was also under investigation by the office, which included 85 rapes and nearly 60 sexual offenses against children. This is similar to 2011. This year however there has been an increase in reports. This maybe can be explained by there being more awareness and debate in the community about domestic violence. Alcohol and drugs are involved in about 60% - 70% of the reports at the hands of the perpetrators.

Treatment for men is a four week program in rehabilitation after staying about ten days at the National Centre of Addiction Medicine (SÁÁ) and then they are provided with support from an outpatient unit for 2-3 months. The treatment for women is separate from the men and the support from an outpatient unit is longer, from 6 to 12 month. Men who return can receive a special treatment with a special support at an outpatient unit for one year. There is also a special treatment for men who are 55 years of age or older.

Special treatment is for children and adolescents at the National Centre of Addiction Medicine and there are eleven rooms at the hospital. This treatment began operating in 2000. When adolescents come into therapy it is to try to work with their families and the child protection services and the aims are to bring him or her as soon as possible in the natural environment again. There is also an aim to educate and support parents of addicted adolescences and help them to cope with the situation.
Drug users who inject heroin, morphine and other opioids are often considered the most vulnerable addicts. Heroin is not included in the drugs market in Iceland. On the other hand some strong painkillers have been abused in this country instead of heroin and morphine is famous for the materials from the debate.

Maintenance drugs methadone or buprenorphine combined with social and psychiatric rehabilitation has revolutionized the treatment and prognosis of these patients over the last twenty years or so. SAA began providing a maintenance outpatient unit at the National Centre of Addiction Medicine in September 1999. At the National Centre of Addiction Medicine there are 65 rooms and they are full the whole year round. Taking into account the rehabilitations, each day about 130 people seek treatments and that does not include the outpatient’s resources. Other services for addicts and their relatives are Child services - Children protection, Social services and the Red Cross which provide for example housing, drive around with clean needles, medicine, condoms and so forth guided by the philosophy of harm reduction.

In Iceland is also offered an addiction therapy by the hand of Religious organizations, about thirty individuals are in treatment every day and usually 70 to 80 people on the waiting list. The treatment is a minimum of six weeks, but individuals can be in up to six to eight months.

Three Halfway house for about twenty individuals on each place are also running by the hand of Religious organizations. One of this halfway house is also running by the Social services on the capital area, in that house people don’t have to had treatment and be sober. But they cannot be using alcohol or other drugs in the house. Religious organizations also provide food for those who need help, they offers morning coffee, side dishes and hot meals for lunch, every day of the year, weekends as well as holidays. Visits are by and over 180 people per day all year round. About 65 thousand meals are provided in the cafeteria every year.

At all treatment places in Iceland, people are encouraged to go in self-help groups Alcohol Anonymous. AA are very strong in Iceland there is approximately 300 AA meetings per week, or around 16,000 thousand meetings a year.

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What's your News?

We would like to hear from our members! What contributions, policy change or presentations have you been making in addictions? Send us your news and you could be featured on our members page. There are many addictions educators doing great work out there, so don’t be bashful, tell us what exciting projects you are working on.
The SALIS Collection: ATOD
Book Archive
Andrea L. Mitchell

Founded in 1978, the Substance Abuse Librarians and Information Specialists, known as SALIS, is an international association of alcohol, tobacco, and other drug (ATOD) librarians and information specialists, whose main purpose has been to promote the collection, organization, management and dissemination of objective, accurate and timely ATOD information, and the professional development of its members. Currently the group has members from Australia, Canada, Europe, the Middle East and the US.

Over more than a decade, this group has been witnessing the elimination of the special ATOD libraries and information centers, and concomitantly the loss of members in the SALIS organization. In addition many of the government produced ATOD databases have also been eliminated. To date more than 30 libraries have been closed, including among others both the NIAAA and NIDA libraries in the US, Drug Scope in the UK, Toxibase in France, and most recently a major collection in Australia. When NIAAA defunded the alcohol science bibliographic database (ETOH) and the AOD Thesaurus in 2003, the SALIS Advocacy committee lead a campaign to try to reverse the decision. In 2006 when the National Institute on Drug Abuse closed their library, again the group rallied, but to no avail. In 2012, Addiction published an editorial entitled, Collective Amnesia: Reversing the Global Epidemic of Addiction Library Closures written by members of the SALIS Advocacy Committee, which described the extensive loss and decimation of the ATOD information infrastructure and made recommendations calling for the creation of ATOD digital archives. Nine letters to the editor were published in a later issue, all supportive of the recommendations.

One of the members of the committee attended a conference at the internet Archive (IA) in San Francisco and was made aware of the digital archives that were being created by partnerships between other libraries and the IA. Sharing this information with the group, plans were formulated to partner with the IA and develop an ATOD collection. The IA has state of the art equipment and volunteer “scribes” who digitize the materials. Costs for digitizing, at approximately $30 per book, meant that SALIS had to find funding. Given the downturn in funding in the ATOD field, this was not an easy task. But by 2013, they had received seed money from the Joel and Maria Fort Foundation, which would cover the cost of the first 100 books. Once these were digitized, it was thought that they would then have something to show for raising more monies. Then in late 2013, NIAAA made it known that they planned to donate their library to a good home. Seeing this as an opportunity, SALIS put in a proposal for the books and were delighted when they were selected as the recipient. In addition, NIAAA awarded SALIS more seed money.

Since then the Digitization project or “Digs”, as it is referred to by the group, has been busy with a variety of tasks to organize and facilitate the process. To make the project known, articles in the SALIS newsletter were written and presentations or updates were made at several conferences. In 2013, with the SALIS conference in Berkeley, a tour of the Internet Archive in San Francisco was arranged giving attendees a chance to meet Brewstere Kahle, head of the IA and a very charismatic individual. This more than anything seemed to energize people, and the project activities.

A website database, to keep track of books donated and sent to the Archive was created. Since finding funds was an issue, the project group members decided to select from the NIAAA list of books, those titles which were considered classic and or most sought in the field. By late 2014 nearly 100 books had been digitized and were made available to the project group on the IA beta site. Seeing the full text of these books in The SALIS Collection: Alcohol, Tobacco and Other Drugs was a high point for the project members in December last year. The 37th Annual SALIS conference in San Diego in the Spring of 2015 provided the opportunity to unveil The SALIS collection for the first time publicly. More than 300 titles are now available, all searchable by author, title, or subject, and available to be borrowed for up to a two week period by anyone anywhere who has access to the internet.

Although funding is still a big issue, and more book donations are needed, the group is positive about future growth. If you have books or funds to donate, please contact the head of the Digs project:: Andrea Mitchell <amitchell@salis.org>
On December 21, 1970 there was a historic, although not well publicized meeting that took place between Elvis Presley and President Richard M. Nixon in Washington, D.C. Apparently, Elvis had written a six page letter to President Nixon requesting a meeting because of concerns about drug use among young people (Presley felt that Beatles music was corrupting American youth and encouraging them to turn to drugs). In this meeting, Presley requested that Nixon officially appoint him “a Federal Agent at Large” within the Bureau of Narcotics and Dangerous Drugs, so that Elvis could reach out to young people and dissuade them from drug abuse. Allegedly, Presley’s own prescription drug abuse may have been in full swing at that time and on August 16, 1977 Presley died of what was alleged to be cardiac arrhythmia resulting from taking a combination of codeine, Valium, morphine and Demerol. Presley’s official autopsy results are sealed until 2025.

Presley’s request of Richard Nixon points to something that most addiction educators have known for quite some time, i.e. people sometimes get involved in the addictions profession for the wrong reasons. A case in point occurs when students with active addiction issues and/or concurrent mental health issues seek to become addiction counselors or when students have family members experiencing Substance Use Disorders [SUD], whom they hope to save by becoming counselors. Although there are many benefits of having recovering persons who aspire to work in this profession, there are a multitude of problems that arise when untreated individuals with addiction, codependency or mental health issues enter the profession for inappropriate reasons much like Elvis Presley wanting to become an official federal drug enforcement agent.

As addiction studies educators we can relate to the pride we feel when our students grow and mature as they move through our collegiate training programs and then go on to excel as addictions counselors. However, most of us are aware of instances where students do not progress well or may encounter difficulties that lead faculty to question whether the student is appropriate to be working the addictions counseling profession. These difficulties may include academic problems, interpersonal problems, maladaptive personality traits (e.g. egocentricity, lacks of empathy) or emotional/psychological difficulties (Barnett, 2008). Henderson and Dufrene (2012) researched various types of problematic student behaviors and found eight categories: 1) ethical transgressions 2) symptoms of a mental health diagnosis, 3) intrinsic characteristics 4) counseling skill deficits 5) issues with receiving and responding to feedback 6) self-reflective deficits and 8) procedural compliance. We cannot emphasize too strongly, that our role as addiction educators is not one of diagnosing or treating these issues, however, as addiction educators we have a professional, moral and ethical responsibility to address student difficulties appropriately. Another factor to take into account is whether student deficiencies that were not properly addressed during their training, could put future clients at risk or whether colleges or universities may be liable to lawsuits from clients or employers (Custer, 1994). This is why the responsibilities of counselor educators to address these issues during the student’s training are delineated in the accreditation standards of NASAC and CACREP. As educators it is imperative that we are training addictions counselors who are both academically competent as well as emotionally stable.
In Part 1 of this two-part series, we will describe some of the types of difficulties that students may encounter and in Part 2, we will discuss examples of how we as faculty might address some of these issues in accordance with accreditation standards. Both articles will highlight our dual role as addiction educators in terms of our responsibility to our students (student assistance) and our responsibility to the addictions counseling profession (gatekeepers).

Foster and McAdams (2009) define the gatekeeping role as one in which it is responsibility of all counselors (including counseling students in training) to intervene with professional colleagues and supervisors who engage in behavior that could threaten the welfare those receiving their services (Foster & McAdams, 2009, p. 271). The student assistance model (which was derived from employee assistance programs adopted by many corporations) takes the approach that distressed or troubled students should receive remediation rather than being subject to harsh disciplinary or punitive sanctions. The role of faculty involved in student assistance or remediation is not to diagnose or treat but rather to connect troubled students with helpful resources. In the role of gatekeepers, counselor educators who determine that students are inappropriate to work in the counseling profession may be counseled out of the training program, or face suspension or expulsion. Research by Russell, DuPree, Beggs, Peterson & Anderson (2007) examines how counselor supervisors respond to various student difficulties with remediation or gatekeeping types of approaches given the types of difficulties students present with.

Examples of Gatekeeping and Student Assistance Roles

Academic Deficits

Not all students are well-prepared to undertake the requirements of an addiction studies curriculum. Often students may find particular undergraduate or graduate coursework difficult. This may be the result of a lack of study skills, a learning disorder or because of outside stressors that make it difficult for students to devote adequate time to their studies. In situations like these, students run into potential problems when they refrain from asking for help from faculty and supervisors/advisors. In many instances, academic skill deficits can be ameliorated by referring students for tutoring or to the college/university’s disability services. The issues that are often more problematic are when students engage in cheating or plagiarism. (e.g. a student admitted to having purchased a term paper online because he was unable to devote time to the project because of having to work overtime at his job) or when students do not shoulder their responsibility when working on group projects with other students. While cheating or plagiarism may reflect a momentary lapse of judgment as in the case cited above, an incident of this type could reflect a pattern poor decision-making that would be of concern for a future counselor who must adhere to strict ethical standards. In these instances, remediation may take the form of providing the student with opportunities to determine the reasons for the indiscretion and to determine what steps they need to take to avoid situations like this in the future. Although colleges and universities often have specific sanctions for cheating and plagiarism, role of counselor educator faculty would be to go beyond those sanctions to assist the student in finding ethical alternatives. It is important to emphasize that whatever remedial recommendations are offered to students, they are not punitive and do not violate Americans with Disabilities Act (ADA) mandates.

Substance Use Disorder and Mental Health Difficulties

It is not unusual to discover instances where students present with untreated SUD or mental health disorders. These types of difficulties are problematic because they may not become evident until the student has been accepted into the program. As a result, situations may arise that are of concern for addiction educators. Here are two examples:
Bob is currently attending a community college where he is majoring in Human Services and is an Addictions Counseling specialization track. He became interested in becoming an addictions counselor after he completed an eight week residential alcohol and drug program when he was a high school senior. Bob indicates that in his senior year he was prescribed Percocet for a sports injury and had become addicted to these pain medications. He also admits to smoking pot and drinking with his teammates prior to his injury. Once he completed the rehab Bob was no longer using Percocet. However, he claims that since he was “never addicted” to pot or alcohol, he continued to smoke pot regularly to deal with social anxiety. He declined to participate in outpatient counseling and did not feel that he needed to attend Narcotics Anonymous. Bob had made it known to his professors that he was clean from Percocet but never brought up his other drug or alcohol use until he was charged with a DUI which made it into the local newspapers. His faculty advisor happened to see the article in the newspaper.

Tara is currently applying to a graduate addictions counseling program. On her admissions essay, she disclosed that she interest in becoming an addictions counselor as a result of her own struggles with substance addiction and mental health issues. Tara explained that she had been addicted to alcohol and Xanax and while she was in residential treatment, she had been diagnosed with Bipolar Disorder and was started on a mood stabilizer. In her admissions interview, Tara explained to the graduate admissions committee that she was now two years sober, was actively attending AA and NA, was receiving personal counseling and was also being successfully maintained on a mood stabilizer. Tara explained that she felt all of these measures were vital to her recovery.

In the situations described above, both students had made disclosures about a substance use disorder(s) and mental health issues. Needless to say, a student would never be excluded from admission to a program based on a mental health disorder or SUD as that would be in violation of ADA laws. However, this brings into question the addiction counseling program’s obligations once a disorder is disclosed. In the case of Tara, she has taken appropriate steps to obtain treatment and maintains her recovery from both disorders. However, what if Tara were experience a relapse or decides to stop taking her medication against medical advice? What is the responsibility of the program to assist Tara get back on track with her recovery and when would it be appropriate for her to continue her studies? Also would the stress of resuming her studies be contraindicated to her recovery? Again, the role of an addiction educator faculty is to assist Tara in making the best decisions, given her goals of successfully completing the academic program. In order to accomplish this, it is helpful to have those treating Tara (and Tara herself) weigh in on these issues. In the case of Bob, addiction educators would be more likely to step into the gatekeeper role (e.g. Ziomek-Daigle & Christensen, 2010), by exploring with Bob whether it’s appropriate for him to pursue an addictions counseling career. For example in the NAADAC Ethical Standards under IV. Professional Responsibilities the following is addressed in Standard 1 Counselor Attributes:

*Addiction professionals, whether they profess to be in recovery or not, must be cognizant of ways in which their use of psychoactive chemicals in public or in private might adversely affect the opinion of the public at large, the recovery community, other members of the addiction professional community or, most particularly, vulnerable individuals seeking treatment for their own problematic use of psychoactive chemicals. Addiction professionals who profess to be in recovery will avoid impairment in their professional or personal lives due to psychoactive chemicals. If impairment occurs, they are expected to immediately report their impairment, to take immediate action to discontinue professional practice and to take immediate steps to address their impairment through professional assistance.*
Most state licensure boards require that counselors and counselor applicants are not currently engaged in active substance use.

In our experience, it is somewhat easier to provide remedial recommendations when students present with mental health and substance use disorders and are receptive to working on these issues. However, there are instances where students appear to resent feedback they receive from faculty and profession supervisors or seem impervious to such feedback (Burgess, 1994). These types of difficulties are found when students present with interpersonal skill deficits, immaturity, an inability to manage conflict, lack of flexibility or self-reflection deficits (Henderson & Dufrene, 2012). Some of these characteristics are suggestive of personality disorder traits. By their very nature, most personality disorders share commonalities (e.g. a lack of insight, lack of empathy, blaming others for shortcomings and interpersonal difficulties) which do not lend to making good counselors. It is common for these student to lack insight into why profession supervisors, peers or faculty are expressing concerns regarding his or her behavior and will tend to view any corrective recommendations as punitive rather than helpful. McAdams and Foster (2007) present an example where a student had brought a lawsuit against the counselor education program and university she was attending. We are also aware of an instance where a field supervisor raised concerns regarding a student’s dressing provocatively at her internship placement. The student became outraged when her field supervisor suggested that she dress more appropriately.

**Profession Placement & Clinical Skill Deficits**

Profession experience is an integral part of addiction education and training, as it allows students to practice various counseling skills under the supervision of a credentialed addiction professional in a licensed treatment setting. Internships provide students with an opportunity to develop a professional identity as an addiction counselor by modeling their behavior based upon observing addiction counselors in action. Profession placements also provide students with the opportunity to witness and enact ethical decision-making based upon the NAADAC Ethical Standards. Generally when students encounter difficulties in their profession placements they usually revolve around clinical skill deficits or problems with ethical behavior. Even with training in the ethical standards, some students encounter difficulty in translating the written ethical code into daily practice in their profession sites, especially when it comes to boundary violations, confidentiality, multicultural competence, integrity and seeking consultation from supervisors (Henderson & Dufrene, 2012). The following is an example where a student ran into difficulties while doing his internship:

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John is a 2nd year graduate student in a Masters degree program which has an addictions counseling specialization. He is currently an internship at an inpatient alcohol and drug program which serves both men and women with various types of substance use disorders. John primarily co-leads groups and also has a few individuals clients. In a recent individual session, a client disclosed that she had been a sexually victimized as a teenager. John knew of another client in the program who disclosed similar issues in another group so John suggested that his individual client speak with this other client since they shared similar issues and could possibly help one another. When John’s group client found out that he had broken her confidentiality she was outraged and reported the incident to the clinical director who then made John’s faculty advisor aware of the transgression.

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In this case, John had committed a serious ethical breach, yet was also defensive and resentful of remediation recommendations. He defended himself by stating he was acting in the best interests of his clients. In the most egregious of ethical violations faculty needs determine the need to impose their role as gatekeepers via suspension or expulsion or whether remediation will allow a student like John to make connections between ethical standards and ethical professional behavior in the profession.

These are just a few of the types of difficulties that faculty may encounter pertaining to student behavior. In Part II of this article we will talk more about the remediation and gatekeeping process and procedures.

References
The purpose of INCASE is to provide a global forum for the examination and 
debate of issues concerning post secondary education in addiction studies, 
and to enhance the quality of training and education in addiction studies, to 
disseminate professional knowledge and share ideas regarding addiction 
studies and scholarship in the field of addiction studies. To develop standards 
and implement an accreditation process for addictions studies programs 
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Members keep abreast of the developments in the field via annual confer-
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ad hoc committees, and issues oriented task forces.