

AN ABSTRACT OF THE DISSERTATION OF

Kathy E. Biles for the degree of Doctor of Philosophy in Counseling presented on April 22, 2004.

Title: A Formative Evaluation of Pre-Service Preparation of Substance Abuse Counseling in CACREP Accredited School Counseling Programs.

Abstract approved:

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Substance abuse is a prevalent occurrence among adolescents. A review of the literature revealed that adolescent substance abuse has a strong connection to their academic performance. School counselors address adolescents' academic and personal/social needs by providing services through prevention education, responsive services, and collaboration with community members. Yet, there is a dearth of literature as to whether pre-service school counselors are prepared to deal with substance abuse issues.

The purpose of this study was to evaluate pre-service substance abuse training provided in CACREP accredited school counseling programs. The instrument utilized was entitled School Counselor Pre-Service Preparation in Grief/Loss and Substance Abuse Counseling. The survey included three questions concerning substance abuse training for pre-service school counselors and three questions concerning Grief/Loss training. The substance abuse questions and data were utilized for this particular study. The surveys were mailed to a total of 150 CACREP accredited school counseling programs, and 79 programs responded to the survey, resulting in a response rate of 53 percent.

The results revealed that the majority of CACREP accredited programs in this study offered substance abuse training through either required or elective coursework. Limitations of the study, implications for CACREP accredited programs, and recommendations for future research are also discussed.

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**A Formative Evaluation of Pre-Service Preparation of Substance Abuse Counseling in
CACREP Accredited School Counseling Programs**

**By
Kathy E. Biles**

A DISSERTATION

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I understand that my dissertation will become part of the permanent collection of Oregon State University libraries. My signature below authorizes release of my Dissertation to any reader on request.

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Kathy E. Biles, Author

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DEDICATION

This dissertation and completion of my doctoral degree would not have been possible without the commitment, continuous support, encouragement and love of my family. This work is dedicated with love to my husband Dennis and my children Joe, Joshua, and Shawna.

A Formative Evaluation of Pre-Service Preparation of Substance Abuse Counseling in CACREP Accredited School Counseling Programs

Chapter 1: Introduction

The prevalence of substance abuse remains widespread among adolescents in the United States. Today over half (53%) of youth have tried an illicit drug by the time they finish high school. In fact, three out of ten students (30%) will have used some illicit drug other than marijuana by the end of 12th grade (Johnston, O'Malley, & Bachman, 2003). As a result, adolescent substance abuse has been a cause of concern for educators, counselors, parents and the medical profession for quite some time.

According to the Substance Abuse and Mental Health Services Administration (SAMHSA) 2003 adolescents who abuse alcohol and other illegal substances have less of a chance of being successful in school and/or completing high school. Substance abuse contributes to a higher absentee rate from school, more of a chance of having other mental health issues, committing suicide, or committing violent acts (SAMHSA, 2003).

The *No Child Left Behind* Legislation of 2001 recognized that all students have a right to a safe and drug free environment. Under this legislation, schools must report school safety statistics to the public on a school-by-school basis. School districts must provide a plan and implement programs for keeping schools safe and drug free (www.ed.gov, 2003).

Previous to this legislation, prevention programs and curriculum to educate adolescents about the negative effects of substance abuse had been implemented in schools across the nation. Some programs, such as Drug Abuse Resistance Education

(DARE), were implemented as early as elementary school and began in the 1980s. (McCoy, Metsch, & Inciardi, 1996). Substance abuse curriculums are often taught as part of the health curriculum or by school counselors. Some prevention programs have recently been deemed, through research, as not very effective.

With the recent *No Child Left Behind* legislation, the Office of Safe and Drug-Free Schools (OSDFS) has increased its role in providing funding for drug and violence prevention programs. They also are committed to partnerships and coordinating efforts in establishing comprehensive school health education policy (www.ed.gov, 2004).

School counselors also have a major role in providing a safe and drug free school. In addition to promoting prevention programs in the schools, school counselors also provide individual and small group counseling. Lambie and Rokutani (2002) addressed the need for school counselors to have specific knowledge involving adolescent substance abuse, such as identification of the symptomology of adolescent substance abuse. They reported that many school counselors in graduate programs lack specific training in the area of substance abuse.

There is a general belief that school counselors have been trained in substance abuse issues and are trained to provide interventions, such as referral for an assessment, for these students. Yet many school counselors have not had specific training in substance abuse (Lenhardt, 1994; Hawes & Benton, 1990). Morgan and Toloczko (1997) reported that although substance abuse training was in some CACREP programs, there was still a need to provide consistent substance abuse training in graduate counseling programs.

Scope of the Study

School counselors are provided with training in their pre-service counseling programs, in content areas such as designing and providing guidance programs, individual and small group counseling. They may not be provided with training in substance abuse counseling. Therefore, this study will look at pre-service school counseling programs accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP). There were 150 CACREP school counseling programs as of December 2003 that were invited to respond to a survey designed by the author.

These school counseling programs will be sent a survey requesting information on whether or not they provide training on substance abuse counseling. They will also be asked what specific content is taught and how many credits or hours the students can earn.

Rationale

School counselors offer services to students, school staff, and community members not only in the areas of academic achievement but in prevention, responsive services, community partnerships and collaboration and consultation (Myrick, 2003).

The American School Counselor Association's (ASCA) National Model, A Framework for School Counseling Programs (2003), describes four major components of a school guidance program. These are accountability, delivery system, foundation, and management system. These components are designed to provide school counselors a

mechanism with which to design, coordinate, implement, manage, and evaluate their programs for students' success (ASCA, 2003).

In addition to counselor education programs utilizing the ASCA National Model framework to train school counselors, CACREP accredited counselor education programs also follow a set of standards. These standards provide minimal criteria for the preparation of professional counselors, counselor educators, and student affairs professional. The core areas are professional identity, social and cultural diversity, human growth and development, career development, helping relationships, group work, assessment, and research and program evaluation.

Both CACREP Standards (2001) and ASCA's National Model (2003) of school counseling are general guidelines that provide a framework for counselor education programs to provide consistent training to pre-service school counselors.

Yet there is a dearth of literature on substance abuse counseling training in school counselor programs (Bauman, Siegel, Falco, Szymanski, Davis & Seabolt, 2003; Goldberg, 1995). This should be an area of concern for counselor educators and school counselors, since school counselors are being asked to establish accountability in their school guidance and counseling programs.

As noted in the overview of adolescent substance abuse in chapter 2, alcohol and marijuana are two substances that still have a fairly high rate of abuse by adolescents. According to Johnston et al. (2003) perceived risk of use, perceived benefits of use, and availability are all factors that determine whether adolescents will use or abuse drugs. These risk factors, along with resiliency factors, may also contribute to reducing

adolescent substance abuse. Are these risk and resiliency factors addressed in substance abuse counseling training?

The purpose of this dissertation is to ascertain how many CACREP school counseling programs are training pre-service school counselors in substance abuse counseling and to determine what content is being taught.

Research Questions

This study examines the following research questions:

Research Question 1:

How is training in substance abuse counseling delivered in your program?

Research Question 2:

What specific content is covered in the area of substance abuse counseling in your course(s)?

Research Question 3:

If substance abuse counseling is not covered in your curriculum, what are the primary reasons?

Glossary of Terms

ASCA

American School Counseling Association, the professional association for school counselors.

Binge use of alcohol (Binge drinkers)

Binge use of alcohol was defined as drinking five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least one day in the past 30 days (SAMHSA, 2003).

CACREP

Council for the Accreditation of Counseling and Related Educational Programs, counselor education accrediting body.

CASA

The National Center on Addiction and Substance Abuse at Columbia University. Conducts research on addiction and substance abuse.

Cocaine

Cocaine is a stimulant, whose effects last only a few minutes. This substance has no acceptable medical uses and is highly addictive. (Johnson, 2003).

Crack Cocaine

Crack is cocaine with increased potency. Crack is the strongest and most dangerous form of cocaine. It is also the most addictive form of cocaine. (Johnson, 2003).

Current Use

Any reported use of a specific substance in the past 30 days. (SAMHSA, 2003).

DASIS

Drug and Alcohol Services Information System. The DASIS consists of three data sets developed with state governments. These data collection efforts provide National and State-level information on the substance abuse treatment system. (SAMHSA, 2003).

Ecstasy

Ecstasy is a synthetic drug possessing both stimulant and hallucinogenic properties. Although it is usually taken in pill form, it can be injected, snorted, or used in suppository form. It is considered one of the club drugs or “date rape” drugs. (Johnson, 2003).

Heavy Use of Alcohol

Drinking five or more drinks on the same occasion (i.e. at the same time or within a couple of hours of each other) on 5 or more days in the past 30 days. Heavy alcohol users also were defined as binge users of alcohol (SAMHSA, 2003).

Illicit drugs

Illicit drugs include marijuana, cocaine, inhalants, hallucinogens (including LSD, PCP, or Ecstasy), heroin, or nonmedical use of psychotherapeutics, which include stimulants, sedatives, tranquilizers, and pain relievers. Illicit drug use refers to use of any of these drugs.

Intervention

A specific act that provides assistance to the adolescent.

Lifetime Use

Use of a specific drug at least once in the respondent’s lifetime. This measure includes respondents who also reported last using the drug in the past 30 days or past 12 months (SAMHSA, 2003).

NIDA

National Institute on Drug Abuse.

Nonmedical Pain reliever use

The use of any prescription drug (pain reliever, sedative, stimulant, or tranquilizer) that was not prescribed for the person, and was taken only for the experience or feeling it caused. (SAMHSA, 2003).

Past Month Use

This measure indicates use of a specific drug in the 30 days prior to the interview. Respondents who indicated past month use of a specific substance also were classified as lifetime and past year users (SAMHSA, 2003).

Past Year Use

This measure indicates use of a specific substance in the 12 months prior to the interview. This definition includes those respondents who last used the substance in the 30 days prior to the interview. Respondents who indicated past year use of a specific substance also were classified as lifetime users (SAMHSA, 2003).

Primary Prevention

Attempts, usually through education, to minimize or prevent the occurrence of substance use/abuse. This prevention includes education and activities that are designed to prevent the onset of drug use, abuse, and/or dependency, as well as reduce the risk that individuals will develop problems as a result of substance use (Gonet, 1994).

SAMHSA

Substance Abuse and Mental Health Services Administration, Office of Applied Studies. The Office of Applied Studies serves as a central point for data collection, analyses, and dissemination activities on the incidence and prevalence of substance abuse

treatment facilities and services, and the costs and outcomes of substance abuse treatment programs.

Secondary Prevention

Using an intervention to identify and work with individuals who are exhibiting high risk behaviors for involvement with alcohol and other drugs, for using alcohol and other drugs, or for getting into trouble with their drug use. Often referred to as early intervention (Gonet, 1994).

Substance abuse

For the purpose of this dissertation, substance abuse will encompass substance abuse, dependence, and addiction. Substance abuse is defined in this paper as the categories in the Diagnostic and Statistical Manual IV (DSM-IV, 1994) that refer to substance related disorders and substance induced disorders. These disorders include the active use and/or dependency of any mood-altering substance. Substances include alcohol, cannabis, amphetamines, cocaine, hallucinogens, inhalants, opioids, nicotine, caffeine, sedatives, prescription drugs, as well as legal drugs. (DSM-IV, 1994)

Substance use incidence

The use of a substance for the first time (new use) (SAMHSA, 2003).

Tertiary Prevention

Treatment and rehabilitation, which prevents further damage to the addict and those affected, and prevents relapse. (Royce & Scratchley, 1996). Provide support to the adolescent in reducing risk of using or the avoidance of a chronic condition. Can be considered relapse prevention; assisting adolescent's transition from treatment back into school and supporting and reinforcing an adolescent's recovery program (Gonet, 1994).

Overview of Dissertation

This study will review the literature on the historical role of school counselors in guidance programs and how the role has evolved to include providing responsive services and primary and secondary prevention. An overview of substance abuse in the United States and an extensive overview on adolescent substance abuse will also be addressed in chapter 2.

Statistics used for this study are taken from the 2002 National Survey on Drug Use and Health: National Findings reported by Substance Abuse and Mental Health Services Administration. Additional information supported by this study was reported by Johnston, O'Malley, and Bachman's (2003) *Overview of Key Findings 2002 on Monitoring the Future*.

Chapter 2 also contains more detailed information on CACREP standards and its role in school counseling training. Chapter 3 contains the methodology for this study. Detailed information is provided on participants, demographics, and measures utilized in this study. A detailed description of the survey and how it is coded is also provided in chapter 3.

Chapter 4 describes the results found from the returned surveys. It provides a presentation of data analysis along with a non-evaluative explanation of the results. A summary of data and results are provided in a table format.

Chapter 5 provides a discussion on the research questions and an evaluation of the research questions. Conclusion of the results and overall study will be discussed.

The author provides limitations of the study, along with implications for researchers and practitioners. Recommendations and a summary of results and findings will conclude this study.

Chapter 2: Literature Review

Introduction

This review examines the literature on a) substance abuse in the United States, b) adolescent substance abuse in the United States, c) the history of school counseling and d) the role of the school counselor with primary and secondary substance abuse prevention. CACREP's school counseling standards, as they relate to substance abuse prevention, are also reviewed. The literature review further delineates the problem and provides the rationale for the examination of current CACREP programs and their training of substance abuse interventions to pre-service school counselors.

Overview of Substance Abuse in the United States

Substance abuse is defined in this paper as the categories in the Diagnostic and Statistical Manual IV (DSM-IV) that refer to substance related disorders and substance induced disorders. These disorders include the active use and/or dependency on any mood-altering substance. Substances include alcohol, cannabis, amphetamines, cocaine, hallucinogens, inhalants, opioids, nicotine, caffeine, sedatives, prescription drugs, as well as legal drugs (DSM-IV, 1994).

Drug use, of all kinds, has been part of society throughout the ages. Zeldin, as cited by Van Wormer and Davis (2003), suggested there has been no civilization whose citizens have not tried to escape from pain, stress, boredom or to alter their consciousness, with the help of alcohol, tobacco, tea, coffee, or plants of various sorts.

For example, the Aztecs had 400 gods of drink and drunkenness to help them escape into semiconscious bliss and cacti and mushrooms they ate to help them face battle.

Trends

It has only been since the 1900's that we have seen prohibition and considerable concern for substance abuse and addiction. Historically, substance use trends and patterns are not constant. University of Michigan Institute for Social Research has been monitoring the trends and patterns of drug use since 1975 through the Monitoring the Future Project, funded by the National Institute on Drug Abuse (Gonet, 1994). Substance abuse began long before 1975 though.

Recognizing substance abuse as a national issue, President John F. Kennedy convened the White House Conference on Drug Abuse in 1962 (Gonet, 1994). Four hundred drug experts from treatment agencies, hospitals, research centers, the courts, and police attended this two-day conference. According to Gonet (1994), the recognition of misinformation about drug use and the concept and term drug abuse were two results from this conference. The other important result was a move toward providing medical treatment for addicts. Two key objectives were 1) the elimination of illicit traffic in drugs and 2) the rehabilitation of drug addicts, which would help them become productive members of society.

The first national surveys on illicit drug use were telephone polls of college students conducted by the Gallup Organization (Harrison & Pottieger, 1996). In 1967, 5% of college students reported some marijuana use, and 1% indicated that they had tried LSD. By 1969, these numbers had quadrupled to 22% and 4%, respectively. By 1971,

51% of all college students reported using marijuana sometime in their lifetime, 41% had used in the past year, and 30% had used in the past 30 days. Some experience with hallucinogens was reported by 18%, 22% had tried amphetamines, 15% had tried barbiturates, 7% had tried cocaine and 2% had tried heroin (Harrison & Pottieger, 1996).

The annual number of persons beginning their use of marijuana increased from 1965 until 1973. From 1973 to 1978, the annual number of first time marijuana remained level at approximately 3.5 million per year. According to SAMHSA (2003) the number of first time users declined to 1.6 million in 1990, and then rose to 2.8 million in 1995. From 1995 to 2001, there was no consistent trend, with estimates varying between 2.5 and 3.0 million per year

Since 1975, about half of marijuana first time users each year were females (51 percent in 2001). Prior to 1975, females comprised fewer than half of new users, on average. SAMHSA (2003) reported trends in cocaine, heroin, hallucinogens, inhalants, alcohol and psychotherapeutic drugs (or prescription-type pain reliever, tranquilizer, stimulant, or sedative, including methamphetamine. These trends were estimated based on retrospective reports of age at first substance use by survey respondents interviewed during 2002. Therefore, SAMHSA (2003) acknowledged this data was subject to several sources of bias, such as memory errors, underreporting due to social acceptability and fear of disclosure.

Additionally, these trends depict a fluctuation from the early 1970's to present time substance use. This may be due to the social and political environment. While governmental agencies were recognizing substance abuse as a community problem, the National Commission on Marijuana and Drug Abuse proposed that societal changes may

have contributed to the change and growth in marijuana use among youth. They stated that American institutions had decreased in their ability to “help the individual find his place in society” (Harrison & Pottieger, 1996, p 5). Work had become less significant in importance and people were less likely to find meaning in their work or recreational purposes.

Other historical factors identified by the National Commission on Marijuana and Drug Abuse were the push for urbanization, the family unit became more mobile, and the loss of a sense of belonging to a community. There was an increase in leisure and increase in affluence which maximized individual choice. According to Harrison and Pottieger (1996) drug use became linked to hippies and the counterculture during the 1960's. Drug use was a symbol of protest and a demonstration of rebellion, especially during the Vietnam War.

Additionally, the increase in marijuana use could be related to the fact that it was considered a social group drug. Using marijuana in groups contributed to the youth's identity and camaraderie with other youth. Johnston, as cited by Harrison and Pottieger (1996), described this drug use as counterculture, which he defined as a group of young people “turned off” by many American institutions. He reported two attitudinal measures of this counterculture movement and their relationship to drug use as alienation from government and anti-Vietnam War sentiment. Youth were exposed to a tremendous amount of political turmoil throughout the 60's, such as the civil rights movement, the Vietnam War, and the assassination of key political leaders. There were protests, riots, battles, and other evidence of major unrest in the country (Harrison & Pottieger, 1996).

In 1970, President Nixon announced the first “war on drugs” that would expand the government’s role in fighting the importation of illegal drugs and drug trafficking. The Comprehensive Drug Abuse Prevention Abuse and Control Act of 1970 combined prior anti-drug legislation and established categories of illicit drugs according to perceived dangerous qualities (Gonet, 1994).

During the 1980’s and the 90’s, the Reagan and Bush administration continued the war on drugs. President George Herbert Walker Bush supervised an eight-year effort to fight drug trafficking into the United States from other countries. According to Gray (1998) the war on drugs saw an anti-drug budget which had tripled during this time.

Economic Cost

The cost of reducing the supply of drugs is not the only area where billions of dollars have been spent. According to a study issued by the White House Office of National Drug Control Policy (ONDCP) illegal drugs cost the U. S. economy \$143 billion in 1998 and projected a loss of \$160 billion for 2000 (Alcoholism and Drug Abuse Weekly, 2002). This study reported the cost of drug abuse in the United States from 1992 to 1998.

Among the findings of this report, drugs cost the U.S. economy \$98.5 billion in lost earnings, \$12.9 billion in health care costs, and \$32.1 billion in other costs, including social welfare costs and goods and services lost to crime. Crime-related expenses cost \$88.9 billion, or 62 percent of the total. These include goods and services lost to crime, property damage, work hours missed by crime victims and those incarcerated, and criminal justice system costs (Alcoholism & Drug Abuse Weekly, 2002).

This study further stated that societal costs of drug abuse are expected to increase at a rate of 5.8 percent between 1998 and 2000. Drug related health care costs grew at a rate of 2.9 percent annually between 1992 and 1998.

In addition to health care, under-productivity costs due to drug abuse-related illness and incarceration were the two fastest growing areas between 1992 and 1998. The number of persons incarcerated for offenses related to drug abuse increased 5.8 percent annually during this period. Those incarcerated during this time, reported more than 100 days of marijuana or cocaine use in their lifetime (Alcoholism & Drug Abuse Weekly, 2002).

While considering the economic costs of substance abuse, one must also consider consumers expenditures for drugs and alcohol. One report from the National Center on Addiction and Substance Abuse at Columbia University (CASA) 2003 furnished such figures. This report researched excessive alcohol consumption in adults and then estimated consumer expenditure. Excessive consumption was considered to be an average of 3.3 drinks per day, while heavier drinkers consumed, on average 12.7 drinks per day. Overall, a total of \$116.2 billion was spent for alcohol consumption in 1999 (CASA, 2003).

CASA (2003) estimated consumer expenditure of underage and adult alcohol consumption. In order to do this, data from three different national surveys for 1999 were utilized. They were National Household Survey on Drug Abuse (NHSDA), Monitoring the Future (MTF), and the Youth Risk Behavior Survey (YRBS). National surveys have often been instrumental in substance abuse research.

National Surveys

The first national survey of drug use in the general population was the National Commission on Marijuana and Drug Abuse in 1971. The commission reported that marijuana became a common form of recreation for middle and upper class college youth in the mid-1960's. This trend spread across the country, into colleges and high schools (Harrison & Pottieger, 1996).

Since 1975, *Monitoring the Future* has conducted a long-term study of American adolescents, college students, and adults through age 40. They reported their findings in several ways. First, they provided an overview of adolescent use, easy for anyone to read and understand. They also provided a more extensive analysis of the study's findings on secondary students. The study's findings on American college students and young adults are reported in a second series of volumes. For the purpose of this study, I report data from *Overview of Key Findings* (Johnston et al., 2003) and the Results from the 2002 National Survey on Drug Use and Health: National Findings (SAMHSA, 2003), an extensive analysis on secondary students.

Adolescent Substance Abuse

Some experts believe that adolescent drug use mirrors adult drug use and the social attitudes of the day (Gonet, 1994). Yet, others state that adolescent addiction differs from adult addiction. For instance, Royce and Scratchley (1996) stated that adolescents believe that adults drink to relieve stress and anxiety or to relieve personal problems. When surveyed, adolescents stated using substances because of peer pressure

and simply to get high or drunk. Adolescents use substances specifically for the physical effect (Royce & Scratchley, 1996).

Physical and Psycho-social factors

Gonet (1994) and Royce and Scratchley (1996) agree, along with studies from Substance Abuse and Mental Health Services Administration (SAMHSA), that substance abuse effects on adolescents are conceivably different than on adults. Substance use and abuse can disrupt an adolescent's development in many ways. These include such areas as forming identity, and learning coping and social skills. According SAMHSA (1999) an adolescent who has not met the developmental tasks is likely to enter his or her 20's unprepared for life as an adult.

Research studies show that alcohol-dependent teens showed impaired memory, altered perception of spatial relationships, and verbal skill deficiencies. It also takes less alcohol to damage a young brain than to damage a fully mature brain. The young brain is damaged more quickly (SAMHSA, 2003; Royce & Scratchley, 1996).

Furthermore, when adolescents begin abusing substances, their development is arrested at the age they first begin the abuse. For example, if an adolescent began abusing alcohol and marijuana at the age of 13 and continues until the age of 18, when an intervention takes place, that 18 year old will still be 13 emotionally (Gonet, 1994). Additionally, the earlier a person begins substance using behavior, the more rapid the addiction (Royce & Scratchley, 1996; Gonet 1994).

SAMHSA (2002) has reported connections with alcohol abuse and academic performance. There is a higher truancy rate for students who are drinkers. Heavy

drinkers and binge drinkers ages 12 to 17 were twice as likely to say their school work is poor than those who did not drink in the past month. Students drinking alcohol during adolescence have a reduced ability to learn, compared with those youth who do not drink until adulthood.

Hallifors, Vevea, Iritani, Cho, Khatapousi and Saxe (2002) conducted a meta-analysis of survey data that spanned twenty years and retrieved from 58 communities (and their school districts). These researchers sought to determine if there were specific risk indicators of substance abuse. They identified truancy, low grade point average (GPA) and sexual activity as strong predictors of student drug use.

Adolescent substance abuse has also been linked to health risks, aggressive behavior, and risky sexual behavior. According to the 2001 Youth Violence and Substance Use study, adolescents age 12 to 17 who reported violent behaviors in the past year reported higher rates of past year illicit drug or alcohol use compared with adolescents who did not report violent behavior. Almost 12 percent of adolescent drinkers (about 1.2 million 7th - 12th graders) engaged in alcohol-related physical fighting. Youths ages 12 to 17 who had engaged in binge drinking were four times as likely to have carried a handgun in the past year compared with youths who had not engaged in binge drinking. (SAMHSA, 2003).

Among male high school students, 39 percent say it is acceptable for a boy to force sex with a girl who is drunk or high (SAMHSA, 2003). It has also been reported that teenage girls who are heavy drinkers are five times more likely than nondrinkers to engage in sexual intercourse and a third less likely to use condoms (SAMHSA, 2003;

Van Wormer & Davis, 2003). Twenty-four percent of sexually active teens polled reported they had done more sexually than they planned because of their substance use. Also, researchers estimate that alcohol use is implicated in one – to two-thirds of sexual assault and “date rape” cases among teens and college students (SAMHSA, 2003).

Gender

According to SAMHSA (2003) adolescent females who drink exhibit higher levels of estradiol (an estrogen) and testosterone than nondrinking girls. High levels of estrogen may contribute to an increased risk for specific diseases, such as breast cancer; high levels of testosterone are associated with an increased risk of substance use. Other health risk includes bodily injury while being under the influence.

Recently, while working with adolescent girls who disclosed being sexually active and using substances, they voiced their concern for not possibly being able to stop a sexual advance while under the influence of a substance. These young women stated also that they feel pressured by males to drink alcohol or use other substances and then have sex. Van Wormer and Davis (2003) reported that girls were often introduced to alcohol by their boyfriends, who may be older and more likely to drink.

According to a report by CASA (2003) girls are often offered drugs by a boyfriend, a female acquaintance, or a young female relative. The report also suggests that girls are often more likely to receive offers to smoke, drink or use drugs in private settings. While girls may use in a more private setting, boys are more likely to receive these same offers to use in public settings. A male acquaintance, a young male relative or a parent or stranger are more likely to offer drugs to boys.

Girls differ from boys in their ease of obtaining substances, such as tobacco, alcohol. More girls than boys (72.9 percent vs. 64 percent) are not asked to show proof of age to purchase cigarettes. Teenage girls are more likely than teenage boys to report that cocaine, LSD and heroin are easy to obtain (CASA, 2003).

According to SAMHSA (2003), while the most recent rate of illicit drug use was higher for boys, aged 12 to 17, girls were more likely to use psychotherapeutics drugs nonmedically than boys. Additionally, girls and boys in the 12 to 17 year age group had comparable rates of alcohol use.

While comparing gender similarities and differences as it pertains to substance use and abuse, it has been suggested that girls and boys use drugs for different reasons. For example, young females tend to use alcohol or drugs to improve mood, increase confidence, reduce tension, cope with problems, lose inhibitions, enhance sex or lose weight, whereas young males tend to use alcohol or drugs for sensation seeking or to enhance their social status (CASA, 2003).

Von Warmer and Davis (2003) noted that males respond differently to nicotine's rewarding effects than do females. Males smoke cigarettes to relieve boredom and fatigue or increase arousal and concentration, while females smoke to decrease stress, anger and other negative feelings. Females often smoke cigarettes, and even drink alcohol, in an attempt to control their weight (Von Warmer & Davis, 2003; CASA, 2003).

Abusing substances can be more problematic for females than males when it comes to physical, mental health, and social issues. As previously mentioned, females have an increased risk, from drinking, of diseases such as breast cancer. Females also

appear to be more susceptible than males to brain damage from heavy use of Ecstasy. They are more likely, than male abusers, to experience health disorders such as liver disease and cardiac problems (CASA, 2003; Van Wormer & Davis, 2003).

Physical health is not the only thing impacted for young males and females by their substance abuse. Co-occurring disorders, such as depression and attention deficit/hyperactivity disorder, must be taken into consideration.

Co-occurring disorders.

According to the Center for Substance Abuse Prevention (CSAP) seven to ten million Americans have at least one mental disorder in addition to an alcohol or drug disorder. Among 12 to 17 year olds who were current drinkers, 31 percent exhibited extreme levels of psychological distress and 39 percent exhibited serious behavioral problems (CSAP, 2002).

Besides depression and suicide, there are other co-occurring disorders such as conduct disorder, attention-deficit/hyperactivity disorder, and eating disorders. Shrier, Harris, Kurtland, and Knight (2003) reported that sixty percent of adolescents, in a treatment setting, reported the presence of at least one type of psychiatric symptom in the past 12 months. Girls were more likely than boys to report any symptoms. Anxiety symptoms were the most commonly reported, followed by symptoms of depression among girls and attention deficit disorder (ADD) among boys. Additionally, girls were more likely than boys to report symptoms of depression and eating disorders. (Shrier et al, 2003).

Some of the literature suggests that girls with substance abuse disorders or problems are likelier to have been sexually abused. For example, Riehman, Bluthenthal, Juvonen, and Morral (2003) stated that drug using girls in the criminal justice system experience more sexual abuse and have higher rates of depression than boys. In a large multi-site study of drug using adolescents in substance abuse treatment, girls reported significantly higher rates of sexual abuse than did boys. In this same sample, more than twice as many girls than boys (16.5% vs. 5.9%) were diagnosed with clinical depression (Riehman et al. 2003).

Substance abuse contributes to risky and aggressive behavior, and underage drinking has been linked with teen suicide. SAMHSA (2003) reported that studies found girls who drink are more likely to be victims of self-inflicted violence. For instance, among eighth grade girls who drink heavily, 37 percent reported attempting suicide, whereas 11 percent of girls who do not drink report attempting suicide.

Understanding the impact of substance abuse on adolescent development is important information for school counselors to possess in order to assess substance abuse problems in their school and community. It is also important to possess knowledge of the trends of substance use. Gathering data from national surveys such as Monitoring the Future (2002) assists school counselors and counselor educators in developing and delivering programs to school communities.

2002 National Survey Findings

The 2002 National Survey on Drug Use and Health: National Findings (SAMSHA, 2003) reported that an estimated 19.5 million Americans, or 8.3 percent of

the population aged 12 or older, were current illicit drug users. Current drug use denotes the use of an illegal drug during the month prior to the survey interview. According to the survey, about half of Americans aged 12 or older reported being current drinkers of alcohol in the 2002 survey (51.0 percent). Furthermore, more than one fifth (22.9 percent) of persons 12 or older participated in binge drinking at least once in the 30 days prior to the survey and heavy drinking was reported by 6.7 percent of the population aged 12 or older.

The report also indicated that the prevalence of current alcohol use increases with age. For example, from 2.0 percent at age 12 to 6.5 percent at age 13, 13.4 percent at age 14, 19.9 percent at age 15, 29 percent at age 16, and 36.2 percent at age 17. The rate reached a peak of 70.9 percent for persons 21 years old. Furthermore, among youths who were heavy drinkers, 67.0 percent also were current illicit drug users, whereas among nondrinkers, the rate was only 5.6 percent (SAMHSA, 2003).

About 10.7 million persons aged 12 to 20 reported drinking alcohol in the month prior to the survey interview in 2002 (28.8 percent of this age group). Of these, nearly 7.2 million (19.3 percent) were binge drinkers and 2.3 million (6.2 percent) were heavy drinkers. Additionally, about 1 in 7 aged 12 or older (14.2 percent, or 33.5 million persons) drove under the influence of alcohol at least once in the 12 months prior to the 2002 interview. (SAMHSA, 2003).

The 2002 National Survey on Drug Use and Health also reported trends in lifetime substance use. For instance, the percentage of youths aged 12 to 17 who had ever used marijuana declined slightly from 2001 to 2002 (21.9 to 20.6 percent). Among young adults aged 18 to 25, the rate increased slightly from 53.0 percent in 2001 to 53.8

percent in 2002. They also reported a decline in the lifetime cigarette use among youths aged 12 to 17 from 37.3 percent in 2001 to 33.3 percent in 2002. The rate of lifetime daily cigarette use among youths aged 12 to 17 declined from 10.6 percent in 2001 to 8.2 percent in 2002. There also was a small decline in lifetime prevalence among young adults (37.7 to 37.1) from 2001 to 2002.

Johnston et al. (2003) reported the most significant change in 2002 was the drop for the first time in recent years in the use of Ecstasy in all three grades. Ecstasy, otherwise known as a “date rape” drug, use had been climbing since 1998 through 2001. In the 2002 national survey, there was a 20 percent drop.

Another trend that has been on the rise since 1989 is the prevalence of lifetime pain reliever use. SAMHSA (2003) described the use of non-medical pain reliever as the use of a prescription pain reliever, stimulant, or tranquilizer by a person that the prescription was not originally prescribed for.

Pain reliever incidence increased from 1990, when there were 628,000 initiates, to 2000, when there were 2.7 million. In 2001, the number had not significantly changed from 2000 (SAMHSA, 2003). In a two year study, CASA (2004) found the most commonly abused prescription drugs are opiotes such as Percodan, OxyContin and Vicodin; central nervous system depressants such as Valium and Xanax; and stimulants such as Ritalin and Adderall. The most dramatic increases in the abuse of prescription medications have occurred among 12 to 17 year olds and 18 to 25-year olds (CASA, 2004). Youth aged 12 to 17 increased use of non-medical pain reliever from 2001 (9.6 percent) to 2002 (11.2 percent). It had been 1.2 percent in 1989.

Also measured were the trends in initiation of substance use, otherwise known as incidence. Estimates of substance use incidence, or initiation, concern the number of new users of illicit drugs, alcohol, or tobacco during a given year. These estimates supplement prevalence estimates as measures of the Nation's substance use problem. Incidence data reports emerging patterns of use, where prevalence estimates describe the extent of use of substances over some period of time.

There were an estimated 2.6 million new marijuana users in 2001. This number is similar to the numbers of new users since 1995, but above the number in 1990 (1.6 million) (SAMHSA, 2003).

New daily cigarette smokers decreased from 2.1 million in 1998 to 1.4 million in 2001. Among youths under 18, the number of new daily smokers decreased from 1.1 million per year between 1997 and 2000 to 757,000 in 2001. This corresponds to a decrease from about 3,000 to about 2,000 new youth smokers per day (SAMHSA, 2003).

The national survey results also show that marijuana is the most commonly used illicit drug, with a rate of 6.2 percent. Of the 14.6 million past month marijuana users in 2002, about one third, or 4.8 million persons, used it on 20 or more days in the past month. Also in this report, an estimated 2.0 million people (0.9 percent) were current cocaine users, 567,000 of whom used crack. Crack is the strongest and most dangerous form of cocaine. Hallucinogens were used by 1.2 million people, including 676,000 users of ecstasy. There were an estimated 166,000 current heroin users (SAMHSA, 2003).

One School District Survey from a Western State

How do these figures from the 2002 National Survey on Drug and Alcohol use in the United States relate closer to home (i.e. Oregon)? A local school district participated in a study from 1998 through 2002, which was funded by The National Institute on Drug Abuse (NIDA) and the Center for Substance Abuse Prevention (CSAP). This study, known as the Diffusion Project, reported substance use by sixth and eighth grade students, who had reported using one of seven drugs within the past 30 days prior to taking the survey. This study found alcohol use by sixth graders had increased from 3.8% in 1998 to 5.9% in 2002. Inhalants had decreased in use by sixth graders from 10.6% to 5.2% in 2002. Marijuana use stayed at 0.5%, and tobacco use also had increased. Eighth grade students' use of alcohol had decreased from 24.2% in 1998 to 21.2% in 2002, but their marijuana use had almost doubled from 5.3% in 1998 to 10.4% in 2002 (Office of Mental Health and Addiction Services, 2002).

More recently, the high school principal at one local school in Oregon stated that there were 33 expulsion hearings conducted during the 2002-2003 school year. Of those 33 expulsions, 28 expulsions were for drug use or distribution (S. Ussery, personal communication, August 2003). In fact, at the middle school where I work as a school counselor, there were three expulsions for drug use or distribution. Several eighth grade students were suspended ten days for possession of marijuana. Finally, two eighth grade students decided to leave school before the end of the school year in order to attend residential treatment for marijuana use.

School counselors from this particular school district had implemented an educational prevention curriculum at the elementary and middle school level. Due to the

apparent increase of substance abuse in this local middle and high school, school counselors were faced with providing more interventions, such as referrals to community agencies, counseling students who had substance abuse issues in small group settings, and some relapse prevention.

In order for school counselors to work with students and address the challenges of adolescent substance abuse and other issues, school counselors need to have a clear conceptual understanding of adolescence and developmental theory (Lambie & Rokutani, 2002). This knowledge and understanding is instrumental if school counselors are to develop and work from a comprehensive guidance counseling program.

School Counseling

Comprehensive school counseling guidance models and the role of the school counselor is an essential element in this study. School counseling programs are designed to focus on the academic, career and personal/social development of all students (Campbell & Dahir, 1997). The history of school counseling, professional organization standards, and ethical and legal implications will be reviewed in this section. The role of school counseling in prevention and intervention will also be reviewed in this section.

History

The school guidance and counseling profession has evolved over the past one hundred years. Vocational Guidance was introduced in the early 1900's. In 1909, Frank Parsons organized the Vocational Bureau of Boston, while Eli Weaver established guidance foundations in the New York Public schools. Jesse B. Davis was instrumental in

forming the first professional guidance association, The National Vocational Guidance Association, in 1913 (Myrick, 2003).

The history of school guidance and counseling has been well documented in the literature (Myrick 2003; Green & Keys, 2001; Gysbers & Henderson 2001). In the beginning, school guidance introduced the concept of matching young people to jobs and preparing them for the world of work (Myrick 2003).

As education evolved and the social and political climate changed, school guidance and counseling also changed. For instance, testing and assessments became important during the 1920's, for schools, industry and the military (Myrick, 2003). During both World War I and World War II tests were used to screen and place draftees.

Another major era for change in the guidance and counseling profession was during the 1950's, especially 1957 with the Russian's launching of Sputnik, which was the first manned space flight. Congress responded to this scientific and technological achievement by passing The National Defense Act of 1958. According to Myrick (2003) this bill was one of the most significant events in the history of the school counseling profession. This bill recognized the importance of guidance and counseling and provided funds for the preparation of school counselors.

Another important figure in the school counseling movement was Gilbert Wrenn. He was appointed to chair the Commission on Guidance in the American Schools. The commission was to study the role of school counselor, as well as his or her preparation. This led to Gilbert Wrenn's writing and publishing *The Counselor in a Changing World* in 1962 (Myrick, 2003).

According to Wrenn (1962) the counselor's role should include providing individual and group counseling to students, as well as consulting with parents and teachers. Wrenn wrote about the necessity of a much expanded role of the school counselor, which could contribute to maximizing student potential by emphasizing personal growth, self-determination, and self-responsibility (Myrick, 2003).

School counseling programs have been based on a comprehensive developmental model since the late 1960's and early 1970's (Green & Keys 2001). In 1970, Dinkmeyer and Caldwell introduced the *Developmental Counseling and Guidance: A Comprehensive, School Approach*. With this developmental model, school counselors' focus for services was preventative in nature and emphasized assisting all students with mastery of appropriate developmental tasks.

According to Green and Keys (2001), this developmental model introduced several key philosophical principles as guidelines for program development. First, developmental guidance should be an essential part of the educational process and aligned with the school's mission and philosophy.

Secondly, the model included teachers as an important part of the program delivery system. In addition, the program functions best when there is a planned set of services directed at helping students accomplish tasks that lead to effective cognitive and affective development. Lastly, the program included direct and indirect services, such as counseling, appraisal, and group counseling as well as consultation with parents and teachers (Green & Keys 2001).

Other key people in the support of comprehensive developmental models were Norman Gysbers and Patricia Henderson. Gysbers and Henderson (1997) described the

origin of the first organizational framework for the comprehensive guidance program model published in 1974. The original organizational framework for the comprehensive guidance program model contained three categories of functions: curriculum-based functions, individual facilitation functions, and on-call functions.

In addition to the use of comprehensive school counseling guidance models to promote students' academic success, members with the Education Trust (Edtrust) have been promoting the inclusion of school counselors in school reform (Edtrust, 2004). Recently, the members for the Education Trust implemented the National Counselor Training Initiative (NSCTI) in February 2002. This initiative has a very specific vision, which views school counselors as ideally situated in schools to serve as advocates to promote school-wide success for all groups of students.

School counselors perform actions that support quality education for all groups of students. According to members of the Education Trust, school counselors need to be a part of the accountability system. School counselors are often in the best position to assess the school for systemic barriers that limit academic success for all groups of students (Edtrust, 2004).

As the school guidance counseling profession has evolved over the course of history, the roles and expectations of the school counselor have also changed. School counselors have an opportunity to define their roles and describe how they contribute to the academic success, social and emotional well-being, and career development of all students.

Professional Organization Standards

The American School Counselor Association (ASCA), in 1994, began the process of developing national standards for school counseling programs. ASCA believed that national standards for school counseling programs were inherent to an effective school counseling program (Campbell and Dahir, 1997).

According to Campbell and Dahir (1997) the American School Counselor Association (ASCA) National Standards for School Counseling Programs stated that school counselors must be prepared to function in a variety of roles that support the academic, career, and personal/social development of students.

In order to support students in these areas, ASCA described the primary components of delivery as counseling, consultation, coordination, case management and program evaluation. ASCA also advised that in order to achieve balance among these program components, it is necessary to maintain a realistic counselor to student ratio. The recommended ratio of one school counselor to 100 students (ideal) to one counselor per 300 students (maximum) is crucial in implementing a standards-based, comprehensive school counseling program (Campbell & Dahir, 1997).

Although the ASCA National Standards do not offer specific course content that school counselor education programs should teach, Perusse, Goodnough, and Noel (2001) found that 53.8 percent of counselor education programs surveyed, introduced the ASCA National Standards guidelines in their school counseling coursework.

In addition to the ASCA National Standards, ASCA developed the National Model, A Framework for School Counseling Programs and distributed it to members

(ASCA, 2003). In this model, ASCA describes four major components of a school guidance program. These are accountability, delivery system, foundation, and management system. These components are designed to provide school counselors a mechanism with which to design, coordinate, implement, manage and evaluate their programs for students' success (ASCA, 2003).

This current national model builds on the earlier National Standards and provides guidance for states and individual school districts in which to develop and manage an effective school guidance program. Norman Gysbers stated "It is my belief that school counselors who work within the structure of a comprehensive program, such as the ASCA National Model for School Counseling Programs, are empowered to be strong advocates for the students and parents they serve" (ASCA, 2003, p. 24).

Ethical and Legal Issues

Confidentiality is a primary ethical and legal issue that school counselors need to be aware of when working with adolescent's substance abuse issues. First, ASCA provides ethical standards for school counselors. These ethical standards address confidentiality, student records, danger to self and others, appropriate referrals, and counseling plans, to name a few. The school counselor also has ethical standards in regards to responsibilities to parents (ASCA, 2003).

Under the ASCA (2003) ethical standards, school counselors have a responsibility to keep student information and records confidential as specified by federal and state laws and written policies. It is understood that normally the counselor maintains the counselor client confidentiality.

ASCA (2003) also defined the instances where it is legally and ethically necessary to limit confidentiality such as when the student is in imminent danger of hurting self or someone else. Also, the school counselor is required to provide parents with accurate information when necessary. It is the parents' right to have information concerning their child.

Federal law titled "Confidentiality of Alcohol and Drug Abuse Patient Record" (Code of Federal Regulations 42CFR2.14, 2000) affords confidentiality to minors receiving alcohol and other drug services. Unless mandated by states requiring parental consent to treatment, adolescents may seek alcohol and drug abuse treatment without parental notification.

School counselors are required to work within ethical and legal guidelines when competing for Federal Safe and Drug Free Schools and Communities monies. School counselors need to provide researched based prevention programs. According to Coll (1995) schools that provided primary and secondary prevention programs could significantly increase service delivery effectiveness and reduce the legal risk present for school counselors by formalizing and incorporating procedures guided by current laws.

Primary prevention attempts to minimize or prevent substance use and abuse. This prevention includes education in the classroom, counseling setting, or a small group setting. Secondary prevention consists of an intervention in which students receive more in-depth counseling (Gonet, 1994). For example, if a school counselor identifies an adolescent experiencing substance abuse problems, on-site services, such as group and individual counseling can be delivered. The school counselor may legally be able to discuss the student's problems with other school staff in order to determine the extent of

the problem, such as in a care team format. But, the legal implication is that once the student is evaluated and begins substance abuse counseling, school personnel must comply with federal regulations for confidentiality.

Confidentiality must be maintained for adolescents experiencing substance abuse problems and seeking assistance. A conflict exists when under the Family Educational Rights and Privacy Act (FERPA, 2004), the student's record may be reviewed by the parent or adolescent (20 USC1232 §99.10 Subpart B). If the adolescent has refused consent, the school counselor legally cannot discuss his or her case with the parent. Yet, if the parent request to review the adolescent's record, by FERPA, the school counselor must provide the school record for the parent's review (FERPA, 2004).

According to Coll (1995) an exception to the confidentiality law occurs when the adolescent discloses a serious crime, such as homicide, rape, kidnapping, child abuse and neglect, assault with a deadly weapon. The counselor should attempt to get consent from the student, but counselor disclosure to the proper agencies is permitted as an exception under the confidentiality regulations.

School counselors have an ethical responsibility to their students, parents and school administrators. When a conflict or question arises concerning confidentiality or legal consent, school counselors need to consult with colleagues and their administrators to ensure the safety and privacy of the client. According to Glosoff and Pate (2002) school counselors need to know applicable ethical codes and state and local applicable laws and remain vigilant of ethical and legal concerns.

School Counselors' Role in Primary and Secondary Prevention

As stated earlier, school counselors provide services to students, school staff and community members not only in the areas of academic achievement but in prevention, responsive services, community partnerships and collaboration and consultation (Myrick, 2003). Therefore, this literature review looks at the role of school counselors in providing prevention to students with substance abuse issues.

Lambie and Rokutani (2002) stated that school counselors face many challenges in their work counseling adolescents who are abusing substances. To illustrate, these authors suggested that school counselors are often not trained in identification of the symptomology of substance abuse, the role of the family in the perpetuation and healing of substance abuse, or the role of the school counselor working with adolescent substance abuse issues from a systems perspective. Because substance abuse is often viewed ambivalently, parents and helping professionals may experience difficulty differentiating between nonproblematic and problematic substance use.

Hawes & Benton (1990) conducted a needs assessment study of school counselors in rural school settings. According to these researchers, perceptions exist that school counselors possess the skills necessary to work with students with substance abuse issues, although school counselors are not consistently trained in substance abuse issues. The study revealed that high school and middle school counselors, more so than elementary school counselors, felt they needed more training concerning substance abuse. The findings concluded that counselors need training in developing techniques to confront the

student, training in interventions, such as helping the student access appropriate treatment programs or support groups and consultation with parents or agencies.

In addition, as models for effective school counseling programs develop and change with the needs of the students, schools and communities, the roles of school counselor change and may need to be redefined. For example, one aspect of the school counselor's role is providing responsive services for at-risk youth and their families. Keys, Bemak, and Lockhart (1998) identified 24 areas of knowledge and skills for the school counselor, which hold particular relevance to the counselor working with at-risk youth. The 24 areas are placed within four major themes. One theme relates to understanding the differences between normal and abnormal development and recognizing students who are functioning outside the range of normal development. This includes knowledge and use of the Diagnostic and Statistical Manual of Mental Disorders. Another theme pertains to acquiring skills for direct and indirect services, including short-term models of intervention, family counseling, individual crisis intervention and collaborative consultation (Keys et al., 1998). All four of the themes recommend the need for school counselors to gain specific knowledge about substance abuse and providing appropriate interventions.

Primary Prevention

As mentioned previously, primary prevention attempts to reduce or stop the occurrence of substance use and abuse. Royce and Scratchley (1996) further defined primary prevention as direct and indirect prevention. Direct prevention aims at blocking or removing the causes of substance abuse. Some strategies utilized in direct prevention

are: 1) Alter public attitudes, socio-cultural factors, and environmental conditions 2) Educate the community, especially high-risk populations, concerning the risk and consequences of substance abuse 3) Influence positively the individual's decision-making skills regarding use, misuse, or nonuse and 4) Provide adequate role models and other means of developing social skills and coping skills.

Indirect primary prevention refers to strategies or interventions that are not directly aimed at substance abuse, but its prevention is the hoped for outcome. Examples of indirect prevention are improving the quality of life and developing adequate social skills (Royce & Scratchley, 1996). Indirect primary prevention in the school environment might resemble a program that promotes a feeling of belonging in all students, in which students feel involved and connected to school.

Education and skills building training are generally used in schools as early as elementary school in the effort to prevent children from experimenting or falling prey to the pressure of using alcohol, tobacco or other drugs. According to Gonet (1994) this prevention needs to begin as soon as kindergarten.

In one study that attempted to identify the successful components of a prevention program, students reported the two most important factors of their prevention program were providing a safe, confidential setting at school during which discussions about drugs and alcohol were encouraged, and being able to have open lines of communication with parents about drugs and alcohol (Coker, 2001)

Recent research has found some programs, such as D.A.R.E to be ineffective (Clayton, Leukefeld, Harrington, & Cattarello, 1996) because of the conflicting messages students receive. Other programs that involved "one-shot" assemblies and presentations

were found to be ineffective (Gonet, 1994). In order for school counselors to address substance abuse issues, they must be able to explore and implement researched-based prevention programs in their school's counseling programs.

Schinke, Brounstein, and Gardner (2002) researched numerous prevention programs in order to identify factors that contributed to successful prevention programs. They reviewed theory and developed a conceptual framework in which to determine the effectiveness of prevention programs.

Schinke et al. (2002) discovered that prevention programs which consistently focused on risk and protective factors were generally more effective. They stated risk factors include biological, psychological/behavioral, and social environmental characteristics such as family history of substance use, depression or antisocial personality disorder, or residence in neighborhoods where substance use is tolerated.

Risk factors also can include early aggressive behavior, lack of parental supervision substance abuse, drug availability and poverty (NIDA, 2004). Simply stated, the more risk factors a student experiences, the more likely it is that he or she will experience substance use and related problems in adolescence or as a young adult.

The National Institute on Drug Abuse (NIDA) also recognized that risk and protective factors can affect children at different stages of their lives. Risk factors can add to a person's risk and increase the likelihood of substance abuse. They stated that at each stage, risks occur that can be changed through prevention and interventions. Furthermore, early childhood risks, such as aggressive behavior, can be changed or prevented with school, family, and community interventions. If not addressed, negative

behavior can create more risks, which contributes to academic failure and social difficulties, which put children at further risk for drug abuse (NIDA, 2004).

Just as risk factors have been found to contribute to substance abuse, protective factors have been recognized as reducing the risk of substance abuse. Schinke et al. (2002) also described protective factors and resilience that acted as safeguards for adolescents against substance abuse disorders. They stated that just because a student may have numerous risk factors, the same student may be provided with protective factors that build resilience and reduce the chances of substance abuse disorders.

Search Institute (2003) also defined 40 developmental assets that contribute to protective and resiliency factors. These assets consist of positive experiences and qualities considered essential to raising young people.

The developmental assets framework is divided into two groups of 20 assets. The first group is the external assets. These 20 assets are the experiences that adolescents receive from their environment. The second group is the internal assets, which identify characteristics and behaviors that reflect positive internal growth and development of adolescents (Search Institute, 2003). Research has found the more assets adolescents have in their life, the more likely they are to make sound decisions and resist substance use and abuse.

NIDA developed sixteen principles of prevention to help parents, educators, and community leaders provide research-based substance abuse programs. The first four principles address risk factors by utilizing protective factors. NIDA state that these four principles should address all forms of drug abuse, alone or in combination, including underage use of legal drugs (e.g., tobacco or alcohol) and the inappropriate use of legally

obtained substances (e.g., inhalants), prescription medications, or over-the-counter drug (NIDA, 2004).

Principle five addresses family-based prevention programs which should enhance family bonding and include parenting skills; practice in developing, discussing, and enforcing family policies on substance abuse; and training in drug education and information. School counselors, with community partnership and collaboration can contribute to family-based prevention.

Additionally, school prevention programs are developed from principle six through eight. NIDA defined these three principles as developmentally appropriate for elementary through high school students. For example, principle seven is designed for elementary school children and targets academic and social-emotional learning to address risk factors for drug abuse, such as early aggression, academic failure and school dropout. The prevention should focus on developing skills in self-control, emotional awareness; communication, social problem-solving and academic support (NIDA, 2004).

Four of the principles also address community prevention programs. The last five principles address prevention program delivery. NIDA stated that research-based prevention programs can be cost-effective. For every dollar invested in prevention, a savings of up to \$10 in treatment for alcohol or other substance can be realized (NIDA, 2004).

In addition to school counselors providing primary prevention in schools, they need to possess knowledge and skills in securing funding, such as grants through SAMHSA Substance Abuse Treatment and Prevention and Safe and Drug Free School, in

order to not only provide primary prevention in their school counseling program but also to build a successful secondary prevention program (Schinke et al. 2002).

Thombs (1999) stated that there have been school based preventive interventions that have demonstrated effective approaches to deterring substance use among youth. Additionally, there were several community based preventive interventions, with parent and school components that also proved effective in deterring adolescent substance abuse. Many school counselors already provide research based curriculum in the classroom, or support teachers' guidance lessons.

Mclaughlin and Vacha (1993) stated that in order for school based prevention programs to be successful, they must be linked with outside institutions and families in the local community. They argued that the school counselor is in a position to act as the liaison, bridging school, family and community programs.

Secondary Prevention

Because of the statistics of substance abuse, such as the National Survey on Drug Use and Health (2002), more is needed from schools and communities in the prevention of adolescent substance abuse. School counselors could provide secondary prevention in their schools, as part of a comprehensive guidance counseling program.

Royce and Scratchley (1996) stated "addiction can be prevented from developing into serious problems through intervention, whereby it is interrupted in its problem or moderate state" (p. 198). Simply stated, early detection and treatment are considered secondary prevention. Other elements of secondary prevention include public education,

which teach about the dangers of substance abuse, and the promoting the acceptance of treatment, contribute to an effective prevention program.

Palmer and Paisley (1991) presented a structured school-based program for intervention, or secondary prevention. In the school, secondary prevention is an intervention in which the school counselor is able to identify and assess what the student's needs are, such as a referral for an in-depth assessment or attending an in-school counseling group.

According to Palmer and Paisley (1991) a school based Student Assistant Program consists of identification, assessment, referral and follow-up. The school counselor, with training, is able to provide an assessment. A referral may be made to another professional who is trained to conduct a thorough assessment. Other referrals might be more appropriate, such as to an outside agency or more intensive counseling. Follow-up is considered a progress check to determine whether the intervention met the student's needs, and whether the student needs continuing support.

Similarly, Johnson (2003) described the continuum of prevention model used by the National Institute of Drug Abuse. This model has been normally initiated in three stages of problem development, offering a continuum of intervention from educative information on one end to recovery on the other end.

This continuum of care promotes primary prevention, secondary prevention and tertiary prevention. Tertiary prevention is considered to be the actual treatment and rehabilitation of the person with the addictions. According to Royce and Scratchley (1996) although this level is considered treatment, it is still also considered prevention because it prevents further damage to the addict and those affected, and prevents relapse.

The school counselor is able to provide support if the student is returning to school from treatment.

While working with numerous students, as they returned from residential or intensive inpatient treatment programs, the author found that the students needed and wanted the additional support in adjusting to school, home and their environment. These students were learning to use new coping skills, along with living without the use of their substance, and often trying to find a new peer group in which they fit.

Johnson (2003) stated that for adolescents' there must be developmentally appropriate intervention methods, which consider not only family relationships, but also peer relationships, academic-work environment, and the community. School counselors, with their training, are able to create interactive environments such as peer counseling groups and skill development, in addition to educational classes.

School counselors, with training, are in a prime position to provide screening and initial assessment of adolescents who may be at risk of or are abusing substances. According to SAMHSA Treatment Improvement Protocol (TIP) Series 31 (1999), many health and judicial professionals, including school counselors, street youth workers, probation officers, and pediatricians should possess screening expertise. Schools should screen youth who show an increased oppositional behavior, significant changes in grade point average, and an increasing number of unexcused absences.

School counselors, with training, could provide an initial assessment with recommendation for further interventions. School counselors are afforded opportunities to access important information concerning the adolescents' lived experiences such as school history, academic performance, extracurricular activities and attendance problems.

Also, school counselors often know or can easily find out information about the adolescent's peer relationships, interpersonal skills, gang involvement, and neighborhood environment (SAMHSA, 1999).

Furthermore, an initial assessment is one intervention that the school counselor can perform in order to collaborate and coordinate services for the adolescent. Adelman and Taylor (2002) stated that school support programs can provide an extensive range of preventive and corrective activity directly addressing students' needs and problems. School counselors can play a pivotal role in coordination and collaboration of services for students at risk of failure or dropping out because of substance abuse and other issues.

Allen (1994) described the school counselor as the most appropriate educator to facilitate a culture of collaboration in order to promote positive student outcomes. The school counselor provides information on outside resources and acts as change agent to develop collaborative relationships by facilitating change through programs of prevention and intervention for all students. Conceivably, school counselors working within a comprehensive developmental counseling and guidance program, are best situated to coordinate school-linked and community-linked services for students.

In a recent Drug and Alcohol Services Information System (DASIS) report, about 10 percent (15,000) of substance abuse admissions aged 18 or younger were referred by schools. School-referred youth admissions to substance abuse treatment mostly involved marijuana (56 percent) or alcohol (24 percent) as the primary substance of abuse. Furthermore, admissions referred by schools were more likely to be receiving treatment for the first time than admissions referred by other sources (85 vs. 66 percent) (DASIS, 2004).

According to Sales (2000), all counselors, no matter what work setting or clientele, will counsel individuals with presenting or related substance abuse problems. However, he also stated that prior to completion of a training program school, rehabilitation, and mental health counselor education programs do not require advanced knowledge in this area. Still it has been proffered that school counselors can, should, and need to be able to recognize and provide interventions for adolescents dealing with substance abuse. Yet one question remains. Is there sufficient training for school counselors in counselor preparation programs?

To address this issue Hayes & Paisley (2002) recommended restructuring school counselor preparation programs and adopting a systemic approach to enable school counselors to serve as educational leaders who advocate for all children. Counselor educators also need to ask themselves challenging questions about the content of courses and preferred teaching strategies employing CACREP Standards as a guideline for the basic content of preparation programs. Courses, such as substance abuse training or addictions are not mentioned. In many programs content areas such as educational leadership, educational psychology, families, schools and communities are elective courses, taught outside the department with collaborating faculty from other departments (Hayes, Paisley, 2002).

Furthermore, in a proposal for the transformation of the school counselor training program at the University of Nebraska in Lincoln, Scheel (2003) wrote that an important principle foundational to the proposal suggested that school counselors should gain training about the comprehensive guidance role. The model emphasized four primary functions of a school counselor: 1) responsive services, (i.e. counseling, crisis

intervention; consultation), 2) guidance curriculum, 3) administrative services and 4) evaluation and assessment. The proposed classes in the schema included developmental psychopathology in children and adolescents and psychology of the child or adolescence. Still, the proposal did not state specifically if substance abuse and addiction would be addressed in one of these content courses.

CACREP Standards

Introduction

The American Counseling Association (ACA) created the Council for Accreditation of Counseling and Related Educational Programs (CACREP) in 1981. CACREP was designed to provide a national set of consistent standards for counselor education programs, which today is considered the “Gold Standard” for counselor education. These standards provide minimal criteria for the preparation of professional counselors, counselor educators, and student affairs professionals.

CACREP accredited programs must document how each program meets the standards set forth in six sections: I) the institution II) program objectives and curriculum III) clinical instruction IV) faculty and staff V) organization and administration VI) evaluations in the program.

CACREP standards are written to ensure students develop a professional counselor identity and become proficient with knowledge and skills to be effective counselors. Specifically, there are eight core elements in section II, which prescribes curricular experiences and demonstrated knowledge required of all students in all counselor programs.

These common core areas defined as: 1) professional identity, 2) social and cultural diversity, 3) human growth and development, 4) career development, 5) helping relationships, 6) group work, 7) assessment, and 8) research and program evaluation. These core areas are required for the nine programs, one being school counseling, that CACREP grant accreditation.

In addition to the general eight core areas that guide all counselor education programs, CACREP Standards (2001) also prescribe a list of curricular experiences and demonstrated knowledge and skills that are required of all students in a school counseling program. Curricular areas specific for school counseling programs are: 1) foundations of school counseling 2) contextual dimensions of school counseling and 3) knowledge and skill requirements for school counselors. The knowledge and skill requirements are further divided into three areas of program development, counseling and guidance, and consultation. (See Appendix A).

CACREP (2001) recognized the personal social domain within the counseling and guidance knowledge area. Described in section C.2.h. (Knowledge and skill requirements for school counselors), school counselors must be knowledgeable in approaches to recognizing and assisting children and adolescents who may use alcohol or other drugs or who may reside in a home where substance abuse occurs.

Furthermore, CACREP (2001) delineated under section C.3.c (Consultation) that school counselors will know strategies and methods of working with parents, guardians, families, and communities to empower them to act on behalf of their children. School counselors will also demonstrate the knowledge and skills in conducting programs that

are designed to enhance students' academic, social, emotional, career, and other developmental needs.

CACREP (2001) stated that no professional preparation program is ever complete. Advances in knowledge, skills and technology within the counseling profession, require life-long learning for counselors as well as monitoring and review of professional standards.

Role of CACREP in School Counseling Training

Both CACREP Standards (2001) and ASCA's National Model (2003) of school counseling are general guidelines that provide a framework for counselor education programs to provide consistent training to pre-service school counselors. The literature discussing CACREP accredited counselor education programs' course content and delivery of substance abuse training is almost nonexistent.

Interestingly, only a few studies were found specific to substance abuse or addictions training in counselor education programs. One study by Morgan and Toloczko (1997) surveyed CACREP accredited programs to determine what type of addictions information made up the course content and whether the courses were required or elective. They reported that 97% (n=70) of their respondents indicated addiction-related training in counselor education was needed. Additionally, only 21 (30%) of the programs required the course and 77% of the programs provided it as an elective.

Carroll (2000) cited Buckalew and Daly's (1986) call for counselor education programs to train school counselors in counseling students with drug issues. She further stated that by 1991, only seven CACREP accredited counselor education programs

reportedly offered opportunities for students to specialize in substance abuse counseling. Carroll's (2000) study looked at what interventions counselors would choose to use with a hypothetical client based on how many credit hours of addictions training they had received. Carroll (2000) found that counseling students with at least 3 semester hours of instruction in substance abuse counseling are more likely than students who have received less instruction to treat or refer a client for substance dependence rather than another problem.

Carroll (2000) recognized the limitation of her study and suggested that further research was needed to extend her study. She stated that it would be necessary to conduct a broader study to determine the content of the substance abuse instruction participants had received.

In a national survey of CACREP- accredited counselor programs, Perusse, Goodnough and Noel (2001) investigated how counselor educators across the country prepare entry level school counseling students to meet their future job requirements. They described CACREP's 1994 standards, in general terms, and acknowledged that even though CACREP provides structure for school counseling programs, there is variation within CACREP-accredited programs. Furthermore, they reported that course content for counselor education programs may be influenced by state certification and licensure requirements. One of their findings on course content was that out of 189 useable surveys, 62 (32.8%) counselor education programs required substance abuse counseling for school counseling students. Out of these, 9 (14.5 %) programs had required specifically designed substance abuse counseling for school counseling students (Perruse et al 2001).

Additionally, Lenhardt (1994) stated that substance abuse training within academic programs seemed underdeveloped. She cited a number of authors from literature written throughout the 1980's and 1991, all of whom strongly supported the need for counselor education programs to train counselors in primary prevention, as well as intervention skills in substance abuse courses.

Finding limited information on CACREP-accredited counselor education programs providing substance abuse counseling courses for school counselors, while reviewing the literature for this study, supports the need for this study.

Support for the Approach to the Study

The limited amount of literature found on substance abuse counseling training in school counseling programs, while reading literature that reported the need for substance abuse counseling training, guided the approach to this study. Hawes and Benton (1990) conducted a needs assessment of rural school counselors and found that school counselors needed specific training in drug abuse prevention and intervention training. Additionally, information concerning risk and resiliency factors related to substance abuse is required by school counselors.

Carroll (2000) suggested further research be conducted to determine course content and the number of required or elective hours students needed to complete. Morgan and Toloczko (1997) conducted a telephone survey to determine course content and the number of hours that counselor education programs required of their students. At the time of their study, there were only 86 CACREP programs and only 70 of those

programs responded to the telephone survey. Today, there are 153 CACREP school counseling programs.

Considering the recommendations and expanding on previous research (Carroll, 2000; Morgan & Toloczko (1997), a written survey was designed by the researcher. Also, the written survey was used in order to reduce the possibility of nonresponse error. The survey will also invite comments, which provides the opportunity to gain additional information that may have been excluded from a provided set of answers. The survey will be mailed to all school counseling programs.

Summary

Substance abuse continues to present concerns for adults and children in the United States. Studies since the 70's have followed trends of substance use. Although some illicit drug use among adolescents has decreased, other drugs are still popular and readily available.

School counselors are instrumental in providing primary prevention and could and should be providing secondary prevention. Yet the literature reveals that they are not generally trained in substance abuse counseling. School counselors' interventions with adolescents would contribute to a positive safe and drug free school environment.

ASCA's Framework for School Counseling programs provides a framework for school counselors to develop comprehensive guidance counseling programs. These programs help school counselors provide services to all students and contribute to academic, personal/social and emotional well being.

CACREP accredited school counseling programs also follow a set of standards, in addition to the National Standards and ASCA framework, in which counselor educators design and train pre-service school counselors. Yet, these standards are general guidelines and do not dictate exact course requirements. The CACREP (2001) standards state that school counselors will meet the competency of recognizing and assisting children and adolescents who may use alcohol or other drugs or who may reside in a home where substance abuse occurs.

To this end, it is not clear if CACREP-accredited programs have consistent training for school counselors, due to a lack of literature and research in this area. For example, only one study by Morgan and Toloczko (1997) has surveyed CACREP-accredited counselor training. Since that one study CACREP-accredited school counseling programs have nearly doubled since then.

Chapter 3: Methodology

This chapter outlines the methodology used for this study. The following areas will be addressed: an overview of the study, population and participants, research design, research procedures, demographic and programmatic variables, measurement procedures, data analysis and methodological limitations.

Overview

This is a quantitative study designed to assess the training of pre-service school counselors in substance abuse counseling in CACREP school counseling programs. The author designed a survey instrument specifically for this study. The Dillman method was used to administer the instrument. Survey results are analyzed using descriptive statistics.

Population/Participants

The population for this study consists of 150 CACREP liaisons from school counseling programs in the United States. The list of CACREP school counseling programs was obtained from the American Counseling Association (ACA, 2003) Council for Accreditation of Counseling and Related Programs (CACREP) website December 2003. The participants in this study were seventy nine ($n=79$) CACREP liaisons who responded to the survey.

Respondents Demographics

Fifty three (n=42) percent of the respondents were female and forty seven percent (n=37) were male. The majority of the respondents reported their racial/ethnicity as white, euro, non Hispanic/Latino (92%). The remainder of the respondents reported their racial/ethnicity as Asian/Pacific Islander (1%), Hispanic/Latino (1%), Multiracial (White Euro American and Native American) (2%) and two percent declined to respond.

Forty percent of the respondents were full professors, with associate professors (33%), assistant professors (24%), and full time instructor/lecture (1%) constituting the rest of the respondents. One respondent (1%) indicated other as employment status. The respondents reported a range of one to 33 years in Counselor Education.

The majority of the respondents reported the semester school system (n=72, 91.1%) as being the system their schools used. Six respondents (7.6%) reported being on the quarter system, while one respondent reported their school used a trimester.

Respondents also indicated the length of their school counseling programs in credits.

The majority of the respondents' school counseling program required 48 credits (45.6%).

The next most prevalent required credits were 60 credits (19%). The rest of the school counseling programs ranged from 42 (1.3%) to 95 (1.3%) credits.

Respondents also indicated the number of school counseling masters students annually accepted into their programs. There was a wide range of students accepted in to programs, with the smallest number of seven (1.3%) and 100 students (2.5%) making up the largest number. The most common number of students accepted into a school

counseling program was 20 students (15.2%). Other programs with similar student averages were 15 students or (12.7%), 10 students (11.4%) and 25 students (10.1).

The survey included demographic information concerning the number of faculty in the department with training and experience in substance abuse counseling. Thirty nine percent ($n=31$) reported having one faculty member with training and experience. Thirty five percent ($n=28$) reported two faculty member and ten percent ($n=8$) reported not having any faculty members with training and experience in substance abuse counseling. Ten percent of the respondents reported having three to five faculty members in the department with training and experience. Five percent ($n=4$) did not provide an answer.

Research Design

A descriptive research design is used in this study. A survey instrument entitled "Pre-Service Preparation in Grief/Loss and Substance Abuse Counseling Survey" was designed by the author and another researcher. The author designed the survey questions for the section specific to substance abuse counseling. Therefore, only the questions pertaining to substance abuse counseling will be analyzed for this study. The demographics section of the survey was designed by the author and a second researcher, and will be shared by both researchers.

Content and face validity were established by two means of ensuring validity. First, a pilot survey, along with request for feedback, was mailed to six school counseling programs in a Western State. The responses were incorporated into the first version of the questionnaire. Next, the survey section containing the substance abuse counseling

questions was then distributed to five professors with expertise in substance abuse counseling and school counseling programs. Recommendations from three professors were used to modify the survey.

The questionnaire contained three sections. The first section asked eight demographic questions regarding the program and respondent. The second section was on pre-service substance abuse training. The third section addressed pre-service grief and loss training. The third section's data is not used for this study.

The substance abuse training section asked three questions. Each question had a checklist of possible responses. Respondents were requested to check all answers that applied to their program. The first question asked if and how training in substance abuse counseling was delivered in their program. The five possible responses each included an area where course title and number of credits could be hand written on the survey. The second question addressed specific content covered in the substance abuse counseling curriculum. The third and last question asked what reasons substance abuse counseling was not covered in the curriculum, if respondent had answered no on the first question. See Appendix B for the complete final survey instrument.

Research Procedures

The "School Counselor Pre-Service Preparation in Grief/Loss and Substance Abuse Counseling Survey" was submitted to the Oregon State University Institutional Review Board and approved for dissemination to human subjects in January, 2004.

The survey was distributed using The Total Design Method by Dillman (2000).

The author initiated all mailings from Corvallis, Oregon. All return envelopes were addressed to the author at her box at Oregon State University. In February 2004, each CACREP school counseling program was mailed a packet including the following:

1. A signed cover letter explaining the purpose of the study, ensuring confidentiality, outlining voluntary participation, and stating informed consent is implied by the return of the enclosed survey (Appendix B).
2. A copy of the School Counselor Pre-Service Preparation in Grief/Loss and Substance Abuse Counseling Survey (Appendix C).
3. A self addressed, stamped envelope. The envelope was addressed to the two researchers at their box at Oregon State University.
4. A self addressed, stamped postcard for participants to voluntarily return if they are willing to be contacted for follow up questions or future studies related to grief and loss and/or addictions counseling (see Appendix D).

Exactly one week after the first mailing of the survey, a follow up postcard was sent to all programs (Appendix E). The postcard will serve both as a thank you to those who have already completed and returned the survey, and as a reminder to do so for those who have not.

Three weeks after the first mailing, a follow up letter (Appendix F), survey and self-addressed, stamped return envelope was sent to all non-respondents. A final appeal letter, including the survey and self-addressed, stamped return envelope will be sent to all non-respondents five weeks after the initial mailing.

The returned surveys were cross referenced with the sender number on the envelopes with the master list of CACREP programs and examined for completeness.

Each participant may elect to receive a copy of the results. This will also be noted on the master list. Upon final completion of the study, respondents who requested a copy will be sent the results.

Variables

The survey instrument includes the demographic and school counseling program variables. Each entry on the survey is considered a variable and will be coded and entered into the SPSS statistical program. The following variables are coded as follows:

Demographic Variables

Gender : Specify gender as male, female or other.

Coding:

1: Female	2: Male
3: Other	999: Missing

Racial/ethnic identity: Respondents are asked to check all that apply to best describe their racial/ethnic identity.

Coding:

1	African American/Black, non Hispanic/Latino
2	American Indian/Native/Alaskan Native, non Hispanic
3	Asian or Pacific Islander, non Hispanic/Latino
4	Hispanic/Latino
5	White, Euro, non Hispanic/Latino
6	Multiracial

7	If none of the above choices apply to you, please use your own description.
8	Decline to respond
999	Missing

Employment status: Respondents are asked to provide their employment status.

Coding:

1	Full Professor
2	Associate Professor
3	Assistant Professor
4	Full time instructor/lecturer
5	Part time adjunct professor/lecturer
6	Other
999	Missing

Length of Term: Respondents are asked to check the term system followed by their university.

Coding:

1	Semester
2	Quarter
999	Missing

Length of School Counselor degree program in credits: Respondents are asked to write the number of credits required to complete the school counselor program.

Coding:

1:	Number of credits
999	Missing

Number of school counseling masters' students annually accepted into your program:

Respondents are asked to specify the number of students generally accepted into the school counseling program on an annual basis.

Coding:

#	Number of students
999	Missing

Number of faculty in your department who have training and experience in substance abuse and grief/loss counseling: Respondents are asked to supply a number of faculty in his/her department with training and experience in the two subject areas.

Coding:

#	Substance abuse counseling
999	Missing entry in substance abuse counseling
#	Grief/loss counseling
999	Missing entry in grief/loss entry

Additional comments: Respondents have the opportunity to include written comments.

Coding: verbatim

Texts or Readings utilized in courses: Respondents have the opportunity to write names of textbooks or supplemental materials utilized in the course.

Program Variables:

How is training in substance abuse counseling delivered in your program: Respondents are asked to choose the type of course or module through which substance abuse counseling training is delivered. Space is also provided for respondents to write course title(s) and the number of credits or hours in the course or courses.

Coding:

1: Yes	2: No	999: Missing	Required course(s) in program
1: Yes	2: No	999: Missing	Elective course(s) in program
1: Yes	2: No	999: Missing	Specific Module in required course
1: Yes	2: No	999: Missing	Specific module in elective course
1: Yes	2: No	999: Missing	Not included in program at this time

What specific content is covered in the area of substance abuse counseling in your course/s: Respondents are asked to choose from a list what content areas are covered in their program. The respondents are also given the opportunity to write in a response, not listed.

1: Yes	2: No	Substance abuse and dependence theory
1: Yes	2: No	DSM IV Criteria for substance abuse and dependence
1: Yes	2: No	Assessment of substance abuse and dependence

1: Yes	2: No	Stages of Addiction
1: Yes	2: No	Types of interventions
1: Yes	2: No	Treatment modalities
1: Yes	2: No	Relapse prevention
1: Yes	2: No	Referral resources
1: Yes	2: No	School based prevention program
1: Yes	2: No	Risk/resiliency factors
1: Yes	2: No	Etiology of addiction

If substance abuse counseling is not covered in your curriculum, what are the primary reasons: Respondents are asked to specify the reasons substance abuse counseling training is not offered in their program.

Coding:

1: Yes	2: No	No room to add more credits
1: Yes	2: No	Not a CACREP requirement
1: Yes	2: No	Lack of staff willing/able to teach
1: Yes	2: No	Financial limitations
1: Yes	2: No	Not a relevant topic area to include for school counselor
1: Yes	2: No	It is offered in another department

Data Analysis

Descriptive statistics are defined as statistical procedures that organize and summarize data (Cronk, 2002). They provide simple summaries about the sample from

which data was obtained. Therefore, descriptive statistics are utilized to organize and summarize the collected data in this study. All data will be entered into and analyzed by SPSS statistical program. For each question, frequencies, and measures of central tendency, including mean and standard deviation will be computed.

This study's purpose is to determine how many CACREP programs are currently offering substance abuse counseling training and what information is included in the courses. There are several opportunities on the survey for respondents to include written comments in this study. The written information will be reported verbatim in a summary of each question.

Methodological Limitations

This study has several methodological limitations. First, 150 CACREP school counseling programs across the country were included in this study, while non-CACREP school counseling programs were not included in the sample. Therefore, the data gleaned from this study is only representative of CACREP school counseling programs.

A nonresponse error is a possible limitation of this study. This occurs when a significant number of people do not respond to the survey and are different from those who do respond to the survey (Dillman, 2000). For example the CACREP liaison may not be the actual person who needs to complete the survey. Although the list of CACREP programs was recently acquired, it may not be as up to date with the correct name of the CACREP liaison.

Additionally, the CACREP liaison may pass the survey along to another faculty member. Regardless of who received the survey to complete, that person may not be the professor who teaches the substance abuse class or have accurate knowledge of the course content.

Chapter 4: Results

This chapter describes the statistical analyses gleaned from the results of the survey conducted in this study. Tables accompanying analysis of the data will be presented according to survey questions.

The central purpose of this study was to gather information concerning pre-service substance abuse training in CACREP accredited school counseling programs. Therefore, questionnaires were sent to all CACREP accredited programs in the United States. A total of 150 questionnaires were mailed, adhering to the Dillman Total Design Method (2000).

A total of 79 CACREP programs responded to receiving the questionnaire, resulting in a response rate of 53 percent. All questionnaires were determined to be usable.

The analysis of the data for the study is presented in three sections. The first section reports the data on the various delivery methods of substance abuse training in school counseling programs. The frequency and range of credit hours for each delivery method are also reported. Respondents had the opportunity to write the title of their courses. These titles will also be included in table format in this chapter.

The second section presents the results of course content. While respondents had eleven specific topics in which to check, they also had the opportunity to include content that was not listed.

The third section reports the primary reasons that substance abuse is not covered in their curriculum. Respondents were provided with six reasons in which to choose and the opportunity to write in a reason that may have not been included.

Training Delivery Method

Of the 79 respondents, ninety-one percent ($n=72$) reported that their programs included training of some sort, while eight percent ($n=6$) did not offer any substance abuse training. Thirty five percent ($n=25$) indicated students received substance abuse training through required courses. Of these thirty five percent, seventy two percent ($n=18$) of the programs indicated their student take at least a 3 credit course. One program required a 2 credit class, one program required a 4 credit class, and 2 programs required 6 credits or two courses in substance abuse.

Sixty seven percent ($n=48$) reported substance abuse training was received in one or more elective courses. The most common number of credits obtained from an elective course were 3 credit hours or 46% of programs ($n=33$). The range of credits for an elective course ranged from one credit to 18 credits. Several programs offered a certificate in substance abuse counseling, while one program also included an opportunity for students to participate in a field experience.

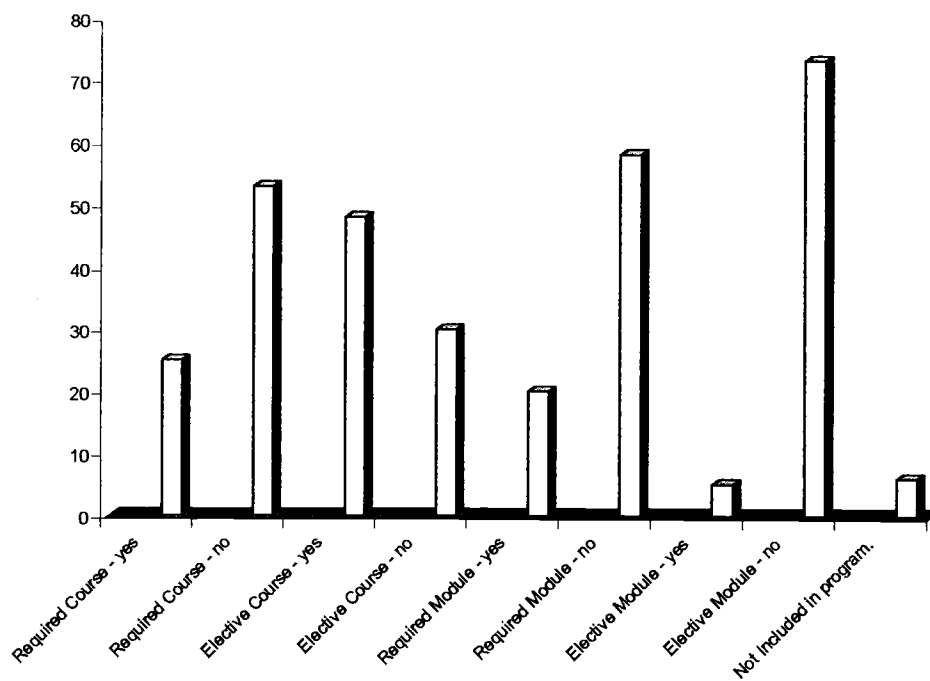
Twenty eight percent ($n=20$) conducted substance abuse modules in a required course. Substance abuse modules in required courses ranged from 3 credits (13%) to 15 credits/hours (.01%). Some respondents reported the required modules were in courses such as internship, practicum, and other topics in counseling education.

The last category for training delivery method was receiving substance abuse training in a module in an elective course. Seven percent ($n=5$) of the respondents reported this delivery method for their students to receive substance abuse training. Credits in an elective module ranged from 2 credits to 12 credits. Only three programs included the number of credits on their returned survey.

Overall, only eight percent ($n=6$) reported no substance abuse training was provided to students in school counselor programs. One respondent wrote a statement of being unsure if substance abuse training was offered in the curriculum for school counselors and left the three questions blank.

TABLE 1

Training Delivery Method



Course Titles

Fifty two percent ($n=38$) respondents indicated the name of their required course or the name of the course in which substance abuse was delivered in module format. Names for required courses were often entitled Substance Abuse Counseling, The Addictive Process or Chemical Dependency. A summary of the titles, along with delivery method is contained in table two.

TABLE 2	
Summary of Courses Offered	
Course Title	
Required Courses	
Drug & Alcohol Counseling	
The Addictive Process	
Approaches to Drug and Alcohol Counseling	
Substance Abuse Counseling	
Developmental Counseling in Schools	
Counseling Students with Disabilities	
Chemical Dependency	
Overview of Substance Abuse Counseling	
Assessment and Treatment of Substance Abuse	
Chemical Dependency and Violence Prevention	

TABLE 2 (Cont.) Summary of Courses Offered	
Course Title	
Required	
Substance Abuse Prevention	
Counseling and Addictions	
Addictions Behavior Counseling	
Elective Course	
Addictions Counseling & Prevention	
Substance Abuse Counseling	
Counseling the Alcoholic	
Introduction to Chemical Dependency Counseling	
Introduction to Substance Abuse	
Chemical Dependency	
Addictive Behavior; Issues in Substance Abuse	
Counseling the Abuser of Drugs/alcohol	
Chemical Dependency Counseling	
Counseling for Addictions	
Seminar in Substance Abuse I & II	
Addictions	
Module in Required Course	
Crisis Intervention Strategies	
Advance Diagnosis	

Counseling Special Needs Students
TABLE 2 (Cont.) Summary of Courses Offered
Course Title
Module in Required Course
Counseling Children & Adolescents
School Counseling and development
Counseling Adolescents and Parents
Counseling the Substance Abuser
Practicum
Internships
Group Supervision
Development Across the Lifespan
Community Counseling
Module in Elective Course
Substance Abuse Counseling
Counseling the Substance Abuser
Crisis Implementation
Drug and Alcohol Counseling

Course Content

The second survey question asked respondents to choose specific content covered in the area of substance abuse counseling in their course/s. A list of eleven topics was

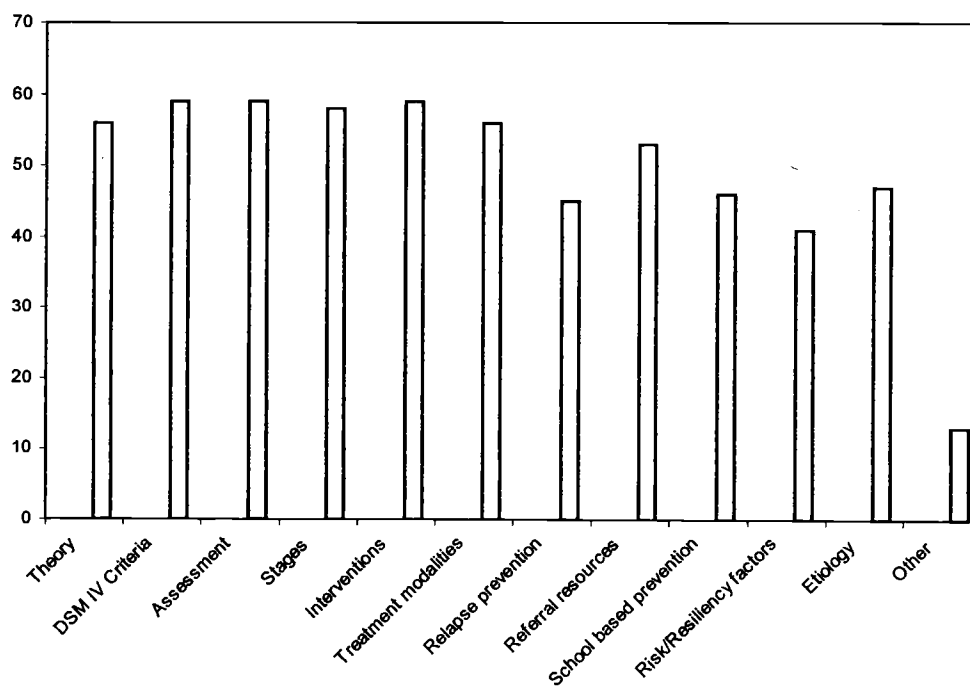
described, along with an option to choose other content area not listed. A space was also provided for respondents to write additional content.

Thirty six percent ($n=26$) respondents indicated teaching all eleven content areas of substance abuse counseling. While eight percent ($n=6$) of all respondents do not offer any substance abuse training, seven percent ($n=5$) of those that do offer training, were not sure what specific content was provided in courses. Seventy percent ($n=51$) respondents indicated at least some of the course content areas provided in their courses.

Nineteen percent ($n=13$) respondents checked the other box and provided additional course content covered in their classes.

Table three provides a list of course content areas, along with the number of respondents covering the content area in their courses.

TABLE 3: Course Content



Other Content Covered

Nineteen percent ($n=13$) respondents indicated they provide other course content areas in their preparation of school counselors in the area of substance abuse. Although there were thirteen responses, approximately six respondents included comments concerning the additional content.

One respondent stated their content includes applications to deaf population. Another stated course content area included the impact of addictions on diverse populations. Two programs include motivational interviewing in their course content. Two more programs include family systems in their substance abuse courses.

Reasons Provided for Not Covering Substance Abuse Training

The third question on the survey asked respondents to indicate the primary reasons, or circumstances, why substance abuse counseling is not covered in their program, if they had indicated it was not included in their program.

Although there was an eight percent ($n=7$) response to substance abuse not covered in the program, other respondents who included some substance abuse training still chose to respond to question three. Twenty percent ($n=16$) indicated there was no room to add more credits to their program.

Ten percent of all respondents ($n=8$) indicated that substance abuse training was not a CACREP requirement. While ten percent checked this response, two respondents stated in the comment section that substance abuse is a requirement. Several other respondents stated that substance abuse training was a requirement for community agency counselors.

A small percentage (.06%, $n=5$) indicated they did not offer substance abuse counseling training because of a lack of staff able or willing to teach the course. Several respondents provided statements concerning the ability to cover only so much mandatory course work in a limited amount of credits or hours. There was also a small percentage (.06%, $n=5$) that indicated financial limitations were another reason for not including substance abuse training in their program.

One additional reason for not including substance abuse counseling in school counseling programs was due to training being provided in another department. Six respondents indicated that training was provided in other departments, while one respondent wrote social work as the other department.

One reason, which stated that training was not a relevant topic area for school counselors, was not indicated by any respondents. Several respondents stated the need or importance of training school counselors in the area of substance abuse.

Summary

This chapter presented the results of this study. The data indicates that ninety one percent ($n=79$) of CACREP accredited programs include substance abuse training to school counselors. While substance abuse training is required by CACREP, only thirty five percent ($n=25$) respondents indicated students received substance abuse training through required courses. Sixty seven percent ($n=48$) reported substance abuse training was received in one or more elective courses. One respondent wrote that while their

students are offered an elective course, few choose to take it. Additionally, ten percent of all respondents ($n=8$) indicated that substance abuse training was not a CACREP requirement.

Chapter V: Discussion

Substance abuse is a prevalent occurrence for adolescents. Today over half (53%) of youth have tried an illicit drug by the time they finish high school (Johnston, O'Malley, & Bachman, 2003). While much attention has been given to this topic, no research has examined what specific preparation is being provided to pre-service school counselors.

The purpose of this descriptive study was to evaluate the pre-service preparation in substance abuse counseling in CACREP accredited school counseling programs. The instrument utilized was a survey entitled School Counselor Pre-Service Preparation in Grief/Loss and Substance Abuse Counseling Survey. The survey included three questions concerning substance abuse training for pre-service school counselors and three questions concerning Grief/Loss training. The substance abuse data were utilized for this particular study. The participants were 79 CACREP accredited school counseling programs. Implications for CACREP accredited programs as well as recommendations for future research are discussed in this chapter.

Summary of Survey Questions

The survey was designed to ascertain as much information in as simple and straightforward a format. Specific answer choices for delivery method (question #1) and reason why substance abuse counseling is not covered (question #3) were considered to be related to the structure of most Counselor Education Programs. Course content answer choices (question #2) were specific to the knowledge area of substance abuse and

substance abuse counseling. Opportunity was provided for respondents to write comments or additional answers as needed.

Question #1: How is training in substance abuse counseling delivered in your program?

While CACREP Standards (2001) provide minimal criteria for the preparation of professional school counselors, the standards do not dictate the delivery method or credit hours required to obtain the knowledge set forth in their standards. Clinical instruction is the only area that has a set amount of required clock hours and the prescribed setting in which school counselors obtain training. Therefore counselor education programs have the autonomy to provide these minimum criteria in a variety of methods and time.

In this study, ninety one percent ($n=72$) of CACREP accredited school counseling programs reported providing substance abuse training in some manner. The primary delivery method for providing such training is through elective course work (67%, $n=48$). Forty six percent ($n=33$) of these students receive one three credit course. Several respondents reported that students have an opportunity to take up to 18 credits for an additional certificate in substance abuse counseling. Yet, several other respondents claimed that while substance abuse training is offered as an elective, few students choose to take it.

Only thirty five percent ($n=25$) of the respondents reported that substance abuse training was received through a required course. The average credit for this course work was three credits. Twenty eight percent ($n=20$) respondents reported receiving some training as a module in another course.

It appears that most respondents' programs provide training in substance abuse counseling, with only a small percent (8%, $n=6$) that do not provide any training. While these programs provide the training, it is not known how many students choose to take the elective courses or receive training in the modules of other elective course work.

Comments from respondents also help provide another dimension to the picture of substance abuse training, that descriptive statistics can not. For example, one respondent reported that while training in substance abuse issues were not offered in the program, it was offered in summer workshops on violence, bullying and death education. Also, several respondents reported that issues concerning substance abuse naturally come up during practicum or internships and that is how they address it.

Although the primary delivery method for training students in substance abuse counseling was elective course work, several respondents stated their coursework was designed for community/mental health track counselors and not for school counselors or that it was not a requirement for school counselors.

It appears by the higher percentage of programs that provide elective course work, and the additional comments of it not being required for school counselors, that possibly those programs do not realize that knowledge in the area of substance abuse and interventions is a required CACREP Standard (2001).

Question #2: What specific content is covered in the area of substance abuse counseling in your course/s?

Substance abuse is one of the most prevalent health care problems in the United States. As school counselors are confronted with students and their families struggling

with substance abuse issues, it is important for them to have a basic knowledge of substance abuse and dependence theory and the knowledge to identify, assess, and intervene with appropriate referrals (Johnson, 2003).

In question two, nine of the eleven specific content areas covered in substance abuse counseling is basic information that is generally covered in an introduction or survey course on addictions. Those nine content areas were: 1) Substance abuse and dependence theory 2) DSM IV criteria for substance abuse and dependence 3) Assessment of substance abuse and dependence 4) Stages of Addiction 5) Types of Interventions 6) Treatment modalities 7) Relapse prevention 8) Referral Resources and 9) Etiology of addiction. Two additional content areas on the list are directed specifically for school counselors. Those content areas were: 1) School based prevention programs and 2) Risk/resiliency Factors.

No Child Left Behind Act: (Title IV part A Office for Safe and Drug Free Schools and Communities), and some state education departments, require schools to implement researched based substance abuse prevention programs. Additionally, the knowledge of risk and resiliency factors is instrumental in researching and implementing effective prevention programs (NIDA, 2004).

In addition to the eleven content areas, respondents had the opportunity to indicate other and write additional content area that is included in their training. seventy four percent ($n=51$) respondents reported at least some of the course content areas were covered in their courses. Thirty six percent ($n=23$) indicated teaching all eleven content areas of substance abuse counseling. Only seven percent ($n=5$) reported they were not sure what specific content was provided in their courses.

Overall, the course content areas that are covered the most are substance abuse and dependence theory (77%, $n=56$), DSM IV criteria for substance abuse and dependence (81%, $n=59$), assessment of substance abuse and dependence (81%, $n=59$), stages of addiction (80%, $n=58$), types of intervention (81%, $n=59$), and treatment modalities (77%, $n=56$). Referral resources was also covered seventy three percent ($n=53$) of the time.

These topics seem easier to also address as modules of required or elective courses. For example, school counseling students may receive this information while taking measurements and assessment course, a DSM-IV diagnostic course or while learning case conceptualization during internship.

The course content areas that were not covered as often were relapse prevention, school based prevention programs, risk and resiliency factors and the etiology of addiction. Several respondents wrote questions marks after school based prevention program and risk resiliency factors. Possibly the respondents did not know if these were offered in their courses, or were unclear to what they might mean.

Eighteen percent ($n=13$) of the respondents indicated they include additional content in their course/s. Several respondents include family systems in their course. There were also two programs that include motivational interviewing as part of their course work. These two programs also reported utilizing textbooks on motivational interviewing. Interestingly enough, three programs also include content on the impact of substance abuse on diverse and special needs populations.

Respondents who indicated what textbooks were utilized in their programs reported an array of varies textbooks. At least five respondents reported utilizing the

DSM-IV TR as their textbook. This also led me to believe that substance abuse training may be provided as a module in a diagnostic type class.

Overall, forty percent (n=29) of the respondents reported the materials they used to provide the content areas for their substance abuse training. In addition to textbooks, these programs made use of journals, information from the internet, and materials from national programs such as SAMHSA and NIDA.

Question # 3. If substance abuse counseling is not covered in your curriculum, what are the primary reasons or circumstances?

The respondents that answered question one with “not included in program at this time” were asked to skip to question 3. The third question on this survey then provided a list of six reasons why substance abuse counseling was not covered in the curriculum. An additional answer they could check was other. Respondents were asked to check all that apply.

These reasons were: 1) No room to add more credits 2) Not a CACREP requirement 3) Lack of staff willing/able to teach 4) Financial limitation and 5) Not a relevant topic area to include for school counselors. Although eight percent (n=6) of respondents reported not including substance abuse training in their curriculum, twenty percent (n=16) of the respondents indicated that substance abuse counseling was not provided due to no room. Ten percent (n=8) respondents reported that substance abuse training was not a CACREP requirement. Lack of staff willing/able to teach and

financial limitations were equally reported (.06%, $n=5$). Only three percent ($n=3$) of the respondents indicated that training was provided by another department.

Therefore, it appears some respondents chose to indicate why substance abuse training was not provided more in depth or as a required course. Along with respondents answering question three when they provided substance abuse training in some sort of manner, several respondents included written comments. Several respondents remarked that they felt that substance abuse was an important area to cover, but it was unrealistic to add separate courses for each topic.

These same respondents, along with a few others reported how they managed to incorporate substance abuse in course work such as internships, practicum, and development across the lifespan. Although some programs reported providing substance abuse training through modules in elective courses, it is not clear how many hours or even how many students receive this training.

It is also necessary to mention that ten percent of the respondents believe that substance abuse training is not a CACREP requirement. Therefore, the other ninety percent must know or realize that CACREP standards require school counselors to be cognizant of substance abuse issues, their impact on their students and families, and approaches to assisting their students with these issues (CACREP, 2001).

Limitations of Study

There are recognizable limitations that emerged while conducting this study. Data utilized in this study was extrapolated from seventy nine respondents from CACREP accredited programs. This limits the generalizability of the results.

Additional limitations are due to the surveys being mailed to the coordinators of the CACREP accredited programs. Other limitations to consider lie within the survey instrument designed for this study.

Generalizability

Sample

The survey was mailed to 150 CACREP accredited programs. According to Rubin & Babbie (2000) a response rate of 60 percent is considered a good response rate and prevents less chances of significant response bias. The response rate for this survey was 53 percent. Therefore, one limitation is that all CACREP accredited programs are not represented.

Another limitation is that the survey population is only from CACREP accredited programs. Non-CACREP school counseling programs were not included in this study. Not utilizing a control group and having a comparison of two groups limits the results in a way that the information can only be applicable to a small group. Therefore, the results may only apply to CACREP accredited school counseling programs in the United States.

Respondents

Several limitations exist due to the respondents who answered the survey. First, there may be bias of the respondents who took the time to respond and return the surveys. Secondly, the survey was mailed to the schools' CACREP coordinators. The coordinators may not be aware of the exact content of each of their courses. Several respondents commented on not being sure of the content. One respondent stated "As

usual, survey assumes that coordinators know content of all courses, dumb ass assumption.”

Additionally, coordinators could have delegated another member of the department, with such knowledge, to answer the survey. Several respondents stated that substance abuse courses were mostly taught by adjunct faculty. Although question two was answered with some specific areas checked, there is no way of knowing if these respondents consulted with the adjunct faculty for definite content areas taught.

Also, with a forty seven percent nonresponse rate, a nonresponse error is a possible limitation of this study. This occurs when a significant number of people do not respond to the survey and are different from those who do respond to the survey (Dillman, 2000).

Instrument

Several limitations emerged from this study based on the survey design. While compiling the results from this survey, it was discovered that some terms may not have been clearly understood and needed defining. For example, in the demographics section, the respondents were asked to write the number of faculty in their department with training and experience in substance abuse counseling. Several respondents wrote question marks over the words training and experience. Several more wrote comments concerning how the answers depended on how training and experience were defined.

Nomenclature

In addition to the lack of defining training and experience, another limitation may have been the lack of substance abuse nomenclature in the area of content. Several content areas that were covered the least in coursework were school based prevention programs and risk/resiliency factors. Relapse prevention was also not covered as often. Some respondents wrote questions marks after these. While theory, DSM IV criteria and assessment may be common nomenclature for counselor educators, other content listed may not be commonly understood.

Credit versus hours

Additionally, on the first question, the respondents were asked to supply the number of credits students received in their course work. They were also asked to write the number of credits of the modules they received in classes. This question was not consistent with a similar question for the grief/loss portion of the survey.

The same question was asked on the grief/loss portion of the survey, in which the respondents were asked to provide the number of module hours within the credited course(s). It was discovered that respondents replied in what appeared to be credits. Accurate data would have been gleaned had they been asked to write the number of hours within the credited classes, consistently for both questions.

Co-Research

As previously stated, the instrument in this study was designed and shared by two researchers. There were two sets of three questions addressing each topic. This

presented additional limitations to this study. First, as previously stated, there may have been possible confusion due to the inconsistency of the credit versus hours in the first set of questions. Secondly, attempting to address two topics prevented more in depth questioning for each topic.

Also, the CACREP coordinator may have had the opportunity to obtain the necessary answers pertaining to content addressed in coursework on one topic. But, having to take the time to pass this survey to two professors may have contributed to the non-response rate.

The data from this study and the limitations of this research also help direct implications for counselor educators and for further research. Furthermore, challenges for counselor educators within CACREP accredited programs are discussed in the next section of this chapter.

Implications for CACREP School Counseling Programs

A primary issue that emerged from the data is that although substance abuse training is a requirement in pre-service school counseling programs (CACREP, 2001), only thirty five percent ($n=25$) of CACREP accredited programs offer their substance abuse training as a required course. As some respondents' in this study commented on the need for substance abuse training, other respondents questioned how to include additional training in an already "jammed pack" curriculum.

Borrowing from previous research literature and data from this study, recommendations for the inclusion of required substance abuse training can be made for

counselor educators. Ideally, at least one course on substance abuse and addictions should be the standard.

Implication for Practitioners

Course Content

Lambie and Rokutani's (2002) research suggested that many school counselors do not know the symptoms of adolescent drug abuse and often rely on the same diagnostic signs used with adult substance abuse abusers. In addition to recognizing warning signs of adolescent substance abuse, school counselors can intervene with the young person and his or her family before the substance abuse becomes more severe.

Hurst (2003) also stated that school counselors and teachers need to be more aware of student symptoms of substance abuse, and be more willing to address them. During the annual Safe and Drug-Free Schools Conference (Hurst, 2003), reported that many educators do not know how to talk about problems such as drug abuse with students and parents. Including adolescent substance abuse, such as symptomology, and discussion of issues with parents and teachers are important content to add substance abuse training.

Morgan and Toloczko (1997) conducted a survey of CACREP counseling programs that focused on counselor training in addictions. The results gleaned from the survey and syllabi revealed that counseling skills, which included focus on assessment, diagnosis, case management, treatment, relapse prevention, and tools of recovery were provided in 57 out of 70 programs. Twenty-seven programs provided a basic overview, which focused on pharmacology, models of addiction, etiology, epidemiology,

community resources, and intervention. Furthermore, seven programs included prevention and education, which consisted of programs for youth and at-risk populations and alcohol and other drug curricula.

In a Delphi study conducted by Klutschowski and Troth (1995), in which they wanted to determine, from experts in the chemical dependency field, what were important components for a substance abuse counselor education curriculum, a list of essential components was suggested for substance abuse counselors. It must be noted that while this study was geared specifically for substance abuse counselor training programs, the topics seem relevant in the preparation to pre-service school counselors.

This study produced a list of essential components of a counseling program for substance abuse counselors. Ethics, counseling, the 12 core areas, 12-step programs of Alcoholics Anonymous (AA) and Narcotics Anonymous (AA), drug education, and alcohol abuse were at most recommended by the expert training recommendations.

Training Models

Lenhardt (1994) presented a collaborative substance abuse model for training counselors. This model was an experiment funded by a federal grant and designed by a counselor education department. The study promoted a three week summer institute format for training. There were two levels of training. The beginners level of training, which included graduate students and school personnel without previous training. The advanced level was composed of school personnel with some previous training.

Another model which counselor educators could utilize is fashioned after the Oakland Counselor Academy. Splete and Grisdale (1992) designed the Oakland Counselor Academy as a year long program in which school counselors attended one

weekend each month, for twelve months. Although this program was designed for school counselors in the field, a similar program could be established for pre-service school counselors.

Waidley and Pappas (1992) also reported the success of the Oakland Counselor Academy. In their study, school counselors reported a high satisfaction with their training in additional skills, knowledge, networking and professional development. This model could be utilized by counselor educators not only as a method for meeting CACREP Standards but also as a way to collaborate with schools and community resources.

Integrating Content in general Counseling Courses

As previously stated, training in substance abuse counseling could be interwoven within other counseling courses, utilizing problem-solving pedagogy. For example, within foundations of school counseling, problem-solving teams could design a comprehensive guidance program. Pre-service school counselors could choose a focus, such as substance abuse, and describe the research and how they will address the problem in their comprehensive guidance program.

Another area where counselor educators could provide preparation of substance abuse counseling for students is in a group course. McClanahan, McLaughlin, Loos, Holcomb, Gibbins, and Smith (1998) conducted a training project, utilizing a group format and found efficacy in training school counselors to intervene with students at risk for substance abuse.

The training project consisted of a three day initial training. This training was comprised of experiential group training over a course of ten weeks, and concurrent

training, which provided group supervision meetings over the course of twenty-two weeks.

The three day initial training provided didactic information such as local statistics regarding substance abuse by secondary students, etiology of adolescent substance abuse, identification of substance users and high-risk students, patterns of alcohol and other drug usage and profiles of student drug users, and specialized services for at-risk adolescents. There was also training on how to effectively conference with parents and group programming as prevention. The second two days of training consisted of conducting group (McClanahan et al. 1998).

The second segment of training was an experiential segment, in which the school counselors attended small groups over ten successive weeks. These groups focused on content areas related to risk factors, vulnerabilities of substance use, and on life-skills training strategies. There was a list of objectives that the counselors worked to meet through activities, information and discussion.

The concurrent training provided group supervision during the ten weeks that the school counselors conducted group with the adolescents. Group supervision meetings were provided by a licensed, doctoral level psychologist experienced in group techniques (McClanahan et al. 1998).

Lambie and Rokutani (2002) further suggested utilizing a systems perspective in working with adolescents and their families. The systems perspective views substance abuse as possibly serving a function within the family. The adolescent substance abuser may be seen as the symptom bearer for an unbalanced family system (Lambie & Rokutani, 2002).

Addressing substance abuse and its role within the family systems in a family systems course seems an appropriate avenue for counselor educators to provide more training. Several respondents in this study reported providing family systems within their substance abuse course.

Additional course work in which substance abuse can be addressed is the practicum and internship/supervision experience. Although several respondents reported that this topic comes up naturally, it should be addressed whether the topic arises or not during internship and practicum. One way to do this is by including evidence-based research within the supervision experience. Utilizing an evidence based research approach could not only enhance the pre-service school counselors' knowledge of substance abuse but also increase skills of utilizing evidence based research in professional practice (Bartley, Biles, Low, Nakazawa, & Windish, 2003).

One respondent from this study stated that the researcher should consider the CACREP changes that required community counseling programs to provide training in DSM-IV TR, diagnosis, assessment, etc. Therefore, substance abuse training may take place in a DSM-IV class.

Several respondents also incorporate Motivational Interviewing in their substance abuse coursework. Motivational Interviewing is motivational enhancement therapy (MET) developed by William Miller and Stephen Rollnick (Thombs, 1999). Motivational interviewing was designed to deal with the critical issue in helping a person with an addiction problem: ambivalence about change. The theoretical basis for MET is the stages of change model, in which the focus is on moving clients from contemplation to preparation (Miller & Rollnick, 2002).

Utilizing a learner-centered approach, students could be asked to abstain from a substance or habit for a month. While participating in this abstinence exercise, they would keep a journal. Throughout this segment of training, students would role play as counselors and client, and use motivational interviewing to help each other through their abstinence exercise.

Counselor educators could incorporate motivational interviewing into the coursework for substance abuse training or into a theories class. From a constructivist perspective, there are many learner centered approaches of incorporating much needed preparation of substance abuse counseling into one class or various courses, depending on the constraints of each CACREP accredited counselor education program.

Implications for Future Research

Based on the results of this study and recommendations from previous studies reviewed in this study, further research is needed in substance abuse counseling preparation for pre-service school counselors. Questions concerning the interpretation of CACREP standards, the number of students actually receiving preparation in elective coursework and the discrepancy between number of hours and credits are all areas for future research.

The first question that arises from this study is how counselor educators are interpreting the 2001 CACREP Standards in the area of substance abuse knowledge. Ten percent (n=8) of the respondents reported that substance abuse counseling was not a CACREP requirement, while sixty seven (n=48) percent respondents offer substance abuse training in elective courses.

It appears that while sixty seven percent of CACREP accredited programs offer elective course work, it is not mandatory. If substance abuse counseling knowledge is offered in elective course work, does this meet CACRP Standards (2001) requirement? Furthermore, if students are receiving substance abuse counseling training through elective courses, how many students then actually elect to take these courses?

An exit survey of pre-service school counselors could be conducted to ascertain which course work they chose to take and how many hours or credits they received in substance abuse training. Additionally, a comparison study could be conducted of school counselors in the field. This survey's objective would determine how much substance abuse training school counselor had received and whether those counselors felt adequately prepared to address substance abuse issues.

Furthermore, future research should be conducted to determine what substance abuse training specific to school counselors meets CACREP 2001 Standards. As mentioned earlier as a limitation to this study, nomenclature in substance abuse courses may be lacking. This also may be why there is a discrepancy in the interpretation of the CACREP Standards (2001).

Such areas as risk and resiliency factors, school and research based prevention programs, and referral to community services seem to be the least presented information in counselor education preparation. Yet, all these topics not only need to be an essential component in a pre-service school counseling program, they are also important factors of a comprehensive school guidance program.

Pedagogy

In addition to addressing content areas to include in pre-service school counseling courses and training models, methods for learning such material should be considered. Morgan & Toloczko (1997) revealed course requirements and learning experiences, such as tests, research paper or written or oral reports in their study. Nelson and Neufeldt (1998) proposed that constructivist methods should be considered in producing reflective counselors. Methods such as the use of reflective teams and problem based learning could be utilized in a substance abuse course.

Constructivism, learner-centered principles and problem based learning consist of strategies needed to tailor education to adults. According to O'Donnell (1997) there are basic assumptions from the constructivism perspective. Developing substance abuse training while operating under these assumptions, or characteristics, would allow pre-service school counselors to gain meaningful information and experience.

For example, one of these characteristics is that the learner is an active participant in the learning process and shapes personal meaning from situations. The personal meaning is either informed or constrained by prior knowledge. With this in mind, pre-service school counselors could attend 12-step meetings and provide reflection journals on the experience.

In addition to utilizing learner-centered pedagogy to creatively provide substance abuse training in one course, such training may be interwoven in other courses or provided in workshops. One respondent wrote how adding separate courses for each topic is unrealistic. The respondent further stated that students are encouraged to seek out elective courses in substance abuse and to attend workshops or training when available.

Conclusion

House and Sears (2002) reported the critical need for school counselors to move beyond their current roles as helper-respondents in order to become leaders and advocates for success of all students. In order to meet the demands for accountability in school reform, counselor educators needed to utilize reflective inquiry about current counselor education practices and the preparation of pre-service school counselors.

School counselors are in a unique position, which allows them to provide interventions, support adolescents and the family system to promote change. School counselors can be a resource and liaison between the student, the family, the school and community agencies and treatment programs.

Clearly, if school counselors are to contribute to educational reform and the overall academic success of students, societal problems such as substance abuse need to be addressed in schools, communities, and at the national level. House and Sears (2002) stated that counselor educators empower counselors to be leaders and change agents in society, when they promote systemic change through critical inquiry. Just as school counselors are to be proactive in developing all students' academic success, so must counselor educators in their mission to prepare school counselors for such work.

The results of this study show that many counselor educators are addressing substance abuse issues by preparing their pre-service school counselors. But more work is needed. Further research and creative problem solving will allow counselor educators to prepare pre-service school counselors to work with students with substance abuse problems.

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Appendix A**Council for Accreditation of Counseling and Related
Educational Programs (CACREP)****The 2001 Standards****SECTION II****PROGRAM OBJECTIVES AND CURRICULUM**

A. A comprehensive mission statement has been developed that brings the program into focus and concisely describes the program's intent and purpose. The mission statement

1. describes the types of students it serves, its geographic orientation, and the priorities and expectations of the faculty;
2. is the basis for the development of program objectives and curriculum;
3. is published and available to faculty and students; and
4. is reviewed at least once every three (3) years and revised as needed.

B. The program objectives

1. reflect current knowledge and positions from lay and professional groups concerning the counseling and human development needs of a pluralistic society;
2. reflect the present and projected needs of a pluralistic society for which specialized counseling and human development activities have been developed;
3. reflect input from all persons involved in the conduct of the program, including program faculty, current and former students, and personnel in cooperating agencies;
4. are directly related to program activities; and
5. are written so that they can be assessed.

C. Programs in Career Counseling, College Counseling, Community Counseling, Gerontological Counseling, School Counseling, and Student Affairs are comprised of a minimum of two full academic years, defined as four semesters or six quarters of approved graduate-level study with a minimum of 48-semester credit hours or 72-quarter credit hours required of all students. Programs in Mental Health Counseling and Marital, Couple and Family Counseling/Therapy are comprised of approved graduate-level study with a minimum of 60-semester credit hours or 90-quarter credit hours required of all students.

D. Students actively identify with the counseling profession by participating in professional associations such as the American Counseling Association (ACA), its divisions, branches, and affiliate organizations, and by participating in seminars, workshops, or other activities that contribute to personal and professional growth.

E. Over the course of one academic term, students meet for a minimum of 10 clock hours in a small-group activity approved by the program. This planned group requirement is intended to provide direct experiences as a participant in a small group.

F. Consistent with established institutional due process policy and *ACA Ethical Standards*, when evaluations indicate that a student is not appropriate for the program, faculty should assist in facilitating the student's transition out of the program and, if possible, into a more appropriate area of study.

G. Flexibility is provided within the program's curriculum to accommodate individual differences in student knowledge and competencies.

H. Syllabi are distributed at the beginning of each curricular experience, are available for review by all enrolled or prospective students, and include all of the following:

1. objectives;
2. content areas;
3. required text(s) and/or reading(s);
4. methods of instruction, including a clear description of how content is delivered (e.g., lecture, seminar, supervised practical application, distance learning); and
5. student performance evaluation criteria and procedures.

I. Evidence exists of the use and application of research data among program faculty and students.

J. Each program for which accreditation is sought must show a history of graduates.

K. Curricular experiences and demonstrated knowledge in each of the eight common core areas are required of all students in the program. The eight common core areas follow.

1. PROFESSIONAL IDENTITY - studies that provide an understanding of all of the following aspects of professional functioning:

- a. history and philosophy of the counseling profession, including significant factors and events;
- b. professional roles, functions, and relationships with other human service providers;
- c. technological competence and computer literacy;
- d. professional organizations, primarily ACA, its divisions, branches, and affiliates, including membership benefits, activities, services to members, and current emphases;
- e. professional credentialing, including certification, licensure, and accreditation practices and standards, and the effects of public policy on these issues;
- f. public and private policy processes, including the role of the professional counselor in advocating on behalf of the profession;
- g. advocacy processes needed to address institutional and social barriers that impede access, equity, and success for clients; and
- h. ethical standards of ACA and related entities, and applications of ethical and legal considerations in professional counseling.

2. SOCIAL AND CULTURAL DIVERSITY - studies that provide an understanding of the cultural context of relationships, issues and trends in a multicultural and diverse society related to such factors as culture, ethnicity, nationality, age, gender, sexual orientation, mental and physical characteristics, education, family values, religious and spiritual values, socioeconomic status and unique characteristics of individuals, couples, families, ethnic groups, and communities including all of the following:

- a. multicultural and pluralistic trends, including characteristics and concerns between and within diverse groups nationally and internationally;

- b. attitudes, beliefs, understandings, and acculturative experiences, including specific experiential learning activities;
- c. individual, couple, family, group, and community strategies for working with diverse populations and ethnic groups;
- d. counselors' roles in social justice, advocacy and conflict resolution, cultural self-awareness, the nature of biases, prejudices, processes of intentional and unintentional oppression and discrimination, and other culturally supported behaviors that are detrimental to the growth of the human spirit, mind, or body;
- e. theories of multicultural counseling, theories of identity development, and multicultural competencies; and
- f. ethical and legal considerations.

3. HUMAN GROWTH AND DEVELOPMENT - studies that provide an understanding of the nature and needs of individuals at all developmental levels, including all of the following:

- a. theories of individual and family development and transitions across the life-span;
- b. theories of learning and personality development;
- c. human behavior including an understanding of developmental crises, disability, exceptional behavior, addictive behavior, psychopathology, and situational and environmental factors that affect both normal and abnormal behavior;
- d. strategies for facilitating optimum development over the life-span; and
- e. ethical and legal considerations.

4. CAREER DEVELOPMENT - studies that provide an understanding of career development and related life factors, including all of the following:

- a. career development theories and decision-making models;
- b. career, vocational, educational, occupational and labor market information resources, visual and print media, computer-based career information systems, and other electronic career information systems;
- c. career development program planning, organization, implementation, administration, and evaluation;

- d. interrelationships among and between work, family, and other life roles and factors including the role of diversity and gender in career development;
- e. career and educational planning, placement, follow-up, and evaluation;
- f. assessment instruments and techniques that is relevant to career planning and decision making;
- g. technology-based career development applications and strategies, including computer-assisted career guidance and information systems and appropriate world-wide web sites;
- h. career counseling processes, techniques, and resources, including those applicable to specific populations; and
- i. ethical and legal considerations.

5. HELPING RELATIONSHIPS - studies that provide an understanding of counseling and consultation processes, including all of the following:

- a. counselor and consultant characteristics and behaviors that influence helping processes including age, gender, and ethnic differences, verbal and nonverbal behaviors and personal characteristics, orientations, and skills;
- b. an understanding of essential interviewing and counseling skills so that the student is able to develop a therapeutic relationship, establish appropriate counseling goals, design intervention strategies, evaluate client outcome, and successfully terminate the counselor-client relationship. Studies will also facilitate student self-awareness so that the counselor-client relationship is therapeutic and the counselor maintains appropriate professional boundaries;
- c. counseling theories that provide the student with a consistent model(s) to conceptualize client presentation and select appropriate counseling interventions. Student experiences should include an examination of the historical development of counseling theories, an exploration of affective, behavioral, and cognitive theories, and an opportunity to apply the theoretical material to case studies. Students will also be exposed to models of counseling that are consistent with current professional research and practice in the field so that they can begin to develop a personal model of counseling;
- d. a systems perspective that provides an understanding of family and other systems theories and major models of family and related interventions. Students will be exposed to a rationale for selecting family

and other systems theories as appropriate modalities for family assessment and counseling;

e. a general framework for understanding and practicing consultation. Student experiences should include an examination of the historical development of consultation, an exploration of the stages of consultation and the major models of consultation, and an opportunity to apply the theoretical material to case presentations. Students will begin to develop a personal model of consultation;

f. integration of technological strategies and applications within counseling and consultation processes; and

g. ethical and legal considerations.

6. GROUP WORK - studies that provide both theoretical and experiential understandings of group purpose, development, dynamics, counseling theories, group counseling methods and skills, and other group approaches, including all of the following:

a. principles of group dynamics, including group process components, developmental stage theories, group members' roles and behaviors, and therapeutic factors of group work;

b. group leadership styles and approaches, including characteristics of various types of group leaders and leadership styles;

c. theories of group counseling, including commonalities, distinguishing characteristics, and pertinent research and literature;

d. group counseling methods, including group counselor orientations and behaviors, appropriate selection criteria and methods, and methods of evaluation of effectiveness;

e. approaches used for other types of group work, including task groups, psycho educational groups, and therapy groups;

f. professional preparation standards for group leaders; and

g. ethical and legal considerations.

7. ASSESSMENT - studies that provide an understanding of individual and group approaches to assessment and evaluation, including all of the following:

a. historical perspectives concerning the nature and meaning of assessment;

- b. basic concepts of standardized and non-standardized testing and other assessment techniques including norm-referenced and criterion-referenced assessment, environmental assessment, performance assessment, individual and group test and inventory methods, behavioral observations, and computer-managed and computer-assisted methods;
- c. statistical concepts, including scales of measurement, measures of central tendency, indices of variability, shapes and types of distributions, and correlations;
- d. reliability (i.e., theory of measurement error, models of reliability, and the use of reliability information);
- e. validity (i.e., evidence of validity, types of validity, and the relationship between reliability and validity);
- f. age, gender, sexual orientation, ethnicity, language, disability, culture, spirituality, and other factors related to the assessment and evaluation of individuals, groups, and specific populations;
- g. strategies for selecting, administering, and interpreting assessment and evaluation instruments and techniques in counseling;
- h. an understanding of general principles and methods of case-conceptualization, assessment, and/or diagnoses of mental and emotional status; and
- i. ethical and legal considerations.

8. RESEARCH AND PROGRAM EVALUATION - studies that provide an understanding of research methods, statistical analysis, needs assessment, and program evaluation, including all of the following:

- a. the importance of research and opportunities and difficulties in conducting research in the counseling profession,
- b. research methods such as qualitative, quantitative, single-case designs, action research, and outcome-based research;
- c. use of technology and statistical methods in conducting research and program evaluation, assuming basic computer literacy;
- d. principles, models, and applications of needs assessment, program evaluation, and use of findings to effect program modifications;

- e. use of research to improve counseling effectiveness; and
- f. ethical and legal considerations.

STANDARDS FOR SCHOOL COUNSELING PROGRAMS

In addition to the common core curricular experiences outlined in Section II.K, the following curricular experiences and demonstrated knowledge and skills are required of all students in the program.

A.FOUNDATIONS OF SCHOOL COUNSELING

- 1.history, philosophy, and current trends in school counseling and educational systems;
- 2.relationship of the school counseling program to the academic and student services program in the school;
- 3.role, function, and professional identity of the school counselor in relation to the roles of other professional and support personnel in the school;
- 4.strategies of leadership designed to enhance the learning environment of schools;
- 6.knowledge of the school setting, environment, and pre-K—12 curriculum;
- 7.current issues, policies, laws, and legislation relevant to school counseling;
- 8.the role of racial, ethnic, and cultural heritage, nationality, socioeconomic status, family structure, age, gender, sexual orientation, religious and spiritual beliefs, occupation, physical and mental status, and equity issues in school counseling;
- 9.knowledge and understanding of community, environmental, and institutional opportunities that enhance, as well as barriers that impede student academic, career, and personal/social success and overall development;
- 10.knowledge and application of current and emerging technology in education and school counseling to assist students, families, and educators in using resources that promote informed academic, career, and personal/social choices; and

11.ethical and legal considerations related specifically to the practice of school counseling (e.g., the *ACA Code of Ethics* and the *ASCA Ethical Standards for School Counselors*).

B.CONTEXTUAL DIMENSIONS OF SCHOOL COUNSELING

Studies that provide an understanding of the coordination of counseling program components as they relate to the total school community, including all of the following:

1. advocacy for all students and for effective school counseling programs;
2. coordination, collaboration, referral, and team-building efforts with teachers, parents, support personnel, and community resources to promote program objectives and facilitate successful student development and achievement of all students;
3. integration of the school counseling program into the total school curriculum by systematically providing information and skills training to assist pre-K—12 students in maximizing their academic, career, and personal/social development;
4. promotion of the use of counseling and guidance activities and programs by the total school community to enhance a positive school climate;
5. methods of planning for and presenting school counseling-related educational programs to administrators, teachers, parents, and the community;
6. methods of planning, developing, implementing, monitoring, and evaluating comprehensive developmental counseling programs; and
7. knowledge of prevention and crisis intervention strategies.

C. KNOWLEDGE AND SKILL REQUIREMENTS FOR SCHOOL COUNSELORS

1. Program Development, Implementation, and Evaluation

- a. use, management, analysis, and presentation of data from school- based information (e.g., standardized testing, grades, enrollment, attendance, retention, placement), surveys, interviews, focus groups, and needs assessments to improve student outcomes;

- b. design, implementation, monitoring, and evaluation of comprehensive developmental school counseling programs (e.g., the *ASCA National Standards for School Counseling Programs*) including an awareness of various systems that affect students, school, and home;
- c. implementation and evaluation of specific strategies that meet program goals and objectives;
- d. identification of student academic, career, and personal/social competencies and the implementation of processes and activities to assist students in achieving these competencies;
- e. preparation of an action plan and school counseling calendar that reflect appropriate time commitments and priorities in a comprehensive developmental school counseling program;
- f. strategies for seeking and securing alternative funding for program expansion; and
- g. use of technology in the design, implementation, monitoring and evaluation of a comprehensive school counseling program.

2. Counseling and Guidance

- a. individual and small-group counseling approaches that promote school success, through academic, career, and personal/social development for all;
- b. individual, group, and classroom guidance approaches systematically designed to assist all students with academic, career and personal/social development;
- c. approaches to peer facilitation, including peer helper, peer tutor, and peer mediation programs;
- d. issues that may affect the development and functioning of students (e.g., abuse, violence, eating disorders, attention deficit hyperactivity disorder, childhood depression and suicide)
- e. developmental approaches to assist all students and parents at points of educational transition (e.g., home to elementary school, elementary to middle to high school, high school to postsecondary education and career options);

- f. constructive partnerships with parents, guardians, families, and communities in order to promote each student's academic, career, and personal/social success;
- g. systems theories and relationships among and between community systems, family systems, and school systems, and how they interact to influence the students and affect each system; and
- h. approaches to recognizing and assisting children and adolescents who may use alcohol or other drugs or who may reside in a home where substance abuse occurs.

3. Consultation

- a. strategies to promote, develop, and enhance effective teamwork within the school and larger community;
- b. theories, models, and processes of consultation and change with teachers, administrators, other school personnel, parents, community groups, agencies, and students as appropriate;
- c. strategies and methods of working with parents, guardians, families, and communities to empower them to act on behalf of their children; and
- d. knowledge and skills in conducting programs that are designed to enhance students' academic, social, emotional, career, and other developmental needs.

D. CLINICAL INSTRUCTION

For the School Counseling Program, the 600 clock hour internship (Standard III.H) occurs in a school counseling setting, under the supervision of a site supervisor as defined by Section III, Standard C.1-2. The requirement includes a minimum of 240 direct service clock hours.

The program must clearly define and measure the outcomes expected of interns, using appropriate professional resources that address Standards A, B, and C (School Counseling Programs).

Appendix B Cover Letter

Dear Faculty:

We are writing to ask your help in a study of CACREP school counseling program curriculum. Each day school counselors encounter students facing issues involving substance abuse and grief and loss. According to the National Institutes of Health 2002 National Survey, some drug use has declined but alcohol use remains widespread. More than half (62%) of the 12th graders and a fifth (21%) of the 8th graders report having been drunk at least once in their life. Loss is universally prevalent in the lives of our children. Fifty percent will experience the divorce of their parents, and 20 percent will experience the death of a parent before they finish high school. As counselor educators, we have a responsibility to ensure the professionals we train are adequately prepared to effectively work with these current counseling issues.

We are currently doctoral students researching the training of school counselors in the areas of grief/ loss and addictions. Our interests in these areas are threefold. We collectively have over a decade of work as school counselors, grief counselors and addictions counselors, and have experienced first hand the ramifications of these issues on youth. Secondly, as graduate students in Counselor Education and Supervision at Oregon State University, we have supervised interns grappling with effectively helping their students with these issues. Lastly, we have both served as trainers in these areas, and know the value, and rewards of assisting professionals becoming proficient service providers.

We need your help. As a CACREP Counseling program that provides a graduate program in school counseling, your participation in this study is needed. Your participation will provide vital data on the delivery of grief/loss and addiction training across the nation.

The results of this descriptive study are intended to ascertain how training in these areas is being delivered in school counseling programs. The results of this survey will be utilized in our doctoral dissertations, as well as future research articles. Furthermore, the results may well have broad implications for all counselor education programs.

The answers you provide will be kept confidential to the extent permitted by law. Special precautions have been established to protect the confidentiality of your responses. The number on your return envelope is the only identifying information you return. Your questionnaire will be destroyed once your responses have been recorded. There are no foreseeable risks to you as a participant in this project; nor are there any direct benefits. However, your participation is extremely valued. Your participation in this study is voluntary, and the return of the questionnaire will indicate your informed consent.

If you have any questions about the survey, please contact: Lori Low: (541) 760-1105, lori.low@corvallis.k12.or.us, Kathy Biles: kbiles@earthlink.net or Dr. Michael A. Ingram: ingramm@orst.edu. If you have questions about your rights as a participant in this research project, please contact the Oregon State University Institutional Review Board (IRB) Human Protections Administrator at IRB@oregonstate.edu or (541) 737-3437.

Thank you for your help. We appreciate your cooperation and prompt return of the enclosed survey.

Sincerely,

Lori L. Low, MS, PhD Candidate
Candidate

Kathy Biles, MS, PhD

Appendix C

School Counselor Pre-Service Preparation in Grief / Loss and Substance Abuse Counseling Survey

Gender

- Female
- Male
- Other

Which best describes your racial/ethnic identity?

Check all that apply.

- African American/Black, non Hispanic/Latino Origin
- American Indian/Native/ Alaskan Native, non Hispanic/Latino
- Asian or Pacific Islander, non Hispanic/Latino
- Hispanic/Latino White, not of Hispanic Origin
- Multiracial
- If none of the above choices apply to you, please use your own description:
- Decline to respond

Employment Status with this CACREP University

- Full professor
- Associate professor
- Assistant professor
- Full time instructor/ lecturer
- Part time adjunct professor/ lecturer
- Other:

Length of Term

- Semester
- Quarter

Length of School Counseling degree program in credits _____

Number of school counseling masters students annually accepted into your program _____

**Number of faculty in your department with training and experience in:
Substance abuse counseling _____
Grief /loss counseling _____**

This section covers substance abuse training designed to increase counselors' knowledge and skills working with students with substance abuse issues.

How is training in substance abuse counseling delivered in your program?

Check all that apply.

- | | |
|---|---------------------------|
| <input type="checkbox"/> Required course(s) in program | |
| <i>Course title:</i> | <i>Number of Credits:</i> |
| <input type="checkbox"/> Elective course(s) in program | |
| <i>Course title:</i> | <i>Number of Credits:</i> |
| <input type="checkbox"/> Specific module in required course(s) | |
| <i>Course title:</i> | <i>Number of Credits:</i> |
| <input type="checkbox"/> Specific module in elective course(s) | |
| <i>Course title:</i> | <i>Number of Credits:</i> |
| <input type="checkbox"/> Not included in program at this time. If \checkmark here, please skip to question 3. | |

What specific content is covered in the area of substance abuse counseling in your course/s?

Check all that apply.

- Substance abuse and dependence theory
- DSM IV Criteria for substance abuse and dependence
- Assessment of substance abuse and dependence
- Stages of addiction
- Types of interventions
- Treatment modalities
- Relapse prevention
- Referral resources
- School based prevention programs
- Risk/Resiliency Factors
- Etiology of Addiction
- Other content not listed _____

If substance abuse counseling is not covered in your curriculum, what are the primary reasons?

Check all that apply.

- No room to add more credits
- Not a CACREP requirement
- Lack of staff willing/ able to teach
- Financial limitations
- Not a relevant topic area to include for school counselors
- It is offered in another department. *Please specify what department:*
- Other:

**Please Turn to
Next Page**

This section covers grief and loss training which is curriculum specifically designed to increase counselors skills working with students in the areas of grief, loss, and bereavement.

1. How does your program specifically train school counselors in grief and loss counseling?

Check all that apply.

- Required course in program
Course Title: _____ *Number of Credits:* _____
- Elective course in program
Course Title: _____ *Number of Credits:* _____
- Specific module in required course
Course Title: _____ *Number of Hours:* _____
- Specific module in elective course
Course Title: _____ *Number of Hours:* _____
- Not specifically included in program at this time. *If ✓ here, please skip to question 3.*

2. What specific content is covered in the area of grief/loss counseling in your course/s?

Check all that apply.

- Grief and loss theory
- Areas of childhood loss and grief including death and secondary losses
- Myths about grief and loss
- Signs and indicators of grief
- Psychological tasks of grief
- Developmental responses to loss
- Grief resolution techniques _____ *Individual* _____ *Group*
- Complicated bereavement and unresolved grief
- Memory work and its importance
- Cultural differences in grief and mourning
- Grieving special losses such as suicide, murder, and terrorism
- Trauma vs. Grief
- Crisis intervention in the schools
- Death education in the schools
- Personal issues involving loss, grief and death
- Counselor Self Care, Burnout and Compassion Fatigue
- Other(s): _____

3. If grief/loss counseling is not currently included in your curriculum, what are the primary reasons?

Check all that apply.

- No room to add more credits
- Not a CACREP requirement
- Lack of staff willing/ able to teach
- Financial limitations
- Not a relevant topic area to include for school counselors
- It is offered in another department. *Please specify what department:* _____

Additional Comments:

Texts or Readings utilized in courses
Grief/Loss

Substance Abuse

If you would like a copy of the results of this study, we will be happy to provide them for you. Please indicate this by writing RESULTS on the back of your return envelope. Again, thank you for participating in this study. If you are willing to be contacted in the future regarding future research in these areas, please return the enclosed post card with your contact information.

Appendix D
Future Contact Postcard

Dear Faculty,

This postcard is in no way associated with the enclosed research study and you are requested to mail it separately, so as to protect your confidentiality when completing the School Counseling Pre-service Training in Grief/Loss and Substance Abuse Survey.

We are collecting the names of individuals who would be willing to be contacted in the future for more in depth interviews or questionnaires on these topics. If you, or a colleague is willing or interested, please provide your contact information below. Thank you in advance for your help.

Sincerely,

Lori L. Low, PhD Candidate

Grief and Loss Contact:

Name

Email

Phone

University

Kathy Biles, PhD Candidate

Substance Abuse Contact:

Name

Email

Phone

University

Appendix E
One Week Follow-up Postcard

Dear NAME

February 12, 2004

Last week you received a questionnaire entitled the School Counseling Pre-service Training in Grief/Loss and Substance Abuse Survey. You were selected as a CACREP school counseling program, all of who are being asked for their input on these important topics. Your participation is voluntary and completion of the survey indicates your informed consent.

If you have already completed and returned it to me, please accept our sincere thanks. Your input is invaluable. If you have not, please do so today. The survey is short, and your input is needed to accurately represent gold standard CACREP school counseling program content.

We know you are very busy. If you did not receive a questionnaire, or it has been misplaced please e-mail us at lori.low@corvallis.k12.or.us and we will promptly send another. Again, thank you for your participation.
Sincerely,

Lori L. Low, MS, PhD Candidate
Oregon State University, Counselor Education Department

Kathy Biles, MS, PhD Candidate

Appendix F
Three Week Follow-up Letter

March 4, 2004

Dear NAME:

During the last two months, we have sent you several mailings about the research we are conducting on the training school counselors receive in the areas of substance abuse and grief and loss counseling. To date, we have not yet received your completed questionnaire.

The high number of questionnaires returned is encouraging, however, we are concerned that those like yourself who have not responded have different and critical information to contribute. Whether or not we will be able to accurately describe how CACREP programs deliver pre-service training in substance abuse and grief and loss counseling depends on you and the others who have not yet responded.

If you have already completed the enclosed survey, and it has not reached us yet, please accept our sincere thanks and we apologize for any inconvenience. If you have not had the opportunity to complete the survey or have inadvertently misplaced it, we have enclosed one for your convenience. It is very short, and we urge you to take a few minutes to complete and return it now.

The answers you provide will be kept confidential to the extent permitted by law. Special precautions have been established to protect the confidentiality of your responses. The number on your return envelope is used to contact those who have not returned their questionnaire, so we do not burden those who have responded. Your questionnaire will be destroyed once your responses have been tallied. There are no foreseeable risks to you as a participant in this project; nor are there any direct benefits. However, your participation is extremely valued. Your participation in this study is voluntary, and the return of the questionnaire will indicate your informed consent.

If you have any questions about the survey, please contact:

Lori Low (541) 760-1105, lori.low@corvallis.k12.or.us,

Kathy Biles (503)-606-2694, kbiles@earthlink.net or

Dr. Michael A. Ingram (541) 737-3550.

If you have questions about your rights as a participant in this research project, please contact the Oregon State University Institutional Review Board (IRB) Human Protections Administrator at IRB@oregonstate.edu or (541) 737-3437.

We appreciate your willingness to participate, and look forward to receiving your completed survey promptly. If you would like a copy of the results, please indicate by writing Results across the back of the envelope. If you decide to decline this opportunity, please inform us by returning the blank questionnaire in the enclosed envelope.

Thank you for your time.

Sincerely,

Lori L. Low, MS, PhD Candidate

Kathy Biles, MS, PhD Candidate