

Masthead Logo

University of Pennsylvania
ScholarlyCommons

Doctorate in Social Work (DSW) Dissertations

School of Social Policy and Practice

Spring 5-20-2019

BARRIERS TO ATTAINING HIGHER EDUCATION AMONG SUBSTANCE ABUSE COUNSELORS

Steven Dawson

The University of Pennsylvania School of Social Policy and Practice, Stevendawsonlcsw@gmail.com

Follow this and additional works at: https://repository.upenn.edu/edissertations_sp2

Part of the [Higher Education Commons](#), and the [Social Work Commons](#)

Recommended Citation

Dawson, Steven, "BARRIERS TO ATTAINING HIGHER EDUCATION AMONG SUBSTANCE ABUSE COUNSELORS" (2019).
Doctorate in Social Work (DSW) Dissertations. 134.
https://repository.upenn.edu/edissertations_sp2/134

This paper is posted at ScholarlyCommons. https://repository.upenn.edu/edissertations_sp2/134
For more information, please contact repository@pobox.upenn.edu.

BARRIERS TO ATTAINING HIGHER EDUCATION AMONG SUBSTANCE ABUSE COUNSELORS

Abstract

Twenty-three million people over the age of 12 meet criteria for a substance use disorder. Drug overdose is currently the number one cause of injury-related death in the US. From 1999 to 2017, almost 218,000 people died from overdoses related to opioids. In 2017, opioid overdoses were five times higher than they were in 1999. The financial cost of substance abuse in the US is estimated at \$700 billion annually. Evidence-based approaches have been shown to improve outcomes, yet substance use treatment has the lowest rates of utilization of evidence-based practices of any health care discipline.

Graduate level education has been shown to increase the use of evidence-based practice. However, most states require low educational requirements for substance abuse counselors. This gap in education negatively impacts the use of evidence-based practice and is linked to many ethical issues in the field.

Many studies have looked at the role of education in the use of evidence-based practices but little is understood regarding the multiple barriers substance abuse counselors experience. A mixed-methods study was conducted to investigate these barriers to higher education among substance abuse counselors in New York State. In a total of 124 participants, a significant correlation was observed between counselor's willingness to pursue a graduate level degree and their beliefs in evidence-based approaches versus traditional 12 step ideology. Material and philosophical institutional support were significantly correlated with intentions to further one's education. Based on these findings, recommendations for treatment and policy are provided.

Degree Type

Dissertation

Degree Name

Doctor of Social Work (DSW)

First Advisor

Lani Nelson-Zlupko

Second Advisor

Lina Hartocollis

Keywords

Substance Abuse, Addiction, Non Traditional Students, Higher Education, Institutional Barriers

Subject Categories

Higher Education | Social and Behavioral Sciences | Social Work

**BARRIERS TO ATTAINING HIGHER EDUCATION AMONG SUBSTANCE ABUSE
COUNSELORS
Steven Dawson**

A DISSERTATION

in

Social Work

Presented to the Faculties of the University of Pennsylvania

in

Partial Fulfillment of the Requirements for the

Degree of Doctor of Social Work

2017

Lani Nelson-Zlupko, Ph.D., LCSW
Dissertation Chair

John L. Jackson, Jr., PhD
Dean, School of Social Policy and Practice

Dissertation Committee

Lina Hartocollis, Ph.D., LCSW Dean of Students
Director, Clinical DSW Program
Adjunct Assistant Professor

ACKNOWLEDGEMENT

I would like to express my deepest appreciation to my amazing wife Vanessa Dawson for her unwavering support and encouragement through this process. Her support and willingness to allow our lives to take this direction and her ability to hold the space for me as I stumbled forward through this process means the world to me.

To my mother, Mary Ann Dawson, who never got to see her son make good on this promise, I dedicate this work to you, lady.

To my dissertation committee, Lina Hartocollis and especially to my chair, Lani Nelson-Zlupko for their valuable advice, mentorship and support through this incredible journey. I would also like to thank the University of Pennsylvania for providing the perfect environment, education and rigor necessary for me to complete this study.

A special thanks is owed to Jeff Johnson-Curry for his ability to help my entire cohort and I through the logistics of the program and for always providing an engaging and calming presence when we needed it most.

A profound thank you is owed to the staff as well as the clients I have worked with in the field of substance use treatment and prevention. You helped me find my voice and my calling. You taught me about strength, perseverance and passion. My hope is that my work can grow in a direction that will help you in yours.

And finally, to my anonymous friends in church basements around the world, thank you for a promise now received.

ABSTRACT

BARRIERS TO ATTAINING HIGHER EDUCATION AMONG SUBSTANCE ABUSE

COUNSELORS

Steven Dawson, LCSW

Lani Nelson-Zlupko, Ph.D., LCSW

Twenty-three million people over the age of 12 meet criteria for a substance use disorder. Drug overdose is currently the number one cause of injury-related death in the US. From 1999 to 2017, almost 218,000 people died from overdoses related to opioids. In 2017, opioid overdoses were five times higher than they were in 1999. The financial cost of substance abuse in the US is estimated at \$700 billion annually. Evidence-based approaches have been shown to improve outcomes, yet substance use treatment has the lowest rates of utilization of evidence-based practices of any health care discipline.

Graduate level education has been shown to increase the use of evidence-based practice. However, most states require low educational requirements for substance abuse counselors. This gap in education negatively impacts the use of evidence-based practice and is linked to many ethical issues in the field.

Many studies have looked at the role of education in the use of evidence-based practices but little is understood regarding the multiple barriers substance abuse counselors experience. A mixed-methods study was conducted to investigate these barriers to higher education among substance abuse counselors in New York State. In a total of 124 participants, a significant correlation was observed between counselor's willingness to pursue a graduate level degree and their beliefs in evidence-based approaches versus traditional 12 step ideology. Material and philosophical institutional support were significantly correlated with intentions to further one's education. Based on these findings, recommendations for treatment and policy are provided.

TABLE OF CONTENTS

ACKNOWLEDGEMENT.....	ii
ABSTRACT.....	iii
LIST OF FIGURES.....	vii
CHAPTER ONE:	
HISTORY OF SUBSTANCE ABUSE TREATMENT IN AMERICA.....	6
Disease Model and Asylums.....	6
Mutual Aid Societies and the Twelve-Step Movement	7
Synanon and the Birth of Therapeutic Communities.....	11
Deinstitutionalization.....	12
Therapeutic Communities Thrive after Deinstitutionalization	13
Lag in Regulation and Standards for Treatment	14
CHAPTER TWO:	
EVOLUTION OF BEST PRACTICES FOR SUBSTANCE ABUSE TREATMENT AND CO-OCCURRING DISORDERS.....	16
Separate Treatment	17
Parallel versus Integrated Treatment	18
Evidence-Based Best Practices for Substance Abuse Treatment	19
Failure to Provide Best Practices and Integrated Comprehensive Care	20
CHAPTER THREE:	
BARRIERS TO BEST PRACTICES IN SUBSTANCE ABUSE TREATMENT	Error!
Bookmark not defined.	
Lower Standards for Treatment	24
Personal Recovery History Favored Over Science-Based Approaches.....	25
Institutional resistance to change	26
Resistance Highly Correlated with Educational Background.....	30
Resistance to Best Practices in the Treatment of PTSD among Substance Abuse Counselors.....	31
Ethical Issues	33
CHAPTER FOUR:	
SOCIOECONOMIC AND PERSONAL BARRIERS TO HIGHER EDUCATION AMONG SUBSTANCE ABUSE PROVIDERS	Error! Bookmark not defined.
Pursuit of Higher Education among Traditional and Nontraditional Students	36
Substance Abuse Counselors as Non Traditional Students	37

Extrinsic and Intrinsic Barriers Impede Advanced Degrees and Exposure to Best Practices: Need for Comprehensive Study	38
---	----

CHAPTER FIVE: RESEARCH QUESTION.....	40
---	----

CHAPTER SIX: MEASURES AND METHODS.....	41
---	----

Measure.....	41
Sample.....	43
Data Collection and Analysis Procedures.....	43
Human Subject Protections.....	44
Limitations	45
Timeline	Error! Bookmark not defined.
Data on Refusers and Drop-outs.....	46

CHAPTER 7: FINDINGS.....	47
-----------------------------	----

Factors Impacting Willingness to Attend Graduate School.....	50
Additional Barriers Among Substance Abuse Counselors	55
Differences of Percentage of Responses by Demographic Factors	60
Gender.....	67
Race.....	69
Length of time as a counselor	73
Recovery Status	81
Marital Status	89
Number of Children	92
Conclusion and Discussion.....	104

CHAPTER 8: DISCUSSION AND IMPLICATIONS.....	105
--	-----

Financial challenges exacerbated by personal addiction histories.....	105
Evidence Based Interventions versus the value of personal recovery experience	106
Institutional biases against evidence based approaches.....	106
Limitations of the Study.....	108
Implications of the Results for the Field.....	109
Recommendations for further research.....	111
Conclusion	111

APPENDIXES.....	125
Appendix A: The Twelve Steps of Alcoholics Anonymous.....	125
Appendix B: Sample of Online Consent.....	126
Appendix C: OASAS Scope of Practice Initiative	129

LIST OF FIGURES

Figure		Page
1.	Rates of Use	1
2.	Rates of Referral Sources	2
3.	Factors and Demographics	39
4.	Table 14: Age	51
5.	Table 15: Gender	51
6.	Table 16: Race/Ethnicity	51
7.	Table 17: Length of Time as a Counselor	51
8.	Table 18: Personal Recovery Status	51
9.	Table 19: Marital Status	51
10.	Table 20: Number of Children	53
11.	Table 21: Yearly Income	53
12.	Table 22: Likelihood to pursue a Graduate Degree	54
13.	Table 23: Time to Complete Degree	54
14.	Table 24: Intention to Pursue a Graduate Degree	54
15.	Table 25: Adequate Funding	54
16.	Table 26: Adequate Funding; Debt	54
17.	Table 26: Belief in the Benefit of Higher Education	56
18.	Table 28: Willingness to Embrace New Models of Treatment	56
19.	Table 29: Family Support	56
20.	Table 30: Organizational Support; Philosophical	56
21.	Table 31: Organizational Support; Material	57

22.	Table 32: Belief in the Benefit of Personal Recovery	57
23.	Table 33: Access to Childcare	58
24.	Table 34: Access to Childcare; Employer Assistance	58
25.	Table 35: Time to Complete Degree; Age	65
26.	Table 36: Intention to Pursue a Graduate Degree; Age	66
27.	Table 37: Adequate Funding; Age	67
28.	Table 38: Belief in the Benefit of Higher Education; Age	68
29.	Table 39: Willingness to Embrace New Models of Treatment; Age	68
30.	Table 40: Family Support; Age	69
31.	Table 41: Likelihood to pursue a Graduate Degree; Gender	69
32.	Table 42: Time to Complete Degree; Gender	70
33.	Table 43: Adequate Funding, Gender	71
34.	Table 44: Likelihood to pursue a Graduate Degree; Race/Ethnicity	71
35.	Table 45: Time to Complete Degree; Race/Ethnicity	72
36.	Table 46: Adequate Funding; Race/Ethnicity	72
37.	Table 47: Likelihood pursue Graduate Degree; Length of Time as a Counselor	73
38.	Table 48: Time to Complete Degree; Length of Time as a Counselor	74
39.	Table 49: Intention Pursue Graduate Degree; Length of Time as a Counselor	75
40.	Table 50: Adequate Funding; Length of Time as a Counselor	76
41.	Table 51: Belief Benefit of Higher Education; Length of Time as a Counselor	77
42.	Table 52: Willingness Embrace New Models Treatment; Length of Time Counselor	78
43.	Table 53: Family Support; Length of Time as a Counselor	79
44.	Table 54: Belief in the Benefit of Personal Recovery; Length of Time as a Counselor	80

45.	Table 55: Likelihood to pursue a Graduate Degree; Personal Recovery Status	81
46.	Table 56: Belief in the Benefit of Higher Education; Personal Recovery Status	82
47.	Table 57: Willingness Embrace New Models of Treatment; Personal Recovery Status	83
48.	Table 58: Family Support; Personal Recovery Status	84
49.	Table 59: Organizational Support; Philosophical; Personal Recovery Status	85
50.	Table 60: Belief in the Benefit of Personal Recovery; Personal Recovery Status	86
51.	Table 61: Likelihood to pursue a Graduate Degree; Marital Status	87
52.	Table 62: Intention to Pursue a Graduate Degree; Marital Status	88
53.	Table 63: Access to Childcare; Marital Status	89
54.	Table 64: Likelihood to pursue a Graduate Degree; Number of Children	90
55.	Table 65: Time to Complete Degree; Number of Children	100
56.	Table 66: Belief in the Benefit of Higher Education; Number of Children	101
57.	Table 67: Likelihood to pursue a Graduate Degree; Yearly Income	102
58.	Table 68: Intention to Pursue a Graduate Degree; Yearly Income	103
59.	Table 69: Adequate Funding; Yearly Income	104
60.	Table 70: Belief in the Benefit of Higher Education; Yearly Income	105
61.	Table 71: Willingness to Embrace New Models of Treatment; Yearly Income	106
62.	Table 72: Access to Childcare; Yearly Income	106

INTRODUCTION

The Substance Abuse and Mental Health Services Administration (SAMHSA, 2017), conducted a national survey on drug use and health and found that an estimated 18.2 million people aged 12 or older needed substance use treatment but only 1.0 million acknowledged needing treatment. Of the 1.0 million people who saw a need for treatment only 5.7 percent of them actually received it. The Centers for Disease Control (CDC, 2016) reports that drug overdose is currently the number one cause of injury-related death in the United States and was responsible for 43,982 deaths in 2014. According to the National Institute on Drug Abuse (NIDA, 2016), the financial cost of substance abuse in the United States is estimated at more than \$700 billion annually. These costs are related to crime, loss in work productivity, and health care costs.

Figure 1 below shows the use rates of the most common drugs.

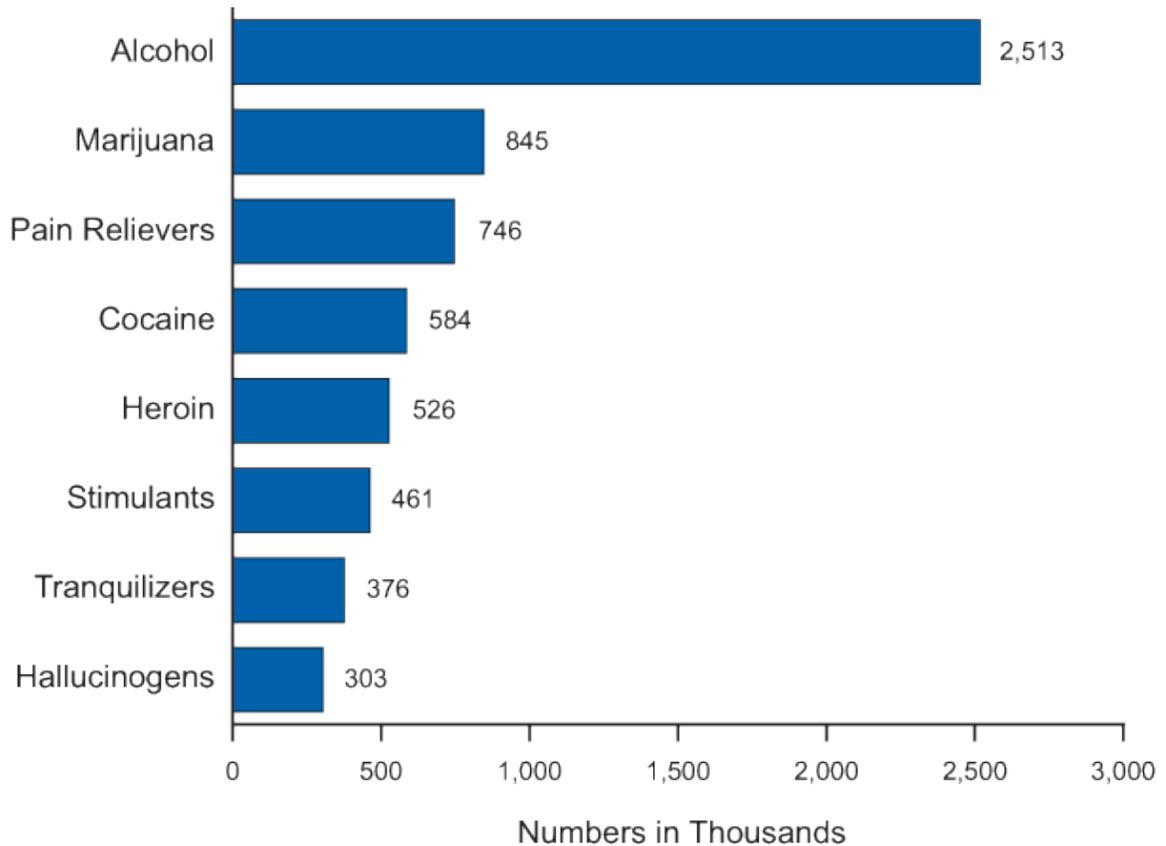


Figure 1 Rates of Use

Alcohol is the most used drug and is associated with the highest levels of treatment episodes; however, many individuals who present for treatment use multiple substances. The type of treatment received is related to the level of function and the severity of drug condition.

Figure 2 below shows the rates of utilization of the most common levels of treatment.

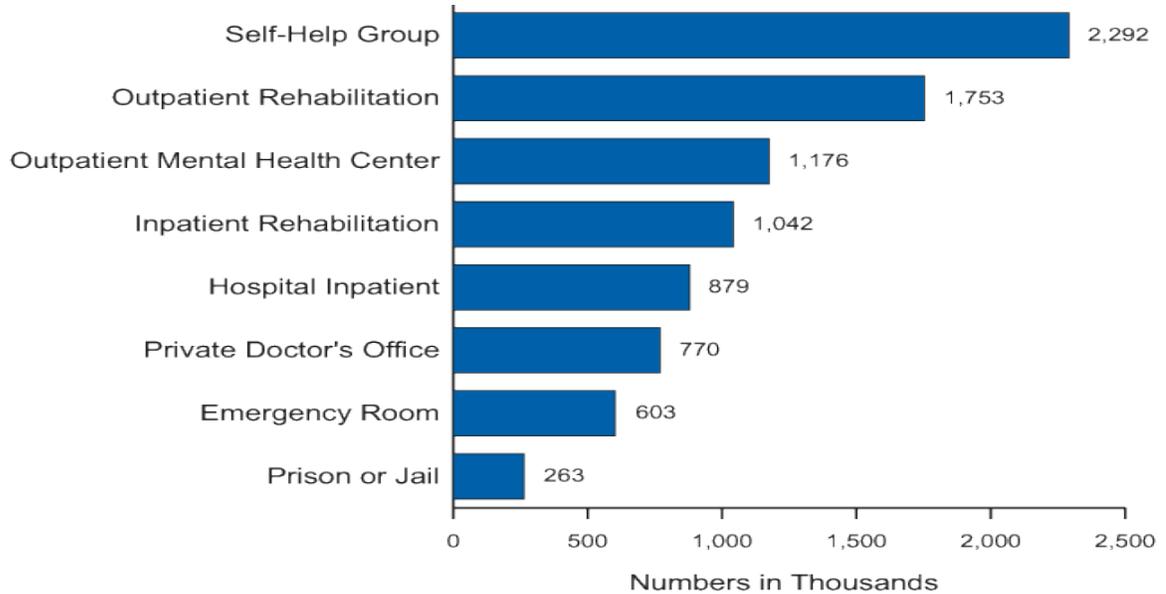


Figure 2 Rates of Referral Sources

Further complicating substance use treatment is the high prevalence of co-occurring disorders. A co-occurring disorder is the result of an individual suffering from both a substance use disorder and a mental health disorder (Corcoran & Roberts, 2015). According to SAMHSA's 2016 National Survey on Drug Use and Health, approximately 7.9 million adults in the United States had co-occurring disorders. According to SAMSHA.gov (2016),

People with mental health disorders are more likely than people without mental health disorders to experience alcohol or substance use disorder. Co-occurring disorders can be difficult to diagnose due to the complexity of symptoms, as both may vary in severity. In many cases, people receive treatment for one disorder while the other disorder remains untreated. This may occur because both mental and substance use disorders can have biological, psychological, and social components. Other reasons may be inadequate provider training or screening, an overlap of symptoms, or that other health issues need to

be addressed first. In any case, the consequences of undiagnosed, untreated, or undertreated co-occurring disorders can lead to a higher likelihood of experiencing homelessness, incarceration, medical illnesses, suicide, or even early death. (para. 3)

Moreover, according to SAMSHA (2013), the criminal justice system is the main referral source for substance use treatment. According to Mumola and Karberg (2006) and SAMSHA (2016), 74% of people in state prisons met criteria for a substance use disorder (SUD), 63% of federal prisoners met criteria for mental health disorders, and 42% of state prisoners and 49% of jail inmates met the criteria for co-occurring substance use and mental health disorders.

Of the 23 million individuals purported to need treatment, only 2.5 million sought professional treatment in 2014 (SAMSHA, 2014), indicating that access to treatment remains a real problem in the U.S. Fortunately, a variety of evidence-based treatments are available to those who do seek care. These treatments range from cognitive behavioral therapy to contingency management, motivational enhancement therapy, medication-assisted therapy and more (see Chapter 2 for a more comprehensive discussion of evidence-based treatment). Such treatment shows positive results in helping individuals deal with and recover from substance use disorders (Corcoran & Roberts, 2015; SAMSHA, 2016, Schmidt et al., 2012).

Yet, despite the evidence of the effectiveness of these approaches, the field of substance abuse treatment has resisted implementing evidence-based treatments. In fact, substance use as a field of practice has the lowest rates of utilization of evidence-based practices (or EBPs) of any health care discipline (Schmidt et al., 2012). McGlynn et.al. 2003 sought to gain clarity about the rates of use of evidence-based practices in a variety of healthcare settings. They called a random sample of adults in various cities across the country and interviewed them regarding their experiences with the healthcare system. The study also looked at these individual's medical records for the 2 most recent years. They found that 60% of medical patients in the U.S. received

treatment that met clinical standards while only 10.5% of people receiving treatment for alcohol dependence received evidence-based care (McGlynn et al., 2003).

One of the strongest predictors of utilization of best practices is advanced education. Counselors who pursue graduate level degrees show greater adherence to evidence-based practice, greater openness to new ideas, a better understanding of countertransference and an increased ability to identify ethical issues (Olmstead et.al, 2012; Toriello, 1999). However, the field of substance abuse – unlike most fields of mental health today – does not require a graduate degree to practice frontline counseling (Doukas & Cullen, 2011; Davis, Ancis, & Ashby, 2015) and, research suggests that counselors who are not educated and trained to utilize EBPs lack sufficient training to adequately help clients deal with dual diagnosis, trauma histories, and histories of adverse childhood experiences (Doukas & Cullen, 2011; Davis et al., 2015).

The impact of this gap in higher education not only appears to impede best practices and is especially problematic in the care of substance abuse patients with complicated trauma or dual-diagnosis histories, but there is another problem: lower education among counselors is also linked to problematic ethical decision making in substance abuse centers (Gallagher, 2010; Toriello, 1999). According to one study comparing rates of ethical violations between substance abuse counselors and other human services professionals in the state of Texas, researchers found that,

Certified Addiction Counselors had a 12.4% higher rate of ethical violations compared to Licensed Social Workers, a 17.1% higher rate than Licensed Psychologist, an 18.8% higher rate than Licensed Professional Counselors, and a 26.3% higher rate than Licensed Marriage and Family Therapist. Second, 84.6% of all ethical violations for substance abuse treatment professionals were for dual relationships and exploitation of patients, this includes sexual relationships with a current or former patient. 46.2% of the ethical violations for Certified Addiction Counselors from 2003-2007 were for dual relationships and 38.4% were for the exploitation of patients. (Gallagher, 2010, p. 1).

These findings have been replicated elsewhere. A study of 360 individuals certified to provide substance abuse treatment revealed that counselors who possessed a graduate level education showed a greater ability to identify ethical issues that counselors with a bachelor's degree or less (Toriello & Benschhoff, 2003).

The number of people needing adequate care for substance abuse is substantial. Effective strategies geared to meet the complex needs of these people are necessary and available. Yet the field of substance abuse remains strikingly behind the times in its adoption and regulation of best practices. The purpose of this dissertation was to explore in further detail the barriers to evidence-based practice utilization in the field of substance abuse. Specifically, this dissertation begins with an examination of the history of the drug treatment field and how it has evolved to under-utilize evidence-based practices. I then explore best practices in the field of substance abuse, particularly given the complex treatment needs of the population who often experiences dual-diagnosis of a substance abuse problem and a mental health disorder. I go on to provide a thorough examination of the current barriers to advancing higher education among substance abuse counselors. Using the lens of systems theory, both intrinsic and extrinsic factors were explored. Finally, drawing on these existing barriers, a large-scale survey methods study was conducted in which the varying rates of these barriers to higher education were ascertained. Findings are analyzed and presented; as implications are drawn to inform standards of care guidelines aimed at successfully overcoming the barriers to higher education – and best practices – among substance abuse counselors. Recommendations are outlined to help overcome the current paucity of the utilization of best practices in this field.

CHAPTER ONE:

HISTORY OF SUBSTANCE ABUSE TREATMENT IN AMERICA

The treatment of substance use is not new. Evidence of treatment shows up as early as ancient Egypt, where individuals who were said to be “Mad from wine and beer” were sent to stay at houses that were made up of families of healers (Levine, 1978). The use of retreats and the idea of confinement in private institutions are referenced in both ancient Greek and Roman writings (Levine, 1978). The use of seclusion and confinement grew popular in the United States in the late 1800s and has evolved into our current paradigms of treatment.

Disease Model and Asylums

The first modern documented forms of substance abuse treatment were the disease model and the asylum approach. In the mid-19th century, Dr. Benjamin Rush was the first to refer to substance use as a disease (as opposed to a character or moral issue). By doing this he placed treatment into the world of a medical model and initiated the concept of “treating” a patient with a specific approach (Rush, 1814). This concept gained the support of other notable physicians of that day, including Drs. Eli Todd, Samuel Woodward, and Joseph Turner (Rush, 1814). At the time, these physicians saw addiction treatment as a public duty and that patients needed specialized care to recover. Attempts to address substance use as a public health issue at that time had ranged from forced confinement and imprisonment to public social movements like the temperance movement, which eventually led to the failed experiment of prohibition (White, 1998). The asylum approach, or the placement of an addicted person into an institution, was aimed at “drying out” individuals with the expectation that they would return to society as “whole men” (White, 1998). The medication was a core component of both the disease model and the asylum approach, and medical professionals were the ones who administered these

programs. While the medical world saw this sort of confinement as the solution to the problem of the “drunkard,” the reality was more subjective, as told by one recovering addict in William L. White’s (1998) book *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*:

I have born the most unfair comments and insinuations from people utterly incapable of comprehending for one second the smallest part of my suffering, or even knowing that such could exist. Yet they claim to deliver opinions and comments as though better informed on the subject of opium eating than anybody else in the world, I have been stung by their talk as by hornets, and have been driven to solitude to avoid the fools. (p. 27)

Between the 1890s and 1920s, these so-called “inebriate asylums” began to die off, resulting from lack of funding and social support (White, 1998). In the wake of asylums dwindling, many peer-based groups like the Washingtonians began to emerge. Members of these groups took pledges and worked together as “fellow inebriates” to try to maintain collective sobriety. This was the beginning of mutual aid that would soon become a cornerstone in the treatment of substance use.

Mutual Aid Societies and the Twelve-Step Movement

The Washingtonians eventually disbanded, but other groups like the Quaker-based Oxford Group took their place. The Oxford Group relied on a spiritual component to help create a shift in the individual’s personality that could help them move away from drugs and towards God (Kurtz, 1979; White, 1998). This program was the foundational program for the most well-known of all self-help groups, Alcoholics Anonymous (AA) and the Twelve Step Movement. This movement remains a core component of most treatment facilities in the U.S. today.

The Twelve Step movement is associated with the founding of Alcoholics Anonymous - a self-help group initiated in Akron, Ohio in 1945 by Bill Wilson and Dr. Bob Smith. These two men met when Bill Wilson, who was trying to stay sober with the help of the Oxford Group, was

in Akron Ohio on a business trip. The business venture did not turn out as planned, and Bill was contemplating a relapse. Instead of drinking, he used the tools of the Oxford Group and reached out to local ministers, asking if they knew of any “alcoholics” he could speak with. He was directed to Dr. Bob Smith, a podiatrist who had been suffering from substance use issues for many years. Bill went to Dr. Smith’s home and began using the principles of mutual aid that he learned from the Oxford Group to connect with Bob by sharing his own story of use and recovery (Alcoholics Anonymous, 2001; Kurtz, 1979).

This principle of alcoholics sharing their experience with other alcoholics is the cornerstone of the Twelve Step philosophy. Out of this first meeting, the foundation of AA was born. With influences ranging from medical professionals who had worked with Bill Wilson and who described the addiction process as an “allergy,” to the steps and spiritual influence of the Oxford Group and the input of the first 100 members of the group, the founders wrote the book Alcoholics Anonymous, known by members as “The Big Book” (Alcoholics Anonymous, 2001). Some of the principal components of this program are a commitment to the disease model of addiction, the “allergy,” and the admission of personal powerlessness over the drug. The Twelve Step Program relies on a spiritual mechanism, and, although the program does not align with a specific religion, the concept of God as higher power and the reliance on that relationship are foundational tenants of this program. AA describes itself as a program of attraction, not promotion, meaning that members do not recruit participants but rather work with individuals who have an honest desire to commit to the program. Because this program is voluntary, issues of power and social positioning within the group are theoretically minimal (Alcoholics Anonymous, 2001; Kurtz, 1979). The steps within the program require a deep commitment to personal change and growth, and a new member will often work with a senior member referred

to as a sponsor. (A copy of the 12 steps of Alcoholics anonymous is included in Appendix A). Sponsors are responsible for taking new members through the twelve steps and helping them engage and utilize the groups to help enhance their environmental supports and coping skills (*Alcoholics Anonymous*, 2001). This group was one of the first to allow individuals to take full responsibility for their own care; it was also one of the first to acknowledge the need for attachments and the repairing of relationships.

Alcoholics Anonymous changed the landscape of substance use treatment in America (Vaillant, 2006; White, 1998; Whitley, 2010). With the advent of this peer-led, disease model based program, the field had a demonstrated peer support system that offered an alternative to confinement. The idea that these groups improved the quality of life of the alcoholic in profound ways was the primary source of its growing popularity. During the early days of Alcoholics Anonymous, there were no detailed studies exploring the outcomes of the program. The Program itself gave a vague statistic about its effectiveness in their seminal publication *Alcoholics Anonymous* as follows:

Of Alcoholics who came and really tried, 50% got sober at once and remained that way; 25% sobered up after some relapses, and among the remainder, those who stayed on with AA showed improvement. Other thousands came to a few AA meetings and at first, decided they didn't want the program. But great numbers of these—about two out of three—began to return as time passed. (*Alcoholics Anonymous*, p. XX, 2001)

It is unclear where these statistics came from but from this writer's personal observations, these statistics are still quoted today in A.A. meetings as well as some treatment programs.

Many critics of these statistics point to the lack of hard data collected on the program's outcomes (Vaillant, 2006; White, 1998; Whitley, 2010). Kaskutas, (2009) conducted a literature review of the effectiveness of Alcoholics Anonymous and discussed the challenges of documenting outcomes. She referenced a review published by the Cochrane Group that looked at

outcome studies of both AA and 12-step facilitation (TSF), which is a form of specialty treatment that introduces clients to the twelve steps and AA programs during treatment. Cochrane review suggested that people planning to participate in twelve-step programs or TSF be made aware of the lack of experimental evidence supporting the effectiveness of these approaches. However, Kaskutas (2009) does discuss studies that show optimal outcomes for TSF at one- and three-year periods. Kaskutas (2009) also points to other researchers and scholars like Rudy Moos who make strong recommendations for clients to be referred to AA prior to other forms of treatment, this recommendation is mostly based on observational studies that show less problematic alcohol use for those clients first exposed to AA. Kaskutas's review concludes that:

Among the rigorous experimental studies, there were two positive findings for AA effectiveness, one null finding, and one negative finding. Among those that statistically addressed selection bias, there were two contradictory findings and two studies that reported significant effects for AA after adjusting for potential confounders such as motivation to change. Readers must judge for themselves whether their interpretation of these results, on balance, supports a recommendation that there is no experimental evidence of AA effectiveness (as put forward by the Cochrane review). As for the scorecard for the other criteria, the evidence for AA effectiveness is strong: rates of abstinence are approximately twice as high among those who attend AA (criteria 1, magnitude); higher levels of attendance are related to higher rates of abstinence (criteria 2, dose-response); these relationships are found for different samples and follow-up periods (criteria 3, consistency); prior AA attendance is predictive of subsequent abstinence (criteria 4, temporal); and mechanisms of action predicted by theories of behavior change are evident at AA meetings and through the AA steps and fellowship (criteria 6, plausibility) (Kaskutas, 2009, p. 12).

While this study shows that AA can be effective and is especially effective when partnered with other evidence-based approaches, it is important to note that AA was never intended to be a formal treatment program. As White (1998) discusses, the early founders of AA came to the conclusion that AA should not be an organized treatment facility based program but should remain self-help, peer-led program. It is interesting to note that early in the founding of Alcoholics Anonymous the discussion about professionalizing the 12 steps into treatment

facilities. During this discussion, Bill Wilson, one of the founding members proposed the idea of creating AA hospitals. This plan involved employing sober members of AA as treatment providers and the treatment approach was designed around the twelve steps. The reaction from the early membership was as follows.

The moment we were through presenting the proposal, those alcoholics really did work us over! They rejected the idea of missionaries. Paid workers, they said, would kill our goodwill with alcoholics... if we went into the hospital business, everybody would say it was a racket. (White, 1998, p.163)

There were some failed attempts at formalizing AA but in the end, it was decided that AA should remain as it was and that it should not become an institutionalized program. However, some members did take the concepts of AA and the twelve steps and used them to create a new type of treatment setting. In this new approach, a heavy focus was placed on the value of shared experience as members of AA began to professionalize their recovery into treatment programs that used other recovering individuals as counselors. Nowhere was this concept taken more literally than in the therapeutic communities.

Synanon and the Birth of Therapeutic Communities

The birth of the therapeutic community movement can be traced to Charles Dederich. Dederich entered the rooms of Alcoholics Anonymous in 1958 to get help with an addiction to alcohol and Benzedrine (White, 1998). Within a few years, he became obsessed with the recovery movement and described himself as a “frantic and fanatical Alcoholics Anonymous fellow” (Levine, 1978). During this time, researchers were conducting medication trials in an attempt to “cure” the disease of alcoholism (White, 1998). One of these experiments was the LSD experiment at the University of California. Dederich was involved in this research and was reported to have had a surge of emotional catharsis and developed a life mission to help other alcoholics (White, 1998). This mission took the form of his Synanon Institution. The program

was loosely based on what Dederich had learned in AA and leaned heavily on the concept of one alcoholic working with another alcoholic. Dederich employed a variety of group work and individual counseling. Dederich's tactics were built on the idea that the alcoholic needed to be broken down and then rebuilt into a socially accepted individual. Importantly, there are little to no data to support the utility of this approach, yet it flourished unchecked in the United States for decades. The Synanon organization lasted 30 years and went through three different incarnations, each more restrictive, punitive, and dangerous than the previous (White, 1998). Dederich's model was very profitable, and Dederich engaged in financial schemes and criminal behavior for which he was arrested and charged with attempted murder after other members of his program put a rattlesnake in the mailbox of a news reporter who had written a critical piece on the program (White, 1998).

Deinstitutionalization

Another influence of this movement came as a result of the creation and effectiveness of antipsychotic medications like chlorpromazine, commonly known as Thorazine, and its ability to allow psychotic patients to manage their symptoms. This allowed many individuals who had been confined to state hospitals to return to society with an improved quality of life. This mass exodus from institutions is known now as the deinstitutionalization movement.

Deinstitutionalization was a policy that was introduced in the 1950s and 1960s in the United States and involved releasing large amounts of individuals who had been confined in state-run mental health institutions. In 1955, it was estimated that 560,000 people were being treated in state-run facilities. This number represented almost half of all mental health treatment episodes. Due to deinstitutionalization, that number had been reduced to 160,000 by 1977. This new number represented only 10% of mental health treatment episodes (Gronfein, 1985). This

policy was seen as liberating and was linked with the introduction of effective medications that helped manage some of the symptoms of these mental health issues (Corcoran & Roberts, 2015; Novella, 2008).

However, in many communities, the release of these individuals – many of them substance abusers with co-occurring disorders - was not coupled with the creation of adequate outpatient services (White, 1998). As a result, many of these individuals found themselves in other systems that were not prepared to offer them the services they needed. Many released patients found themselves homeless, in jail, or in other forms of treatment such as rapidly rising therapeutic communities (Corcoran & Roberts, 2015; Davis, Fulginiti, Kriegel, & Brekke, 2012).

Therapeutic Communities Thrive after Deinstitutionalization

To adapt to this influx of new clients following deinstitutionalization, the treatment field attempted to adopt the theories of democratic therapeutic communities which had been popular in Europe during the 1940s and 50s (Manning & Rawlings, 2004). These programs were built on concepts that included an informal communal atmosphere, a central place for group meetings including expressive therapy, sharing the work of maintaining and running the community, sharing authority, and the identification of therapeutic roles for the patients (Manning & Rawlings, 2004; Novella, 2008; White, 1998). Therapeutic communities in the U.S. devolved into Dederich's model of treatment that used these concepts in punitive ways and attempted to change behavior through confrontation and behavioral modification. These programs employed individuals with recovery histories rather than professionally trained mental health providers. The therapeutic community movement grew into the treatment standard for substance use treatment in the 1960s and 1970s (Vaillant, 2006; Whitley, 2010).

It is important to note that the Synanon program, as well as the early substance abuse

therapeutic communities, did not engage in evaluation of their treatment model; indeed, they often worked to keep research from being done. Some outside parties conducted studies looking at post-treatment success, but these studies were not considered valid, and the ability to quantify the success rates of these early programs remains a challenge (Manning & Rawlings, 2004; White, 1998).

These programs were founded by either member of AA or former members of Synanon, were built around the 12 steps, and utilized recovering individuals as counselors (Vaillant, 2006; White, 1998; Whitley, 2010). In the 1970s, drug treatment grew tremendously (Whitley, 2010). The Joint Commission on Accreditation of Hospitals developed standards that brought drug treatment into the medical community and allowed for reimbursement. Treatment centers began opening up all over the country. To meet the high demand for counselors, there was a push to utilize the recovery community to provide these services (Whitley, 2010). Some individuals would even begin working in the field before they had completed their own treatment (Vaillant, 2006; White, 1998; Whitley, 2010). In this way, the role of substance abuse counselor has long been viewed as an apprenticeship position where the new clinician learns from working with and observing a more seasoned counselor much in the same way that a new member of AA might work with a sponsor (Vaillant, 2006; Whitley, 2010).

Lag in Regulation and Standards for Treatment

As the field grew, state and federal laws began to regulate substance use treatment, prevention, and certifications. Because a graduate degree was never set as the standard requirement, unique education programs were established for substance abuse counselors that were not permitted in other areas of mental health counseling. A class of paraprofessional providers, known as substance abuse counselors (SACs), was created. Despite the recognition by

state boards that there were specific topics and techniques relevant to the best practice of substance use counseling and despite these standards being mandated to be acquired among regular mental health providers such as social workers and psychologists, these standards were not and are still not mandated among SACs. This remains true in most states today (Kerwin, Walker-Smith, & Kirby, 2006; OASAS, 2016; SAMSHA, 2014), and the core tenants of SAC training today remain firmly grounded in the philosophy of self-help concepts (Kerwin et al., 2006).

It is interesting to note how the history of the disease model, self-help approach, and in particular, the twelve-step philosophy are widely adhered to today. This continues despite a growing body of research pointing to alternative forms of evidence-based care, particularly among high-need, complex patients. In looking at the barriers to pursuing higher education for substance use counselors, it is important to look at how the historical beliefs about treatment and the role of the twelve steps and in some cases the rejection of evidence-based approaches have impacted attitudes towards gaining advanced training, education and clinical understandings of empirically backed concepts.

CHAPTER TWO: EVOLUTION OF BEST PRACTICES FOR SUBSTANCE ABUSE TREATMENT AND CO-OCCURRING DISORDERS

The concept of co-occurring disorders was recognized and discussed as early as the 1700s, but despite this early exploration, the concept got very little attention in regard to treatment approaches or policy changes in the United States until the 1970s. In 1979, the psychologists Woody and Blaine (1979) brought attention to the relationship between substance use and mental health disorders like bipolar and unipolar depression and anxiety. Despite their early attention given to co-occurring disorders, the dual diagnosis did not gain focus in the field of substance abuse treatment or in mental health until the 1990s (Flynn & Brown, 2006). Dual diagnosis is now understood largely as the rule, not the exception.

Current estimates for comorbid mental health issues range from 30% to 90% (Cacciola et al. 2008; Havassy, Alvidrez, & Owen, 2004; Libby, Orton, Stover, & Riggset, 2005; Mortlock et al. 2011). Research indicates that up to 75% of people seeking treatment for a substance use disorder meet criteria and require treatment for co-occurring disorders. (Cacciola et al. 2008; Drake et al. 2001; Libby et al. 2005; O'Brien et al. 2004). In an extensive empirical review of the prevalence of people in substance abuse treatment experiencing co-occurring disorders, Horsfall, Cleary, Hunt, & Walter (2009) reported that 37% of people with alcohol disorders and 53% with other drug disorders also had a comorbid psychiatric condition. These researchers further reported that individuals with schizophrenia were three times more likely to abuse alcohol and six times more likely to abuse other drugs than individuals without schizophrenia.

This high prevalence of co-occurring disorders makes treatment needs complex and suggests a need for integrated treatment models that are designed to treat both conditions at the

same time while also addressing systems and concrete needs like housing, employment, basic needs, skills training, and education (Cridland, Deane, Hsu and Kelly, 2012). However, the concept of “separate treatment” that is, of treating a substance abuse problem first or in isolation from other psychological or social problems continues to be used in many treatment settings in the United States despite the evidence that it is less effective for clients with co-occurring disorders (Brown, Bennett, Li, & Ballack, 2011, Flynn & Brown, 2008, Kelly, Daley and Douaihy, 2012).

Separate Treatment

The concept of separate treatment is based on the Twelve Step model that considers the use of a drug as the primary problem that must be treated before all other priorities. With abstinence as the measure of success, interventions are focused on drug use, relapse prevention, and connection with self-help programs like Alcoholics Anonymous or Narcotics Anonymous (NA) (Vaillant, 2006). AA and NA, as noted, are self-help programs and utilize a mutual aid peer support model that require participants to be motivated to join the program. When applied as a treatment program, much of the mutual aid and peer support is relegated to counselors who may or may not have been in recovery themselves (Vaillant, 2006; White, 1998). As such, treatment providers’ understanding of the Twelve Steps was not consistent, and often confusion of roles and the pressures of the agency took away from the unique delivery system of the Twelve Step programs. In addition, many participants in treatment programs did not come to treatment by choice but were often mandated by the court or other agencies. As a result, many participants did not share abstinence as their primary goal (Vaillant, 2006). With a single focus of abstinence, these approaches did not acknowledge or address co-occurring disorders.

Because the field of substance abuse - perhaps unlike most other fields of medical or mental health treatment – has relied so heavily on provider staff with personal recovery histories themselves, the issue of complex and varying treatment needs of patients becomes complex. Personal knowledge of a particular recovery philosophy such as the twelve steps may be useful when a patient has a similar treatment need profile, or when abstinence is the only goal embraced by all of the patients. But when a particular philosophy is not sufficient to treat more complex needs, does not keep up with more advanced nuanced methods, or when it is in conflict with the stated goal of a patient, over-adherence by a practitioner to an approach becomes problematic. This phenomenon has been linked to clients leaving treatment and or not learning to adequately address mental health issues while in substance abuse treatment (Whitley, 2010).

Of particular note, in the traditional treatment substance abuse treatment approach, mental health conditions are viewed as secondary to a substance use problem, and it is common for counselors to say that clients must be sober before they can address the mental health issue. Often counselors have a perceived fear that addressing mental health issues may trigger the individual to relapse; this fear persists despite numerous studies showing that this is not the case (Whitley, 2010). In fact, current research suggests just the opposite.

Parallel versus Integrated Treatment

Parallel treatment arose in an attempt to treat both substance use problems and psychological and social problems; however, initially, the approach that was taken was to address these problems as unique diagnoses to be treated through separate interventions (Mangrum, Spence, & Lopez, 2006). In parallel treatment, a practice which still goes on today, a client may be assigned to a group on cognitive behavioral therapy for depression and then also be involved in a separate group on relapse prevention. This may occur at separate sites or in the

same clinic, and the substance use treatment often utilizes a traditional approach focused on the Twelve Step philosophy (Mangrum, et al. 2006). This approach is certainly viewed as an improvement to traditional approaches that did not address non-substance related problems; however, outcome research indicates that parallel treatment is far less effective than integrated treatment (Mangrum, et al. 2006).

Integrated treatment was designed to address the complexities that exist in this population simultaneously. Integrated treatment views substance use disorders and mental health issues in a combined way and treats both conditions with the same approach (Horsfall et al. 2009; Nissen, 2014). The traditional approach to substance abuse treatment leans heavily on the concepts developed by self-help groups and views abstinence as the goal of treatment. Often the treatment of mental health issues is either ignored or dealt with after the individual has achieved a sufficient period of sobriety. While parallel treatment divides services and often has an individual seen for their substance use treatment in one facility and the mental health piece in another, integrated treatment treats both issues as a unified problem and uses a single point of treatment. In addition, integrated treatment seeks to address concrete psycho-social, environmental and economic needs like housing, healthcare, employment, social / relationship issues, and other case management needs. Research across a wide spectrum of programs and populations repeatedly supports the use of integrated models, for substance abusers as well as those with co-occurring psychological disorders and is currently recommended by SAMSHA as the best practice for treatment in the field (Hser, Evans, Huang, & Anglin 2004; McCarty et al., 2007; Zhang, Gerstein, & Friedmann 2008).

Evidence-Based Best Practices for Substance Abuse Treatment

According to SAMSHA and OASAS, the use of evidence-based practices are considered

best practice for both substance use treatment and prevention as well as best practice for co-occurring disorders like SUD and depression, SUD and anxiety, SUD and PTSD and many others. The literature on these approaches is enormous and shows directly targeted effectiveness for numerous settings and diagnosis. Reviewing these in detail is beyond the scope of this dissertation but it is important to note that these approaches are considered best practice. These approaches include but are not limited to Cognitive Behavioral Therapy (CBT), Contingency Management Interventions, Community Reinforcement Approach, Motivational Enhancement Therapy, The Matrix Model, 12 Step Facilitation Therapy, Family Behavioral Therapy, and Medication Assisted Therapy (MAT) (Corcoran & Roberts, 2015). Each of these approaches meets the standard for EBP and is listed as a “Best Practice” by SAMSHA (2016) and OASAS (2016) for use in substance abuse treatment.

Failure to Provide Best Practices and Integrated Comprehensive Care

It is important to note the multiple and complex socio-economic needs of this population when their complex needs go unmanaged. Statistics indicate overutilization of inpatient psychiatric hospitalization, high-cost crisis related to medical care, and high use of the criminal justice system. Due to the complexity of co-morbid conditions, treatment providers would be wise to incorporate less expensive treatment services like case management; yet these services are widely underutilized in traditional substance abuse treatment programs (Lydecker et al., 2010).

Looking specifically at a few well-conducted studies, it is evident that integrated treatment results in better outcomes than other models. For example, Mangrum et al. (2006) conducted a study to examine the treatment outcomes of individuals with co-occurring mental health diagnosis and substance use disorders. The study compared the outcomes of integrated

treatment versus parallel treatment. Mangrum et al. hypothesized that due to the neglect of parallel treatment approaches to address the interactive nature of the co-morbid conditions, that parallel treatment actually creates a “revolving door” of treatments that never truly address the nature of the issue. Parallel treatment was an improvement over traditional substance use treatment, but the addition of specialty mental health groups was not sufficient to meet the needs of this complex population. Mangrum et al. (2006) discussed how clients who received parallel treatment benefited from the intervention while in treatment but struggled to maintain those benefits after treatment ended. Researchers drew their sample from the Texas Dual Diagnosis Pilot Project and utilized two of the project’s treatment sites. They used random assignment of eligible clients in each program and assigned individuals to either an integrated treatment program or to a traditional parallel service condition. A total of 216 clients were assigned to either an integrated treatment group or a parallel control group. Researchers assessed participants every three months after the intervention for up to one year. Results showed that the group that received integrated treatments reduced the number of hospitalizations, decreasing from 12.2% to 3.3% while the group that received parallel treatment showed an increase from 6.5% to 10.8%. In regard to psychiatric hospitalization, the study also indicated that the integrated treatment group had a reduction from 5.7% to 2.4%, and the parallel group showed an increase from 2.5% to 6.1%. For arrest rates, the integrated treatment group showed a reduction from 11.4% to 7.3%, while the parallel treatment group showed a reduction from 10.8% to 9.7%.

Other studies have not only supported these findings but suggest that long-term exposure to integrated treatment yields even more positive results. Studies exploring the effectiveness of integrated models showed that treatment that was integrated and lasted 18 months or longer resulted in greater treatment engagement, decreased substance use, longer and better-sustained

remission, and similarly a decrease in hospitalizations (Lydecker et al., 2010; Mangrum et al., 2006). Mangrum et al. acknowledged that the decrease in psychiatric symptoms was not as well documented in their study, but they did show that in integrated models that involved the family, those symptoms decreased as well. It is important to note that Lydecker and Mangrum, along with other outcome researchers, indicate that outcome research with this population is complicated and often not well controlled and that due to the nature of the population where attrition is a constant issue. However, even despite these problems, research findings point strongly in the favor of integrated treatment in increasing positive outcomes for substance users and especially so for those with co-morbid social and mental health-related disorders.

Similarly interested in the connection between mental health diagnoses and substance abuse, Lydecker et al. (2010) conducted a study to explore the outcomes of integrated treatment for substance use and co-occurring depression. These researchers compared treatment outcomes for veterans who had a dual diagnosis of depression and substance use disorders. A total of 206 participants were assigned to receive traditional Twelve Step facilitation groups and pharmacotherapy or placement in an integrated model of integrated cognitive behavioral therapy group with standard pharmacology. This was a longitudinal study that followed the participants for one year after the intervention to determine differences in the effectiveness of both mental health and substance-related symptoms. The choice to explore the interconnecting disorders of depression and substance use was based on the high rate of co-morbidity of the two conditions (Lydecker et al., 2010). The depressive disorder has a lifetime prevalence rate of 16.6%, and alcohol abuse has a lifetime prevalence rate of 13.2% (Lydecker et al., 2010). The Twelve Step facilitation group participants were engaged in education groups about the 12 steps and encouraged to attend self-help meetings and become active in the 12-step program. Of the 229

veterans who met criteria for the study, 206 returned for initial assessment and were allocated to the two treatments using random assignment. The study's authors compared the longitudinal patterns of the clinical outcomes of the two groups and found that individuals with comorbid depressive disorder receiving integrated treatment showed improvements in both substance abuse disorder symptoms as well as mental health symptoms, while individuals in the parallel control group only showed improvement in their substance abuse disorder symptoms. The results from the integrated approach showed a sustained decrease in substance involvement up to one-year post-treatment, while the control group showed increased levels of relapse. The study also found that attendance rates and early treatment motivation were also predictors of long term results.

The results also indicated a need for greater, not less, focus on psychosocial issues like depression among participants. It is important to note one limitation in the study design was that some of the members of the Twelve Step facilitation group included individuals who only had substance use disorders. Future studies of this kind should limit the inclusion criteria to those with co-morbid conditions to get a more reliable outcome measure in regard to the effectiveness of integrated treatment. Despite this limitation, and even possibly more compelling because of it, this study's outcomes reinforce the efficacy of integrated treatment and makes a strong case for the current guidelines that suggest integrated treatment be the standard of practice in the field of substance use treatment as well as treatment with co-morbid conditions.

If sufficient outcome data exist to demonstrate that integrated treatment is successful, what explains the resistance among treatment agencies and providers towards adopting and utilizing best practices? Chapter Three explores the low utilization rates and possible institutional reasons for resistance towards evidence-based practice in the field of substance abuse treatment.

CHAPTER THREE:
BARRIERS TO BEST PRACTICES IN SUBSTANCE ABUSE TREATMENT

Despite SAMSHA’s recommendations based on the repeated findings of empirical research that integrated treatment is the most effective form of treatment to address the needs of substance abusing population, and despite the poor outcomes now evident when best practices are not utilized, the use of best practices in substance abuse treatment is not universal. This chapter explores the reasons that may help explain these very low utilization rates, including lower industry standards, institutional resistance, and concerns about organizational willingness to adopt new treatment methods.

Lower Standards for Treatment

Unlike other fields of mental and behavioral health, a graduate degree was never set as the standard requirement for the field of substance use treatment. As a result, a class of paraprofessional providers, known as substance abuse counselors (SACs), was created. This group is often given the same duties in a treatment program as a social worker or psychologist despite the large gap in education and training. These counselors often engage in counseling sessions and group work that entail the same goals and approaches as a mental health counselor would use, yet if these same counselors were working in a mental health facility they would not be considered qualified to provide these same services due to their education level. There has been an increasing focus from state boards pushing for the adoption and use of techniques relevant to the best practice of substance use counseling and despite these standards being mandated to be acquired among regular mental health providers such as social workers and psychologists, these standards were not and are still not mandated among SACs (Kerwin et al., 2006; OASAS, 2016; SAMSHA, 2014).

By contrast, the United States Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMSHA) (2013) reported that almost 98% of states required a graduate degree to provide mental health counseling, but 45% of states did not require any college degree—let alone graduate studies—to provide substance abuse counseling. For addiction counselors, about 50-55% of those certified or practicing in the field had at least a master’s degree, 75% had a bachelor’s degree, and the remainder had either some college, a high school diploma, or a GED. Although the field of substance use treatment was founded on a workforce that was mostly made up of professionals with personal recovery histories, there was an increase in non-recovering personnel that began to emerge in the 1970s. The NAADAC, the Association for Addiction Professionals (2012), estimated that of the 77,000 addiction providers in America, between 25% and 65% identified as being in recovery, with most other studies reporting rates between 30-40%. The best available estimate is that those in recovery currently represent 25-65% of all addiction professionals (White, Evans, & Lamb, 2009). It cannot be underestimated how the lack of mandating advanced education is playing a role in the lack of adherence to best practices – continuing to place substance abuse clients at risk for a poorer quality of care, worse outcomes, and higher exposure to ethical violations, as indicated earlier.

Personal Recovery History Favored Over Science-Based Approaches

Another possible factor explaining the low utilization of evidence-based practices in substance abuse treatment may be linked to a preference for counselors with personal experience with recovery. Nielson (2015) notes that the use of integrated treatment has been met with resistance from traditional substance use treatment providers that favor counselors with personal recovery histories, many of whom adhere to self-help, Twelve Step approach both personally and

professionally. In a follow-up study, Nielson (2016) explored the belief systems of both counselors with and without recovery status through schemas and found that counselors with recovery status had a tendency to see their clients through a traditional disease model lens where counselors without personal histories saw their clients on a continuum. The recovering counselors also had high levels of over-identification with their clients, seeing themselves and the clients as different because of the substance use where counselors without histories were able to relate to clients but not overly identify. This study is important to consider when looking at how beliefs about personal recovery influence the use of different treatment modalities. To further examine this, Crabb and Linton (2007) conducted a grounded-theory qualitative study to explore the beliefs of counselors with and without a recovery status. The study interviewed eight counselors. The interviews showed a strong correlation between recovery status and the implementation of evidenced-based practices. Recovery status did not correlate with a belief about EBP, only the use of it. Crabb and Linton went on to explain that counselors in recovery had a tendency to view the recovery process from a personal viewpoint, holding a belief that the way they recovered can be used as a template for anyone who is trying to recover. Crabb and Linton suggest that:

The gap between research and practice may be detrimental to the Substance Abuse treatment field. If practitioners continue to ignore research advances in the field, it may hinder their ability to be more effective in the treatment of SA disorders. (2007, p. 5)

Institutional resistance to change

In addition to personal recovery histories that may influence openness to science-based best practices, there appear to be a variety of other factors also impeding evidence-based care in the field of substance abuse. A major national initiative in this area was undertaken by Schmidt et al. (2012) in response to a national survey that explored the implementation of evidence-based

practices in substance abuse health care settings across the country. Schmidt and colleagues conducted a three-year multisite evaluation to explore the process and outcomes of the Advancing Recovery Program, a program specifically geared to overcome barriers against the use of evidence-based treatment in substance abuse clinics. These researchers compared the use of medically assisted treatment (MAT) and contingency management as two evidenced-based methods to explore openness to the adoption of these methods.

To examine this more closely, Schmidt and his team of researchers conducted mixed methods study exploring the impact of a Robert Wood Johnson Foundation national initiative that sought to provide models that would encourage the use of new evidence-based therapies in substance abuse facilitates. These researchers identified barriers to the adoption of evidence-based practices. They suggested that counselors often failed to use evidence-based practices because of a lack of awareness, training, real-world experience, and education. Schmidt and colleagues also identified that counselors often had negative attitudes towards new treatment philosophies and techniques. These biases were identified as the result of competing beliefs about medical, psychiatric, and self-help paradigms that were influencing the use of more traditional techniques. The unique aspect of this study was that it focused in on organizational support and beliefs rather than focusing specifically on the counselors themselves. “Research on barriers to implementing new therapies for alcohol and drug use disorders has focused on the individual clinician and, to a more limited extent, the treatment organization” (Schmidt et al., 2012, p. 1).

This study was able to identify how the climates of these organizations and the treatment culture within these agencies affected counselors’ attitudes towards the use of evidence-based practices. In their conclusion, Schmidt and colleagues (2012) noted that the barriers to the use of

these evidence-based practices were present across all levels of the treatment program studied. The problem was systemic and pervasive, and that strong organizational structure and culture improved the use of EBPs: “Management practices and staff turnover can affect rates of clinical innovation, organizational capacity—as reflected in larger treatment programs, highly credentialed staff, strong information processing capacities, and well-resourced patients—is positively associated with rates of adopting evidence-based practices” (Schmidt et. al, 2012, p. 2).

The study also discusses how belief and program culture impacted the willingness to change and adapt to new types of treatment:

Our qualitative observations suggested that one reason for this was that the two types of therapy called for different kinds of systems change. One was a “hard” pharmacological technology and the other a “softer” behavioral one requiring rather complex changes in service delivery to sustain increased use (Schmidt et al., 2012, p. 7).

In their conclusion, the researchers stated that “[t]his evaluation underscores the potential for systems change to promote a wider range of clinical options as well as the significant barriers that must be overcome” (Schmidt et al., 2012, p. 8).

Riera (2013) conducted a study using a 12-question survey with substance abuse counselors. The researcher began attending staff meetings at several treatment centers. Riera collected 44 surveys and used 43. The educational background included counselors who held high school diplomas, associate’s, bachelor’s, master’s, and doctoral degrees. Contingency management is an effective, evidence-based practice for the treatment of substance abuse. It has been shown to be effective in a variety of treatment settings. Riera assumed that contingency management would be widely accepted because of its evidence of support; the researcher was surprised to find that it was not used to its fullest application or potential in the field of substance

abuse treatment. Riera discussed how the substance abuse treatment field has been reluctant to integrate evidence-based practices, citing the various studies that show that substance abuse treatment providers are the least likely health care providers to utilize EBPs. This researcher's study looked at the factors that were influencing the use of this evidence-based practice and found that counselors who had a greater level of education and those counselors who had more experience showed a positive opinion towards contingency management. In regard to education level, the study showed that counselors who possessed a master's degree or above were the most likely to use contingency management even when they did not completely understand the model. This is an important finding because the data suggest that education level has a positive influence on the use of evidence-based practices with this population. Likewise, Najavits, Kivlahan, and Kosten (2011) suggested that a lack of education and training in addition to the role of personal recovery history is keeping practitioners from using evidence-based practices in substance abuse treatment. The divide between the use of research to inform practice appears to be reduced when counselors are trained in the specific models; however, even with the push towards these training and an emphasis on the use of continuing education classes for substance abuse counselors, the gap remains.

It is essential to comprehensively understand that factors involved in keeping substance abuse counselors from pursuing higher levels of education. Doukas and Cullen (2011) suggest that there may be an issue of power and internalized oppression within the ranks of counselors who have less education than counselors who have gone on to higher degrees. The less educated counselors report a desire to gain further education and become more active members of the treatment team, but despite this desire Whitley (2010) suggests that many substance use counselors view gaining a master's degree as a way to advance in their profession as opposed to

advancing their clinical skills. As a result, many counselors only pursue an advanced degree in order to move from the clinical realm into the administrative realm. Pinto, Yu, Spector, Gorroochurn, and McCarty (2010) suggest that many substance use counselors do want to learn new techniques and tools and that when these counselors are involved in research and trained to deliver evidence-based techniques, they become very engaged and utilize the tools in their ongoing practice. Actual empirical studies have not yet fully examined these providers' thoughts, opinions, and motives, so this remains unclear.

Resistance Highly Correlated with Educational Background

When it pertains to attitudes about the use of best practices, McCarty et al. (2007) sought to explore the characteristics, opinion, and beliefs of direct care workers in the field of substance use to gain insight into what was affecting the low rates of integration of evidence-based practices. A major finding was that resistance levels varied based on the educational attainment levels of counselors. These researchers sent surveys to 6,030 potentially eligible direct care workers, collecting useable data from 3,786 individuals. This included 1,757 counselors, 522 medical personnel, and 908 support staff. Findings revealed that 33% of respondents had state certification, 16% had national certification, and 45% had professional certifications. In regard to degree level, 27% had a high school diploma or less, 37% had an associate degree or bachelor's degree, and 36% had a master's or doctoral degree. Ninety-three percent of medical staff possessed a professional license; counselors and managers represented 44% and 47% respectively, with managers possessing more national certifications at 24% to 18% respectively. Fifty-eight percent of managers had advanced degrees, compared to 42% of counselors. The researchers stated that this breakdown is not representative of the field because the national rate

of graduate-level counselors with advanced degrees is 36%. The data suggest education and job type showed a statistically significant relationship.

Managers-supervisors tended to have more positive opinions about specific evidence-based practices and more negative opinions about traditional beliefs. Medical staff had more positive opinions about the use of medications. Generally, individuals with graduate degrees had more positive opinions about evidence-based practices and more negative opinions about traditional beliefs. (McCarty et al., 2007)

The information gained from this study provides useful insight into the level of education serving as a barrier to the application of evidence-based practices in substance use treatment in general.

Resistance to Best Practices in the Treatment of PTSD among Substance Abuse Counselors

In a study exploring use of best practices in a highly complex population, Gielen, Krumeich, Havermans, Smeets, and Jansen (2014) utilized a qualitative study design to interview substance use counselors' rates of use and under-use of integrated treatment for the co-morbid conditions of substance use and post-traumatic stress disorder, or PTSD. PTSD was selected for the study due to the high rate of correlation between the disorders with prevalence rates of 35% (Gielen et al., 2014). Research suggests that individuals who present for substance use treatment have experienced high rates of trauma, with exposure ranging from 89-97.4% (Gielen et al., 2014). With these high levels of comorbidity, the researchers sought to discover why clinicians were not utilizing effective, integrated models of treatment as standard practice. To do this, they conducted interviews with 14 staff members who worked on different wards in an addiction care facility. They designed their questions to find out what the current understanding of the prevalence rates were, how clients were assessed for PTSD, how this information was utilized in treatment planning, and what course of treatment was used when this condition was discovered. Gielen et al. analyzed the results of the interviews using inductive analysis. The results showed

that across the board, there was a lack of understanding about the prevalence rates, with one psychologist stating, “I’ve never seen real PTSD, so its prevalence is quite low,” and other clinicians giving estimates of the prevalence rates at around 1% or less. The study also found a preference for traditional or parallel treatment based on fear of overly activating the client. One participant stated, “Sometimes doing nothing is less harmful. The real trauma therapy is not done here because it usually impedes addiction treatment.” Despite the across-the-board misdiagnosis and misunderstanding of PTSD and SUD, the study did find in its limited sample size that based on education level, there was a discrepancy as to the understanding of PTSD and the role of integrated treatment. Findings indicated that counselors with a bachelor’s degree or less under-identified co-occurrence of PTSD at a higher rate than the clinical staff with a master’s degree or higher. The interviews showed that many counselors believed that co-morbid conditions needed to be treated after a patient was sober and that often times engaging in trauma treatment could cause a relapse. These beliefs are not supported by research and in fact have been shown to be counterproductive for treatment, because often the SUD is used as a tool of self-regulation and often helps individuals deal with their trauma symptoms. By focusing on both disorders simultaneously, the individual is able to develop coping skills for both the SUD and the PTSD symptoms (Gielen et al., 2014).

The lack of knowledge of the PTSD created an environment where the condition was underdiagnosed and often ignored. This lack of understanding led to the condition not being assessed or treated (Gielen et al., 2014). These results were consistent with the premise of this study. The research gives further support for the use of evidence-based approaches to substance use treatment and further lends credibility to the use of integrated treatment for co-occurring disorders, yet the research also shows the underutilization of these techniques that are directly

related to the skills, training, and philosophy of both counselors and agencies. Education, specifically graduate level education, was a predictor of utilization of appropriate assessment, diagnosis, and treatment planning. The study also suggests that traditional beliefs about the nature of integrated treatment and ingrained resistance to new models are affecting the use of evidence-based practice. Gielen et al. suggested that this may be due to counselors in the field having difficulty accepting and applying these new models and concepts. Because of this lack of understanding and lack of education about best practice, outcome rates for substance use treatment remain low, and the overall effectiveness of addiction treatment remains in question (McCarty et al., 2007).

Ethical Issues

Perhaps most worrisome, the gap in education about best practices among drug treatment providers has not only harmed clinical approaches to clients; it is also sadly linked major ethical issues in the field (Toriello, 1999; Toriello & Benschhoff, 2003). Toriello and Benschhoff (2003) explored the role of education in recognizing ethical dilemmas and found that counselors who possessed graduate education showed a greater ability to identify ethical issues that counselors with a bachelor's degree or less. Few researchers have measured the rates of ethical dilemmas based on education, but as mentioned in the problem statement, Gallagher (2010) found that Certified Addiction Counselors had a 12.4% higher rate of ethical violations compared to Licensed Social Workers, a 17.1% higher rate than Licensed Psychologist, an 18.8% higher rate than Licensed Professional Counselors, and a 26.3% higher rate than Licensed Marriage and Family Therapist. In addition, Gallagher found that an alarming 84% of all ethical violations for substance abuse treatment providers were explained by dual relationships and exploitation of patients including sexual relationships with a current or former patient. Over 46% of ethical

violations for Certified Addiction Counselors between 2003 and 2007 were for dual relationships; over 38% were for the exploitation of patients (p. 1).

The literature demonstrates that integrated treatment has shown positive outcome results with people with co-occurring disorders presenting for substance abuse treatment. The literature also shows that substance abuse treatment has the lowest rates of applying evidence-based treatment compared to other health care fields. And research shows that higher education may be one of the best predictors of adherence to integrated empirically-based practices. Finally, the research shows that exposure to higher education and best-practices is protective against ethical violations in the field. Chapter Four focuses on the micro and macro barriers that hinder access to higher education among people in general, and then more specifically looks at issues of access to higher education among drug treatment counselors.

CHAPTER FOUR:
SOCIOECONOMIC AND PERSONAL BARRIERS TO HIGHER EDUCATION
AMONG SUBSTANCE ABUSE PROVIDERS

In addition to attitudes favoring a particular philosophy of substance abuse treatment that can impede one's openness to seeing the value of evidence-based practice taught in higher education, there are very real barriers, socioeconomic and societal, that impede access to higher education among the general population of adults. These factors can multiply the challenges for substance abuse counselors and are important to explore because barriers can turn motivation into frustration very easily. It is imperative to identify not only intrinsic issues of openness, attitude, and motivation towards higher education, but also systemic and environmental issues like time, and cost and organizational support for higher learning.

Scanlan and Darkenwald (1984) sought to identify the deterrents to participation in continuing education for health-related adult learners in general. They sought to gain a better understanding of these factors in order to address an over-focus of prior research on internal motivation and a gap in focus on societal barriers. To do this they developed the Deterrents to Participation Scale (DPS), a scale exploring personal and environmental factors affecting access to higher learning. Their study surveyed 479 individuals from the field of allied health, specifically physical therapists, medical technologists and respiratory therapists in New Jersey who were currently employed in their field. The scale was designed to measure the significance of six factors that were identified as deterrents: disengagement, lack of quality, family constraints, cost, lack of benefit and work constraints. Disengagement referred to the level of activity and involvement a participant invested in the education process. This included their desire and level of importance that they gave to continuing education. Lack of quality referred to

both general and specific perceptions the individuals had of the program's value, more specifically, any inadequacies that they perceived the program has. Family constraints explored the influence of outside of the job responsibilities focusing on family expectations and roles and their impact on the ability to engage in education opportunities. Cost as a potential deterrent to higher education was assessed by participants' perceived ability to afford continuing education. Lack of benefit looked at the assigned worth that participants gave to attaining higher education. Work constraints looked at perceived conflicts within the work environment, including conflicts between work demands and scheduling versus the time needed outside of work to complete the education programs.

Findings suggest that the DPS did predict these six factors; and, the scale achieved an alpha reliability rating of .91. From their study, these six factors provided a new way of looking at the deterrents to participation in higher education that is more comprehensive. This has opened an important door into understanding the barriers that exist but are oftentimes not addressed in policy in regard to increasing participation in continuing education. By exploring barriers to participation, it is possible to identify specific system needs and use that information to shape policy. And, the DPS Scale has been successfully used elsewhere to predict problems that need to be adequately addressed in order to open up access to higher learning (Valentine & Daikenwald, 1990).

Pursuit of Higher Education among Traditional and Nontraditional Students

While the United States has long been a leader in graduate-level education, it has struggled to provide access to graduate-level education for individuals from underrepresented populations (English & Umbach, 2016). Organizations have made strides to provide more access and opportunity to these groups, but these efforts have not resulted in an equal level of

opportunity to nontraditional students. Because the graduate level degree is not a requirement for substance use counselors, the motivation to pursue the degree is not necessarily internal but may be related to more external motivators like career advancement or an increase in salary; this is especially relevant for nontraditional students. Knutsen (2011) defined nontraditional students as:

Students (sometimes referred to as adult learners) are 24 years of age or older and have been out of school for a period of time. When these adults return to school they maintain responsibilities such as employment, family and other responsibilities of adult life, regardless of full or part-time status (p. 27).

Substance abuse counselors often fall into this category; this is especially true for counselors who have personal recovery histories. Marshall (2013) elaborated on the definition of nontraditional students as:

Those who are underrepresented in Higher Education and includes those from lower socio-economic groups, mature students, those with non-standard qualifications, BME (black minority ethnic) students, students with disabilities, those from a care background, etc. These groups frequently overlap; for example, the disadvantage that a young student faces at eighteen may make them less likely to maintain a continuous educational journey resulting with them attending Higher Education as an adult learner with non-standard qualifications (p. 2).

Substance Abuse Counselors as Non-Traditional Students

Many substance abuse counselors who are in recovery meet the criteria for non-traditional students. Substance use is considered a disability, and according to Mulvey, Hubbard, and Hayashi (2003), 60.4% of the substance abuse workforce is over the age of 45. The overlap of these identities, when combined with other levels of social positioning, places these recovering counselors in a challenging situation when considering whether or not to pursue a graduate degree. This complexity is further complicated by the fact that a graduate degree is not currently necessary for them to continue in their position.

**Extrinsic and Intrinsic Barriers Impede Advanced Degrees and Exposure to Best Practices:
Need for Comprehensive Study**

The deterrents identified by Scanlan and Daikenwald in the DPS provide a helpful beginning framework for understanding a more systemic view of what factors, intrinsic and extrinsic, can impede a person’s access to higher education. If we couple their work with the comprehensive analysis of the history of substance abuse treatment in the United States, it is clear that any discussion about deterrents to evidence-based practice in this field must examine a full array of factors, from time and cost to perceived benefits; to reluctance to stray from the Twelve Step Model; to organizational support; and personal recovery history. To date, such a study has not been conducted.

In order to address this gap, a study is proposed here which comprehensively explores the field-specific factors impeding access to higher education in order to explore substance abuse counselors’ attitudes and intentions as well as perceived barriers to the attainment of higher education. Specifically, the following field-specific factors will be explored (see Table 3).

Table 3

Factors and Demographics

Factors	Demographic variables
Intention to pursue graduate degree	Age
Time to complete degree	Gender
Adequate funding for education	Race
Belief in the benefits of higher education	Ethnicity
Willingness to embrace new models of treatment	Length of time as a counselor
Family Support	Recovery status
Organizational support (philosophical support)	Marital status
Organizational support (material)	Number of children

Belief in the benefit of personal recovery experience	Yearly income
Access to childcare	Current level of education

CHAPTER FIVE: RESEARCH QUESTION

Mental health treatment providers have found evidence-based practices highly beneficial in their use with substance use clients, especially those with co-occurring mental health disorders, and so implementation of these practices could continue to grow. If members of the field of substance abuse treatment continue to resist the best new practices, co-occurring clients are likely to suffer the most. Given the strong body of evidence supporting the use of integrated treatment, it has become necessary to explore the reasons for these interventions not being used as the standard of practice in substance use treatment.

This study explores the strong connection between recovering counselors and traditional approaches to treatment, as well as the unique barriers that are keeping these counselors from advanced degrees. This study examines the motivation, beliefs, and economic and systemic barriers to graduate level education for substance abuse counselors with and without recovery histories. Specifically, this study asked the following question:

To what extent are providers' intentions to pursue further education correlated with: a) Intention to pursue a graduate degree; b) Adequate funding for education; c) Time to complete the degree; d) Belief in the benefits of higher education; e) Willingness to embrace new models of treatment; f) Organizational support (material); g) Organizational support (philosophical); h) Belief in the benefit of personal recovery experience i) Family support j) Access to childcare.

CHAPTER SIX:

MEASURES AND METHODS

In order to comprehensively explore the intrinsic and extrinsic barriers to accessing higher education among substance abuse counselors, a survey methods study was conducted in which a large representative sample of providers was asked to complete an online survey created specifically for this study, inquiring about intentions and ability to pursue higher education. Procedures for this exploratory online survey study are detailed here.

Measure

An online questionnaire was created for the purposes of this study which drew upon the Deterrents to Participation Scale (DPS) but was adapted to field specific questions for substance abuse treatment. Specifically, participants were asked to rank their degree of agreement with 38 questions based on the variables described. Ten factors were explored. Participants were asked to indicate on a five-point Likert scale how influential they considered each factor to be in making a decision to pursue a graduate degree level program, with scoring being recorded as follows; 1. Not Important, 2. Slightly Important, 3. Somewhat Important, 4. Quite Important, 5. Very Important; or 1: Strongly Disagree, 2: Somewhat Disagree, 3: Agree, 4: Somewhat Agree, 5: Strongly Agree. The factors that will be examined by the scale are a) Time to complete degree, b) Intention to pursue a graduate degree c) Adequate funding for education, c) Belief in the benefits of higher education, e) Willingness to embrace new models of treatment, f) Family support g) Organization support (philosophical support) h) Organizational support (material support) i) Belief in the benefit of personal recovery experience and j) Access to childcare (if applicable). The study included ten variables that were measured as well as correlated with the following demographic variables: a) age b) gender c) race d) ethnicity e) Length of time as a

counselor f) recovery status g) marital status h) number of children i) yearly income j) current level of education.

Online questionnaires have many advantages. This method of data collection is a faster way of collecting data from the respondents as compared to other survey methods such as paper-and-pencil method and personal interviews. Using an online questionnaire helps in the ease of data collection (Nulty, 2008). This was a survey that benefited from a large sample size, and more respondents were able to be contacted and in less time via the internet. In addition, in order to explore a multivariate analysis, a large sample size is necessary. In this way, the survey questionnaire was rapidly deployed and completed by the respondents. Another advantage is the cost. Traditional survey methods often require great expense to deliver and collect. Conducting an internet survey facilitates low cost and fast data collection from the target population (Nulty, 2008). Automation in data input and handling was also an asset. With online surveys, the respondents were able to answer the questionnaire by means of inputting their answers while connected to the internet. The responses were automatically stored in a survey database, providing hassle-free handling of data and a smaller possibility of data errors (Nulty, 2008). In this study, the strength of using a heterogeneous sample is that it allowed for a more representative sample of the counselors and did not focus directly on individual characteristics. This also created a large data set that was used to observe other aspects of this question including how gender and race correlate with the dependent variables. This could be of benefit in future studies of this kind. The challenge of doing a study of this kind is attrition. Online studies are easy to ignore and because the participants are anonymous there is the little opportunity of following up with non-responders (Nulty, 2008). To deal with this issue of attrition, the study used a large sample size. This large sample size should account adequately for attrition.

According to Nulty, online surveys generally yield a 33-35% response. We sent invitations to over 40 different training programs and treatment programs across NY state. While we did not get all of them to participate we did receive 195 responses and of those, we were able to use 124.

Sample

Using nonprobability sampling and a purposive sampling method as described by Rubin and Babbie (2014), the link to the questionnaire was sent to substance abuse training centers in New York State as well as substance abuse treatment agencies. A list of these programs was acquired from the OASAS website, and all are listed as approved training facilities and treatment providers for the CASAC and CASAC-T. These programs were asked to send the link to the survey to the members of their alumni lists, and current counselors, meaning individuals who have successfully completed their training program or who are currently working in the treatment program. The survey itself had a first page that sorted the respondents through inclusion and exclusion criteria. Inclusion criteria included being currently employed counselors working in the field of substance abuse treatment. Participants had to possess either a CASAC or a CASAC-T and had to possess a bachelor's degree. Participants had to be engaged in direct practice with patients. The exclusion criteria included any counselor who possessed a master's degree or higher and participants working in a supervisory or administrative position.

Data Collection and Analysis Procedures

Once the data was collected through the Qualtrics system, they were correlated by the available Qualtrics software and downloaded into an SPSS spreadsheet. Categorical data were analyzed using spearman correlation. The study focused on the percentage of scores between variables, particularly correlation between the dependent variable, willingness to pursue a master's degree, and the independent variables a) Time to complete degree, b) Intention to

pursue a graduate degree c) Adequate funding for education, c) Belief in the benefits of higher education, e) Willingness to embrace new models of treatment, f) Family support g) Organization support (philosophical support) h) Organizational support (material support) i) Belief in the benefit of personal recovery experience and j) Access to childcare These percentages are compared to the variable of a) age b) gender c) race d) ethnicity e) Length of time as a counselor f) recovery status g) marital status h) number of children i) yearly income j) current level of education.

Descriptive statistics were utilized to describe the extent to which the ten factors and ten variables to determine to what extent each concept affects the counselor's willingness to pursue higher education. Descriptive statistics helped to create quantitative percentage data that described the unique barriers that are impacting substance abuse counselor's ability to pursue a graduate level degree. Because of this, we were able to examine the variables of, a) Time to complete degree, b) Intention to pursue a graduate degree c) Adequate funding for education, c) Belief in the benefits of higher education, e) Willingness to embrace new models of treatment, f) Family support g) Organization support (philosophical support) h) Organizational support (material support) i) Belief in the benefit of personal recovery experience and j) Access to childcare and see what clusters emerged when looking at a) age b) gender c) race d) ethnicity e) Length of time as a counselor f) recovery status g) marital status h) number of children i) yearly income j) current level of education.

Human Subject Protections

The online questionnaire contained a consent page. The study was explained, and individuals chose to select an "agree" or "disagree" box. If they agreed, then they were taken to the questionnaire. Consent was implied by clicking to continue. If they selected the disagree box,

they thanked for their time. (A copy of the online consent is in Appendix B).

The project was conducted with anonymous online questionnaires. Each training center was provided with the link that they then sent to their graduates and counselors. No personal, identifying information was gathered from the questionnaire. All data were reported in aggregate form so all information was kept confidential. Participants' IP addresses were not collected to limit the chance that personal information could be collected. The first page of the survey included questions to determine inclusion criteria, and the second page had a consent that explained the purpose of the study, the types of questions that will be asked, and the approximate time the questionnaire would take to complete. Confidentiality was also explained. Participants could either accept or decline the consent.

There was little risk of harm to the participants in this study. The benefits of the study could shape policy in higher education and allow more access to advanced degrees for substance use counselors. There was no direct benefit to the participants; however, the results of the study may lead to policy changes and funding opportunities for substance use counselors that will increase access and opportunity for them to pursue graduate level degrees.

Limitations

This was a quantitative study that utilizes internet surveys to gather data. Due to the nature of quantitative research, there are some limitations to the data gathered. While this study gives numerical data on the beliefs of the participants, a deep explanation of their needs and opinions—such as might be elicited by interviews—cannot be gathered. Because this was a large study and the location and organization of the participants was not known, it was not possible to explore the role of the type of organizations in an in-depth way other than via participants' reviews of their organizational structure. While we did gather some information about the

perceived organizational support, gathering a deeper understanding of the role of treatment culture would only be possible through a qualitative study. In addition, the use of internet surveys is efficient, but due to the personal nature of a person's recovery status, there was the potential for the omission of this detail or of counselors opting out of the study due to this qualifier. There was no way to control for this, but it is important to note that this is a possible limitation. By defining recovering counselors as nontraditional students, this brings up issues of social positioning and intersectionality within the sample. While this study was able to show correlations of beliefs based on some aspects of social positioning, it would require a qualitative analysis to really demonstrate the impact these identities have on the participants. These limitations were primarily the result of the study design and cannot be overcome in this format; however, there is still a great deal of value in gaining this quantitative information, and research moving forward can use this new data to inform and support the need for qualitative studies that can further explore the identified limitations of this study.

Data on Refusers and Drop-outs

In an online survey, it is difficult to gain information on refusers. There was no intervention, so there was not a need to discuss dropout rate

CHAPTER 7:

FINDINGS

Description of the Sample

The study derives its findings from an online survey sent to 300 potential respondents. Of that 300, 195 people took the survey, from that 194, 124 met inclusion criteria giving the study a response rate of 64%. This is a very high response rate for a survey study and suggests a high level of interest in the topic from this population. The sample was drawn from the alumni lists of 6 CASAC training facilities in New York State and 10 OASAS certified treatment facilities in New York State. These agencies were found on the OASAS approved partners list. Initial emails were sent to all agencies on these lists and the 16 agencies represent the agencies that agreed to participate in the study. Each week for 6 months these partner agencies sent an anonymous email with a link to our survey to all of their CASAC's, CASAC-t's and former trainees.

This study sought to determine the level of counselor's willingness to pursue a graduate level degree based on demographic factors as well as other contributing factors emerging from the literature including, a) time to complete degree, b) intention to pursue a graduate degree, c) adequate funding for education, d) belief in the benefits of higher education, e) willingness to embrace new models of treatment, f) family support, g) organization philosophical support for continuing empirically-based education h) organizational material support for continuing empirically-based education), i) belief in the benefit of personal recovery experience, and j) access to childcare. The demographic factors examined were age, gender, race/ethnicity, length of time as a counselor, recovery status, marital status, number of children, and yearly income. The charts below show the breakdown of the participants.

Table 3: Age

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 18-25	7	5.6	5.6	5.6
26-33	32	25.8	25.8	31.5
34-41	40	32.3	32.3	63.7
42-49	36	29.0	29.0	92.7
50-65	9	7.3	7.3	100.0
Total	124	100.0	100.0	

Table 4: Gender

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	2	1.6	1.6	1.6
d Female	61	49.2	49.2	50.8
Male	58	46.8	46.8	97.6
Trans Male	3	2.4	2.4	100.0
Total	124	100.0	100.0	

Table 5: Race/Ethnicity

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Asian	7	5.6	5.6	5.6
Black or African American	30	24.2	24.2	29.8
Latino/Hispanic	26	21.0	21.0	50.8
c White/Caucasian	61	49.2	49.2	100.0
Total	124	100.0	100.0	

Table 6: Length of Time as Counselor

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 1-5 years	64	51.6	51.6	51.6
6-10 years	26	21.0	21.0	72.6
less than 1 year	23	18.5	18.5	91.1
more than 10 years	11	8.9	8.9	100.0
Total	124	100.0	100.0	

Table 7: Recovery Status (Are you personally in recovery?)

	Frequency	Percent	Valid Percent	Cumulative Percent
No	68	54.8	54.8	54.8
Valid Yes	56	45.2	45.2	100.0
Total	124	100.0	100.0	

Table 8: Marital status (Married?)

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid No	65	52.4	52.4	52.4
Yes	59	47.6	47.6	100.0
Total	124	100.0	100.0	

The age of the participants varied with the majority of the participants being between the ages of 34-41 (32.26%) followed by ages 42-49 (29.03%), 26-33 (25.81%), 50-65 (7.26%) and finally 18-25 (5.56%). According to OASAS's Credentialing Unit Breakdown Report (2019), the average age of current CASAC's is 53.

Among participants, gender was split fairly evenly between male and female with 49.2% identifying as female, 46.8% identifying as male and 2.4% identified as Trans-male. Only 1.6% chose to not disclose their gender. According to OASAS's Credentialing Unit Breakdown Report (2019), the gender breakdown of the current CASAC's in New York is 65.32% female to 34.63% male.

In terms of race, 49.2% of participants identified as White, 24.2% identified as Black 21% identified as Latino/Hispanic and 5.7 identified as Asian. According to OASAS's Credentialing Unit Breakdown Report (2019), the racial breakdown of the current CASAC's in New York is 57.1% White, 24% Black, 11.8% Hispanic, 3.3% not specified, 1.5% other, 1.2% Asian/Pacific Islander and .09% Alaskan. Study respondents were fairly racially representative of CASAC's in New York, with a slightly higher Hispanic participant rate.

The largest percent of our respondents have been working in the field as a counselor for 1-5 years (51.61%). 20.97% have been working as counselors for 6-10 years, 18.55% have been working as counselors for less than 1 year and 8.87% have been working for more than 10 years. OASAS does not keep statistics on the demographics and the researcher was unable to confirm if the numbers are generalizable to the field as a whole.

The author was also interested in looking at the differences in responses between counselors who identify in recovery and counselors who do not identify as in recovery to see if their wiliness was significantly different. In our study, 54.8% of respondents identified as "not in

recovery and the remaining 45.2% identified as “in recovery”. This is in line with current estimates that suggest the recovering counselor's rate be around 40%.

The majority of respondents are not married with 52.42 responding as “not married and 47.58% responding as “Married”. We were also interested in seeing how having children might influence a person’s willingness to pursue a graduate degree. In our study, 45.97% reported not having children. Of the respondents who reported having children, 46.77% reported having 1-2 children and 7.26% reported having 3-4 children.

In regard to yearly income, 41.13% of respondents reported earning between 35,001-4,2000 dollars per year. 35.48% reported earning between 25,001 and 35,000 per year, 14.52% earned 42,001-55,000, 5.65% earned 18,000-25,000, 1.61% reported earning more than 65,000.

It is important to note that OASAS does not keep a record of their CASAC-T based on these categories.

Table 9: Number of Children

		Valid	Cumulative
		Percent	Percent
Valid	1-2 children	58	46.8
	3-4 children	9	7.3
	No children	57	46.0
	Total	124	100.0

Table 10: Yearly Income

		Frequency	Percent	Valid	Cumulative
				Percent	Percent
Valid	18,000-25,000	7	5.6	5.6	5.6
	25,001-35,000	44	35.5	35.5	41.1
	35,001-42,000	51	41.1	41.1	82.3
	42,001-55,000	18	14.5	14.5	96.8
	55,001-65,000	2	1.6	1.6	98.4
	more than 65,000	2	1.6	1.6	100.0
	Total	124	100.0	100.0	

Factors Impacting Willingness to Attend Graduate School

Using the Spearman Correlation Analysis, the goal was to determine what barriers existed for counselors based on these demographic factors and our variables to determine to what extent these factors and variables influenced the ability of the participants to pursue graduate level

degrees. First, the correlation between dependent variable of wiliness to pursue a graduate level degree was correlated with a) Time to complete degree, b) Intention to pursue a graduate degree, c) Adequate funding for education, d) Belief in the benefits of higher education, e) Willingness to embrace new models of treatment, f) Family support, g) Organization support (philosophical support), h) Organizational support (material support), i) Belief in the benefit of personal recovery experience, and j) Access to childcare. Spearman correlation analysis was conducted to determine this correlation. The results of the Spearman correlation analysis are shown in Table 9. A level of significance of 0.05 was used in the Spearman correlation analysis.

Result of the Spearman correlation analysis showed that counselors have a greater willingness to pursue a master’s degree when they feel that they have time to complete the degree ($r(122) = 0.47, p < 0.001$), a strong intention to pursue a graduate degree ($r(122) = 0.83, p < 0.001$), adequate funding for education ($r(122) = 0.37, p < 0.001$), belief in the benefits of higher education ($r(122) = 0.54, p < 0.001$), a willingness to embrace new models of treatment ($r(122) = 0.56, p < 0.001$), support from their organization in terms of philosophical support for the value of advanced education ($r(122) = 0.33, p < 0.001$), h), material organizational support for pursuing advanced education ($r(122) = 0.31, p < 0.001$), and greater access to childcare ($r(59) = 0.33, p = 0.01$). b, c).

Table 11: How likely are you to pursue a graduate level degree?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1.0 Not important	23	18.5	18.5	18.5
	2.0 Slightly important	47	37.9	37.9	56.5
	3.0 Somewhat important	23	18.5	18.5	75.0
	4.0 Quite important	20	16.1	16.1	91.1
	5.0 Very important	11	8.9	8.9	100.0
	Total	124	100.0	100.0	

Table 12: Time to complete degree: I have the time necessary to complete a graduate level degree

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1.0 Strongly disagree	17	13.7	13.7	13.7
	2.0 Somewhat disagree	30	24.2	24.2	37.9
	3.0 Agree	18	14.5	14.5	52.4
	4.0 Somewhat agree	51	41.1	41.1	93.5
	5.0 Strongly agree	8	6.5	6.5	100.0
	Total	124	100.0	100.0	

Table 13: Intention to pursue a graduate degree: I intend to pursue a graduate degree

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1.0 Strongly disagree	21	16.9	17.1	17.1
	2.0 Somewhat disagree	10	8.1	8.1	25.2
	3.0 Agree	23	18.5	18.7	43.9
	4.0 Somewhat agree	51	41.1	41.5	85.4
	5.0 Strongly agree	18	14.5	14.6	100.0
		Total	123	99.2	100.0
Missing	System	1	.8		
	Total	124	100.0		

Table 14: Adequate funding for education: I have access to the necessary funds to pursue a graduate level degree, including financial aid, saving and loans

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1.0 Strongly disagree	31	25.0	25.0	25.0
	2.0 Somewhat disagree	37	29.8	29.8	54.8
	3.0 Agree	17	13.7	13.7	68.5
	4.0 Somewhat agree	32	25.8	25.8	94.4
	5.0 Strongly agree	7	5.6	5.6	100.0
	Total	124	100.0	100.0	

Table 15: Adequate funding for education: I have too much debt to take on the expense of a graduate level degree

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1.0 Strongly disagree	7	5.6	5.6	5.6
	2.0 Somewhat disagree	33	26.6	26.6	32.3
	3.0 Agree	17	13.7	13.7	46.0
	4.0 Somewhat agree	30	24.2	24.2	70.2

	5.0 Strongly agree	37	29.8	29.8	100.0
	Total	124	100.0	100.0	

Table 16: Belief in the benefits of higher education: I believe that getting a graduate level degree would increase my skill level as a counselor

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1.0 Strongly disagree	9	7.3	7.3	7.3
	2.0 Somewhat disagree	14	11.3	11.3	18.5
	3.0 Agree	5	4.0	4.0	22.6
	4.0 Somewhat agree	23	18.5	18.5	41.1
	5.0 Strongly agree	73	58.9	58.9	100.0
	Total	124	100.0	100.0	

Table 17: Willingness to embrace new models of treatment: It is important to use evidence-based approaches to substance use treatment

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	2.0 Somewhat disagree	16	12.9	12.9	12.9
	3.0 Agree	7	5.6	5.6	18.5
	4.0 Somewhat agree	32	25.8	25.8	44.4
	5.0 Strongly agree	69	55.6	55.6	100.0
	Total	124	100.0	100.0	

Table 18: Family support: I would pursue a graduate level degree if I had adequate family support

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1.0 Strongly disagree	10	8.1	8.1	8.1
	2.0 Somewhat disagree	9	7.3	7.3	15.3
	3.0 Agree	26	21.0	21.0	36.3
	4.0 Somewhat agree	43	34.7	34.7	71.0
	5.0 Strongly agree	36	29.0	29.0	100.0
	Total	124	100.0	100.0	

Table 19: Organizational support (philosophical support): My agency embraces new evidence-based practices and provides education and supports to the staff in how to implement these techniques

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1.0 Strongly disagree	3	2.4	2.4	2.4
	2.0 Somewhat disagree	16	12.9	12.9	15.3
	3.0 Agree	16	12.9	12.9	28.2
	4.0 Somewhat agree	74	59.7	59.7	87.9
	5.0 Strongly agree	15	12.1	12.1	100.0
	Total	124	100.0	100.0	

Table 20: Organizational support (material support): My agency provides financial assistance to pursue graduate-level training

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1.0 Strongly disagree	70	56.5	56.5	56.5
	2.0 Somewhat disagree	33	26.6	26.6	83.1
	3.0 Agree	3	2.4	2.4	85.5
	4.0 Somewhat agree	6	4.8	4.8	90.3
	5.0 Strongly agree	12	9.7	9.7	100.0
	Total	124	100.0	100.0	

Table 21: Belief in the benefit of personal recovery experience: Being in recovery is an asset in providing substance abuse treatment

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1.0 Strongly disagree	7	5.6	5.6	5.6
	2.0 Somewhat disagree	11	8.9	8.9	14.5
	3.0 Agree	40	32.3	32.3	46.8
	4.0 Somewhat agree	44	35.5	35.5	82.3
	5.0 Strongly agree	22	17.7	17.7	100.0
	Total	124	100.0	100.0	

Table 22: Access to childcare: I have adequate childcare to pursue a graduate degree

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1.0 Strongly disagree	6	4.8	9.8	9.8
	2.0 Somewhat disagree	8	6.5	13.1	23.0
	3.0 Agree	8	6.5	13.1	36.1
	4.0 Somewhat agree	26	21.0	42.6	78.7
	5.0 Strongly agree	13	10.5	21.3	100.0

	Total	61	49.2	100.0
Missing	System	63	50.8	
Total		124	100.0	

Table 23: Access to childcare My employer offers assistance with childcare

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1.0 Strongly disagree	44	35.5	72.1	72.1
	2.0 Somewhat disagree	8	6.5	13.1	85.2
	3.0 Agree	3	2.4	4.9	90.2
	4.0 Somewhat agree	4	3.2	6.6	96.7
	5.0 Strongly agree	2	1.6	3.3	100.0
	Total	61	49.2	100.0	
Missing	System	63	50.8		
Total		124	100.0		

These correlations were expected to support hypotheses drawn from the literature regarding willingness to pursue higher education. Study participants echoed many of the barriers experienced in populations not engaged in the field of substance use. This fact is further compounded by the datum that shows additional barriers that are unique to this field and create an even larger burden on the substance use treatment workforce. As we explore these unique barriers it is necessary to frame these additional barriers as just that, additional.

Additional Barriers Among Substance Abuse Counselors

In addition to factors that influence most people in regard to graduate level education. The datum in this study suggests that substance abuse counselors experience additional barriers to this education path. The role of personal recovery was shown to be a significant determinant as was a belief in the usefulness of evidence-based practices versus traditional 12 step philosophy. However, one of the most compelling findings was the degree to which a lack of organizational support was experienced as a significant barrier. This barrier showed up – not only in the

quantitative section of the survey but also was a primary theme in the open-ended qualitative section as evidenced by comments offered by participants. 35 of the participants utilized the comment option to share additional thoughts about the topic. The most common theme offered was regarding organizational support. Those whose organizations supported ongoing education were clear about that link; and conversely, the study showed where lack of organizational support hindered the intent, attitude and likeliness of participants to advance their education.

The following quotes elucidate the benefits that are created by positive organizational support.

“I am in recovery but I see the need for further education of people in the field. I think I am lucky because my agency agrees and helps employees through some tuition reimbursement and flexible scheduling.”

“My employer has been great. They offer flexible scheduling around classes, I found a program that offers some online classes and will let me use my current job as my internship and my employer offers tuition reimbursement based on my grades. I am really excited to be moving forward with my education. I think that more employers should do these things to support counselors, especially if they are going to start requiring us to get masters degrees.”

“My agency puts an emphasis on education. We get a reduced caseload, tuition assistance, and a flex schedule if we go for a graduate degree. I am looking to start an MSW [Masters in Social Work] in the fall. I am lucky, I have a family that is supportive, a good workplace and a husband who helps with the kids. I know not everyone has that, but I think it still would not be possible for me if it wasn't for the employer helping me out. I would like to see more agencies follow our lead.”

It is evident in both the quantitative results of the survey and these qualitative comments that there is a high desire for these counselors to engage in higher education and that the role of the agency has a major impact on their ability to do this. This stands in strong contrast to the respondents who work in agencies that either do not provide help or do not support the idea of higher education. The following quotes identify some of the barriers that a lack of organizational support creates.

“I work at an "old school" type of agency. They have an anti-evidence based view and the only time they want people to get graduate degrees are for promotions to management. I want to grow as a counselor and I worry sometimes that being in this agency will make that more difficult. I do think that being in recovery can be an asset if it is used right but I have also seen people cross boundaries because they over relate to the clients. I think that if the agency were pushed to be more evidence-based it would go a long way.”

“I would love to get an MSW [Masters in Social Work] but I can't afford it and I don't have the time. The things in the survey that referenced my agency helping out with scheduling and paying for it but I don't know how that would work. We are already understaffed and underpaid. I think that if OASAS wants us to get a degree and they are going to make us do that, then they should help out too. Maybe if the help came from several places then it would be easier. I also think that those of us who are older and have families will need even more help and support.”

“My agency is trapped in the past. They focus on the 12 steps and nothing else. They offer no encouragement or support in advanced degrees and they do not believe in evidence-based practice.”

“I work in an agency that frowns on evidence-based work. I hate it here and I hope that getting a better degree will let me find a more open-minded agency.

Based on these responses one can get a real sense of how organizational support can influence the willingness to pursue a graduate level degree. These results were consistent with respondents who identify as in recovery as well as respondents who are not. This demonstrates the power of the beliefs of the agency and shows that these beliefs have a major influence on how counselors see the need and role of higher education and evidence-based practice.

Results of the Spearman correlation analysis further showed that willingness to pursue a master's degree by counselors was significantly negatively correlated with c) Adequate funding for education ($r(122) = -0.19, p = 0.03$) and belief in the benefit of personal recovery experience ($r(122) = -0.29, p < 0.001$).

“I am in recovery but I see the need for further education of people in the field. I think I am lucky because my agency agrees and helps employees through some tuition reimbursement and flexible scheduling.”

“My agency puts a strong emphasis on continuing education, they have a tuition reimbursement program and they focus us on evidence-based practices. I notice that the counselors who are open about being in recovery do not take advantage of this and often try to force 12 step concepts on the clients.”

Balancing Work and Personal Recovery

The need for adequate funding was expected and is consistent as a barrier for most individuals in regard to pursuing higher education, however in the qualitative responses we see unique needs of this population begin to emerge especially for the respondent who had a personal recovery history. Many described a history of financial disarray, not unexpected among people with substance abuse histories. Many also described a pitting of financial and work needs with the need to maintain personal sobriety through regular attendance at self-help meetings:

“I don't know how I would be able to go back to school. I am in recovery so I go to 3-5 meetings a week, I sponsor 5 people, I work full time, I have kids and a husband, I have no idea how I would do it. In addition, my drug use wreaked havoc on our finances and I am in debt up to my eyes. I know that OASAS is thinking of requiring the master's degree for counselors and I honestly worry about how many people like me will not be able to meet the new requirements.”

Comments like this show the unique needs of this population and also reinforce what themes emerged from the literature review, that substance abuse counselors face multiple life barriers that are unique to their field. For these reasons, substance abuse counselors who are seeking graduate level degrees may need to be seen **as nontraditional students** and receive the same types of support that we give to students who are given this distinction.

Attitudes about Personal Recovery vs. Evidence-Based Practice

One of the barriers that emerged from the data that requires further consideration was the role that a belief in the value of a personal recovery history has on the client's willingness to pursue a graduate level degree. In the following quotes, we can see how the belief in personal recovery and the 12 steps creates a barrier to attaining a graduate level degree for some counselors.

"There is too much of a focus on science and not enough on the need for traditional 12 step solutions. We are doing more harm than good and becoming too soft as a field. The pressure to get an "education" suggests that life experience is not good."

"My kids are all grown. I think that this focus on new techniques is pointless. The 12 steps work if people work them. That is it. I have been sober for 25 years and it was AA and the rooms [that led to my sobriety]. The new stuff is just smoke and mirrors."

"I think that they are trying to get rid of counselors who have a personal experience by forcing us to use these other methods and get degrees that don't do anything. The pay stays basically the same and the 12 steps work if you work them, these new techniques don't have the same success rates. I think that if they want us to get bigger degrees then they need to make that possible. Both OASAS and the employers."

"I hate this push to make good counselors get degrees and do this evidence-based nonsense. I got sober with 12 steps, and that is the program that works. These other approaches are just attempts to let non-recovering counselors do the work. It is unnecessary and it should stop. No one can help an addict like another addict and the field just doesn't get it."

"I am not in recovery but I think that all this focus on new stuff is stupid. Use the steps, I have seen them work. We need to get "back to basics" as my boss says. Personal experience is the best. I have learned so much from the other counselors who are in recovery. That is the best way. We need to keep it simple. No need for grad degree."

"I am not in recovery myself, but I do believe that the steps work best and that having recovery experience makes you better able to help. I have worked at the same agency my entire career and they are 12 steps based."

These are powerful statements that show there is still a strong stigma in the field that holds to older concepts of recovery and treatment. It is important to note that these comments about the benefits of 12 steps over evidence-based and lived experience over education came from both recovering and non-recovering respondents which suggests that these beliefs are not

just held by the recovery community and are often times the results of the institutions beliefs about personal experience being trained into the workers. It is also important to note that these statements make reference to the 12 steps themselves and not 12 step facilitation which is an evidence-based practice (Brown et al., 2006). 12 step facilitation, while not producing the results of other evidence-based approaches like Integrated Cognitive Behavioral Therapy, Multi-dimensional family therapy, Motivational interviewing or many of the other approaches (McGovern, 2003), does still show positive benefits and can serve as a link to the self-help community. The reliance on the concepts of the 12 step programs over evidence-based approaches by substance abuse counselors is important to note when looking at the wiliness of pursuing graduate level degrees.

The following quote demonstrates a reverse response where participants saw recovery status and the belief in using the 12 step model as a detriment:

“There needs to be education for the counselors who are in recovery. They act like they have some secret knowledge that the rest of us don't have. They overshare their personal experience and they are anti-science in so many ways. Also, I have seen too many ethical issues come up because they don't know where their recovery ends and the client's starts. They should be the focus of education initiatives. I could figure it out if I have to and I would love an MSW but I think the real issue in the field is these counselors who rely on their own experience instead of evidence-based tools.”

These findings suggest a need to strengthen agency philosophy and bring it in line with best practice and it suggests a need to provide more institutional support both material as well as philosophical. If counselors are having these feelings about higher education and new approaches to the work, then this needs to be addressed.

Differences of Percentage of Responses by Demographic Factors

In order to look more deeply into some of the nuances of the barriers to attending graduate school, further categorical statistical analyses were conducted. A Chi-square test of difference was conducted to determine whether there are significant differences in the counselors' willingness to pursue a master's degree with the factors of a) time to complete degree, b) intention to pursue a graduate degree, c) adequate funding for education, d) belief in the benefits of higher education, e) willingness to embrace new models of treatment, f) family support, g) organization support (philosophical support), h) organizational support (material support), I) belief in the benefit of personal recovery experience, and j) access to childcare by differences of demographic factors. The specific demographic factors include age, gender, race/ethnicity, length of time as a counselor, recovery status, marital status, number of children, and yearly income. The demographic factor of the current level of education was not included in the analysis since all the counselor samples have the same current level of education which is having a Bachelor's degree. The results of the chi-square test are shown in Table 10. A level of significance of 0.05 was also used in the chi-square test. The following sections will explore the results of the chi-square test in relation to each of the study variables.

Age

Result of the chi-square test showed that age was significantly correlated with counselors' willingness to pursue a master's degree ($X^2(16) = 49.28, p < 0.001$), across all of the following variables: a) Time to complete degree ($X^2(16) = 49.80, p < 0.001$), b) Intention to pursue a graduate degree ($X^2(16) = 62.19, p < 0.001$), c) Adequate funding for education in terms of having debt ($X^2(16) = 55.06, p < 0.001$), d) Belief in the benefits of higher education ($X^2(16) = 55.85, p < 0.001$), e) Willingness to embrace new models of treatment ($X^2(12) = 35.53, p <$

0.001), and f) Family support ($X^2(16) = 31.24, p = 0.01$). The cross tabulation of survey responses by age are shown in the table below.

In regard to age and likely hood to pursue a graduate level degree, it was observed that younger counselors show a greater interest in graduate education than older counselors. Younger counselors also reported having more time to complete a degree and scored highest on the belief in the benefits of higher education, willingness to embrace new evidence-based approaches to substance use and feeling that they had enough support from their family. In regards to adequate funding for a degree, the older counselors reported being in a better financial position than younger counselors, but it was interesting to note that the age range with the second highest availability of funding was the youngest age surveyed 18-25

a) Time to complete degree: I have the time necessary to complete a graduate level degree *
Age

Table 24: Crosstab

			Age					
			18-25	26-33	34-41	42-49	50-65	Total
a) Time to complete degree: I have the time necessary to complete a graduate level degree	1.0 Strongly disagree	Count	0	2	2	7	6	17
		% within Age	0.0%	6.3%	5.0%	19.4%	66.7%	13.7%
	2.0 Somewhat disagree	Count	1	4	11	12	2	30
		% within Age	14.3%	12.5%	27.5%	33.3%	22.2%	24.2%
	3.0 Agree	Count	1	1	10	6	0	18
		% within Age	14.3%	3.1%	25.0%	16.7%	0.0%	14.5%
	4.0 Somewhat agree	Count	4	23	14	10	0	51
		% within Age	57.1%	71.9%	35.0%	27.8%	0.0%	41.1%
	5.0 Strongly agree	Count	1	2	3	1	1	8
		% within Age	14.3%	6.3%	7.5%	2.8%	11.1%	6.5%
Total	Count	7	32	40	36	9	124	
	% within Age	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	

Table 25: Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	49.798 ^a	16	.000
Likelihood Ratio	47.663	16	.000
N of Valid Cases	124		

a. 16 cells (64.0%) have expected count less than 5. The minimum expected count is .45.

Table 26: Intention to pursue a graduate degree: I intend to pursue a graduate degree *
Age

		Crosstab						
		Age						
		18-25	26-33	34-41	42-49	50-65	Total	
b) Intention to pursue a graduate degree: I intend to pursue a graduate degree	1.0 Strongly disagree	Count	0	3	1	10	7	21
		% within Age	0.0%	9.4%	2.6%	27.8%	77.8%	17.1%
	2.0 Somewhat disagree	Count	0	7	0	3	0	10
		% within Age	0.0%	21.9%	0.0%	8.3%	0.0%	8.1%
	3.0 Agree	Count	1	3	7	12	0	23
		% within Age	14.3%	9.4%	17.9%	33.3%	0.0%	18.7%
	4.0 Somewhat agree	Count	4	15	23	9	0	51
		% within Age	57.1%	46.9%	59.0%	25.0%	0.0%	41.5%
	5.0 Strongly agree	Count	2	4	8	2	2	18
		% within Age	28.6%	12.5%	20.5%	5.6%	22.2%	14.6%
Total		Count	7	32	39	36	9	123
		% within Age	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	62.186 ^a	16	.000
Likelihood Ratio	64.159	16	.000
N of Valid Cases	123		

a. 14 cells (56.0%) have expected count less than 5. The minimum expected count is .57.

Table 27: Adequate funding for education: I have access to the necessary funds to pursue a graduate level degree, including financial aid, saving and loans * Age

			Crosstab					
			Age					
			18-25	26-33	34-41	42-49	50-65	Total
c) Adequate funding for education: I have access to the necessary funds to pursue a graduate level degree, including financial aid, saving and loans	1.0 Strongly disagree	Count	0	10	8	11	2	31
		% within Age	0.0%	31.3%	20.0%	30.6%	22.2%	25.0%
	2.0 Somewhat disagree	Count	3	5	16	13	0	37
		% within Age	42.9%	15.6%	40.0%	36.1%	0.0%	29.8%
	3.0 Agree	Count	1	6	5	4	1	17
		% within Age	14.3%	18.8%	12.5%	11.1%	11.1%	13.7%
	4.0 Somewhat agree	Count	3	7	9	8	5	32
		% within Age	42.9%	21.9%	22.5%	22.2%	55.6%	25.8%
	5.0 Strongly agree	Count	0	4	2	0	1	7
		% within Age	0.0%	12.5%	5.0%	0.0%	11.1%	5.6%
Total	Count	7	32	40	36	9	124	
	% within Age	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	

Chi-Square Tests			
	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	21.102 ^a	16	.175
Likelihood Ratio	26.457	16	.048
N of Valid Cases	124		

a. 15 cells (60.0%) have expected count less than 5. The minimum expected count is .40.

Table 28: Belief in the benefits of higher education: I believe that getting a graduate level degree would increase my skill level as a counselor * Age

			Crosstab					
			Age					
			18-25	26-33	34-41	42-49	50-65	Total
d) Belief in the benefits of higher education: I believe that getting a graduate level degree would increase my skill level as a counselor	1.0 Strongly disagree	Count	0	1	0	5	3	9
		% within Age	0.0%	3.1%	0.0%	13.9%	33.3%	7.3%
	2.0 Somewhat disagree	Count	0	1	1	12	0	14
		% within Age	0.0%	3.1%	2.5%	33.3%	0.0%	11.3%
	3.0 Agree	Count	0	0	2	2	1	5
		% within Age	0.0%	0.0%	5.0%	5.6%	11.1%	4.0%
	4.0 Somewhat agree	Count	0	4	10	6	3	23
		% within Age	0.0%	12.5%	25.0%	16.7%	33.3%	18.5%
	5.0 Strongly agree	Count	7	26	27	11	2	73
		% within Age	100.0%	81.3%	67.5%	30.6%	22.2%	58.9%
Total	Count	7	32	40	36	9	124	
	% within Age	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	

Chi-Square Tests			
	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	55.846 ^a	16	.000
Likelihood Ratio	56.797	16	.000
N of Valid Cases	124		

a. 18 cells (72.0%) have expected count less than 5. The minimum expected count is .28.

Table 29: Willingness to embrace new models of treatment: It is important to use evidence-based approaches to substance use treatment * Age

			Crosstab					
			Age					Total
			18-25	26-33	34-41	42-49	50-65	
e) Willingness to embrace new models of treatment: It is	2.0 Somewhat disagree	Count	0	1	3	10	2	16
		% within Age	0.0%	3.1%	7.5%	27.8%	22.2%	12.9%
	3.0 Agree	Count	0	0	0	6	1	7
		% within Age	0.0%	0.0%	0.0%	16.7%	2.2%	5.6%

important to use		% within Age	0.0%	0.0%	0.0%	16.7%	11.1%	5.6%
evidence based	4.0 Somewhat agree	Count	1	7	17	5	2	32
approaches to		% within Age	14.3%	21.9%	42.5%	13.9%	22.2%	25.8%
substance use	5.0 Strongly agree	Count	6	24	20	15	4	69
treatment		% within Age	85.7%	75.0%	50.0%	41.7%	44.4%	55.6%
Total		Count	7	32	40	36	9	124
		% within Age	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	35.526 ^a	12	.000
Likelihood Ratio	37.192	12	.000
N of Valid Cases	124		

a. 12 cells (60.0%) have expected count less than 5. The minimum expected count is .40.

Table 30: Family support: I would pursue a graduate level degree if I had adequate family support * Age

			Crosstab					
			Age					Total
			18-25	26-33	34-41	42-49	50-65	
f) Family support: I	1.0 Strongly	Count	0	3	0	5	2	10
would pursue a	disagree	% within Age	0.0%	9.4%	0.0%	13.9%	22.2%	8.1%
graduate level	2.0 Somewhat	Count	0	2	1	6	0	9
degree if I had	disagree	% within Age	0.0%	6.3%	2.5%	16.7%	0.0%	7.3%
adequate family	3.0 Agree	Count	0	5	9	7	5	26
support		% within Age	0.0%	15.6%	22.5%	19.4%	55.6%	21.0%
	4.0 Somewhat agree	Count	5	14	14	10	0	43
		% within Age	71.4%	43.8%	35.0%	27.8%	0.0%	34.7%
	5.0 Strongly agree	Count	2	8	16	8	2	36
		% within Age	28.6%	25.0%	40.0%	22.2%	22.2%	29.0%
Total		Count	7	32	40	36	9	124
		% within Age	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests			
	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	31.235 ^a	16	.013
Likelihood Ratio	36.664	16	.002
N of Valid Cases	124		

a. 16 cells (64.0%) have expected count less than 5. The minimum expected count is .51.

Gender

Results of the chi-square test also showed that counselors' perceived level of barrier to pursue graduate studies was significantly different by gender. In particular, women were more likely to feel they had the time to complete a graduate degree than men ($X^2(12) = 23.25, p = 0.03$); but less likely to report having adequate funding; while men were more likely to report having too much debt as an impediment ($X^2(12) = 23.19, p = 0.03$). The cross-tabulation of survey responses by Gender are shown in the table below

Table 31: How likely are you to pursue a graduate level degree? * Gender

		Crosstab					
		Gender			Total		
		Female	Male	Trans Male			
How likely are you to pursue a graduate level degree?	1.0 Not important	Count	1	9	13	0	23
		% within Gender	50.0%	14.8%	22.4%	0.0%	18.5%
	2.0 Slightly important	Count	1	24	21	1	47
		% within Gender	50.0%	39.3%	36.2%	33.3%	37.9%
	3.0 Somewhat important	Count	0	12	9	2	23
		% within Gender	0.0%	19.7%	15.5%	66.7%	18.5%
	4.0 Quite important	Count	0	11	9	0	20
		% within Gender	0.0%	18.0%	15.5%	0.0%	16.1%
	5.0 Very important	Count	0	5	6	0	11
		% within Gender	0.0%	8.2%	10.3%	0.0%	8.9%
Total	Count	2	61	58	3	124	
	% within Gender	100.0%	100.0%	100.0%	100.0%	100.0%	

Chi-Square Tests			
	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	8.753 ^a	12	.724
Likelihood Ratio	9.080	12	.696
N of Valid Cases	124		

a. 10 cells (50.0%) have expected count less than 5. The minimum expected count is .18.

Table 32: Time to complete degree: I have the time necessary to complete a graduate level degree * Gender

		Crosstab					
		Gender					
			Female	Male	Trans Male	Total	
a) Time to complete degree: I have the time necessary to complete a graduate level degree	1.0 Strongly disagree	Count	0	7	10	0	17
		% within Gender	0.0%	11.5%	17.2%	0.0%	13.7%
	2.0 Somewhat disagree	Count	1	14	15	0	30
		% within Gender	50.0%	23.0%	25.9%	0.0%	24.2%
	3.0 Agree	Count	0	9	8	1	18
		% within Gender	0.0%	14.8%	13.8%	33.3%	14.5%
	4.0 Somewhat agree	Count	1	26	22	2	51
		% within Gender	50.0%	42.6%	37.9%	66.7%	41.1%
	5.0 Strongly agree	Count	0	5	3	0	8
		% within Gender	0.0%	8.2%	5.2%	0.0%	6.5%
	Total	Count	2	61	58	3	124
		% within Gender	100.0%	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests			
	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	5.312 ^a	12	.947
Likelihood Ratio	6.892	12	.865
N of Valid Cases	124		

a. 12 cells (60.0%) have expected count less than 5. The minimum expected count is .13.

Table 33: Adequate funding for education: I have access to the necessary funds to pursue a graduate level degree, including financial aid, saving and loans * Gender

			Crosstab				
			Gender				
			Female	Male	Trans Male	Total	
c) Adequate funding for education: I have access to the necessary funds to pursue a graduate level degree, including financial aid, saving and loans	1.0 Strongly disagree	Count	0	17	12	2	31
		% within Gender	0.0%	27.9%	20.7%	66.7%	25.0%
	2.0 Somewhat disagree	Count	0	19	17	1	37
		% within Gender	0.0%	31.1%	29.3%	33.3%	29.8%
	3.0 Agree	Count	0	8	9	0	17
		% within Gender	0.0%	13.1%	15.5%	0.0%	13.7%
	4.0 Somewhat agree	Count	2	12	18	0	32
		% within Gender	100.0%	19.7%	31.0%	0.0%	25.8%
	5.0 Strongly agree	Count	0	5	2	0	7
		% within Gender	0.0%	8.2%	3.4%	0.0%	5.6%
	Total	Count	2	61	58	3	124
		% within Gender	100.0%	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests			
	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	12.730 ^a	12	.389
Likelihood Ratio	13.143	12	.359
N of Valid Cases	124		

a. 12 cells (60.0%) have expected count less than 5. The minimum expected count is .11.

Race

The data suggests that counselors who identified as Asian (43%)? And counselors who identified as White/ Caucasian (29.5%) are more likely to pursue a graduate degree than counselors who identified as Black/African American (27%) or Latino/Hispanic (8%). However,

respondents who identified as White/ Caucasian (51%) and Black/African American (50%) reported the highest rates of having the time to pursue a graduate degree. Asian respondents (71%) and counselors who identified as White/ Caucasian (46%) felt they had the necessary funds to pursue a graduate degree while counselors who identified as Latino/Hispanic (35%) and Black/African American (23%) reported low ability to afford the graduate degree. This is significant and needs to be addressed, as the cost is a major barrier to education and there is an increased risk that counselors from these demographic groups could be barred access to this necessary level of education.

Results of the chi-square test also showed that race/ethnicity was significantly correlated with counselors' feelings about having time to complete a degree ($X^2(12) = 23.25, p = 0.03$) and adequate funding for education in terms of having debt ($X^2(12) = 23.19, p = 0.03$) were significantly different among counselors with different race/ethnicity groups. Respondents identifying as White (50.8%) and respondents identifying as black (50%) scoring the highest percentages in terms of having the time to complete a graduate degree and Latino/Hispanic (42.3%) and Asian (28.6%). The cross-tabulation of survey responses by race/ethnicity is showed in the table below

Table 34: How likely are you to pursue a graduate level degree? * Race/Ethnicity

		Crosstab					
		Race/Ethnicity					
			Black or African American	Latino/Hispanic	White/ Caucasian	Total	
How likely are you	1.0 Not important	Count	2	4	6	11	23
to pursue a		% within Race/Ethnicity	28.6%	13.3%	23.1%	18.0%	18.5%

graduate level degree?	2.0 Slightly important	Count	1	14	11	21	47
		% within Race/Ethnicity	14.3%	46.7%	42.3%	34.4%	37.9%
	3.0 Somewhat important	Count	1	4	7	11	23
		% within Race/Ethnicity	14.3%	13.3%	26.9%	18.0%	18.5%
	4.0 Quite important	Count	2	6	2	10	20
		% within Race/Ethnicity	28.6%	20.0%	7.7%	16.4%	16.1%
	5.0 Very important	Count	1	2	0	8	11
		% within Race/Ethnicity	14.3%	6.7%	0.0%	13.1%	8.9%
Total		Count	7	30	26	61	124
		% within Race/Ethnicity	100.0%	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	10.622 ^a	12	.562
Likelihood Ratio	13.069	12	.364
N of Valid Cases	124		

a. 11 cells (55.0%) have expected count less than 5. The minimum expected count is .62.

Table 35: Time to complete degree: I have the time necessary to complete a graduate level degree * Race/Ethnicity

			Crosstab				
			Race/Ethnicity				
			Black or African		White/		
			Asian	American	Latino/Hispanic	Caucasian	Total
a) Time to complete degree: I have the time necessary to complete a graduate level degree	1.0 Strongly disagree	Count	1	2	8	6	17
		% within Race/Ethnicity	14.3%	6.7%	30.8%	9.8%	13.7%
	2.0 Somewhat disagree	Count	3	11	7	9	30
		% within Race/Ethnicity	42.9%	36.7%	26.9%	14.8%	24.2%

3.0 Agree	Count	1	2	0	15	18
	% within	14.3%	6.7%	0.0%	24.6%	14.5%
	Race/Ethnicity					
4.0 Somewhat agree	Count	2	13	10	26	51
	% within	28.6%	43.3%	38.5%	42.6%	41.1%
	Race/Ethnicity					
5.0 Strongly agree	Count	0	2	1	5	8
	% within	0.0%	6.7%	3.8%	8.2%	6.5%
	Race/Ethnicity					
Total	Count	7	30	26	61	124
	% within	100.0%	100.0%	100.0%	100.0%	100.0%
	Race/Ethnicity					

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	23.247 ^a	12	.026
Likelihood Ratio	25.894	12	.011
N of Valid Cases	124		

a. 12 cells (60.0%) have expected count less than 5. The minimum expected count is .45.

Table 36: Adequate funding for education: I have access to the necessary funds to pursue a graduate level degree, including financial aid, saving and loans * Race/Ethnicity

Crosstab

			Race/Ethnicity				Total
			Asian	Black or African American	Latino/Hispanic	White/Caucasian	
c) Adequate funding for education: I have access to the necessary funds to pursue a graduate level degree, including financial aid, saving and loans	1.0 Strongly disagree	Count	1	11	10	9	31
		% within	14.3%	36.7%	38.5%	14.8%	25.0%
	Race/Ethnicity						
	2.0 Somewhat disagree	Count	1	10	7	19	37
		% within	14.3%	33.3%	26.9%	31.1%	29.8%
	Race/Ethnicity						
	3.0 Agree	Count	1	4	3	9	17
		% within	14.3%	13.3%	11.5%	14.8%	13.7%
	Race/Ethnicity						
		Count	4	3	6	19	32

	4.0 Somewhat agree	% within Race/Ethnicity	57.1%	10.0%	23.1%	31.1%	25.8%
	5.0 Strongly agree	Count	0	2	0	5	7
		% within Race/Ethnicity	0.0%	6.7%	0.0%	8.2%	5.6%
Total		Count	7	30	26	61	124
		% within Race/Ethnicity	100.0%	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests			
	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	16.282 ^a	12	.179
Likelihood Ratio	18.383	12	.105
N of Valid Cases	124		

a. 10 cells (50.0%) have expected count less than 5. The minimum expected count is .40.

Length of Time as a Counselor

Length of time as a counselor significantly correlated with multiple perceived barriers to graduate school. According to the survey, the longer one has been a counselor, the less likely the respondent was to pursue further education, this was shown by their responses to questions of intention to pursue it or a willingness to embrace new models of treatment. This is a crucial thing to take into account. As the age of the counseling workforces goes up, their ability to, based on barriers, access graduate level decreases. This must be taken into account as policy changes and places these counselors in the challenging position of going back to school while also nearing retirement.

Results of the chi-square test showed that counselors' willingness to pursue a master's degree ($X^2(12) = 48.12, p < 0.001$), a) Time to complete degree ($X^2(12) = 48.41, p < 0.001$), b) Intention to pursue a graduate degree ($X^2(12) = 46.10, p < 0.001$), c) Adequate funding for

education in terms of having debt ($X^2(12) = 21.73, p = 0.04$), d) Belief in the benefits of higher education ($X^2(12) = 53.76, p < 0.001$), e) Willingness to embrace new models of treatment ($X^2(9) = 26.91, p < 0.001$), f) Family support ($X^2(12) = 26.96, p = 0.01$), and I) Belief in the benefit of personal recovery experience ($X^2(12) = 23.93, p = 0.02$) were significantly different among counselors with different length of time as counselors. The cross tabulation of survey responses by length of time as counselors are shown below.

Table 37: How likely are you to pursue a graduate level degree? * Length of Time as Counselor

		Crosstab					
		Length of Time as Counselor					
					more than 10		
			1-5 years	6-10 years	less than 1 year	years	Total
How likely are you to pursue a graduate level degree?	1.0 Not important	Count	4	11	1	7	23
		% within Length of Time as Counselor	6.3%	42.3%	4.3%	63.6%	18.5%
	2.0 Slightly important	Count	29	8	9	1	47
		% within Length of Time as Counselor	45.3%	30.8%	39.1%	9.1%	37.9%
	3.0 Somewhat important	Count	13	6	4	0	23
		% within Length of Time as Counselor	20.3%	23.1%	17.4%	0.0%	18.5%
	4.0 Quite important	Count	14	0	6	0	20
		% within Length of Time as Counselor	21.9%	0.0%	26.1%	0.0%	16.1%
	5.0 Very important	Count	4	1	3	3	11
		% within Length of Time as Counselor	6.3%	3.8%	13.0%	27.3%	8.9%
Total	Count	64	26	23	11	124	
	% within Length of Time as Counselor	100.0%	100.0%	100.0%	100.0%	100.0%	

Chi-Square Tests

	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	48.412 ^a	12	.000
Likelihood Ratio	51.883	12	.000
N of Valid Cases	124		

a. 13 cells (65.0%) have expected count less than 5. The minimum expected count is .98.

Table 38: Time to complete degree: I have the time necessary to complete a graduate level degree * Length of Time as Counselor

		Crosstab					
		Length of Time as Counselor					
					more than 10		
			1-5 years	6-10 years	less than 1 year	years	Total
a) Time to complete degree: I have the time necessary to complete a graduate level degree	1.0 Strongly disagree	Count	5	7	0	5	17
		% within Length of Time as Counselor	7.8%	26.9%	0.0%	45.5%	13.7%
	2.0 Somewhat disagree	Count	15	9	4	2	30
		% within Length of Time as Counselor	23.4%	34.6%	17.4%	18.2%	24.2%
	3.0 Agree	Count	11	3	3	1	18
		% within Length of Time as Counselor	17.2%	11.5%	13.0%	9.1%	14.5%
	4.0 Somewhat agree	Count	28	7	14	2	51
		% within Length of Time as Counselor	43.8%	26.9%	60.9%	18.2%	41.1%
	5.0 Strongly agree	Count	5	0	2	1	8
		% within Length of Time as Counselor	7.8%	0.0%	8.7%	9.1%	6.5%
	Total	Count	64	26	23	11	124
		% within Length of Time as Counselor	100.0%	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests			
	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	25.820 ^a	12	.011
Likelihood Ratio	27.316	12	.007

a. 12 cells (60.0%) have expected count less than 5. The minimum expected count is .71.

**Table 39: Intention to pursue a graduate degree: I intend to pursue a graduate degree *
Length of Time as Counselor**

			Crosstab				
			Length of Time as Counselor				
			1-5 years	6-10 years	less than 1 year	more than 10 years	Total
b) Intention to pursue a graduate degree: I intend to pursue a graduate degree	1.0 Strongly disagree	Count	4	10	1	6	21
		% within Length of Time as Counselor	6.3%	38.5%	4.5%	54.5%	17.1%
	2.0 Somewhat disagree	Count	2	3	5	0	10
		% within Length of Time as Counselor	3.1%	11.5%	22.7%	0.0%	8.1%
	3.0 Agree	Count	13	7	1	2	23
		% within Length of Time as Counselor	20.3%	26.9%	4.5%	18.2%	18.7%
	4.0 Somewhat agree	Count	33	5	12	1	51
		% within Length of Time as Counselor	51.6%	19.2%	54.5%	9.1%	41.5%
	5.0 Strongly agree	Count	12	1	3	2	18
		% within Length of Time as Counselor	18.8%	3.8%	13.6%	18.2%	14.6%
Total		Count	64	26	22	11	123
		% within Length of Time as Counselor	100.0%	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	46.099 ^a	12	.000
Likelihood Ratio	46.335	12	.000
N of Valid Cases	123		

a. 13 cells (65.0%) have expected count less than 5. The minimum expected count is .89.

Table 40: Adequate funding for education: I have access to the necessary funds to pursue a graduate level degree, including financial aid, saving and loans * Length of Time as Counselor

		Crosstab					
		Length of Time as Counselor					
			1-5 years	6-10 years	less than 1 year	more than 10 years	Total
c) Adequate funding for education: I have access to the necessary funds to pursue a graduate level degree, including financial aid, saving and loans	1.0 Strongly disagree	Count	16	7	6	2	31
		% within Length of Time as Counselor	25.0%	26.9%	26.1%	18.2%	25.0%
	2.0 Somewhat disagree	Count	22	6	8	1	37
		% within Length of Time as Counselor	34.4%	23.1%	34.8%	9.1%	29.8%
	3.0 Agree	Count	9	3	4	1	17
		% within Length of Time as Counselor	14.1%	11.5%	17.4%	9.1%	13.7%
	4.0 Somewhat agree	Count	13	9	4	6	32
		% within Length of Time as Counselor	20.3%	34.6%	17.4%	54.5%	25.8%
	5.0 Strongly agree	Count	4	1	1	1	7
		% within Length of Time as Counselor	6.3%	3.8%	4.3%	9.1%	5.6%
	Total	Count	64	26	23	11	124
		% within Length of Time as Counselor	100.0%	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests			
	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	9.535 ^a	12	.657
Likelihood Ratio	9.361	12	.672
N of Valid Cases	124		

a. 10 cells (50.0%) have expected count less than 5. The minimum expected count is .62.

Table 41: Belief in the benefits of higher education: I believe that getting a graduate level degree would increase my skill level as a counselor * Length of Time as Counselor

			Crosstab				
			Length of Time as Counselor				
			1-5 years	6-10 years	less than 1 year	more than 10 years	Total
d) Belief in the benefits of higher education: I believe that getting a graduate level degree would increase my skill level as a counselor	1.0 Strongly disagree	Count	2	4	0	3	9
		% within Length of Time as Counselor	3.1%	15.4%	0.0%	27.3%	7.3%
	2.0 Somewhat disagree	Count	2	10	1	1	14
		% within Length of Time as Counselor	3.1%	38.5%	4.3%	9.1%	11.3%
	3.0 Agree	Count	3	2	0	0	5
		% within Length of Time as Counselor	4.7%	7.7%	0.0%	0.0%	4.0%
	4.0 Somewhat agree	Count	13	3	2	5	23
		% within Length of Time as Counselor	20.3%	11.5%	8.7%	45.5%	18.5%
	5.0 Strongly agree	Count	44	7	20	2	73
		% within Length of Time as Counselor	68.8%	26.9%	87.0%	18.2%	58.9%
Total		Count	64	26	23	11	124
		% within Length of Time as Counselor	100.0%	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests			
	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	53.762 ^a	12	.000
Likelihood Ratio	50.151	12	.000
N of Valid Cases	124		

a. 14 cells (70.0%) have expected count less than 5. The minimum expected count is .44.

Table 42: Willingness to embrace new models of treatment: It is important to use evidence-based approaches to substance use treatment * Length of Time as Counselor

Crosstab

		Length of Time as Counselor				Total	
			1-5 years	6-10 years	less than 1 year	more than 10 years	
e) Willingness to embrace new models of treatment: It is important to use evidence-based approaches to substance use treatment	2.0 Somewhat disagree	Count	5	7	1	3	16
		% within Length of Time as Counselor	7.8%	26.9%	4.3%	27.3%	12.9%
	3.0 Agree	Count	1	5	0	1	7
		% within Length of Time as Counselor	1.6%	19.2%	0.0%	9.1%	5.6%
	4.0 Somewhat agree	Count	15	6	9	2	32
		% within Length of Time as Counselor	23.4%	23.1%	39.1%	18.2%	25.8%
	5.0 Strongly agree	Count	43	8	13	5	69
		% within Length of Time as Counselor	67.2%	30.8%	56.5%	45.5%	55.6%
Total		Count	64	26	23	11	124
		% within Length of Time as Counselor	100.0%	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	26.908 ^a	9	.001
Likelihood Ratio	25.212	9	.003
N of Valid Cases	124		

a. 8 cells (50.0%) have expected count less than 5. The minimum expected count is .62.

Table 43: Family support: I would pursue a graduate level degree if I had adequate family support * Length of Time as Counselor

Crosstab

		Length of Time as Counselor				Total
--	--	-----------------------------	--	--	--	-------

			1-5 years	6-10 years	less than 1 year	more than 10 years	
f) Family support: I would pursue a graduate level degree if I had adequate family support	1.0 Strongly disagree	Count	3	5	0	2	10
		% within Length of Time as Counselor	4.7%	19.2%	0.0%	18.2%	8.1%
	2.0 Somewhat disagree	Count	3	5	0	1	9
		% within Length of Time as Counselor	4.7%	19.2%	0.0%	9.1%	7.3%
	3.0 Agree	Count	13	4	4	5	26
		% within Length of Time as Counselor	20.3%	15.4%	17.4%	45.5%	21.0%
	4.0 Somewhat agree	Count	25	6	12	0	43
		% within Length of Time as Counselor	39.1%	23.1%	52.2%	0.0%	34.7%
	5.0 Strongly agree	Count	20	6	7	3	36
		% within Length of Time as Counselor	31.3%	23.1%	30.4%	27.3%	29.0%
Total	Count		64	26	23	11	124
	% within Length of Time as Counselor		100.0%	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests			
	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	26.961 ^a	12	.008
Likelihood Ratio	30.542	12	.002
N of Valid Cases	124		

a. 11 cells (55.0%) have expected count less than 5. The minimum expected count is .80.

Table 44: Belief in the benefit of personal recovery experience: Being in recovery is an asset in providing substance abuse treatment * Length of Time as Counselor

		Crosstab			
		Length of Time as Counselor			Total

			1-5 years	6-10 years	less than 1 year	more than 10 years	
i) Belief in the benefit of personal recovery experience:	1.0 Strongly disagree	Count	5	1	0	1	7
		% within Length of Time as Counselor	7.8%	3.8%	0.0%	9.1%	5.6%
Being in recovery is an asset in providing substance abuse treatment	2.0 Somewhat disagree	Count	8	2	1	0	11
		% within Length of Time as Counselor	12.5%	7.7%	4.3%	0.0%	8.9%
	3.0 Agree	Count	23	9	6	2	40
		% within Length of Time as Counselor	35.9%	34.6%	26.1%	18.2%	32.3%
	4.0 Somewhat agree	Count	20	6	15	3	44
		% within Length of Time as Counselor	31.3%	23.1%	65.2%	27.3%	35.5%
	5.0 Strongly agree	Count	8	8	1	5	22
		% within Length of Time as Counselor	12.5%	30.8%	4.3%	45.5%	17.7%
Total		Count	64	26	23	11	124
		% within Length of Time as Counselor	100.0%	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests			
	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	23.925 ^a	12	.021
Likelihood Ratio	24.559	12	.017
N of Valid Cases	124		

a. 12 cells (60.0%) have expected count less than 5. The minimum expected count is .62.

Recovery Status

What we found in the data suggests that counselors who are not in recovery were more likely to pursue a graduate degree, slightly higher belief in the benefits of higher education, much higher willingness to embrace new models of treatment and scored higher on family

support. The two groups scored fairly equally when reporting on the agency philosophical support, each rating it in the middle of the Likert scale. Not surprising, the respondents who were in recovery scored much higher when asked about their belief in the benefit of personal recovery. This is important information to process, it shows that recovery status will serve as a potential barrier across the board. This is suggestive to any policy that will work to increase the number of graduate level counselors, there is a risk that by not addressing these barriers in the current workforce and beyond, that the field could lose the valuable asset that recovering counselors provide as well as disconnecting the field from its historical past

Result of the chi-square test showed that counselors' willingness to pursue a master's degree ($X^2(4) = 17.35, p < 0.001$), d) Belief in the benefits of higher education ($X^2(4) = 10.20, p = 0.04$), e) Willingness to embrace new models of treatment ($X^2(3) = 32.63, p < 0.001$), f) Family support ($X^2(4) = 9.62, p = 0.05$), g) Organization support (philosophical support) ($X^2(4) = 10.20, p = 0.04$), and I) Belief in the benefit of personal recovery experience ($X^2(4) = 48.56, p < 0.001$) were significantly different among counselors with different recovery status. The cross-tabulation of survey responses by recovery status is shown below.

Table 45: How likely are you to pursue a graduate level degree? * Recovery Status (Are you personally in recovery?)

		Crosstab			
		Recovery Status (Are you personally in recovery?)			
		No	Yes	Total	
How likely are you to pursue a graduate level degree?	1.0 Not important	Count	11	12	23
		% within Recovery Status (Are you personally in recovery?)	16.2%	21.4%	18.5%
	2.0 Slightly important	Count	19	28	47

		% within Recovery Status	27.9%	50.0%	37.9%
		(Are you personally in recovery?)			
	3.0 Somewhat important	Count	20	3	23
		% within Recovery Status	29.4%	5.4%	18.5%
		(Are you personally in recovery?)			
	4.0 Quite important	Count	14	6	20
		% within Recovery Status	20.6%	10.7%	16.1%
		(Are you personally in recovery?)			
	5.0 Very important	Count	4	7	11
		% within Recovery Status	5.9%	12.5%	8.9%
		(Are you personally in recovery?)			
Total		Count	68	56	124
		% within Recovery Status	100.0%	100.0%	100.0%
		(Are you personally in recovery?)			

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	17.351 ^a	4	.002
Likelihood Ratio	18.807	4	.001
N of Valid Cases	124		

a. 1 cells (10.0%) have expected count less than 5. The minimum expected count is 4.97.

Table 46: Belief in the benefits of higher education: I believe that getting a graduate level degree would increase my skill level as a counselor * Recovery Status (Are you personally in recovery?)

Crosstab

	Recovery Status (Are you personally in recovery?)		Total
	No	Yes	

d) Belief in the benefits of higher education: I believe that getting a graduate level degree would increase my skill level as a counselor	1.0 Strongly disagree	Count	1	8	9
		% within Recovery Status (Are you personally in recovery?)	1.5%	14.3%	7.3%
	2.0 Somewhat disagree	Count	6	8	14
		% within Recovery Status (Are you personally in recovery?)	8.8%	14.3%	11.3%
	3.0 Agree	Count	2	3	5
		% within Recovery Status (Are you personally in recovery?)	2.9%	5.4%	4.0%
	4.0 Somewhat agree	Count	13	10	23
		% within Recovery Status (Are you personally in recovery?)	19.1%	17.9%	18.5%
	5.0 Strongly agree	Count	46	27	73
		% within Recovery Status (Are you personally in recovery?)	67.6%	48.2%	58.9%
Total		Count	68	56	124
		% within Recovery Status (Are you personally in recovery?)	100.0%	100.0%	100.0%

Chi-Square Tests			
	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	10.201 ^a	4	.037
Likelihood Ratio	10.918	4	.028
N of Valid Cases	124		

a. 4 cells (40.0%) have expected count less than 5. The minimum expected count is 2.26.

Table 47: Willingness to embrace new models of treatment: It is important to use evidence-based approaches to substance use treatment * Recovery Status (Are you personally in recovery?)

Crosstab

		Recovery Status (Are you personally in recovery?)			
		No	Yes	Total	
e) Willingness to embrace new models of treatment: It is important to use evidence based approaches to substance use treatment	2.0 Somewhat disagree	Count	2	14	16
		% within Recovery Status (Are you personally in recovery?)	2.9%	25.0%	12.9%
	3.0 Agree	Count	3	4	7
		% within Recovery Status (Are you personally in recovery?)	4.4%	7.1%	5.6%
	4.0 Somewhat agree	Count	10	22	32
		% within Recovery Status (Are you personally in recovery?)	14.7%	39.3%	25.8%
	5.0 Strongly agree	Count	53	16	69
		% within Recovery Status (Are you personally in recovery?)	77.9%	28.6%	55.6%
	Total	Count	68	56	124
		% within Recovery Status (Are you personally in recovery?)	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	32.628 ^a	3	.000
Likelihood Ratio	34.638	3	.000
N of Valid Cases	124		

a. 2 cells (25.0%) have expected count less than 5. The minimum expected count is 3.16.

Table 48: Family support: I would pursue a graduate level degree if I had adequate family support * Recovery Status (Are you personally in recovery?)

Crosstab

		Recovery Status (Are you personally in recovery?)			
		No	Yes	Total	
f) Family support: I would pursue a graduate level degree if I had adequate family support	1.0 Strongly disagree	Count	6	4	10
		% within Recovery Status (Are you personally in recovery?)	8.8%	7.1%	8.1%
	2.0 Somewhat disagree	Count	6	3	9
		% within Recovery Status (Are you personally in recovery?)	8.8%	5.4%	7.3%
	3.0 Agree	Count	9	17	26
		% within Recovery Status (Are you personally in recovery?)	13.2%	30.4%	21.0%
	4.0 Somewhat agree	Count	30	13	43
		% within Recovery Status (Are you personally in recovery?)	44.1%	23.2%	34.7%
	5.0 Strongly agree	Count	17	19	36
		% within Recovery Status (Are you personally in recovery?)	25.0%	33.9%	29.0%
	Total	Count	68	56	124
		% within Recovery Status (Are you personally in recovery?)	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	9.622 ^a	4	.047
Likelihood Ratio	9.780	4	.044
N of Valid Cases	124		

a. 3 cells (30.0%) have expected count less than 5. The minimum expected count is 4.06.

Table 49: Organizational support (philosophical support): My agency embraces new evidence-based practices and provides education and supports to the staff in how to implement these techniques * Recovery Status (Are you personally in recovery?)

		Crosstab			
		Recovery Status (Are you personally in recovery?)			
		No	Yes	Total	
g) Organizational support (philosophical support): My agency embraces new evidence based practices and provides education and supports to the staff in how to implement these techniques	1.0 Strongly disagree	Count	3	0	3
		% within Recovery Status (Are you personally in recovery?)	4.4%	0.0%	2.4%
	2.0 Somewhat disagree	Count	6	10	16
		% within Recovery Status (Are you personally in recovery?)	8.8%	17.9%	12.9%
	3.0 Agree	Count	6	10	16
		% within Recovery Status (Are you personally in recovery?)	8.8%	17.9%	12.9%
	4.0 Somewhat agree	Count	41	33	74
		% within Recovery Status (Are you personally in recovery?)	60.3%	58.9%	59.7%
	5.0 Strongly agree	Count	12	3	15
		% within Recovery Status (Are you personally in recovery?)	17.6%	5.4%	12.1%
Total	Count	68	56	124	
	% within Recovery Status (Are you personally in recovery?)	100.0%	100.0%	100.0%	

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	10.199 ^a	4	.037
Likelihood Ratio	11.666	4	.020
N of Valid Cases	124		

a. 2 cells (20.0%) have expected count less than 5. The minimum expected count is 1.35.

Table 50: Belief in the benefit of personal recovery experience: Being in recovery is an asset in providing substance abuse treatment * Recovery Status (Are you personally in recovery?)

		Crosstab			
		Recovery Status (Are you personally in recovery?)			
		No	Yes	Total	
i) Belief in the benefit of personal recovery experience: Being in recovery is an asset in providing substance abuse treatment	1.0 Strongly disagree	Count	7	0	7
		% within Recovery Status (Are you personally in recovery?)	10.3%	0.0%	5.6%
	2.0 Somewhat disagree	Count	10	1	11
		% within Recovery Status (Are you personally in recovery?)	14.7%	1.8%	8.9%
	3.0 Agree	Count	33	7	40
		% within Recovery Status (Are you personally in recovery?)	48.5%	12.5%	32.3%
	4.0 Somewhat agree	Count	16	28	44
		% within Recovery Status (Are you personally in recovery?)	23.5%	50.0%	35.5%
	5.0 Strongly agree	Count	2	20	22
		% within Recovery Status (Are you personally in recovery?)	2.9%	35.7%	17.7%
	Total	Count	68	56	124
		% within Recovery Status (Are you personally in recovery?)	100.0%	100.0%	100.0%

Chi-Square Tests			
	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	48.557 ^a	4	.000
Likelihood Ratio	55.851	4	.000
N of Valid Cases	124		

a. 3 cells (30.0%) have expected count less than 5. The minimum expected count is 3.16.

Marital Status

Of married and non-married respondents, neither group reported a high likelihood of pursuing a graduate degree, yet the unmarried respondents did score higher on the intention to pursue the degree. This is a curious finding and begs the question of what creates the likelihood in a participant that does not have an interest in the degree. The married couples reported more access to childcare but the response rates in this category were too low to show significance.

Result of the chi-square test showed that counselors' willingness to pursue a master's degree ($X^2(4) = 12.87, p = 0.01$), b) Intention to pursue a graduate degree ($X^2(4) = 10.53, p = 0.03$), and j) Access to childcare ($X^2(4) = 12.90, p = 0.01$) were significantly different among counselors with different marital status. The cross-tabulation of survey responses by marital status is showed in the table below.

Table 50: How likely are you to pursue a graduate level degree? * Marital status (Married?)

		Crosstab		
		Marital status (Married?)		
		No	Yes	Total
1.0 Not important	Count	5	18	23

How likely are you to pursue a graduate level degree?	2.0 Slightly important	% within Marital status (Married?)	7.7%	30.5%	18.5%
		Count	28	19	47
		% within Marital status (Married?)	43.1%	32.2%	37.9%
	3.0 Somewhat important	Count	11	12	23
		% within Marital status (Married?)	16.9%	20.3%	18.5%
	4.0 Quite important	Count	14	6	20
		% within Marital status (Married?)	21.5%	10.2%	16.1%
	5.0 Very important	Count	7	4	11
		% within Marital status (Married?)	10.8%	6.8%	8.9%
Total		Count	65	59	124
		% within Marital status (Married?)	100.0%	100.0%	100.0%

Chi-Square Tests			
	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	12.873 ^a	4	.012
Likelihood Ratio	13.407	4	.009
N of Valid Cases	124		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 5.23.

Table 51: Intention to pursue a graduate degree: I intend to pursue a graduate degree * Marital status (Married?)

		Crosstab			
		Marital status (Married?)			
		No	Yes	Total	
b) Intention to pursue a graduate degree: I intend to pursue a graduate degree	1.0 Strongly disagree	Count	5	16	21
		% within Marital status (Married?)	7.8%	27.1%	17.1%
	2.0 Somewhat disagree	Count	7	3	10

		% within Marital status (Married?)	10.9%	5.1%	8.1%
	3.0 Agree	Count	11	12	23
		% within Marital status (Married?)	17.2%	20.3%	18.7%
	4.0 Somewhat agree	Count	32	19	51
		% within Marital status (Married?)	50.0%	32.2%	41.5%
	5.0 Strongly agree	Count	9	9	18
		% within Marital status (Married?)	14.1%	15.3%	14.6%
Total		Count	64	59	123
		% within Marital status (Married?)	100.0%	100.0%	100.0%

Chi-Square Tests			
	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	10.533 ^a	4	.032
Likelihood Ratio	10.896	4	.028
N of Valid Cases	123		

a. 1 cells (10.0%) have expected count less than 5. The minimum expected count is 4.80.

**Table 52: Access to childcare: I have adequate child care to pursue a graduate degree *
Marital status (Married?)**

		Crosstab			
		Marital status (Married?)			
		No	Yes	Total	
j) Access to childcare: I have adequate child care to pursue a graduate degree	1.0 Strongly disagree	Count	4	2	6
		% within Marital status (Married?)	23.5%	4.5%	9.8%
	2.0 Somewhat disagree	Count	2	6	8
		% within Marital status (Married?)	11.8%	13.6%	13.1%
	3.0 Agree	Count	5	3	8
		% within Marital status (Married?)			

	% within Marital status (Married?)	29.4%	6.8%	13.1%
4.0 Somewhat agree	Count	3	23	26
	% within Marital status (Married?)	17.6%	52.3%	42.6%
5.0 Strongly agree	Count	3	10	13
	% within Marital status (Married?)	17.6%	22.7%	21.3%
Total	Count	17	44	61
	% within Marital status (Married?)	100.0%	100.0%	100.0%

Chi-Square Tests			
	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	12.896 ^a	4	.012
Likelihood Ratio	12.326	4	.015
N of Valid Cases	61		

a. 5 cells (50.0%) have expected count less than 5. The minimum expected count is 1.67.

Number of Children

The majority of respondents had no children and those without children, not surprisingly, scored the highest on likelihood to pursue a graduate degree, time to complete the degree, belief in the benefits of higher education. This study's respondents were slightly less likely to be female than the total population of CASACS in New York, so it is possible that issues of child-rearing, to the extent that it impacts females more than males, may need to be examined as a potential barrier to providers seeking higher education.

Result of the chi-square test showed that counselors' a) Time to complete degree ($X^2(8) = 21.46, p < 0.001$), d) Belief in the benefits of higher education ($X^2(8) = 24.19, p < 0.001$), and j) Access to childcare ($X^2(8) = 26.80, p < 0.001$) were significantly different among counselors

with number of children. The cross-tabulation of survey responses by a number of children grouping is showed below.

Table 53: How likely are you to pursue a graduate level degree? * Number of Children

		Crosstab				
		Number of Children				
		1-2 children	3-4 children	No children	Total	
How likely are you to pursue a graduate level degree?	1.0 Not important	Count	15	3	5	23
		% within Number of Children	25.9%	33.3%	8.8%	18.5%
	2.0 Slightly important	Count	26	3	18	47
		% within Number of Children	44.8%	33.3%	31.6%	37.9%
	3.0 Somewhat important	Count	6	2	15	23
		% within Number of Children	10.3%	22.2%	26.3%	18.5%
	4.0 Quite important	Count	7	0	13	20
		% within Number of Children	12.1%	0.0%	22.8%	16.1%
	5.0 Very important	Count	4	1	6	11
		% within Number of Children	6.9%	11.1%	10.5%	8.9%
Total		Count	58	9	57	124
		% within Number of Children	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests			
	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	15.181 ^a	8	.056
Likelihood Ratio	17.030	8	.030
N of Valid Cases	124		

a. 5 cells (33.3%) have expected count less than 5. The minimum expected count is .80.

Table 54: Time to complete degree: I have the time necessary to complete a graduate level degree * Number of Children

Crosstab

			Number of Children			
			1-2 children	3-4 children	No children	Total
a) Time to complete degree: I have the time necessary to complete a graduate level degree	1.0 Strongly disagree	Count	11	4	2	17
		% within Number of Children	19.0%	44.4%	3.5%	13.7%
	2.0 Somewhat disagree	Count	19	1	10	30
		% within Number of Children	32.8%	11.1%	17.5%	24.2%
	3.0 Agree	Count	7	0	11	18
		% within Number of Children	12.1%	0.0%	19.3%	14.5%
	4.0 Somewhat agree	Count	18	3	30	51
		% within Number of Children	31.0%	33.3%	52.6%	41.1%
	5.0 Strongly agree	Count	3	1	4	8
		% within Number of Children	5.2%	11.1%	7.0%	6.5%
Total	Count	58	9	57	124	
	% within Number of Children	100.0%	100.0%	100.0%	100.0%	

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	21.459 ^a	8	.006
Likelihood Ratio	22.141	8	.005
N of Valid Cases	124		

a. 7 cells (46.7%) have expected count less than 5. The minimum expected count is .58.

Table 55: Belief in the benefits of higher education: I believe that getting a graduate level degree would increase my skill level as a counselor * Number of Children

Crosstab

			Number of Children			
			1-2 children	3-4 children	No children	Total
1.0 Strongly disagree	Count		9	0	0	9

d) Belief in the benefits of higher education: I believe that getting a graduate level degree would increase my skill level as a counselor		% within Children	15.5%	0.0%	0.0%	7.3%
	2.0 Somewhat disagree	Count	5	1	8	14
		% within Children	8.6%	11.1%	14.0%	11.3%
	3.0 Agree	Count	3	2	0	5
		% within Children	5.2%	22.2%	0.0%	4.0%
	4.0 Somewhat agree	Count	13	1	9	23
		% within Children	22.4%	11.1%	15.8%	18.5%
	5.0 Strongly agree	Count	28	5	40	73
		% within Children	48.3%	55.6%	70.2%	58.9%
Total		Count	58	9	57	124
		% within Children	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	24.188 ^a	8	.002
Likelihood Ratio	26.109	8	.001
N of Valid Cases	124		

a. 8 cells (53.3%) have expected count less than 5. The minimum expected count is .36.

Yearly Income

Result of the chi-square test showed that counselors' willingness to pursue a master's degree ($X^2(20) = 39.61, p = 0.01$), b) Intention to pursue a graduate degree ($X^2(20) = 32.66, p = 0.04$), c) Adequate funding for education in terms of having debt ($X^2(20) = 35.30, p = 0.02$), d) Belief in the benefits of higher education ($X^2(29) = 53.70, p < 0.001$), e) Willingness to embrace new models of treatment ($X^2(15) = 34.30, p < 0.001$), and j) Access to childcare ($X^2(20) = 37.59,$

$p = 0.01$) were significantly different among counselors with different yearly income. The cross tabulation of survey responses by yearly income grouping are shown below.

Table 56: How likely are you to pursue a graduate level degree? * Yearly Income

			Yearly Income			
			18,000-25,000	25,001-35,000	35,001-42,000	42,001-55,000
How likely are you to pursue a graduate level degree?	1.0 Not important	Count	0	4	7	10
		% within Yearly Income	0.0%	9.1%	13.7%	55.6%
	2.0 Slightly important	Count	1	16	23	6
		% within Yearly Income	14.3%	36.4%	45.1%	33.3%
	3.0 Somewhat important	Count	2	9	11	1
		% within Yearly Income	28.6%	20.5%	21.6%	5.6%
	4.0 Quite important	Count	2	11	7	0
		% within Yearly Income	28.6%	25.0%	13.7%	0.0%
	5.0 Very important	Count	2	4	3	1
		% within Yearly Income	28.6%	9.1%	5.9%	5.6%
	Total	Count	7	44	51	18
		% within Yearly Income	100.0%	100.0%	100.0%	100.0%

			Crosstab	
			Yearly Income	
			55,001-65,000	more than 65,000
How likely are you to pursue a graduate level degree?	1.0 Not important	Count	1	1
		% within Yearly Income	50.0%	50.0%
	2.0 Slightly important	Count	0	1
		% within Yearly Income	0.0%	50.0%
	3.0 Somewhat important	Count	0	0
		% within Yearly Income	0.0%	0.0%
	4.0 Quite important	Count	0	0
		% within Yearly Income	0.0%	0.0%

	5.0 Very important	Count	1	0
		% within Yearly Income	50.0%	0.0%
Total		Count	2	2
		% within Yearly Income	100.0%	100.0%

Chi-Square Tests			
	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	39.611 ^a	20	.006
Likelihood Ratio	38.713	20	.007
N of Valid Cases	124		

a. 21 cells (70.0%) have expected count less than 5. The minimum expected count is .18.

**Table 57: Intention to pursue a graduate degree: I intend to pursue a graduate degree *
Yearly Income**

			Yearly Income			
			18,000-25,000	25,001-35,000	35,001-42,000	42,001-55,000
b) Intention to pursue a graduate degree: I intend to pursue a graduate degree	1.0 Strongly disagree	Count	0	4	7	8
		% within Yearly Income	0.0%	9.1%	13.7%	44.4%
	2.0 Somewhat disagree	Count	0	7	1	2
		% within Yearly Income	0.0%	15.9%	2.0%	11.1%
	3.0 Agree	Count	1	4	13	4
		% within Yearly Income	16.7%	9.1%	25.5%	22.2%
	4.0 Somewhat agree	Count	3	22	22	3
		% within Yearly Income	50.0%	50.0%	43.1%	16.7%
	5.0 Strongly agree	Count	2	7	8	1
		% within Yearly Income	33.3%	15.9%	15.7%	5.6%
Total		Count	6	44	51	18

% within Yearly Income	100.0%	100.0%	100.0%	100.0%
------------------------	--------	--------	--------	--------

		Crosstab			
		Yearly Income			
		55,001-65,000	more than 65,000		
b) Intention to pursue a graduate degree: I intend to pursue a graduate degree	1.0 Strongly disagree	Count	1	1	21
		% within Yearly Income	50.0%	50.0%	17.1%
	2.0 Somewhat disagree	Count	0	0	10
		% within Yearly Income	0.0%	0.0%	8.1%
	3.0 Agree	Count	1	0	23
		% within Yearly Income	50.0%	0.0%	18.7%
	4.0 Somewhat agree	Count	0	1	51
		% within Yearly Income	0.0%	50.0%	41.5%
	5.0 Strongly agree	Count	0	0	18
		% within Yearly Income	0.0%	0.0%	14.6%
Total		Count	2	2	123
		% within Yearly Income	100.0%	100.0%	100.0%

Chi-Square Tests			
	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	32.664 ^a	20	.037
Likelihood Ratio	34.359	20	.024
N of Valid Cases	123		

a. 21 cells (70.0%) have expected count less than 5. The minimum expected count is .16.

Table 58: Adequate funding for education: I have access to the necessary funds to pursue a graduate level degree, including financial aid, saving and loans * Yearly Income

		Yearly Income			
		18,000-25,000	25,001-35,000	35,001-42,000	42,001-55,000
c) Adequate funding for education: I have access to the necessary funds to	1.0 Strongly disagree	Count	0	15	13
		% within Yearly Income	0.0%	34.1%	25.5%

pursue a graduate level degree, including financial aid, saving and loans	2.0 Somewhat disagree	Count	3	9	19
		% within Yearly Income	42.9%	20.5%	37.3%
	3.0 Agree	Count	0	9	6
		% within Yearly Income	0.0%	20.5%	11.8%
	4.0 Somewhat agree	Count	4	7	10
		% within Yearly Income	57.1%	15.9%	19.6%
	5.0 Strongly agree	Count	0	4	3
		% within Yearly Income	0.0%	9.1%	5.9%
Total		Count	7	44	51
		% within Yearly Income	100.0%	100.0%	100.0%

Crosstab

		Yearly Income			
		55,001-65,000	more than 65,000		
c) Adequate funding for education: I have access to the necessary funds to pursue a graduate level degree, including financial aid, saving and loans	1.0 Strongly disagree	Count	0	0	31
		% within Yearly Income	0.0%	0.0%	25.0%
	2.0 Somewhat disagree	Count	1	0	37
		% within Yearly Income	50.0%	0.0%	29.8%
	3.0 Agree	Count	0	0	17
		% within Yearly Income	0.0%	0.0%	13.7%
	4.0 Somewhat agree	Count	1	2	32
		% within Yearly Income	50.0%	100.0%	25.8%
	5.0 Strongly agree	Count	0	0	7
		% within Yearly Income	0.0%	0.0%	5.6%
Total		Count	2	2	124
		% within Yearly Income	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	26.241 ^a	20	.158
Likelihood Ratio	29.620	20	.076
N of Valid Cases	124		

a. 21 cells (70.0%) have expected count less than 5. The minimum expected count is .11.

Table 59: Belief in the benefits of higher education: I believe that getting a graduate level degree would increase my skill level as a counselor * Yearly Income

			Yearly Income			
			18,000-25,000	25,001-35,000	35,001-42,000	42,001-55,000
d) Belief in the benefits of higher education: I believe that getting a graduate level degree would increase my skill level as a counselor	1.0 Strongly disagree	Count	0	2	1	6
		% within Yearly Income	0.0%	4.5%	2.0%	33.3%
	2.0 Somewhat disagree	Count	0	2	6	5
		% within Yearly Income	0.0%	4.5%	11.8%	27.8%
	3.0 Agree	Count	0	1	3	1
		% within Yearly Income	0.0%	2.3%	5.9%	5.6%
	4.0 Somewhat agree	Count	0	8	8	4
		% within Yearly Income	0.0%	18.2%	15.7%	22.2%
	5.0 Strongly agree	Count	7	31	33	2
		% within Yearly Income	100.0%	70.5%	64.7%	11.1%
	Total	Count	7	44	51	18
		% within Yearly Income	100.0%	100.0%	100.0%	100.0%

Crosstab

			Yearly Income		
			55,001-65,000	more than 65,000	
d) Belief in the benefits of higher education: I believe that getting a graduate level degree would increase my skill level as a counselor	1.0 Strongly disagree	Count	0	0	9
		% within Yearly Income	0.0%	0.0%	7.3%
	2.0 Somewhat disagree	Count	0	1	14
		% within Yearly Income	0.0%	50.0%	11.3%
	3.0 Agree	Count	0	0	5
		% within Yearly Income	0.0%	0.0%	4.0%
	4.0 Somewhat agree	Count	2	1	23
		% within Yearly Income			

		% within Yearly Income	100.0%	50.0%	18.5%
	5.0 Strongly agree	Count	0	0	73
		% within Yearly Income	0.0%	0.0%	58.9%
Total		Count	2	2	124
		% within Yearly Income	100.0%	100.0%	100.0%

Chi-Square Tests			
	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	53.700 ^a	20	.000
Likelihood Ratio	49.686	20	.000
N of Valid Cases	124		

a. 24 cells (80.0%) have expected count less than 5. The minimum expected count is .08.

Table 60: Willingness to embrace new models of treatment: It is important to use evidence-based approaches to substance use treatment * Yearly Income

			Yearly Income			
			18,000-25,000	25,001-35,000	35,001-42,000	42,001-55,000
e) Willingness to embrace new models of treatment: It is important to use evidence-based approaches to substance use treatment	2.0 Somewhat disagree	Count	0	3	5	8
		% within Yearly Income	0.0%	6.8%	9.8%	44.4%
	3.0 Agree	Count	0	1	3	3
		% within Yearly Income	0.0%	2.3%	5.9%	16.7%
	4.0 Somewhat agree	Count	2	13	12	3
		% within Yearly Income	28.6%	29.5%	23.5%	16.7%
	5.0 Strongly agree	Count	5	27	31	4
		% within Yearly Income	71.4%	61.4%	60.8%	22.2%
Total	Count	7	44	51	18	

% within Yearly Income 100.0% 100.0% 100.0% 100.0%

		Crosstab			
		Yearly Income			
			55,001-65,000	more than 65,000	
e) Willingness to embrace new models of treatment: It is important to use evidence-based approaches to substance use treatment	2.0 Somewhat disagree	Count	0	0	16
		% within Yearly Income	0.0%	0.0%	12.9%
	3.0 Agree	Count	0	0	7
		% within Yearly Income	0.0%	0.0%	5.6%
	4.0 Somewhat agree	Count	0	2	32
		% within Yearly Income	0.0%	100.0%	25.8%
	5.0 Strongly agree	Count	2	0	69
		% within Yearly Income	100.0%	0.0%	55.6%
Total		Count	2	2	124
		% within Yearly Income	100.0%	100.0%	100.0%

Chi-Square Tests			
	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	34.300 ^a	15	.003
Likelihood Ratio	30.898	15	.009
N of Valid Cases	124		

a. 17 cells (70.8%) have expected count less than 5. The minimum expected count is .11.

**Table 61: Access to childcare: I have adequate childcare to pursue a graduate degree *
Yearly Income**

		Yearly Income				
			18,000-25,000	25,001-35,000	35,001-42,000	42,001-50,000
j) Access to childcare: I have adequate childcare to pursue a graduate degree	1.0 Strongly disagree	Count	0	1	5	
		% within Yearly Income	0.0%	6.7%	17.2%	
	2.0 Somewhat disagree	Count	0	1	5	

		% within Yearly Income	0.0%	6.7%	17.2%
3.0 Agree	Count		1	4	0
	% within Yearly Income		50.0%	26.7%	0.0%
4.0 Somewhat agree	Count		0	4	15
	% within Yearly Income		0.0%	26.7%	51.7%
5.0 Strongly agree	Count		1	5	4
	% within Yearly Income		50.0%	33.3%	13.8%
Total	Count		2	15	29
	% within Yearly Income		100.0%	100.0%	100.0%

Crosstab

			Yearly Income		
			55,001-65,000	more than 65,000	
j) Access to childcare: I	1.0 Strongly disagree	Count	0	0	6
have adequate childcare		% within Yearly Income	0.0%	0.0%	9.8%
to pursue a graduate	2.0 Somewhat disagree	Count	0	0	8
degree		% within Yearly Income	0.0%	0.0%	13.1%
	3.0 Agree	Count	0	0	8
		% within Yearly Income	0.0%	0.0%	13.1%
	4.0 Somewhat agree	Count	1	1	26
		% within Yearly Income	100.0%	100.0%	42.6%
	5.0 Strongly agree	Count	0	0	13
		% within Yearly Income	0.0%	0.0%	21.3%
Total		Count	1	1	61
		% within Yearly Income	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	21.008 ^a	20	.397
Likelihood Ratio	26.214	20	.159
N of Valid Cases	61		

a. 26 cells (86.7%) have expected count less than 5. The minimum expected count is .10.

Conclusion and Discussion

The purpose of this study was to identify and better understand the barriers to graduate level education among substance use counselors. General variables previously identified in the literature as impacting decisions around ongoing education were tested alongside factors more unique to substance abuse counselors, including personal recovery histories, attitudes about the 12 Step philosophy and length of time serving as a counselor. In addition, perception about graduate school as well as barriers for attending were further explored against demographic variables within this population, including age, race, gender, and length of time serving as a counselor.

The sample was derived from a list of providers in treatment agencies and in New York State. A total of 300 were sent, and a total of 194 responded with 124 meeting inclusion criteria. Results were analyzed using Spearman correlation and Chi-Square tests for significance.

Results are discussed here within the context of the current movement within the field of substance abuse in the state of New York and beyond to consider making a graduate level degree the new standard for employment in this field. The chapter will conclude with discussions regarding the limitations of the study, implications of the results and recommendations for policy changes and further research.

CHAPTER 8:

DISCUSSION AND IMPLICATIONS

Results of this study support hypothesis generated by the literature. Traditional barriers that members of the general population site as hindrances to further education were recorded among this population, including the time to complete the degree, adequate funding for education, family support and access to. However, both quantitative and qualitative findings from this study suggest that substance abuse counselors face unique barriers to attaining graduate-level degrees that are not found in the general population. These barriers include financial challenges exacerbated by personal addiction histories, tensions between believing in empirical science versus the value of personal experience as someone in recovery; and institutional biases against empirical science and further education espoused by counseling organizations themselves. These findings are discussed in more detail here.

Financial Challenges Exacerbated by Personal Addiction Histories

Through the use of both the quantitative data that showed that financial insecurity had a strong impact on the respondents but at an increased level for those identifying as in recovery as well as the qualitative datum that showed, in the respondents own words that their recovery history played a role in their financial considerations for graduate school.

”my drug use wreaked havoc on our finances and I am in debt up to my eyes.”

“I worry about being able to find a grad program that would work with my schedule and accept my degree. But the biggest deal is money. My addiction destroyed my credit and created a lot of debt. If there as some way of helping folks in recovery afford the degree, I would absolutely want to get one.”

This extra piece that is unique to counselors in recovery is an important consideration as the field moves forward with a push towards a graduate degree as the standard. The positive

benefit of personal recovery experience is an important and unique aspect of the field of substance abuse and if the financial strain keeps these counselors from meeting the new standard, then the field runs the risk of losing these valuable voices and assets in the work.

Evidence-Based Interventions Versus the Value of Personal Recovery Experience

This study revealed that while the field is changing, especially with new counselors entering the field, there is still a significant divide between counselors who believe in personal recovery experience of evidence-based treatment approaches. This divide was shown to influence the participant's willingness to pursue a graduate degree with counselors who have a higher belief in personal experience over evidence-based being far less likely to pursue a graduate degree than counselors who believed in the evidence-based model. It is important to note that these beliefs did not correlate just with recovery status but this belief was present in both groups. This suggests that the field needs to find a way to engage those who do not see the value of evidence-based approaches and find ways to increase the buy-in of these counselors and help make connections between the traditions of the self-help movement with the innovative science-based approaches that are merging and showing positive results.

Institutional Biases Against Evidence-based Approaches

Perhaps the most foundational of the unique barriers limiting substance abuse counselors' likelihood to attend graduate school is that many substance abuse counselors are employed in organizations who do not philosophically support advanced education. This study's findings suggest that a significant number of participants are employed in agencies that do not provide philosophical (17%) or material (83.1%) support for advanced education. These conditions exerted a significant impact on respondents' intentions and willingness to advance their education. This was particularly relevant because of the way organizational support also

influenced the other variables examined in this study. Findings revealed that counselors employed in programs which provided philosophical support for the use of evidence-based interventions were significantly themselves more likely to indicate the importance of graduate-level degrees in enhancing their skill set and were more personally likely to express willingness to do so. On its face this may seem like an obvious correlation, but further analysis of organized opposition to the value of empirically-based education revealed even stronger trends among the individuals employed therein to oppose advanced education as well as indicate barriers to attending graduate school. Counselors employed in these agencies indicated not just an unwillingness but an outright disregard for the value of advanced degrees and the evidence-based approach. This result from the study shows the power of the organization to influence the direction of the field and it also gives the field a target for improving outcomes and participation.

Demographic data yielded further insights. The age of counselor and length of employment significantly predicated attitudes about graduate school. With younger counselors who were new to this work showed higher levels of wiliness and greater ability to pursue graduate level degrees. That said, it is important to note that, the influence of institutional support remained consistent across the demographic variable such that even among younger and newer counselors, resistance to evidence-based education was evident by those employed in organizations who did not espouse openness to this approach.

Perhaps the most surprising and valuable result found in the study was the extent to which institutional support impacted the willingness of the participants to pursue a graduate degree. Data indicated that where agencies actively encouraged counselors to pursue a graduate degree for the purpose of becoming more effective counselors and backed that encouragement

with material support like tuition reimbursement, flexible scheduling, the willingness among providers increased significantly along with the belief in evidence-based practice:

“For me, I think that there should be more institutional support for us to move up as counselors. It is strange that the master’s degree isn’t seen as a way to be a better counselor but it is seen as a step to get a supervisor’s position. I think we should be focusing on making better counselors because I think we need it in this field. I also think that the agency should have to do some of the heavy liftings here. If not them then OASAS should do more than little training. There should be money and fell time so that we can work and move forward in our career.”

“I am planning to go to grad school and I know it will be a benefit. Being in recovery will make this harder. I have meetings that I have to attend, I have family obligations and my BA is not in a related field. I worry about being able to find a grad program that would work with my schedule and accept my degree. But the biggest deal is money. My addiction destroyed my credit and created a lot of debt. If there as some way of helping folks in recovery afford the degree, I would absolutely want to get one. I know that they may be requiring a grad degree soon and I worry about people like me and our ability to stay in this field. “

This result held true across the recovery and non-recovery participants and shows the power of the system to influence the belief system of the workforce. This is such a powerful point because this gives the field a target to focus on. As the field evolves into a graduate level degree field, education and support must focus on the agencies themselves and additional support must be given through trainings, hiring practice and philosophy expansion so that treatment facilities are bought in to both the rich history of the substance use field as well as an emphasis on evidence-based practices and not just word.

Limitations of the Study

While the response rate was very high for this study (64%), and while many of the demographic data are in line with state averages in regard to age, gender and race, it is not possible to ascertain if any additional themes or counter-themes might have presented in non-responders. Also, findings were based on self-report; no systemic analysis of agencies’ actual philosophical and material support for graduate studies or empirical science were obtained. In

addition, the study only looked at counselors who have a bachelor's degree. By not looking at counselors who have an associate's degree or only a high school diploma or GE, the broader understanding of the needs of these counselors was not recorded. OASAS reports that there are currently 6,482 CASAC's in New York State (No data on CASAC-T was available) Of this number 1643 have an associate degree or less, 1564 possess a Bachelor's degree. Because our study was limited to Bachelors level counselors we missed out the potential data of 1643.

Implications of the Results for the Field

The primary purpose of the study was to examine the barriers to attaining a graduate level degree among substance abuse counselors in order to help the field address gaps in service that might be addressed by better use of evidence-based practice. This study became more relevant with OASAS's new scope of practice initiative. This initiative was designed to encourage the current workforce to pursue higher levels of education and did this by designating competency and job duties based on education and training levels. A copy of this initiative is provided in Appendix C. As the field continues to adapt and evolve to increase the use of evidence-based practice and as the fields of mental health and substance use treatment continue to merge, the graduate degree will almost inevitably become the standard. In order to make sure that the current workforce can adapt and continue to participate in an effective way, a deeper understanding is needed of what such a transition will require. The first step in this is to look at what barriers exist for current counselors so that, as a field, professionals and researchers working together can develop the appropriate level of assistance to ensure that valued substance abuse counselors, with their passion and valuable contributions, are not left behind. Results of this study showed that there is value in re-examining this population through the lens of nontraditional students. Specifically, they face unique impediments to obtaining education that

the general population does not. Their personal histories can be more complex and disadvantaging; and, their years of exposure, personally and organizationally, to a philosophy that rejects empirical science over the use of the 12-Step model, present a level of resistance not experienced in many other areas of employment. Those of us committed to improving the field of substance abuse must work to meet substance abuse counselors where they are, and recognize they did not get here in a vacuum. This may require providing more access to affordable online graduate programs, allowing students to use their current job as their internship, developing graduate degrees specific to this field and focusing on making the master's degree useful for the work they are doing. In addition, funding through institutional grants and needs-based scholarships will be necessary to make sure that everyone has equal access to these degrees. These suggestions can be implemented at the state and federal level and can be created by unique partnerships with universities and the governing boards of professions like social work, psychology and mental health counseling.

As this study has revealed, all such initiatives will fall short if the facilities themselves do not provide the necessary support to the counselors and create an environment that not only believes in the evolution of the field but supports it through shifts in philosophy as well as material support. The recommendation here involves a program evaluation to determine the philosophy and communication of philosophy as part of the licensing of programs, this would be a way of ensuring that programs are implementing best practice and integrating the concepts in their institutional mission through training, supervision and internal support. In addition, working with agencies to find ways of assisting counselors in attaining the necessary time, support and financial capabilities is essential if this transition is to work for everyone. This support could be through a flexible schedule, internship opportunities or childcare support. On

the federal level, student loan forgiveness for substance use counselors as well as paid internship grants and childcare vouchers for nontraditional students could be increased to support the transitioning counseling population. One final point: it is not a stretch to suggest that providing a well-planned, multi-faceted transition plan which understands substance abuse counselors intimately for their unique experiences and which substantially aims to protect their jobs, could be viewed as a form of sobriety maintenance for those with personal recovery histories in this population who experience employment as a key motivator for success. By contrast, any attempt to move too quickly, or too-shortsightedly towards requiring advanced education without fully understanding the layers of impediments, could potentially result in systemic rates of increased relapse for those counselors with personal recovery histories; a personal, social and financial tragedy we might surely want to avoid. As a field, we need to look at ways to increase understanding, build partnerships and shared knowledge between agencies and researchers, agencies and employees and employees to employees.

Recommendations for Further Research

Further research could apply this type of examination to locations beyond New York; region by region explorations of the trends and needs of substance abuse counselors should be conducted to inform local initiatives. In addition, qualitative studies exploring the beliefs of treatment programs, directors and boards should be conducted to determine the extent of the philosophical beliefs of institutions. Reviews of actual training manuals and practices could shed light on the use of science and lack thereof.

Conclusion

There is little question that the field of substance abuse needs to come in line with others in the field of mental health treatment by adhering more tightly to skills informed by empirical

evidence. Rates of substance use continue to soar, and sobriety rates post-treatment remain too low. Yet we need to be careful and informed as we push to make this shift to evidence-based practice. In requiring, advocating or requiring advance degrees, it is essential that policymakers and treatment professionals understand and remove the barriers that substance abuse counselors will face in that transition. The field needs to equip its employees with the resources, materials and philosophical support to actually obtain this outcome. Anything less will be set up for failure; one the field cannot afford.

The purpose of the study was to determine to what extent counselor's willingness to pursue a graduate level degree is influenced by variables like finances, time, organizational support and beliefs in the value of empirical science. This study also examined how these variables differed in relation to the demographic factors of age, gender, race/ethnicity, length of time as a counselor, recovery status, marital status, number of children, and yearly income. The results of the study showed that this population was influenced in a unique way and that the willingness to pursue graduate level degrees was influenced by many factors. In addition to personal factors like finances and time, findings revealed that there was a powerful correlation between the agencies' beliefs in graduate-level education and their belief in the validity and use of evidence-based practice that influenced the counselors to a greater degree than expected. This finding provides us with a powerful and important tool in addressing the needs of this population and should be given more focus by the governing bodies of the profession.

This study revealed that, while decreasing, there is still a significant stronghold belief in the value of personal recovery over empirical training; and, that belief is statistically significantly negatively correlated with willingness to embrace continued education.

As our field continues to evolve in its noble mission to help those who suffer from substance use, we must make sure that we are taking care of those we employ to do this sacred work. We must make sure that as we continue to expect more from our workforce, that we are providing them with the support they need to make this complicated transition.

“This was good. I think that people need to know that some of us would do the thing if we had the support. That means to me that the employer needs to step up. If we need to get more school then they should help with something, like childcare or reworking the schedule like the survey says.”

We must be aware of the social, environmental, financial, racial and philosophical barriers that they may face. We need to be mindful of the historical nature of this field, its strong ties to the self-help movement and its own history of growth, oppression and clinical wisdom.

“I am nearing retirement so it doesn't make sense for me to go back to school. I do think we need more people with graduate level degrees. I have been in the field long enough to see how things have changed and I know that some folks don't adjust well to change but I think that as time goes on people will accept the need to get higher education. It is important and I also think that agencies like OASAS and OMH could do something to help workers get access to the degree. Especially those who are in recovery and have extra demands as well as nontraditional students and single parents. This is a good study and I hope it helps.”

In the chapter “How it works” from the big book of Alcoholics Anonymous it is stated:

“Rarely have we seen a person fail who has thoroughly followed our path.”

There is wisdom in this statement. It is a statement that is read at the beginning of many AA meeting and it provides a level of comfort and security that allows the members of the meeting to feel safe in the idea that those that came before them worked hard to create the environment, tools, and fellowship that could support them in their time of need. As a field, this is our charge, to create the environment, the tools and the fellowship that can help our field move confidently in the direction of a more efficient, effective, ethical and responsive service industry. This now

means a meaningful marriage of mindsets between the benefits of the self-help community and the power of evidence based tools. We owe this to our clients, to our workforce and to those recovery pioneers who came before us and those who will follow after us.

References

- Alcoholics Anonymous: The big book* (4th ed). (2001). New York, NY: Alcoholics Anonymous World Services.
- Brown, C & Bennett, M & Li, L and Ballack, A. (2011). Predictors of initiation and engagement in substance abuse treatment among individuals with co-occurring serious mental illness and substance use disorders. *Journal of Addictive Behaviors* 36, 439-447. <https://doi.org/10.1016/j.addbeh.2010.12.001>
- Bureau of Labor Statistics. (n.d.). *Occupational outlook handbook*. Washington, DC. Retrieved from <http://www.bls.gov/ooh/community-and-social-service/substance-abuse-and-behavioral-disorder-counselors.htm>
- Cacciola, J. S., Pecoraro, A., & Alterman, A. I. (2008). Development of ASI psychiatric severity cut-off scores to identify co-occurring psychiatric disorders. *International Journal of Mental Health and Addiction*, 6(1), 77–92. <https://doi.org/10.1007/s11469-007-9103-7>
- Centers for Disease Control. (2016). *CDC 24/7: Prescription Opioid Data*. Retrieved from <http://www.cdc.gov/drugoverdose/data/overdose.html>
- Corcoran, K. & Roberts, A. (2015). *Social workers' desk reference* (3rd ed). New York, NY: Oxford University Press.
- Crabb A.C, & Linton, M., J. (2007). A qualitative study of recovering and nonrecovering substance abuse counselors' belief systems. *Journal of Addictions & Offender Counseling*, 28(1), 4-20. <https://doi.org/10.1002/j.2161-1874.2007.tb00028.x>
- Cridland, E. K., Deane, F.P., Hsu, C. (2012). *International Journal of Mental Health Addiction* 10: 670. doi:10.1007/s11469-011-9364-z

- Davis, T. A., Ancis, J. R., & Ashby, J. S. (2015). Therapist effects, working alliance, and African American women substance users. *Cultural Diversity and Ethnic Minority Psychology*, 21(1), 126-135. <http://proxy.library.upenn.edu:2092/10.1037/a0036944>
- Davis, L., Fulginiti, A., Kriegel, L., & Brekke. (2012). *Current Psychiatry Reports* 14: 259. doi:10.1007/s11920-012-0271-1
- Doukas, N., & Cullen, J. (2011). Addiction counselors in recovery: Perceived barriers in the workplace. *Journal of Addiction Research & Therapy*, 2(3). Retrieved from <https://www.omicsonline.org/addiction-counselors-in-recovery-perceived-barriers-in-the-workplace-2155-6105.1000112.php?aid=1575>
- Drake, R. E., Essock, S.M., Shaner, A., Carey, K. B., Minkoff, K., Kola, L., & Rickards, L. (2001). Implementing dual diagnosis services for clients with severe mental illness. *Psychiatric Services*, 52(4), 469–476. <https://doi.org/10.1176/appi.ps.52.4.469>
- English, D., & Umbach, P. D. (2016). Graduate school choice: An examination of individual and institutional effects. *The Review of Higher Education*, 39(2), 173-211. doi:10.1353/rhe.2016.0001
- Flynn, P. M., & Brown, B. S. (2006). Co-occurring disorders in substance abuse treatment: Issues and prospects. *Journal of Substance Abuse Treatment* 34, 36-47. <https://dx.doi.org/10.1016%2Fj.jsat.2006.11.013>
- Gallagher, J. (2010). Ethical violations: A quantitative study comparing human service professions. Retrieved from <http://recoverytoday.net/Mar09/gallagher.html>
- Gielen, N., Krumeich, A., Havermans, R. C., Smeets, F., & Jansen, A. (2014). Why

- clinicians do not implement integrated treatment for comorbid substance use disorder and posttraumatic stress disorder: A qualitative study. *European Journal of Psychotraumatology*, 5(0). doi:10.3402/ejpt.v5.22821
- Gronfein, W. (1985) Psychotropic drugs and the origins of deinstitutionalization. *Social Problems*, 32(5) 437-454. Retrieved from <http://www.jstor.org/stable/800774>
- Havassy, B. E., Alvidrez, J., & Owen, K. K. (2004). Comparisons of patients with comorbid psychiatric and substance use disorders: Implications for treatment and service delivery. *The American Journal of Psychiatry*, 161(1), 139-145.
<https://doi.org/10.1176/appi.ajp.161.1.139>
- Horsfall, J., Cleary, M., Hunt, G. E., & Walter, G. (2009). Psychosocial treatments for people with co-occurring severe mental illnesses and substance use disorders (dual diagnosis): A review of empirical evidence. *Harvard Review of Psychiatry*, 17(1), 24-34.
doi:10.1080/10673220902724599
- Hser, Y., Evans, E., Huang, D., & Anglin, D. M. (2004). Relationship between drug treatment services, retention, and outcomes. *Psychiatric Services*, 55(7), 767-774.
<http://proxy.library.upenn.edu:2092/10.1176/appi.ps.55.7.767>
- Kelly, T., Daley, D., Douaihy, A. (2012). Treatment of substance abusing patients with comorbid psychiatric disorders. *Journal of Addictive Behaviors*, 37, 11-24.
<https://doi.org/10.1016/j.addbeh.2011.09.010>
- Kerwin, M. E., Walker-Smith, K., & Kirby, K. C. (2006). Comparative analysis of state requirements for the training of substance abuse and mental health counselors. *Journal of Substance Abuse Treatment*, 30(3), 173-181.
<http://proxy.library.upenn.edu:2100/10.1016/j.jsat.2005.11.004>

- Knutsen, D. W. (2011). *Motivation to Pursue Higher Education* (Unpublished doctoral dissertation). Bourbonnais, IL: Olivet Nazarene University School of Graduate Continuing Studies.
- Kurtz, E. (1979). *Not-God: A history of Alcoholics Anonymous*. Center City, MN: Hazelden Educational Services.
- Levine, HG. (1978). The discovery of addiction. *Changing conceptions of habitual drunkenness in America*. *Journal of Studies on Alcohol* 39:1, 143-174
- Libby, A. M., Orton, H. D., Stover, S. K., & Riggs, P. D. (2005). What came first, major depression or substance use disorder? Clinical characteristics and substance use comparing teens in a treatment cohort. *Addictive Behaviours*, 30(9), 1649–1662.
- Lydecker, K. P., Tate, S. R., Cummins, K. M., McQuaid, J., Granholm, E., & Brown, S. A. (2010). Clinical outcomes of an integrated treatment for depression and substance use disorders. *Psychology of Addictive Behaviors*, 24(3), 453-465. doi:10.1037/a0019943
- Mangrum, L. F., Spence, R. T., & Lopez, M. (2006). Integrated versus parallel treatment of co-occurring psychiatric and substance use disorders. *Journal of Substance Abuse Treatment*, 30(1), 79-84. <http://proxy.library.upenn.edu:2100/10.1016/j.jsat.2005.10.004>
- Manning, J. L., & Rawlings, B. (2004). *A culture of enquiry: Research evidence and the therapeutic community*. New York, NY: Human Sciences Press, Inc.
- Marshall, C. A. (2013). Good foundations: Prediction of degree success in non-traditional students. *Widening Participation and Lifelong Learning*, 15(2), 22-42.
doi:10.5456/wpll.15.2.22
- McCarty, D., Fuller, B. E., Arfken, C., Miller, M., Nunes, E. V., Edmundson, E., . . . Wendt, W. W. (2007). Direct care workers in the national drug abuse treatment clinical trials

network: Characteristics, opinions, and beliefs. *Ps*, 58(2), 181-190.

doi:10.1176/ps.2007.58.2.181

McGlynn, E. A., Asch, S. M., Adams, J., Keeseey, J., Hicks, J., DeCristofaro, A., & Kerr, E. A. (2003). The quality of health care delivered to adults in the United States. *The New England Journal of Medicine*, 348, 2635-2645. <https://doi.org/10.1056/NEJMsa022615>

McGovern, M. and Carroll, K. 2003. Evidence-based practices for substance use disorders. *Psychiatric Clinics of North America*, 26: 991–1010.

McGovern, M. P., Lambert-Harris, C., Alterman, A. I., Xie, H., & Meier, A. (2011). A randomized controlled trial comparing integrated cognitive behavioral therapy versus individual addiction counseling for co-occurring substance use and posttraumatic stress disorders. *Journal of Dual Diagnosis*, 7(4), 207-227.

<http://proxy.library.upenn.edu:2092/10.1080/15504263.2011.620425>

Mortlock, K. S., Deane, F. P., & Crowe, T. P. (2011). Screening for mental disorder comorbidity in Australian alcohol and other drug residential treatment settings. *Journal of Substance Abuse Treatment*, 40, 397–404.

Mulvey, K. P, Hubbard, S., & Hayashi, S. (2003). A national study of the substance abuse treatment workforce. *Journal of Substance Abuse Treatment*, 24(1), 51-57.

[http://dx.doi.org/10.1016/S0740-5472\(02\)00322-7](http://dx.doi.org/10.1016/S0740-5472(02)00322-7)

Mumola, C. J., & Karberg, J. C. (2006). *Drug use and dependence state and federal prisoners*. Washington, DC: Bureau of Justice Statistics.

NAADAC, the Association for Addiction Professionals. (2012). Situational analysis: Recovery to practice (RTP). Retrieved from

http://www.naadac.org/assets/1959/situational_analysis_final.pdf

- Najavits, L. M., Kivlahan, D., & Kosten, T. (2011). A national survey of clinicians' views of evidence-based therapies for PTSD and substance abuse. *Addiction Research & Theory*, *19*(2), 138-147. doi:10.3109/16066350903560176
- National Institute on Drug Abuse. (2016). Advancing addiction science. Retrieved from <http://www.cdc.gov/drugoverdose/data/overdose.html>
- New York State Office of Alcoholism and Substance Abuse Services. (2013). *2013 interim report: Statewide comprehensive plan 2012-2016*. Albany, NY. Retrieved from <https://www.oasas.ny.gov/pio/commissioner/documents/5YPIntReport2013.pdf>
- New York State Office of the Professions. (2016). *License requirements*. Albany, NY. Retrieved from <http://www.op.nysed.gov/prof/mhp/mhclic.htm#edu>
- Nielson, E. M. (2015). *Substance abuse counselors' beliefs about addiction and willingness to implement evidence-based practice* (Doctoral dissertation). Retrieved from PsycINFO. (1664224765; 2015-99040-143)
- Nielson, E. M. (2016). Substance Abuse Counselors' Recovery Status and Self-Schemas: Preliminary Implications for Empirically Supported Treatment Implementation. *Journal of Drug and Alcohol Research*, *5*, 235982. <http://doi.org/10.4303/jdar/235982>
- Nissen, L. B. (2014). Alcohol and drug prevention, intervention, and treatment literature: A bibliography for best practices. *Best Practice in Mental Health*, *10*(1), 59-97. Retrieved from <https://works.bepress.com/laura-nissen/5/>
- Novella, E. J. (2008). Theoretical accounts on deinstitutionalization and the reform of mental health services: A critical review. *Medicine, Health Care and Philosophy* *11*: 303. doi:10.1007/s11019-008-9123-5

- Nulty, D. D. (2008). The adequacy of response rates to online and paper surveys: What can be done? *Assessment & Evaluation in Higher Education*, 33(3), 301-314.
doi:10.1080/02602930701293231
- O'Brien, C., Charney, D., Lewis, L., Cornish, J., Post, R., Woody, G., & Weisner, C. (2004). Priority actions to improve the care of persons with co-occurring substance abuse and other mental disorders: A call to action. *Biological Psychiatry*, 56(10), 703–713.
<https://doi.org/10.1016/j.biopsych.2004.10.002>
- Office of Alcoholism and Substance Abuse Services. (2016). *OASAS certification application process*. Albany, NY. Retrieved July from <https://oasas.ny.gov/index.cfm?level=training>
- Olmstead, T. A., Abraham, A. J., Martino, S., & Roman, P. M. (2012). Counselor training in several evidence-based psychosocial addiction treatments in private US substance abuse treatment centers. *Drug and Alcohol Dependence*, 120(1-3), 149-154.
<http://proxy.library.upenn.edu:2100/10.1016/j.drugalcdep.2011.07.017>
- Office of Mental Health. (2016). *OMH and OASAS integration study*. Albany, NY. Retrieved from <https://www.omh.ny.gov/omhweb/integration-study/>
- Pinto, R. M., Yu, G., Spector, A. Y., Gorroochurn, P., & McCarty, D. (2010). Substance abuse treatment providers' involvement in research is associated with willingness to use findings in practice. *Journal of Substance Abuse Treatment*, 39(2), 188-194.
doi:<http://proxy.library.upenn.edu:2092/10.1016/j.jsat.2010.05.006>
- Riera, T. (2013). Substance abuse treatment and contingency management: The role of education and experience on the counselor's view and utilization of an evidence-based practice (Master's thesis). Retrieved from ProQuest Dissertations & Theses Global: Health & Medicine. (1407230530)

- Rush, B. (1823). *An inquiry into the effects of ardent spirits upon the human body and mind: With an account of the means of preventing, and of the remedies for curing them.* Boston: Loring.
- Rubin, A. and Babbie, E.R. (2014). *Research methods for social work* (8th ed.). Belmont, CA: Cengage Learning.
- Scanlan, C. S., & Darkenwald, G. G. (1984). Identifying deterrents to participation in continuing education. *Adult Education Quarterly*, 34(3), 155-166.
doi:10.1177/0001848184034003004
- Schmidt, L. A., Rieckmann, T., Abraham, A., Molfenter, T., Capoccia, V., Roman, P., & Mccarty, D. (2012). Advancing recovery: Implementing evidence-based treatment for substance use disorders at the systems level. *Journal of Studies on Alcohol and Drugs*, 73(3), 413-422. doi:10.15288/jsad.2012.73.413
- Substance Abuse and Mental Health Services Administration (2016). *Report to Congress on the nation's substance abuse and mental health workforce issues.* Rockville, MD.
- Substance Abuse and Mental Health Services Administration. (2014a). *Behavioral health trends in the United States: Results from the 2014 national survey on drug use and health.* Rockville, MD. Prepared by RTI International (HHSS283201300001C)
- Substance Abuse and Mental Health Services Administration. (2014b). *Results from the 2013 national survey on drug use and health: Summary of national findings.* Rockville, MD. (14-4863)
- Substance Abuse and Mental Health Services Administration. (2014c). *Data on substance abuse treatment facilities.* Rockville, MD. (14-4809). Retrieved from http://www.samhsa.gov/data/DASIS/NSSATS2012_Web.pdf

- Toriello, P. J. (1999). Substance abuse counselors: The influence of education level and recovery status on the perception of ethical dilemmas and the need for training on ethical dilemma resolution (Doctoral dissertation). Retrieved from PsycINFO. (619444196; 1999-95018-243).
- Toriello, P. J., & Benschoff, J. J. (2003). Substance abuse counselors and ethical dilemmas: The influence of recovery and education level. *Journal of Addictions & Offender Counseling*, 23(2), 83-98. doi:10.1002/j.2161-1874.2003.tb00173.x
- Valentine, T. & Darkenwald, G. G. (1990). Deterrents to participation in adult education: Profiles of potential learners. *Adult Education Quarterly*, 41, 29-42.
doi:10.1177/0001848190041001003
- Vaillant, G. E. (2006). *The natural history of alcoholism revisited*. Cambridge, MA: Harvard University Press.
- White, W. L. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Hill Systems/Lighthouse Institute.
- White, W., Evans, A., & Lamb, R. (2009). Reducing addiction-related social stigma. *Counselor*, 10(6), 52-58.
- Whitley, C. E. M. (2010). Social work clinical supervision in the addictions: Importance of understanding professional cultures. *Journal of Social Work Practice in the Addictions*, 10(4), 343-362. doi:http://proxy.library.upenn.edu:2100/10.1080/1533256X.2010.521071
- Woody, G. E., & Blaine, J. (1979). Depression in narcotic addicts: Quite possibly more than a chance association. In R. L. Dupont, A. Goldstein, J. O'Donnell, & B. Brown (Eds.), *Handbook on drug abuse* (pp. 277-285). Washington, DC: US Government Printing Office.

Zhang, Z., Gerstein, D. R., & Friedmann, P. D. (2008). Patient satisfaction and sustained outcomes of drug abuse treatment. *Journal of Health Psychology, 13*(3), 388-400.
<http://proxy.library.upenn.edu:2092/10.1177/1359105307088142>

APPENDIXES

Appendix A: The Twelve Steps of Alcoholics Anonymous

THE TWELVE STEPS OF ALCOHOLICS ANONYMOUS

1. We admitted we were powerless over alcohol—that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these Steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs. (pp. 59-60)

Appendix B: Sample of Online Consent

Title of the Research Study: Barriers to Attaining a Master's Degree for Substance Use Counselors with Personal Recovery Histories.

Protocol Number: 00000

Principal Investigator: Steven Dawson, 1644 64th street Brooklyn, NY 11204, 716-380-1782,
steven.dawson.lmsw@gmail.com

Co-investigator: N/A

Emergency Contact: Steven Dawson, 1644 64th street Brooklyn, NY 11204, 716-380-1782,
steven.dawson.lmsw@gmail.com

You are being asked to take part in a research study. This is not a form of treatment or therapy. It is not supposed to detect a disease or find something wrong. Your participation is voluntary which means you can choose whether or not to participate. If you decide to participate or not to participate there will be no loss of benefits to which you are otherwise entitled. Before you make a decision you will need to know the purpose of the study, the possible risks and benefits of being in the study and what you will have to do if you decide to participate.

If you do not understand what you are reading, do not sign it. If you decide to participate, you will be asked to check the "Accept" box on this form. If you choose to not participate, simply check the box "Decline".

The purpose of the study is to learn more about the barriers for substance abuse counselors in pursuing a master's degree. This is part of a dissertation. The study is exploring the extent to

which individuals in recovery and working as substance use counselors experience different barriers to advanced degrees than counselors who are not in recovery.

You were selected because you are currently a licensed counselor according to recent data provided by the Office of Alcohol and Substance Abuse Services (OASAS). You are being asked to join this study because we are interested in the experiences of current counselors. In addition, you are currently employed as a counselor working in the field of substance use treatment. You either possess a CASAC or a CASAC-T. You are currently engaged in direct practice with patients. You do not possess a master's degree or higher and you are not working in a supervisory or administrative position.

The questionnaire should take less than 30 minutes to complete. This is an online study and you can take this from any computer with internet access. You will be asked 37 questions and asked to rate the degree to which you agree or disagree with the question. Some additional demographic information will also be requested.

All data will be collected in aggregate form so the questionnaire is 100% confidential. IP addresses are not collected so no personal identification of any kind is collected and the questionnaires cannot be traced.

There is no direct benefit to you. However, your participation could help us understand the barriers to higher education that people in your field are experiencing, which can benefit you indirectly. In the future, this may help other people to have better access or supportive policy that can aide in the acquisition of higher education opportunities.

Your alternative to being in the study is to not be in the study. You may choose to join the study or you may choose not to join the study. Your participation is voluntary. There is no penalty if

you choose not to join the research study. You will lose no benefits or advantages that are now coming to you, or would come to you in the future.

There is no cost to participate in the study, and there is no payment for being in the study.

If you have questions, concerns or complaints regarding your participation in this research study or if you have any questions about your rights as a research subject, you should speak with the Principal Investigator listed on page one of this form. If a member of the research team cannot be reached or you want to talk to someone other than those working on the study, you may contact the Office of Regulatory Affairs with any question, concerns or complaints at the University of Pennsylvania by calling (215) 898-2614.

When you check the “Accept” button on this document, you are agreeing to take part in this research study.

Accept

Decline

Appendix C: OASAS Scope of Practice Initiative



SUD COUNSELOR SCOPES OF PRACTICE/CAREER LADDER

Qualifications for Each Level of Staff Working in OASAS Certified Treatment Programs

In January 2017, the Scopes of Practice/Career Ladder Chart was implemented to promote opportunities for advancement and job growth. It also ensures that counselors are performing tasks within a reasonable range of their competency (based on licensure, credentials, education level, and work experience). The first phase of the implementation resulted in all current CASACs and all new CASACs through 7/1/2018 being grandparented into the CASAC Level 2 category without regard to their highest level of education. Post 7/1/2018, the CASAC 2 level will require an Associate's Degree and all other counselor levels will be available upon renewal.

CASAC-Trainees – nothing has changed regarding the CASAC -Trainee level regarding the functions they can perform.

CASAC Reciprocity Level – Remains at the CASAC level. The other levels are NYS specific and not eligible for national/international reciprocity. OASAS will issue CASAC Advance and Master levels beginning 1/1/2018.

CASAC LEVELS

Requirement for Staff that are CASACs and performing the duties on the [Scope of Practice Chart](#) in OASAS certified treatment settings. OASAS will officially designate an individual's CASAC level beginning 7/1/2018. Each OASAS program must designate all CASAC levels by 7/1/2018 and individuals may only perform the level of duties associated with their assigned level on the Scope of Practice chart.

REQUIREMENTS NEXT RENEWAL PERIOD POST 1/1/18 THRU 12/30/20	CASAC	CASAC 2	CASAC Advanced Level	CASAC Advanced GRANDPARENTING *only for those not already meeting Advanced CASAC criteria	CASAC Master Level
Min. GED HS Diploma	•				
Min. of Associates Degree in Human Services		•			
Min. of Bachelor's Degree			•		
Min. of Master's Degree in Human Services					•
30-Hour Training in Clinical Supervision			•	•	•
CURRENT CLINICAL SUPERVISOR: At least two years of full-time (4000 hours) clinical supervision experience in the last five years, providing regular face-to-face supervision for one or more QHPs who are primary counselors and carry a regular caseload of clients.				•	
Must hold CASAC for min. of 3 consecutive years.					•
Criminal Background Check	•	•	•	•	•



NON-CASAC STAFF and other QHP LEVELS

Requirement for Staff that Are **NOT CASACs** and performing the duties on the [Scope of Practice Chart](#) in OASAS certified treatment settings. Each OASAS program must designate all staff levels by 7/1/2018. Individuals may only perform the level of duties associated with their assigned level on the Scope of Practice chart.

Requirements Post 7/1/2018	Counselor Assistant	Bachelor's HS OR Master's HS May provisionally perform QHP clinical functions for 36 months. *Not QHPs	Counselor Advanced Level Grandparenting Bachelors Only POST 7/1/2018 THRU 12/31/20	Counselor Advanced Level Grandparenting RN with no Bachelor's Degree POST 7/1/18 THRU 12/31/20	Counselor Advanced Level	Counselor Master Level
Min. GED/HS Diploma	•					
Min. Bachelor's Degree		• Human Services	•		•	
QHP Status					•	•
RN (QHP)				•		
Min. Master's Degree in Human Services						•
30-Hour Training in Clinical Supervision			•	•	•	•
Must Hold QHP Status for at least 3 years.						•
CURRENT CLINICAL SUPERVISOR: At least two years of full-time (4000 hours) clinical supervision experience in the last five years, providing regular face-to-face supervision for one or more QHPs who are primary counselors and carry a regular caseload of clients.			•	•		
Addiction Specific Training Required	•	•				
Criminal Background Check	•	•	•	•	•	•