ABSTRACT

TREATMENT AND SUBSTANCE ABUSE COUNSELOR CHARACTERISTICS VALUED BY CLIENTS

Approximately 37-57% of substance abuse counselors are in recovery themselves (Curtis & Eby, 2009; Knudsen, Ducharme, & Roman, 2006; McNulty, Oser, Johnson, Knudsen, & Roman 2007). With such high numbers it seems surprising that little research has been conducted on how clients perceive SA counselors who are former substance abusers (Curtis & Eby, 2009). In addition, the education that SA counselors have varies both in terms of number of years of education as well as in terms of discipline (Toriello & Benshoff, 2003). These two factors have the potential to affect the client counselor relationship and in turn, client treatment. This qualitative study will focus on clients' perceptions of valued characteristics of SA treatment and SA counselors. There will be emphasis placed on the role of SA counselor recovery status and educational background; and how these two factors can potentially affect client treatment. It is hoped that knowledge will be gained regarding client preferences of characteristics of SA counselors and of treatment in general. It is possible that the findings may be used to alter approaches to treatment and/or SA counselor vocational requirements.

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TREATMENT AND SUBSTANCE ABUSE COUNSELOR CHARACTERISTICS VALUED BY CLIENTS

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APPROVED

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CHAPTER 1: INTRODUCTION

Approximately 37 to 57% of substance abuse (SA) counselors are in "recovery" themselves (Curtis & Eby, 2009; Knudsen, Ducharme, & Roman, 2006; McNulty et al., 2007). The term "in recovery" refers to an individual with a history of substance abuse but who is not currently using/abusing alcohol or other substances. With such high numbers it seems surprising that little research has been conducted on how clients perceive substance abuse counselors who are former substance abusers (Curtis & Eby, 2009).

Another unique fact about substance abuse treatment is that the educational background of substance abuse (SA) counselors varies greatly from having only a high school diploma to possessing a master's degree or higher (Knudsen et al., 2006). With the recent passage of several pieces of legislation such as the Affordable Care Act (ACA), and Mental Health and Substance Abuse Parity in California; (AB154) not only will there be more accessibility for mental health and substance abuse treatment but many states will have new educational requirements for SA counselors as well. These changes within the field of addictions treatment make the question regarding what the educational requirements for SA counselors should be, a pertinent one. For some states, those new requirements may include licensure and a master's degree or higher (Alcoholism and Drug Abuse Weekly, 2012; Beall, 2012). Some of the changes in mental health and SA treatment have already begun to go into effect; such as shifting to requiring electronic medical records. Changes to SA counselor educational requirements are set to go into full effect January 1, 2014 (Standora, 2012). The effects of these changes (to the educational requirements of SA counselors), have the potential to change the way that clients experience substance

abuse treatment. Some research has shown that educational background was not a significant predictor of positive outcomes for clients and that positive outcomes for clients have been significantly associated with client counselor rapport (Lambert, 2013). Another key issue that would make the change difficult and possibly impractical is that many individuals who have been working in the SA field may not have the means to comply with new educational requirements. Substance abuse counselors often work long hours for low wages--conditions that are often not conducive to attaining a professional degree. In light of those factors it is also possible that by having higher educational standards for SA counselors, treatment and outcomes for clients may improve. By examining clients' perceptions of valuable SA counselor traits we can begin to get a clearer picture of what individuals within the social work profession should advocate for in regards to serving this population. This is an important topic to explore given the potential that recovery status and education of SA counselors can have on client treatment

Problem Statement

There are several challenges that can arise when SA treatment is being provided by SA counselors that are in recovery. It is possible that a substance abuse counselor that is in recovery may relapse (Adams & Warren, 2010). A relapse of a SA counselor could potentially negatively affect the relationship with that counselor's clients as well as the program and agency, and it may even affect the clients' outlook on recovery and the possibility to achieve it in their own life. It is also possible that a recovering SA counselor may be biased in terms of how they experienced the recovery process. For example, a counselor might feel that what worked for them will also work for their clients, even when clients' circumstances may differ greatly from their own (Crabb & Linton, 2007). To illustrate this

further, a former opiate abuser who has successfully maintained sobriety from opiates without the use of methadone may balk at clients' inquiries regarding the use of methadone in the recovery process. The way that a counselor who is in recovery interacts with their clients can also be different because of recovery status. Toriello and Strohmer (2004) conducted research that showed that substance abuse counselors who are in recovery had different body language while interacting with their clients than those counselors who were not in recovery. Prior research on the topic of the effects of substance abuse counselors' recovery status on client perceptions has had mixed results. In one study, English (1987) found that clients tended to view counselors with a history of recovery as more expert, attractive, and trustworthy. Creegan (1984) found that there was no effect for recovery status of SA counselors.

While it seems logical that someone in recovery themselves would be able to relate to someone new to recovery; because they have similar experiences which would likely aid in the ability to build rapport, evidence based practice dictates that before such a claim can be made there must be evidence. The empowerment approach in social work suggests that treatment be "client centered." This supports the need to involve clients in evaluating their own treatment. Inquiring about client perceptions regarding their SA counselor's recovery status represents a relevant focus of inquiry into this topical area.

Another unique trait regarding SA counselors is that their educational backgrounds tend to vary greatly; sometimes even within a single institution (Toriello & Benshoff, 2003). The educational background for substance abuse counselors can range from a high school diploma with a two –year certificate in progress, to a licensed professional possessing a master's degree.

Purpose of Study

For purposes of this study we will focus on the possible effect of SA counselor recovery status and educational background on client perceptions. Based on the theory of social identity, previous related research, and the passage of new legislation it appears that these factors as well as client perceptions of valued SA counselor characteristics and treatment characteristics in general are worthy of investigation. Prior research conducted examined "counselor credibility" which was measured through three perceptions of clients: expertness, attractiveness, and trustworthiness. Results from this research suggest the degree to which clients view their counselor as credible directly influences the counselors' ability to facilitate change (Guinee & Tracey, 1997; Heppner & Claiborn, 1988). It is possible that clients may perceive a SA counselor as more credible based on their recovery status and/or educational background. In addition, recent legislation passed regarding healthcare reform is allowing states to set their own education requirements regarding SA counselors (Alcoholism & Drug Abuse Weekly, 2012). In some states after January 1st 2014 SA counselors will be required to possess a master's degree. Information from this study may serve to support or challenge the impending changes as a result of the passage of the Affordable Care Act of 2010.

Substance Abuse Counselor Education/Training Requirements at Present

The educational requirements to become a SA counselor are somewhat confusing. The national Commission for Certifying Agencies approves education and certification for substance abuse counseling to be provided by accrediting agencies at the state level. Essentially this means that the accrediting agency grants the ability for certifying agencies to authorize certification of individuals who will be providing SA counseling. Different states have different accrediting

agencies that provide training and certification; specific minimum requirements such as number of field hours are set by the accrediting agencies and state legislature (http://www.adp.ca.gov). This means that requirements differ between states. Many agencies providing substance abuse treatment services require the SA counselors that they employ to possess certification or be in the process of obtaining certification in drug and alcohol counseling in order to be hired.

In California, according to the California Department of Alcohol and Drug Programs, and the California Code of Regulations (CCR, Title 9, Chapter 8, and section 13000) as of 2005, an individual providing substance abuse counseling must be registered with a certifying agency such as California Associates for Drug and Alcohol Education (CAADE) or California Associates of Addiction Recovery Programs (CAARR). In addition, after registering the individual has 5 years to complete a total of 155 hours in education and training. This education includes training on addiction counseling competencies (which are developed by the Substance Abuse and Mental health Services Administration, SAMHSA), ethics training, training regarding communicable diseases (such as HIV/Aids), providing services to gay, lesbian, and transgendered individuals as well as cultural competency, and sexual harassment.

The training surrounding certification and competencies can be obtained by formal schooling or going through one of many state approved, accredited private schools focused on addictions treatment. Lastly, the prospective certified drug and alcohol counselor is required to complete a specified minimum documented hours of supervised training and work experience providing counseling services in an alcohol and drug program. Individuals can be hired to provide SA counseling without being registered for certification and have 6 months to register and begin their formal education (http://www.adp.ca.gov). Certifying agencies for drug and

alcohol counseling/treatment also have their own requirements which may differ in terms of factors such as hours of field experience/internship, number and types of classes, continuing education requirements, and even length of sobriety on the part of the SA counselor; also referred to as "clean time." For example the certifying agency CAADE requires 250 hours of field experience as part of the requirements to become certified; while CAARR only requires 160 hours of field experience (http://www.caade.org; http://www.caarr.org).

This means that SA counselors can provide treatment without actually having any education regarding substance abuse for at least a period of 6 months. It is also important to recognize that while there is some effort on the part of the state to set minimum requirements the standards and specifics regarding certification vary between states and also differ among certifying agencies. Further, there may be many certifying agencies within a given state. California Drug and Alcohol Associates for Drug and Alcohol Education (CAADE) and CAARR were two California certifying agencies previously mentioned but there are several others such as: California Association of Alcohol and Drug Abuse Counselors (CAADAC), California Certification Board of Chemical Dependency Counselors (CCBCDC), and the Association of Christian Drug and Alcohol Counselors (ACAD).

In 2011, the California state legislature passed the Mental Health Substance abuse Parity Act, (AB 154).This bill addressed the issue that mental health and substance abuse treatment was not being covered by insurance companies to the same degree that medical care was covered. In many cases insurance companies did not cover the cost of treatment for mental illness and/or substance abuse treatment at all (Beall, 2011).

Of the insurance plans that did cover mental health and substance abuse treatment a typical plan might limit mental health and substance abuse treatment at a lifetime cap of $50,000; while the same plan would cover $1,000,000 for other services. The passage of the Mental Health and Substance Abuse Parity Act now requires insurers in California to cover the costs of treatment for mental health and substance abuse to the same degree that their policies cover other medical costs. With these changes comes both increased access to services as well as increased demand.

Changes to Substance Abuse Counselor Education/Training Requirements (2012-2015)

Another important piece of legislation that will affect the way that substance abuse treatment is provided is the Affordable Care Act (ACA). The ACA was signed into law in 2010, and is part of the Obama administration's national drug control strategy (Humphreys & McLellan, 2010). In addition to providing more coverage for individuals seeking substance abuse treatment via the expansion of Medicaid, the Obama administration has consulted with various professionals working in the field of substance abuse as well as psychologists, community based organizations, recovering addicts, and concerned citizens. By spending several months discussing the complex issues surrounding SA treatment a strategy was developed and four guiding principles were established which are:

1. Substance use disorders exist on a continuum and each point requires a specific response.
2. Addiction is a chronic disease.
3. Services for substance use disorder patients should be part of mainstream healthcare.

4. Recovery from addiction is a reality and should be celebrated.

For purposes of this paper we will focus on point number three. This echoes the call for insurance companies to cover the cost of treatment. In light of the fact that insurance companies will now be required to cover substance abuse treatment there has been much debate about what this means for SA counselors and their educational requirements to practice SA counseling. It is believed that insurance companies will likely refuse to authorize services for SA counselors who are not certified and/or do not possess formal education.

Under the ACA it was rumored that the Obama administration was going to establish new national requirements for SA counselor education requirements (Alcoholism & Drug Abuse Weekly, 2012). As of March 2012, the Substance Abuse and Mental Health Services Administration (SAMHSA) director H. Westley Clark, M.D. stated in Alcoholism and Drug Abuse Weekly that the federal government has decided not to set educational requirements for SA counselors and will leave that up to the states (Alcoholism & Drug Abuse Weekly, 2012). There is much controversy around the legislative changes that have taken place and some states are pushing to require a master's degree to become a SA counselor. The ACA goes into full effect as of January 2014, and therefore many states remain undecided as to what they will require of SA counselors and the debates surrounding feasibility of providing services and determining the best care for clients are raging.

According to the Bureau of Labor and Statistics as reported in 2008, employment of SA counselors and behavioral disorder counselors is predicted to expand by 21%, a rate much higher than average growth for all occupations (Standora, 2012). Standora points out that only half of states mandate a specific substance abuse counseling credential whereas over 85% of states require a

master's degree for the mental health practitioner licensee. Standora PhD, LADC, CADC, CASAC, is a director of Chemical Dependency Counseling degree Program and the Substance Abuse Certification program at Kingsborough Community College of the City University of New York. She acknowledges a need to professionalize the SA treatment field but also brings up key points that highlight the complexities involved with doing so.

Standora expresses that professionals working in the SA field who have advanced degrees are often not specifically trained in SA treatment. For example many such professionals have degrees in psychology, social work, and vocational rehabilitation. As laws in California currently state individuals who have a master's degree in the above mentioned fields and who are licensed (e.g., a Licensed Clinical Social Worker) do not have to obtain certification in SA to provide SA treatment. This is true even when the individual may have never taken any specific courses regarding SA.

Interestingly, individuals without such degrees may have more training regarding SA treatment and often have personal experience regarding SA, which may make them more effective when working with clients. This illustrates that more education is not necessarily equated with gaining knowledge that is explicitly relative to SA counseling. This suggests that more education does not necessarily make a SA counselor better equipped when working in the SA field. Outcome data have not been thoroughly examined regarding SA counselor education level and type; nor has educational background's association with positive outcomes for clients receiving SA treatment.

In light of these factors Standora asserts that while there certainly may be benefits to requiring more education, with the projected increased demand for services, the value of the personal experience and specific training of many SA

counselors, and the issues of low wages for SA counselors it is important to carefully determine what the new requirements should be and how they can gradually be implemented without causing a shortage of SA counselors in the wake of projected increased demand for services (Standora, 2012). The issue of low wages for SA counselors is a major point of contention; the annual salaries for SA counselors in the United States for full-time employees range from $24,404 to $47,119, with a median income at $33,228. This is an important factor to note when increasing the educational requirements for SA counselors because many cannot afford to go back to school while earning these wages. Also, if an individual does obtain additional credentials such as a master's degree it is unlikely that they would want to continue to work for such low wages; and lastly because a large percentage of SA treatment will now be covered by Medicaid and government subsidized health insurance it is likely that tax payers will be unsupportive of increasing wages for SA counselors.

National Agencies' Recommendations

A newly formed national agency regarding SA treatment, "National Addiction Studies Accreditation Commission" (NASAC), is currently working on a way to develop procedures that can aid in the development of curriculum and standards of practice for SA counselors from the level of an associate's degree through the doctoral level. Efforts to support financial aid for SA counselors going back to school to become certified, licensed, or obtain a college degree are now being discussed among the NASAC and SAMHSA. This is an important concept to take notice of for persons both in the field of SA and those who lobby for worker rights/adequate healthcare; such as social workers (Standora, 2012).

For SAMHSA's part according to director Dr. Clark their focus will be on competencies rather than recommending specific educational requirements (Alcoholism & Drug Abuse Weekly, 2012). Clark stated that, "At the end of the day, degrees generally reflect training, but competencies are more important." Competencies refer to guidelines that are meant to ensure best practices and involve such areas as knowledge, skills, and approaches to working with clients. Competencies are meant to increase the likelihood that SA counselors and their superiors are utilizing evidence based strategies that are culturally competent and seek to eliminate the negative aspects of transference and counter transference with clients (http://www.kap.samhsa.gov). The Substance Abuse and Mental Health Services Administration is working with the NASAC to develop competencies curriculum (Standora, 2012).

Current Proposed Changes for California as of 2012

According to California legislative information retrieved from the California State legislature's website, as of January 1, 2014, the state shall issue a Certified Drug and Alcohol Counselor certificate (CADC) within 30 business days to persons who meet the following requirements:

1. The state shall issue a Certified Drug and Alcohol Counselor Certificate (CADC) within 30 business days to any persons who meets the following requirements:

- Completed and submitted an application for certification to a certifying agency
- Submitted and passed state and federal criminal background checks
- Paid the fees required

As of January 1, 2015, the state shall issue a CADC to individuals within 30 business days who meet the following requirements:

2. The state department receives documentation from a certifying agency that states that the individual has met either of the following requirements:

- Completed the education requirements of, passed examination administered by, and completed all other requirements, including work experience requirements of the certifying agency. These educational requirements include a minimum of 315 classroom hours and 160 hours of supervised practicum. The examination administered by the certifying agency shall be psychometrically validated to the appropriate level of education and shall examine the person's knowledge of the materials specified in Section 11999.53.
- Possess an earned associate of arts or associate of science in alcohol and drug counseling, or other equivalent degree recognized by the department from an institute of higher learning and has completed 160 hours of supervised practicum, and passed a test administered by a certifying agency.

3. Completed 2,080 hours of work experience as specified in Section 11999.54, that are within the scope of practice for a counselor. The work experience shall be gained within 6 years of the application for certification.
4. Submitted and passed federal and state background checks.
5. Completed the application for a certificate and satisfied any other requirements of this division for certification as a Certified Alcohol and Drug Counselor (CADC).

6. Paid the fees required (specified in Section 11999.74, http://leginfo.legislature.ca.gov.).

Participants

Participants in this study were eight adult male and eight adult female clients who were receiving services at "Supportive Solutions" (Central Valley, California) residential drug treatment facility during the month of January 2013. The only exclusion criterion for this study was inability to speak and read English and for male clients, those that were in the Residential Multi-Services Program (RMS), were excluded as well per the men's coordinator. The men's coordinator felt that this protocol should be implemented for the safety of the researcher. The (RMS) program consists solely of recent parolees many of which have been convicted of violent crimes some of which were committed against women. Supportive Solutions' residential facility is not a locked facility and does not have armed security. In light of these factors the men's coordinator felt that it was in the best interest of the researcher to limit male participants to that of the Therapeutic Community (TC) program.

About Supportive Solutions

Supportive Solutions is a large community based organization that provides a variety of services to individuals. Supportive Solutions has facilities located in 10 states across the country as well as two locations abroad. This non-profit organization has been in existence for over 30 years and provides services to adult men and women, teens, and their families. Some specific details about this agency have been omitted in order to preserve the privacy of the agency; this includes the agency's name. "Supportive Solutions" is a fictitious name and is not an actual residential drug treatment agency itself.

Supportive Solutions, California residential drug treatment facility (Central Valley),where this study was conducted, provides SA treatment to persons from all walks of life including persons who are on probation and parole, have pending Child Protective Services Cases, and those who just need assistance with their SA issues (i.e. private pay or Medi-Cal clients). There are approximately 200 clients housed at the residential facility at any given time. Many clients also have their children with them. Children 10 years of age or under are able to reside with their mother or father while she or he is completing treatment at the facility.

The model for treatment implemented at Supportive Solutions is recovery and co-occurring based. Clients attend a wide range of classes that cover topics such as relapse prevention, co-occurring education, drug and alcohol education, and sexual education classes to name a few. Clients also participate in SA counseling, feelings group, and have access to onsite mental health services. Clients are expected to follow the guidelines and rules of the program, meet with their SA counselor weekly, and attend 30 or more hours of classes and groups weekly.

Instrument

The instrument used was the "Client Perceptions of Treatment and Substance Abuse Counselors" questionnaire developed by the researcher (see Appendix A). The instrument has not been standardized but is presumed to have face validity.

Methods

An announcement was made on both the male and female side of Supportive Solution's drug treatment facility by reading of the informed consent form. Volunteers were asked to participate in the study and told that they would be

placed in a drawing for a $25 Target gift card. A sign-up sheet was placed outside of the Staff on Duty office (this is where clients can use the phone get medication etc.). Clients signed up for a time slot and the researcher confirmed appointment times by leaving written notice in the Staff on Duty Office. Interviews were conducted in a private room at the facility.

Participants were read the informed consent form (see Appendix B), researcher and participant both signed said form, and participants received their own copy. The researcher then asked the participants to create pseudonyms for themselves to ensure confidentiality. The researcher also urged participants to be honest and made the participants aware that the researcher was an impartial party. Interviews began and participants were asked to state demographic information and to respond to the questions found on the Client Perceptions of Treatment and SA counselors' Questionnaire. All interviews were audio-recorded with permission of the participant.

Potential Benefits

Information gathered from this study has the potential to inform addictions treatment services at micro, mezzo, and macro levels. With regard to the participants' compensation there was none other than the possibility of winning a $25 Target gift card.

Potential Risks

It was assumed that participants were at minimal risk for some psychological disturbance due to engaging in the interviews. We attempted to combat this by informing them that should they feel distressed they would be able to speak to any of the many counselors on duty at the facility. If they did not wish

to speak with any of the counselors the researcher would have made arrangements for them to speak with another professional outside of the facility.

CHAPTER 2: LITERATURE REVIEW

In this section the previous research regarding SA counselors, client perceptions of SA counselors, educational backgrounds of SA counselors, and recovery status of SA counselors will be discussed. In addition the limitations of the previous research, purpose for the current work, and framework and theory that have helped to conceptualize the current study will also be explained.

Much of the research surrounding substance abuse counselor characteristics is largely quantitative, typically focuses on evaluating the SA counselor and the SA counselors' performance and opinions. The research is somewhat sparse when looking at the effects of educational background and recovery status on client treatment (Adams & Warren, 2010; Curtis & Eby, 2010). It is important to examine the effects of educational background and recovery status on client treatment and client perceptions because educational background and recovery status vary greatly among SA counselors and has the potential to affect the client counselor relationship.

Educational Background

Prior research has shown that the educational background for SA counselors can range from a high school diploma, to a 2-year drug treatment certification, to several years postgraduate training. In addition to length of training, educational background for SA counselors also varies in terms of field of study (Knudsen et al., 2006). Some counselors have specific training in SA while others have degrees/training in counseling, criminal justice, psychology, and social work, among other areas (Toriello & Benshoff, 2003). Substance abuse counselor educational background may be an important factor in the treatment of clients as persons with different educational backgrounds will experience different training,

which can influence methods chosen for treatment, ethical training, and even specific training regarding body language positioning when working with clients; all of which has the potential to affect client treatment and recovery (Crabb & Linton, 2007; Knudsen et al., 2006; Toriello & Benshoff, 2003;Toriello & Strohmer, 2004).

However, some prior research has shown that there are no significant differences among SA counselors with different educational backgrounds with regard to clinical duties performed (Knudsen et al., and 2006). Knudsen et al. (2006) found that the only thing that differed significantly between SA counselors that had professional degrees and those that did not was salary; the former having the higher. It is important to note that this research only looked at the length of time persons working in the SA field spent performing clinical duties which were either directly working with a client (SA counseling) or documenting said work. No relationships between educational background and client outcomes were explored.

Toriello and Benshoff (2003) explored a possible relationship between SA counselors' education level and the influence of recovery and education level on ability to recognize ethical dilemmas. An assessment tool was created consisting of 21 items which contained descriptive opposing actions to take regarding fictional clients in fictional ethical dilemmas. Surveys were mailed to more than 400 persons possessing or working toward certification in SA counseling. Of the 227 respondents 57% had a master's degree or higher, 23% had a bachelor's degree, 19% had an associate's degree and/or high school diploma, and 5 % had no professional degree or certification. Over half of respondents (67%) asserted they were not recovering addicts. Data collected from the surveys were analyzed via ANOVAs.

Results showed that persons with no more than an associate's degree were significantly more sensitive to ethical dilemmas presented in the assessment tool than participants with higher degrees. This means that those SA counselors with associate's degrees were more adept at identifying ethical dilemmas than their counter parts which had higher levels of education. One possible explanation offered for this is that those with an AA degree likely had said AA degree in drug and alcohol counseling and this specific training may focus more on the issue of ethics within the field of SA. Therefore those individuals with specialized (but not necessarily university level training) were able to more readily recognize ethical dilemmas relative to the SA field. There was no main effect for recovery status.

Another study examined the frequency of informal discussions unrelated to client treatment and recovery status and training of SA counselors (Martino, Ball, Nich, Frankforter, & Carroll, 2009). Prior research has shown that personal self-disclosures on the part of SA counselors that are unrelated to client treatment can be damaging to the client counselor relationship (McDaniel et al., 2007). Substance abuse counselors from various educational backgrounds were sought for participation from California, Connecticut, Oregon, Pennsylvania, and Maryland. SA counselors were observed in several stages of treatment with clients in order to establish a baseline of rates of informal discussions. Next SA counselors were assigned to receive training in Motivational Interviewing (MI) or left to "counsel as usual."

Motivational interviewing; which replaces the former "confrontational approach" to working with clients in addictions treatment involves getting the client to see that his or her SA has become a problem in their lives without directly telling them why this is true. For example a SA counselor operating from a MI framework might say something to a client like, "how does your SA benefit you?"

They then might follow up with the question "how does it negatively affect your life?" A confrontational SA counselor would *tell* the client how their SA affecting their life negatively and if the client did not agree they may accuse the client of being in denial.

Sessions with clients were audio-recorded and rated by 15 independent raters. The raters examined informal speech, and adherence to MI training objectives, such as the use of reflective statements versus direct confrontation, change in client motivation, therapeutic alliance, and counselor treatment orientation and recovery status. A total of 76 participants completed the study. Half of SA counselors reported being in recovery themselves. Results from this study indicated that SA counselors who were trained in MI talked informally significantly less than those who "counseled as usual." There was no effect for SA counselors' recovery status on rate of informal conversation (although it should be noted that SA counselors' self-disclosure regarding their own SA history was not considered informal because it could be perceived relevant to treatment). Unfortunately, specific educational background (such as associate's degree versus master's degree) as a factor in rate of informal conversation was not examined.

Recovery Status

In addition to educational background of SA counselor another interesting characteristic which may play a role in effective client treatment and which varies among SA counselors is the recovery status of the SA counselor. Prior research has found that rates of SA counselors who are in recovery themselves range from 37% (McNulty et al., 2007) to 57% (Knudsen et al., 2006). Interestingly, SA counselors who are in recovery are reported to be less likely to have professional training /graduate degrees (Culbreth, 2000; Hecksher, 2007).

Curtis and Eby (2010) speak to the value that can be added to treatment being provided by a SA counselor who is in recovery. They connect social identity theory with the potentially positive effects that recovering SA counselors can have; it may be possible that clients can more readily identify with former substance abusers (or fellow addicts) and make the connection that they too can stop using and become a productive member of society. Instead of exploring the effects of recovery status on client relationships Curtis and Eby examined the relationship between SA counselors' recovery status and professional and organizational commitment. While Curtis and Eby hypothesized those SA counselors who were in recovery would score higher than those who were not on the modified Meyer's six-item measure of professional and organizational commitment, this was only significantly true for professional commitment.

Another quantitative study explored the possible impact of the interaction between SA counselor credibility, interactional style, recovery status, and non-verbal behavior (Toriello & Strohmer, 2004). Toriello and Strohmer argue that because 50-60% of individuals who began SA treatment do not complete it. The credibility of SA counselors is crucial in increasing their ability to influence clients' engagement in treatment. Social influence research has proclaimed that the degree to which clients perceive their counselors as credible greatly influences the capacity to which counselors (in general) can produce change in their clients (Guinee & Tracey, 1997). Several prior studies have determined that non-verbal behaviors such as eye contact, hand gestures, and body leaning have consistently been connected in increased perceptions of counselor credibility (Heppner & Claiborn, 1988; Leierer, Strohmer, Kern, Clemons-Guidry, Roberts, & Curry, 1998; Strohmer, Cochcran, & Arokiasamy, 1996). It should be noted however that the counselors in this research were not SA counselors.

In addition, Toriello and Strohmer also point out that there is conflicting research on the effects of SA counselor recovery status and perceptions of the SA counselor with English (1987) finding that clients perceived SA counselors in recovery as more expert (proficient in the profession), attractive (likeable), and trustworthy(dependable/faithful); while Creegan (1984) found no such effect. In Toriello and Strohmer's study participants were 116 persons receiving SA counseling at one of three residential programs in New Orleans. Clients watched videos of counselors working with clients and read a background history about the counselor they were going to view. They then watched the video and rated the counselors' credibility using the "Counselor Rating Form-Short" (CRF-S; Corrigan & Schmidt, 1983). There were at least 10 participants assigned to the various counselor backgrounds and intervention styles. Results indicated that SA counselors who exhibited facilitative non-verbal behavior were rated as more attractive than those who only exhibited neutral non-verbal behavior. Attractiveness and trustworthiness were factors that accounted for nearly 32% of the variance in participants' ratings of their willingness to work with the SA counselor depicted in the videos. Recovering SA counselors were not rated significantly differently in terms of credibility.

Another related study involved the roles performed by peer educators during outreach among heroin addicts in India (Dhand, 2006). This qualitative study explored the duties and perceptions of peer educators roles and characteristics which were self- reported as well as inquired about via the clients served. An issue presented unique to this study was that some of the peer educators were still using heroin while performing outreach duties. Outreach services were performed by SHARAN a non-governmental organization located in Yamuna Bazaar, New Delhi (Dhand, 2006). Role theory (Goffman, 1959) was

used in construction of this study; in short, role theory presumes that people are members of social positions and because of this they hold certain expectations of their behavior and the behavior of others.

The researcher in this study observed fieldwork of peer educators over the span of 7 months. Semi-structured interviews were also conducted with peer educators and clients. A total of eight peer educators were consistently observed by the researcher in this study; all of which were active or former users except one. Common themes among clients regarding peer educators and their perceptions were the following; "Peer educators are just doing their duty, and they do drugs in hiding," Some clients also felt that peer educators should, "be an ex-user from the area, but not currently using. They should be a clean, well groomed with a bag and a copy (notebook)." One thing that both peer educators and clients agreed on was that peer educators should not look or act like clients.

Relapse or abuse of substances on the part of a SA counselor is a real concern for those SA counselors in recovery and the clients they serve. In a "point of view" article by Adams and Warren (2010), the researchers share their experiences in working in the substance abuse field. They provide narratives that relate to the actual experiences they had while working with SA counselors that were in recovery over the course of 20 years (neither of them were in recovery themselves). The narrative examples they used depicted well-trained and successful counselors whom were in recovery and eventually relapsed. The relapse caused staff to become polarized and angered clients who now questioned the credibility of the program. Adams and Warren also cite the issue of a lack of research conducted on the effects of treatment being provided by SA counselors who are in recovery.

Limitations of Current Research

It is clear from examining prior research that there is a gap regarding client perspectives on SA counselor recovery status and educational background, qualitative approaches regarding client perceptions of SA counselors and the aforementioned characteristics, and relationship between SA counselors' characteristics and treatment outcomes for clients. While the quantitative studies mentioned are valuable in that most have large diverse samples and rigorous evaluation methods as well as standardized tools of measurement, they typically do not focus on the perceptions of clients but rather comprise the participant pool of SA counselors themselves and/or often employ evaluation of SA counselor characteristics by researchers who are not in recovery.

Interestingly, these same studies often refer to the SA counselors' characteristics as potentially having a direct effect on the relationship with clients and in turn assert that relationship has the potential to affect client recovery and outcomes of treatment (Adams & Warren, 2010; Martino et al., 2009; Toriello & Benshoff, 2003). In addition, no research was discovered that specifically examined the relationships between the recovery status and educational background of SA counselors and their clients' preferences or outcomes.

The two qualitative articles found relating to the presented topic supported the assertion that there is a lack of research in this area and that, as stated previously this is an important topic to explore because of the potential it has to effect client treatment. The study conducted in India contains interviews with clients regarding valued SA counselor characteristics but appears limited in that the interviews were unstructured and did not focus specifically on SA counselor recovery status and educational background (Dhand, 2006). A valuable piece of information gained via this study was the concept that clients preferred peer

educators to be former but not current users and that peer educators should not "look or act like clients." This seems to imply that the clients desire a certain standard of professionalism on the part of SA counselors. This study focused on heroin users and was conducted in India, which also affects the ability to generalize findings to other populations abusing different substances.

Adams and Warren (2010) echo the need for more research on SA counselors who are in recovery and they present interesting narratives about the dangers of relapse of SA counselors who are in recovery themselves. Again, the issue with this study is that it does not inquire directly to clients about their experiences and preferences. Another weakness is that the authors who are not in recovery themselves are merely discussing their experiences in working with recovering SA counselors, which could be biased and/or inaccurate.

Grounded Theory

The current study hopes to address the gaps in prior research by imploring a qualitative grounded theory approach focused on characteristics clients' value in SA counselors with emphasis on educational background and recovery status. Grounded theory is typically utilized when there is a lack of research on a given topic (Creswell, 2007).

Social Identity Theory

Based on the theory of social identity it seems likely that clients will value "recovering" SA counselors. The term social identity refers to an individual's sense of self in a social context which is derived from the activities they engage in, the type of language that they use, and the people that they associate with and often seek to emulate. Social identity is formed through the actions and behaviors of an individual and how the surrounding world views; and often labels that

person based on those sets of behaviors and actions (Tajfel, 1982). Often the labels that society places on individuals that fit into certain categories seek to reinforce the very behavior that has caused that individual to receive said label.

This occurs often for positive labels but can occur for negative labels as well (e.g., counter culture). Also, individuals sharing a social identity will look to each other to mirror the behaviors that they see as fitting with that identity. Being labeled as a "drug addict" is a type of social identity. Many people working in the SA field will say that one can, "recover," from addiction but one will always be an addict. Based on these notions it may be likely that if an addict can view another addict who is exhibiting more positive lifestyle choices and behaviors that one's own definition of what it means to be an addict will be expanded and therefore their own identity could have the potential to be expanded and/or altered.

Social Identity theory also has a lot to do with groups. Individuals typically prefer their group (what is referred to as an "in group") to the outside group (or "out group") (MacKinnon & Heise, 2010; Tajfel, 1982). Addicts can also be thought of as a group that has shared experiences, language, customs, and values. Based on this, it is likely that clients may perceive other addicts, client peers and SA counselors whom are in recovery as their "in group" and prefer working with them as opposed to non-recovering SA counselors who would be considered an "out group." It is also likely that some education will be desired on the part of the SA counselors as prior research has indicated that clients value professionalism (Stets & Burke, 2000).

Perspectives in Social Work

The client centered approach in contemporary social work practice also makes the case for a need to involve clients in their own treatment and assessment

of treatment program. One way to involve them may be to find out what they feel are important characteristics in SA counselors and in SA treatment in general. The choice to interview clients who are in in residential treatment was based on the notion that many of those clients have been through treatment numerous times and will have likely encountered many different SA counselors and types of treatment programs. While it is true that they have not been able to maintain sobriety, they may have knowledge at the very least, about what has not worked for them. It was also hoped that by working with a contained sample a higher rate of retention will occur. In addition, the location of the proposed study is also strength. Supportive Solutions' California, (Central Valley) residential drug treatment facility is located in one of the most culturally and ethnically diverse regions in the US and treats persons from all SA backgrounds, (alcohol to heroin).

CHAPTER 3: METHODOLOGY

This section will focus on the methodology of the current study and how the theory of social identity and framework of grounded theory have informed the methods chosen. The details regarding participants and data collection will also be explained here.

Grounded Theory

Grounded theory is an approach used in qualitative research when there has been little work generated on the topic to be explored. The purpose of grounded theory is to "generate" or "discover," a theory according to Strauss and Corbin (Creswell, 2007). Grounded theory was developed in 1967 by two sociologists Glaser and Strauss who asserted that theories should be grounded in data from the field, especially in areas concerned with interactions and social processes of people (Creswell, 2007). Appropriate uses of grounded theory include gathering data from people who have all experienced a specific type of social process, in this case SA treatment, including SA counseling.

The grounded theory framework does not include creating a hypothesis or making specific predictions about what would be discovered in the data, but rather lets the data serve to create a theory about the area studied (Dey, 1999). Charmaz (as cited in Dey, 1999) developed a constructivist grounded theory. This approach focuses on social situations and allowed for more reflexivity on the part of the researcher. Constructivist grounded theory also places the role of the researcher as an equal participant rather than an "all knowing analyst," (Creswell, 2007). This approach differed from that of Glaser and Strauss in that as the data were being collected Charmaz would allow for changes in that process to occur while it was taking place, while Glaser and Strauss did not (Dey, 1999). To illustrate this

Charmaz might notice while conducting interviews with participants that many of them seem to come from military backgrounds even though she did not include questioning about this phenomenon she may choose to ask questions about it as she discovered it may have some relevance.

Once data have been collected the researcher begins the process of "open coding." Open coding refers to the construction of major categories within the data. While Strauss & Glaser would then select one core phenomenon from the major categories to focus on and develop a theory from, Charmaz places more emphasis on views, values, beliefs, feelings, assumptions and ideologies of individuals (Creswell, 2007). Charmaz would develop catergories, themes, and sub-themes and attempt to make connections between them. Charmaz's approach also places emphasis on gathering rich data, carefully coding said data, and not minimizing the role of the researcher. Charmaz suggests that the researcher should make decisions about the process and categories throughout the research process, bring questions to the data and advance personal values, experiences, and priorities (Creswell, 2007). For purposes of this study Charmaz's constructivist approach to grounded theory was implemented. It is important to note that Charmaz acknowledges that any conclusions developed by grounded theorists are "suggestive, incomplete, and inconclusive," (Creswell, 2007).

Participants

Participants in this study were eight adult male and eight adult female clients ages 20 to 53, who were receiving services at Supportive Solutions, Central Valley residential drug treatment facility during January 2013. There were originally nine female clients signed up to participate but one potential participant did not show up for her scheduled interview and was out of the facility; therefore

she was dropped from the study. Seven of the participants identified as White, four African American, two Native American, and two as Hispanic. Participants in residential drug treatment were sought for the following reasons; 1) They are currently receiving treatment so their experiences were fresh in their minds, 2) little research has examined perceptions of treatment and SA counselors on the part of the client, 3) persons receiving services in a residential setting have serious addiction problems and are likely to have been in treatment before; therefore they have likely had many experiences with different SA counselors and treatment programs, and 4) clients in a residential program are easily located and therefore less likely to drop from the study.

The only exclusion criteria for this study were inability to speak and read English and for male participants, those in the Residential Multi-Services program (RMS) were excluded as well. The men's coordinator felt that this protocol needed to be implemented to protect the safety of the researcher. Clients in the (RMS) program are recent parolees many of which have committed violent offenses some of which have been against women. All female clients were in the Women to Women program (which is equivalent to the men's Therapeutic Community program) with the exception of one client who was in the Mella program. The Therapeutic Community and Women to Women program are 30 to 90 day programs and clients in these programs get services paid for under various contracts such as Child Protective Services; or they may also be private pay clients. The Mella program is for pregnant or parenting women and they can stay at the facility with their children for up to 6 months. The RMS program is for recently paroled clients many of which are participating in work release programs and stay at the facility for 6 months to 1 year.

Instrument

The instrument used was the Client Perceptions of Treatment and Substance Abuse Counselors questionnaire which was developed by the researcher, (see Appendix A). Approval of the study and questionnaire was received by the Department of Social Work Education, the Committee for the Protection of Human Subjects at California State University, Fresno, and Supportive Solutions. The instrument's development was based on prior research and a gap in knowledge about what clients perceive to be valuable characteristics in substance abuse counselors and treatment in general; and whether or not educational background and recovery status are of importance to individuals in recovery.

The questions were developed simply because no prior research was discovered in which clients in SA treatment were asked directly about SA counselor educational background and recovery status, SA counselor characteristics in general, or valued characteristics of treatment. When developing the questions the researcher did so in a way to attempt to keep the identity of both the participants as well as that of the SA counselors concealed. This was done in an effort to protect the SA counselor-client relationship as well as ensure honest responses. It was believed by the researcher that if participants could be assured that their responses would not be identified by the SA counselors then they would feel more comfortable in sharing both positive and negative details regarding SA counselors and treatment. The instrument has not been standardized and thus findings cannot be generalized to other populations. The instrument is presumed to have face validity. It was estimated that interviews conducted using this instrument would take approximately 30 to 45 minutes to complete.

Procedure

An announcement (reading of the informed consent form) was made on both the male and female side of Supportive Solutions' drug treatment facility asking for volunteers to participate in the study. For the female prospective participants the announcement was made before a drug and alcohol class commenced. For male prospective participants the announcement was made after a group therapy session had ended. The decision to solicit potential participants in this fashion was determined by the coordinators of each side of the facility. After both male and female clients had been informed about the study they were told that should they choose to participate they would be entered to win a $25 target gift card; they were advised that two gift cards would be awarded one for male participants and one for female participants. Sign-up sheets were placed outside the "Staff on Duty Office," on both the male and female sides of the facility. (This is where clients go to receive their medication, make phone calls, and pick up paper work or other things that they need while in the program).

Fourteen volunteers were sought and potential participants were told that if more volunteers came forward than the 14 sought all names would be taken by the researcher and drawn at random. The researcher removed the sign-up sheets approximately an hour after posting to avoid having to exclude potential participants. A total of 17 participants signed up for the study and because this number was very close to the 14 sought the researcher allowed all to participate in anticipation that some participants may drop from the study. Appointments for interviews were confirmed with the clients via written notice from the researcher which was left with the "Staff on Duty," in the Staff on Duty Office. Interviews were conducted at the facility in a private room. Participants were read the informed consent form, informed about the possible length of interview, (30-45

minutes), asked for permission to audio-record, if they had any questions, and to sign the consent form. They were also given a copy of the informed consent to keep, (see Appendix B).

Prospective participants were informed that audio-recording was a requirement for participation and if they chose not to be audio-recorded they would have been thanked for their time and interest and informed that there would be no penalty for choosing not to participate. All participants agreed to audio-recording. After agreeing to the audio-recording they were then asked to create a pseudonym for themselves. The researcher hoped that by asking the participants to choose their own name they would feel as though they were an equal participant in the research, (which is consistent with the constructivist grounded theory framework) and that they would also be assured that their anonymity was being protected. The researcher made it clear that anything they said would be anonymous, that it would not impact their treatment, and that the researcher was an impartial party who wanted them to be as honest as possible.

Commencement of the interviews and recording then began. Participants were first asked to state their age, ethnicity/race, number of times in substance abuse treatment (including both residential and out-patient), and drug of choice. After responding to those questions they were then asked to answer the questions from the Client Perceptions of Treatment and Substance Abuse Counselors Questionnaire (see Appendix A). Participants were asked to consider all SA counselors and all programs of treatment that they had been involved with. The questions from the questionnaire were read aloud by the researcher in an interview style format. Some additional questions were added to certain interviews as they related specifically to those clients' experiences. This was determined while the interviews were progressing and participants were sharing their experiences.

Keeping the constructivist grounded theory approach in mind the researcher maintained flexibility and allowed participants to share what they felt was important for interested parties involved in SA treatment to know. When participants gave short or cursory responses to the questions the researcher asked additional open-ended questions; and if it appeared the participant did not understand the question the researcher posed it a differently until it appeared from the participants' response that they understood and the participant stated that they understood . This allowed for collection of rich data, which although not generalizable has the potential to inform future work in this area.

After all interviews had been completed the names of all participants were written on equal size papers and placed inside a small box. An intern who was uninvolved with the study was asked to draw two names, (one male and one female). Participants were informed by the researcher that they had won on January 28, 2013. Participants were informed that the gift card would be held under their name in the Staff on Duty Office per the men's coordinator.

Potential Benefits

At the mezzo/macro level some implications for practice may surface evidence is found to support better outcomes for clients receiving clinical support from persons in recovery; especially if this is true for those with advanced degrees. Looking at traits valued by clients in conjunction with positive outcomes for clients would be the next logical step. It is possible that if the previous were true then we may be able to rationalize garnering funding to support former addicts receiving 4 or more years of education in the field of substance abuse. Prior research has found that recovering SA counselors tended to have less education than their non-recovering peers (Curtis & Eby, 2010). At the micro level, by

involving clients in helping to evaluate the traits of effective substance abuse counselors we are empowering them and using evidence based practice to guide us in providing the best and most effective means of care for those struggling with addiction. With regard to the client's compensation there was none other than the possibility of winning a $25 Target gift card.

Potential Risks

It is assumed that participants were at minimal risk for some psychological disturbance from engaging in the interviews. We attempted to combat this by informing them that should they feel distressed they would able to speak to any of the many counselors on duty at the facility. This was explained both verbally as well as written in the informed consent which they signed. Had any distressed participant not wished to speak with any of the counselors arrangements would have been made for them to speak with another professional either through County Behavioral Health or via the Fresno State Marriage and Family Therapy Center. None of the participants expressed disturbance nor did they request to see a mental health professional. Anonymity of participants and counselors were protected by the use of pseudonyms in the interviews and completed thesis. The recordings and consent forms will be destroyed within a year of completion of the study. Only the researcher will have access to the recordings (they will be kept on password protected computer) and consent forms (they will be kept in locked filing cabinet). Where quotes are used language style or other identifying information was altered or eliminated in the interest of preserving anonymity.

CHAPTER 4: RESULTS

This chapter will focus on the results from the analysis of the 16 completed interviews. Interviews were sent to Verbal Ink to be transcribed (all identifying participant information had been removed). Interviews were read and re-read to identify themes in a process called open coding. Once themes emerged they were then broken down further into smaller categories in the process of axial coding. These procedures were conducted under the previously mentioned framework of grounded theory. After full saturation of the data (exhaustion of reading and re-reading transcriptions to fully populate themes) had been reached the following major components emerged; characteristics of SA counselors which were further broken down into valued personality characteristics, negative personality characteristics, valued life experiences, recovery status, and education. Characteristics of treatment were also examined by looking at positive characteristics in general, unexpected findings related to treatment and negative aspects of treatment in general. Positive and negative characteristics of treatment specific to Supportive Solutions, Central Valley residential treatment were also explored; this was further broken down into male and female sides of the facility which the research will show differ greatly. Figure 1 illustrates the aforementioned categories and themes discovered.

It was the intent of the researcher to gain insight into the characteristics that clients receiving SA treatment desire in SA counselors and in treatment in general. The approach of constructivist grounded theory was implemented in light of the fact that little research had been conducted in this area and in this fashion. Educational background and recovery status were two main areas of focus regarding SA counselor characteristics because of the variance within the field and

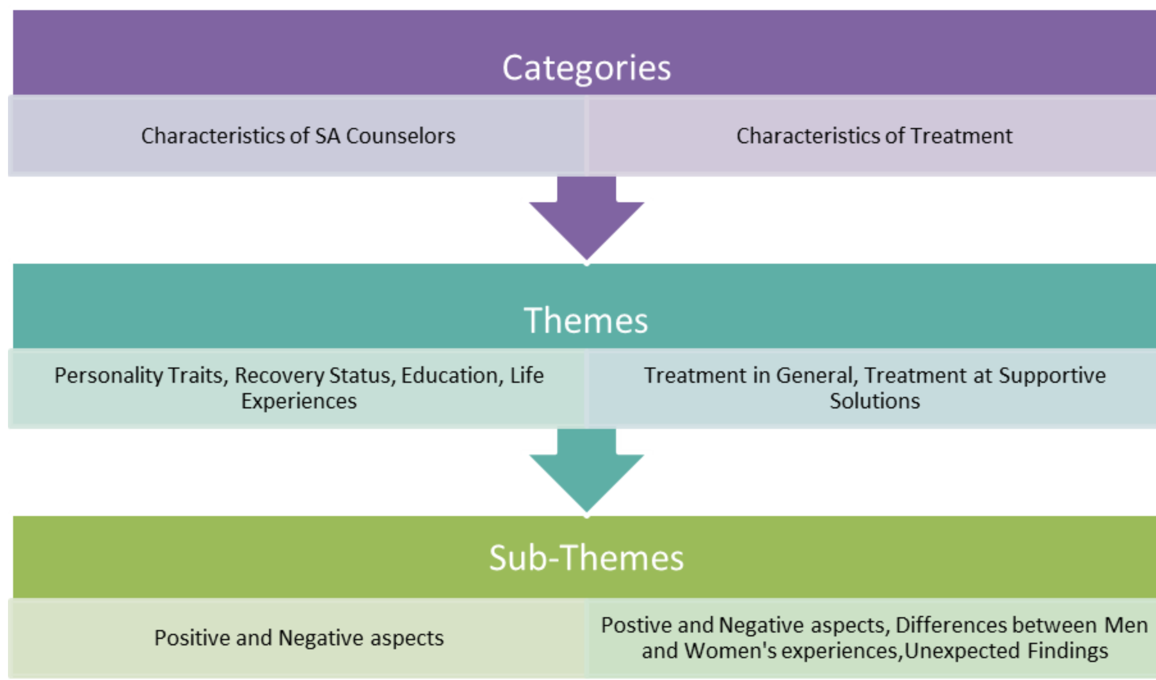

Figure 1. Categories, themes, and sub-themes

the likelihood that these factors can potentially influence client treatment. When asked if they thought that having a formal education was important for a SA counselor to possess 12 of the 16 participants stated that they felt it was very important. Ten of the 16 participants felt that a SA counselor being in recovery themselves makes them a more effective SA counselor. In addition, when asked what makes a SA counselor more effective or what makes someone a good SA counselor, having their own experience with drugs and/or alcohol and sharing those experiences with their clients were among the most frequently mentioned valued characteristics.

No specific areas of focus were identified regarding treatment in general or for treatment at Supportive Solutions; however interesting data on this topic were gathered and could potentially be used to inform the development of new studies. This will be explained later in the chapter. First we will begin with demographic information of clients and then proceed to SA counselor characteristics.

Demographic Information of Participants

Participants were eight male and eight female clients (N= 16), receiving treatment at Supportive Solutions' residential facility. Seventeen had originally signed up; one participant was dropped because they did not show up for the interview. The participants ranged in age from 20 to 53 years. The average age of participants was 33 years. Seven of the participants were White, two Native American, four African American, and three were Hispanic. Six of the participants stated their drug of choice to be methamphetamine, three stated alcohol, six were poly- substance abusers, and one stated their drug of choice to be marijuana and gambling. Only three participants had never previously been in SA treatment. The range of number of times in treatment was once to 12 previous occasions. The mode for number of times in treatment was two times prior to currently being in treatment, or a total of three times. Interviews ranged in length from 8.27 minutes to 52.20 minutes. The average length of an interview was 18.16 minutes.

Characteristics of SA Counselors

Valued Personality Characteristics

Many characteristics were mentioned as being valuable and aiding an individual in being a good or effective SA counselor. Among the top three in order from most mentioned were having their own experience with drugs and alcohol, being caring, and being honest. Other characteristics frequently mentioned were listening to clients, making time for clients, being respectful, sharing their own experiences, being genuine, treating people as individuals, having empathy, advocating for clients, and "calling them out" or challenging clients.

Participant "Heidi" stated the following about what makes someone a good/effective SA counselor:

> "I had a really good counselor in Tahoe… She was – she is an alcoholic, but she, um, had been through just many life experiences. Plus she was stern. I think counselors very much need to not take no crap from anybody 'cause I'll tell you what, being an addict, we can con you faster than anybody…but yeah, she was a very, very good counselor. And, um, I don't know. They just gotta have it in 'em."

Like many of the other participants Heidi seemed to value someone who had experience with drugs and/or alcohol, shared those experiences, and was caring but also challenged her. Heidi also seems to be alluding to having passion or drive regarding their work when she says, "they just gotta have it in them." Another participant "Chris" stated:

> "And, uh, my counselor, he's a good man… He help me if I got any problems or something. He help me. He looked out for me by going to court, and I-I thanking my life for that, and I mean I'm still here, so."
>
> "So I get, I get help in here."
>
> ".. if I can't do it, like I went to my,.. counselor now. It's like, well, uh I said I be having a-a problem, uh, like the little homework, like reading time. And he was like, "Well, do the best you can, and if you can't, I-I'll help you, or you can get some help out there." And, uh, that's what I did I went out there and got some help, and I went to my counselor, and I was like, "I did the best I can," and he just showed me like respect me, and it was like, "Oh, okay. Well, at least you showed me that you did something."

Chris' comment illustrates how much clients in residential drug treatment value a SA counselor who advocates for them. By actually going to court in support of his client this counselor showed how much he cared and was able to keep that client in treatment and out of jail. Chris also shows how important it is

for SA counselors to treat people as individuals. Homework is a requirement of the program at Supportive Solutions, but Chris being functionally illiterate had a difficult time. At another facility Chris asked for help with his assignments and was refused and terminated because he could not complete the homework assignments on his own. He has now found a counselor who is willing to work with him and take into consideration Chris' unique situation. Participant "Clark" gave the following analogy regarding what makes someone an effective SA counselor:

> "…it's not your-your education and your addiction and your who you are, it's a whole range of things, your-your background, your – the – everything, everything about you. If you can combine who you are with the education and with the-the suffering that goes on and, uh, the powerful feeling you have once you get into recovery and have stayed in recovery for a while, it's like you have to nail those things in to get a counselor. You don't just get a counselor – Like, we develop a drug addiction, … counselor is not just made. It's not just stamped up and pressed to the line."
> "This is you have to have a whole bunch of – it's like making a – if – making a meal or making a cake or making a – there are steps, and you have to have certain ingredients, and they have to be combined in certain ways, at certain times at certain temperatures – that's – you don't just get a counselor. These-these people aren't just generated."

One of the few participants to mention education on their own, Clark demonstrates the need to have a counselor, who has experienced addiction, also has some education and has been successful at maintaining sobriety.

"Simone" echoes the desire for not only having a SA counselor who has had a history with SA, but also to have a SA counselor who shares their experiences:

> "Um, what I like about some of the substance abuse counselors is that they have their own stories to tell. They have they come from partly the same backgrounds, so they understand the emotions and feelings that we, as addicts, are going through."

Heidi also states a need for SA counselors to share their stories:

> "… we got a couple counselors here that are really good. But they're strong women in recovery, and they are very passionate about the recovery, and they have done it on their own. And, you know, that – that really – that's one of the big things that gives me chills."
>
> "'…we just had a lady talk – one of our counselors talk last night about her story. And I really do think also to make a good counselor is that they do need to share their story with us because then we respect them. We respect what they've gone through, and that we see that they're standing on their own two feet and they're doing it. They're doing it step by step. But we need to know that 'cause, guess what, we can't read their minds."

Heidi later expressed during her interview that she did not really care for one of the counselors until she shared her story and the ongoing struggles that comprise it. It appears that clients feel more empathy and respect for their counselors when they realize that they have, been in similar circumstances.

Negative Personality Characteristics of SA Counselors

Next the negative characteristics of SA counselors were explored. Not making time for the client was one of the most common complaints among those

interviewed. In addition, lacking or having the opposite traits that were listed as being positive; for example being dishonest or having a lack of passion were also viewed negatively. Clients also listed the following as being negative characteristics of SA counselors; expecting a client's recovery to be the same as their own, and when a SA counselor who is in recovery relapses or continues to use.

"Sarah" had this to say regarding making time and being honest:

> "I like honest and open people, you know what I mean? I don't like someone to sit there and lie to me. At the same time, I'm not gonna sit there and lie to another person, but you know what I mean, with my counselors, she's always telling me, "Come back, come back." I would like her to just be honest, like, "I don't got time right now," rather than giving me the runaround."

For Sarah it appears that she was much more bothered by his counselor not being straight with her than not having the time to spend with her.

"Simone" had this to say:

> "..what I dislike is when someone who – I understand that they have college education about substance abuse, but if they haven't really put their selves in this or been in the situation their selves, then it like, kinda bugs me when they like, teach class and then they – they're trying to explain how we should feel about it and it's like, you don't even – they don't even know."

It appears that having experience with drugs and alcohol abuse is often crucial for making a connection with many of the clients that were interviewed. Having that experience is not always a positive thing for some clients; as Tom, David and Bonnie will illustrate:

"Tom" shares his experience:

"Uh, I've had a counselor in another program before that actually went out and used and that kind of – and I – and I was – I had knew him for six months from counseling, from him being a counselor at the – at the program and that kind of, I don't know. It made me set back and I got kinda in relapse mode and I went to drink a little after, because I – I – I liked the counselor there and when he had whatever was going on, I ended up being hurt by it or whatever."

David had a similar experience:

"Well, the first one, the one … was a Christian based program, but the guy was a hypocrite. He tried to preach about how doing drugs is bad and doing this was bad, and we're all going to hell in God's eyes and stuff like that. And the whole thing was is that he was using pills too. He was popping painkillers, and he didn't have a prescription or anything like that. He was getting high. And he tried to sound like he was all high and mighty and that God kept him clean and stuff, and he wasn't really clean. He was lying to himself. I wasn't able to stay clean. I was like – I was – I lost too much after the program. I never picked up meth again because of the stories he would tell me about what meth did. But all I did was switch substances and I went to pills."

In both cases Tom and David experienced having a SA counselor who relapsed. Both stated that it was a disappointment which shook their faith in the concept of recovery. Interestingly, both admitted relapsing shortly after their counselors did (or after they became aware that their counselors did), and David actually ended up switching to the same substance of abuse as his counselor (pills). David was asked if he felt like his choice to use pills was related to the

incident with his former SA counselor. David said that he felt in part that it was, (at the time this occurred he was only 18 years-old). David felt that his relapse was mostly due to his own choices but acknowledges that the experience with his counselor likely played a role in his relapse.

"Bonnie" had an interesting example of a SA counselor not advocating for her clients and expecting the client's recovery to mirror her own:

> "… when you get the tough love one who's been on crack cocaine for 35 years, and she's – just doesn't have any tolerance for anything, and she's probably just like, "It is what it is, and that's what it is. Deal with it. Toughen up." And it's like, "Okee dokee." So she didn't really like how much – even though she's been there for 35 years and then she's – like, she lost her kids, so her relating to me losing my kids was, "Oh, well. I lost my son for this many years and didn't get to see him, so get used to it." So it kind of had a negative effect on – she didn't really care if I got my kids back because she had lost her son for so many years to the point where he was an adult and he didn't want to talk to her. So she wasn't proactive in me getting my kids back."
>
> "So I feel like that might have been kind of like a personal grudge she held from her life and carried it over to her work, which is going to negatively impact everyone that she has with a CPS case because, I mean the goal is to get better and get your kids home –
>
> – because no one is going to care about them like you."

Bonnie's example shows just how serious the effects of a SA counselor's own experiences can have on the treatment and success of their clients. In talking with Bonnie further she explained that when you have a Child Protective Services (CPS) case that there are certain things that you are required to do in order to get

visitation with your children and to get custody returned to you. Bonnie went on to explain that while in rehab you are often still required to attend classes that CPS provides or connects you with. Another issue that Bonnie had was that some SA counselors did not want her leaving the residential facility, but by keeping her there and not allowing her to leave and attend classes required by CPS they may be putting her at risk for losing her children on a permanent basis. Child Protective Services set limits on the amount of time that a parent has to complete the requirements to regain custody; often this time period is only 6 to 18 months.

"Katie" resented the label of addict and felt stigmatized by it:

> "…lack of communication skills. Here, it's lack of communication skills. Poor judgment and more or less of the stigma… by being labeled as an addict or a – a mental health patient, you know? And I don't like to be labeled as an addict and I don't want others to label me as well because it's not right, you know? I'm here in recovery to get help and not to, uh, have judgment passed up on me. There is and has been some bias issues, uh, between staff and clients. I've been one of them and you know, I'm the type of person. I look at that person heart and see that if the heart is good, then the whole body is good, and as long as someone is trying to reach out for help, regardless of how many times they've used, how many times they've relapsed or backslid, then there should be some resources available to us other than just being locked up in a jail setting.

Katie did not like to feel stigmatized and she felt that people were often cast out to quickly for using drugs. She later said that she felt more should be done to prevent drugs coming into the facility such as more through searches of the clients just coming into the program or for those just returning from a social pass. Katie felt that if drugs were found then the SA counselors should work with the clients

rather than just kicking them out, because they have a problem; she seemed to exude a "relapse is part of recovery attitude."

"Jeff" took issue with counselors who lacked life experience and were forgetful. Here he shares some of those experiences:

> "…what I dislike about the substance abuse counselors is that some of them just don't have real life experiences so they can't truly relate. It's like when you're calling about your, your DVD player to a company and they're flipping through a book trying to give you the, an answer, and they tell you this and you're like "no, no, no, no," you know what I mean? That's not right, you know? "Oh, oh, hold on. I'm sorry." Flip, flip, flip, flip, and it, it's not real. We're people. We have real lives and families … not everything can be taken out of a book."
>
> "You've got to have some sort of, in my personal opinion, a knowledge of reality is different than the knowledge you get from a book because not everything applies to everyone. I don't care, it doesn't, you know. There is a lot that I've learned from them about myself, from textbook, but there's all kinds of unexplainable stuff. There's all kinds of stuff that we just can't figure out, you know, and ah, or how to combat certain situations."
>
> "… my immediate counselor, he's a textbook counselor but his partner counselor is a real life counselor who's been an addict and stuff, so when I can't get it from the one, I have to get it from the other counselor, and, and I try not to hurt his feelings, you know, and vice versa. Sometimes I don't want to hear the real life stuff. I want to hear the textbook stuff because that's what, that's what I need is the textbook, the textbook stuff because I'm experiencing a textbook situation or symptom or whatever you want to call it."

> "… another thing is, ah, they get really forgetful. They're forgetful because they have so many people and so much stuff, and, and sometimes I've had to like literally jog their memory to get what I'm entitled to already, I'm supposed to. I'm entitled to something specific,… and I couldn't think of how to jog the memory of my counselor so I had to go above his head, and it took two good sittings and talking to, and then I jogged the memory of the coordinator, you know, which he's a substance abuse counselor also, you know."

Jeff's point about being forgetful bolsters the notion that having high caseloads can negatively impact client treatment. Also interesting, the fact that he feels that sometimes he wants a "text book" counselor while other times he needs someone with "real life experience." This seems to support the notion that the ideal SA counselor would have both life experience and education. In this case Jeff's " text book" counselor has a BA in social work and certification in drug and alcohol counseling, while the "real life" counselor has certification in drug and alcohol counseling.

Valued Life Experiences

Many of the participants interviewed stated that being in recovery and sharing one's own experiences with substance abuse; especially when the SA counselor has abused the same substance as the client or has experienced similar negative consequences from their addiction is very much appreciated on the part of the client. Negative consequences from substance abuse may include the following; losing children to CPS, spending time in jail or prison, and being homeless to name a few. Even though participants highly valued having a counselor who was in recovery themselves most asserted that they would prefer

the SA counselor to have at least 5 or more years of "clean time,"(sobriety). Most also preferred a SA counselor who had several years of experience in the field, and had at least 2 years of education, especially regarding drug and alcohol abuse. Several participants also stated that they felt it was important for SA counselors to have a background in psychology and criminology.

SA Counselor Recovery Status

There have been several examples given previously regarding SA counselor recovery status as shown under positive characteristics of SA counselors. The very first characteristic that most participants shared as being a positive trait of a SA counselor was someone who had similar experiences as themselves and who shared those experiences. When asked how they would feel about working with a SA counselor who was not in recovery there were many mixed responses given. Some participants shared that they would question the motives of that individual thinking that they might be "in it for the money."

This is what "Victoria" had to say:

"Um, I think that they're just like, doing it for the money, basically."

Others actually said that they might enjoy working with a counselor who was not in recovery themselves.

"Katie," explained:

> ".. I have known of a few that now that they're in recovery and they've got jobs, a couple here… and other programs, I feel and I believe that they should – um, they should consider that they too were once an addict, but they don't. They – it's sort of like they forget where they come from. You should never forget where you come from because it makes you the person that you are today."

> "...It's like their crap doesn't stink all of a sudden. Oh, you're better than – you're more superior because you have a job and you're here at Supportive Solutions, and oh, by the way, you just so happen to be my counselor, but don't forget, we were out there working the streets together, got high under the same tents and so on and so forth, ate out of the same trash dumpsters and robbed and did what we did together, but today you're a counselor here. You don't know me.
>
> You can't even get a, "Hello. Good morning. How is your day?" Uh, "Can I please have a moment with you? …you can't get that. It's sad. It – it makes me feel like, "Okay, so now you guys are in it just for the money."

Interestingly, participants identified that people who aren't in recovery can present the image that they are merely working for a pay check just as well as someone who is in recovery. Also important, Katie's illustration that just because someone had a similar problem with SA does not mean that they will be sympathetic to others currently struggling with addiction. In reality those counselors whom are former substance abusers may possibly feel that they are somehow superior to those who have not managed to overcome issues with SA. It seems that this type of thinking may intensify the more they observed the same people come back into the same program repeatedly. When Katie was asked how she would feel about working with a SA counselor who is not in recovery Katie stated:

> "It would be new, fun, exciting, and interesting. It would be something that I would actually look forward to, because then it's like going to the school – a new school for the first day, meeting new people, and learning new things about each other. They get to know you. You get to know them and you might actually find out that you have a lot in common, more with this

person than you do versus someone that's been here and someone that's actually lived in recovery."

Clark who had known a SA counselor who had not been in recovery but had an impact on him shared this interesting insight regarding having a SA counselor who was not in recovery themselves:

"… I remember when I had been here like just a couple of months. Uh, in 2011, and they were like – and some people were-were at this counselor, and he's a guy, and they were like, "Why should we listen to you?" You know what I mean? "You've never had an addiction." And I was like, "W-w-wait a second. You guys need to stop and think about who this is you're talking to. This guy has four kids. The youngest one, has a disability – a child with a disability that's life threatening. He said this child will not live, has had multiple surgeries, would not live past 8 years old. He's 12 years old now, still have his problems. This single father raises four children with problems that you have no idea about that he has to deal with on a daily basis, and yet he's never succumbed to drug addiction. He's never succumbed to… his rigors of life.

…He's done what we have not been able to do."

Clark brings up an interesting point not mentioned by the other participants. While Katie and Clark seemed excited and open to the possible experience of working with a counselor who was not in recovery still others like Josie had this to say:

"I wouldn't feel that comfortable because then I would feel like if they couldn't relate to me, they didn't understand what I was talking about, and -- is I wouldn't want them to judge me for it, you know, because regardless, thoughts have to go through their head and like, yeah. It, it's hard being

addicted to something, and only the ones who have been addicted to a drug can relate, you know? Like other people who don't have that experience, they feel like a sympathy towards the person, I feel, and like yeah, I don't know. I wouldn't feel that comfortable with them."

It appeared that participants felt they could more easily relate to and trust a SA counselor who was in recovery themselves; however it also appeared that what was most important was that the counselor cared and that they could develop a rapport with them.

When asked if having someone they cared about and were very close to that had a substance abuse problem was enough of an experience with drugs and alcohol to help them relate to a client this was also answered with mixed feelings.

Chloe stated:

"I don't know, 50/50?

… It's not going to be the same because they don't know what it feels like to have an addiction problem.

They see the other aspect, you know, because they're dealing with someone who does or they might have grown up with a parent or someone who does, but they don't know exactly what it feels like to have the problem."

Jeff asserts that it depends on how much the person who was struggling with addiction let them see:

"It's enough to relate and it's enough to empathize but unless the parent came clean and spoke honestly to the child or to the loved about the addiction and what it actually did to them and where it actually takes you, then they won't actually know or truly understand how sick. These addictions make people sick."

Several clients stated that while someone having a close personal relationship with an addict might be able to relate a little more to clients struggling with addiction than someone who was not in recovery and was not close to someone in an addiction or recovery it could never be the same as actually experiencing addiction first-hand. Several others stated that a SA counselor with those experiences would be helpful because they could help the client to see the perspective of others and realize the pain and hurt they may have caused others, some participants viewed this in a negative way; almost alluding that the SA counselor would gang up with their family members against them.

David illustrates this perspective:

> "… I think, lean more towards being the victim. Like, they'd side more with the family than the addict, that is the counselor would side with the addict's family."

Several participants did feel that having a SA counselor who did not have a history with SA but knew someone that did would aid them in being an effective SA counselor.

Josie introduces the concept of a "survivor."

> "I'm not saying all counselors should have it but somewhat of a past history so that way I could be like, okay, if she did, I could do it, you know? If I know how much they literally struggled to get where, that gives me more ambition and drive to succeed, you know? I think that really helps us to, especially the women, 'cause at least of us don't have nobody to depend on, and to actually have a – because I never had my mother in my life so to actually have an older woman figure in my life, I really do look up to that…"

> "A survivor – I would say a survivor of it who knew friends, who, you know, some, something because it takes just that little bit of experience, you know what I'm saying?"

After examining all transcribed interviews it appears that over-all most participants preferred their counselors to have at least some personal experience with addiction; either, first hand or through someone who they were close to.

SA Counselor Education

Most participants (12 of the 16 interviewed) felt that having a formal education was important for SA counselors. Three of the participants did not think it was very important but rather somewhat important. These participants seemed to feel that a person's experience was more important or could be more important, or possibly of equal importance as education. One participant expressed that he did not know much about formal education and did not feel that he was in a position to answer those questions related to education.

Clark described an interesting way to evaluate if a person is a good candidate to be a SA counselor:

> "Um, I don't know…That's a good question, decide things about us and what we can do, where we're at in our recovery and-and you know asking to go out and take care of business and do things, they-they decide things on a case-by-case basis. And so I think by and large things used there should be minimal requirements, like there are now."
>
> **…** uh, someone can maybe still own a site or-or panels that you would have to appear before, like we do when we phase up.
>
> Someone should have to be able to go and-and submit a certain amount of written information and a certain amount of interview information, both.

> and then with… All of that. You should be able to get a full grip on – and someone in toto about who they are, their background, their education, their …then have like a screening process, like they do when they hire here or when they leave from here."

Clark illustrates the importance of viewing the potential counselor as a whole and seems to assert that you cannot judge someone on education alone. Most participants agreed that there should be some minimum educational requirements set, most feeling that an associate's degree would be sufficient. Several clients also stated "the more education the better."

"James" agrees:

> "The more, um, honestly I guess, the more and the better, you know. It's, because you put so much time into it, you know what I mean? You want to learn, you know different aspects of it, um, you know, like the social work, um, psychology, you know. So I believe the more the better, you know, because then you have more insight, you know, in what's going on, especially, ah, psychology, you know what I mean? You could pretty much pick apart the brain. You know what they're thinking, you know what I mean, and you pretty much know a little bit more of what's going on as opposed to somebody just coming out of high school or, you know, or just with an Associate, you know what I mean. So the more the better, I think…."

James also mentions specific areas of education that a SA counselor should have. Seven participants stated that SA counselors should be educated in Drug and Alcohol Counseling, Five listed psychology as being important, and one participant felt criminology would give a SA counselor insight into clients'

manipulative behavior and the experiences that many people in SA treatment have had with the legal system.

Choice About Their Own SA Counselor

Most said that they would prefer a counselor in recovery, but with 5 or more years clean time. Some said that they would prefer a counselor who abused the same substance that they had.

"Chloe" illustrates this:

> "It's just like with me. I've never done drugs, so when I look at these people that do drugs, and I'm like, "Why in the world would you choose to-to do that?" 'Cause I don't know. That's why I would rather have someone who-whose experienced alcohol."

Interestingly, with regard to SA counselor education, often those who previously said that a 2-year degree in drug and alcohol counseling would be sufficient later changed their perspective. When asked if they could choose their own SA counselor often those same individuals stated that they would want their SA counselor to have a bachelor's degree or higher. Participants also tended to want a SA counselor with a high number of years of experience in the field; ranging from 5 to 15 years.

Figure 2 illustrates the valued characteristics of SA counselors as perceived by client participants of this research. It should be noted that personality characteristics are placed centrally and at the highest point because, based on what the bulk of participants shared, having those personality traits may trump education and personal experience; while personal experience and education appeared to be equally important or could potentially trump each other.

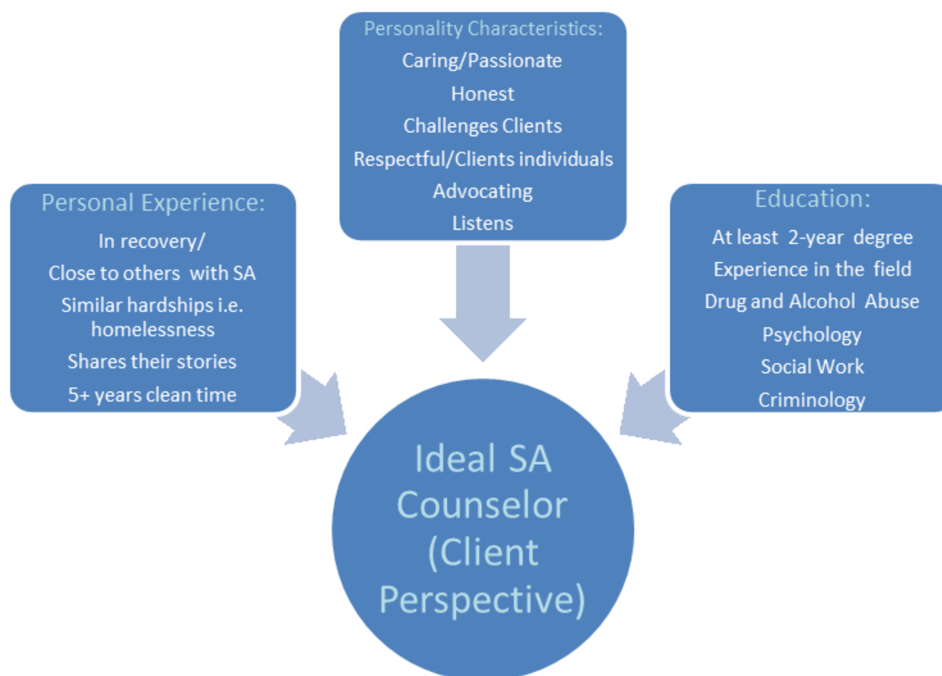

Figure 2. Valued substance abuse counselor characteristics

<u>Treatment Characteristics</u>

When discussing aspects of treatment in general it quickly became clear that participants wanted to share positive and negative aspects of not only their treatment experiences in general but those experiences specific to Supportive Solutions as well. The researcher felt that looking at both in general experiences and perspectives as well as Supportive Solutions specific information would be beneficial not only to clients of Supportive Solutions, but Supportive Solutions in general, as well as being beneficial to the study and potentially others who may read it. We will first begin by looking at the positive aspects of treatment in general and then move to Supportive Solutions specific information.

In general, treatment characteristics that were found to be positive and aiding in recovery from the perspective of the participants were "programming" which referred to having classes, consistency, implementing 12 steps (Narcotics

Anonymous/Alcoholics Anonymous), having access to mental health services, linking individuals to resources, and thorough discharge planning.

Unexpected Findings

One participant, "Victoria," talked about how she attended a Native American rehabilitation center that utilized a lot of Native American practices in the recovery process such as drumming and sweats. She stated that she really enjoyed this residential treatment center located in Washington but said that when she relapsed she was unable to go back because of a lengthy waiting list and ended up at Supportive Solutions.

In Victoria's own words:

> "Well, the first time I went to treatment, it was really good for me because they do a sweat for the Native Americans and um, do drumming, do all kinds of other Native American activities."

Another participant Heidi suggested that there be a different approach for women in treatment. She suggested women having domestic violence classes, parenting classes and child development classes. Here is what she had to say:

> "The women get abused a lot …when they've been out there …there's been prostitution. There's been a lot of – I mean in the world. Trust me, it still is like a man versus – um, you know, they're still a little bit higher than us. For some reason, in a lot of unhealthy relationships, always the man is the higher one."

> "I do think that, um, women just need to be lifted up and to know that they can do it on their own. They don't need a man to do it…Um, just, uh, to appreciate themselves and to – yeah. It's just a totally different thing. Men

don't really – I mean there's some, far and few, that have that issue too, but men are totally different than us. We're way different than men."

"And to show that they don't need a man in order to get out there, to stay clean, and to keep their babies and to do all that stuff. That they can do it on their own."

Heidi brings up interesting points here; that women may be more likely to experience traumatic events such as domestic violence, rape, sexual abuse, and prostitution. These issues can likely be contributing factors to substance use and abuse and therefore residential drug treatment programs may better serve clients by confronting these issues and referring clients when possible to other sources of support once they leave the facility in an effort to increase their client's success.

In addition to these unexpected findings, three of the 16 participants expressed enjoyment regarding being involved in the research. When told at the end of the interview about when they could expect to hear if they had won the gift card for their participation they said that they did not care about that and were happy to be involved.

Negative Aspects of Treatment

Overwhelmingly participants stated that SA counselors having high caseloads and/or programs being understaffed as one of the most common negative aspects of treatment. In addition, not having classes every day or lack of consistency within a program was also viewed as negative. Many participants also felt that programs should utilize and implement the ideology of NA/AA or at least allow for representatives to come into a facility to facilitate meetings and allow those clients wanting to attend to do so. Many participants also stated that some programs they experienced had poor discharge planning and/or they did not make

connections with other agencies regarding resources for clients such as housing. One client Chris, who was mentioned earlier, spoke about a program's unwillingness to offer him support in completing homework assignments:

> "Well, uh, I'm having problems with the little homework I'm supposed to be doing," and they was like, "Oh, if you can't do the homework, uh, we're going to have to have – you're going to have a problem then." Well, it's like – well, if you've got a problem with me doing the homework he-… I'm like, "Could you give me some help or something?" And they was like, "Well, we don't have no tutor or nothing in here that can help you,"

Chris' experience illuminates the importance of a program to be understanding of peoples differing needs and abilities. Chris was told that if he was unable to complete the homework he would not be able to remain in that particular program.

Sarah took issue with new clients that were detoxing being placed in rooms with other clients. She said:

> "…what I don't like is set – having them set detox people with us to stay in our room when they're coming off of whatever drug of choice they have. I think they should put all the detox women together. Because it may be – it may be hard for some of the people to react on that. They might wanna get up and walk out and use, you know what I mean?" This interesting point seems to fall under the category of having better organization within the program. Another participant illustrates the need for consistency, Josie stated the following:
>
> "…what I don't like is the fact that I, they push off some of the groups, you know. They like will take a group one week and then we won't have it the

next week. And I remember even telling them, "I need it every week." If I could get it every day, I would want it every day. I need it every day."

Many of the women echoed the need for more classes and more consistency. This began to make it clear there were issues related to treatment that were Supportive Solutions specific and even more those issues seemed localized to the female side of the facility. This will be explored further in the next section. Figure 3 illustrates client valued characteristics of treatment:

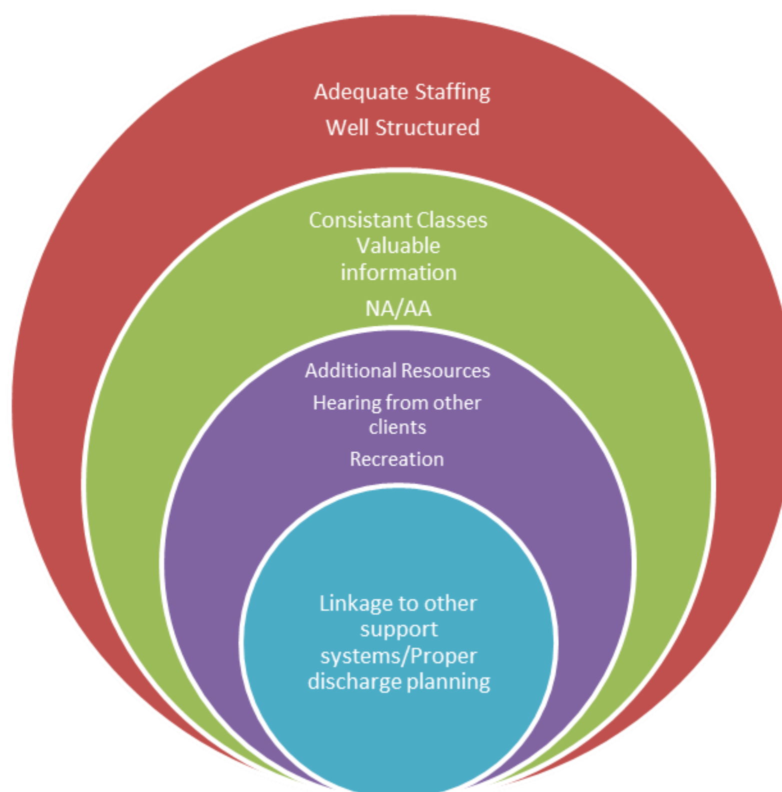

Figure 3. Valued characteristics of treatment

Supportive Solutions Specific Treatment

Positive Aspects: Female

Female participants cited caring staff, getting to hear from other clients, building positive/supportive relationships with other clients, classes and allowing clients to come back (either for treatment when they had relapsed or to come visit) were all positive aspects of treatment at Supportive Solutions. Josie had the following to say regarding positive attributes of the facility:

> "Um, the classes, the women, knowing that I'm not alone through it, and like I come from where I would push women away in the streets and I never have friends so like just the fact that they actually take the time to wonder what's wrong with me, like they back me up, they care, you know? My friend today was like, "You can't leave because I'll tie up you to the bed. I'll seize you and I'll tie you to the bed," so I'm like, "Okay, I am not to leave," you know? And that makes me stronger, but yeah."

Many participants echoed Josie's perspective of what had been working on the female side of Supportive Solutions. Unfortunately, there were a lot of negative comments made, more so than positive for the female side.

Negative Aspects: Female

Among the negative aspects of treatment in general specific to the female side of Supportive Solutions' California, Central Valley residential drug treatment facility were; lack of staff including SA counselors, lack of classes being taught, no NA/AA, disparities between the men and women in the facility, (such as no library/computer room access for the women and little recreational activities for the women), theft issues and lack of resources for women in the way of hygiene products and clothing, and a need for better searching of entering clients to ensure

that drugs are not brought into the facility. Both the female and male clients also opposed the punishment of all for something that an individual client had done.

Katie had a lot to say regarding all of these issues:

> "We need, uh, um, a lot more consistency with staff. It needs to be consistent and you know, we need someone to listen to us, um, and hear us out, and um, there should be more staff available to us, like, during med times and – and when we need to get into the SOD office to use the phone to get medications and – because for some, myself…It's just very stressful during the holidays when you're locked up and you're kinda not able to go out. You're limited."
>
> "Okay, and half the time there's not even no classes going on here and there should be. There should be a process group. There should be a feelings check. There should be a number of things. I mean I can like, literally make a list, but if we don't have the staff and the support to back us up and be our support system while we're here and some – for the ones that don't have family and can't go out and um, you know, then what good is it? It's – it's pointless. It's useless. We don't have the classes to support us so we can get the tools and resources that we need. It's useless. No one wants to do study hall all day long and then mind you, we're studying about something that we don't even know about…"
>
> "There's no explanation as to what's going on. No one ever seems to have the answers to anything. No one seems to understand anything. It's just you guys – they have study hall. What are we studying?"
>
> "It's all sorts of things that go on. The night before last, a girl's son busted his head open. There was no staff here, none whatsoever, and we can't leave on our own or we'll get discharged from the program."

…We had to literally run all the way over here to other side, around the corner, to the men's side and get SOD staff and then he still had to figure out who was gonna buddy this lady to go out to Valley Children's to take her baby and how long we're gonna be gone. He had to figure out where the out of the house memos was and who does he get to sign in and should he call XXX? [the women's coordinator]

Should he call? It was crazy. It was chaotic. It sanded me,…Last night, the – one of the newborn infants here was running a fever of 102. It took them a whole hour to get that newborn baby out the hospital, find the available staff to transport, find the out of the house memos, figure out who signed it, who's gonna buddy her, who's gonna pick her up. That shouldn't have been an issue. It should've been right away, get on the phone and call 911, the paramedics.

"There should be available staff here to search us appropriately and properly search our personal belongings as well so there is no more drugs and alcohol that comes onto the premises. There was drugs bought in here. There was alcohol here on the premises …and they should have gotten that person help instead of just kicking them out to the streets and saying,

"Nope, you can't be here."

and we've gone on containment and lockdown because of issues and things like that and it's not right."

"I didn't put that bottle in her hand, or give him that spoon, or put a straw up his nose and vice versa. They didn't do it to me, you know? It was a conscious decision that I made and I know that we're not perfect. We're all imperfect, but things can be ran a lot better and a lot smoother if we had available and appropriate staff."

> “The other issue is the reason I said we need more staff. It’s because it’s been a –thievery has been a problem here forever … A lot of girls come in off the streets or out of jail.”
>
> “They don’t have the hygiene. The people that have been here, they’re in their rooms and taking others’ hygienes and clothing. They should have a donation closet here. There – there’s a whole lot they should give you.”
>
> “Yeah, or make a little paper coupons out of dollars, fake dollars, and people could come in and purchase those dollars once they start stepping and phasing and they can buy some things here for the ones that are less fortunate and don’t really have money to purchase these items …and start getting some donations here for the new intakes and stuff that come in, things would run a whole lot much smoother and see about getting some funding.”

The information that Katie gave during her interview was very detailed. She illustrates that being short staffed not only affects someone’s treatment but it can also affect their safety and in the case of clients who have children in the facility, their children’s safety as well. Clients do not have cars and are not allowed to have cell phones at Supportive Solutions. Thus, in an emergency they rely on staff to be there and call for help for them or give them access to a phone at very least. Katie brings up an interesting way to solve the issue of theft at the facility and sheds light on the need to provide more hygiene products and clothing to female clients.

Bonnie weighs in on the disparity regarding recreational activities for the men and women:

> “From what I hear, the men over here have pool tables, computer labs and all sorts of things, and we over there have nothing.

So for some reason, I think – and the men get to go shop-shopping while…I think the men get spoiled when we're in treatment. I think some more recreational activities would be a lot better for us,…Something something to do, some chess games and dominoes – I don't know – something to keep us from nipping at each other all day over there."

Bonnie is correct that the men appear to have a lot more recreational and other resources available to them. The men have even been taken to parks to have barbeques and to play baseball. They have a library and computer lab that appeared was used by women as well, but the female participants made it clear that they were never given access to it. The men also have a pool table and weights to lift in the courtyard. Bonnie went on to say that it is important for people in recovery to have some recreational activities not only to cut down the boredom but to help them learn how to have fun without drugs. Also important to recovery as expressed by participants was learning how to socialize without the use of drugs or alcohol. She went on to say:

"…when you've been high or drunk your whole life, and then you go back out there and you try and shoot a game of pool, you feel like, "Oh, my God, you know. I think I'm going to screw this up." You get real nervous. You don't really know how to experience that. So it would be nice to have a little bit of that."

Chloe felt that there were a lot of disparities between the men and women's side. She gave the following statement:

"Uh, just regarding Supportive Solutions, like the guys' side program all day long, and when I asked one of our counselors here why, they said it was because …their director advocates for them and gets them pamphlets and classes and all that kind of stuff whereas we don't have that on the

> girls' side. We pretty much have classes a couple times a week, and then we have study halls and watch TV all day. And kids the kids are run around like crazy.
>
> So it's just unstructured, and honestly, if I was paying out of my pocket to come to this rehab, I'd be gone."

Another participant felt the presence of NA/AA was lacking and that clients needed exposure to the 12 steps. Heidi stated:

> "Uh, some of the downfalls, I think that they need to put more NA and AA meetings around here. There's classes, but they're not as helpful as I think they should be. I think they definitely need to – to tell women is there – their options out there when they get out 'cause we don't have any NA or AA meetings there. None."

Interestingly the men have NA meetings provided every Sunday at 10 am. Heidi also felt that clients in general should be given resources regarding NA/AA before they leave. Other women echoed this and felt that resources should also include housing, medical, mental health and any other type of social service information. Participants in the study said that they felt others had been unsuccessful because of improper discharge planning and said without resources an individual can easily end up homeless and back on the streets using again.

Positive Aspects: Male

In general the men were more positive about their experiences at Supportive Solutions than the women. Several men when asked to state negative experiences or things they would change about the program said "nothing." Male participants shared that caring staff, getting to hear from other clients, support and knowing they can come back when they leave, access to NA/AA meetings, and

good classes were among the positive aspects of the program being run at Supportive Solutions. More specifically, the classes that many male participants cited as being the most helpful were feelings group, relapse prevention, and anger management.

Clark had this to say:

> "Uh, everything has been helpful for me, not only the, um – not only from a, um, a rest and ordered environment and clean environment … the total comprehensive nature of the care here at Supportive Solutions, uh, are in group settings and one-on-one, and-and, uh, and counseling and personal advice…I'm just enthralled with every aspect of the comprehensive nature of the care here at Supportive Solutions, both, uh, accredited and personal in nature. These people not only – as I mentioned, the people who use here that you don't fully understand until you stay for a while, but these people love me until I can love myself. See, it's not about counseling and not about – it's-it's these people care about Clark until Clark can begin to care about Clark again, because, in my addiction, I do not. I do not. And by its very nature, you don't."

Clark presents a supportive environment that is consistent. This is much different than what the women described.

Negative Aspects: Male

While there were less criticisms among the male side of the facility a few of the male participants gave SA counselors having high caseloads/lack of availability, punishment of all when one person breaks the rules, and negative attitudes of other clients as being negative aspects of treatment at Supportive Solutions. As mentioned previously the male participants exhibited a lot of

gratitude towards being in the program at Supportive Solutions. It was very difficult to get them to admit to negative aspects within the program but Tom mentioned the following:

> “Sometimes on occasions you’ll get a person maybe that comes in and they may be negative and you tend to have to deal – you – you know you have to kind of be with different people in the group, in the house or program, and sometimes if you – you know, if you don’t allow it – if you – if you do stay around someone with negativity a lot, then you can kind of start being negative with the program yourself, but it just depends. You know.”

Over-all the men were positive and the few negative comments regarding Supportive Solutions specific treatment were not things that Supportive Solutions could necessarily control; they cannot control others attitudes. Though this was one of the few issues that male participants would speak about, many said that even when other clients exhibited negative attitudes about the treatment facility and/or recovery they did not let it affect them.

In summary, by completing this research it was discovered that participants typically preferred a SA counselor that had some personal experiences with drugs and alcohol (whether an addict themselves or a “survivor”), had some type of formal education (at minimum a 2-year degree), and if in recovery participants preferred 5 or more years of sobriety. In general participants valued a SA counselor who was caring, genuine, shared their own experiences, was honest, passionate, and respectful, challenged their clients, had the ability to listen, advocated for their clients, and treated clients as individuals.

CHAPTER 5: DISCUSSION

In this chapter the findings of the research will be discussed and compared to what researchers have uncovered in the past. There were a lot of similarities found in this study as compared with previous research especially the two qualitative studies that were mentioned in the literature review. In general terms if the findings can be boiled down to one major conclusion regarding client valued SA counselor characteristics it is that the most important aspect of their character is the ability to build a rapport with their client. For treatment it appears that structure and consistency are key.

Comparisons to Previous Research

This appears to be consistent with identity theory that was previously mentioned. The first trait most participants listed as being a valued characteristic of a SA counselor was having their own experiences with drugs and/or alcohol and sharing those experiences. The reasons given for this were often “because I can feel comfortable sharing my own experiences and know that I am not being judged.” Even in groups labeled as negative people tend to favor members of the same groups they belong to. In the case of SA this often gives the SA counselor credibility as well; and as mentioned previously the ability that one perceives their counselor (in general, not specific to SA counselors) as credible may be directly associated with that counselor’s ability to facilitate change (Guinee & Tracy, 1997).

Having formal education was valued by most participants as well. In general when people seek professional help for a problem they want to know that the person they have enlisted to help them has more knowledge then they do. This was demonstrated in not only the current study but in the study conducted by

Dhand (2006) as well. Participants in Dhand's study agreed that "peer educators" (which could also be thought of as SA counselors in recovery), should not look or act like clients, but that they should be a former user. Prior research also indicted that client's value professionalism (Stets & Burke, 2000). In the Dhand study (2006) it was also mentioned that clients desired peer educators to be former but not current users. In the current study two of the participants were negatively affected by experiencing their SA counselor relapse and they too ended up relapsing shorty after. Similar experiences were noted in the Adams and Warren article (2010). This seems to suggest what participants in the current study suggested; that SA counselor relapse can have a serious impact on client treatment and that it may be ideal for SA counselors who are in recovery to have a minimum length of clean time requirement. Future research should examine if persons who are in recovery are less likely to relapse after maintaining sobriety for a certain amount of time and possibly establish what the recommended length of clean time should be.

Conclusions of this Study

More powerful than education and recovery status it appeared, was having a SA counselor who cared. This was based on client statements toward the end of interviews where many said that they felt what was most important was that their SA counselor cared. Characteristics such as ability to listen, being genuine, respecting clients, making time for clients, advocating for clients, and sharing personal stories seemed to trump everything else. It appears that because the nature of the SA counselor client relationship involves sharing inmate details of one's life having a SA counselor who is in recovery lends itself to that but does not necessarily mean that they will have the aforementioned traits to go along with

that experience. As mentioned by some of the participants, if a SA counselor is in recovery but expects your recovery to "look the same as theirs" then their recovery status may actually make them a less effective SA counselor. Katie's mention of observing a SA counselor who was in recovery and how her attitude seemed to change (Katie had known her before) and the SA counselor seemed to look down on those that used to be her peers because she had overcame her addiction, and possibly wondered why they could not do the same illustrates this.

For treatment in general it is clear that, having adequate numbers of staff, having quality classes that are consistent, and linking clients to resources are among the most important aspects of treatment in general expressed by participants of this study. Without the classes and one to one counseling clients will not learn the tools they need to maintain sobriety outside the facility. The development of packets of information that clients can take with them upon their departure and effective thorough discharge planning may likely increase the rates of success among clients. One participant also suggested the idea of allowing clients to choose their own SA counselor. This suggestion may not be feasible, but may possibly be considered in a more constricted manner where clients could be matched based on mutual goals for what treatment should look like including characteristics of SA counselors. This seems to relate to Chloe's desire to have a SA counselor who had abused the same substance that she had (alcohol). The mention of culture specific treatment as well as the need for mental health services to be integrated with SA treatment are also interesting aspects to consider when developing or evaluating a SA treatment program.

Limitations

The small sample size in this study does not allow for generalization to the greater population of individuals struggling with addiction. Another limitation in this study is that the instrument of measure is not standardized and therefore its reliability is unknown. In addition, it is also possible that participants who are still being treated for SA are not adept at accurately identifying characteristics in treatment and SA counselors that are valuable or lead to successful outcomes for recovery because they have not yet completed a successful recovery from addiction. Another limitation of this study is that there was only one researcher developing the questionnaire, conducting interviews, and analyzing the data. A team of researchers involved in all aspects of this study would have likely reduced researcher bias. In addition, in keeping with Charmaz's constructivist grounded theory approach, it may have been beneficial to involve the participants in the coding of their own data. Despite these potential limitations the frame work of this study provides a good foundation for learning more about what traits clients' value in treatment and SA counselors. As we learn more about this field an understanding for program and SA counselor traits that contribute to successful outcomes for clients may be reached. If this is achieved the potential to alter substance abuse treatment to better serve clients and their families will be possible.

Implications for Future Research

Future research should gather more information via client interviews regarding the same topics discussed here to saturate the data. In addition, client perceptions should be examined in relation to client outcomes. Both qualitative as well as quantitative methods should be implemented. This type of research has the potential to effect SA treatment at all levels; micro, mezzo, and macro. At the

macro level research on SA counselors could potentially be used to develop national standards for SA counselors regarding education and recovery. (With regard to recovery; research could potentially support a specific span of sobriety ideal for those individuals in recovery that wish to become SA counselors). It appears that there is a strong need to explore the relationship between recovery status, education level and area of study, and client outcomes before the recommendation of what the new standards should be for SA counselors.

Development of national standards has long been discussed and is in need of urgent exploration, especially with the impending full implementation of the Affordable Care Act. In addition, at the macro level social workers and other related professionals may now have some evidence that suggests it may be wise to support garnering funding for those in recovery to receive 4 or more years of education as participants valued SA counselors who were both in recovery and had a high level of education. At the mezzo level this research could help to shape not only the hiring practices of agencies but inner agency relations as well and potentially support a more integrated or holistic approach to client treatment. Many clients mentioned a need for linkage with other resources prior to discharge. For Supportive Solutions specifically, the current study can shed light on areas which need improvement and may give insight as to what steps could be taken to better serve their clients.

At the micro level it is easy to see that client treatment could be positively affected if research like that conducted in the current study continues to be developed and explored. Rates of success among clients of SA treatment are not very high; only about 3.5% of those who complete a treatment program will maintain sobriety 2 years out (Supportive Solutions, outcome data). The United States government is increasing access to drug rehabilitation programs via the

Affordable Care Act, therefore both clients of treatment programs as well as taxpayers will all benefit from more affective SA treatment.

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APPENDICES

APPENDIX A: CLIENT PERCEPTIONS OF TREATMENT AND SUBSTANCE ABUSE COUNSELORS

Appendix A

Client Perceptions of Treatment and Substance Abuse Counselors

Questionnaire

1) Have you been in treatment before? If so, how many times and where?

2) What has your experience in treatment been like? For Example, What has been helpful to you and what has not?)

3) What do you like or dislike about interactions or relationships with substance abuse counselors that you have encountered?

4) Have you had substance abuse counselors that have been in recovery themselves?

If yes,

A. What do you think makes them more or less affective?

B. How has the recovery status of counselors that you have worked with affected the relationship you have had with them?

5) How would you feel about working with a substance abuse counselor who is not in recovery? Why?

6) Do you think that having a close family member or friend who struggled with addiction is a close enough experience with substance abuse for a non-recovering SA counselor to be able to relate to a client? Why?

7) Do you think it is important for a SA counselor to have a formal education? Why? What type of education or training do you think they should have? Why?

8) Do you know what the educational background of your substance abuse counselors have been? How has this affected your relationships/treatment?

9) What do you think makes someone a good/effective substance abuse counselor?

10) Can you think of a substance abuse counselor (without naming them) who had a great impact on you either positively or negatively? Do you remember why? What was this person like in terms of recovery status and educational background?

11) If you could choose your own SA counselor what would their recovery status be? What would their educational background be? Why? How important do you think recovery status and educational background are for SA counselors?

12) Is there anything else you would like to add regarding substance abuse counselors and/or treatment?

APPENDIX B: INFORMED CONSENT

Appendix B

Informed Consent

You are invited to participate in a study conducted by graduate student Janna Tassop of the Department of Social Work Education at California state University, Fresno. We hope to learn about your experinces in the recovery process and what characteristics you value in substance abuse counslors. You were selected as a possible participant for this study because you have knowledge that is valuable to the study. If you decide to participate, the researcher will set up a time to meet with you privatley at your convience and will conduct an interview with you. **The interview will be audiorecorded** and will not include your name or other identifying information. You will be asked to choose a pseudonym (fake name) to keep your information confidential.**We also ask that when speaking about counselors you refrain from using their names. You can create a pseudonym for them or you can ask the researcher to do so.** Your interview will be uploaded onto the researcher's personal computer and transcribed. This computer is password protected with only the researcher having knowledge of the password. After a period of 1 year the recordings will be deleted. The transcriptions will be coded for themes and summarized as part of the construction of a master's thesis. Results will be written in way that ensures confidentiality of partcipants as well as counselors' identities.If quotes are used language style or other potentially identifying information will be altered in a way that maintains both confidentiality as well as the content.

It is assumed that the risks for participating in this study are minimal. While being interviewed and asked about your experiences it is possible that you may have some unpleasant thoughts or feelings . If this occurs the researcher will gladly arrange depending on your preference, for you to speak to any of the counselors on duty at WestCare or another professional. By conducting this research it is hoped that we will learn about what clients feel is beneficial to them in recovery and what characteristics they value in substance abuse counselors. In turn, it is possible that this study could potentially change approaches to serving clients struggling with substance abuse. We cannot guarantee, however that you will receive any benefits from this study. For your involvement you will be entered into a drawing to win a $25 Target gift card. (Two gift cards will be given out).

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. You can be assured that no one aside from the researcher will have acess to the content of the interviews nor will your responses affect your treatment.

Your decision whether or not to participate will not prejudice your future relations with California State University, Fresno and/or WestCare. If you decide to participate, you are free not to answer all the questions,to withdraw your consent, or to discontinue participation without penalty. **Your treatment at WestCare will not be affected if you choose to leave the study.Your participation *will not* effect your counselors' evaluation of your progress in the program.** The committee on the Protection of Human Subjects at California State University, Fresno has reviewed and approved the present research.

If you have any questions you are encouraged to contact Dr. Betty Garcia my thesis professor at (559)-278-2550 she will be happy to answer any questions you may have. Questions regarding the rights of research subjects may be directed to Constance Jones, Chair, CSUF Committee on the Protection of Human Subjects, (559) 278-4468.
You will be given a copy of this form to keep.

YOU ARE MAKING A DECISION WHETHER OR NOT TO PARTCIPATE. YOUR SIGNATURE INDICATES THAT YOU HAVE DECIDED TO PARTICIPATE, HAVING READ THE INFORMATION PROVIDED ABOVE.

Date Signature of participant

____

Date Signature of researcher

____

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