The Rehabilitation Professional, 25(2), pp. 87–96

2016 IARP Survey on Salary and Impressions of the CORE/CACREP Merger

Scott Beveridge and Jeff DiNardo

George Washington University

The following study builds upon prior research on counseling salary surveys completed by the American Counseling Association (ACA) and the Commission on Rehabilitation Counselor Certification (CRCC). This specific effort is to determine the current state of salary distribution within the International Association of Rehabilitation Professionals (IARP). The survey instrument was created by utilizing and building on the existing ACA and CRCC salary surveys in the counseling field and refined with the assistance of a Delphi panel of the IARP members. The Delphi panel that created the survey instrument had an average of 31 years clinical experience in rehabilitation counseling. The survey participants included 412 members of the International Association of Rehabilitation Professionals who completed the online survey to provide the data to examine the average annual salary and the current demographics of the IARP organization, impressions of the CORE/CACREP merger and the economic impact of disability on earnings capacity.

It is common practice to review the current distribution of salaries within a field in order to ascertain the degree to which the return on investment of time and resources required is worthwhile for an individual to make an informed decision if the profession is appropriate for their needs. In addition, individuals can determine if potential discrepancies exist in compensation for different sectors of rehabilitation counseling (e.g., public, non-profit, private, forensic) or to provide a benchmark for which individuals in the field can negotiate their own salary needs when obtaining employment. There is also a history of such a practice specifically in the counseling and mental health fields. The American Counseling Association (ACA) and the Commission on Rehabilitation Counselor Certification (CRCC) completed salary surveys in 2014 and 2008 respectively. The following paper seeks to build upon this precedent by conducting a salary survey specific to counselors who belong to the International Association of Rehabilitation Professionals (IARP).

The CRCC (2008) salary survey utilized 1,220 Certified Rehabilitation Counselors to obtain an index of annual income. The CRCC constructed a survey of 32 items, which was distributed electronically. Their results indicated that the majority of participants who responded to their sample were women (72%); almost half were over the age of 50, Caucasian (85%), and working in the south (39%). In the CRCC survey the average annual salary reported was $57,716. There were also the key findings of the relatively older age of respondents, a limited number of minority group participants (15% of sample), and salary by gender found that males earned $69 per hour compared to females who earned $53 per hour (CRCC, 2008). The limited number of ethnicities present in the CRCC survey suggests that diversity may be a needed area of focus in recruiting new rehabilitation counselors. There was also a significant difference between the salary of clinicians with a master's degree, earning $53 per hour, and clinicians with a doctoral degree, who earned $83 per hour. Less than 10% of the rehabilitation counselors in the sample attained a doctorial degree. This finding serves to reinforce the benefits of attaining a higher level of education.

The CRCC salary survey found that one-fifth of the participants (21%) identified as having a disability, while 79% of the participants did not report that they have experienced a disability. When disability status is examined in relation to earnings, the average salary among disabled rehabilitation counselors who possess a CRC credential was slightly lower ($54 per hour) than those participants who did not experience a disability who earned $58 per hour.

Regarding the primary work setting the CRCC survey found that over one-third of all respondents (36%) reported that they worked in a State rehabilitation agency, with a corresponding average annual salary of $47,600, which was the second lowest in the field.

The researchers found that the two highest work settings for annual earnings were Business/Industry earning $78 per hour and Federal Agency (e.g., U.S. Department of Veterans Affairs) who earned $74 per hour, but these two work settings only represented less than 4% of all respondents in the CRCC salary survey. The Private Practice Practitioner was found to be the third highest primary work setting (12%) and also the third highest average annual salary earning $72,400 per year.

The CRCC salary survey also examined the primary job category where rehabilitation counselors worked. Over one-third of all respondents reported their primary job category as Rehabilitation Counselor, with a corresponding average annual survey of $50,000. Vocational Evaluators were also found to be earning $50,000 but only represented 2% of all respondents in the survey. Forensic/Expert Witness respondents were found to earn the highest average salary at $93,000 per year, but they were also a very small proportion of the sample at 2% of all respondents. The next category earning the second highest average annual salary were Administrators/Managers/Owners who earned $78,000 per year and represented 15% of all respondents in the CRCC salary survey.

Building upon this work, the ACA (2014) used a similar approach to complete their first survey on counselor compensation. The ACA constructed a survey of 46 items which was distributed electronically. Roughly 9,000 mental health counselors, rehabilitation counselors, school counselors, and counselor educators participated in this effort. In order to avoid any potential bias, they also reached out to clinicians who both were and were not members of the ACA. The average salary ranged from $40,421 for mental health counselors, $53,299 for school counselors, $53,561 for rehabilitation counselors, and $66,405 for counselor educators. Additionally, the ACA survey found that employment benefits (e.g. medical and dental), offered to counselors were at better rates than the national standard across professions. Some other interesting findings of the ACA survey found that 30% of counselors do not possess a license (LPC, LCPC) and 34% hold a second position outside their primary workplace (e.g., part time private practice). Work settings are very diverse for mental health counselors, though 90% of school counselors work in K-12 settings and 45% of rehabilitation counselors in this sample work for state or local government. Based on the data, clinicians in the Midwest were 25.6% of the sample, Southeast account for 27.5%, Southwest 15.1%, Mid-Atlantic 11.3%, Southwest 8.1%, Northwest 7.6%, New England 7.3% and Canada represented the smallest region at 0.1% of the geographical distribution in the ACA survey.

In the ACA survey the largest work settings for all counselors in the sample were determined to be 20% in the Self-employed/Private Practice, 19% in K-12 Schools, 15% in College/University, 14% Counseling/Rehabilitation Agency – Private, State and Federal Government 8%, and the smallest work settings were Pastoral/Religious, Insurance Companies and Correctional Facilities each at 1%.

One additional source of information about rehabilitation counselors who work as vocational experts was available via the 2016 Expert Witness Fees and Practices Survey. This was not published as a peer-reviewed article, it was a survey conducted by Expert Pages in collaboration with a private market research firm DeBow Communications. Ltd. They have been conducting biannual surveys of expert witness compensation in multiple fields for over a decade. Their survey conducted online is based on confidential responses from 700 experts in numerous fields throughout North America. Of the total sample, approximately 40% were current ExpertPages accredited members (a private referral agency for expert witnesses) and 60% were not. The survey questionnaire asked 24 questions and was conducted from November 2015 through January 2016. This survey found that employment and vocational experts charged a mean hourly rate of $334 per hour and that expert's base rate often contained built-in adjustments involving a higher fee for depositions and court appearances and a lower base rate for travel time. Almost three-out-of-four vocational experts (73%) utilized formal, signed retainer agreements. In addition, a majority (60%) always or most often require a minimum fee for engagements. They found that most vocational experts are self-employed (83%) with a small staff, only one-in-five (19%) work full-time for a firm that is primarily involved in expert witness and litigation consulting work and approximately half (45%) work for a company that is not involved in expert witness/litigation consulting work (e.g., college, university) and have a part time private practice.

Method

A descriptive, convergent parallel mixed-methods research design was implemented for the current study. This approach utilized quantitative and qualitative approaches to develop the model that would drive the research questions. In this design, the researchers aimed to collect both the quantitative and qualitative data from participants simultaneously. Both sets of data (quantitative and qualitative) were analyzed separately for possible themes and findings.

The Delphi method utilizes consultation from a panel of experts in order to actively participate in the process of developing the instruments to be disseminated among participants and research questions for investigation (Vazquez-Ramos, Leahy, & Hernandez, 2007). The

Delphi method was originally formulated to address an issue at the Rand Corporation in the

1950s (Hsu & Sandford, 2007). When the method was developed, the goal was to form a group consensus with the intention to predict both the present findings and future trends. By discussing future trends, researchers could seek findings that would develop innovation by hypothesizing the outcomes of specific changes in practice. The intention of using the Delphi method is to address a particularly complicated issue, which uses the group opinion of experts in a particular field. The reasoning behind operating within a group consensus is to prevent biased perspectives from the researchers and influencing views from the participants within the development of the study. During the process, the opinions held by the panel of experts are treated to several rounds of review and feedback, which would refine the consensus of the opinions (Hsu & Sandford, 2007; Vazquez-Ramos, Leahy, & Hernandez, 2007). Forming these several consensus opinions would allow for further exploration of alternatives to form resolutions for the specific issue addressed (Hsu & Sandford, 2007).

The construction of the IARP survey instrument was based on items from the 2008 CRCC and 2014 ACA studies. Additionally, three open-response prompts were included to allow for a qualitative inquiry as to rehabilitation counselor experiences with the Council on Rehabilitation Education (CORE) and Council for Accreditation of Counseling & Related Educational Programs (CACREP) merger, any perceived effects of the merger on future income, or any financial impact of significant life events, such as a disability as defined by the American Community Survey (2014) including hearing, vision, ambulatory, cognitive, self-care, and independent living. The preliminary instrument was provided to a Delphi panel of ten experts with a mean of 31.13 years of experience who provided three rounds of feedback on the creation and revision of the IARP salary survey instrument. The final IARP salary survey instrument contained 26 items. This process followed the accepted peer-reviewed methodology common for Delphi consultation (Hsu & Sandford, 2007; Vazquez-Ramos, Leahy, & Hernandez, 2007).

The sample for this study consisted of 412 participants who were all current members of the International Association of Rehabilitation Professionals. A total of 501 IARP members began the survey with 412 completing it and 89 partially completing the survey resulting in an 82% completion rate. Participants were recruited via the secure email invitation program provided by Survey Gizmo, one of the country's leading professional, web-based survey providers. In order to protect confidentiality of participants, we revised the Survey Gizmo application to refrain from storing or collecting Internet protocol (IP) addresses, e-mail addresses, or any identifying information. Furthermore data was kept confidential in a password-protected and encrypted file to protect the information. IARP sent out the secure survey link to their listserv in order to promote participation in the survey. The average time it took participants to complete the survey was 17 minutes. Prior to sending the invitations and recruiting the participants, the researchers obtained Internal Review Board (IRB) approval from The George Washington University Office of Human Research and the IRB of the International Association of Rehabilitation Professionals. Participation in the study consisted of reviewing the informed consent web page, clicking on a link and then providing quantitative and qualitative answers to the online questionnaire.

Responses were downloaded from Survey Gizmo into Microsoft Excel and then imported into SPSS version 21 in order to analyze descriptive statistics for the quantitative data and into Atlas.ti version 7 to code qualitative responses. The demographic variables included age, gender, race/ethnicity, disability status, temporary disability status, highest level of education, practice setting, primary geographic region, region according to US census, employment classification, pay rate, years practicing, and license and certification status. Qualitative analysis followed an open coding procedure with descriptive analysis for the three open-ended questions to determine which themes were reported most frequently (Saldana, 2009). No higher order qualitative analyses were conducted with Atlas.ti. For more detailed listing of qualitative codes found, please refer to the tables listed in the appendix.

Results

The descriptive analysis of survey results provided a portrait of the demographic makeup and average salary for members in the International Association of Rehabilitation Professionals. The average income reported was $125,927.62 and a median salary of $95,000. Twelve participants did not report total income and three reports were removed (0, 250, and 6000) as they seemed to be input errors. There were several high reports from survey participants (five above $500,000), although there was not sufficient justification remove them as outliers. As a result, due to several participants who were earning very high levels of compensation in their practice there was a strong positive skew of the income data.

The average age in the sample was 55 years old with a standard deviation of 11.5 years. The lowest reported age was 24 and the highest was 76. Compared to a member needs survey completed by the IARP in 2014, there was roughly the same distribution of members' ages with both studies having about 70% of participating members over the age of 50. This resulted in a pos-

itive skew of the reported age of participants towards the older age brackets.

With the self-reported gender breakdown, the participants in our sample of IARP members were more likely to identify as female (62%) than male (38%). We did not have sufficient representation between groups to determine if there were any statistically significant gender impacts on salary. However, the mean salary for women was $103,316.05 and the mean salary for men was $156,397.02. While there wasn't a statistical comparison of gender by education, reviewing the frequencies in educational levels made it appear that men were more frequently pursuing Juris Doctor (JD) degrees compared to females.

The sample for this study was overwhelmingly from a Caucasian or White background (91.5%). Only 2.4% reported identifying as Latino or Hispanic and only 1.9% reported identifying as African-American or Black. No other group (e.g., Pacific Islanders, Arab, Middle Eastern, Native American, Asian Indian) represented more than 1% of the sample including multiracial individuals and those who chose not to disclose (0.9%).

Most of the participants in the study did not report having a disability (87%). One write-in comment to a later open-ended question specified temporary disability status, which suggests that some may have perceived this question as pertaining only to permanent disability. It is likely that disability reports are underestimated and the decision of choosing not to disclose (2%) supports the idea that there continues to be some stigma or professional risk associated with such disclosure. However, in the open-ended question, about 20% of participants indicated they experienced a disability as defined by the American Community Survey (ACS). The ACS question 18a defines disability as "the interaction among physical, emotional, and mental health and the physical and social environment wherein these interactions results in limitations of activities and restrictions to full participation" (US Census Bureau, 2014, p. 57). Furthermore, the ACS highlights the specific subparts of disability including hearing difficulty, cognitive difficulty, ambulatory difficulty, self-care difficulty, and independent living difficulty (p. 57). When temporary disability was specified the number of self-reported individuals reporting disability status increases (34%). Write in answers included individuals who referenced missing work due to a disability such as being out for sixteen weeks due to an acute medical condition, so they were added into the "Yes" proportion. Four participants mentioned having a temporary disability, but continuing to work without any interruption in earning capacity.

The majority of participants 76.7% reported having a master's degree as the highest level of education, 11.2% reported having a doctorate, 6.9% reported a bachelor's degree, 4.0% reported other, 0.5% reported a medical degree, 0.5% reported an associate's degree, and 0.2% reported a law degree. Some individuals reported more than one highest level of education (e.g. two master's degrees) and were included in the other category. Another common trend is some individuals would write in the degree they were currently working on or referenced having a pre-graduate certificate (e.g. job development and job placement) or a post-graduate certificate (e.g. forensic rehabilitation counseling). Overall, the master's degree was the most common level by a significant margin. The distribution is also similar to the results found in the 2014 IARP member needs survey, though a smaller proportion of participants reported Bachelor's degree as the highest level in our study.

As would be expected, the highest frequency of geographic region indicated work taking place in urban settings (50%). Percentages gradually decreased in relation to the population of the area as would logically follow (35% in suburban and 15% in rural). Some members (n=71) commented on working in multiple settings, so multiple responses were sorted into each category and the total number of responses for this descriptive analysis was (N=483). Distribution of IARP members by US Census Region is relatively close to the proportion of US Population according to 2010 Census Data (US Census Bureau, 2010). There was a slight higher incidence of IARP members in the northeast (New England & Middle Atlantic) compared to the population of individuals living there, but each region seems to be well represented for the data analysis.

According to study results most IARP members identify with working primarily in private practice settings (72.6%). When comparing average salary with results found in other surveys, this may partially account for the significantly higher average salary found in this particular research effort. Most IARP members are currently working full time (77%). Some write-ins included working 25-30 hours a week, being self-employed, and a few indicated that they were currently searching to find work. Most individuals appeared to be paid via billable hours (59%), which is interesting to consider in the context of most respondents also report working full time hours (at least 40 hours per week). Furthermore, the average salary for participants who reported having a billable hour rate by case was $140,794.97. This is higher than the salary for participants who report being paid hourly for total hours worked ($132,022.22), those who report a set annual salary ($90,022.95), and participants who wrote in their answer ($112,384.34).

The average number of years practicing was 25 with a standard deviation of roughly 12 years. Compared to data collected in the 2014 IARP Member needs survey, this distribution is nearly identical. The high level of clinical experience is a likely contributor to the relatively higher average salary found in this study when compared to other research on counselor's sala-

ries (ACA and CRCC). The majority of participants reported having over twenty years of experience (69%), there appeared to be a relatively similar number of professionals working in each experience band (9% 16-20 years, 7% 11-15 years, 7% 6-10 years, 6% 2-5 years, and 2% less than one year).

A wide variety of professional credentials were represented though CRCC status was represented significantly more than others (see Table 1). Some individuals specified multiple licenses (e.g., LPC, LCPC) or certifications (e.g., CDMS, CCM, ABVE) and were counted in each category although overall proportion remained divided by the number of participants in the study. The most common write in was Certified Vocational Evaluation Specialist (n=16). Other write-ins were mostly isolated examples of specialized practice areas (e.g., NBCC, LMFT, Career Counselor, Substance Abuse Counselor).

For those participants who have obtained licensure, the following table (Table 2) represents the frequency counts of where these licenses are maintained. Some individuals reported licensure in multiple states with most of these examples comprised of geographically clustered regions like PA, NJ, and DE. Some individuals wrote in that they were "licensed nationally" which may also represent multiple states of licensure or a misunderstanding between the definition of licensure and certification as currently there is no national-level license in the United States.

For the qualitative open-ended response to the experience in hearing about the CORE/CACREP merger (N=355), a third of participants indicated that they have not heard a lot or anything about the merger. It appears that the most common means of relaying such material is occurring through email from professional organizations (25.25%). It is worth noting that many of these responses specifically indicated information provided through the IARP Listserv indicating that members are receiving and engaging with material being sent out by IARP's headquarters. Others focused more on general

Table 1

License and Certification Responses

License and Certification	Frequency	Proportion of Total Responses
Commission on Rehabilitation Counselor Certification	307	74.51%
Licensed Professional Counselor (LPC & LCPC)	113	27.43%
Certified Case Manager	88	21.36%
Certified Disability Management Specialist	87	21.12%
Life-care Planner	80	19.42%
American Board of Vocational Experts	73	17.72%
Rehabilitation Provider	46	11.17%
Case Manager	43	10.44%
Licensed Rehabilitation Counselor	34	8.25%
National Board Certified Counselor	23	5.58%
Career Counselor	23	5.58%
Registered Nurse	22	5.34%
Occupational Therapist	10	2.43%
Psychologist	7	1.70%
Certified Professional Disability Management	6	1.46%
CRRN	6	1.46%
Alcohol/Drug Counselor	6	1.46%
Psychological Counselor	5	1.21%
Licensed Marriage and Family Therapist	5	1.21%
Substance Abuse Treatment Provider	4	0.97%
Licensed Clinical Social Worker	3	0.73%
Physical Therapist	3	0.73%
Certified Substance Abuse Counselor	3	0.73%
AALNC	2	0.49%
Physician	2	0.49%
Recreation Therapist	1	0.24%
Physician Assistant	1	0.24%
Genetic Counselor	0	0.00%
Other - Write In	75	18.20%

Table 2
State Licensure

State	Frequency	State	Frequency
AL	6	NE	4
AK	0	NV	0
AZ	6	NH	1
AR	3	NJ	12
CA	12	NM	0
CO	2	NY	4
CT	4	NC	8
DE	3	ND	1
FL	11	OH	16
GA	11	OK	1
HI	2	OR	5
ID	0	PA	23
IL	13	RI	2
IN	3	SC	4
IA	2	SD	1
KS	3	TN	4
KY	0	TX	13
LA	15	UT	2
ME	2	VT	0
MD	4	VA	11
MA	14	WA	20
MI	8	WV	4
MN	3	WI	13
MS	0	WY	0
MO	5	Canada	10
MT	3	National	14

reactions to the merger with relatively equal frequencies of concerns or optimism. Please refer to Table 3 in the Appendix for full list of qualitative codes regarding the CORE/CACREP merger.

With regard to the open-ended question on the financial impact of the CORE/CACREP merger on their income 363 participants provided a response to this question. The majority of participants do not feel as though the CORE/CACREP merger will have a dramatic influence on their income (51.9%). This may relate to the majority of participants who also reported limited exposure to or knowledge of the merger. Perhaps the lack of concern about effects on income mitigates interest in the subject or conversely a brief review of the subject was enough to alleviate any potential concerns. A larger overall theme representative of the greatest reported concern was the threat to rehabilitation counselor professional identity. There were many hypothesized effects of this perceived loss, but many shared the general worry about the dissolution of the specialty area of rehabilitation counseling. Additionally, since the sample appeared to be relatively older and well established with regard to clinical experience and earning capacity, there may be less need to worry about future systemic academic changes between CORE and CACREP affecting individual professional practice in the private sector.

Finally, in response to significant life events that have affected income (e.g., disability according to the ACS definition), the majority of participants did not report a significant life event that had an impact on income (62.4%). The exact wording of this open-ended question was, "Have you experienced any significant life events or situations, such as disability (as defined by the American Community Survey: hearing, vision, cognitive, ambulatory, self-care, and independent-living) that have impacted your ability to work? If so, please discuss." There were 342 participants who provided a response to this question. It is interesting to note that these events appeared to occur at a greater level of frequency than any disclosures of disability or temporary disability from earlier items. Although a direct statistical comparison could not be completed due to unequal representation, it was interesting to note that for individuals who did not report a significant life event the average salary was $122,830 (95% confidence interval $107,411 - $138,248) while the average salary for individuals reporting a significant life event was $125,664 (95% confidence interval $97,846 - $153,483). There is a wider confidence interval for the significant life event group as would be expected due to smaller number, but it did generally appear that these individuals were able to return to work and obtain income similar if not higher to the no significant life event group. This seems to be an argument supporting the efforts of vocational rehabilitation and rehabilitation counseling given that individuals are resilient enough to return to work following a disability according to the ACS definition and maintain a significant earning capacity.

Discussion

It would be interesting to follow up on the average age when individuals join the International Association of Rehabilitation Professionals to examine why membership tends to skew towards an older age bracket. It could relate to the fact that many members join the organization after first establishing their professional practice and years of completing their education. IARP has recently increased its efforts to recruit younger members via the student membership status for individuals at accredited institutions. Future longitudinal research with IARP will determine if these outreach efforts were successful and if they had effect on the demographic portrait of IARP members.

The gender discrepancy also stood out, though more information would be needed to determine the seemingly significant difference here. Especially considering there were more women in the sample (62% vs. 38%), perhaps they just happened to be a few male participants with high incomes, which skewed the central tendency measures (mean salary for women was $103,316.05 and for men $156,397.02).

The Rehabilitation Counseling field has emphasized the importance of multicultural sensitivity and it has been suggested that there is an underutilization of rehabilitation services by members from minority communities (LeBlanc & Smart, 2007). This also appeared to be true for the number of minority members who are currently a part of the IARP (8.5%). It will be interesting to see if these recent endeavors to increase student membership will have an impact on the race and ethnicity distribution going forward.

The distinction between the number of individuals identifying with having a disability and those reporting significant life events was also interesting. It may suggest that individuals are less likely to identify as disabled, even temporarily, despite meeting the criteria established by the American Community Survey. This may be due to the stigma and potential prejudice of identifying as an individual with a disability. It may also call into question how some vocational experts utilize the ACS to determine earning capacity of evaluees during forensic vocational evaluations. It was very interesting that the IARP participants who reported having a disability according to the ACS definition had a higher average salary when compared to those who never experienced a disability, $125,664 vs. $122,830 respectively. There are potentially interesting implications for this issue as rehabilitation counselors specialize in working with individuals living with disabilities, maximizing their earning capacity and quality of life. Currently rehabilitation counselors and vocational experts utilize significantly different methodologies to determine vocational rehabilitation potential and earning capacity of persons with a disability. It appears that there is a need for more peer-reviewed evidence based practices to objectively and reliably determine an individual's future earning capacity. This is one of the criticisms of forensic rehabilitation counseling that two different experts (plaintiff vs. defense) can arrive at very different determinations of an individual's rehabilitation potential and earning capacity based on the same facts, medical reports and testing data.

Limitations

Although every effort was taken to utilize sound methodology, including descriptive, qualitative, and ex post facto approaches for the study, several limitations should be taken into consideration. The first limitation of the current study relates to the research sample and the study's external validity. Although the sample size of this study (N = 412) was appropriate for the analyses completed, a larger sample of IARP members would increase the generalizability of the findings. A second potential limitation related to the sample is self-selection bias. Self-selection bias occurs when the group being studied has any form of control over whether to participate. Lavrakas (2008) posits, "Self-selection will lead to biased data, as the respondents who choose to participate will not well represent the entire target population" (p. 808). Participants' decision to participate may be related to traits that could potentially affect the study, thus, the participants who completed the survey may be a non-representative sample. The data collected were obtained via self-report, which is also understood as a potential threat to validity. The final limitation is the lack of generalizability to other counseling practitioners in the United States since this study only included counselors working in the private sector from the International Association of Rehabilitation Professionals.

Suggestions for Future Research

Future research could be expanded to include longitudinal research with the International Association of Rehabilitation Professionals to track the growth of earnings of rehabilitation counselors working in the private sector. This research could also examine self-reported rates for billable hours that counselors working in the private sector charge for their services. It would be interesting to determine if there are geographical influences on the rates that rehabilitation counselors charge for their services (e.g., major metropolitan areas vs. rural areas) or by type of case (e.g., medical malpractice, marital dissolution, workers' compensation). The IARP Delphi panel did not recommend that this question on billable rates be included in the IARP survey and thus this data was not collected in this study.

Research that compares and contrasts the earnings of rehabilitation counselors working in the public domain across the United States, private non-profits, proprietary, and forensic sectors should be conducted and would increase the validity of the findings. In addition, future studies could delve deeper into specific benefits that rehabilitation counselors earn as part of their compensation (e.g., healthcare, long term disability, 401K, life insurance) and would provide prospective students, graduates and individuals seeking employment with additional information when they are deciding where to practice.

Conclusion

Thus, in conclusion results from the IARP salary survey found that counselors working in the private sec-

tor were earning significantly higher wages compared to prior research efforts that the ACA and CRCC conducted. This can be particularly attributed to the fact that this sample was relatively older, had significant clinical experience and worked primarily in the private for profit sector. In this sample of counselors it was interesting to find that individuals who reported experiencing a significant life event (e.g., disability) according to the American Community Survey earned a higher mean salary than those who never experienced a disability.

The rehabilitation counseling profession is currently at a turning point regarding the qualifications of rehabilitation personnel (i.e., ending of CSPD requirements, Workforce Innovation and Opportunity Act) and the CORE/CACREP merger and it's future effect on accreditation standards for counselors. Finally, this study provides evidence in support of additional education for counselors working in the private sector as wages increase with additional educational attainment and professional credentials. Counselors will require increased training as the diversity of clients broadens to include a vast breadth of racial and ethnic identities, intellectual, mental, and physical disabilities and an influx of returning veterans who will require rehabilitation services.

References

American Counseling Association. (2014). *Counselor compensation study*. Alexandria, VA: Author.

Commission on Rehabilitation Counselor Certification. (2008). *2008 salary report: An update on salaries in the rehabilitation counseling profession*. Schaumburg, IL: Author.

ExpertPages. (2016). *2016 Expert Witness Fees and Practices Survey: An Assessment of current fees and practices by professionals actively engaged as expert witnesses or litigation consultants.* Sausalito, CA: Author.

Hsu, C., & Sandford, B. A. (2007). The Delphi technique: Making sense of consensus. *Practical Assessment, Research and Evaluation, 12*(10), 1–8.

LeBlanc, S., & Smart, J. F. (2007). Outcome Discrepancies Among Racially/Ethnically Diverse Consumers of Vocational Rehabilitation Services. *Journal of Applied Rehabilitation Counseling, 38* (1), 3–11.

Saldana, J. (2009). *The coding manual for qualitative researchers.* Thousand Oaks, CA: SAGE.

US Census Bureau. (2010). *United States Census 2010.* Retrieved from http://www.census.gov/2010census/.

US Census Bureau. (2014). *American Community Survey 2014.* Retrieved from https://www.census.gov/programs-surveys/acs/.

Vázquez-Ramos, R., Leahy, M., & Hernández, N. (2007). The Delphi Method in rehabilitation counseling research. *Rehabilitation Counseling Bulletin, 50*(2), 111–118.

Author Notes

Scott Beveridge is an Associate Professor at the George Washington University's Department of Counseling and Human Development. Jeff DiNardo is a PhD candidate at George Washington University.

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

The first author received no financial support for the research, authorship, and/or publication of this article. The second author who is a PhD candidate at the George Washington University received a small stipend of $500 from IARP for his assistance on the Delphi panel logistics, data collection and SPSS data entry.

Appendix A
Tables for Qualitative Responses

Table 3
Experience Hearing About CORE / CACREP Merger

Frequency	Code	Percentage of Total Responses
139	None or limited experience	33.7%
104	Via email communication with professional organizations	25.2%
58	Missing response	14.1%
27	Reported general negative concerns	6.6%
20	No response via "n/a"	4.9%
16	Report concerns about professional identity of rehab counseling	3.9%
15	Via conference presentations	3.6%
14	Reported feeling optimistic	3.4%
11	Report concerns about licensing	2.7%
8	Report general confusion	1.9%
7	Have been following the situation for some time	1.7%
5	Via published articles	1.2%
4	Report feeling like it has been over discussed	1.0%
3	Report lack of information/ information being hidden	0.7%
1	Writing PhD dissertation on the topic	0.2%

Table 4
Potential Effects of Merger on Income

Frequency	Code	Percentage of Total Responses
214	Reported no effect	51.9%
98	Reported Unsure	23.8%
49	Missing response	11.9%
26	No response via "n/a"	6.3%
13	Reported decrease due to increased competition	3.2%
8	Reported potential difficulty in finding new work/ moving between states	1.9%
5	Reported potential increase due to more opportunity	1.2%

Table 5
Significant Life Events That Affected Income

Frequency	Code	Percentage of Total Responses
257	None reported	62.4%
70	Missing response	17.0%
22	Recovery from Surgery	5.3%
17	Ambulatory Issues	4.1%
15	Chronic Illness	3.6%
8	Mental Health Issue	1.9%
6	Hearing Impairments	1.5%
5	Accident/Injury	1.2%
5	Motor Vehicle **Accidents**	1.2%
3	Temporary Disability	0.7%
2	Hospitalization	0.5%
1	Maternity Leave	0.2%
1	Military Injury	0.2%