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# EXTENT AND STRUCTURE OF TREATMENT OF SUBSTANCE ABUSERS IN MULTISERVICE MENTAL-HEALTH AGENCIES: A WORK BEHAVIOR ANALYSIS

by

Patricia Galatas Von Steen

A Dissertation Submitted to
the Faculty of The Graduate School at
The University of North Carolina at Greensboro
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of the Requirements for the Degree
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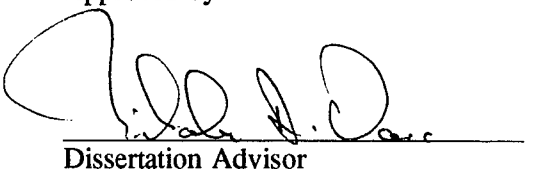
Approved by



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APPROVAL PAGE

This dissertation has been approved by the following committee of the Faculty of The Graduate School at The University of North Carolina at Greensboro.

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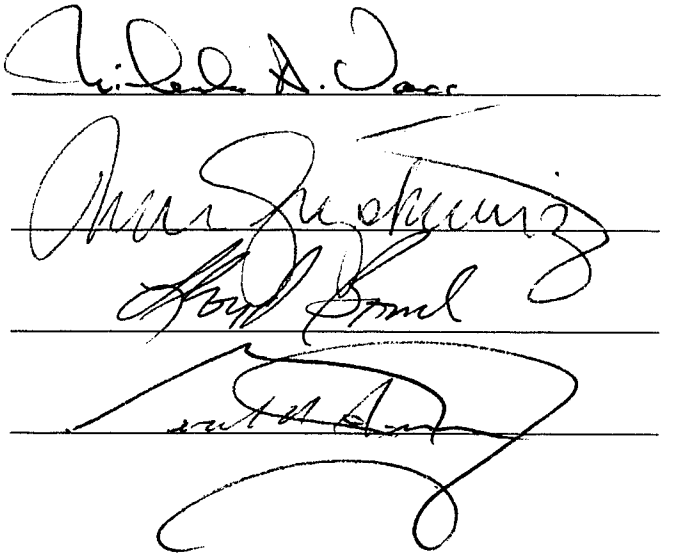

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This study investigated the provision of substance-abuse counseling in multiservice mental-health agencies by examining the work behaviors of mental-health service providers. The Treatment of Substance Abusers in Multiservice Mental Health Agencies Questionnaire was mailed to a sample of multiservice mental-health agencies in the 14 states that comprise the southern region of the United States. A series of exploratory factor analyses were performed on the frequency of occurrence, criticality, and combined (overall importance) item scores to determine the major dimensions underlying the work behaviors.

Results of the factor analyses indicated that the work behaviors of mental-health service providers, when providing substance-abuse counseling in multiservice mental-health agencies are characterized by five factors: (1) Substance-Abuse Specialty Counseling, (2) Assessment and Appraisal, (3) Counseling Process, (4) Professional Practice, and (5) Family Counseling. The frequency of occurrence analysis and combined analysis for the overall importance score resulted in the above factor sequence, but the criticality analysis yielded the following sequence: (1) Substance-Abuse Specialty Counseling, (2) Assessment and Appraisal, (3) Counseling Process, (4) Professional Practice, and (5) General Practice.

A comparison with other work-behavior analyses of professional counselors indicated a similarity between five factors in each study. Implications for counselors in training and counselor educators are discussed.

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# CHAPTER I

## INTRODUCTION

The United States Department of Health and Human Services (1994) estimated that in 1993, 12 million Americans 12 years or older used illicit drugs. Prevalence rates for alcohol use indicated that 11 million Americans 18 years of age or older were heavy drinkers. Three million of the latter population also were using illicit drugs. Of concern is that half of the 12 to 17 year olds surveyed perceived the occasional use of marijuana or trying cocaine, phencyclidine, or heroin as no great risk. They also perceived that having five or more drinks once or twice a week was not a risk. While these figures illustrate the severity of the substance-abuse problem, they are only an indication of the degree to which substances are being abused in the United States. It is increasingly evident that substance abuse contributes heavily to individual, family, and community problems (Black, 1979; Doweiko, 1990; Wegscheider, 1981). George (1990) indicated that drug-related suicides, homicides, automobile accidents, or other accidents are the leading cause of death in the United States. Asbury, Walker, and Maholmes (1992) and Symmonds-Mueth (1990) reported that domestic violence, child abuse, and divorce occur in much greater numbers in families that abuse substances. Additionally, those who abuse substances are more prone to work-related difficulties, infectious diseases, malnutrition, and psychosomatic and psychiatric disorders (Arif & Westermeyer, 1988; Blum & Roman, 1985; Kinney, 1983; Koenigsberg, Kaplan, Gilmore, & Cooper, 1985; Lett, 1987; Mirin & Weiss; 1991).

Treatment for those who abuse substances primarily takes place in two general settings: substance-abuse treatment facilities and community multiservice mental-health centers (Brown, Gfroerer, Thompson, & Bardine, 1985; National Institute on Drug Abuse, 1982). Googins (1984)

speculated that 1 out of every 10 clients in human service agencies potentially may need substance-abuse services and that an additional 20% to 40% of clients have been directly affected by someone who is a substance abuser. Since treatment of substance abusers involves a number of stages (i.e., assessment and/or crisis intervention, clinical intervention, and follow-up care), multiservice mental-health agencies play an important part in the provision of services to substance abusers (Stanton, 1988).

Despite the prevalence and pervasiveness of substance abuse, and the number of substance abusers seeking treatment in multiservice mental-health agencies, there has been some reluctance on the part of agencies to address the needs of substance abusers. One obvious barrier is the number of substance abusers who are hesitant to divulge their substance-abuse history or are in denial of their substance abuse. A second barrier is the lack of training of mental-health service providers in substance-abuse counseling. Substance-abuse training and coursework for mental-health service providers has been sparsely documented. Within counselor education training programs, training in substance-abuse counseling ranges from brief references of substance abuse in the general coursework to extensive experiential and didactic instruction (Hollis & Wantz, 1994; McDermott, Tricker, & Farha, 1991; Wigtil & Thompson, 1984).

The issue of substance-abuse training has special significance for professional counselors. Hosie, West, and Mackey (1988) studied 287 substance-abuse centers accredited by the Joint Commission on Accreditation of Hospitals and found many opportunities for the employment of professional counselors in these facilities. Other researchers (Burtnett, 1986; Hollis & Wantz, 1994; Richardson & Bradley, 1985; West, Hosie & Mackey, 1987) have reported that professional counselors also are taking advantage of the numerous opportunities for employment in mental-health agencies.

As professional counselors make a transition from the academic training environment to employment in community multiservice mental-health agencies, it is imperative that they possess the competencies needed to be effective. West et al. (1987) conducted one of the first studies that examined the specific roles and subsequent training needs of professional counselors employed in mental-health agencies. They surveyed the clinical directors of 250 multiservice mental-health agencies recognized by the National Institute of Mental Health. One significant finding was that professional counselors in multiservice mental-health agencies serve clients with a range of disorders as identified in the DSM-III, including those with substance-use disorders. While the West et al. (1987) study was informative regarding the range of services provided by professional counselors, they noted that their findings did not provide a complete picture of a professional counselor's role in multiservice mental-health agencies. Further investigations of the roles of professional counselors in multiservice mental-health agencies, especially those related to counseling clients with substance-abuse problems, are necessary to strengthen counselor training programs.

## Need for the Study

One professional area in need of clarification is the work of professional counselors and other mental-health service providers in multiservice mental-health agencies who provide services to substance-abusing clients. The focus of many studies concerning the responsibilities of mental-health service providers, and their knowledge and skills when working with clients with substance-abuse-related problems, have been limited to comparisons between professional and paraprofessional or recovering and non-recovering staff within substance-abuse treatment facilities.

Generally, researchers tend to agree that basic knowledge and skills in counseling substance-abusing clients is imperative (Hosie et al., 1988; Levy, 1964; Stanton, 1988). As

Stanton (1988) reported, mental-health service providers in different settings employ the same skills; only the emphasis or intensity with which the skills are applied varies.

One way to assess the parameters of substance-abuse training necessary for professional counselors working in multiservice mental-health agencies is through a work behavior analysis of the substance-abuse counseling provided by these agencies. This research would be beneficial to both educators and mental-health service providers (Rubin, Matkin, Ashley, Beardsley, May, Onstott, & Puckett, 1984). Educators could use the findings to develop a curriculum to assist counselors in training to gain proficiencies in the treatment of substance abuse. It also would allow professional counselor training programs with already established substance-abuse curricula to assess the appropriateness of their training. The research would provide a realistic perspective of counseling substance-abuse clients within multiservice mental-health agencies, and would provide information concerning the critical skills needed by professional counselors seeking employment in their agencies (Banken & McGovern, 1992; Levy, 1964; Nietzel & Fisher, 1981; Nicholas, Gerstein, & Keller, 1988; Schmitt & Ostroff, 1986).

## Statement of the Problem

Past analyses of work behaviors for counseling substance-abuse clients primarily have focused on substance-abuse specialty counselors in substance-abuse treatment facilities. These studies also have been initiated for credentialing or certification purposes (Birch & Davis, 1984; National Certification Reciprocity Consortium/Alcohol and Other Drug Abuse, Inc., 1992). While the knowledge gained from these studies has provided a framework for training, they have not specifically addressed the critical skills necessary for preparing professional counselors to be effective in counseling substance abusers in multiservice mental-health agencies.

An important task of professional counselor education programs is to assure that counselors in training are receiving knowledge and developing skills necessary for effective work

with clients in a variety of mental-health settings. One of the ways to determine the parameters of training professional counselors to work with substance abusers in multiservice mental-health agencies is to conduct a work behavior analysis concerning counseling substance-abuse clients in these agencies. The present study was undertaken to address this need. Examined were work behaviors that are specific to counseling substance abusers in multiservice mental-health agencies.

## Research Questions

This study examined the following research questions:

1. What is the factor structure of work behaviors which characterize the treatment of substance abusers in multiservice mental-health agencies, as measured by ratings of frequency of occurrence on the Treatment of Substance Abusers in Multiservice Mental-Health Agencies Questionnaire?
2. What is the factor structure of work behaviors which characterize the treatment of substance abusers in multiservice mental-health agencies, as measured by criticality ratings on the Treatment of Substance Abusers in Multiservice Mental-Health Agencies Questionnaire?
3. What is the factor structure of work behaviors which characterize the treatment of substance abusers in multiservice mental-health agencies, as measured by combined frequency of occurrence and criticality ratings on the Treatment of Substance Abusers in Multiservice Mental-Health Agencies Questionnaire?

## Definition of Terms

The following terms are defined as they apply in this study:

Treatment - a therapeutic intervention (George, 1990).

Substance Abusers - individuals who continue to use alcohol or other mood-altering chemicals despite the adverse consequences (e.g., physical, psychological, social, occupational, legal) that their continued usage causes (George, 1990; Lewis, Dana, & Blevins, 1988).

Mental-Health Service Providers - individuals who provide comprehensive outpatient and inpatient/residential mental-health treatment care and services. The literature defines mental-health service providers as marriage and family therapists, psychiatrists, psychologists, psychiatric nurses, professional counselors, social workers, and substance-abuse counselors (paraprofessionals) (Hershenson & Power, 1987; Orford, 1992; Palmo & Weikel, 1986; Sheppard, 1991).

Multiservice Mental-Health Agencies - those agencies that receive state funding and provide comprehensive outpatient and inpatient/residential mental-health treatment care and services. Comprehensive services include inpatient and outpatient care, emergency services, partial hospitalization, and consultation and education (National Institute of Mental Health, 1985, 1990; West, et al., 1987).

Work Behavior Analysis - is an investigation of the general structure of work activities performed by individuals in the same job position. For the purpose of this study, a work-oriented job analysis was conducted which described the work outcomes or tasks completed by mental-health service providers when providing counseling for substance abusers in multiservice mental-health agencies (Lopez, Kesselman, & Lopez, 1981).

## Organization of the Study

This dissertation study is presented in five chapters. Chapter I is an introduction to the prevalence of substance abuse and treatment of those who present to multiservice mental-health agencies with substance-abuse problems. The chapter provides an overview of the investigation,

including the need for the study, statement of the problem, research questions, and definition of terms.

Chapter II contains the review of related literature section of the study. This chapter reviews the literature related to multiservice mental-health agencies and substance abuse, mental-health service providers, and mental-health service provider training for treating substance abusers. The purpose of work behavior analyses and the analyses that relate to this study will be discussed.

Chapter III addresses the design and methodology used in the study. Research questions are re-stated. Participants and procedures are described, including those used to develop the Treatment of Substance Abusers in Multiservice Mental-Health Agencies Questionnaire. The data analyses used in the study are introduced.

Chapter IV reports the factor analytic procedures used to determine the factor structure of work behaviors which characterize the treatment of substance abusers in multiservice mental-health agencies. The five factors derived from the exploratory analyses are presented.

Chapter V contains a summary of the research findings and the limitations of the study. The implications of the findings for counselors in training and counselor educators are discussed. Lastly, recommendations for further research are explored.

# CHAPTER II

# REVIEW OF RELATED LITERATURE

This chapter, which is divided into two main sections, provides a discussion of literature relevant to a study of the treatment of substance abusers in multiservice mental-health agencies. The first section of this chapter includes literature on (a) the prevalence and treatment of substance abusers in multiservice mental-health agencies, (b) mental-health service providers in multiservice mental-health agencies, and (c) training standards and credentialing for substance-abuse specialty counselors. The second section of this chapter includes a summary of the purposes of work behavior analyses and studies that have been conducted for professional counselors and substance-abuse specialty counselors.

## Multiservice Mental-Health Agencies and Substance Abuse

Community multiservice mental-health agencies were originally established to serve individuals with severe and chronic mental illnesses. However, due to the range of psychological and social problems of today's clients, mental-health agencies, which once offered only specialized services have broadened their services to meet the needs of a diverse client population, including individuals who abuse substances (Langsley, 1980; Winslow, 1982).

Brown et al. (1985) indicated that drug-abuse treatment often takes place in two general settings: drug-abuse treatment programs and community multiservice mental-health agencies. The National Institute on Drug Abuse (NIDA) (1982) found that of the 3,013 drug-abuse treatment units known to them, 1,327 or 44% were dedicated to drug-abuse treatment only while 754 or 25% were based in community multiservice mental-health agencies. The remaining 935 units were located in hospital settings (12%), correctional settings (3%), or other facilities (16%).

Among the treatment units, 54% of clients were treated in free standing drug-abuse treatment facilities, 16% in community multiservice mental-health agencies, 12% in hospital settings, 3% in correctional facilities, and 15% in other facilities.

Googins (1984) speculated that 1 out of every 10 clients in human service agencies could potentially need substance-abuse services, and an additional 20% to 40% of clients have been directly affected by someone who is a substance abuser. A similar finding was noted by Cummings (1979) who identified that 23% of the patients in psychotherapy in a metropolitan mental-health center were suffering from substance-abuse problems or emotional problems exacerbated by substance abuse. This finding may be due to the high rate of clients at mental-health agencies who are dually diagnosed as having a psychiatric disorder and a substance-abuse problem (Koenigsberg et al., 1985; Lett, 1987).

The role of multiservice mental-health agencies when working with substance-abuse problems is varied. Some agencies provide a range of services including consultation, education and prevention programs, and a full range of substance-abuse treatment services, while others view their role as restricted to the linkage between intake and long-term treatment facilities (Hershenson & Power, 1987; Renner, 1976). Renner (1976) stated that the needs of substance abusers in multiservice mental-health centers include crisis intervention and emergency medical care, detoxification, medical or psychiatric inpatient care, halfway house placement, and/or aftercare. He also reported, however, that despite the large number of substance abusers who use multiservice mental-health centers as their point of entry into the care-giving system, multiservice mental-health centers often have neglected the needs of these clients. One of the stated reasons for the failure to identify the problems of substance abusers or to provide them with minimal attention only, is the large number of people who come to multiservice mental-health agencies with individual and family concerns, which they do not recognize as being substance-abuse-related

(Cuskey & Premkumar, 1973; Kagle, 1987; King & Lorenson, 1989; Mayer, 1983). Other reasons for not identifying substance-abuse problems include mental-health service providers' lack of acceptance of the severity of the problem, inadequate networking with referral sources, inaccurate diagnosis due to lack of training, and prejudices toward substance abusers (Allen, Peterson, & Keating, 1982; Cuskey & Premkumar, 1973; Googins, 1984; Kagle, 1987; King & Lorenson, 1989; Knox, 1969, 1971, 1973; Lawson, 1982; LoSciuto, Aiken, & Ausetts, 1984; Mayer, 1983; Renner, 1976).

## Mental-Health Service Providers

Research has shown that a multidisciplinary group of professionals and paraprofessionals often form the treatment team of multiservice mental-health agencies (Banken & McGovern, 1992; Burtnett, 1986; West et al., 1987). One specialized group of the mental-health service providers in multiservice mental-health agencies is substance-abuse specialty counselors.

### Roles of Mental-Health Service Providers

Weikel and Palmo (1989) described community-based multiservice mental-health agencies as staffed by individuals from a core of mental-health disciplines. Mental-health service providers comprise paraprofessionals and professionally trained and/or certified counselors working in mental-health agencies, psychiatrists, psychologists, social workers, or psychiatric nurses (Mulligan, McCarty, Potter, & Krakow, 1989). Subsequently, the roles of those titled mental-health service providers often can be non-discipline-specific and confusing. The literature regarding the specific roles of mental-health service providers from different disciplines has been sparse, with the exception of counselors working in mental-health agencies. Hershenson and Power (1987) broadly defined the counselor's role in mental-health centers as one of prevention, advocacy, consultation, education, mediation, and mentoring. Similarly, Leighton (1990)

categorized the spectrum of efforts of community mental-health service providers' as curing, alleviating, averting relapse, preventing first occurrence, and health promotion.

The Occupational Outlook Handbook (U.S. Department of Labor, 1994) reports that the personal and social problems treated by counselors in mental-health agencies include drug and alcohol abuse, family violence, suicide, work-related problems, criminal behavior, problems of aging. Counselors addressing these problems also work with rape victims, individuals and families trying to cope with illness and death, and individuals with emotional problems.

West et al. (1987) investigated the counselor's role in multiservice mental-health agencies. Their research determined that counselors perform a host of administrative duties and a range of clinical interventions with individuals, groups, and families in a variety of mental- health settings (e.g., outpatient and partial hospitalization.)

It is apparent from the literature that the position of mental-health service providers or, more specifically, counselors in multiservice mental-health agencies, encompass a broad range of roles with each role entailing a variety of activities and requiring a different set of behaviors and competencies. One role often referred to in relation to multiservice mental-health agency counseling is working with clients having substance-abuse problems. Van Wormer (1986) reported that counselors working with substance-abuse clients need to have knowledge and skills as a diagnostician, teacher, "broker" (liaison), advocate, therapist, and group leader. Cuskey and Premkumar (1973) stated these roles are important during all phases of addiction treatment including crisis intervention, progressive treatment, social re-entry, and following discharge from treatment. Hence, mental-health service providers play an important role in the treatment of substance abusers since substance-abuse treatment may be initiated or continued within the multiservice mental-health agency.

Loesch and Vacc's (1993) study of the work behaviors of professional counselors supported the importance of counselors obtaining knowledge and skill in counseling substance abusers. Of the 722 Nationally Certified Counselors responding to the survey, 236 indicated that counselees would consider it "critically important" for counselors to be able to counsel substance abusers, although they may not frequently perform this work behavior. An additional 220 respondents indicated that being able to counsel substance abusers was "very important" in their professional capacity. In summary, mental-health centers and mental-health service providers play an important role in the recognition and treatment of substance abusers at all stages of treatment.

Proficiency versus Specialization in Treating Substance-Abuse Clients

There appear to be opposing views related to general counseling proficiency or specialization in substance-abuse counseling. One view is that all mental-health service providers should be proficient in substance-abuse counseling. The other view is that only those with special interest in substance-abuse counseling should receive specialized training.

In a related discipline, but useful in this situation, is the work done by a American Psychological Association Committee which recognizes specialties and proficiencies in psychology. They defined proficiencies as "a circumscribed domain of practice for which there is a demonstrated public need and that has been recognized by the profession" (DeGrott, 1994, p. 48). They described specialization as that which entails advanced knowledge and skills in specific skill area.

Richardson and Bradley (1985) noted the significance of this issue to curriculum development based on a survey of community agency counseling programs within counselor education programs. Of the 309 counselor education programs responding, 35 or 11% reported that the principle barrier to developing a community agency counseling graduate program was

differences in philosophical orientation and beliefs of the faculty concerning generic or specialized training of counselors.

Proficiency in Substance-Abuse Counseling

Advocators of the proficiency model recommend infusing the "body" of knowledge concerning substance-abuse treatment in general counseling skills (Stanton, 1988). Hence, mental-health service providers are trained as generalists and obtain a level of competency in counseling substance abusers as well as other populations.

A few studies have been conducted to evaluate the effectiveness of such training. Randolph (1979) surveyed community multiservice mental-health agency directors concerning their expectations of the skills and characteristics of master's-level personnel. Within the cluster of items that examined employee's skills in relation to specialized populations and settings, none of the items were ranked high; the item that addressed working with clients who abuse alcohol or drugs was ranked as moderate. Randolph (1979) suggested that community multiservice mental-health agency directors may prefer to hire master's-level practitioners who have good general skills, with the assumption being that their skill development in working with special populations will take place within the job setting.

A similar finding was noted by DeRidder, Stephens, English, and Watkins (1983). They surveyed 345 administrators from community multiservice mental-health agencies within Tennessee to determine the importance of master's-level counselor qualifications. Their goal was to determine the importance of 13 skill areas as they affect counselors' functioning within 11 community multiservice mental-health agencies, for the purpose of designing relevant curricula for counselors training to work in community multiservice mental-health agencies. Of the 21 mental-health centers which responded, competency in substance and child-abuse was ranked 10th among

the 13 skill areas. The four core competencies found to be universally important to the administrators were learning and adjustment, counseling, ethics, and report writing.

An important factor that has to be considered, especially in multiservice mental-health agencies, is the skills needed by mental-health service providers to counsel clients during the 1990's. As Powell (1993) stated, counselor skills and competencies will need to broaden as the characteristics of substance abusers change. Substance abusers of the 1990's have more chronic illnesses, financial and legal problems, psychological difficulties, and societal problems. This forces mental-health service providers, who are likely to counsel substance abusers, to expand their repertoire of skills to include proficiencies in various modes of substance-abuse treatment and treatment approaches. The counseling literature has argued that there is a need to prepare counselors to work with a complex and heterogeneous clientele (Hershenson, 1988; Wantz, Scherman, & Hollis, 1982). In the substance-abuse field, experts agree that substance-abuse counseling should be a specialty and those who treat substance abusers need special training (Banken & McGovern, 1992).

Substance-Abuse Specialty Counseling

Within the realm of counselor education programs, some writers have noted a trend toward counselor specialization (Richardson & Bradley, 1985; Wantz et al., 1982). Richardson and Bradley (1985), in a study of counselor education program curricula, found that elective courses were "highly specialized, sometimes nontraditional, and highly responsive to current professionals' needs" (p. 180). Two of the most frequently offered elective courses were alcoholism and drug addiction. Richardson and Bradley (1985) indicated that accreditation, certification, and licensure standards dictate the specific expertise necessary for counselors to effectively function in community agency settings and thereby impact educational preparation.

Several predictions have been made regarding counselor specialization and its impact on counselor training programs. In 1980, members of the American Mental Health Counselors Association predicted that during the period 1985 to 1989, the mental-health profession would become highly specialized, which would extend into the year 2000 and beyond (Anderson & Parente', 1980). Krumboltz and Menefee (1980) predicted that by the year 2000, counselors' responsibilities will change as they are forced to be more accountable for counseling outcomes. Also, they will become highly specialized due to a diverse client population, and will increasingly provide preventive and transitional counseling. Counselor educators will be forced to provide individualized training programs that address specific competencies necessary for specializations. In addition, counselors in training will have to show competence in skill and knowledge areas as demonstrated by behavior samples.

## Training Standards for Treating Substance Abusers

Selin and Svanum (1981) stated that the "pervasiveness of drug-related problems means that mental-health care professionals should have at least a basic understanding of the evaluation and treatment of alcoholism and drug-related problems" (p. 7). However, an extensive review of the literature demonstrates a level of variation concerning substance-abuse training in mental-health training programs. The substance-abuse knowledge and skills needed by mental-health service providers, if they are to function effectively, have yet to be clearly delineated in the literature. The American Board of Medical Specialties (ABMS) and Council for Accreditation of Counseling and Related Education Programs (CACREP) have two contrasting approaches to specialty training in substance abuse. The American Board of Medical Specialties (ABMS) (Galanter, Kaufman, Schnoll, & Burns, 1991) provides specific guidelines for education in medical specialties. The ABMS's specialty program in substance abuse advises that trainees receive instruction in scientific issues and their applicability to prevention and treatment,

interpersonal techniques, approaches to identification of substance abuse, how to confront substance abusers, the settings in which interventions take place, and treatment approaches. In contrast, the CACREP, which offers specialty accreditation in community counseling and mental-health counseling, does not provide specific guidelines or make reference to the need to provide substance-abuse training. However, the CACREP standards do specifically indicate that students in the gerontological, marriage and family, and student affairs specialty programs need to be knowledgeable and skill competent in substance-abuse counseling.

Although accreditation organizations' standards regarding substance-abuse training are diverse, several researchers (e.g., King & Lorenson, 1989; Renner, 1976) agree that mental-health service providers must receive adequate training in looking for a connection between client problems and substance abuse. Mental-health service providers need to know how to assess whether clients who have a substance-abuse problem should receive treatment in a specialized substance-abuse facility or remain in the mental-health system. To counsel alcohol-abuse clients, they specifically need to be knowledgeable and competent in assessment and diagnosis, limit setting and leverage, client contracts for changing drinking behavior, alcoholism education, and different treatment modalities (i.e., group, family, self-help groups) (King & Lorenson, 1989).

Professional Counselors

Many counselor education programs have recognized the importance of specialized study in substance-abuse counseling. Hollis and Wantz (1994) found that the number of specialized courses in substance-abuse counseling has been steadily rising since the mid-1980's. Of the 280 units responding to the curricula portion of the survey, 60 indicated a plan to add a substance-abuse course to their curricula, making it the number one ranked course to be added during the years 1993-1995. The addition of marriage and family courses ranked a close second. Interestingly though, more programs were adding an emphasis in marriage and family counseling

over substance abuse. Perhaps the difference could be attributed to faculty certification. Of the 706 faculty members responding to the survey, 429 indicated they held certifications in marriage and family while only 37 held an alcohol-, drug-, or substance-abuse certification.

McDermott et al. (1991) support specialized training of professional counselors in substance-abuse counseling, although they reported that many counseling graduate programs continue to include alcohol counseling as a brief component within other coursework. They studied students' ability to make more appropriate responses to an alcoholic client or to score higher on a post-training objective test about alcohol consumption following a three-hour unit of instruction about alcoholism. Their findings demonstrated that while factual knowledge may be imparted in a limited time period, a longer period of instruction may be necessary to enhance students' clinical skills. McDermott et al. (1991) advocated for the development of (a) training models in substance abuse, and (b) guidelines related to substance-abuse curricula.

One counselor education program, which recognized the importance of specialized training to enhance students' clinical skills, linked with several community agencies to create an intensive alcohol-abuse training program (Wigtil & Thompson, 1984). This program, in cooperation with a community agency and court system, provided students with an opportunity to learn about alcohol-abuse counseling by offering education and counseling to court-referred clients who were arrested, charged, and convicted of driving while intoxicated. Prior to becoming involved with the program, counseling students had to first attend the same program as clients and participate in didactic and experiential opportunities to strengthen their skills. Students who completed the program were found to apply their learnings in their own work settings and were more proactive in dealing with clients' alcohol-abuse-related problems.

Individual professional counselors also recognize the need for training in substance abuse. Wilcoxon and Puleo (1992) investigated the professional-development needs of AMHCA

members. Of the 288 who responded to the survey, 210 indicated that their needs, in counseling special populations, involved working with clients who had substance-abuse problems.

Practicing Psychologists

Several researchers (e.g., Hawes, Benton, & Bradley, 1990; Lubin, Bradley, Woodward, & Thomas, 1986; Selin & Svanum, 1981) indicated that many psychology programs are concerned about the problems of substance abusers, but their curricula have not reflected the concern. For example, Selin and Svanum (1981) studied 107 American Psychological Association (APA)-approved clinical training programs to assess their level of training in substance abuse. The results indicated that students received minimal coursework and experience with substance abusers. Of the 42% of the programs offering at least one course in substance abuse, the courses were provided on an elective basis. In 66% of the programs, students received some exposure to substance-abuse issues, but often it was interwoven into the more general required coursework, resulting in exposure that comprised approximately 12% of the total class time.

The Selin and Svanum (1981) study was replicated by Lubin et al. (1986) with a slightly different sample of psychology programs. They assessed the substance-abuse training in 89 APA-approved counseling and clinical psychology programs. Their findings were similar to the earlier study except that the number of programs with at least one course in substance abuse decreased. However, the amount of attention given to substance abuse in the general coursework increased from that of the Selin and Svanum (1981) study. In both studies, the program directors indicated that substance-abuse training is presently inadequate and should be a higher priority in graduate programs. Selin and Svanum (1981) argued that until graduate programs recognize the need to provide students with specialized training in substance abuse, mental-health professionals will remain indifferent to the problem.

Social Workers

A majority of the studies of social work training in substance abuse have not focused on the level of training but the outcome of such training. Specifically, the literature has addressed the ramifications of social workers' attitudes toward substance abusers, the specific skills necessary to provide effective treatment to substance abusers, and social workers' willingness to treat substance abusers.

Several researchers (e.g., Bailey, 1970; Duxbury, 1983; Googins, 1984; Kilty, 1975) have studied the effect of social workers' substance-abuse training on their attitude and willingness to treat substance abusers. Bailey (1970) conducted a study of the effects of training on the attitudes of social caseworkers. The post-training measure indicated that social caseworkers tended to exhibit a greater willingness following training to view the treatment of alcoholics as part of their regular professional responsibility.

Studies regarding social workers' biases toward alcoholics have not been as favorable. Peyton, Chaddick, and Gorsuch (1980) distributed questionnaires that directly and indirectly measured the willingness of 80 social work graduate students to treat alcoholics. The indirect measure employed case vignettes, and the direct measure asked respondents to choose from a list of 15 client types, those which they preferred to treat. On the indirect measure, students showed a bias against alcoholics. On the direct measure, only 29 of the 80 respondents reported they would be willing to treat alcoholics. The researchers concluded that (a) the students may have attended to information in the vignettes other than that pertaining to the indicators of alcoholism, and (b) if students were not attending to substance-abuse indicators in the study, they also may not attend to them when doing treatment planning and implementation in other settings.

Duxbury (1983) replicated the Peyton et al. (1980) study and corroborated their findings. The 40 students who responded to the indirect measure indicated only a slightly negative bias

toward working with alcoholics. In contrast, 42% of the 38 students who chose to respond to the direct measure indicated a negative bias toward working with alcoholics, even though 69% of them had previous experience with treating alcoholics. Students' experiences with alcoholics did not significantly correlate with their willingness to treat them. Students chose specific clients based on their belief that clients could benefit from their professional skills and experience. Even those who had previous experience with alcoholics reportedly did not believe they had a sufficient level of skill to diagnose and treat alcoholics. This finding does not support that of Bailey (1970) which indicated that previous experience may correlate with more positive attitudes towards alcoholics. Duxbury (1983), who indicated that social-work graduate students must at least understand the precursors of alcoholism, the importance of their attitude toward alcoholics, and community sources for referring alcoholic clients, inferred that students may continue to perceive alcoholics as difficult even with advanced training.

Other researchers have sought to clarify factors that act as barriers to social workers being able to recognize and treat those with substance-abuse problems (Googins, 1984; Kagle, 1987; Kilty, 1975). Kagle (1987) examined 100 representative case records of social workers employed in four practice settings and conducted interviews with social workers of 85 of the cases. Substance abuse was identified as a problem in 12 case records, but interviews revealed that substance abuse may have been a problem in another 27 cases. The social workers reported several reasons for not discussing the concern of substance abuse with clients: (a) it was not the client's primary problem, (b) focusing on substance abuse may have distracted attention from the real problem or have a negative effect, (c) there was a absence of substance-abuse treatment programs in the area or those in existence were ineffective, (d) referrals were of a medical and not a social-service function, (e) others in the agency would not agree with the referrals, or (f) the client or family was not ready to deal with the problem. Kagle (1987) noted that the social

workers in their study possessed the knowledge to provide secondary prevention for substance abuse but felt constrained by professional and organizational norms.

Googins (1984) identified six general factors that prevent social workers from making appropriate referrals of clients to alcoholism treatment or treating the alcoholics themselves. These factors include informational and attitudinal myths about alcoholism, pessimism concerning treatment, failure to clarify alcohol abuse as a symptom or as a cause, fear of confrontation, denial by their employing agencies, and the belief that specialized alcoholism-treatment programs are available for referral of clients, if needed. Googins (1984) indicated that these barriers prevent human service agencies from developing an "adequate infrastructure" for serving substance-abusing clients.

## Credentialing in Substance-Abuse Specialty Counseling

In the substance-abuse field, certification requirements have often not required academic credentialing (Kolpack, 1992). This is partly due to the high percentage of recovering substance abusers who have served as the primary mental-health service provider to substance abusers. However, Blum and Roman (1985) predicted that "the pressures for universalism and standardization of credentials will prevail, and that eventually the only route of entry into these occupations (alcohol-related), for both recovered alcoholics and non-alcoholics will be formal academic training" (p. 376).

The literature indicates that counselors, whether recovering counselors or non-addicted counselors, enhance their credibility among substance abusers when they obtain professional credentials. (Lobello, 1984; Mulligan et al., 1989; Rohrer, Thomas, & Yasenchak, 1992.) Kolpack (1992) conducted a survey of 230 alcoholism counselors in treatment centers in Wisconsin and found that the recovering counselors were either certified (74%) or working toward

certification (24%), while 62% of the non-addicted counselors were certified and 35% had plans to become certified.

Milgram (1990) indicated that the purpose of certification is to document that an individual has met an educational component, developed certain skills, and met the employment criteria. However, requirements differ by certifying organization. Milgram (1990) indicated that some of the general content areas covered in substance-abuse education include information on the effects of alcohol and drugs on the body, alcoholism and drug dependency, treatment, counseling, crisis intervention, screening, intake, orientation and assessment, ethics, case management and the development and coordination of treatment plans, client evaluation, follow-up reporting, and record keeping.

Rohrer et al. (1992) surveyed 66 male and 24 female clients in a residential substance-abuse treatment center to assess what they believed were the characteristics of an effective addictions counselor. The respondents indicated that the counselor's positive traits, in rank order, were understanding, concerned, caring, experienced, honest, certified, good listener, streetwise, easy to talk to, direct, and open minded. For this sample of clients, it appears that mental-health service providers with general knowledge in counseling would be sufficiently qualified and trained to provide substance-abuse counseling in their respective agencies.

No singular national certifying body exists in the substance-abuse field and certifications offered vary by certification organization and state. Some offer a more general certification in alcohol and drug abuse, while others offer separate certification in alcoholism counseling or drug-abuse counseling. The national organizations that presently offer substance-abuse specialty certification for counselors are the International Certification Reciprocity Consortium/Alcohol and Other Drug Abuse, Inc. (ICRC/AODA) and the National Association of Alcoholism and Drug Abuse Counselors (NAADAC). In order to recognize the training of degreed professionals, the

National Board for Certified Counselors (NBCC), along with ICRC/AODA, NAADAC, and the Commission on Rehabilitation Counselor Certification (CRCC) also offer a substance-abuse specialty certification. The title given those who qualify for the specialty certification through NBCC is the Master's Addiction Counselor (MAC). The certification programs for these various organizations are summarized in more detail below:

International Certification Reciprocity Consortium/Alcohol and Other Drug Abuse, Inc. (ICRC/AODA). A certification reciprocity program is offered through the International Certification Reciprocity Consortium/Alcohol and Other Drug Abuse, Inc. (ICRC/AODA). It consists of 26,000 alcohol and drug-abuse counselors certified by 43 international certifying bodies (J.P. Henderson, personal communication, July 14, 1994). This agency administers the National Certification Examination for the credentialing boards they represent, and they have three levels of certification: Certified Addictions Counselor, Certified Drug Counselor, and Alcohol and Drug Counselor.

National Association of Alcoholism and Drug Abuse Counselors (NAADAC). The largest autonomous certifying organization for alcohol and drug abuse counselors is the National Association of Alcoholism and Drug Abuse Counselors (NAADAC). NAADAC offers both a single and dual credential for alcoholism and drug-abuse counselors. At present, approximately 18,000 drug and alcohol counselors have either the National Certified Addiction Counselor Level I or II certifications, each of which requires varying levels of professional experience and informal academic preparation.

Master's Addiction Counselor Certification. Milgram (1990) argued that degreed persons are not afforded an opportunity to obtain certification through alternative routes even though they are becoming more predominant in the substance-abuse field. Like all non-degreed substance-abuse counselors, degreed professionals must seek classroom hours in the core areas and obtain

the work experience specified by organizations who certify substance-abuse counselors. Due to the lack of recognition of alternative educational training (i.e., master's degrees in counseling or social work), degreed professionals are discouraged from either entering the substance-abuse field or engaging in the certification process (Van Wormer, 1986). Milgram (1990) called for increased flexibility in the certification process to attract counselors and to meet the needs of substance abusers. Relatedly, Van Wormer (1986) indicated that all mental-health professionals not professionally trained in counseling (e.g., social workers, non-degreed staff, business undergraduates) receive the generic term "counselor" in the substance-abuse field, and thereby lose their professional identity.

In order to address the concerns related to recognition of the formal academic training earned by master's level counselors, four national certification organizations are offering a master's level certification in substance-abuse counseling, titled the Master's Addiction Counselor (MAC). The four organizations are the International Certification Reciprocity Consortium/Alcohol and Other Drug Abuse, Inc. (ICRC/AODA, formerly National Certification Reciprocity Consortium), the National Association of Alcoholism and Drug Abuse Counselors (NAADAC), the National Board of Certified Counselors (NBCC), and the Commission on Rehabilitation Counselor Certification (CRCC). Each organization either presently has their own substance-abuse specialty certification or is in the process of implementing one. The effective date of this initiative was January, 1995 (T. Clawson, personal communication, September 15, 1994).

## Work Behavior Analyses

The literature indicates that mental-health service providers work with substance abusers or those with substance-abuse related problems. Additionally, training programs have recognized the need to provide opportunities for mental-health service providers to obtain competency or a

specialization in substance-abuse counseling. However, a lack of specificity of the work behaviors exhibited by mental-health service providers when providing services for substance abusers in multiservice mental-health agencies has left many programs without direction for curriculum development. A work behavior analysis of multiservice mental-health agencies concerning substance-abuse counseling will provide academic programs with the necessary direction for training counselors and other mental-health service providers.

Thompson and Thompson (1982), who reviewed 26 federal court cases centered around job-analyses procedures, identified five necessary standards for avoiding legal scrutiny when conducting work behavior analyses. The first standard states that a work behavior analysis must be performed on the exact job for which the selection device will be used, and the person conducting the analysis must be able to describe the procedure employed. The second standard involves the collection of data for the work behavior analysis, which includes obtaining pre-analysis data from interviews with incumbents, supervisors, and administrators; training manuals or other publications; on-the-job observations; questionnaires; and checklists. Thirdly, all the tasks, duties, and activities relevant to the job should be included in the job analysis. The fourth standard involves the types of information gleaned and the valid construction of work behavior studies. While a host of items (e.g., critical incidents, aspects, aptitudes) are assessed, Thompson and Thompson (1982) found that knowledge, skills, and abilities are most frequently mentioned in court cases. Fifth, tasks should be identified prior to a work behavior analysis if it is to be deemed acceptable.

One of the first tasks involved in conducting a work behavior analysis is to decide which conceptual model is most appropriately aligned with the purpose of the analysis to be conducted. Cornelius, Carron, and Collins (1979) and Lopez et al. (1981) described three models used in developing work behavior analyses: (a) job-oriented approach which focuses on work activities,

(b) worker-oriented approach which identifies the behaviors inherent in completing work tasks, and (c) trait-oriented approach which examines the abilities required to perform the work.

Once a model is chosen, conceptual, procedural, and analytical decisions must be examined (Loesch & Vacc, 1993). As Loesch and Vacc (1993) indicated, some key conceptual decisions include the purpose of the analysis, how the results will be used, and the type of information desired. Procedural decisions involve methodological issues and the task format (e.g., which rating scales will be used to examine the individual tasks).

The most widely known purpose of work behavior analyses is to seek compliance with the "Uniform Guidelines on Employee Selection Procedures" (1978). The 1971 landmark case of Griggs v. Duke Power Company set a legal need for job analyses in validating selection procedures as outlined in the Equal Employment Opportunity Commission Guidelines (EEOC) (Kuehn, Stallings, & Holland, 1990). The EEOC Guidelines provide employers and test users with a link between selection procedures and job performance in order to lessen the adverse impact on minority groups. While validity investigations for credentialing examinations may be less rigorous than those used for employee selection procedures, the EEOC Guidelines and the litigation that led to their development, set a precedence for work behavior analyses of credentialing examinations (Kuehn et al., 1990; Shimberg, 1990; Smith & Hambleton, 1990).

Similar to the broader federal guidelines, the Standards for Educational and Psychological Testing (American Educational Research Association [AERA], American Psychological Association, and National Council on Measurement in Education, 1985) address the importance of demonstrating a link between credentialing test content and job analyses. As the Standards (AERA et al., 1990) indicate, "The primary purpose of licensure or certification is to protect the public. One of the most crucial reasons for conducting work behavior analyses is to protect the

public by assuring that professionals possess the knowledge and skills necessary for competent performance (Jaeger, 1990a; Nelson, 1994).

The results of work behavior analyses have been used to design training programs, establish performance-appraisal systems, guide career-planning efforts, compare compensation for similar jobs (Lopez et al., 1981; Sanchez & Levine, 1989), or delineate the similarity or dissimilarity between work activities of individuals in similar positions (Loesch & Vacc, 1993; Valle, 1979). There are clearly solid reasons for conducting work behavior analyses.

## Work Behavior Analyses of Mental Health Service Providers

Several extensive work behavior analyses of mental-health service providers have been conducted. An analysis of the work behaviors of professional counselors will be followed by two analyses that specifically examining the work behaviors of substance-abuse specialty counselors.

### Professional Counselors

Loesch and Vacc (1993) conducted a study of the work behaviors of professional counselors as a means of providing professional and legal support for the National Counselor Examination (NCE). The general-practice NCE is administered by the National Board for Certified Counselors (NBCC) as part of their counselor-certification process. The authors based their study on several premises: (a) the respondent pool would be limited to National Certified Counselors (NCCs) from a variety of work settings, (b) the study would focus on the work-oriented behaviors of professional counselors, (c) the study would be exploratory in nature, and (d) work behaviors chosen would reflect those performed by all professional counselors in lieu of those who perform specialty functions.

The initial items for the work behavior analysis survey were obtained from the professional literature and materials, and through extensive solicitation from practicing counselors. The solicitation announcements to counselors yielded approximately 500 work behavior statements

which were then collapsed with the behaviors obtained from the literature and professional materials. The authors then critically examined the list of statements to eliminate duplications, inappropriate statements, and/or those not deemed to be work behaviors. A revised list was created consisting of 329 counselor work behaviors.

The second phase of the item-refinement process involved sending the survey to all ACA membership division officers and a select group of representatives from the American Association of State Counselor Boards (AASCB). These 71 professionals modified and/or edited the survey, resulting in a final list of 151 work behavior statements which were judged to be appropriate for inclusion in the survey.

The third phase involved constructing the survey and survey packet and selecting a random sample of NCCs. Respondents were asked to indicate the frequency and importance of each work behavior item using a 5-point response scale. The scale ranged from "never" to "routinely" for frequency and "of no importance" to "critically important" for the importance of each work behavior. Demographic data were also obtained from each respondent. The final survey was forwarded to 1,500 NCCs in March, 1991.

Data analyses were based on 694 usable surveys. Demographic data indicated that over 60% of the respondents were female and held a Master's degree. Approximately 43% of those responding were employed in educational settings, while an additional 41% were employed in non-educational settings (i.e., private practice, hospitals, or counseling centers). A large percentage of those indicating that they held professional licenses were licensed as professional counselors.

Descriptive data analyses were initially conducted on each of the survey items. The demographic data were collapsed into dichotomies and frequency and importance response means

were then examined using the ANOVA F tests to test for significance between independent means using a $p = .01$ level of significance.

An exploratory factor analysis to identify clusters of items from responses was considered the primary data analytic technique in this study. Principal factors using orthogonal and oblique transformations were employed to estimate the factor structure. A minimum loading criterion of .40 was used to determine the resulting five-factor structure for the frequency and importance data sets. The five factors were identified as, fundamental counseling practice, counseling for career development, professional practice, counseling groups, and counseling families. Further analyses of the mean item means of the work behavior frequencies within the five clusters indicated that responding counselors engaged in fundamental counseling practice and counseling groups more frequently than they engaged in the other three factors.

The final analysis involved combining the frequency and importance data using the multiplicative method to determine a combined weighting of the two scales. This was conducted to obtain an overall analysis of the work behavior analysis data.

Substance-Abuse Specialty Counselors

Valle (1979) discussed the importance of a clearer delineation of the roles of substance-abuse counselors beyond the confines of the substance-abuse setting in order to allow for professional autonomy. While treatment and program goals continue to dictate the degree of role differences among substance-abuse specialty counselors, it has become clear through work behavior analyses, that many substance-abuse specialty counselors share common role behaviors, regardless of their work setting, preparation, and experience (Birch & Davis, 1984).

National Institute on Alcohol Abuse and Alcoholism (NIAAA)/Birch and Davis Project. The milestone in establishing a core set of job tasks for substance-abuse specialty counselors came as part of an effort to create model credentialing assessment and standards for substance-abuse

specialty counselors in conjunction with the National Institute on Alcohol Abuse and Alcoholism (NIAAA) (Birch & Davis, 1984). The purpose was threefold: (a) to derive a set of substance-abuse specialty counselor job tasks, (b) establish a core set of knowledge and skills that reflect competencies expected by the substance-abuse counseling field of its specialty counselors, and (c) select assessment techniques for credentialing substance-abuse specialty counselors.

Birch and Davis (1984), through literature reviews and the assistance of a team of experts in substance-abuse treatment and representatives of state-level credentialing systems and counselor organizations created a list of 187 job tasks with 16 dimensions for inclusion in the final survey. The survey requested that respondents indicate on a 5-point Likert-type scale, the importance of each job task and amount of time spent per task. An additional survey was created for measuring the importance of knowledge and skills of substance-abuse specialty counselors so comparisons between tasks and knowledge and skills could be assessed. An attached profile sheet requested substance-abuse specialty counselor characteristics (i.e., type of service, size of program staff, number of years worked as a paid counselor, level of formal education, recovery status, and certification status) for between-group comparisons.

The researchers indicated that one constraint of the study was the absence of a comprehensive list of practicing substance-abuse specialty counselors from which to draw the sample of counselors. Therefore, a sample of 3,295 substance-abuse specialty counselors was assembled from membership lists of constituency organizations and state lists of certified substance-abuse specialty counselors. Half of the sample was asked to respond to the job tasks survey, while the other half was forwarded the survey regarding substance-abuse specialty counselor knowledge and skills. A total response rate of 32% (N=1,062) was found for both surveys. Of the 1,062 respondents, 438 completed the job task survey.

The analyses performed on the job tasks survey included frequency rankings of job tasks on the importance and time-spent dimensions, correlations between the two scale rankings for all respondents and then by substance-abuse specialty counselor characteristic subgroups (i.e., authors collapsed demographics for ease in making comparisons), and differences in importance ranks between subgroups. Means were also calculated and ranked for each item in the task survey. They were used to compare subgroups within the respondent sample. The results indicated that one set of core job tasks exist for substance-abuse specialty counselors with little variance noted between subgroups. A correlation of .9 was found for the importance and time-spent rankings for all cases and for most of the subgroups, thus indicating that those tasks which substance-abuse specialty counselors viewed as most important were also tasks they spent the most time performing. Only a few job tasks were viewed as "critically important" or "a lot of time spent on this task" which were the highest rankings on each scale. At the opposite end of the scale, respondents indicated that all tasks were of some importance. However, they indicated they didn't spend any time on one-third of the job tasks.

The team of experts in substance-abuse treatment, after analyzing the task survey results, chose 91 tasks (based on rankings and group consensus) for inclusion in the core of substance-abuse specialty counselors' job tasks. The core tasks were then linked with 188 core knowledge and skill areas that are necessary to perform tasks in order to meet Federal EEOC regulations for credentialing systems. The 91 tasks, which were further grouped into 12 core functions, became the basis of many state and national credentialing initiatives (Banken & McGovern, 1992). These core functions are (a) assessment, (b) initial and ongoing treatment planning, (c) individual, family, and group counseling, (d) group counseling, specifically, (e) crisis intervention, (f) discharge and aftercare planning, (g) aftercare and follow-up activities, (h) client orientation,

(i) case consultation, (j) confidentiality, (k) referral and client advocacy, (l) personal and professional growth.

An example of a credentialing organization adopting the 12 core functions was the National Association for Alcohol and Drug Abuse Counselors (NAADAC). Through the initiatives of NAADAC's Certification Commission, a National Certified Addiction Counselor (NCAC) Examination was created in 1991 (B. Malone, personal communication, September 2, 1994). The knowledge base for the NCAC Examination centers around four areas: pharmacology of psychoactive substances, counseling practice, theoretical base of counseling, and professional issues related to alcoholism and drug-abuse treatment. According to Malone, the Birch and Davis Project findings served as the foundation for the NCAC Examination knowledge domains.

International Certification Reciprocity Consortium/Alcohol and Other Drug Abuse, Inc. (ICRC) Role Delineation Study. The International Certification Reciprocity Consortium/Alcohol and Other Drug Abuse, Inc. (ICRC/AODA) (formerly National Certification Reciprocity Consortium/Alcohol and Other Drug Abuse, Inc.) is an organization of members of alcohol and drug-abuse certification boards. It presently consists of 26,000 alcohol and drug-abuse specialty counselors who are certified by 43 member certification boards in Canada, Sweden, 39 states, the District of Columbia, and the U.S. Air Force, Navy, and Marines (J. P. Henderson, personal communication, July 14, 1994). The ICRC/AODA developed the first national examination for alcohol and drug-abuse specialty counselors. A 1991 Role Delineation Study, conducted by ICRC and Columbia Assessment Services, Inc. (CAS), defined the content of the examination (NCRC/AODA, 1992).

Through the use of surveys, observation, and group discussion, the ICRC and CAS asked expert alcohol and drug- abuse specialty counselors to describe the knowledge, skills, and abilities that define substance-abuse specialty counselor job performance competencies, and to identify

critical performance domains. The latter included assessment, counseling, case management, education, and professional responsibility. This process was identified as the Role Delineation Study.

Once the performance domains were defined, a random sampling of professionals in the substance-abuse field were surveyed regarding the importance of, and amount of time spent on, each performance domain. Their responses validated the original Role Delineation Study of expert opinions and the performance domains noted earlier. According to Henderson (personal communication, July 14, 1994), the findings of the Role Delineation Study are used by substance-abuse specialty counselor training programs nationally.

# CHAPTER III

# METHODOLOGY

The current study examined the provision of counseling services for substance-abuse clients in multiservice mental-health agencies. This chapter reports the research questions addressed, a description of the respondents and the multiservice mental-health agencies that participated in the survey, instrumentation and the procedures used to develop the questionnaire, and the procedures used to conduct the study. The final section reports the procedures used in collecting the data and the statistical analyses that were used to examine the data.

## Research Questions

The purpose of this study was to examine the following research questions:

1. What is the factor structure of work behaviors which characterize the treatment of substance abusers in multiservice mental-health agencies, as measured by ratings of frequency of occurrence on the Treatment of Substance Abusers in Multiservice Mental-Health Agencies Questionnaire?
2. What is the factor structure of work behaviors which characterize the treatment of substance abusers in multiservice mental-health agencies, as measured by criticality ratings on the Treatment of Substance Abusers in Multiservice Mental-Health Agencies Questionnaire?
3. What is the factor structure of work behaviors which characterize the treatment of substance abusers in multiservice mental-health agencies, as measured by combined frequency of occurrence and criticality ratings on the Treatment of Substance Abusers in Multiservice Mental-Health Agencies Questionnaire?

The following information, which is not integral to this study but important in gaining additional knowledge concerning the multiservice mental-health agencies that participated in this study, was also obtained: (a) approximate number of mental-health service hours and substance-abuse counseling hours provided weekly by each agency, (b) number of mental-health service providers in the agencies who represent the primary professional affiliations of marriage and family therapist, psychiatrist, psychologist, psychiatric nurse, professional counselor, social worker, substance-abuse specialty counselor (master's level), and substance-abuse specialty counselor (non-master's level), (c) weekly average substance-abuse counseling hours provided by individuals who represent the different primary professional affiliations, and (d) the amount of substance-abuse counseling that is provided weekly by individuals from the different professional affiliations who are employed in small, medium, and large size agencies.

## Participants

The population examined in this study were the agency administrators or their representatives at 367 multiservice mental-health agencies separated into clusters, or regions, in the 14 states that comprise the southern region of the United States. The states included are Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, South Carolina, North Carolina, Tennessee, Texas, Virginia, and West Virginia. Of the 367 agencies represented in the population, 117 representatives responded on behalf of their agencies.

A random cluster sampling of regions, referred to as catchment areas, districts, community service boards, or centers, in 13 of the 14 states was conducted from mental-health services lists provided by each state's mental-health administrative office. An exception is Tennessee, for which the list of multiservice mental-health agencies was obtained through the Tennessee Association of Mental Health Organizations. In order to assure each state was represented in the study, a minimum of two regions or a total of 25 multiservice mental-health

agencies from each state were included in the sample. When necessary, more regions were chosen from individual states in order to meet the study's minimum criteria of 25 multiservice mental-health agencies per state.

Representatives from regional administrative offices, or if necessary, representatives from mental-health agencies were initially contacted by telephone to request their participation in the study. After the agency representatives agreed to participate in the study, the questionnaire packets were forwarded to each representative for distribution to their respective agencies or directly to the respondents in the agencies.

The number of questionnaires forwarded to the mental-health agencies in each state and the return rate by state are shown in Table 1. A total of 117 representatives from mental-health agencies returned completed questionnaires, representing a return rate of 32%. This rate of return, considering the complexity of the questionnaire, compared favorably with the findings of Kerlinger (1986). Descriptive information regarding the participants is presented in Table 2. Approximately 39% of the respondents who completed the questionnaire on behalf of their agencies were female and 59% were male. Most of the respondents were Caucasian (81%), 10% were African-American, 7% represented other minority groups, and 2% did not indicate their ethnic origin. With regard to educational level, 72% of the agency respondents held master's degrees. Respondents' positions in the agency they represented varied. The primary representatives responding on behalf of 50% of the agencies were the Clinical Director/Supervisor of Personnel, while 14% were mental-health service providers. Another 35% of the respondents, classified as "other" on the questionnaire, were noted to hold positions as program directors, facility managers, executive directors, substance-abuse program directors, outreach coordinators, or quality directors.

Table 1

Number of Questionnaires Mailed and Received by State

| State | Questionnaires Mailed | Questionnaires Received |
|---|---|---|
| Alabama | 25 | 8 |
| Arkansas | 26 | 1 |
| Florida | 28 | 5 |
| Georgia | 27 | 9 |
| Kentucky | 29 | 3 |
| Louisiana | 25 | 11 |
| Mississippi | 25 | 7 |
| Maryland | 27 | 10 |
| North Carolina | 27 | 12 |
| South Carolina | 25 | 9 |
| Tennessee | 26 | 5 |
| Texas | 27 | 9 |
| Virginia | 25 | 7 |
| West Virginia | 25 | 9 |
| Unknown | | 12 |
| Total | 367 | 117 |

The number of years that respondents had been employed by their agency varied. The largest group (33%) had been employed 16-25 years, while the second largest group (25%) had been employed 6-10 years. A vast majority of the respondents (70%) had received over 40 clock hours in substance-abuse training.

## Instrumentation

An established instrument did not exist to examine the work behaviors considered significant in the provision of substance-abuse counseling in multiservice mental-health agencies. Therefore, an important part of this research project was the development of the questionnaire used in this investigation.

Table 2.

Demographic Information of Representatives Responding on Behalf of Agencies

| Characteristic | Frequency | Percent |
|---|---|---|
| Gender | | |
| Female | 45 | 38.5 |
| Male | 69 | 59.0 |
| Missing | 3 | 2.6 |
| Ethnicity | | |
| American Indian/Alaskan Native | 3 | 2.6 |
| Black/African American | 12 | 10.3 |
| Hispanic/Latino | 2 | 1.7 |
| White/Caucasian | 95 | 81.2 |
| Other Minority | 2 | 1.7 |
| Missing | 3 | 2.6 |
| Educational Level | | |
| High School | 1 | .9 |
| Associates | 9 | 7.7 |
| Bachelors | 14 | 12.0 |
| Masters | 84 | 71.8 |
| Doctoral | 7 | 6.0 |
| Missing | 2 | 1.7 |
| Position in the Agency | | |
| Clinical Director/Supervisor of Personnel | 58 | 49.6 |
| Mental-Health Service Provider | 16 | 13.7 |
| Other Title | 41 | 35.0 |
| Missing | 2 | 2.6 |
| Years Employed as a Mental-Health Service Provider | | |
| 0 to 5 years | 17 | 14.5 |
| 6 to 10 years | 29 | 24.8 |
| 11 to 15 years | 18 | 15.4 |
| 16 to 25 years | 38 | 32.5 |
| 25 years or more | 12 | 10.3 |
| Missing | 3 | 2.6 |
| Clock Hours of Substance-Abuse Training | | |
| 0 to 9 | 7 | 6.0 |
| 10 to 19 | 13 | 11.1 |
| 20 to 29 | 8 | 6.8 |
| 30 to 39 | 8 | 6.8 |
| 40 (college course equivalent to 45) or more | 79 | 67.5 |
| Missing | 2 | 1.7 |

## Questionnaire

The Treatment of Substance Abusers in Multiservice Mental-Health Agencies Questionnaire (Appendix A) consists of 205 work behaviors of mental-health service providers when counseling substance-abuse clients in multiservice mental-health agencies. Of the 205 items, 11 were repeated and served as a validity scale. Respondents indicate the relative frequency and relative criticality each work behavior in which the agency engages. The instrument uses a 5-point Likert-type scale. Each phase in the construction procedure of the instrument is summarized below.

### Initial Item Generation

In this phase, an extensive review of the literature related to the work behaviors of substance-abuse specialty counselors was conducted. The tasks and behaviors suggested in the literature assisted in generating a preliminary list of work behaviors performed by substance-abuse counselors. After this was completed, the work behavior statements of two previously conducted work behavior analyses of substance-abuse specialty counselors was conducted. Thus the Development of Model Professional Standards for Counselor Credentialing (Birch & Davis, 1984) and the Role Delineation study (NCRC/AODA, 1992) question were reviewed, and when appropriate, modified to be work behaviors. A final step in generating the initial list of items, was to review the items used in the National Board for Certified Counselors Work Behavior Study (Loesch & Vacc, 1993). In total, this phase of instrument development yielded 571 work behavior items.

### Item Refinement

The resulting list of 571 work behaviors related to counseling substance-abuse clients was edited and reduced to 181 items after statements with similar meanings were either eliminated or combined with other statements. The second step in this phase involved the participation of five

experts in counseling substance-abuse clients. One expert had a doctoral degree in counseling and had 15 years of experience in schools and private practice. The four other experts held the Master's degree in counseling; three had three years of experience in mental-health settings and two had over three years of experience counseling substance abusers in substance-abuse treatment and school settings.

The experts were asked by letter to modify, edit, condense, or add to the existing list of 181 work behaviors. Their review resulted in the addition of 18 items, rewriting of 18 items, and reordering of all the items within the questionnaire. The recommendations made by these experts resulted in a 191-item questionnaire.

The final step in this phase was to submit the revised 191-item questionnaire to other subject-matter experts. These subject-matter experts consisted of five mental-health service providers who were working in a multiservice mental-health agency, and four substance-abuse specialty counselors who were working in a substance-abuse treatment facility. The experts in the multiservice mental-health agency held a master's degree in counseling and had an average of six years of experience in mental-health counseling. The substance-abuse specialty counselors had an average of five years of experience in counseling substance abusers, and all held the North Carolina Certified Substance Abuse Certification. No restrictions were placed on the experts about how to refine the list of items, but they were specifically asked to determine whether each item should be included in the questionnaire and whether it was placed in the proper order on the questionnaire. Their suggestions included eliminating work behaviors performed by non-counseling staff or other agency staff, adding 3 items, and rewriting other items.

The item refinement phase of the study resulted in a final list of 194 items, each of which represented a work behavior conducted by mental-health service providers when providing substance-abuse counseling in multiservice mental-health agencies.

Survey Construction

In order to assess the validity of the representatives' responses, 11 work behaviors were repeated in the questionnaire as shown in Table 3. The final questionnaire included 205 items. The correlation coefficients between the items ranged from .50 to .83.

Table 3

Correlation Coefficients for Work Behavior Items that Comprised the Validity Scale for the Treatment of Substance Abusers in Multiservice Mental Health Agencies Questionnaire

| Item Numbers | Work Behavior | Correlation Coefficients |
|---|---|---|
| 13, 38 | Assess for learning disabilities | .75 |
| 14, 53 | Clarify client's support systems | .63 |
| 32, 108 | Inform family of family dynamics/roles | .61 |
| 55, 111 | Clarify family counseling goals | .59 |
| 26, 58 | Evaluate extent of client's psychological dysfunction | .57 |
| 60, 93 | Assist client recognize strengths and limitations | .71 |
| 65, 96 | Utilize different treatment approaches | .62 |
| 69, 97 | Use brief therapy techniques | .83 |
| 99, 143 | Assess client's readiness for discharge | .63 |
| 150, 176 | Participate in staff decision-making processes | .50 |
| 151, 166 | Conduct case reviews to assure quality services | .67 |

The questionnaire consisted of 12 pages, including instructions and a section with 10 demographic questions. The demographic section included questions regarding the respondent's gender, ethnic origin, educational level, years of employment as a mental-health service provider, level of training in substance abuse, and position within the agency. This section also included questions regarding the number of mental-health service providers in the agency and their primary professional affiliation, the number of mental-health service hours provided weekly by the agency,

substance-abuse counseling hours provided weekly by the agency, and the total number of substance-abuse counseling hours provided weekly by mental-health service providers from different professional affiliations (e.g., marriage and family therapy, psychiatry, psychology).

## Procedures

The requested number of questionnaire packets were forwarded to the representatives at the regional administrative offices in each state for distribution to their respective multiservice mental-health agencies. When the representatives were at the individual agencies or a regional representative requested a direct mailing, the questionnaire packets were forwarded directly to the representatives at their respective agencies. A cover letter to the regional director (Appendix B) that explained the purpose of the study accompanied the questionnaire packets sent to regional administrative offices. Each questionnaire packet included a cover letter to the agency director (Appendix C), one Treatment of Substance Abusers in Multiservice Mental-Health Agencies Questionnaire (Appendix A), and a stamped, self-addressed envelope.

The cover letter to the agency director conveyed information about the study. The questionnaire booklet included a respondent notice that requested that the agency director, or the agency representative completing the questionnaire, complete it on behalf of all mental-health service providers within the respective agency and not just those who specialize in substance-abuse counseling. Also included in the questionnaire booklet was an instruction sheet describing the procedures for completing the questionnaire. The agency director or the agency representative was instructed to return the completed questionnaire to the researcher in a stamped, self-addressed envelope by a specified date. A reminder postcard (Appendix D) was mailed to the full sample two weeks after the final mailing of the questionnaire packets.

Respondents were instructed to respond to each work behavior item twice. First, they were asked to respond to the relative frequency of occurrence with which the mental-health

service providers in their agency engaged in each work behavior using a 5-point Likert-type scale (1=never, 2=rarely, 3=occasionally, 4=frequently, and 5=routinely). Secondly, the 205 items were repeated and the respondent was asked to respond to the relative criticality that clients would place on mental-health service providers being able to perform the work behavior effectively. Again, they used a 5-point Likert-type scale (1=not critical, 2=minimally critical, 3=somewhat critical, 4=critical, 5=very critical) to respond to the criticality of each item.

Each completed questionnaire returned was coded with an identification number to assure proper entry into the VAX computer network at The University of North Carolina at Greensboro. The item means for the total sample were used to replace missing data for individual items. Data resulting from the survey were analyzed using the Statistic Analysis System data analysis program (SAS, 1990).

## Data Analyses

The primary objective of this study was to develop a list of work behaviors which characterize the substance-abuse counseling provided by mental-health service providers in multiservice mental-health agencies. Descriptive statistics and factor analyses were conducted to address the study's research questions.

Descriptive statistics analyses were conducted first to address Question Four. This included mean scores, standard deviations, frequencies, and percentage distributions. The remaining questions were addressed with factor analysis. An exploratory factor analysis was then conducted on the frequency and criticality ratings individually. Then, the combined ratings (frequency of occurrence and criticality) of overall importance were calculated by employing a formula which weights frequency of occurrence and criticality values on the Questionnaire (Kane, Kingsbury, Colton, & Estes, 1989). In order to arrive at an optimal grouping solution of work behavior items, principal axes factor analyses were conducted. The number of work behavior

"factors" were determined using traditional criteria (i.e., proportion of variance accounted for and substantive interpretability), and both orthogonal and oblique solutions were investigated.

# CHAPTER IV

## RESULTS AND DISCUSSION

This chapter reports the results of factor-analytic procedures used to determine the factor structure of work behaviors. The factor structure characterize the treatment of substance abusers in multiservice mental-health agencies as measured by ratings on the Treatment of Substance Abusers in Multiservice Mental Health Agencies Questionnaire (hereafter referred to as the Questionnaire).

A series of exploratory factor analyses were performed to examine the underlying factors of participants' responses to the frequency, criticality, and combined ratings (or overall importance) of items on the Questionnaire. First, the 11 repeated items (see Table 3) that helped to comprise the validity scale on the Questionnaire were excluded from the data file. Secondly, principal factors analyses were conducted for each research question, followed by oblique and orthogonal transformations using the promax and varimax rotation procedures, respectively. Since both rotation procedures resulted in similar factors, the varimax (uncorrelated) factors were used in subsequent analyses (Jaeger, 1990b; SAS, 1990).

The results of the analyzed data are presented in response to the questions cited in Chapter III. Each question is addressed in chronological order. To prepare the reader for the factor analysis, the 117 responses to each work behavior statement with the mean scores and standard deviations for the frequency of occurrence and criticality rating scales are reported and discussed.

Frequency of Occurrence Responses to Each Work Behavior Statement

The mean and standard deviation of the representatives' responses concerning the frequency of occurrence ratings for each work behavior item are reported in Table 4. The means ranged from 1.82 to 4.94. Of the 205 items included in the survey, only 18 items had means less than 3.00 which indicated that most of the 117 respondents occasionally to routinely perform a majority of the work behaviors listed. The five items with the highest means for frequency ratings were (1) Item 46--obtain client's informed consent prior to counseling ($\overline{x}$ = 4.94), (2) Item 160--maintain case notes, records, and/or files ($\overline{x}$ = 4.91), (3) Item 47--complete release of information forms ($\overline{x}$ = 4.85), (4) Item 29--obtain client's medication history ($\overline{x}$ = 4.79), and (5) Item 37--assess potential for client to harm self/others ($\overline{x}$ = 4.79).

Table 4

Responses to Each Work Behavior Statement with Mean Ratings and Standard Deviations For Frequency of Occurrence and Criticality

| | | Frequency of Occurrence | | Criticality | |
|---|---|---|---|---|---|
| | Item | M | SD | M | SD |
| 1. | Obtain substance abuse history | 4.70 | 0.58 | 4.46 | 0.71 |
| 2. | Determine severity of client's substance abuse problem | 4.44 | 0.83 | 4.52 | 0.75 |
| 3. | Assess degree of client's understanding of his/her substance dependency | 4.08 | 0.98 | 4.08 | 0.93 |
| 4. | Conduct pretreatment diagnostic interview | 4.42 | 0.93 | 4.26 | 0.90 |
| 5. | Evaluate existing (precounseling) client data | 4.11 | 0.95 | 3.94 | 0.94 |
| 6. | Discuss client's reasons for seeking treatment | 4.67 | 0.66 | 4.35 | 0.77 |
| 7. | Assess client's motivation for treatment | 4.54 | 0.76 | 4.23 | 0.85 |
| 8. | Assess client's participation in 12-step program | 3.66 | 1.21 | 3.48 | 1.10 |
| 9. | Assess psychosocial needs | 4.55 | 0.72 | 4.37 | 0.70 |
| 10. | Assess spiritual functioning | 3.36 | 1.20 | 3.29 | 1.14 |
| 11. | Identify client's internal/external resources | 4.39 | 0.86 | 4.29 | 0.72 |
| 12. | Assess client's educational history | 4.52 | 0.89 | 3.69 | 0.99 |
| 13. | Assess for learning disabilities | 3.59 | 1.18 | 3.63 | 0.95 |

| | Item | Frequency of Occurrence | | Criticality | |
|---|---|---|---|---|---|
| | | M | SD | M | SD |
| 14. | Clarify client's support systems | 4.39 | 0.78 | 4.23 | 0.77 |
| 15. | Assess client's family history of addictive disorders | 4.18 | 1.01 | 4.00 | 0.92 |
| 16. | Assess client's strengths and limitations | 4.54 | 0.78 | 4.46 | 0.78 |
| 17. | Systematically observe client's behaviors | 4.07 | 1.05 | 4.05 | 0.91 |
| 18. | Select appraisal instruments/techniques for counseling | 3.56 | 1.17 | 3.68 | 1.10 |
| 19. | Integrate assessment results | 3.91 | 1.05 | 3.96 | 0.98 |
| 20. | Use assessment results to aid client in making decisions | 3.84 | 1.06 | 3.91 | 0.95 |
| 21. | Use assessment results to aid in intervention selections | 3.91 | 1.06 | 3.93 | 0.94 |
| 22. | Administer substance abuse assessment instruments | 3.20 | 1.35 | 3.43 | 1.22 |
| 23. | Use self-report personality inventories | 2.71 | 1.11 | 2.77 | 1.04 |
| 24. | Use intelligence test results | 2.44 | 0.95 | 2.56 | 0.91 |
| 25. | Use nontest appraisal techniques | 3.67 | 1.05 | 3.31 | 1.00 |
| 26. | Evaluate extent of client's psychological dysfunction | 4.22 | 0.91 | 4.18 | 0.79 |
| 27. | Determine DSM-IV classification | 4.74 | 0.80 | 4.32 | 0.96 |
| 28. | Evaluate need for client referral for further assessment | 4.40 | 0.89 | 4.23 | 0.85 |
| 29. | Obtain client's medication history | 4.79 | 0.57 | 4.64 | 0.62 |
| 30. | Assist client in understanding of test results | 3.73 | 1.06 | 3.74 | 0.94 |
| 31. | Interview client's significant others | 3.54 | 0.87 | 3.96 | 0.80 |
| 32. | Inform family of family dynamics/roles | 3.38 | 0.88 | 3.67 | 0.89 |
| 33. | Assess match between client's needs and program services | 4.36 | 0.89 | 4.38 | 0.73 |
| 34. | Determine if client will be admitted for treatment | 4.76 | 0.62 | 4.68 | 0.54 |
| 35. | Evaluate need for client referral for treatment | 4.61 | 0.72 | 4.44 | 0.81 |
| 36. | Analyze cost-benefit of treatment alternatives | 2.85 | 1.24 | 3.01 | 1.19 |
| 37. | Assess psychosocial for client to harm self/others | 4.79 | 0.48 | 4.82 | 0.47 |
| 38. | Assess for learning disabilities | 3.08 | 1.14 | 3.36 | 0.90 |
| 39. | Determine necessity for an intervention | 4.31 | 0.90 | 4.18 | 0.82 |
| 40. | Inform client about program services | 4.69 | 0.56 | 4.31 | 0.71 |
| 41. | Explain program policies and procedures | 4.42 | 0.82 | 4.09 | 0.91 |
| 42. | Contract with client regarding program rules | 4.11 | 1.03 | 3.97 | 1.04 |
| 43. | Inform client about ethical standards and practice | 3.78 | 1.19 | 3.76 | 1.11 |
| 44. | Inform client about legal aspects of counseling | 3.71 | 1.18 | 3.74 | 1.12 |

| | Item | Frequency of Occurrence | | Criticality | |
|---|---|---|---|---|---|
| | | M | SD | M | SD |
| 45. | Inform client about detoxification process | 3.33 | 1.25 | 3.64 | 1.27 |
| 46. | Obtain client's informed consent prior to counseling | 4.94 | 0.33 | 4.76 | 0.62 |
| 47. | Complete release of information forms | 4.85 | 0.45 | 4.73 | 0.59 |
| 48. | Co-construct comprehensive treatment plans | 4.49 | 0.90 | 4.38 | 0.89 |
| 49. | Establish counseling goals and objectives | 4.78 | 0.63 | 4.66 | 0.66 |
| 50. | Identify source-of-problem alternatives | 4.14 | 0.87 | 4.08 | 0.86 |
| 51. | Assist client in setting short-term and long-term goals | 4.56 | 0.78 | 4.50 | 0.64 |
| 52. | Negotiate with client a time frame for goal attainment | 4.29 | 0.92 | 4.12 | 0.84 |
| 53. | Clarify client's support systems | 4.27 | 0.87 | 4.22 | 0.79 |
| 54. | Involve significant others in treatment planning | 3.47 | 0.83 | 3.76 | 0.87 |
| 55. | Clarify family counseling goals | 3.59 | 1.07 | 3.91 | 0.89 |
| 56. | Implement treatment plans | 4.70 | 0.69 | 4.61 | 0.74 |
| 57. | Clarify mental health service provider/client roles | 4.22 | 0.89 | 4.14 | 0.86 |
| 58. | Evaluate extent of client's psychological dysfunction | 4.46 | 0.83 | 4.38 | 0.69 |
| 59. | Evaluate client's movement toward counseling goals | 4.46 | 0.83 | 4.36 | 0.76 |
| 60. | Assist client recognize strengths and limitations | 4.39 | 0.86 | 4.29 | 0.84 |
| 61. | Assist client in evaluation of progress in treatment | 4.38 | 0.85 | 4.26 | 0.81 |
| 62. | Self-evaluate counseling progress | 4.05 | 0.92 | 4.08 | 0.92 |
| 63. | Develop a therapeutic relationship with client | 4.66 | 0.57 | 4.64 | 0.65 |
| 64. | Organize or facilitate an intervention | 3.75 | 1.03 | 4.01 | 0.90 |
| 65. | Utilize different treatment approaches | 4.26 | 0.79 | 4.14 | 0.79 |
| 66. | Use affective-oriented counseling techniques | 3.68 | 0.79 | 3.74 | 0.85 |
| 67. | Use behavioral-oriented counseling techniques | 3.96 | 0.76 | 3.95 | 0.85 |
| 68. | Use cognitive-oriented counseling techniques | 3.98 | 0.73 | 4.00 | 0.81 |
| 69. | Use brief therapy techniques | 3.62 | 0.77 | 3.67 | 0.97 |
| 70. | Use media resources in counseling | 3.32 | 1.03 | 3.07 | 1.05 |
| 71. | Counsel client concerning life-style change | 4.13 | 0.83 | 4.13 | 0.90 |
| 72. | Counsel client concerning sexual abuse | 3.78 | 0.83 | 4.16 | 0.78 |
| 73. | Counsel client concerning human sexuality | 3.30 | 0.81 | 3.59 | 0.90 |
| 74. | Counsel client concerning physical abuse | 3.78 | 0.80 | 4.07 | 0.81 |
| 75. | Counsel client concerning personal change | 4.16 | 0.79 | 4.25 | 0.81 |

| | Item | Frequency of Occurrence | | Criticality | |
|---|---|---|---|---|---|
| | | M | SD | M | SD |
| 76. | Counsel client concerning personality change | 3.61 | 0.93 | 3.70 | 0.98 |
| 77. | Counsel client concerning spiritual issues | 3.22 | 1.06 | 3.58 | 1.05 |
| 78. | Explore client's educational opportunities | 3.71 | 0.80 | 3.69 | 0.78 |
| 79. | Provide appropriate homework assignments | 3.62 | 0.98 | 3.72 | 0.94 |
| 80. | Educate client about self-help groups | 4.14 | 1.00 | 4.15 | 0.90 |
| 81. | Make 12-step assignments | 3.13 | 1.39 | 3.34 | 1.33 |
| 82. | Process 12-step assignments | 3.07 | 1.37 | 3.26 | 1.33 |
| 83. | Clarify client's moral/spiritual issues | 3.11 | 1.13 | 3.43 | 1.13 |
| 84. | Facilitate client exploration of the consequences of substance abuse | 4.18 | 0.99 | 4.38 | 0.85 |
| 85. | Educate client about consequences of substance abuse | 4.29 | 0.86 | 4.40 | 0.79 |
| 86. | Provide impetus for client to remain in treatment | 4.10 | 0.84 | 4.21 | 0.81 |
| 87. | Discuss positive urine drug screens with client | 3.44 | 1.40 | 3.83 | 1.22 |
| 88. | Counsel client about irregular attendance | 4.11 | 0.98 | 4.15 | 0.98 |
| 89. | Address violation of agency rules | 3.83 | 1.12 | 4.01 | 1.04 |
| 90. | Counsel client concerning defense mechanisms | 3.82 | 1.05 | 3.92 | 0.99 |
| 91. | Counsel client regarding relapse prevention | 4.10 | 1.09 | 4.35 | 0.93 |
| 92. | Counsel client regarding other addictive disorders | 3.80 | 1.05 | 4.06 | 0.93 |
| 93. | Assist client recognize strengths and limitations | 4.23 | 0.85 | 4.26 | 0.79 |
| 94. | Reframe client's problem(s) | 3.94 | 0.79 | 3.96 | 0.81 |
| 95. | Provide crisis intervention | 4.32 | 0.79 | 4.60 | 0.56 |
| 96. | Utilize different treatment approaches | 4.14 | 0.77 | 4.15 | 0.80 |
| 97. | Use brief therapy techniques | 3.68 | 0.89 | 3.66 | 1.01 |
| 98. | Manage violent or destructive clients | 3.36 | 1.07 | 4.26 | 0.94 |
| 99. | Assess client's readiness for discharge | 4.36 | 0.88 | 4.32 | 0.75 |
| 100. | Prepare client for termination from counseling | 4.22 | 0.90 | 4.23 | 0.85 |
| 101. | Conduct former client follow-up activities | 2.73 | 1.11 | 3.27 | 1.14 |
| 102. | Counsel children | 3.58 | 1.39 | 3.97 | 1.17 |
| 103. | Counsel adolescents | 3.77 | 1.34 | 4.06 | 1.17 |
| 104. | Counsel adults | 4.61 | 0.77 | 4.46 | 0.75 |
| 105. | Counsel older persons | 3.83 | 1.05 | 4.15 | 0.97 |
| 106. | Counsel specialized populations (i.e., pregnant women, disabled) | 3.72 | 1.03 | 4.10 | 0.94 |

| | Item | Frequency of Occurrence | | Criticality | |
|---|---|---|---|---|---|
| | | M | SD | M | SD |
| 107. | Establish rapport with family and significant others | 3.83 | 0.89 | 4.16 | 0.83 |
| 108. | Inform family of family dynamics/roles | 3.63 | 0.96 | 3.91 | 0.90 |
| 109. | Inform family members of family counseling guidelines and goals | 3.69 | 1.01 | 3.93 | 0.92 |
| 110. | Clarify familial behavior norms | 3.45 | 0.97 | 3.74 | 0.90 |
| 111. | Clarify family counseling goals | 3.63 | 1.06 | 3.94 | 0.93 |
| 112. | Develop family conflict resolution strategies | 3.61 | 0.93 | 3.91 | 0.90 |
| 113. | Counsel concerning family change | 3.59 | 0.89 | 3.93 | 0.92 |
| 114. | Counsel concerning family member interaction | 3.66 | 0.86 | 3.74 | 0.90 |
| 115. | Counsel concerning martial discord | 3.62 | 0.89 | 3.94 | 0.93 |
| 116. | Counsel concerning divorce | 3.25 | 0.95 | 4.00 | 0.81 |
| 117. | Use multigenerational family counseling techniques | 2.67 | 1.01 | 3.98 | 0.79 |
| 118. | Use structural family counseling techniques | 2.98 | 0.92 | 4.00 | 0.81 |
| 119. | Use strategic family counseling techniques | 3.06 | 0.90 | 4.02 | 0.78 |
| 120. | Use behavioral family counseling techniques | 3.22 | 1.01 | 3.76 | 0.90 |
| 121. | Educate significant others about self-help groups | 3.73 | 0.96 | 3.21 | 1.09 |
| 122. | Counsel significant others concerning substance abuse | 3.62 | 1.04 | 3.27 | 0.97 |
| 123. | Select clients for group participation | 3.97 | 1.16 | 3.35 | 0.93 |
| 124. | Inform clients of group counseling guidelines and goals | 4.23 | 1.11 | 3.48 | 0.92 |
| 125. | Systematically observe group members' behavior | 4.21 | 1.13 | 3.85 | 0.94 |
| 126. | Identify harmful group-member behaviors | 4.25 | 1.10 | 3.98 | 0.93 |
| 127. | Evaluate progress toward group goals | 4.15 | 1.12 | 3.82 | 1.05 |
| 128. | Facilitate conflict resolution among group members | 4.11 | 1.09 | 4.13 | 1.05 |
| 129. | Assist with group members' feedback to each other | 4.12 | 1.10 | 4.15 | 1.03 |
| 130. | Determine group counseling effectiveness | 4.00 | 1.15 | 4.16 | 1.02 |
| 131. | Use "structured" activities during group counseling | 3.80 | 1.08 | 4.16 | 1.00 |
| 132. | Use leader-centered group counseling leadership techniques | 3.41 | 1.10 | 4.16 | 0.97 |
| 133. | Use group-centered group counseling leadership techniques | 3.56 | 1.10 | 4.10 | 0.99 |
| 134. | Use laissez-faire group counseling leadership techniques | 2.43 | 0.97 | 4.06 | 0.97 |
| 135. | Facilitate client's development of decision-making skills | 4.01 | 0.88 | 3.66 | 1.05 |
| 136. | Facilitate client's development of job-search skills | 3.16 | 0.89 | 3.15 | 1.05 |
| 137. | Assist disabled clients with assignments | 3.44 | 1.00 | 3.58 | 1.01 |

| | Item | Frequency of Occurrence | | Criticality | |
|---|---|---|---|---|---|
| | | M | SD | M | SD |
| 138. | Observe client for side effects of medication | 4.44 | 0.90 | 2.51 | 1.10 |
| 139. | Monitor drug screening test results | 3.71 | 1.44 | 4.06 | 0.84 |
| 140. | Communicate with funding sources regarding client's treatment | 3.10 | 1.27 | 3.47 | 0.88 |
| 141. | Consult with other members of treatment team | 4.53 | 0.68 | 3.77 | 0.97 |
| 142. | Provide client information when authorized | 4.61 | 0.66 | 4.41 | 0.92 |
| 143. | Assess client's readiness for discharge | 4.46 | 0.81 | 3.99 | 1.29 |
| 144. | Assist client resolve problems of daily living (i.e., housing, legal) | 4.08 | 0.85 | 3.31 | 1.31 |
| 145. | Investigate half-way house alternatives | 3.21 | 1.18 | 4.53 | 0.60 |
| 146. | Assist client in constructing effective support systems | 3.96 | 0.92 | 4.35 | 0.73 |
| 147. | Assist client in obtaining temporary sponsor | 2.80 | 1.31 | 4.37 | 0.76 |
| 148. | Arrange aftercare services | 3.87 | 1.23 | 4.11 | 0.89 |
| 149. | Involve significant others in aftercare planning | 3.31 | 1.14 | 3.59 | 1.20 |
| 150. | Participate in staff decision-making processes | 4.39 | 0.75 | 4.17 | 0.87 |
| 151. | Conduct case reviews to assure quality services | 4.38 | 0.90 | 3.48 | 1.30 |
| 152. | Match client's needs with community resources | 4.07 | 0.92 | 4.04 | 1.18 |
| 153. | Network with community resources | 4.12 | 0.11 | 3.75 | 1.17 |
| 154. | Advocate client's interests with appropriate systems (i.e., courts, employer) | 3.97 | 1.02 | 4.30 | 0.83 |
| 155. | Support client participation in leisure activities | 3.84 | 0.96 | 4.35 | 0.81 |
| 156. | Facilitate return-to-work conferences | 2.61 | 1.18 | 4.19 | 0.88 |
| 157. | Participate in case conferences | 3.97 | 1.05 | 4.24 | 0.86 |
| 158. | Make oral case presentations to treatment team | 3.88 | 1.12 | 4.03 | 1.00 |
| 159. | Assign client to a mental health service provider | 4.14 | 0.85 | 3.89 | 0.89 |
| 160. | Maintain case notes, records, and/or files | 4.91 | 0.29 | 3.16 | 1.22 |
| 161. | Solicit client's perception of treatment program | 4.20 | 0.84 | 4.03 | 0.86 |
| 162. | Assess programmatic needs | 4.15 | 0.90 | 3.88 | 0.85 |
| 163. | Establish programmatic service goals | 4.04 | 0.95 | 4.15 | 0.81 |
| 164. | Provide clinical supervision | 4.39 | 0.89 | 4.62 | 0.64 |
| 165. | Provide administrative supervision | 4.32 | 1.03 | 4.28 | 0.83 |
| 166. | Conduct case reviews to assure quality services | 4.33 | 0.96 | 4.19 | 0.78 |
| 167. | Evaluate counselors' performance | 4.25 | 1.01 | 4.14 | 0.87 |
| 168. | Provide counselor skill-development training | 3.95 | 1.08 | 4.47 | 0.71 |

| | Item | Frequency of Occurrence | | Criticality | |
|---|---|---|---|---|---|
| | | M | SD | M | SD |
| 169. | Coordinate volunteer activities | 2.48 | 1.34 | 4.23 | 0.89 |
| 170. | Mediate treatment staff/client conflict | 3.24 | 1.00 | 4.38 | 0.73 |
| 171. | Attend staff meetings | 4.60 | 0.71 | 4.37 | 0.78 |
| 172. | Administer treatment program | 4.32 | 1.04 | 4.30 | 0.83 |
| 173. | Allocate financial resources for treatment program | 3.25 | 1.52 | 2.85 | 1.19 |
| 174. | Develop program-related reports | 3.86 | 1.07 | 3.85 | 1.00 |
| 175. | Conduct fund-raising activities for program development/maintenance | 1.82 | 1.11 | 4.14 | 0.90 |
| 176. | Participate in staff decision-making processes | 4.23 | 0.92 | 4.32 | 0.86 |
| 177. | Provide orientation to new personnel | 4.22 | 0.98 | 3.66 | 1.31 |
| 178. | Participate in program research activities | 2.88 | 1.20 | 3.79 | 1.02 |
| 179. | Perform clerical tasks (i.e., filing, typing letters) | 3.21 | 1.23 | 2.55 | 1.42 |
| 180. | Engage in client data analyses | 3.10 | 1.11 | 4.20 | 0.84 |
| 181. | Communicate needs for services in the community | 3.49 | 0.94 | 4.29 | 0.84 |
| 182. | Conduct community outreach | 3.42 | 1.08 | 3.14 | 1.12 |
| 183. | Organize professional conferences and seminars | 2.58 | 1.11 | 3.03 | 1.34 |
| 184. | Provide consultation to other agencies | 3.87 | 0.94 | 3.38 | 1.06 |
| 185. | Serve as liaison with other agencies | 3.82 | 0.92 | 3.83 | 1.00 |
| 186. | Serve on committees within the agency | 3.97 | 0.97 | 3.73 | 1.00 |
| 187. | Educate non-treatment staff about counseling services | 3.43 | 1.01 | 3.56 | 1.01 |
| 188. | Educate non-treatment staff about substance abuse | 3.18 | 1.08 | 3.50 | 1.07 |
| 189. | Develop appraisal instrument/technique | 2.67 | 1.13 | 3.00 | 1.20 |
| 190. | Evaluate media resources | 2.62 | 1.06 | 2.83 | 1.14 |
| 191. | Use computers for program data management | 3.60 | 1.29 | 3.85 | 1.08 |
| 192. | Engage in professional/community public relations | 3.66 | 1.02 | 3.83 | 0.98 |
| 193. | Develop networks with other mental health service providers | 3.85 | 1.00 | 3.97 | 0.89 |
| 194. | Attend conferences | 3.79 | 0.94 | 3.93 | 0.99 |
| 195. | Deliver presentations at conferences | 2.63 | 1.04 | 2.73 | 1.19 |
| 196. | Review ethical standards | 3.58 | 1.02 | 4.08 | 0.89 |
| 197. | Review legal statutes and regulations | 3.61 | 1.07 | 4.04 | 0.91 |
| 198. | Read current professional literature | 3.97 | 0.82 | 4.16 | 0.80 |
| 199. | Participate in continuing education/skill enhancement | 4.14 | 0.90 | 4.29 | 0.79 |

| | Item | Frequency of Occurrence | | Criticality | |
|---|---|---|---|---|---|
| | | M | SD | M | SD |
| 200. | Receive clinical supervision | 4.20 | 0.98 | 4.38 | 0.79 |
| 201. | Develop own professional goals and objectives | 4.03 | 0.82 | 4.25 | 0.74 |
| 202. | Participate in self-help group activities | 2.90 | 1.11 | 3.19 | 1.14 |
| 203. | Collaborate in research with other mental health service providers | 2.70 | 1.10 | 3.00 | 1.11 |
| 204. | Write for publication | 1.97 | 1.00 | 2.21 | 1.14 |
| 205. | Use prevention measures to guard against burnout | 3.13 | 1.06 | 4.18 | 0.96 |

The five work behaviors performed least frequently were (1) Item 175--conduct fund-raising activities for program development/maintenance ($\bar{x}$ = 1.82), (2) Item 204--write for publication ($\bar{x}$ = 1.97), (3) Item 134--use laissez-faire group counseling leadership techniques ($\bar{x}$ = 2.43), (4) Item 24--use intelligence test results ($\bar{x}$ = 2.44), and (5) Item 169--coordinate volunteer activities ($\bar{x}$ = 2.48).

Criticality Responses to Each Work Behavior Statement

The work behavior statement, mean, and standard deviation for the representatives' responses concerning the criticality ratings for each item are reported in Table 4. The means ranged from 2.21 to 4.82. Of the 205 items included in the survey, only 8 items had means less than 3.00. The response of 3.00 or greater to 197 items indicated that most of 117 respondents believed that it was somewhat critical to critical that mental-health service providers in multiservice mental-health agencies be able to perform those behaviors effectively.

Among the criticality data, the five items with the highest means were (1) Item 37--assess potential for client to harm self/others ($\bar{x}$ = 4.82), (2) Item 46--obtain client's informed consent prior to counseling ($\bar{x}$ = 4.76), (3) Item 47--complete release of information forms ($\bar{x}$ = 4.73), (4) Item 34--determine if client will be admitted for treatment ($\bar{x}$ = 4.68), and (5) Item 49--establish counseling goals and objectives ($\bar{x}$ = 4.66).

The five work behaviors rated as least important were (1) Item 204--write for publication ($\bar{x}$ = 2.21), (2) Item 139--observe client for side effects of medication ($\bar{x}$ = 2.51), (3) Item 179--perform clerical tasks (i.e., filing, typing letters) ($\bar{x}$ = 2.55), (4) Item 195--deliver presentations at conferences ($\bar{x}$ = 2.73), and (5) Item 173--allocate financial resources for treatment program ($\bar{x}$ = 2.85).

Research Question One

What is the factor structure of work behaviors which characterize the treatment of substance abusers in multiservice mental-health agencies as measured by ratings of frequency of occurrence on the Treatment of Substance Abusers in Multiservice Mental Health Agencies Questionnaire?

The principle factors analysis of the frequency of occurrence ratings resulted in 45 factors with an eigenvalue of 1.0 or greater. The factors are shown in Table 5. However, the first 5 factors accounted for approximately 86% of the variance in the original set of items, with eigenvalues of 55.17, 10.74, 8.54, 5.94, and 5.52, respectively. Thus, a second factor analysis was performed using the varimax (orthogonal) rotation. Table 6 presents the frequency of occurrence responses with items rank ordered from highest to lowest factor loadings on Factors 1-5. Table 7 includes the 34 items that did not have a factor loading greater than the pre-established factor loading criterion of.40 or higher for item retention. Based on respondent's ratings, the omitted substance-abuse counseling work behaviors were not performed in sufficient frequency to warrant their inclusion. A total of 17 items exceeded the .40 minimum factor loading on more than one factor. Work behavior items were placed on the factor in which they had the highest loading so the factor label is supportable but not always inclusive. The factors resulting from the orthogonal solution were identified as follows: Factor 1: Substance Abuse Specialty Counseling,

Factor 2: Assessment and Appraisal, Factor 3: Counseling Process, Factor 4: Professional Practice, and Factor 5: Family Counseling (see Appendix E).

Table 5

Principal Components Factor Analysis: Frequency of Occurrence Rating Items With Eigenvalues > 1.00

| Factor | Eigenvalue |
|---|---|
| 1 | 55.17 |
| 2 | 10.74 |
| 3 | 8.54 |
| 4 | 5.94 |
| 5 | 5.52 |
| 6 | 4.93 |
| 7 | 4.45 |
| 8 | 4.02 |
| 9 | 3.33 |
| 10 | 3.23 |
| 11 | 3.14 |
| 12 | 2.97 |
| 13 | 2.83 |
| 14 | 2.68 |
| 15 | 2.57 |
| 16 | 2.45 |
| 17 | 2.41 |
| 18 | 2.35 |
| 19 | 2.15 |
| 20 | 2.09 |
| 21 | 2.05 |
| 22 | 1.98 |

| Factor | Eigenvalue |
|---|---|
| 23 | 1.91 |
| 24 | 1.85 |
| 25 | 1.77 |
| 26 | 1.68 |
| 27 | 1.67 |
| 28 | 1.65 |
| 29 | 1.52 |
| 30 | 1.49 |
| 31 | 1.48 |
| 32 | 1.40 |
| 33 | 1.35 |
| 34 | 1.27 |
| 35 | 1.25 |
| 36 | 1.22 |
| 37 | 1.20 |
| 38 | 1.17 |
| 39 | 1.14 |
| 40 | 1.10 |
| 41 | 1.09 |
| 42 | 1.06 |
| 43 | 1.03 |
| 44 | 1.02 |
| 45 | 1.01 |

Table 6

Five-Factor Orthogonal Solution by Highest Item Loading for the Factor Analysis of Frequency of Occurrence Responses

| | | Factor Loadings by Factor | | | | |
|---|---|---|---|---|---|---|
| | Item | 1 | 2 | 3 | 4 | 5 |
| 082. | Process 12-step assignments | .797 | | | | |
| 081. | Make 12-step assignments | .791 | | | | |
| 084. | Facilitate client exploration of the consequences of substance abuse | .749 | | | | |
| 085. | Educate client about consequences of substance abuse | .746 | | | | |
| 083. | Clarify client's moral/spiritual issues | .726 | | | | |
| 147. | Assist client in obtaining a temporary sponsor | .696 | | | | |
| 122. | Counsel significant others concerning substance abuse | .694 | | | | |
| 091. | Counsel client regarding relapse prevention | .690 | .401 | | | |
| 087. | Discuss positive urine drug screens with client | .674 | | | | |
| 092. | Counsel client regarding other addictive disorders | .671 | | | | |
| 022. | Administer substance abuse assessment instruments | .663 | | | | |
| 145. | Investigate half-way house alternatives | .656 | | | | |
| 139. | Monitor drug screening test results | .650 | | | | |
| 077. | Counsel client concerning spiritual issues | .634 | | | | |
| 008. | Assess client's participation in a 12-step program | .625 | | | | |
| 080. | Educate client about self-help groups | .624 | | | | |
| 125. | Systematically observe group members' behavior | .611 | | .438 | | |
| 090. | Counsel client concerning defense mechanisms | .609 | | | | |
| 045. | Inform client about detoxification process | .605 | | | | |
| 010. | Assess spiritual functioning | .599 | .406 | | | |
| 089. | Address violation of agency rules | .593 | | | | |
| 124. | Inform clients of group counseling guidelines and goals | .592 | | .442 | | |
| 086. | Provide impetus for client to remain in treatment | .583 | | | | |
| 148. | Arrange aftercare services | .579 | | | | |
| 146. | Assist client in constructing effective support systems | .574 | | | | |
| 070. | Use media resources in counseling | .571 | | | | |

| | Item | Factor Loadings by Factor | | | | |
|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 |
| 071. | Counsel client concerning life-style change | .569 | | | | |
| 126. | Identify harmful group-member behaviors | .569 | | .466 | | |
| 127. | Evaluate progress toward group goals | .569 | | .494 | | |
| 188. | Educate non-treatment staff about substance abuse | .569 | | | .499 | |
| 123. | Select clients for group participation | .564 | | | | |
| 128. | Facilitate conflict resolution among group members | .545 | | .468 | | |
| 133. | Use group-centered group counseling leadership techniques | .543 | | | | |
| 121. | Educate significant others about self-help groups | .541 | | | | |
| 129. | Assist with group members' feedback to each other | .537 | | .529 | | |
| 137. | Assist disabled clients with assignments | .520 | | | | |
| 131. | Use "structured" activities during group counseling | .514 | | .418 | | |
| 202. | Participate in self-help group activities | .511 | | | | |
| 079. | Provide appropriate homework assignments | .508 | | | | |
| 149. | Involve significant others in aftercare planning | .502 | | | | |
| 140. | Communicate with funding sources regarding client's treatment | .501 | | | | |
| 101. | Conduct former client follow-up activities | .501 | | | | |
| 130. | Determine group counseling effectiveness | .484 | | .462 | | |
| 032. | Inform family of family dynamics/roles | .458 | .449 | | | |
| 156. | Facilitate return-to-work conferences | .445 | | | | |
| 074. | Counsel client concerning physical abuse | .432 | | | | |
| 073. | Counsel client concerning human sexuality | .421 | | | | |
| 023. | Use self-report personality | .408 | | | | |
| 136. | Facilitate client's development of job-search skills | .406 | | | | |
| 132. | Use leader-centered group counseling leadership techniques | .404 | | | | |
| 012. | Assess client's educational history | | .647 | | | |
| 014. | Clarify client's support systems | | .623 | | | |
| 011. | Identify client's internal/external resources | | .619 | | | |
| 015. | Assess client's family history of addictive disorders | .404 | .593 | | | |
| 033. | Assess match between client's needs and program services | | .588 | .443 | | |
| 035. | Evaluate needs for client referral for treatment | | .578 | | | |
| 004. | Conduct pretreatment diagnostic interview | | .575 | | | |

| | Item | Factor Loadings by Factor 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| 020. | Use assessment results to aid client in making decisions | | .571 | | | |
| 026. | Evaluate extent of client's psychological dysfunction | | .569 | | | |
| 031. | Interview client's significant others | | .566 | | | |
| 007. | Assess client's motivation for treatment | | .564 | | | |
| 006. | Discuss client's reasons for seeking treatment | | .560 | | | |
| 002. | Determine severity of client's substance abuse problem | | .557 | | | |
| 018. | Select appraisal instruments/techniques for counseling | | .552 | | | |
| 019. | Integrate assessment results | | .548 | | | |
| 034. | Determine if client will be admitted for treatment | | .547 | | | |
| 039. | Determine necessity for an intervention | | .545 | | | |
| 030. | Assist client in understanding of test results | | .525 | | | |
| 028. | Evaluate need for client referral for further assessment | | .524 | | | |
| 040. | Inform client about program services | | .512 | | | |
| 055. | Clarify family counseling goals | | .510 | | | |
| 037. | Assess potential for client to harm self/others | | .504 | | | |
| 005. | Evaluate existing (precounseling) client data | | .500 | | | |
| 003. | Assess degree of client's understanding of his/her substance dependency | .415 | .487 | | | |
| 021. | Use assessment results to aid in intervention selections | | .484 | | | |
| 013. | Assess for learning disabilities | | .478 | | | |
| 141. | Consult with other members of treatment team | | .475 | | | |
| 107. | Establish rapport with family and significant others | | .467 | | | |
| 001. | Obtain substance abuse history | | .459 | | | |
| 029. | Obtain client's medication history | | .448 | | | |
| 150. | Participate in staff decision-making processes | | .443 | | | |
| 027. | Determine DSM-IV classification | | .440 | | | |
| 078. | Explore client's educational opportunities | | .430 | | | |
| 025. | Use nontest appraisal techniques | | .426 | | | |
| 142. | Provide client information when authorized | | .426 | | | |
| 138. | Observe client for side effects of medication | | .411 | | | |
| 049. | Establish counseling goals and objectives | | | .784 | | |
| 059. | Evaluate client's movement toward counseling goals | | | .737 | | |

| | Item | Factor Loadings by Factor | | | | |
|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 |
| 051. | Assist client in setting short-term and long-term goals | | | .723 | | |
| 056. | Implement treatment plans | | | .713 | | |
| 048. | Co-construct comprehensive treatment plans | | | .706 | | |
| 061. | Assist client in evaluation of progress in treatment | | | .690 | | |
| 060. | Assist client recognize strengths and limitations | | | .686 | | |
| 052. | Negotiate with client a time frame for goal attainment | | | .679 | | |
| 063. | Develop a therapeutic relationship with client | | | .610 | | |
| 050. | Identify source-of-problem alternatives | | | .601 | | |
| 100. | Prepare client for termination from counseling | | | .551 | | |
| 062. | Self-evaluate counseling progress | | | .537 | | |
| 047. | Complete release of information forms | | | .526 | | |
| 009. | Assess psychosocial needs | | | .514 | | |
| 016. | Assess client's strengths and limitations | | .472 | .498 | | |
| 065. | Utilize different treatment approaches | | | .492 | | |
| 042. | Contract with client regarding program rules | | | .490 | | |
| 068. | Use cognitive-oriented counseling techniques | | | .474 | | |
| 067. | Use behavioral-oriented counseling techniques | | | .474 | | |
| 151. | Conduct case reviews to assure quality services | | | .452 | | |
| 094. | Reframe client's problem(s) | | | .447 | | |
| 099. | Assess client's readiness for discharge | | | .431 | | |
| 043. | Inform client about ethical standards and practice | | | .427 | | |
| 135. | Facilitate client's development of decision-making skills | | | .418 | | |
| 197. | Review legal statutes and regulations | | | | .675 | |
| 204. | Write for publication | | | | .650 | |
| 189. | Develop appraisal instrument/technique | | | | .630 | |
| 178. | Participate in program research activities | | | | .619 | |
| 201. | Develop own professional goals and objectives | | | | .606 | |
| 177. | Provide orientation to new personnel | | | | .591 | |
| 187. | Educate non-treatment staff about counseling services | | | | .589 | |
| 167. | Evaluate counselors' performance | | | | .564 | |
| 165. | Provide administrative supervision | | | | .562 | |

| | Item | Factor Loadings by Factor | | | | |
|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 |
| 183. | Organize professional conferences and seminars | | | | .560 | |
| 194. | Attend conferences | | | | .557 | |
| 170. | Mediate treatment staff/client conflict | | | | .551 | |
| 174. | Develop program-related reports | | | | .542 | |
| 203. | Collaborate in research with other mental health service providers | | | | .542 | |
| 192. | Engage in professional/community public relations | | | | .541 | |
| 168. | Provide counselor skill-development training | | | | .541 | |
| 190. | Evaluate media resources | .412 | | | .537 | |
| 181. | Communicate needs for services in the community | | | | .528 | |
| 169. | Coordinate volunteer activities | | | | .511 | |
| 196. | Review ethical standards | | | | .507 | |
| 163. | Establish programmatic service goals | | | | .504 | |
| 198. | Read current professional literature | | | | .495 | |
| 162. | Assess programmatic needs | | | | .489 | |
| 164. | Provide clinical supervision | | | | .488 | |
| 172. | Administer treatment program | | | | .478 | |
| 199. | Participate in continuing education/skill enhancement | | | | .478 | |
| 195. | Deliver presentations at conferences | | | | .474 | |
| 175. | Conduct fund-raising activities for program development/maintenance | | | | .452 | |
| 173. | Allocate financial resources for treatment program | | | | .445 | |
| 193. | Develop networks with other mental health service providers | | | | .441 | |
| 205. | Use prevention measures to guard against burnout | | | | .439 | |
| 180. | Engage in client data analyses | | | | .431 | |
| 179. | Perform clerical tasks (i.e., filing, typing letters) | | | | .417 | |
| 182. | Conduct community outreach | | | | .407 | |
| 102. | Counseling children | | | | | .668 |
| 103. | Counsel adolescents | | | | | .622 |
| 118. | Use structural family counseling techniques | | | | | .603 |
| 119. | Use strategic family counseling techniques | | | | | .578 |
| 116. | Counsel concerning divorce | | | | | .547 |

| | Item | Factor Loadings by Factor 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| 113. | Counsel concerning family change | | | | | .545 |
| 120. | Use behavioral family counseling techniques | | | | | .522 |
| 105. | Counsel older persons | | | | | .515 |
| 115. | Counsel concerning marital discord | | | | | .499 |
| 114. | Counsel concerning family member interaction | | | | | .497 |
| 072. | Counsel client concerning sexual abuse | | | | | .495 |
| 112. | Develop family conflict resolution strategies | | .405 | | | .475 |
| 117. | Use multigenerational family counseling techniques | | | | | .454 |
| 154. | Advocate client's interests with appropriate systems (i.e., courts, employer) | | | | | .433 |
| 109. | Inform family members of family counseling guidelines and goals | | | | | .431 |
| 104. | Counsel adults | | | | | .427 |

Table 7

Frequency of Occurrence Response Items with Orthogonal Solution Factor Loadings Less Than .40 on Any of the Five Factors

| Item Number | Work Behavior |
|---|---|
| 17 | Systematically observe client behaviors |
| 24 | Use intelligence tests |
| 36 | Analyze cost-benefit of treatment alternatives |
| 41 | Explain program policies and procedures |
| 44 | Inform client about detoxification process |
| 46 | Obtain client's informed consent prior to counseling |
| 54 | Involve significant others in treatment planning |
| 57 | Clarify mental health service provider/client roles |
| 64 | Organize or facilitate an intervention |
| 66 | Use affective-oriented counseling techniques |
| 69 | Use brief therapy techniques |
| 75 | Counsel client concerning personal change |

| Item Number | Work Behavior |
|---|---|
| 76 | Counsel client concerning personality change |
| 88 | Counsel client about irregular attendance |
| 95 | Provide crisis intervention |
| 98 | Manage violent or destructive clients |
| 106 | Counsel specialized populations (i.e., pregnant women, disabled) |
| 110 | Clarify familial behavior norms |
| 134 | Use laissez-faire group counseling leadership techniques |
| 144 | Assist client resolve problems of daily living (i.e., housing, legal) |
| 152 | Match client's needs with community resources |
| 153 | Network with community resources |
| 155 | Support client participation in leisure activities |
| 157 | Participate in case conferences |
| 158 | Make oral case presentations to treatment team |
| 159 | Assign client to a mental health service provider |
| 160 | Maintain case notes, records, and/or files |
| 161 | Solicit client's perception of treatment program |
| 171 | Attend staff meetings |
| 184 | Provide consultation to other agencies |
| 185 | Serve as liaison with other agencies |
| 186 | Serve on committees within the agency |
| 191 | Use computers for program data management |
| 200 | Receive clinical supervision |

Research Question Two

What is the factor structure of work behaviors which characterize the treatment of substance abusers in multiservice mental-health agencies as measured by criticality ratings on the Treatment of Substance Abusers in Multiservice Mental Health Agencies Questionnaire?

The principle factors analysis of the criticality ratings revealed 42 factors with a eigenvalue of 1.0 or greater. These are shown in Table 8. However, the first 5 factors accounted for approximately 89% of the total variance, with eigenvalues of 60.60, 9.07, 8.14, 6.36, and 5.12 respectively. Thus, a second factor analysis was performed using the varimax (orthogonal) rotation. Table 9 contains the criticality responses with items rank ordered from highest to lowest loadings on five rotated factors. Based on a pre-established factor loading criterion of .40 or higher for item retention, 33 items were omitted (see Table 10). A total of 34 items exceeded the .40 minimum factor loading on more than one factor. The labels given the five factors that contained the items with the highest loadings in Table 9 are as follows: Factor 1: Substance-Abuse Specialty Counseling, Factor 2: Assessment and Appraisal, Factor 3: Counseling Process, Factor 4: Professional Practice, and Factor 5: General Practice (see Appendix F).

Table 8

Principal Components Factor Analysis: Criticality Rating Items with Eigenvalues $\geq$ 1.00

| Factor | Eigenvalue |
|---|---|
| 1 | 60.60 |
| 2 | 9.07 |
| 3 | 8.14 |
| 4 | 6.36 |
| 5 | 5.12 |
| 6 | 4.81 |
| 7 | 4.54 |
| 8 | 3.92 |
| 9 | 3.34 |
| 10 | 3.23 |
| 11 | 3.07 |
| 12 | 2.87 |

| Factor | Eigenvalue |
|---|---|
| 13 | 2.74 |
| 14 | 2.61 |
| 15 | 2.45 |
| 16 | 2.39 |
| 17 | 2.31 |
| 18 | 2.20 |
| 19 | 2.14 |
| 20 | 2.04 |
| 21 | 1.98 |
| 22 | 1.95 |
| 23 | 1.89 |
| 24 | 1.86 |
| 25 | 1.84 |
| 26 | 1.73 |
| 27 | 1.63 |
| 28 | 1.58 |
| 29 | 1.53 |
| 30 | 1.48 |
| 31 | 1.44 |
| 32 | 1.38 |
| 33 | 1.32 |
| 34 | 1.29 |
| 35 | 1.25 |
| 36 | 1.19 |
| 37 | 1.17 |
| 38 | 1.15 |
| 39 | 1.10 |

| Factor | Eigenvalue |
|---|---|
| 40 | 1.06 |
| 41 | 1.03 |
| 42 | 1.01 |

Table 9

Five-Factor Orthogonal Solution by Highest Item Loading for the Factor Analysis of Criticality Responses

| | | Factor Loadings by Factor | | | | |
|---|---|---|---|---|---|---|
| | Item | 1 | 2 | 3 | 4 | 5 |
| 084. | Facilitate client exploration of the consequences of substance abuse | .804 | | | | |
| 091. | Counsel client regarding relapse prevention | .772 | | | | |
| 082. | Process 12-step assignments | .769 | | | | |
| 126. | Identify harmful group-member behavior | .767 | | | | |
| 081. | Make 12-step assignments | .760 | | | | |
| 092. | Counsel client regarding other addictive disorders | .755 | | | | |
| 085. | Educate client about consequences of substance abuse | .733 | | | | |
| 087. | Discuss positive urine drug screens with client | .710 | | | | |
| 022. | Administer substance abuse assessment instruments | .701 | | | | |
| 080. | Educate client about self-help groups | .699 | | | | |
| 151. | Conduct case reviews to assure quality services | .675 | | | | |
| 083. | Clarify client's moral/spiritual issues | .650 | | | | |
| 090. | Counsel client concerning defense mechanisms | .633 | | | | |
| 152. | Match client's needs with community resources | .631 | | | | |
| 149. | Involve significant others in aftercare planning | .626 | | | | |
| 086. | Provide impetus for client to remain in treatment | .619 | .419 | | | |
| 150. | Participate in staff decision-making processes | .611 | | | | |
| 071. | Counsel client concerning life-style change | .605 | | | | |
| 089. | Address violation of agency rules | .590 | | | | |
| 045. | Inform client about detoxification process | .583 | | | | |

| | Item | Factor Loadings by Factor | | | | |
|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 |
| 128. | Facilitate conflict resolution among group members | .582 | | .488 | | |
| 129. | Assist with group members' feedback to each other | .562 | | .487 | | |
| 125. | Systematically observe group members' behaviors | .537 | | | | |
| 127. | Evaluate progress toward group goals | .535 | | .440 | | |
| 153. | Network with community resources | .530 | | | | |
| 137. | Assist disabled clients with assignments | .520 | | | | |
| 188. | Educate non-treatment staff about substance abuse | .515 | | | | |
| 008. | Assess client's participation in a 12-step program | .514 | .447 | | | |
| 101. | Conduct former client follow-up activities | .508 | | | | |
| 079. | Provide appropriate homework assignments | .507 | | | | |
| 077. | Counsel client concerning spiritual issues | .505 | | | | |
| 141. | Consult with other members of treatment team | .505 | | | | |
| 112. | Develop family conflict resolution strategies | .497 | | | | |
| 099. | Assess client's readiness for discharge | .484 | | | | |
| 073. | Counsel client concerning human sexuality | .474 | | | | |
| 075. | Counsel client concerning personal change | .472 | | | | |
| 159. | Assign client to a mental health service provider | .455 | | | | |
| 074. | Counsel client concerning physical abuse | .454 | | | | |
| 160. | Maintain case notes, records, and/or files | .451 | | | | |
| 158. | Make oral case presentations to treatment team | .448 | | | | |
| 140. | Communicate with funding sources regarding client's treatment | .444 | | | | |
| 148. | Arrange aftercare services | .438 | | | | |
| 023. | Use self-report personality inventories | .434 | | | | |
| 030. | Assist client in understanding of test results | .429 | .409 | | | |
| 094. | Reframe client's problem(s) | .424 | | | | |
| 068. | Use cognitive-oriented counseling techniques | .422 | | | | |
| 070. | Use media resources in counseling | .420 | | | | |
| 067. | Use behavioral-oriented counseling techniques | .417 | | | | |
| 042. | Contract with client regarding program rules | .412 | | .409 | | |
| 202. | Participate in self-help group activities | .409 | | | | |
| 006. | Discuss client's reasons for seeking treatment | | .650 | | | |

| | Item | Factor Loadings by Factor | | | | |
|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 |
| 012. | Assess client's educational history | | .627 | | | |
| 026. | Evaluate extent of client's psychological dysfunction | | .596 | | | |
| 028. | Evaluate need for client referral for further assessment | | .592 | | | |
| 057. | Clarify mental health service provider/client roles | | .585 | | | |
| 014. | Clarify client's support systems | | .583 | | | |
| 005. | Evaluate existing (precounseling) client data | | .577 | | | |
| 011. | Identify client's internal/external resources | | .569 | | | |
| 035. | Evaluate need for client referral for treatment | | .563 | | | |
| 027. | Determine DSM-IV classification | | .561 | | | |
| 029. | Obtain client's medication history | | .549 | | | |
| 015. | Assess client's family history of addictive disorders | .437 | .543 | | | |
| 007. | Assess client's motivation for treatment | | .536 | | | |
| 004. | Conduct pretreatment diagnostic interview | | .534 | | | |
| 040. | Inform client about program services | | .523 | | | |
| 002. | Determine severity of client's substance abuse problem | | .522 | | | |
| 003. | Assess degree of client's understanding of his/her substance dependency | | .510 | | | |
| 039. | Determine necessity for an intervention | | .484 | | | |
| 025. | Use nontest appraisal techniques | | .470 | | | |
| 107. | Establish rapport with family and significant others | | .467 | | | |
| 033. | Assess match between client's needs and program services | | .466 | .424 | | |
| 055. | Clarify family counseling goals | | .466 | .419 | | |
| 156. | Facilitate return-to-work conferences | .427 | .463 | | | |
| 010. | Assess spiritual functioning | .424 | .456 | | | |
| 054. | Involve significant others in treatment planning | | .451 | | | |
| 001. | Obtain substance abuse history | | .448 | | | |
| 154. | Advocate client's interests with appropriate systems (i.e., courts, employer) | | .437 | | | |
| 031. | Interview client's significant others | | .430 | | | |
| 088. | Counsel client about irregular attendance | .401 | .426 | | | |
| 157. | Participate in case conferences | | .426 | | | |
| 078. | Explore client's educational opportunities | | .424 | | | |

| | Item | Factor Loadings by Factor | | | | |
|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 |
| 164. | Provide clinical supervision | | .406 | | | |
| 013. | Assess for learning disabilities | | .404 | .778 | | |
| 056. | Implement treatment plans | | | .778 | | |
| 049. | Establish counseling goals and objectives | | | .699 | | |
| 048. | Co-construct comprehensive treatment plans | | | .693 | | |
| 061. | Assist client in evaluation of progress in treatment | | | .690 | | |
| 131. | Use "structured" activities during group counseling | .508 | | .658 | | |
| 059. | Evaluate client's movement toward counseling goals | | | .649 | | |
| 134. | Use laissez-faire group counseling | .435 | | .644 | | |
| 132. | Use leader-centered group counseling | .510 | | .604 | | |
| 060. | Assist client recognize strengths and limitations | | .472 | .602 | | |
| 133. | Use group-centered leadership techniques | .550 | | .602 | | |
| 051. | Assist client in setting short-term and long-term goals | | .441 | .570 | | |
| 063. | Develop a therapeutic relationship with client | | | .559 | | |
| 130. | Determine group counseling effectiveness | .529 | | .554 | | |
| 147. | Assist client in obtaining a temporary sponsor | | | .537 | | |
| 116. | Counsel concerning divorce | | .416 | .514 | | |
| 046. | Obtain client's informed consent prior to counseling | | | .513 | | |
| 100. | Prepare client for termination from counseling | | | .496 | | |
| 047. | Complete release of information forms | | | .492 | | |
| 062. | Self-evaluate counseling progress | | | .479 | | |
| 115. | Counsel concerning marital discord | | .426 | .472 | | .408 |
| 139. | Monitor drug screening test results | | | .471 | | |
| 052. | Negotiate with client a time frame for goal attainment | | | .464 | | |
| 050. | Identify source-of-problem alternatives | | | .457 | | |
| 103. | Counsel adolescents | | | .455 | | |
| 102. | Counsel children | | | .450 | | |
| 117. | Use multigenerational family counseling techniques | | .420 | .438 | | |
| 135. | Facilitate client's development of decision-making skills | | | .432 | | |
| 064. | Organize or facilitate an intervention | | | .427 | | |
| 113. | Counsel concerning family change | | | .422 | | |

| | Item | Factor Loadings by Factor | | | | |
|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 |
| 109. | Inform family members of family counseling guidelines and goals | | | .422 | | |
| 016. | Assess client's strengths and limitations | | | .422 | | |
| 118. | Use structural family counseling techniques | | .405 | .411 | | |
| 009. | Assess psychosocial needs | | | .403 | | |
| 201. | Develop own professional goals and objectives | | | | .642 | |
| 197. | Review legal statutes and regulations | | | | .632 | |
| 192. | Engage in professional/community public relations | | | | .622 | |
| 200. | Receive clinical supervision | | | .417 | .608 | |
| 185. | Serve as liaison with other agencies | | | | .586 | |
| 204. | Write for publication | | | | .577 | |
| 198. | Read current professional literature | | | | .577 | |
| 041. | Explain program policies and procedures | | | | .576 | |
| 169. | Coordinate volunteer activities | | | | .573 | |
| 205. | Use prevention measures to guard against burnout | | | | .564 | |
| 172. | Administer treatment program | | | | .564 | |
| 190. | Evaluate media resources | | | | .561 | .414 |
| 199. | Participate in continuing education/skill enhancement | | | | .556 | |
| 194. | Attend conferences | | | | .548 | |
| 181. | Communicate needs for services in the community | | | | .537 | |
| 193. | Develop networks with other mental health service providers | | | | .534 | |
| 195. | Deliver presentations at conferences | | | | .532 | |
| 203. | Collaborate in research with other mental health service providers | | | | .529 | |
| 189. | Develop appraisal instrument/technique | | | | .518 | |
| 182. | Conduct community outreach | | | | .509 | .433 |
| 187. | Educate non-treatment staff about counseling services | | | | .508 | .405 |
| 183. | Organize professional conferences and seminars | | | | .505 | |
| 191. | Use computers for program data management | | | | .505 | |
| 171. | Attend staff meetings | | .446 | | .494 | |
| 167. | Evaluate counselors' performance | | | | .488 | |
| 168. | Provide counselor skill-development training | | | | .470 | |

| | Item | Factor Loadings by Factor | | | | |
|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 |
| 178. | Participate in program research activities | | | | .469 | |
| 175. | Conduct fund-raising activities for program development/maintenance | | | | .464 | |
| 173. | Allocate financial resources for treatment programs | | | | .461 | .440 |
| 170. | Mediate treatment staff/client conflict | | | .451 | .458 | |
| 044. | Inform client about legal aspects of counseling | | | | .453 | |
| 180. | Engage in client data analyses | | | | .449 | |
| 184. | Provide consultation to other agencies | | | | .445 | |
| 145. | Investigate half-way house alternatives | | | | .404 | |
| 123. | Select clients for group participation | | | | | .578 |
| 121. | Educate significant others about self-help groups | | | | | .560 |
| 179. | Perform clerical tasks (i.e., filing, typing letters) | | | | | .555 |
| 122. | Counsel significant others concerning substance abuse | | | | | .543 |
| 114. | Counsel concerning family members interaction | .436 | | | | .520 |
| 110. | Clarify familial behavior norms | .436 | | | | .520 |
| 177. | Provide orientation to new personnel | | | | | .490 |
| 124. | Inform clients of group counseling guidelines and goals | | | | | .478 |
| 019. | Integrate assessment results | | | | | .470 |
| 174. | Develop program-related reports | | | | .414 | .461 |
| 144. | Assist client resolve problems of daily living (i.e., housing, legal) | | | | | .432 |

Table 10

Criticality Response Items with Orthogonal Solution Factor Loadings Less Than .40 on Any of the Five Factors

| Item Number | Work Behavior |
|---|---|
| 17 | Systematically observe client behaviors |
| 18 | Select appraisal instruments/techniques for counseling |
| 20 | Use assessment results to aid client in making decisions |
| 21 | Use assessment results to aid in intervention selections |

| Item Number | Work Behavior |
|---|---|
| 24 | Use intelligence test results |
| 32 | Inform family of family dynamics/roles |
| 34 | Determine if client will be admitted for treatment |
| 36 | Analyze cost-benefit of treatment alternatives |
| 37 | Assess potential for client to harm self/others |
| 43 | Inform client about ethical standards and practice |
| 65 | Utilize different treatment approaches |
| 66 | Use affective-oriented counseling techniques |
| 69 | Use brief therapy techniques |
| 72 | Counsel client concerning sexual abuse |
| 76 | Counsel client concerning personality change |
| 95 | Provide crisis intervention |
| 98 | Manage violent or destructive clients |
| 104 | Counsel adults |
| 105 | Counsel older persons |
| 106 | Counsel specialized populations (i.e., pregnant women, disabled) |
| 119 | Use strategic family counseling techniques |
| 120 | Use behavioral family counseling techniques |
| 136 | Facilitate client's development of job-search skills |
| 138 | Observe client for side effects of medication |
| 142 | Provide client information when authorized |
| 146 | Assist client in constructing effective support systems |
| 155 | Support client participation in leisure activities |
| 161 | Solicit client's perception of treatment program |
| 162 | Assess programmatic needs |
| 163 | Establish programmatic service goals |
| 165 | Provide administrative supervision |

| Item Number | Work Behavior |
|---|---|
| 186 | Serve on committees within the agency |
| 196 | Review ethical standards |

Research Question Three

What is the factor structure of work behaviors which characterize the treatment of substance abusers in multiservice mental health agencies as measured by combined frequency of occurrence and criticality ratings on the Treatment of Substance Abusers in Multiservice Mental Health Agencies Questionnaire?

A combined rating for the overall importance of each item was calculated by weighing the frequency of occurrence and criticality scores on the Questionnaire (Kane, Kingsbury, Colton, & Estes, 1989). The final principle factors analysis was conducted on the combined ratings. It resulted in 42 factors with a eigenvalue of 1.0 or greater as shown in Table 11. The first 5 factors accounted for approximately 93% of the variance with eigenvalues of 63.78, 10.25, 8.47, 5.64, and 4.73, respectively. Thus, a second factor analysis was performed using the varimax (orthogonal) rotation. The combined responses with items rank ordered from highest to lowest factor loadings on the 5 factors in Table 12. Based on a pre-established factor loading criterion of.40 or higher for item retention, 33 items were omitted (see Table 13). A total of 22 items exceeded the .40 minimum factor loading on more than one factor. The five factors resulting from the orthogonal rotated factor pattern were: Factor 1: Substance-Abuse Specialty Counseling, Factor 2: Professional Practice, Factor 3: Assessment and Appraisal, Factor 4: Family Counseling, and Factor 5: Counseling Process (see Appendix G).

Table 11

Principal Components Factor Analysis: Combined Ratings with Eigenvalues > 1.00

| Factor | Eigenvalue |
|---|---|
| 1 | 63.78 |
| 2 | 10.25 |
| 3 | 8.47 |
| 4 | 5.64 |
| 5 | 4.73 |
| 6 | 4.11 |
| 7 | 3.91 |
| 8 | 3.72 |
| 9 | 3.40 |
| 10 | 3.10 |
| 11 | 2.93 |
| 12 | 2.67 |
| 13 | 2.66 |
| 14 | 2.53 |
| 15 | 2.43 |
| 16 | 2.26 |
| 17 | 2.20 |
| 18 | 2.16 |
| 19 | 2.04 |
| 20 | 2.03 |
| 21 | 1.94 |
| 22 | 1.82 |
| 23 | 1.76 |
| 24 | 1.74 |
| 25 | 1.70 |

| Factor | Eigenvalue |
|---|---|
| 26 | 1.57 |
| 27 | 1.51 |
| 28 | 1.49 |
| 29 | 1.45 |
| 30 | 1.43 |
| 31 | 1.38 |
| 32 | 1.35 |
| 33 | 1.33 |
| 34 | 1.26 |
| 35 | 1.23 |
| 36 | 1.20 |
| 37 | 1.14 |
| 38 | 1.12 |
| 39 | 1.09 |
| 40 | 1.07 |
| 41 | 1.04 |
| 42 | 1.00 |

Table 12

Five-Factor Orthogonal Solution by Highest Item Loading for the Factors Analysis of Combined Frequency of Occurrence and Criticality Responses (or Overall Importance)

| | | Factor Loadings by Factor | | | | |
|---|---|---|---|---|---|---|
| | Item | 1 | 2 | 3 | 4 | 5 |
| 081. | Make 12-step assignments | .815 | | | | |
| 082. | Process 12-step assignments | .815 | | | | |
| 126. | Identify harmful group-member behaviors | .788 | | | | |
| 084. | Facilitate client exploration of the consequences of substance abuse | .766 | | | | |

| | Item | Factor Loadings by Factor | | | | |
|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 |
| 085. | Educate client about consequences of substance abuse | .724 | | | | |
| 091. | Counsel client regarding relapse prevention | .717 | | | | |
| 125. | Systematically observe group members' behavior | .702 | | | | |
| 080. | Educate client about self-help groups | .698 | | | | |
| 083. | Clarify client's moral/spiritual issues | .697 | | | | |
| 022. | Administer substance abuse assessment instruments | .686 | | | | |
| 147. | Assist client in obtaining a temporary sponsor | .653 | | | | |
| 129. | Assist with group members' feedback to each other | .650 | | | | |
| 092. | Counsel client regarding other addictive disorders | .648 | | | | |
| 087. | Discuss positive urine drug screens with client | .638 | | | | |
| 149. | Involve significant others in aftercare planning | .633 | | | | |
| 090. | Counsel client concerning defense mechanisms | .632 | | | | |
| 133. | Use group-centered group counseling leadership techniques | .630 | | | | |
| 128. | Facilitate conflict resolution among group members | .629 | | | .411 | |
| 127. | Evaluate progress toward group goals | .628 | | | | |
| 071. | Counsel client concerning life-style change | .623 | | | | |
| 008. | Assess client's participation in a 12-step program | .615 | | .427 | | |
| 137. | Assist disabled clients with assignments | .615 | | | | |
| 151. | Conduct case reviews to assure quality services | .613 | | | | |
| 089. | Address violation of agency rules | .608 | | | | |
| 131. | Use "structured" activities during group counseling | .606 | | | .428 | |
| 130. | Determine group counseling effectiveness | .598 | | | | |
| 152. | Match client's needs with community resources | .589 | | | | |
| 124. | Inform clients of group counseling guidelines and goals | .583 | | | | |
| 139. | Monitor drug screening test results | .583 | | | | |
| 077. | Counsel client concerning spiritual issues | .578 | | | | |
| 086. | Provide impetus for client to remain in treatment | .574 | | | | |
| 145. | Investigate half-way house alternatives | .560 | | | | |
| 121. | Educate significant others about self-help groups | .556 | | | | |
| 010. | Assess spiritual functioning | .551 | | .426 | | |

| | Item | Factor Loadings by Factor | | | | |
|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 |
| 079. | Provide appropriate homework assignments | .548 | | | | |
| 045. | Inform client about detoxification process | .546 | | | | |
| 148. | Arrange aftercare services | .542 | | | | |
| 032. | Inform family of family dynamics/roles | .540 | | | | |
| 135. | Facilitate client's development of decision-making skills | .536 | | | | |
| 122. | Counsel significant others concerning substance abuse | .535 | | | | |
| 070. | Use media resources in counseling | .534 | | | | |
| 141. | Consult with other members of treatment team | .531 | | | | |
| 101. | Conduct former client follow-up activities | .526 | | | | |
| 146. | Assist client in constructing effective support systems | .516 | | | | |
| 150. | Participate in staff decision-making processes | .511 | | | | |
| 132. | Use leader-centered group counseling leadership techniques | .501 | | | | |
| 202. | Participate in self-help group activities | .496 | | | | |
| 042. | Contract with client regarding program rules | .493 | | | | .432 |
| 123. | Select clients for group participation | .483 | | | | |
| 068. | Use cognitive-oriented counseling techniques | .481 | | | | |
| 140. | Communicate with funding sources regarding client's treatment | .476 | | | | |
| 023. | Use self-report personality inventories | .469 | | | | |
| 110. | Clarify familial behavior norms | .460 | | .429 | .404 | |
| 099. | Assess client's readiness for discharge | .458 | | | | |
| 088. | Counsel client about irregular attendance | .452 | | | | |
| 075. | Counsel client concerning personal change | .444 | | | | |
| 067. | Use behavioral-oriented counseling techniques | .442 | | | | |
| 073. | Counsel client concerning human sexuality | .439 | .429 | | | |
| 153. | Network with community resources | .434 | | | | |
| 144. | Assist client resolve problems of daily living (i.e., housing, legal) | .415 | | | | |
| 136. | Facilitate client's development of job-search skills | .409 | | | | |
| 178. | Participate in program research activities | | .770 | | | |
| 182. | Conduct community outreach | | .730 | | | |
| 197. | Review legal statutes and regulations | | .692 | | | |

| | Item | Factor Loadings by Factor | | | | |
|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 |
| 204. | Write for publication | | .688 | | | |
| 181. | Communicate needs for services in the community | | .666 | | | |
| 187. | Educate non-treatment staff about counseling services | | .664 | | | |
| 190. | Evaluate media resources | | .658 | | | |
| 203. | Collaborate in research with other mental health service providers | | .658 | | | |
| 189. | Develop appraisal instrument/technique | | .656 | | | |
| 169. | Coordinate volunteer activities | | .642 | | | |
| 174. | Develop program-related reports | | .635 | | | |
| 201. | Develop own professional goals and objectives | | .626 | | | |
| 192. | Engage in professional/community public relations | | .618 | | | |
| 170. | Mediate treatment staff/client conflict | | .596 | | | |
| 183. | Organize professional conferences and seminars | | .590 | | | |
| 195. | Deliver presentations at conferences | | .585 | | | |
| 175. | Conduct fund-raising activities for program development/ maintenance | | .583 | | | |
| 173. | Allocate financial resources for treatment program | | .582 | | | |
| 188. | Educate non-treatment staff about substance abuse | .483 | .575 | | | |
| 205. | Use prevention measures to guard against burnout | | .570 | | | |
| 184. | Provide consultation to other agencies | | .568 | | | |
| 177. | Provide orientation to new personnel | | .564 | | | |
| 185. | Serve as liaison with other agencies | | .561 | | | |
| 180. | Engage in client data analyses | | .543 | | | |
| 167. | Evaluate counselors' performance | | .528 | | | |
| 194. | Attend conferences | | .518 | | | |
| 186. | Serve on committees within the agency | | .516 | | | |
| 198. | Read current professional literature | | .515 | | | |
| 196. | Review ethical standards | | .507 | | | |
| 172. | Administer treatment program | | .504 | | | |
| 179. | Perform clerical tasks (i.e., filing, typing letters) | | .483 | | | |
| 156. | Facilitate return-to-work conferences | | .471 | | .416 | |
| 193. | Develop networks with other mental health service providers | | .470 | | | |

| | Item | Factor Loadings by Factor | | | | |
|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 |
| 168. | Provide counselor skill-development training | | .469 | | | |
| 199. | Participate in continuing education/skill enhancement | | .461 | | | |
| 163. | Establish programmatic service goals | | .441 | | | |
| 191. | Use computers for program data management | | .441 | | | |
| 165. | Provide administrative supervision | | .425 | | | |
| 162. | Assess programmatic needs | | .419 | | | |
| 011. | Identify client's internal/external resources | | | .670 | | |
| 014. | Clarify client's support systems | | | .612 | | |
| 020. | Use assessment results to aid client in making decisions | | | .611 | | |
| 019. | Integrate assessment results | | | .595 | | |
| 012. | Assess client's educational history | | | .589 | | |
| 026. | Evaluate extent of client's psychological dysfunction | | | .585 | | |
| 002. | Determine severity of client's substance abuse problem | | | .570 | | |
| 004. | Conduct pretreatment diagnostic interview | | | .570 | | |
| 039. | Determine necessity for an intervention | | | .568 | | |
| 015. | Assess client's family history of addictive disorders | .422 | | .561 | | |
| 033. | Assess match between client's needs and program services | | | .561 | | .448 |
| 028. | Evaluate need for client referral or further assessment | | | .553 | | |
| 035. | Evaluate need for client referral for treatment | | | .544 | | |
| 018. | Select appraisal instrument/techniques for counseling | | | .542 | | |
| 021. | Use assessment results to aid in intervention selections | | | .539 | | |
| 005. | Evaluate existing (precounseling) client data | | | .525 | | |
| 001. | Obtain substance abuse history | | | .520 | | |
| 006. | Discuss client's reasons for seeking treatment | | | .519 | .410 | |
| 034. | Determine if client will be admitted for treatment | | | .512 | | |
| 016. | Assess client's strengths and limitations | | | .511 | | |
| 003. | Assess degree of client's understanding of his/her substance dependency | .424 | | .510 | | |
| 027. | Determine DSM-IV classification | | | .497 | | |
| 009. | Assess psychosocial needs | | | .496 | | |
| 031. | Interview client's significant others | | | .485 | | |

| | Item | Factor Loadings by Factor | | | | |
|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 |
| 013. | Assess for learning disabilities | | | .468 | | |
| 030. | Assist client in understanding of test results | .419 | | .463 | | |
| 107. | Establish rapport with family and significant others | | | .459 | .456 | |
| 007. | Assess client's motivation for treatment | | | .454 | | |
| 025. | Use nontest appraisal technique | | | .434 | | |
| 055. | Clarify family counseling goals | | | .428 | .422 | |
| 037. | Assess potential for client to harm self/others | | | .428 | | |
| 029. | Obtain client's medication history | | | .428 | | |
| 040. | Inform client about program services | | | .423 | | |
| 118. | Use structural family counseling techniques | | | | .667 | |
| 102. | Counsel children | | | | .659 | |
| 116. | Counsel concerning divorce | | | | .640 | |
| 119. | Use strategic family counseling techniques | | | | .621 | |
| 117. | Use multigenerational family counseling techniques | | | | .609 | |
| 115. | Counsel concerning marital discord | .404 | | | .596 | |
| 120. | Use behavioral family counseling techniques | | | | .596 | |
| 103. | Counsel adolescents | | | | .592 | |
| 113. | Counsel concerning family change | .411 | | .426 | .570 | |
| 109. | Inform family members of family counseling guidelines and goals | .430 | | | .503 | |
| 112. | Develop family conflict resolution strategies | .417 | | .445 | .502 | |
| 114. | Counsel concerning family member interaction | .442 | | .410 | .499 | |
| 105. | Counsel older persons | | | | .401 | |
| 056. | Implement treatment plans | | | | | .680 |
| 049. | Establish counseling goals and objectives | | | | | .678 |
| 048. | Co-construct comprehensive treatment plans | | | | | .647 |
| 059. | Evaluate client's movement toward counseling goals | | | | | .619 |
| 051. | Assist client in setting short-term and long-term goals | | | | | .613 |
| 063. | Develop a therapeutic relationship with client | | | | | .587 |
| 061. | Assist client in evaluation of progress in treatment | | | | | .585 |
| 060. | Assist client recognize strengths and limitations | | | | | .567 |
| 050. | Identify source-of-problem alternatives | | | | | .527 |

| | Item | Factor Loadings by Factor 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| 052. | Negotiate with client a time frame for goal attainment | .420 | | | | .524 |
| 160. | Maintain case notes, records, and/or files | | | | | .466 |
| 200. | Receive clinical supervision | | | | | .456 |
| 062. | Self-evaluate counseling progress | | | | | .456 |
| 065. | Utilize different treatment approaches | .403 | | | | .419 |
| 047. | Complete release-of-information forms | | | | | .403 |

Table 13

Combined Frequency of Occurrence and Criticality Ratings (or Overall Importance) with Orthogonal Solution Factor Loadings Less Than .40 on Any of the Five Factors

| Item Number | Work Behavior |
|---|---|
| 17 | Systematically observe client behaviors |
| 24 | Use intelligence test results |
| 36 | Analyze cost-benefit of treatment alternatives |
| 41 | Explain program policies and procedures |
| 43 | Inform client about ethical standards and practice |
| 44 | Inform client about legal aspects of counseling |
| 46 | Obtain client's informed consent prior to counseling |
| 54 | Involve significant others in treatment planning |
| 57 | Clarify mental health service provider/client roles |
| 64 | Organize or facilitate an intervention |
| 66 | Use affective-oriented counseling techniques |
| 69 | Use brief therapy techniques |
| 72 | Counsel client concerning sexual abuse |
| 74 | Counsel client concerning physical abuse |
| 76 | Counsel client concerning personality change |
| 78 | Explore client's educational opportunities |

| Item Number | Work Behavior |
|---|---|
| 94 | Reframe client's problem(s) |
| 95 | Provide crisis intervention |
| 98 | Manage violent or destructive clients |
| 100 | Prepare client for termination from counseling |
| 104 | Counsel adults |
| 106 | Counsel specialized populations (i.e., pregnant women, disabled) |
| 134 | Use laissez-faire group counseling leadership techniques |
| 138 | Observe client for side effects of medication |
| 142 | Provide client information when authorized |
| 154 | Advocate client's interests with appropriate systems (i.e., courts, employer) |
| 155 | Support client participation in leisure activities |
| 157 | Participate in case conferences |
| 158 | Make oral case presentations to treatment team |
| 159 | Assign client to a mental health service provider |
| 161 | Solicit client's perception of treatment program |
| 164 | Provide clinical supervision |
| 171 | Attend staff meetings |

Question Four

The following information, which is not integral to this study but important in gaining additional knowledge concerning the multiservice mental-health agencies that participate in this study, was also obtained: (a) approximate number of mental-health service hours and substance-abuse counseling hours provided weekly by each agency, (b) number of mental-health service providers in the agencies who represent the primary professional affiliations of marriage and family therapist, psychiatrist, psychologist, psychiatric nurse, professional counselor, social worker, substance-abuse specialty counselor (master's level), and substance-abuse specialty counselor (non-master's level), (c) weekly average substance-abuse counseling hours provided by

individuals who represent the different primary professional affiliations, and (d) the amount of substance-abuse counseling that is provided weekly by individuals from the different professional affiliations who are employed in small, medium, and large size agencies.

Mental health and substance-abuse counseling hours weekly. Descriptive information concerning the agencies are reported in Table 14. A dichotomy existed among the 117 agencies that responded as evidenced by 32% of the agency representatives reporting their agencies provided less than 300 mental-health service hours weekly and another 32% reporting they provided more than 1200 hours weekly. Another 19% of the agency representatives indicated their agencies provided 301-600 mental-health service hours weekly. When examining how many of the total service hours provided weekly were devoted to substance-abuse counseling, 65% of the agencies indicated they provided less than 300 weekly, while 18% provided 301-600 hours weekly.

Table 14

Services Provided by Participating Agencies

| Characteristic | Frequency | Percent |
|---|---|---|
| Mental Health Service Hours Provided Weekly | | |
| 0 to 300 | 37 | 31.6 |
| 301 to 600 | 22 | 18.8 |
| 601 to 900 | 11 | 9.4 |
| 901 to 1200 | 6 | 5.1 |
| 1200 or more | 37 | 31.6 |
| Missing | 4 | 3.4 |
| Substance Abuse Hours Provided Weekly | | |
| 0 to 300 | 75 | 64.1 |
| 301 to 600 | 21 | 17.9 |
| 601 to 900 | 8 | 6.8 |
| 901 to 1200 | 6 | 5.1 |
| 1200 or more | 5 | 4.3 |
| Missing | 2 | 1.7 |

Affiliations Represented. Since one of the goals of this study was to understand the contributions of different professional groups in the responding agencies, staffing patterns and the provision of substance-abuse counseling in the agencies were examined. Representatives were asked to indicate the number of mental-health service providers in their agency whose primary professional affiliation was marriage and family therapist, psychiatrist, psychologist, psychiatric nurse, professional counselor, social worker, substance-abuse specialty counselor (master's level), substance-abuse specialty counselor (non-master's level), or "other". The results of the staffing patterns indicated that 67% of the agencies employed marriage and family therapists, 88% employed psychiatrists, 76% employed psychologists, 82% employed psychiatric nurses, 75% employed professional counselors, 84% employed social workers, 78% employed master's degree substance-abuse specialty counselors, and 75% employed non-master's degree substance-abuse specialty counselors. Thirty-nine of the representatives responded that they employed "other" mental-health service providers, including student interns, non-degree or bachelor's degree case managers, licensed practical nurses, teachers, and teaching assistants.

Substance-Abuse Counseling Hours by Affiliation. Respondents were also asked to indicate the weekly average number of substance-abuse counseling hours provided by the different professional affiliations represented in the agency. Based on the data analyses of time devoted to substance-abuse counseling by the different professional groups, non-master's level substance-abuse specialty counselors and master's level substance-abuse specialty counselors provided a total of 1930 and 1795 hours a week, respectively. Of the other affiliations, professional counselors (1670 hours) and social workers (1465 hours) were shown to generally spend more hours per week providing substance-abuse counseling than marriage and family therapists, psychiatrists, psychologists, and psychiatric nurses (see Table 15).

Table 15

Average Number of Substance Abuse Counseling Hours Provided by Professional Affiliation

| Primary Professional Affiliation | Agencies Employing (N) | Weekly Average of Substance Abuse Counseling Hours | | | | |
|---|---|---|---|---|---|---|
| | | 0-10 | 11-20 | 21-30 | 31-40 | Total |
| Marriage and Family Therapist | 65 | 37 | 8 | 1 | 2 | 400 |
| Psychiatrist | 115 | 76 | 20 | 4 | 5 | 955 |
| Psychologist | 89 | 55 | 15 | 4 | 3 | 705 |
| Psychiatric Nurse | 91 | 51 | 13 | 6 | 8 | 880 |
| Professional Counselor | 101 | 31 | 15 | 18 | 24 | 1670 |
| Social Worker | 108 | 45 | 27 | 11 | 16 | 1465 |
| Substance Abuse Specialty Counseling (Master's Level) | 79 | 7 | 10 | 21 | 31 | 1795 |
| Substance Abuse Specialty Counselor (Non-Master's Level) | 84 | 8 | 12 | 18 | 36 | 1930 |

*Calculated by multiplying the midpoint of the substance abuse counseling hours categories by the number of individuals associated with each affiliation.

Substance-Abuse Counseling Hours by Affiliation and Size of Agency. An examination of the total substance-abuse counseling hours provided weekly by mental- health service providers from the different professional affiliations indicated that, with the exception of the substance-abuse specialty counselors, most provided less than 10 hours weekly in smaller agencies (provided less than 300 mental-health service hours weekly) and medium size agencies. The substance-abuse specialty counselors tended to spend 31 to 40 hours per week providing substance-abuse counseling in the same size agencies.

# CHAPTER V

# SUMMARY, LIMITATIONS, IMPLICATIONS, AND RECOMMENDATIONS

In this chapter, the research findings are summarized, limitations are identified, implications for counselors in training and counselor educators are discussed, and recommendations for further research are explored.

## Summary

This study examined the work behaviors of mental-health service providers when providing substance-abuse counseling in multiservice mental-health agencies. Although work behavior analyses have been conducted on the general practice of professional counselors and on the practice of substance-abuse specialty counselors in substance-abuse treatment facilities, none have been conducted that examined the work behaviors of substance-abuse specialty counselors in multiservice mental-health agencies. The present research addressed this issue.

Studied were 367 multiservice mental-health agencies in 14 states that comprise the southern region of the United States. These agencies were chosen based on the willingness of their regional director, agency director, or designated representative to participate in the study. The Treatment of Substance Abusers in Multiservice Mental Health Agencies Questionnaire was developed by the researcher and forwarded to the mental-health agencies. Responses were received from 117 agencies for a response rate of 32%.

The research questions for this study addressed the factor analytic structure of the work behavior items included in the Questionnaire. The factor analyses conducted on the frequency of occurrence ratings and on a combined rating of the frequency of occurrence and criticality

responses (or overall importance) yielded five relatively distinct factors, even with a relatively high factor loading criterion of .40. The factor analysis of the criticality ratings also resulted in a five-factor solution, but the structure was less defined than the structure created in the other two analyses.

The work behavior items generally clustered into relatively distinct factors although the order or grouping of the factors differed from each of the analyses. The factors for the frequency of occurrence data were identified as Factor 1: Substance-Abuse Specialty Counseling, Factor 2: Assessment and Appraisal, Factor 3: Counseling Process, Factor 4: Professional Practice, and Factor 5: Family Counseling.

The criticality analysis resulted in less distinct clusters than the frequency of occurrence and combined analyses. The factors for the criticality data analysis were Factor 1: Substance-Abuse Specialty Counseling, Factor 2: Assessment and Appraisal, Factor 3: Counseling Process, Factor 4: Professional Practice, and Factor 5: General Practice.

Combining the frequency of occurrence and criticality ratings for an overall hierarchy of factors resulted in the same factors as the frequency of occurrence analysis but in a different order. The combined analysis factors were Factor 1: Substance-Abuse Specialty Counseling, Factor 2: Professional Practice, Factor 3: Assessment and Appraisal, Factor 4: Family Counseling, and Factor 5: Counseling Process.

## Examination of the Factors

This section presents some conclusions about the individual factors derived in this study. An examination of the interface between the factors yielded from the three factor analyses are presented to provide a framework for training mental-health service providers in substance-abuse counseling. Lastly, the work behavior items that did not load on any of the five individual factors are compared to their means for the frequency of occurrence and criticality ratings.

Substance-Abuse Specialty Counseling

Respondents to the Questionnaire on behalf of the agency strongly agreed that substance-abuse specialty counseling involves work behaviors associated with administering substance-abuse assessment instruments, 12-step program practices (including moral/spiritual issues), education about the consequences of substance abuse and other addictive disorders, and relapse prevention. While respondents tended to agree that involving significant others in the aftercare planning process was critical in substance-abuse specialty counseling, they did not strongly agree that this was a frequent work behavior involved in substance-abuse counseling in mental-health agencies. This difference may be explained by the destructive nature of substance abuse on the family system and the erosion of support systems for substance-abuse clients who present for treatment at multiservice mental-health agencies. A parallel finding was the high factor loadings regarding the counseling of clients concerning lifestyle change and informing family members of family dynamics and roles. If substance-abuse clients aspire to reunite their family systems, counseling the client and their families regarding lifestyle change is imperative.

An interesting finding resulting from this study was the agreement by respondents that work behaviors associated with job search skills, physical abuse, and human sexuality be included within the substance-abuse specialty domain and not a more general counseling domain. This finding may support the statistics that illustrate that individuals who abuse substances have a higher rate of work-related difficulties, domestic violence, and are more vulnerable to infectious diseases (Arif & Westermeyer, 1988; Asbury, Walker, & Maholmes, 1992).

Since one of the major tenets of substance-abuse treatment is that group counseling should take place, it is appropriate that the work behaviors related to group counseling primarily loaded with the substance-abuse specialty counseling factor structure. The items with the highest factor loadings across the analyses related to identifying harmful group member behavior, systematically

observing group members' behavior, and assisting with group members' feedback to each other. This finding supports trainees gaining proficiencies in group counseling if they plan to counsel substance-abuse clients in mental-health agencies.

Assessment and Appraisal

The assessment and appraisal factors were defined by work behaviors involved in formulating a composite of the client's history, presenting problems, and appropriate interventions. The three items found to be weighted high for all three factor analyses were Item 12--assess client's educational history, Item 14--clarify client's support system, and Item 11--identify client's internal/external resources. The emphasis on obtaining clients' educational history may be due to the fact that clients' level of education has the potential to impact their ability to be adequate historians and/or adequately engage in the assessment process. Item 6--discuss client's reasons for seeking treatment had the highest factor loading for the criticality analysis by respondents did not show as much agreement about the strength of this work behavior within the assessment domain for the frequency and combined analyses.

Of the agencies that responded to this study, 65% indicated they provide less than 300 hours of substance-abuse counseling hours weekly. Therefore, it is appropriate that work behaviors related to assessing the client's needs and referring them to other agencies in the community or intra-agency program services be strongly weighted within the frequency of occurrence analyses and weighted moderately within the criticality and combined analyses. More specifically, Item 33--assess match between client's needs and program services and Item 35--evaluate needs for client referral for treatment, and Item 28--evaluate need for client referral for further assessment. Relatedly, research shows that many clients assessed and/or treated in multiservice mental-health agencies are dually diagnosed and that a substance-abuse disorder may be a client's principal diagnosis or a secondary diagnosis. Therefore, it is fitting that respondents

agreed that Item 26--evaluate extent of client's psychological dysfunction, is both frequent and critical to the assessment and appraisal process. There was less agreement on mental-health service providers determining a DSM-IV diagnosis for clients they assess. Respondents agreed that determining a diagnostic classification was overall important and critical to the assessment process, but there was less agreement in how frequently that behavior was performed in mental-health agencies.

An examination of the work behaviors within the assessment and appraisal factor across the analyses revealed more similarities between the frequency and combined (overall importance) analysis. One item that had a high factor loading within the criticality ratings but did not load on any of the factors in the frequency and combined analyses was Item 57--clarify mental health service provider/client roles. Similarly, Item 20--use assessment results to aid client in making decisions, loaded high for the frequency and combined analysis but was not included as a work behavior within the assessment and appraisal domain for the criticality ratings. These differences may be explained by the weaker factor structure derived from the criticality analysis. Of interest to those who provide training in substance-abuse counseling, Item 1--obtain substance abuse history, did not have high factor loadings within the assessment domain for either the frequency of occurrence or criticality ratings. One has to ask if substance abuse histories are generally not part of the assessment process in multiservice mental-health agencies? If so, is it because mental-health service providers are not adequately trained in obtaining clients' substance abuse histories?

Counseling Process

The counseling process factors included more distinct work behaviors across the analyses than was found in some of the other factors derived from this study. The work behaviors included in this domain characterize the process of counseling: developing a therapeutic relationship with a client, settings goals, utilizing different treatment approaches, evaluating the

counseling process, and preparing for termination of counseling. While the counseling process factor for the criticality ratings was broader and included many family and group counseling work behaviors, it shared many of the same items as the more distinct counseling process factors for the frequency of occurrence and combined ratings. More specifically, many of the work behaviors related to goal setting, treatment planning, and evaluation of treatment loaded high within the counseling process factor for the criticality ratings, but the highest loaded work behavior was Item 13--assess for learning disabilities. In comparison, Item 13 loaded within the assessment and appraisal domains for the frequency and combined analyses. An examination of the group and family counseling work behaviors included in the counseling process factor for the criticality analysis indicate that (a) the group work behaviors included relate more to the leadership style of the group leader and therefore, their inclusion within this domain is warranted, and (b) both the group and family counseling work behaviors also have high (greater than .40) factor loadings within the substance-abuse specialty factors and family counseling factors, respectively.

The work behaviors that had the highest loadings across the analyses, and are imperative to the counseling process whether one is working with a substance-abusing client or a non-substance-abusing client, were Item 56--implement treatment plans, Item 48--co-construct comprehensive treatment plans, and Item 49--establish counseling goals and objectives. Other items that respondents agreed were imperative to the counseling process included work behaviors involved in developing a therapeutic relationship with the client, setting goals, evaluating of progress toward goals, and assisting clients with recognizing their strengths and limitations. Respondents agreed that Item 50--identify source-of-problem alternatives and Item 52--negotiate with a client a time frame for goal attainment were frequent and overall important to the counseling process but there was less agreement about their inclusion within this domain for the criticality ratings.

Of interest, is the inclusion of Item 200-receive clinical supervision, within the counseling process domain versus the professional practice domain for the combined analysis. Could respondents have viewed the receipt of clinical supervision by mental-health service providers as imperative to the ongoing process of counseling?

Professional Practice

The factors labeled "professional practice" reflected behaviors often associated with professional and administrative functions separate from the direct service provided to clients in agencies. They included the development and ongoing appraisal of professional goals and objectives, staff development, involvement in professional organizations, research, community outreach, supervision, and program maintenance. The cluster of items tended to vary across the analyses with the exception of Item 197--review legal statutes and regulations, and Item 204--write for publication, both of which consistently had high factor loadings. Overall, there were more differences noted across the analyses for the professional practice factors than for most of the other factors resulting from this study.

As with many of the other factors, similarities that existed tended to be more often found between the factors yielded by the frequency of occurrence and combined ratings. More specifically, Item 189--developing appraisal instrument/technique, Item 178--participate in program research activities, and Item 187--educate non-treatment staff about counseling services, had high factor loadings for both the frequency and combined ratings. The exceptions were Item 201--develop own professional goals and objectives which was rated high for both the frequency and criticality analyses and Item 187--educate non-treatment staff about counseling services, which had high factor loadings for both the criticality and combined analyses.

Due to the level of variation that existed between the work behaviors' factor loadings, it was difficult to compare the factors yielded from the three analyses. An examination of the three

analyses revealed that the respondents strongly agreed that work behaviors associated with outreach (i.e., Item 182--conduct community outreach, Item 169--coordinate volunteer activities, Item 183--organize professional conferences and seminars) were frequent, critical, and overall important to mental-health service providers' professional practice within multiservice mental-health agencies. While the only work behavior addressing mental-health service providers' attention to burnout prevention measures included in the survey loaded high within the professional practice factor for the criticality ratings, it did not load as high for the frequency or combined ratings.

Family Counseling

The family counseling factor involved the work behaviors specific to the counseling of families. Since a majority of the family counseling work behaviors for the criticality ratings clustered with the group counseling items and an assembly of other items to form the counseling process factor, comparisons could only be made for the frequency and combined analyses. The work behaviors involved in family counseling that were consistently weighted high across the two analyses were Item 118--use structural family counseling techniques, Item 102--counsel children, Item 119--use strategic family counseling techniques, and Item 116--counsel concerning divorce. Due to the limited number of items included in this domain across the two analyses, the only major disagreement shown among respondents was with Item 117--use multigenerational family counseling techniques, which had a much higher factor loading for the frequency ratings than the combined ratings.

Several items that respondents agreed were overall important to the family counseling process but did not agree were frequently a part of the family counseling domain derived from this study were Item 72--counsel client concerning sexual abuse, Item 104--counsel adults, and Item 154--advocate client's interests with appropriate systems (i.e., courts, employer). It is believed

that Item 154 was included with this domain for the overall importance ratings because respondents viewed the family as one of the systems that mental-health service providers must advocate for their clients' best interest.

General Practice

The final factor resulting from the criticality ratings that was less distinct than any of the other factors that were generated in this study was the "General Practice" factor. It included a compilation of work behaviors often found within the other factors including assessment and appraisal, family counseling, substance-abuse specialty counseling, and professional practice. A review of the items with the highest factor loadings provided some insight into the diversity of work behaviors included in this domain. More specifically, items included were Item 123--select clients for group participation, Item 121--educate significant others about self-help groups, and Item 179--perform clerical tasks (i.e., filing, typing letters).

Comparison of Factors and Item Means

While the Treatment of Substance Abusers in Multiservice Mental Health Agencies Questionnaire identified five distinct factors of work behaviors of those providing substance-abuse counseling in mental-health agencies, there were some items that did not load on any of the five factors. They were Item 17--systematically observe client behaviors, Item 24--use intelligence tests, Item 36--analyze cost-benefit of treatment alternatives, Item 66--use affective-oriented counseling techniques, Item 69--use brief therapy techniques, Item 76--counsel client concerning personality change, Item 95--provide crisis intervention, Item 98--manage violent or destructive clients, Item 106--counsel specialized populations (i.e., pregnant women, disabled), Item 155--support client participation in leisure activities, and Item 161--solicit client's perception of treatment program. While these items did not load on any of the factors derived by this study,

examination of their means for the frequency of occurrence and criticality ratings reveal their significance to the practice of substance-abuse counseling in multiservice mental-health agencies.

The means for the 34 items that did not load at the criterion level on any of the five factors for the frequency of occurrence ratings revealed that 15 of the items had a mean above 4.0 indicating they are frequently to routinely performed. In particular, those items with the highest means were Item 46--obtain client's informed consent prior to counseling, ($\bar{x}$ = 4.94), Item 160--maintain case notes, records, and/or files ($\bar{x}$ = 4.91), Item 171--attend staff meetings ($\bar{x}$ = 4.60), Item 41--explain program policies and procedures ($\bar{x}$ = 4.42), and Item 95--provide crisis intervention ($\bar{x}$ = 4.32).

The means of the 33 items that did not load at the criterion level on any of the five factors for the criticality ratings revealed 18 items that were critical to very critical in the practice of counseling substance abusers. The five items with the highest means were Item 37--assess potential for client to harm self/others ($\bar{x}$ = 4.82), Item 34--determine if client will be admitted for treatment ($\bar{x}$ = 4.68), Item 95--provide crisis intervention ($\bar{x}$ = 4.60), Item 104--counsel adults ($\bar{x}$ = 4.46), and Item 142--provide client information when authorized ($\bar{x}$ = 4.41).

## Comparison With Other Work Behavior Analyses

The factors characterizing the work behaviors of mental-health service providers, when providing substance-abuse counseling, are closely parallel to the domains identified by Loesch and Vacc (1993) in their study of the general practice of Nationally Certified Counselors (NCC): fundamental counseling practice, counseling for career development, professional practice, counseling groups, and counseling families. The fundamental counseling practice and counseling for career development factors of the general practice study encompass many of the work behaviors of the assessment and appraisal, and counseling process domains identified in this study. As expected the group counseling behaviors included in the substance-abuse specialty counseling

factor in this study, along with the behaviors found in the professional practice and family counseling domains resemble the counseling groups, professional practice, and counseling families domains respectively, of the general practice analysis.

A more recent work behavior analysis conducted by Sampson, Vacc, and Loesch (1995) examined the work behaviors of those who engage in the practice of career counseling. Both Nationally Certified Counselors (NCC) and NCC/Nationally Certified Career Counselors were surveyed to identify which career counseling work behaviors were part of the general practice of counseling and which were specific to the practice of career counseling. Unlike the Loesch and Vacc study (1993) but similar to this study, the career-counseling work behavior analysis derived different domains for the importance and frequency data. The eight factors for importance data were (a) career counseling service management, (b) assessment and general counseling, (c) specialized career counseling, (d) special populations, (e) ethical/legal issues, (f) supervision and research/evaluation, (g) theory, and (h) information. The seven factors for frequency data were identified as (a) career counseling service management, (b) specialized career counseling, (c) assessment, (d) special populations, (e) supervision and research/evaluation, (f) ethical/legal issues, and (g) general career counseling. Several of the factors derived from the importance and frequency data of the career study can be collapsed or embedded in the frequency of occurrence and criticality factors of this study. Specifically, the assessment and general counseling domains of the career-counseling work behavior analysis are most like the assessment and appraisal factor of this study. Also, the ethical/legal issues and supervision and research/evaluation domains of the career-counseling work behavior study are most like the professional practice of this study. Lastly, theory is embedded in this study's broader counseling process factor.

## Limitations of the Study

This study was exploratory and therefore, limitations must be acknowledged when considering the results. These limitations are divided into the response rate, analysis, respondents, and the agencies. These limitations provide a basis on which recommendations for further research may be made.

### Response Rate

One limitation is the response rate by the multiservice mental-health agencies. In an attempt to bolster the number of respondents returning the Questionnaire, three contacts were made with either regional directors, agency directors, or their representatives. The contacts involved telephone calls to enlist agency participation, cover letters that accompanied the mailed questionnaires, and follow-up postcards. While at least one mental-health agency responded from each of the 14 states represented in the sample, a return rate of 32% raises the question, "How would the results have changed if respondents from all the multiservice mental-health agencies included in the sample had returned their Questionnaires?" The return rate also affected the degree of statistical analyses that could be performed on the data.

### Analyses

The degree of analyses that could be performed on the data was limited by the response rate. The number of responding agencies (N=117) did not adequately compare with the generally accepted standard of 5 respondents for each Questionnaire item for factor analysis. Hence, the correlation matrix may not be as stable as if 1025 agencies (5 respondents x 205 items) had been sampled and they all responded to the Questionnaire.

The limited response rate also forced the use of the correlation matrix, and not the raw scores, for performing factor analyses procedures. The lack of factor scores, that are normally

generated when factor analyses procedures are performed using the raw data, prevented the ability to perform analyses of variance procedures.

Respondents

Respondents chosen to complete the Questionnaire on behalf of their agencies may have differed in the degree to which they were accessible, cooperative, or interested in the study (Issac & Michael, 1990). Since the study is based on respondents who volunteered to participate, and there were a host of directors or mental-health service providers who were not chosen to participate, or did not elect to participate, the findings may only be generalizable to actual respondents.

One limitation related to the respondents and the instrument is the self-report data. All data was collected through self-report. The study did not include a method to confirm the responses or assess the accuracy of the responses provided by representatives who were responding on behalf of all other mental-health service providers in their respective agencies.

Since one limitation of questionnaires is that they arouse response sets, a validity scale was developed for the Questionnaire. The scale included 11 work behaviors that were repeated in the Questionnaire. The correlation coefficients between the items ranged from .50 to .83 indicating the likelihood of response sets by respondents were minimal.

Agencies

Agencies included in the study were approved for inclusion by their respective regional director, agency directors, or their representatives. Thus, a limitation of the study was the generalizability of the findings to non-participating multiservice mental-health agencies within the 14 states sampled or to state-supported multiservice mental-health agencies in states not included in the sample.

A second methodological limitation involved the representative selected to respond on behalf of the agency. In some agencies, substance-abuse counseling was not distinguished as a specialty service provided to clients. In other agencies it was recognized as a specialty service and as such was a separate department from mental-health services. Hence, the representative selected to respond to the Questionnaire on behalf of an agency may have been a mental-health service provider with limited knowledge of substance-abuse counseling or a substance-abuse specialty counselor whose sole responsibility was to provide substance-abuse counseling.

## Implications

The implications are designed to address the results of the study and its limitations. The implications should focus on counselors in training and counselor educators.

### Counselors in Training

The present study revealed that counseling substance-abuse clients is an integral component of the mental-health services provided in multiservice mental-health agencies. Because studies have reported that professional counselors are taking advantage of the numerous opportunities for employment in mental-health agencies (Hollis & Wantz, 1994), their understanding of the knowledge and skills that are derived from the work behaviors of mental-health service providers in mental-health agencies has far-reaching benefits for them and the individuals they serve. It is recommended that students who aspire to counsel in multiservice mental-health agencies seek opportunities for training in substance-abuse counseling. More specifically, training in substance-abuse assessment, family counseling, group counseling, 12-step principles, relapse prevention, goal setting, and treatment planning.

### Counselor Educators

The findings of this study support the importance of addressing substance-abuse clients in counselor training programs. While other work behavior dimensions identified in this study have

commonly been a part of the curriculum in training programs, knowledge and skills for counseling substance-abuse clients either have been infused into the other dimensions or non-existent.

One important question arising among many professional training programs is the level of specialization that should exist within the broader scope of counseling. While this study did not address the proficiency versus specialization issue specifically, the findings of this study support the importance of addressing substance-abuse clients in counselor training programs, especially since professional counselors were one of the major providers of substance-abuse counseling in the reporting mental-health agencies. An examination of the factors resulting from this study indicate that while substance-abuse counseling was a specialty factor, the treatment of substance abusers still involves broader counseling practices including assessment and appraisal, family counseling, professional practice, and counseling process. Therefore, professional training programs may not need to treat substance-abuse counseling as a specialty in and of itself, as has normally existed, but recognize the importance of a specialized class in substance-abuse counseling or infusing substance-abuse counseling knowledge and skill into the larger framework of counselor training programs. Similarly, programs designed for training non-master's level substance-abuse specialty counselors need to assure that assessment and appraisal, family counseling, professional practice and counseling process are part of the curricula.

A related aspect is the accreditation standards of The Council for Accreditation of Counseling and Related Educational Programs (CACREP) for community counseling and mental-health counseling programs. Based on the results of this study, it is advisable that the CACREP guidelines for the community and mental-health specialty programs include the importance of students being knowledgeable and skilled for working with clients with substance-abuse problems.

## Recommendations for Future Research

The present study resulted in primarily five distinct factors of work behaviors of those providing substance-abuse counseling in multiservice-mental health agencies. However this was an exploratory analysis designed to examine, versus confirm, the underlying factors of participants' responses to the frequency of occurrence, criticality, and combined ratings (or overall importance) of items on the Questionnaire. Future studies using the same list of work behaviors would help confirm whether the same five factors underly the practice of substance-abuse counseling in multiservice mental-health agencies.

This study offered information regarding the work behaviors of mental-health service providers in 117 multiservice mental-health agencies in 14 states. However, future studies involving a larger sample of agencies in the 14 states or more states across the United States are necessary to further define the work behaviors of those who provide substance-abuse counseling in mental-health agencies. Of concern is whether differences exist for non-responding mental-health agencies in the 14 states included in the sample, or agencies in other regions of the country, compared with agencies that responded in the present study.

While the present study focused on the work behaviors of all mental-health service providers in multiservice mental-health agencies, only one provider was asked to respond on behalf of his/her agency. Ideally, this study would have desired more than one mental-health service provider responding on behalf of each agency but a pilot study showed the best results would be obtained by asking only one provider from any professional affiliation to respond on behalf of the agency. While the information gained is valuable to those seeking employment in mental-health agencies regardless of their training or professional affiliation, it may be beneficial to sample more mental-health service providers per agency in the future.

It is recommended that several questions regarding the professional affiliation of mental-health service providers be reworded in future studies in order to enhance the number of comparisons that can be made between the factor scores of providers from the different professional affiliations. For instance, Question #9 in the demographic section of the Questionnaire asked, "For your agency, please circle the weekly average number of substance-abuse counseling hours provided by individuals whose primary professional affiliation is indicated below." The consequence of asking for a report of the hours provided by all the affiliations, and not just the person responding, limited the comparisons that could be made among factor analysis results, since only one person was asking to respond on behalf of the agency but factors were generated on the ratings of only one individual from each of the 117 reporting agencies. For example, it may be useful to understand if the factor analysis results of psychiatrists differ from professional counselors, or if social workers differ from non-master's level substance-abuse specialty counselors.

Another comparison that could be made is whether factor scores differ between the eight professional affiliations, or additional affiliations as applicable, across the different factor analyses. That is, do the factor scores generated by the frequency of occurrence ratings, criticality ratings, and combined (or overall importance) ratings differ by the professional affiliation of the individual responding on behalf of the agency?

The Treatment of Substance Abusers in Multiservice Mental Health Agencies Questionnaire identified five distinct factors of work behaviors of those providing substance-abuse counseling in mental-health agencies. However, some items did not load on any of the five factors in any of the analyses (i.e., Item 17--systematically observe client behaviors, Item 69--use brief therapy techniques, and Item 98--manage violent or destructive clients). Consideration needs

to be given to whether these items need to be reworded to enhance their discriminate capabilities or eliminated.

Lastly, this study did not address the proficiency versus specialization issue specifically. However, the results showed that mental-health service providers are providing substance-abuse counseling in mental-health agencies, although the degree to which they provide it is dependent on their professional affiliation. Future studies may further address the degree to which mental-health service providers should obtain specialized training in substance-abuse counseling.

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# APPENDIX A

## TREATMENT OF SUBSTANCE ABUSERS IN MULTISERVICE MENTAL HEALTH AGENCIES QUESTIONNAIRE

# Treatment of Substance Abusers in Multiservice Mental Health Agencies Questionnaire

The purpose of this survey is to examine the substance abuse services provided by multiservice mental health agencies. Responses should reflect **all** agency personnel.

Treatment of Substance Abusers in
Multiservice Mental Health Agencies Questionnaire

INSTRUCTIONS

Responses are to be provided anonymously and therefore your name should not be included on any of the response sheets.

*Step 1*

For each of the 204 work behaviors listed in Section 1, please *indicate the relative FREQUENCY with which all mental health service providers (marriage and family therapists, psychiatrists, psychologists, professional counselors, social workers, master's level substance abuse specialty counselors and non-master's level substance abuse specialty counselors) would perform each work behavior with substance abusers in their capacity within your multiservice mental health agency.*

For the same list of 204 work behaviors please *indicate the degree of CRITICALITY or IMPORTANCE that the mental health service providers in your multiservice mental health agency would place on being able to perform that behavior effectively.* Please note that the criticality scale is located beside the frequency scale.

*Step 2*

Complete the 10 informational items in Section 2.

*Step 3*

Return the questionnaire to me by
in the stamped envelope addressed:

Patricia G. Von Steen
Department of Counseling and Educational Development
The University of North Carolina at Greensboro
1000 Spring Garden Street
Greensboro, NC 27412-5001

If you have any comments regarding this questionnaire, especially work behaviors that were not included, please write them on the back of this booklet.

Thank you.

## Section 1

**Instructions:** Please respond to the following statements on behalf of all mental health service providers (marriage and family therapists, psychiatrists, psychologists, professional counselors, social workers, master's level substance abuse specialty counselors and non-master's level substance abuse specialty counselors) in your agency.

Use the two scales provided and circle the number of your response for each scale on each item.

| | FREQUENCY SCALE | | | | | CRITICALITY SCALE | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Never | Rarely | Occasionally | Frequently | Routinely | Not Critical | Minimally Critical | Somewhat Critical | Critical | Very Critical |
| 1. Obtain substance abuse history | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 2. Determine severity of client's substance abuse problem | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 3. Assess degree of client's understanding of his/her substance dependency | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 4. Conduct pretreatment diagnostic interview | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 5. Evaluate existing (precounseling) client data | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 6. Discuss client's reasons for seeking treatment | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 7. Assess client's motivation for treatment | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 8. Assess client's participation in a 12-step program | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 9. Assess psychosocial needs | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 10. Assess spiritual functioning | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 11. Identify client's internal/external resources | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 12. Assess client's educational history | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 13. Assess for learning disabilities | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 14. Clarify client's support systems | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 15. Assess client's family history of addictive disorders | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 16. Assess client's strengths and limitations | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 17. Systematically observe client behaviors | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 18. Select appraisal instruments/techniques for counseling | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |

| | FREQUENCY SCALE | | | | | CRITICALITY SCALE | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Never | Rarely | Occasionally | Frequently | Routinely | Not Critical | Minimally Critical | Somewhat Critical | Critical | Very Critical |
| 19. Integrate assessment results | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 20. Use assessment results to aid client in making decisions | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 21. Use assessment results to aid in intervention selections | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 22. Administer substance abuse assessment instruments | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 23. Use self-report personality inventories | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 24. Use intelligence test results | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 25. Use nontest appraisal techniques | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 26. Evaluate extent of client's psychological dysfunction | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 27. Determine DSM-IV classification | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 28. Evaluate need for client referral for further assessment | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 29. Obtain client's medication history | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 30. Assist client in understanding of test results | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 31. Interview client's significant others | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 32. Inform family of family dynamics/roles | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 33. Assess match between client's needs and program services | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 34. Determine if client will be admitted for treatment | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 35. Evaluate need for client referral for treatment | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 36. Analyze cost-benefit of treatment alternatives | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 37. Assess potential for client to harm self/others | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 38. Assess for learning disabilities | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 39. Determine necessity for an intervention | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 40. Inform client about program services | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 41. Explain program policies and procedures | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 42. Contract with client regarding program rules | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |

| | FREQUENCY SCALE | | | | | CRITICALITY SCALE | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Never | Rarely | Occasionally | Frequently | Routinely | Not Critical | Minimally Critical | Somewhat Critical | Critical | Very Critical |
| 43. Inform client about ethical standards and practice | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 44. Inform client about legal aspects of counseling | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 45. Inform client about detoxification process | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 46. Obtain client's informed consent prior to counseling | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 47. Complete release of information forms | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 48. Co-construct comprehensive treatment plans | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 49. Establish counseling goals and objectives | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 50. Identify source-of-problem alternatives | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 51. Assist client in setting short-term and long-term goals | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 52. Negotiate with client a time frame for goal attainment | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 53. Clarify client's support systems | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 54. Involve significant others in treatment planning | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 55. Clarify family counseling goals | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 56. Implement treatment plans | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 57. Clarify mental health service provider/client roles | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 58. Evaluate extent of client's psychological dysfunction | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 59. Evaluate client's movement toward counseling goals | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 60. Assist client recognize strengths and limitations | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 61. Assist client in evaluation of progress in treatment | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 62. Self-evaluate counseling progress | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 63. Develop a therapeutic relationship with client | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 64. Organize or facilitate an intervention | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 65. Utilize different treatment approaches | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 66. Use affective-oriented counseling techniques | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 67. Use behavioral-oriented counseling techniques | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 68. Use cognitive-oriented counseling techniques | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |



OVER

| | FREQUENCY SCALE | | | | | CRITICALITY SCALE | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Never | Rarely | Occasionally | Frequently | Routinely | Not Critical | Minimally Critical | Somewhat Critical | Critical | Very Critical |
| 69. Use brief therapy techniques | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 70. Use media resources in counseling | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 71. Counsel client concerning life-style change | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 72. Counsel client concerning sexual abuse | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 73. Counsel client concerning human sexuality | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 74. Counsel client concerning physical abuse | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 75. Counsel client concerning personal change | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 76. Counsel client concerning personality change | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 77. Counsel client concerning spiritual issues | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 78. Explore client's educational opportunities | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 79. Provide appropriate homework assignments | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 80. Educate client about self-help groups | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 81. Make 12-step assignments | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 82. Process 12-step assignments | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 83. Clarify client's moral/spiritual issues | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 84. Facilitate client exploration of the consequences of substance abuse | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 85. Educate client about consequences of substance abuse | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 86. Provide impetus for client to remain in treatment | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 87. Discuss positive urine drug screens with client | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 88. Counsel client about irregular attendance | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 89. Address violation of agency rules | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 90. Counsel client concerning defense mechanisms | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 91. Counsel client regarding relapse prevention | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 92. Counsel client regarding other addictive disorders | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 93. Assist client recognize strengths and limitations | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |

| | FREQUENCY SCALE | | | | | CRITICALITY SCALE | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Never | Rarely | Occasionally | Frequently | Routinely | Not Critical | Minimally Critical | Somewhat Critical | Critical | Very Critical |
| 94. Reframe client's problem(s) | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 95. Provide crisis intervention | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 96. Utilize different treatment approaches | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 97. Use brief therapy techniques | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 98. Manage violent or destructive clients | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 99. Assess client's readiness for discharge | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 100. Prepare client for termination from counseling | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 101. Conduct former client follow-up activities | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 102. Counsel children | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 103. Counsel adolescents | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 104. Counsel adults | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 105. Counsel older persons | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 106. Counsel specialized populations (i.e., pregnant women, disabled) | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 107. Establish rapport with family and significant others | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 108. Inform family of family dynamics/roles | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 109. Inform family members of family counseling guidelines and goals | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 110. Clarify familial behavior norms | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 111. Clarify family counseling goals | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 112. Develop family conflict resolution strategies | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 113. Counsel concerning family change | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 114. Counsel concerning family member interaction | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 115. Counsel concerning marital discord | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 116. Counsel concerning divorce | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 117. Use multigenerational family counseling techniques | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |



OVER

| | FREQUENCY SCALE | | | | | CRITICALITY SCALE | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Never | Rarely | Occasionally | Frequently | Routinely | Not Critical | Minimally Critical | Somewhat Critical | Critical | Very Critical |
| 118. Use structural family counseling techniques | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 119. Use strategic family counseling techniques | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 120. Use behavioral family counseling techniques | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 121. Educate significant others about self-help groups | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 122. Counsel significant others concerning substance abuse | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 123. Select clients for group participation | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 124. Inform clients of group counseling guidelines and goals | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 125. Systematically observe group members' behaviors | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 126. Identify harmful group-member behaviors | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 127. Evaluate progress toward group goals | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 128. Facilitate conflict resolution among group members | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 129. Assist with group members' feedback to each other | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 130. Determine group counseling effectiveness | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 131. Use "structured" activities during group counseling | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 132. Use leader-centered group counseling leadership techniques | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 133. Use group-centered group counseling leadership techniques | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 134. Use laissez-faire group counseling leadership techniques | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 135. Facilitate client's development of decision-making skills | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 136. Facilitate client's development of job-search skills | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 137. Assist disabled clients with assignments | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 138. Observe client for side effects of medication | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 139. Monitor drug screening test results | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |

| | FREQUENCY SCALE | | | | | CRITICALITY SCALE | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Never | Rarely | Occasionally | Frequently | Routinely | Not Critical | Minimally Critical | Somewhat Critical | Critical | Very Critical |
| 140. Communicate with funding sources regarding client's treatment | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 141. Consult with other members of treatment team | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 142. Provide client information when authorized | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 143. Assess client's readiness for discharge | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 144. Assist client resolve problems of daily living (i.e., housing, legal) | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 145. Investigate half-way house alternatives | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 146. Assist client in constructing effective support systems | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 147. Assist client in obtaining a temporary sponsor | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 148. Arrange aftercare services | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 149. Involve significant others in aftercare planning | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 150. Participate in staff decision-making processes | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 151. Conduct case reviews to assure quality services | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 152. Match client's needs with community resources | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 153. Network with community resources | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 154. Advocate client's interests with appropriate systems (i.e., courts, employer) | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 155. Support client participation in leisure activities | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 156. Facilitate return-to-work conferences | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 157. Participate in case conferences | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 158. Make oral case presentations to treatment team | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 159. Assign client to a mental health service provider | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 160. Maintain case notes, records, and/or files | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 161. Solicit client's perception of treatment program | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 162. Assess programmatic needs | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |



OVER

| | FREQUENCY SCALE | | | | | CRITICALITY SCALE | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Never | Rarely | Occasionally | Frequently | Routinely | Not Critical | Minimally Critical | Somewhat Critical | Critical | Very Critical |
| 163. Establish programmatic service goals | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 164. Provide clinical supervision | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 165. Provide administrative supervision | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 166. Conduct case reviews to assure quality services | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 167. Evaluate counselors' performance | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 168. Provide counselor skill-development training | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 169. Coordinate volunteer activities | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 170. Mediate treatment staff/client conflict | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 171. Attend staff meetings | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 172. Administer treatment program | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 173. Allocate financial resources for treatment program | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 174. Develop program-related reports | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 175. Conduct fund-raising activities for program development/maintenance | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 176. Participate in staff decision-making processes | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 177. Provide orientation to new personnel | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 178. Participate in program research activities | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 179. Perform clerical tasks (i.e., filing, typing letters) | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 180. Engage in client data analyses | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 181. Communicate needs for services in the community | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 182. Conduct community outreach | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 183. Organize professional conferences and seminars | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 184. Provide consultation to other agencies | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 185. Serve as liaison with other agencies | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 186. Serve on committees within the agency | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |

| | FREQUENCY SCALE | | | | | CRITICALITY SCALE | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Never | Rarely | Occasionally | Frequently | Routinely | Not Critical | Minimally Critical | Somewhat Critical | Critical | Very Critical |
| 187. Educate non-treatment staff about counseling services | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 188. Educate non-treatment staff about substance abuse | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 189. Develop appraisal instrument/technique | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 190. Evaluate media resources | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 191. Use computers for program data management | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 192. Engage in professional/community public relations | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 193. Develop networks with other mental health service providers | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 194. Attend conferences | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 195. Deliver presentations at conferences | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 196. Review ethical standards | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 197. Review legal statutes and regulations | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 198. Read current professional literature | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 199. Participate in continuing education/skill enhancement | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 200. Receive clinical supervision | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 201. Develop own professional goals and objectives | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 202. Participate in self-help group activities | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 203. Collaborate in research with other mental health service providers | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 204. Write for publication | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 205. Use prevention measures to guard against burnout | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |

## Section 2

**Instructions:** Please complete the following information about yourself and your agency.

1. Please indicate your gender:
   - ___ (1) Female
   - ___ (2) Male

2. Please indicate your ethnic origin:
   - ___ (1) American Indian/Alaskan Native
   - ___ (2) Asian or Pacific Islander
   - ___ (3) Black/African-American
   - ___ (4) Hispanic/Latino
   - ___ (5) White/Caucasian
   - ___ (6) Other

3. Please indicate your educational level:
   - ___ (1) High school
   - ___ (2) Associate
   - ___ (3) Bachelors
   - ___ (4) Masters
   - ___ (5) Doctoral

4. Please indicate your position in the agency:
   - ___ (1) Clinical director/supervisor of personnel
   - ___ (2) Mental health service provider
   - ___ (3) Other title (please list): _____

5. Length of time (in years) you have been employed as a mental health service provider:
   - ___ (1) 0-5
   - ___ (2) 6-10
   - ___ (3) 11-15
   - ___ (4) 16-25
   - ___ (5) 25+

6. Please indicate the number of clock hours you have received in substance abuse training:
   - ___ (1) 0-9
   - ___ (2) 10-19
   - ___ (3) 20-29
   - ___ (4) 30-39
   - ___ (5) 40 (college course equivalent to 45) or more

7. Please indicate the approximate number of mental health services hours provided weekly in your agency by mental health service providers, collectively:

___ (1) 0-300
___ (2) 301-600
___ (3) 601-900
___ (4) 901-1200
___ (5) more than 1200

8. Of the total number of service hours, approximately how many hours are spent weekly providing substance abuse counseling:

___ (1) 0-300
___ (2) 301-600
___ (3) 601-900
___ (4) 901-1200
___ (5) more than 1200

***One of the goals of this study is to understand the contributions of different professional groups in your agency.***

9. For your agency, please circle the weekly average number of substance abuse counseling hours provided by individuals whose primary professional affiliation is indicated below:

| Primary Professional Affiliation | Weekly Average Substance Abuse Counseling Hours Provided | | | | |
|---|---|---|---|---|---|
| Marriage and Family Therapist | None Employed | 0-10 | 11-20 | 21-30 | 31-40 |
| Psychiatrist | None Employed | 0-10 | 11-20 | 21-30 | 31-40 |
| Psychologist | None Employed | 0-10 | 11-20 | 21-30 | 31-40 |
| Psychiatric Nurse | None Employed | 0-10 | 11-20 | 21-30 | 31-40 |
| Professional Counselor | None Employed | 0-10 | 11-20 | 21-30 | 31-40 |
| Social Worker | None Employed | 0-10 | 11-20 | 21-30 | 31-40 |
| Substance Abuse Specialty Counselor (Master's level) | None Employed | 0-10 | 11-20 | 21-30 | 31-40 |
| Substance Abuse Specialty Counselor (Non-master's level) | None Employed | 0-10 | 11-20 | 21-30 | 31-40 |



OVER

10. Please provide the number of mental health service providers in your agency whose primary professional affiliation is:

_____ Marriage and Family Therapist

_____ Psychiatrist

_____ Psychologist

_____ Psychiatric Nurse

_____ Professional Counselor

_____ Social Worker

_____ Substance Abuse Specialty Counselor (Master's level)

_____ Substance Abuse Specialty Counselor (Non-master's level)

_____ Other (Please list): _____

# APPENDIX B

## LETTER TO REGIONAL DIRECTOR

THE UNIVERSITY OF NORTH CAROLINA
GREENSBORO

**School of Education**
Department of Counseling
and Educational Development

July 28, 1995

Mr. Steve Walker,
Chief of Clinical Support Services
Columbia Area Mental Health Center
11618 Sunset Drive
Columbia, SC 29203

Dear Mr. Walker:

I sincerely appreciate your willingness to participate in the research I am conducting of the work behaviors specific to the provision of substance-abuse services in multiservice mental-health agencies. As I stated during our phone conversation on July 20, 1995, the information gained from this study will assist educators in understanding the substance-abuse training needs of clinical personnel in your agencies. This research is being supported by the Association for Counselor Education and Supervision.

I am requesting that you forward the enclosed 10 packets to the directors of the agencies you supervise. Please note that only agencies that provide mental-health or substance-abuse services should receive a packet. Each packet contains a cover letter (see attached), one Treatment of Substance Abusers in Multiservice Mental Health Agencies Questionnaire and a postage-paid envelope. The responses provided will be combined with those of other multiservice agencies, and no individual responses will be reported. I will provide you with a summary at the conclusion of data collection.

Please forward the packets to the agency directors by August 8, 1995. They are to be returned to me on or before September 4, 1995. If you have any questions concerning the study, please contact me at (910) 547-0033. Again, thank you for your assistance with this research.

Sincerely,

Patricia G. Von Steen, M.A., NCC
Doctoral Candidate

Enc.

Curry Building, UNCG, Greensboro, NC 27412-5001
(910) 334-3423•FAX (910) 334-4120

# APPENDIX C

## LETTER TO AGENCY DIRECTOR

THE UNIVERSITY OF NORTH CAROLINA
**GREENSBORO**

**School of Education**
Department of Counseling
and Educational Development

July 28, 1995

Dear Agency Director:

I am conducting a research investigation designed to provide a profile of the work behaviors specific to the provision of substance-abuse services in multiservice mental-health agencies. The information gained from this study will assist educators in understanding the substance-abuse training needs of the clinical personnel in your agency. This research is being supported by the Association for Counselor Education and Supervision.

Your agency was identified through Mr. Steve Walker, Chief of Clinical Support Services, who included your agency as a data collection site. Enclosed is a Treatment of Substance Abusers in Multiservice Mental Health Agencies Questionnaire and a postage-paid envelope.

I am requesting that you or your designee complete the questionnaire on behalf of all mental-health service providers in your agency, not just those who specialize in substance-abuse counseling. The person that responds to the questionnaire should have knowledge of the services provided to clients with identified or potential substance-abuse problems within the agency and can respond on behalf of all staff.

The questionnaire will take about 30 minutes to complete. Your responses will be combined with those of other respondents in multiservice agencies, and no individual responses will be reported. Your completed questionnaire should be returned by September 4, 1995. If you have any questions concerning the questionnaire, please contact me at (910) 547-0033. Again, thank you for your assistance with this research.

Sincerely,

Patricia G. Von Steen, M.A., NCC
Doctoral Candidate

Enc.

Curry Building, UNCG, Greensboro, NC 27412-5001
(910) 334-3423•FAX (910) 334-4120

# APPENDIX D

## FOLLOW-UP POSTCARD

Several weeks ago, you were sent a questionnaire(s) as part of a study of the work behaviors specific to the provision of substance abuse services in multiservice mental health agencies. If you have returned the questionnaire, thank you for your contribution to this important project.

If you, your designee, or the directors of the centers or programs you distributed the packets to have not completed the questionnaire, please do so and return it by September 15, 1995. This study will assist educators in understanding the substance abuse training needs of the clinical personnel in your agency. The findings will be most useful only if they are based on the judgements of yourself and others in mental health agencies. Thank you for your help.

Patricia Von Steen

# APPENDIX E

## FREQUENCY OF OCCURRENCE ITEMS WITHIN FACTOR CLUSTER

| Item Number | Item |
|---|---|
| **Factor 1: Substance Abuse Specialty Counseling** | |
| 8 | Assess client's participation in 12-step program |
| 10 | Assess spiritual functioning |
| 22 | Administer substance abuse assessment instruments |
| 23 | Use self-report personality inventories |
| 32 | Inform family of family dynamics/roles |
| 45 | Inform client about detoxification process |
| 70 | Use media resources in counseling |
| 71 | Counsel client concerning life-style change |
| 73 | Counsel client concerning human sexuality |
| 74 | Counsel client concerning physical abuse |
| 77 | Counsel client concerning spiritual issues |
| 79 | Provide appropriate homework assignments |
| 80 | Educate client about self-help groups |
| 81 | Make 12-step assignments |
| 82 | Process 12-step assignments |
| 83 | Clarify client's moral/spiritual issues |
| 84 | Facilitate client exploration of the consequences of substance abuse |
| 85 | Educate client about consequences of substance abuse |
| 86 | Provide impetus for client to remain in treatment |
| 87 | Discuss positive urine drug screens with client |
| 89 | Address violation of agency rules |
| 90 | Counsel client concerning defense mechanisms |
| 91 | Counsel client regarding relapse prevention |
| 92 | Counsel client regarding other addictive disorders |
| 101 | Conduct former client follow-up activities |
| 121 | Educate significant others about self-help groups |
| 122 | Counsel significant others concerning substance abuse |

| Item Number | Item |
|---|---|
| 123 | Select clients for group participation |
| 124 | Inform clients of group counseling guidelines and goals |
| 125 | Systematically observe group members' behavior |
| 126 | Identify harmful group-member behavior |
| 127 | Evaluate progress toward group goals |
| 128 | Facilitate conflict resolution among group members |
| 129 | Assist with group members' feedback to each other |
| 130 | Determine group counseling effectiveness |
| 131 | Use "structured" activities during group counseling |
| 132 | Use leader-centered group counseling leadership techniques |
| 133 | Use group-centered group counseling leadership techniques |
| 136 | Facilitate client's development of job-search skills |
| 137 | Assist disabled clients with assignments |
| 139 | Monitor drug screening test results |
| 140 | Communicate with funding sources regarding client's treatment |
| 145 | Investigate half-way house alternatives |
| 146 | Assist client in constructing effective support systems |
| 147 | Assist client in obtaining a temporary sponsor |
| 148 | Arrange aftercare services |
| 149 | Involve significant others in aftercare planning |
| 156 | Facilitate return-to-work conferences |
| 188 | Educate non-treatment staff about substance abuse |
| 202 | Participate in self-help group activities |
| **Factor 2:** | **Assessment and Appraisal** |
| 1 | Obtain substance abuse history |
| 2 | Determine severity of client's substance abuse problem |
| 3 | Assess degree of client's understanding of his/her substance dependency |
| 4 | Conduct pretreatment diagnostic interview |

| Item Number | Item |
|---|---|
| 5 | Evaluate existing (precounseling) client data |
| 6 | Discuss client's reasons for seeking treatment |
| 7 | Assess client's motivation for treatment |
| 11 | Identify client's internal/external resources |
| 12 | Assess client's educational history |
| 13 | Assess for learning disabilities |
| 14 | Clarify client's support systems |
| 15 | Assess client's family history of addictive disorders |
| 18 | Select appraisal instruments/techniques for counseling |
| 19 | Integrate assessment results |
| 20 | Use assessment results to aid client in making decisions |
| 21 | Use assessment results to aid in intervention selections |
| 25 | Use nontest appraisal techniques |
| 26 | Evaluate extent of client's psychological dysfunction |
| 27 | Determine DSM-IV classification |
| 28 | Evaluate need for client referral for further assessment |
| 29 | Obtain client's medication history |
| 30 | Assist client in understanding of test results |
| 31 | Interview client's significant others |
| 33 | Assess match between client's needs and program services |
| 34 | Determine if client will be admitted for treatment |
| 35 | Evaluate need for client referral for treatment |
| 37 | Assess potential for client to harm self/others |
| 39 | Determine necessity for an intervention |
| 40 | Inform client about program services |
| 55 | Clarify family counseling goals |
| 78 | Explore client's educational opportunities |
| 107 | Establish rapport with family and significant others |

| Item Number | Item |
|---|---|
| 138 | Observe client for side effects of medication |
| 141 | Consult with other members of treatment team |
| 142 | Provide client information when authorized |
| 150 | Participate in staff decision-making processes |
| **Factor 3: Counseling Process** | |
| 9 | Assess psychosocial needs |
| 16 | Assess client's strengths and limitations |
| 42 | Contract with client regarding program rules |
| 43 | Inform client about ethical standards and practice |
| 47 | Complete release of information forms |
| 48 | Co-construct comprehensive treatment plans |
| 49 | Establish counseling goals and objectives |
| 50 | Identify source-of-problem alternatives |
| 51 | Assist client in setting short-term and long-term goals |
| 52 | Negotiate with client a time frame for goal attainment |
| 56 | Implement treatment plans |
| 59 | Evaluate client's movement toward counseling goals |
| 60 | Assist client recognize strengths and limitations |
| 61 | Assist client in evaluation of progress in treatment |
| 62 | Self-evaluate counseling progress |
| 63 | Develop a therapeutic relationship with client |
| 65 | Utilize different treatment approaches |
| 67 | Use behavioral-oriented counseling techniques |
| 68 | Use cognitive-oriented counseling techniques |
| 94 | Reframe client's problem(s) |
| 99 | Assess client's readiness for discharge |
| 100 | Prepare client for termination from counseling |
| 135 | Facilitate client's development of decision-making skills |

| Item Number | Item |
|---|---|
| 151 | Conduct case reviews to assure quality services |
| **Factor 4: Professional Practice** | |
| 162 | Assess programmatic needs |
| 163 | Establish programmatic service goals |
| 164 | Provide clinical supervision |
| 165 | Provide administrative supervision |
| 167 | Evaluate counselors' performance |
| 168 | Provide counselor skill-development training |
| 169 | Coordinate volunteer activities |
| 170 | Mediate treatment staff/client conflict |
| 172 | Administer treatment program |
| 173 | Allocate financial resources for treatment program |
| 174 | Develop program-related reports |
| 175 | Conduct fund-raising activities for program development/maintenance |
| 177 | Provide orientation to new personnel |
| 178 | Participate in program research activities |
| 179 | Perform clerical tasks (i.e., filing, typing letters) |
| 180 | Engage in client data analyses |
| 181 | Communicate needs for services in the community |
| 182 | Conduct community outreach |
| 183 | Organize professional conferences and seminars |
| 187 | Educate non-treatment staff about counseling services |
| 189 | Develop appraisal instrument/technique |
| 190 | Evaluate media resources |
| 192 | Engage in professional/community public relations |
| 193 | Develop networks with other mental health service providers |
| 194 | Attend conferences |
| 195 | Deliver presentations at conferences |

| Item Number | Item |
|---|---|
| 196 | Review ethical standards |
| 197 | Review legal statutes and regulations |
| 198 | Read current professional literature |
| 199 | Participate in continuing education/skill enhancement |
| 201 | Develop own professional goals and objectives |
| 203 | Collaborate in research with other mental health service providers |
| 204 | Write for publication |
| 205 | Use prevention measures to guard against burnout |
| **Factor 5:** | **Family Counseling** |
| 72 | Counsel client concerning sexual abuse |
| 102 | Counsel children |
| 103 | Counsel adolescents |
| 104 | Counsel adults |
| 105 | Counsel older persons |
| 109 | Inform family members of family counseling guidelines and goals |
| 112 | Develop family conflict resolution strategies |
| 113 | Counsel concerning family change |
| 114 | Counsel concerning family member interaction |
| 115 | Counsel concerning marital discord |
| 116 | Counsel concerning divorce |
| 117 | Use multigenerational family counseling techniques |
| 118 | Use structural family counseling techniques |
| 119 | Use strategic family counseling techniques |
| 120 | Use behavioral family counseling techniques |
| 154 | Advocate client's interests with appropriate systems (i.e., courts, employer) |

# APPENDIX F

## CRITICALITY ITEMS WITHIN FACTOR CLUSTER

| Item Number | Item |
|---|---|
| **Factor 1: Substance Abuse Specialty Counseling** | |
| 8 | Assess client's participation in 12-step program |
| 22 | Administer substance abuse assessment instruments |
| 23 | Use self-report personality inventories |
| 30 | Assist client in understanding of test results |
| 42 | Contract with client regarding program rules |
| 45 | Inform client about detoxification process |
| 67 | Use behavioral-oriented counseling techniques |
| 68 | Use cognitive-oriented counseling techniques |
| 70 | Use media resources in counseling |
| 71 | Counsel client concerning life-style change |
| 73 | Counsel client concerning human sexuality |
| 74 | Counsel client concerning physical abuse |
| 75 | Counsel client concerning personal change |
| 77 | Counsel client concerning spiritual issues |
| 79 | Provide appropriate homework assignments |
| 80 | Educate client about self-help groups |
| 81 | Make 12-step assignments |
| 82 | Process 12-step assignments |
| 83 | Clarify client's moral/spiritual issues |
| 84 | Facilitate client exploration of the consequences of substance abuse |
| 85 | Educate client about consequences of substance abuse |
| 86 | Provide impetus for client to remain in treatment |
| 87 | Discuss positive urine drug screens with client |
| 89 | Address violation of agency rules |
| 90 | Counsel client concerning defense mechanisms |
| 91 | Counsel client regarding relapse prevention |
| 92 | Counsel client regarding other addictive disorders |
| 94 | Reframe client's problem(s) |

| Item Number | Item |
|---|---|
| 99 | Assess client's readiness for discharge |
| 101 | Conduct former client follow-up activities |
| 112 | Develop family conflict resolution strategies |
| 125 | Systematically observe group members' behavior |
| 126 | Identify harmful group-member behavior |
| 127 | Evaluate progress toward group goals |
| 128 | Facilitate conflict resolution among group members |
| 129 | Assist with group members' feedback to each other |
| 137 | Assist disabled clients with assignments |
| 140 | Communicate with funding sources regarding client's treatment |
| 141 | Consult with other members of treatment team |
| 148 | Arrange aftercare services |
| 149 | Involve significant others in aftercare planning |
| 150 | Participate in staff decision-making processes |
| 151 | Conduct case reviews to assure quality services |
| 152 | Match client's needs with community resources |
| 153 | Network with community resources |
| 158 | Make oral case presentations to treatment team |
| 159 | Assign client to a mental health service provider |
| 160 | Maintain case notes, records, and/or files |
| 188 | Educate non-treatment staff about substance abuse |
| 202 | Participate in self-help group activities |
| **Factor 2:** | **Assessment and Appraisal** |
| 1 | Obtain substance abuse history |
| 2 | Determine severity of client's substance abuse problem |
| 3 | Assess degree of client's understanding of his/her substance dependency |
| 4 | Conduct pretreatment diagnostic interview |
| 5 | Evaluate existing (precounseling) client data |
| 6 | Discuss client's reasons for seeking treatment |

| Item Number | Item |
|---|---|
| 7 | Assess client's motivation for treatment |
| 10 | Assess spiritual functioning |
| 11 | Identify client's internal/external resources |
| 12 | Assess client's educational history |
| 13 | Assess for learning disabilities |
| 14 | Clarify client's support systems |
| 15 | Assess client's family history of addictive disorders |
| 25 | Use nontest appraisal techniques |
| 26 | Evaluate extent of client's psychological dysfunction |
| 27 | Determine DSM-IV classification |
| 28 | Evaluate need for client referral for further assessment |
| 29 | Obtain client's medication history |
| 31 | Interview client's significant others |
| 33 | Assess match between client's needs and program services |
| 35 | Evaluate need for client referral for treatment |
| 39 | Determine necessity for an intervention |
| 40 | Inform client about program services |
| 54 | Involve significant others in treatment planning |
| 55 | Clarify family counseling goals |
| 57 | Clarify mental health service provider/client roles |
| 78 | Explore client's educational opportunities |
| 88 | Counsel client about irregular attendance |
| 107 | Establish rapport with family and significant others |
| 154 | Advocate client's interests with appropriate systems (i.e., courts, employer) |
| 156 | Facilitate return-to-work conferences |
| 157 | Participate in case conferences |
| 164 | Provide clinical supervision |
| **Factor 3: Counseling Process** | |
| 9 | Assess psychosocial needs |

| Item Number | Item |
|---|---|
| 16 | Assess client's strengths and limitations |
| 46 | Obtain client's informed consent prior to counseling |
| 47 | Complete release of information forms |
| 48 | Co-construct comprehensive treatment plans |
| 49 | Establish counseling goals and objectives |
| 50 | Identify source-of-problem alternatives |
| 51 | Assist client in setting short-term and long-term goals |
| 52 | Negotiate with client a time frame for goal attainment |
| 56 | Implement treatment plans |
| 59 | Evaluate client's movement toward counseling goals |
| 60 | Assist client recognize strengths and limitations |
| 61 | Assist client in evaluation of progress in treatment |
| 62 | Self-evaluate counseling progress |
| 63 | Develop a therapeutic relationship with client |
| 64 | Organize or facilitate an intervention |
| 100 | Prepare client for termination from counseling |
| 102 | Counsel children |
| 103 | Counsel adolescent |
| 109 | Inform family members of family counseling and guidelines and goals |
| 113 | Counsel concerning family change |
| 115 | Counsel concerning marital discord |
| 116 | Counsel concerning divorce |
| 117 | Use multigenerational family counseling techniques |
| 118 | Use structural family counseling techniques |
| 130 | Determine group counseling effectiveness |
| 131 | Use "structured" activities during group counseling |
| 132 | Use leader-centered group counseling leadership techniques |
| 133 | Use group-centered group counseling leadership techniques |
| 134 | Use Laissez-faire group counseling leadership techniques |

| Item Number | Item |
|---|---|
| 135 | Facilitate client's development of decision-making skills |
| 139 | Monitor drug screening test results |
| **Factor 4:** | **Professional Practice** |
| 41 | Explain program policies and procedures |
| 44 | Inform client about legal aspects of counseling |
| 145 | Investigate half-way house alternatives |
| 167 | Evaluate counselors' performance |
| 168 | Provide counselor skill-development training |
| 169 | Coordinate volunteer activities |
| 170 | Mediate treatment staff/client conflict |
| 171 | Attend staff meetings |
| 172 | Administer treatment program |
| 173 | Allocate financial resources for treatment program |
| 175 | Conduct fund-raising activities for program development/maintenance |
| 178 | Participate in program research activities |
| 180 | Engage in client data analyses |
| 181 | Communicate needs for services in the community |
| 182 | Conduct community outreach |
| 183 | Organize professional conferences and seminars |
| 184 | Provide consultation to other agencies |
| 185 | Serve as liaison with other agencies |
| 187 | Educate non-treatment staff about counseling services |
| 189 | Develop appraisal instrument/technique |
| 190 | Evaluate media resources |
| 191 | Use computers for program data management |
| 192 | Engage in professional/community public relations |
| 193 | Develop networks with other mental health service providers |
| 194 | Attend conferences |
| 195 | Deliver presentations at conferences |

| Item Number | Item |
|---|---|
| 197 | Review legal statutes and regulations |
| 198 | Read current professional literature |
| 199 | Participate in continuing education/skill enhancement |
| 200 | Receive clinical supervision |
| 201 | Develop own professional goals and objectives |
| 203 | Collaborate in research with other mental health service providers |
| 204 | Write for publication |
| 205 | Use prevention measures to guard against burnout |
| **Factor 5: General Practice** | |
| 19 | Integrate assessment results |
| 110 | Clarify familial behavioral norms |
| 114 | Counsel concerning family member interaction |
| 121 | Educate significant others about self-help groups |
| 122 | Counsel significant others concerning substance abuse |
| 123 | Select clients for group participation |
| 124 | Inform clients of group counseling guidelines and goals |
| 144 | Assist client resolve problems of daily living (i.e., housing, legal) |
| 174 | Develop program-related reports |
| 177 | Provide orientation to new personnel |
| 179 | Perform clerical tasks (i.e., filing, typing letters) |

# APPENDIX G

## COMBINED FREQUENCY OF OCCURRENCE AND CRITICALITY ITEMS (OR OVERALL IMPORTANCE) WITHIN FACTOR CLUSTER

| Item Number | Item |
|---|---|
| **Factor 1: Substance Abuse Specialty Counseling** | |
| 8 | Assess client's participation in a 12-step program |
| 10 | Assess spiritual functioning |
| 22 | Administer substance abuse assessment instruments |
| 23 | Use self-report personality inventories |
| 32 | Inform family of family dynamics/roles |
| 42 | Contract with client regarding program rules |
| 45 | Inform client about detoxification process |
| 67 | Use behavioral-oriented counseling techniques |
| 68 | Use cognitive-oriented counseling techniques |
| 70 | Use media resources in counseling |
| 71 | Counsel client concerning life-style change |
| 73 | Counsel client concerning human sexuality |
| 75 | Counsel client concerning personal change |
| 77 | Counsel client concerning spiritual issues |
| 79 | Provide appropriate homework assignments |
| 80 | Educate client about self-help groups |
| 81 | Make 12-step assignments |
| 82 | Process 12-step assignments |
| 83 | Clarify client's moral/spiritual issues |
| 84 | Facilitate client exploration of the consequences of substance abuse |
| 85 | Educate client about consequences of substance abuse |
| 86 | Provide impetus for client to remain in treatment |
| 87 | Discuss positive urine drug screens with client |
| 88 | Counsel client about irregular attendance |
| 89 | Address violation of agency rules |
| 90 | Counsel client concerning defense mechanisms |
| 91 | Counsel client regarding relapse prevention |
| 92 | Counsel client regarding other addictive disorders |

| Item Number | Item |
|---|---|
| 99 | Assess client's readiness for discharge |
| 101 | Conduct former client follow-up activities |
| 110 | Clarify familial behavior norms |
| 121 | Educate significant others about self-help groups |
| 122 | Counsel significant others concerning substance abuse |
| 123 | Select clients for group participation |
| 124 | Inform clients of group counseling guidelines and goals |
| 125 | Systematically observe group members' behavior |
| 126 | Identify harmful group-member behavior |
| 127 | Evaluate progress toward group goals |
| 128 | Facilitate conflict resolution among group members |
| 129 | Assist with group members' feedback to each other |
| 130 | Determine group counseling effectiveness |
| 131 | Use "structured" activities during group counseling |
| 132 | Use leader-centered group counseling leadership techniques |
| 133 | Use group-centered group counseling leadership techniques |
| 135 | Facilitate client's development of decision-making skills |
| 136 | Facilitate client's development of job-search skills |
| 137 | Assist disabled clients with assignments |
| 139 | Monitor drug screening test results |
| 140 | Communicate with funding sources regarding client's treatment |
| 141 | Consult with other members of treatment team |
| 144 | Assist client resolve problems of daily living (i.e., housing, legal) |
| 145 | Investigate half-way house alternatives |
| 146 | Assist client in constructing effective support systems |
| 147 | Assist client in obtaining a temporary sponsor |
| 148 | Arrange aftercare services |
| 149 | Involve significant others in aftercare planning |
| 150 | Participate in staff decision-making processes |

| Item Number | Item |
|---|---|
| 151 | Conduct case reviews to assure quality services |
| 152 | Match client's needs with community resources |
| 153 | Network with community resources |
| 202 | Participate in self-help group activities |
| **Factor 2:** | **Professional Practice** |
| 156 | Facilitate return-to-work conferences |
| 162 | Assess programmatic needs |
| 163 | Establish programmatic service goals |
| 165 | Provide administrative supervision |
| 167 | Evaluate counselors' performance |
| 168 | Provide counselor skill-development training |
| 169 | Coordinate volunteer activities |
| 170 | Mediate treatment staff/client conflict |
| 172 | Administer treatment program |
| 173 | Allocate financial resources for treatment program |
| 174 | Develop program-related reports |
| 175 | Conduct fund-raising activities for program development/maintenance |
| 177 | Provide orientation to new personnel |
| 178 | Participate in program research activities |
| 179 | Perform clerical tasks (i.e., filing, typing letters) |
| 180 | Engage in client data analyses |
| 181 | Communicate needs for services in the community |
| 182 | Conduct community outreach |
| 183 | Organize professional conferences and seminars |
| 184 | Provide consultation to other agencies |
| 185 | Serve as liaison with other agencies |
| 186 | Serve on committees within the agency |
| 187 | Educate non-treatment staff about counseling services |
| 188 | Educate non-treatment staff about substance abuse |

| Item Number | Item |
|---|---|
| 189 | Develop appraisal instrument/technique |
| 190 | Evaluate media resources |
| 191 | Use computers for program data management |
| 192 | Engage in professional/community public relations |
| 193 | Develop networks with other mental health service providers |
| 194 | Attend conferences |
| 195 | Deliver presentations at conferences |
| 196 | Review ethical standards |
| 197 | Review legal statutes and regulations |
| 198 | Read current professional literature |
| 199 | Participate in continuing education/skill enhancement |
| 201 | Develop own professional goals and objectives |
| 203 | Collaborate in research with other mental health service providers |
| 204 | Write for publication |
| 205 | Use prevention measures to guard against burnout |
| **Factor 3:** | **Assessment and Appraisal** |
| 1 | Obtain substance abuse history |
| 2 | Determine severity of client's substance abuse problem |
| 3 | Assess degree of client's understanding of his/her substance dependency |
| 4 | Conduct pretreatment diagnostic interview |
| 5 | Evaluate existing (precounseling) client data |
| 6 | Discuss client's reasons for seeking treatment |
| 7 | Assess client's motivation for treatment |
| 9 | Assess psychosocial needs |
| 11 | Identify client's internal/external resources |
| 12 | Assess client's educational history |
| 13 | Assess for learning disabilities |
| 14 | Clarify client's support systems |
| 15 | Assess client's family history of addictive disorders |

| Item Number | Item |
|---|---|
| 16 | Assess client's strengths and limitations |
| 18 | Select appraisal instrument/techniques for counseling |
| 19 | Integrate assessment results |
| 20 | Use assessment results to aid client in making decisions |
| 21 | Use assessment results to aid in intervention selections |
| 25 | Use nontest appraisal techniques |
| 26 | Evaluate extent of client's psychological dysfunction |
| 27 | Determine DSM-IV classification |
| 28 | Evaluate need for client referral for further assessment |
| 29 | Obtain client's medication history |
| 30 | Assist client in understanding of test results |
| 31 | Interview client's significant others |
| 33 | Assess match between client's needs and program services |
| 34 | Determine if client will be admitted for treatment |
| 35 | Evaluate need for client referral for treatment |
| 37 | Assess potential for client to harm self/others |
| 39 | Determine necessity for an intervention |
| 40 | Inform client about program services |
| 55 | Clarify family counseling goals |
| 107 | Establish rapport with family and significant others |
| **Factor 4:** | **Family Counseling** |
| 102 | Counsel children |
| 103 | Counsel adolescents |
| 105 | Counsel older persons |
| 109 | Inform family members of family counseling guidelines and goals |
| 112 | Develop family conflict resolution strategies |
| 113 | Counsel concerning family change |
| 114 | Counsel concerning family member interaction |
| 115 | Counsel concerning marital discord |

| Item Number | Item |
|---|---|
| 116 | Counsel concerning divorce |
| 117 | Use multigenerational family counseling techniques |
| 118 | Use structural family counseling techniques |
| 119 | Use strategic family counseling techniques |
| 120 | Use behavioral family counseling techniques |
| **Factor 5:** | **Counseling Process** |
| 47 | Complete release of information forms |
| 48 | Co-construct comprehensive treatment plans |
| 49 | Establish counseling goals and objectives |
| 50 | Identify source-of-problem alternatives |
| 51 | Assist client in setting short-term and long-term goals |
| 52 | Negotiate with client a time frame for goal attainment |
| 56 | Implement treatment plans |
| 59 | Evaluate client's movement toward counseling goals |
| 60 | Assist client recognize strengths and limitations |
| 61 | Assist client in evaluation of progress in treatment |
| 62 | Self-evaluate counseling progress |
| 63 | Develop a therapeutic relationship with client |
| 65 | Utilize different treatment approaches |
| 160 | Maintain case notes, records, and/or files |
| 200 | Receive clinical supervision |