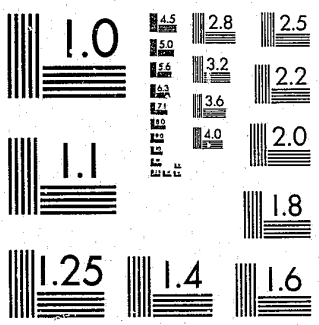

National Institute on Drug Abuse

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Professional and Paraprofessional Drug Abuse Counselors: Three Reports

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Professional and Paraprofessional Drug Abuse Counselors: Three Reports

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The Services Research Reports and Monographs Series are issued by the Services Research Branch, Division of Resource Development, National Institute on Drug Abuse (NIDA). Their primary purpose is to provide reports to the drug abuse treatment community on the service delivery and policy-oriented findings of Branch-sponsored studies. These will include state-of-the-art studies, innovative service delivery models for different client populations, innovative treatment management and financing techniques, and treatment outcome studies.

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The present report is based on a NIDA-funded study of professional and paraprofessional counselors in drug abuse treatment programs. The use of drug treatment counselors with widely varying backgrounds, such as those studied here, can be traced to the 1960s when drug treatment programs underwent a period of rapid proliferation. At this time, ex-addicts were at first sought out by new program administrators for advice and information in setting up the programs (Deitch 1974) and then as paraprofessional counselors. Underlying their employment were several expectations. It was thought, for example, that clients could more readily identify with ex-addicts than with "straight" counselors; that ex-addicts would uniquely understand the language and lifestyle of the client and thus could communicate more effectively; that ex-addicts would be more difficult to con or manipulate and therefore would be capable of making more realistic demands of clients (Brown and Thompson 1976). Concomitant expectations regarding work roles and activities were that ex-addicts would work longer hours at lower pay rates, and that they would be willing and able to handle some of the more troublesome problems in treatment units such as urinalysis monitoring and street work, in addition to frontline intake, hotline and withdrawal counseling (Flores and Rice 1974). However, several or all of these expectations have seemed questionable to many in the field who feel that reliance on addiction history alone may underestimate the needs of the clients and overestimate the resources of the ex-addict. Clearly there are many difficulties: ex-addicts may use their past histories as excuses rather than resources; lack of training may render them incompetent in critical situations; past experience may encourage low tolerance for frustration and for ambiguity; the straight life may require straight role models; overidentification with clients on the one hand and the rigid righteousness of the successfully rehabilitated on the other may lead equally to failure (Suchotliff and Seligman 1974). Finally, the burden of the expectations themselves may lead ex-addict counselors to feel again that they are being manipulated by the system (Mitchell and Graham 1973).

The background of ex-addicts stands in marked contrast to those of other groups of counselors--such as the traditional college-educated professional counselors present in most drug treatment programs. Indeed, the attitudes and expectations of these two groups regarding drug abuse and treatment have sometimes been so disparate as to induce clashes between them when they are employed in the same programs (Wolf et al. 1973).

A third type of counselor employed in drug treatment programs has neither the drug abuse experience of the ex-addict nor the educational background of the professional. These non-ex-addict paraprofessionals who work in drug treatment programs reflect an employment trend which began in the early 1960s (Gartner and Riessman 1974; Grosser et al. 1969; Social and Rehabilitation Service 1974) and which impacted upon the social welfare, mental health, criminal justice, antipoverty and alcoholism treatment systems. The impetus for the utilization of these paraprofessionals was multifaceted and included: the need for service expansion both in types of services offered and in target populations served; a manpower shortage in all service areas, especially those which served the poor or the "deviant"; national and chronic unemployment within specific socioeconomic classes, and a desire to increase the efficiency and effectiveness of services. The employment and utilization of paraprofessionals was also fostered by various pieces of legislation enacted during the 1960s, for example, the Manpower Development and Training Act of 1962, the Economic Opportunity Act of 1964, and various amendments to already existing legislation.[1]

Functioning as counselors in drug treatment programs, then, are three distinct groups

[1]For discussions of the paraprofessional movement which develop these themes, see: Andrade and Burstein 1973; Barker and Briggs 1968; Barr 1967; Benjamin et al. 1966; Brager 1967; Cowin 1970; Gartner and Riessman 1972, 1974; Gordon 1974; Gould et al. 1969; Grosser 1969; Hadley et al. 1970; Lynch et al. 1968; Mandell 1974; National Institute on Alcohol Abuse and Alcoholism 1973; Slavin 1967; Social and Rehabilitation Service 1974; Terwilliger 1966; Wehmer et al. 1974.

groups of people: (1) professional counselors who hold at least a bachelor's degree and who do not have addict backgrounds; (2) ex-addict paraprofessionals who do not usually hold a bachelor's degree; and (3) non-ex-addict paraprofessionals who neither hold a bachelor's degree nor have a history of drug addiction. Although expectations and attitudes held about these groups seem to differ enormously among workers in the field, the professional literature has devoted remarkably little empirical attention to documentation of the actual roles and functioning of the different counselor groups, their attitudinal postures, or the progress of their clients throughout the treatment process.

AREAS EXAMINED IN THIS VOLUME

There are a variety of questions which might be raised about the nature of the three distinct groups of counselors in the drug abuse treatment system. In the present investigation, four broad areas were in fact researched. In each area, an attempt was made to delineate any unique characteristics of counselors in one or another group.

First, the functions and activities of the three counselor groups were contrasted with the goal of delineating what unique role, if any, the three groups of counselors play in drug abuse treatment programs. The results of this exploration are given in the first report in this volume: Professional and Paraprofessional Drug Abuse Counselors: Functions and Activities.

Second, the attitudes of the three counselor groups toward clients and their expectations for their clients were considered. In addition, this study explored the attitudes and expectations of the clients of counselors in the three groups toward their counselors. Since these attitudes are the mirror image of the attitudes of the counselors, these client attitudes are included in the same report in this volume: Professional and Paraprofessional Drug Abuse Counselors: Attitudes of Counselors and Their Clients.

Finally, and again from a client perspective, the progress of clients of the three counselor groups was considered. It was felt that the progress of clients along the variety of dimensions considered in drug abuse treatment, such as reduction of drug use, reentry into the labor force, might reflect the unique strengths and emphases of the various counselor groups in working with clients. It is this third area of research that is the subject of the third report in this volume: Professional and Paraprofessional Drug Abuse Counselors: Progress of Clients in Treatment.

CONTENTS

This volume contains three separate reports.
Each report begins with its own table of contents.

I

Professional and Paraprofessional Drug Abuse Counselors: Functions and Activities

Executive Summary

This report is based on a NIDA-funded study of three groups of counselors working in drug abuse treatment programs: (1) professional counselors who hold at least a bachelor's degree and who do not have addiction histories; (2) ex-addict paraprofessionals who do not usually hold a bachelor's degree; and (3) non-ex-addict paraprofessionals who neither hold a bachelor's degree nor have an addict background. Data were collected in drug-free and methadone maintenance programs located in five major SMSAs--New York; Washington, D.C.; Chicago; Los Angeles; and San Francisco--during the winter of 1976 and the spring of 1977. Personal interviews were conducted with counselors from each of the three groups, with administrators of the programs in which the counselors were employed, and with clients of the respective counselors.

One objective of the study, and the topic of this report, was to delineate what unique roles, if any, the three groups of counselors play in treatment programs and to relate any differences found to counselor characteristics.

It was found that white/Anglo females were most prevalent among professional counselors, and that these counselors tended to be younger, to have briefer tenure in their present positions, and, by definition, to have acquired more academic training than either ex-addict or non-ex-addict counselors. Ex-addict counselors tended to be black males and had gained more previous counseling experience in drug abuse programs, worked more overtime hours, and had somewhat lower salaries than the other two counselor groups. Non-ex-addict counselors tended to resemble ex-addict counselors in their demographic characteristics. They had received more inservice training by current and previous programs than the other two counselor groups, although much of their counseling experience was gained in other settings such as the Criminal Justice System.

When counselors, clients, and administrators were questioned about counselor roles with the aid of a comprehensive list of counselor functions and activities, it was found that the counselor groups were quite similar, for the most part, in their levels of involvement with these activities. This similarity was seen both with relatively frequent (e.g., clerical) tasks and with relatively infrequent (e.g., psychological assessment) tasks. Significant differences in participation levels among counselor groups were found only for those activities which led counselors out of the program--community education, socializing with clients, and counseling in the community. In general, professional and non-ex-addict counselors were involved in few of these outside activities. While some ex-addict counselors were also involved in few of these activities, many others were very much involved with them.

CONTENTS

PROFESSIONAL AND PARAPROFESSIONAL DRUG ABUSE COUNSELORS: FUNCTIONS AND ACTIVITIES

BY

Leonard A. LoSciuto
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1. ORGANIZATION OF THIS REPORT

The report opens with a review of the literature concerned with the functions and activities performed by professional and paraprofessional counselors in a number of service delivery systems. This review is followed by a presentation of the methodology of the study. Here particular emphasis is given to the backgrounds of the three counselor groups. The results follow, reported in three subsections, dealing with: (1) self-reported job activities; (2) a discussion of an activities list from the point of view of counselors, clients, and administrators; and (3) the counselor-category-independent correlates of functions and activities. A summary of findings is provided as the final section of this report.

2. LITERATURE REVIEW

The paraprofessional movement, as previously indicated, has impacted upon a variety of service delivery systems. Four such areas constituted the focus of this literature survey: drug abuse treatment, alcoholism treatment, mental health, and corrections. In addition, articles of interest concerning the utilization of professionals and paraprofessionals in other areas, e.g., antipoverty programs, were included in the review.

Counselor Functions and Activities

In this report the objective is to present literature relevant to the functions which paraprofessionals versus professionals serve and the activities in which these groups engage.[2] The literature presents a plethora of such activities, which have been taxonomized into 13 areas: community education, clerical and service duties, control and enforcement, socializing with clients, counseling in the community, personal aid to clients, administration of clients, administration of programs, counseling in the treatment center, psychological assessment, staff training, interagency relationships, and research. Within each area the literature reviewed has been sorted at two levels.

[2]Virtually no consistent distinctions are made in the literature between paraprofessionals who are ex-addicts and those who are not. Therefore, the two paraprofessional groups are discussed as one in this review.

First, the articles have been separated into those which deal with professionals versus those which deal with paraprofessionals. Within each of these groups of articles a second sort has been made, that is, into the service delivery area (drug abuse, alcoholism, mental health, corrections, and other) to which they pertain. This organization of the literature is reflected in table 1, a catalog of articles, monographs, and books on the functions and activities of counselors. The numbers in the table refer to the numbers of a bibliography presented in the appendix.

The purpose of organizing the literature into chart form was to avoid a fragmented and tedious presentation in which text was interspersed frequently with reference citations. A benefit of the tabular presentation is that a scanning of the table gives a sense of the level of involvement of a counselor group in a class of activities. For example, there are extremely few articles which report the involvement of professionals in providing personal aid to clients--e.g., concrete services such as child care, transportation, assistance in securing health care, and support in the aspects of daily living. There is substantial literature on the involvement of paraprofessionals in this class of activity, however. (See table 1, pp.10-13 for definitions of personal aid and for distributions of references to this topic.) If it is assumed that the amount written about a counselor group vis a vis an activity reflects the level of involvement of the counselor group in the activity, then we can conclude that it is paraprofessionals and not professionals who generally provide such support to clients. The nature of the extant literature gives cause to accept this assumption. A large majority of the articles are descriptions of the experiences of individuals working in service delivery programs; authors mainly reported what they had done or had observed counselors to do in programs.

A number of authors not only listed or described the particular functions and activities performed by professional and paraprofessional counselors, but also provided an indication of the quality of that performance. They reported that the respective counselor group(s) demonstrated competence in a particular task, that they provided valuable treatment or services for clients and for the community, or that a particular counselor group should be assigned specific duties because of special training or experience. These references have been marked with an asterisk (*) in table 1.

While considerably more starred references pertain to paraprofessional counselors, this factor should not be attributed to superior performance of paraprofessionals relative to that of professionals, but rather to the nature of the literature; that is, the vast majority of the extant literature was focused on paraprofessional counselors. Lengthy descriptions of the contributions made by these counselors were provided, while those of professionals often were merely assumed or implied by the respective authors. Perhaps the professionals' relatively standardized academic training and credentials were considered by most researchers to testify to the abilities and accomplishments of this counselor group. Paraprofessionals, on the other hand, are most frequently provided with on-the-job or inservice training and may consequently be seen as requiring critical observation. In addition, perhaps the longstanding participation of professionals compared to the relatively recent utilization of paraprofessionals in counseling and service delivery has prompted researchers to concentrate their efforts on the description and affirmation of the abilities and accomplishments of paraprofessional counselors. Whatever the reason for the nature of the extant literature, an overemphasis on starred references may lead to an inaccurate interpretation of table 1. That is, rather than attending to these particular citations as an indication of differential counselor effectiveness, they should be understood in terms of counselor potential.

In the text which follows, an overview of the activities of professionals and paraprofessionals in each of the 13 areas is given. There are no references cited within the text, since these have been cited in table 1 for each of the 13 areas.

In regard to community education, an examination of table 1 reveals that both professionals and paraprofessionals are responsible for disseminating information concerning their program or information concerning drug abuse, alcoholism, mental health, corrections, etc., to the public at large. Professionals, however, are generally responsible for preparing "official" statements and literature for public distribution, while paraprofessionals provide information to specific individuals who contact the agency with questions and problems. Furthermore, as the intended audience moves along a continuum from that of the public sector toward the local community and its agencies,

Table 1. Literature reporting the functions and activities of professional and paraprofessional counselors

Functions and activities	Professional counselors					Paraprofessional counselors				
	Drug abuse	Alcoholism	Mental health	Corrections	Other	Drug abuse	Alcoholism	Mental health	Corrections	Other
1. Community education										
Provide general public information--e.g., in regard to services, drug abuse, mental illness, alcoholism, etc.	134 155 157		48* 162*	157	10*	145 155	150*	58 69* 84* 122 124	90 108	15 56* 57* 73 74 85 161 174 188
Teach and advise clients, community; conduct workshops	126* 134 157		30 48 77 101* 162*	68 90 157	76 158	126* 145 155		7 26* 30 31 37 58 69* 75 77 78 80 110 122 124 127 138 139 159* 162* 182	16 68 7 90 108 173*	11 15 17* 18 24 33 42 56* 57* 62 63 70 73* 74 76 122 130 131 138 140 174 179

Note — See text preceding this table for explanation of asterisk (*).

Table 1 (Continued)

Functions and activities	Professional counselors					Paraprofessional counselors				
	Drug abuse	Alcoholism	Mental health	Corrections	Other	Drug abuse	Alcoholism	Mental health	Corrections	Other
I. Community education (Continued)										
Interpret program or services to clients, families, community				14	10*	21* 28* 84 88 134* 189	84 151*	3* 7 34 69 77 78 79 84 159 162* 175 184 187	14 16 32* 108	41 57* 70* 73* 74 76 125* 137* 161*
II. Clerical and service duties										
Recordkeeping, report writing			44 48 53 61 162*	14 68* 81 117	33	52 134 136 189	115 186*	3* 4 7 30 31 37 40 53 61 66 69* 77 84* 106 110 124 127 138 162* 184 187	14 32* 68 108	15 18 33 36 41 47 56 57* 73 74 76 119 122 130 138 140 161* 179 188

Note — See text preceding this table for explanation of asterisk (*).

Table 1 (Continued)

Functions and activities	Professional counselors					Paraprofessional counselors				
	Drug abuse	Alcoholism	Mental health	Corrections	Other	Drug abuse	Alcoholism	Mental health	Corrections	Other
II. Clerical and service duties (Continued)										
Messenger					33	136		113 164	68	97 140
III. Control and enforcement										
Investigation/ surveillance				14 68* 81 100 117	15 111	43 126*	150*	106* 162* 169*	13 14* 32* 68 108	15 97 111
Locate and maintain contact with clients				107	10*	21* 43 52 59* 84* 136	84* 121 133 143* 150*	3* 53 66 67 79 84* 122 162* 169*	14* 16 68* 108	18 41 56* 57* 62 63 70* 73 74 160* 161* 170*

Note — See text preceding this table for explanation of asterisk (*).

Table 1 (Continued)

Functions and activities	Professional counselors					Paraprofessional counselors				
	Drug abuse	Alcoholism	Mental health	Corrections	Other	Drug abuse	Alcoholism	Mental health	Corrections	Other
III. Control and enforcement (Continued)						(Especially when intensive or time-consuming)				
Client supervision	88	94 104 105 165	48	14* 32* 68 81 93 100* 117	15 160* 188	28* 29* 59* 88* 126 134 156 189	25* 94 104 105 121 143 165 171	19 26* 34 37 40* 46* 53 56 58 98 110 113 127 128 147 159 162* 179 182 183	14* 16 32* 56* 68* 72 108 121 179	15 33 36 42 56 57* 73 97 119 140 160* 177* 188

Note — See text preceding this table for explanation of asterisk (*).

Table 1 (Continued)

Functions and activities	Professional counselors					Paraprofessional counselors				
	Drug abuse	Alcoholism	Mental health	Corrections	Other	Drug abuse	Alcoholism	Mental health	Corrections	Other
IV. Socialize with clients										
Conduct recreational programs, group activities			48*		15	145	133	3* 12* 19 24 31 37 46* 53 58 69* 75 77 78 84* 87* 110 124 138 159 162*	90	15 17 33 42 57 76 85 122 140 182*
Escort clients on trips, tours; attend social functions with clients			48*	100		145		69* 87* 169*	157	11 15 33 47 57* 63 76 122 138 140 161

Note — See text preceding this table for explanation of asterisk (*).

Table 1 (Continued)

Functions and activities	Professional counselors					Paraprofessional counselors				
	Drug abuse	Alcoholism	Mental health	Corrections	Other	Drug abuse	Alcoholism	Mental health	Corrections	Other
V. Counseling in the community										
Visit homes, families, neighborhoods to motivate persons in need to seek help			54 77		10* 76 85 129 188	21* 29* 52 84* 91* 157	84* 115 133 143* 150	3* 12* 26* 40 54 58 69* 77 78* 79 84* 122 127 139* 159* 162* 169* 175 182	14* 16 68 90 108 157 173*	15 17* 33 56* 57* 63 70* 73* 74 76 85 97 137* 140 160* 161* 170* 188
Observe and assess community problems			139		85 188	157		69* 122 138 139 159 162* 169*	108 157 173*	36* 44 57* 119* 137* 168* 188

Note — See text preceding this table for explanation of asterisk (*).

Table 1 (Continued)

Functions and activities	Professional counselors					Paraprofessional counselors				
	Drug abuse	Alcoholism	Mental health	Corrections	Other	Drug abuse	Alcoholism	Mental health	Corrections	Other
V. Counseling in the community (Continued)										
Crisis intervention	28		44 78 124	14	168	2 8 29* 35 38 43 52 59* 89 145 189 190	133 143*	2 33 35 56 58 77 78* 89 98* 139* 162* 175 176 183	14 68	24 56* 63 76 97 119 168
VI. Personal aid to clients										
Provide role model	167		181			28* 29* 38 39* 43 91 134* 156 167* 180 190	104* 105*	30 31 78* 110 118* 122 139* 159* 162* 169 181 183 184	68	17 33 47 57* 63 70 73* 122*

Note — See text preceding this table for explanation of asterisk (*).

Table 1 (Continued)

Functions and activities	Professional counselors					Paraprofessional counselors				
	Drug abuse	Alcoholism	Mental health	Corrections	Other	Drug abuse	Alcoholism	Mental health	Corrections	Other
VI. Personal aid to clients (Continued)										
Provide information to clients					85 129	88 134* 167	151*	3* 35 46 69* 77 78 86 118 122 124 127 138 139 162*	68 90 108 149	41 56* 57* 63 70* 73* 76 85 131 138 160* 161 174
Assist clients in securing employment, financial assistance, housing, medical and dental care, legal aid, education, training, etc.	157		48*	117 157	10* 15 47 85 129 168 188	8 38 88 134 136 145 157	151	3* 30 31 40 69* 77 78* 79 84* 86 122 124 127 139* 159 162* 182 187	13* 14* 32* 68 90 157	15 17 36* 41 44 47 56* 57* 62 63 70 73* 76 85 121 138 140 160* 161* 168 182* 188*

Note — See text preceding this table for explanation of asterisk (*).

Table 1 (Continued)

Functions and activities	ro e ional counselors					Paraprofessional counselors				
	Drug abuse	Alcoholism	Mental health	Corrections	Other	Drug abuse	Alcoholism	Mental health	Corrections	Other
VI. Personal aid to clients (Continued)										
								3*		
Secure services for clients			78	117	10*	38	143*	31	13	18
					168	134		56	32*	57*
								58	68	62
								77	90	73*
								78*	116	76
								80*		125
								86		160*
								122		161
								127		168*
								139*		182*
								162*		
Provide concrete services to clients--e.g., homemaking, direct care, transportation, etc.			48*	90	10*	8	151	3*	13	11
			101*		33	38		31	32*	15
					47	52		37	68	17*
					188	136		40	90	18
								46		36*
								58		42
								69*		44
								77		47
								78		56*
								79		57*
								84*		62
								86		63
								122		73
								138		74
								139		76
								159*		122
								162*		138
								182		160*
								187		161*
										168
										188

Note — See text preceding this table for explanation of asterisk (*).

Table 1 (Continued)

Functions and activities	Professional counselors					Paraprofessional counselors				
	Drug abuse	Alcoholism	Mental health	Corrections	Other	Drug abuse	Alcoholism	Mental health	Corrections	Other
VI. Personal aid to clients (Continued)										
Provide social and emotional support to clients			48*	100 117	23 28* 29* 38 39* 49 84* 134* 190	49 84* 144 151* 186*	3* 26* 37 40* 46* 53 56 58 66 69* 73 75 77 78 84* 87* 97 118 122 124 139 159 162* 177 183	14 16 32* 56 68 108	17 24 33 36* 42 44 47 56* 57* 62 63 73* 74 76 122 137* 138 140 160* 168* 182	

Note — See text preceding this table for explanation of asterisk (*).

Table 1 (Continued)

Functions and activities	Professional counselors					Paraprofessional counselors				
	Drug abuse	Alcoholism	Mental health	Corrections	Other	Drug abuse	Alcoholism	Mental health	Corrections	Other
VII. Administration of clients										
Evaluation/diagnosis of clients' problems	23 88 134 189	25* 144 151 186*	4* 46* 48 50 61 77 78 84* 159 162* 172	14 32* 68 83 93 108 117	10* 56 76 111 137* 160 188*	38 39* 43 136 152*	105* 144	46* 53 61 77 78 84* 86 114 118 122 159 162* 169* 172	14 108	17 44 47 57* 63 76 111* 188
Design and prescribe treatment/services for clients	28 134	186	4 30 40 46* 48 53 61 67 77 84 97 110 128 162* 182	14 16 32* 68 83 93 108	3* 10* 56 76 179 188	88	25* 105*	46* 53 69* 78 84* 110 128 159*	14 68 108	188

Note — See text preceding this table for explanation of asterisk (*).

Table 1 (Continued)

Functions and activities	Professional counselors					Paraprofessional counselors				
	Drug abuse	Alcoholism	Mental health	Corrections	Other	Drug abuse	Alcoholism	Mental health	Corrections	Other
VII. Administration of clients (Continued)										
Intake evaluation and screening			40 48 101* 159	14	10* 47 56 111	52 88 180*	171 186*	3* 12 19 58 61 69* 84* 98 124 138 141 147 162* 169	68 116	41 47 56* 70* 73 74 111* 160 188
Consultation with other counselor(s) in regard to client treatment/services		6	46* 53 54 77 78 97 113 124 128 162*	14 32* 72 93 135	36* 44 76 168*	134		3* 30 40 46* 53 54 77 78 84* 113 124 127 128 147 162* 169* 177 187	14 32* 56* 68 72 108	36* 44 70 76 160 168* 179 188

Note — See text preceding this table for explanation of asterisk (*).

Table 1 (Continued)

Functions and activities	Professional counselors					Paraprofessional counselors				
	Drug abuse	Alcoholism	Mental health	Corrections	Other	Drug abuse	Alcoholism	Mental health	Corrections	Other
VII. Administration of clients (Continued)		25*	44 51* 86	117	10* 47 188	38 145	105* 133 143* 186*	3* 30 34 35 77 78 79 84* 86* 139 159 162* 182 187	13* 32* 68 116 140*	17 18 35 41 56 57* 62 63 70* 74 76 82* 85 122 137* 138 161* 188
Refer clients to appropriate agencies										
Liaison between clients and professional counselors/agency			101*		10*	28* 29* 38 39* 49 146	49* 121 150* 151*	3 26* 40* 56 77 78* 80* 86 87* 110 118* 122 127 139* 159* 162* 169* 187	13* 14* 68 90 108	17 47 56* 57* 63 70* 73* 74 76 111* 119* 122* 125* 130 137* 138 140 160* 168* 182* 188

Note – See text preceding this table for explanation of asterisk (*).

Table 1 (Continued)

Functions and activities	Professional counselors					Paraprofessional counselors				
	Drug abuse	Alcoholism	Mental health	Corrections	Other	Drug abuse	Alcoholism	Mental health	Corrections	Other
VIII. Administration of program										
			1*							
General program administration	91		3	68	11	49	25*		56	70
	155		24	71	33	52	49		71	122
	167		30	83	63	122	102		72	
	190		31	93	85	134	122		122	
			37	100	132	136	150			
			44	108	140	190				
			46	117	158					
			48		168					
			53		188					
			64							
			78							
			84							
			86							
			113							
			159							
			162*							
			163							
			183							
Establish satellite facilities			54		111*			54	68*	56
								98	71	57*
										89
										111*
										131

Note — See text preceding this table for explanation of asterisk (*).

Table 1 (Continued)

Functions and activities	Professional counselors					Paraprofessional counselors				
	Drug abuse	Alcoholism	Mental health	Corrections	Other	Drug abuse	Alcoholism	Mental health	Corrections	Other
VIII. Administration of program (Continued)										
			1*			(Of Paraprofessionals and/or volunteers)				
			3							
General staff supervision	109*	103	4	14	3*	43		107	71	70
	145		12*	16	10*	52		169	72	140
	189		19	32*	15	134		183	90	
			31	64	17					
			37	68	18					
			40	71	33					
			44	72	47					
			46	100	63					
			48*	108	70					
			53	117	71					
			56	188	76					
			58		85					
			61		96					
			66		119					
			75		122					
			77		132					
			78		137*					
			106		138					
			112		140					
			113		168*					
			122		177*					
			124		178*					
			128							
			138							
			139							
			147							
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			183							
			184							

Note— See text preceding this table for explanation of asterisk (*).

Table 1 (Continued)

Functions and activities	Professional counselors					Paraprofessional counselors				
	Drug abuse	Alcoholism	Mental health	Corrections	Other	Drug abuse	Alcoholism	Mental health	Corrections	Other
VIII. Administration of program (Continued)										
Resolve agency and staff problems			53 66 162*	14 68 93 135	98 140 188					140
Promote and expedite changes in laws, regulations, and policies			1* 78 86 139 162*	16 68				78 139		85 140 188
Develop job descriptions, determine job placements			1* 67 162* 183	71 108	3* 47 140 188				56	74 140
Recruit/employ staff			19 64 67 78 159 162* 178 184	71 108	15 63 74 140			34 107 159 184		
Prepare and administer budget			44 162*	93				34 84		

Note — See text preceding this table for explanation of asterisk (*).

Table 1 (Continued)

Functions and activities	Professional counselors					Paraprofessional counselors				
	Drug abuse	Alcoholism	Mental health	Corrections	Other	Drug abuse	Alcoholism	Mental health	Corrections	Other
VIII. Administration of program (Continued)										
Purchase and/or repair agency supplies, materials			162*	93				3*		
Analyze and evaluate program	167*		12* 44 53 64 66 67 86 97 106 128 147 159 162* 164 184	14 93 108 117 135	50 140 188			138 184	108	
Assist in general program administration				93		28 49 122 189	49 122 150*	4 7 34 61 77 118 162* 183	32* 56 68 71 122	15 17 44 47 57* 74 76 122 131 138 140 168 174

Note -- See text preceding this table for explanation of asterisk (*).

Table 1 (Continued)

Functions and activities	Professional counselors					Paraprofessional counselors				
	Drug abuse	Alcoholism	Mental health	Corrections	Other	Drug abuse	Alcoholism	Mental health	Corrections	Other
VIII. Administration of program (Continued)										
Equipment, building, and/or grounds maintenance, improvement								75 113 164	72	15 33 74 140
IX. Counseling in treatment center										
Prescribe medication/ treatment		133	162* 182						68	
Dispense medication; perform laboratory tests			182	117		52 59* 136 189	133	46 84* 97 162*	72	15 122

Note — See text preceding this table for explanation of asterisk (*).

Table 1 (Continued)

Functions and activities	Professional counselors					Paraprofessional counselors				
	Drug abuse	Alcoholism	Mental health	Corrections	Other	Drug abuse	Alcoholism	Mental health	Corrections	Other
IX. Counseling in treatment center (Continued)								4		
								9		
								19		
								24		
Individual and/or group-counseling	5	94	3	14	3*	5	12	27*	13*	24
	22	103	9	32*	10*	8	94	30	16*	33
	23	104	24	68	15	12	103	31	32*	56
	88*	105	30	83	20	22	104	35	56*	57*
	91*	165	44	90	24	23	105	45	68	70
	109		46*	93	47	38	121	46*	71	73
	134		48*	117	76	43	133	55	72	74
	155		55	157	137*	52	144	56	90	76
	157		65		191	88	150*	57*	116	174
	167		75			89	151	58	157	178*
			77			91*	159	60	173*	179
			101*			109*	165	61		188
			124			134	171	65		191*
			159			136		69*		
			162*			155		75		
			163			156		77		
			177			157		78*		
			178			167		95		
			181			176		97		
			185			179		98		
						189		110		
						190		113		
								118		
								123		
								124		
								139*		
								142		
								159		
								162*		
								176		
								177		
								178		
								181		
								183		
								184		
								185		
								187		

Note — See text preceding this table for explanation of asterisk (*).

Table 1 (Continued)

Functions and activities	Professional counselors					Paraprofessional counselors				
	Drug abuse	Alcoholism	Mental health	Corrections	Other	Drug abuse	Alcoholism	Mental health	Corrections	Other
IX. Counseling in treatment center (Continued)										
Psychotherapy	189		30 46* 61 77 87* 92 97 120 162* 163 166 175 183	32* 93 97	10* 76 97			92 120 176		
X. Psychological assessment										
Administer psychological tests	189		154	93 135				3* 34 61 114 118 147 154	72	
Interpret psychological tests	189		61 162*	93						
Provide specialized skills and services	39* 189	144	61 148 162*	14 32* 68 135 149*	70					

Note — See text preceding this table for explanation of asterisk (*).

Table 1 (Continued)

Functions and activities	Professional counselors					Paraprofessional counselors				
	Drug abuse	Alcoholism	Mental health	Corrections	Other	Drug abuse	Alcoholism	Mental health	Corrections	Other
X. Psychological assessment (Continued)										
Provide technical skills and services			154					3 34 60 61 114 147 154	72	
XI. Staff training										
General staff development	189		1 48* 54 61 64 77 97 101* 124 148 159 162* 163	16 32* 68 117	18 70 76 140 160					130

Note — See text preceding this table for explanation of asterisk (*).

Table 1 (Continued)

Functions and activities	Professional counselors					Paraprofessional counselors				
	Drug abuse	Alcoholism	Mental health	Corrections	Other	Drug abuse	Alcoholism	Mental health	Corrections	Other
XI. Staff training (Continued)			1*							
			2							
Training of paraprofessional counselors and/or volunteers	23	6	4	14	15	23	150*	2	56*	70
	28	49	12*	16	18	43		4	71	130
	49	103	30	68	33	52		34	72	140
	91	115*	31	71	47	89		56		
	109	150*	37	108	63	134		61		
	157	171	40	157	70	145		107		
	189		44		73*			118*		
			45		76			123		
			48*		85			124		
			53		112*			169		
			54		140			183		
			64		158			184		
			66		160					
			67		174					
			77		188					
			78							
			84							
			106							
			112							
			113							
			118*							
			124							
			148							
			159							
			162*							
			163							
			164							
			182							
			183							
			184							
Design curriculum/ teaching materials			3	71	3*				71	
			53	108	15					
			64		73*					
			124		140					
			162*							

Note — See text preceding this table for explanation of asterisk (*).

Table 1 (Continued)

Functions and activities	Professional counselors					Paraprofessional counselors				
	Drug abuse	Alcoholism	Mental health	Corrections	Other	Drug abuse	Alcoholism	Mental health	Corrections	Other
XI. Staff training (Continued)										
Prepare teaching materials			3 53 162*	71	3* 73*			3	71	140 174
Provide specialized skills and services	189	144	53 106 148 162* 183	32* 68 135	70			78		174
Interpret client behavior, "street talk," etc.						28* 29* 39* 49 59* 91* 109* 136	49* 143* 186*	30 46* 69* 77 78* 86 110 118* 138 139* 159* 169*	68* 90 108 116	17 36* 44 47 57* 62 63 73* 76 111* 122 137* 138 160* 168* 170* 174 177* 182* 188

Note — See text preceding this table for explanation of asterisk (*).

Table 1 (Continued)

Functions and activities	Professional counselors					Paraprofessional counselors				
	Drug abuse	Alcoholism	Mental health	Corrections	Other	Drug abuse	Alcoholism	Mental health	Corrections	Other
XII. Interagency relationships										
Establish and maintain contacts with other agencies and community organizations and resources	157		54 64 139 162*	32* 68 108 117 157	10* 15 73* 85 140 188	145 157	150	3* 34 40 69* 78 84* 86 123 139 182	14 68* 90 157	15 57* 63 85 122 130 131 138
Coordinate community, State, National resources			64 162*	68 81 108 117	15 140	49	49* 133	78	71	99 130 140
Develop and promote agency or community programs and resources	157		1* 31 44 48* 53 64 78 139 162*	68 71 72 90 108 117 157	10* 15 33 85 140	52 89 134 145 157	186*	3* 56 69* 78* 79 80 84* 89 107 123 124 139* 159 162* 182	32* 56 68* 71 72 90 149* 157 173*	15 41 57* 63 70 73 85 99 125* 130 131 138 140

Note — See text preceding this table for explanation of asterisk (*).

Table 1 (Continued)

Functions and activities	Professional counselors					Paraprofessional counselors				
	Drug abuse	Alcoholism	Mental health	Corrections	Other	Drug abuse	Alcoholism	Mental health	Corrections	Other
XII. Interagency relationships (Continued)										
Organize community groups for prevention of drug abuse, crime, etc.	126* 134		78	71 90	10* 73* 85	89 126* 134 145		34 60 69 77 78* 89 98 138 139* 159*	56* 68* 71 90 108 122 173*	15 17* 56* 57* 70 73* 76 119 122 138
XIII. Research										
Research in general			48 53 148 159 162* 163	71 72 81 83	10*			7 30 61 75 118 138 187	56* 71	47 56 73 74 122
Research design and implementation			162*	71 72 135	3* 188				56 71 72	

Note — See text preceding this table for explanation of asterisk (*).

Table 1 (Continued)

Functions and activities	Professional counselors					Paraprofessional counselors				
	Drug abuse	Alcoholism	Mental health	Corrections	Other	Drug abuse	Alcoholism	Mental health	Corrections	Other
XIII. Research (Continued)										
Recordkeeping, report writing			162*	68 72 81	188	52 134 136 189	115	69 138 162*	32* 56 68 72 108	18 41 56 161* 188
Interviewing, data processing, etc.			53	71	188	136 152* 153		3* 30 34 58 61 69* 80 138 162*	16* 56* 71 72 83 108	15 56* 188

Note — See text preceding this table for explanation of asterisk (*).

professional involvement decreases markedly and is compensated for by paraprofessional involvement. Paraprofessionals are evidently seen as appropriate for dealing with the clients and local agencies who serve them directly, whereas professional credentials are seen as necessary for public relations work among the public at large.

Table 1 also demonstrates that paraprofessionals have assumed most of the clerical and service duties performed by drug abuse and alcoholism treatment, mental health, and general social service programs. In the field of corrections, there appears to be relatively equal involvement of both types of counselors. However, this distribution of activities and functions is largely due to differential types of clerical and service duties. That is, while paraprofessionals in these programs do the general typing, keep agency records, report counseling interaction and community contacts, and report preliminary investigations, it is largely report writing in areas such as psychotherapy, psychological testing, client disposition and presentence recommendations to the court which are considered the domain of professionals. Also, paraprofessionals are often assigned the preliminary "legwork" for intensive and time-consuming aspects of the professionals' responsibilities. Paraprofessionals prepare preliminary reports which are used as a basis for the professionals' subsequent evaluation and final reports. Therefore, while it appears that clerical and service duties are tasks distributed over both counselor groups, a hierarchical structure is maintained.

This same type of hierarchical structure is evident in the performance of control and enforcement functions and activities. While professionals maintain authority and ultimate responsibility for the satisfactory completion of these tasks and direct paraprofessionals in their completion, it is the paraprofessionals who perform most of the actual work involved.

In all of the literature reviewed for this report, only three references indicated that professional counselors socialized with their clients. In each of these instances, the counselors held bachelor's degrees, but were considered as paraprofessional employees by their agencies. With this in mind, then, it seems accurate to conclude that paraprofessionals constitute the only counselor group which was reported to socialize with clients. The rationale often accompanying these reports indicates that socializing with clients generally is not perceived as "professional behavior" by many program administrators or policymakers.

In regard to counseling functions and activities in the community and providing personal aid to clients, paraprofessional counselors overwhelmingly appear to perform these tasks. In fact, a familiarity with the community, indigenousness, supposed effective communication among members of the same social class and among persons having similar life experiences are all considered advantages of paraprofessional utilization. It is not surprising, therefore, that professional counselors are not often reported to perform these activities and functions.

Functions and activities associated with the administration of clients reveal a hierarchical assignment of tasks as do other areas noted above. Specific tasks such as evaluation or diagnosis and treatment or service prescription, tasks which conceivably require a higher level of expertise, generally are reserved for professional counselors. Areas in which paraprofessionals are reported to engage in these tasks indicate contributions made by these workers and generally not their authority and ultimate responsibility for their performance. Also, professional involvement in consultation generally indicates services performed for outside agencies or organizations, or clinical expertise provided to paraprofessionals. Paraprofessional involvement in this activity generally indicates their seeking guidance from professional staff members or providing assistance to less experienced paraprofessionals or to volunteers working within the program or agency. Less demanding tasks, e.g., intake evaluation and screening, or those which infer a deficit of ultimate authority or clinical expertise, e.g., client referral, are assumed by paraprofessionals. This same counselor group appears to monopolize the liaison function, as would be expected by virtue of the advantages of paraprofessional utilization noted above.

In table 1, program administration appears to be monopolized by professionals. Although professional training generally does not particularly emphasize the development of expertise in this area, the professionals' middle-class orientation may appear especially to prepare them for such tasks. The outstanding exceptions to this rule are those drug abuse and alcoholism treatment programs which are staffed exclusively by ex-addicts or former alcoholics, e.g., Synanon, therapeutic communities, Alcoholics Anonymous.

A comparison of the number of references cited in regard to counseling in the treatment center might lead to the conclusion that this function is primarily performed by professionals with the exception of drug abuse and alcoholism treatment programs and demonstration projects conducted in the areas of mental health and corrections; however, this is not the case. Professionals generally prescribe medications and order laboratory tests, but paraprofessionals generally dispense the prescriptions and perform the tests. Both groups counsel clients, but professionals are concerned more with in-depth psychological or personality variables and the employment of sophisticated techniques, while paraprofessionals are concerned more with informal "daily living" aspects of counseling. The exceptions again are self-help programs in drug abuse and alcoholism treatment where "it takes one to know one" is often the applied ethic. Demonstration projects conducted in the areas of mental health and corrections also evidenced paraprofessional involvement in the area of counseling, but professionals maintained ultimate supervisory responsibility for these functions.

Psychological assessment appears to be exclusively the domain of professional counselors, except in the area of mental health where paraprofessionals have been intensively trained in standardized test administration and scoring. Even in this case, however, interpretation and assessment are reserved for professionals. Since a relatively high level of expertise is required for the administration and interpretation of psychological instruments, it is not surprising that paraprofessionals are generally not found performing these tasks.

An inspection of table 1 reveals that professionals have almost monopolized staff training. This is to be expected since most paraprofessional counselors have little education and are inexperienced with counseling techniques. Senior paraprofessional counselors, however, and especially those working in drug abuse treatment programs, are often ex-addicts who have acquired considerable counseling training and experience. They are reported to provide at least some training for other paraprofessional counselors, even though professionals may contribute to and maintain ultimate responsibility for training in the agencies. The same can be said of experienced paraprofessionals working in mental health.

One area of informal training is worthy of note, that of interpreting client behavior and language. Since the background and life experiences of paraprofessionals are said to be what qualifies them for this function, and because it is the differential social-class orientations between professional counselors and client populations which appear to necessitate or at least recommend performance of this task, it is highly unlikely that professionals would be engaged in this function.

Professionals and paraprofessionals share in the tasks of maintaining positive interagency relationships. Yet this participation is moderated by the type of agency in question. Professionals interact with formal governmental agencies for which a "professional" demeanor is required. This same demeanor, however, tends to be resisted by action-oriented community groups. Members of these groups may prefer to interact with paraprofessionals whose backgrounds are similar to the constituents of the community groups and who, having often come from the same or similar neighborhoods, are more familiar with community issues.

The literature shows that both professionals and paraprofessionals participate in research functions of their programs. Their functions in the research process, are, however, quite different. The professionals are the project directors who design research studies, develop measuring instruments, analyze data, and write research reports. In contrast, the paraprofessionals are involved at the technical level, in interviewing, data processing, and in tabulating data for the professionals who ultimately interpret them. In the few instances where paraprofessionals are said to have conceptualized a specific research project, the approval and support of professionals were generally required before the study could be carried to completion.

The above interpretation of table 1 is based upon the distribution of citations attesting to professional-paraprofessional involvement in specific functions and activities as well as the respective authors' explanations of that involvement. Few of the works cited, however, are of an empirical nature. While some of these references may accurately reflect clinical practice, others may reflect the personal expectations if not biases of the authors. The extent to which this affects the interpretation of table 1 cannot be determined. Therefore, the validity and generalizability of apparent relationships between counselor group and participation in specific functions and activities largely remain open to question.

Counselor Training

The remainder of this report includes a discussion of the backgrounds of the counselors in the sample, with particular consideration of the training, both academic and inservice, that the counselors have received. For this reason, and because of the potential effect of training on the assignment of functions and activities, the training of counselors, as documented in the literature, will be reviewed briefly.

Wide disparities in type and duration of training exist between professional and paraprofessional counselors. Articles which confine the definition of professionals to counselors who have attained greater education than a baccalaureate degree point out that these counselors complete relatively standardized, extensive, and formal training to earn a master's or doctoral-level degree.[3] In contrast, paraprofessionals most frequently are provided with on-the-job or inservice training.[4] This training consists of program orientation, lectures by program staff, and films which are intended to impart information concerning symptomatology, client characteristics, and fundamental counseling techniques. Field trips and discussions between the paraprofessional and his supervisor or staff conferences concerning "problem clients" are also frequent modes of instruction. Some programs, such as the Probation Officer-Case Aide Project (Beless et al. 1972; Clements and Mattick 1972; Gordon 1976), the Baltimore City Alcoholism Clinic (National Institute on Alcohol Abuse and Alcoholism 1973), the Detroit Health Department (Petros et al. 1973), and the Purdue Program (Hadley et al. 1970), have developed more extensive and formalized training curricula for paraprofessionals, some culminating in associate-level degrees.

3. METHODOLOGY

Study Design and Procedures

The Sample

Counselors were included in this study only if they were full-time workers with a caseload of approximately 25 or more clients for whom they had primary responsibility for the treatment regimen. Interviews were conducted with either all or a random sample of counselors in given treatment programs, a number of randomly selected clients of each counselor, and with the top program administrators in order to gather different perspectives on various areas of counselor functioning. In all, 82 counselors were interviewed along with 302 of their clients (table 2), and 29 administrators of their programs. These individuals were from nine methadone maintenance and six drug-free programs within five major cities or surrounding areas--New York; Washington, D.C.; Chicago; Los Angeles; and San Francisco. The 16th program had both a methadone and a drug-free unit.

Criteria for Selection

These cities were chosen in part to insure geographic spread across the country. Another consideration was that major programs from large urban areas seemed desirable since they have relatively large client and counselor populations. This, in turn, insured that sufficient numbers of counselors and clients would be interviewed from each program. When possible, programs were chosen which had all three types of counselors. In only two programs in the sample was a counselor group missing.

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[3]The definition of professional counselor varies across the literature, sometimes including counselors holding bachelor's degrees and, at other times, including only counselors who have attained post-baccalaureate degrees.

[4]For literature on counselor training see: American Personnel and Guidance Association 1967; Beless et al. 1972; Benjamin et al. 1966; Bokos 1974; Christmas 1966; Clements and Mattick 1972; Cooke et al. 1975; Dalali et al. 1976; Danish and Brock 1974; Falkey 1971; Gentry 1974; Gordon 1976; Gottesfelt et al. 1970; Gould et al. 1969; Grosser 1969a; Hadley et al. 1970; Halpern 1969; Jackman 1973; Lederman 1974; Lynch et al. 1968; Magee 1966; National Institute on Alcohol Abuse and Alcoholism 1973; Nolan and Cooke 1970; Persons et al. 1973; Petros et al. 1973; Rieff and Riessman 1965; Rosenberg 1974; Skuja et al. 1975; Sobey 1970; Social and Rehabilitation Service 1974; Teicher et al. 1976; Truax 1969; Van Stone 1974; Wasserman et al. 1975; Waters et al. 1976.

Table 2. Distribution of counselors and clients, by counselor group

	Number of counselors	Number of clients
Professional	31	116
Non-ex-addict paraprofessional	20	71
Ex-addict paraprofessional	31	115
Total	82	302

It was thought ideal to choose about the same number of methadone maintenance programs as drug-free programs in order to control for the effects of treatment modality. This was not possible, however, since there was a smaller proportion of drug-free, as compared to methadone maintenance, programs in the SMSAs surveyed who employed non-ex-addict paraprofessionals. Therapeutic communities were excluded because clients are not often assigned to particular counselors in those settings. Detox units were excluded because their short-term nature, among other factors, discourages the establishment of client-counselor relationships.

Procedures

The procedures used to select and recruit these programs involved initial screening for eligibility using the NDATUS file and several follow-up letters and phone calls to gather more program information and request cooperation. Professional interviewing staff from Creative Socio-Medics Corp. conducted the interviews during the winter of 1976 and the spring of 1977. Each of these interviewers was a professional in the area of drug abuse research and had experience in dealing with studies of addicts.

Each of the interview forms was designed to contribute information to each of the overall study objectives. That is, questions relevant to counselor functions and activities, client-counselor attitudes and interactions, and the progress of clients in treatment were included in each form.

Counselor-category-dependent correlates of functions and activities. In examining the actual day-to-day activities of counselors in the three counselor groups, two basic approaches in gathering data were taken. First, counselors were asked a series of free-answer questions about their jobs, including the total hours worked per week, their income, the size of their caseloads, and the time spent in direct counseling sessions (see table 6 presented later in this paper). They were also asked to enumerate the activities other than counseling, on which they spent their time, indicating how they would modify their jobs to be more in line with what they felt a counselor should do.

In addition, more structured questions relevant to the functions and activities of counselors were asked of all program administrators and clients, as well as the counselors themselves. The main question asked of the three groups was in the form of a comprehensive list of activities in which counselors might engage. The full list of items (given in table 7 presented later) was taken from three sources: (1) a list of counselor activities generated by Kozel and Brown (1973), to describe the functions and activities of professional and ex-addict drug treatment counselors; (2) a second list enumerated by Teare (1974) to describe the potential functions of paraprofessionals in Social and Rehabilitation Services programs; and (3) unstructured personal interviews by ISR staff with several drug counselors. The activities covered 11 areas of counselor functioning: (1) community education, (2) clerical and service duties, (3) control and enforcement, (4) socializing with clients, (5) counseling in the community, (6) personal aid to clients, (7) administration of clients, (8) administration of the program (9) counseling in the treatment center, (10) psychological assessment, and (11) staff training.[5]

[5]These constitute 11 of the 13 areas included in the literature survey. The area of research was omitted since such activities were in the main subsumed under the clerical function. The area of interagency relationships was omitted since at the time of instrument development, we had found no evidence of this function in our sources of activities.

Counselors were asked for each item whether people who worked in the program ever engaged in the activity. If so, they were asked to indicate the frequency with which they themselves engaged in the activity. That is, they were asked if they performed the activity never, once or twice a year, three or four times a year, once or twice a month, once or twice a week, or just about every day. For the same set of activities, administrators were asked whether their counselors were involved in each activity. If so, the administrators were asked which of the three counselor groups, if any, was more involved in the activity. A subset of the activities dealt directly with counselor-client interactions of one form or another. These activities fell into four areas: counseling in the community, counseling in the treatment center, personal aid to clients, and socializing with clients. For these activities clients were asked either whether their counselor had ever performed the activity with them, or alternatively, how frequently, if ever, the counselor had engaged in the activity with them. The particular question asked depended upon whether the activity was more or less "one shot" in nature or whether it was more likely to occur repeatedly.

Counselor-category-independent correlates of functions and activities. There was a third approach taken to the examination of which counselors performed particular activities in the programs. It seemed entirely possible that there were individual counselor characteristics, over and above their group membership as PRO, NEA, or EA, which were related to their level of involvement in particular activities. Six such characteristics were considered. The first three were measures of training. These were (1) number of counseling courses taken; (2) number of job-relevant noncounseling courses taken, e.g., abnormal psychology; (3) number of topics covered in all training courses provided by treatment programs. The second three were measures of on-the-job experience and seniority, (4) number of months in present position, (5) total number of months worked as a counselor in all other programs, and (6) total number of months worked as a counselor in drug treatment programs.

Measures of training were considered because an index of formal educational attainment such as the baccalaureate degree may have little relationship to the relevance of the education for the job. For example, a B.A. in art history may be less directly preparatory for work as a counselor than an associate degree in counseling or inservice training in counseling.

Measures of experience were considered because seniority and/or relevant experience is sometimes the main factor in acquiring certain responsibilities and special functions in an organization. In this regard, as will be seen in the present sample of counselors, professionals had the most formal education followed by non-ex-addict paraprofessionals and then ex-addict paraprofessional counselors. In direct contrast, it is ex-addict paraprofessionals who had the most previous experience as drug counselors, followed by non-ex-addict paraprofessionals and then professionals.

Background of Counselors

Beginning with this section, results of the present study are presented. Counselor background is considered first, followed by counselor activities.

It seemed reasonable to expect that variation in background and experience of counselors apart from their classification into the three groups might play a part in determining their roles, attitudes, and accomplishments. Therefore, counselor sex, ethnicity, and age were recorded, as well as amount and content of formal education and of training experience in drug treatment programs. Abbreviated histories of substance abuse and associated treatment were also taken. Descriptions of the counselors in terms of background are presented here, while in a later section attempts are made to relate these characteristics and variables to counselor roles and activities.

For convenience to the reader, professionals will henceforth be noted as PROs, ex-addict paraprofessionals as EAs, and non-ex-addict paraprofessionals as NEAs.

Demographics: Sex, Ethnicity, and Age

With regard to sex and ethnicity, Chi-square analyses show that the three groups were quite different in composition. PROs were much more likely to be white/Anglos ($\chi^2(8)=23.64$, $p<0.01$) and female ($\chi^2(2)=7.08$, $p<0.05$) than EAs. NEAs as a group were somewhat more like the EAs than they were like the PROs on these demographic dimensions. Table 3 shows that more than half the PROs were female and about two-thirds of them white/Anglos, while only one-fifth of the EA group was female and only one-fifth was white/Anglo. Viewing ethnicity and gender together, only 13 percent of PROs were black males, while they constituted more than 60 percent of the EA group. Only six of all counselors were neither black nor white/Anglo.

Table 3. Counselor sex and ethnicity, by counselor group (in percent)

	Ethnicity			
	Black	White/Anglo	Puerto Rican	
I. Professional counselors:				
Male	26.7 (4)	66.7 (10)	6.7 (1)	48.4 (15)
Female	25.0 (4)	68.8 (11)	6.3 (1)	51.6 (16)
	25.8 (8)	67.7 (21)	6.5 (2)	100 (31)

	Ethnicity				
	Black	White/Anglo	Mexican American	Philipine Chinese	
II. Non-ex-addict paraprofessionals:					
Male	75.0 (9)	16.7 (2)	8.3 (1)	---	60.0 (12)
Female	62.5 (5)	25.0 (2)	---	12.5 (1)	40.0 (8)
	70.0 (14)	20.0 (4)	5.0 (1)	5.0 (1)	100 (20)

	Ethnicity				
	Black	White/Anglo	Puerto Rican	Mexican American	
III. Ex-addict paraprofessionals:					
Male	76.0 (19)	16.0 (4)	4.0 (1)	4.0 (1)	80.6 (25)
Female	50.0 (3)	50.0 (3)	---	---	19.4 (6)
	71.0 (22)	22.6 (7)	3.2 (1)	3.2 (1)	100 (31)

They were distributed evenly among the counselor groups. Five of the six were of Spanish descent, either Mexican or Puerto Rican, and four of the six were males.

Generally speaking, it seems that the ethnic and sex composition of the three counselor groups was not discordant with previous knowledge of the levels of education and rates of drug addiction among males and females of various ethnic groups in the population. With regard to ethnicity in particular, one might hypothesize that the composition of the groups also reflects the job opportunities that are available to different ethnic groups in our society and the abilities of different groups to have access to higher and lower level staff positions.

Another background item significantly differentiating counselor groups was age. Analysis of variance indicated that PROs with a mean age of 29.87 years were significantly younger than either NEAs with a mean age of 36.48, or EAs with a mean age of 39.40 ($F(2,78)=11.12$, $p<0.001$). The age differences are not surprising since PROs often come straight from college graduation to counseling positions, while NEAs have often pursued other early careers before coming to drug counseling. EAs must, of course, run the gamut of addiction and cure before becoming counselors.

Work Experience

The younger age of the PROs is also consistent with the average time they had spent in their current positions, compared to the other groups. PROs averaged about a year and a half tenure in their current positions, compared to slightly more than 2 years for EAs and 3 years for NEAs ($F(2,79)=3.74$, $p<0.05$). In addition to age, another possible explanatory variable for job tenure is the more limited job mobility of the paraprofessional, which may contribute to job stability.

The NEAs were most likely to have previous experience as counselors, even if that experience was not directly in drug treatment programs. Although the differences among groups did not reach statistical significance here ($\chi^2(2)=4.61$, $p<0.10$), they are of interest as a possible indication of the way the groups are viewed by program administrators and other employment decisionmakers. That is, since only 61 percent of EAs had previous counseling experience compared to 81 percent of the PROs and 85 percent of the NEAs, one might hypothesize that the EAs experience as addicts has often been seen as equal to or more valuable than direct counseling experience when selecting counselors.

It is also true, however, that the EAs had somewhat more cumulative experience on the average in drug counseling per se (16 months) than did the NEAs (13 months) or the PROs (7 months), although the differences were not significant. This in itself, of course, might lead to favorable views of the EAs by program administrators compared to other groups. The greater experience of the NEAs was acquired in two other counseling environments--mental health and, especially, the criminal justice system. The PROs had somewhat more experience in counseling in schools, in which environments the experience of the other groups was quite limited.

Education and Training

Given the definitions of counselor groups, few unexpected responses to questions on education could be found. The PROs, of course, all had bachelors' degrees, 42 percent of them had masters' degrees and 29 percent of the rest had at least some graduate training. In contrast, 95 percent of the NEAs and 84 percent of the EAs had high school diplomas, post high school certificates, or at most some college training. The remaining 5 percent of the NEAs and 16 percent of the EAs had less than a high school education.

With the idea that area or field of degree might have some impact on PRO counselor's activities, attitudes, and achievements, their college majors and majors at the master's level were examined individually and together. By far the most popular college major was psychology (40 percent) with sociology second (16 percent) and other social science areas next (another 20 percent). The remainder of majors represented a cross-section of general liberal arts and allied subjects. Areas of concentration for masters' degrees among the 13 counselors who had them were much the same--with psychology, social work, or criminology and sociology the most frequent choices. Relatively little switching of fields was observed from bachelor's to master's work. Only one of the 13 masters' degrees was in a nonsocial science field--student personnel services. However, it is of some interest that not one of the masters' degrees was in counseling per se.

When the paraprofessional groups were asked to enumerate their completed college credits, if any, the NEAs counted an average of 41 credits, and the EAs averaged 21 ($F(1,49)=8.00$, $p<0.01$). The above credit

averages show that both groups have had substantial opportunity for exposure to relevant course work. Indeed when the paraprofessional groups are compared to the PROs in number of counseling courses, PROs report an average of only 4 more courses (PROs averaged 8 in toto) than either paraprofessional group. The difference does not reach statistical significance. It should be kept in mind, however, that these courses may have been high school, college, or graduate school courses--or even weekend seminars, so long as they were offered "in school." When other courses relevant to counseling were inquired about--such as abnormal psychology, personality theory, social deviance--PROs reported significantly more courses (9.72) than either NEAs (5.55) or EAs (2.13) ($F(2,76)=7.70$, $p<0.001$). Generally, while completed study units were certainly more prevalent among the PROs, a fair amount of relevant course work also showed up in the histories of the NEAs, and even the EAs.

Most would agree that many of the appropriate learning experiences for the drug counselor are encountered outside the classroom, in formal or informal training situations within treatment programs. It is noteworthy, then, when training by the current and previous drug program was examined, the EAs were much less likely than NEAs to have had such training. This is especially true for training by a previous program in which only 42 percent of the EAs compared to 58 percent of the PROs and 80 percent of the NEAs had received such training ($\chi^2(2)=7.71$, $p<0.05$).

This again suggests the value, indeed the "mystique," of the addict experience as a selection factor in employment and as an accepted substitute for counseling training and experience. NEAs, having neither the education of the PROs nor the addiction experience of the EAs, may be viewed as requiring compensatory amounts of program training and/or previous experience with counseling.

Despite differences among the groups in the amount of training each has received, on the average, from current and previous jobs as well as in school, significant differences did not appear for individual training topics. The EAs report less frequently that they have been trained on a number of topics, but not consistently so. Indeed, of the nine topics listed in table 4, EAs reported having been trained, on the average, in 6.23, while the corresponding numbers for the PROs and the NEAs were only 6.90 and 7.20, respectively. These differences do not approach statistical significance. Table 4 shows that across topics ranging from the physical an psychological effects of specific drugs to outreach counseling and specific approaches to therapy, a majority of counselors had studied each one, with the exception of program administration which had been studied by only 40 of the 82 counselors.

One quite frequently studied topic, as might be expected, was counseling techniques along with specific therapy methods. More interesting perhaps is the emphasis apparently placed on clerical functioning in the training of these counselors--more than 90 percent of each group claimed to have studied it, making it the most common subject of training. This is perhaps some indication that the typical counselor complaint against the omnipresent concern with paperwork has some justification.

Overall, the data show similarity among the groups in amount of training on most topics--or at least inconsistent differences among the groups from topic to topic--with the EAs somewhat, though not significantly, less often trained. Perhaps the most salient finding is the relatively high frequency of training for all the groups across almost all training areas. The training results from on-the-job training and other settings as well as formal course work. The relative equality of the groups in areas studied may therefore be due to, for example, a balance of heavier formal course work among PROs, inservice training for the NEA, and somewhat less heavy input in both areas for the EA. Another implication is that while the counselor groups have different backgrounds and different images, the areas in which they are expected to perform and their roles and functions within those areas may be largely the same.

Counselor Drug and Treatment Experience

Another aspect of counselor experience which may be associated with counselor roles, activities, and attitudes is type and extent of substance abuse on the part of the counselor. Forty-five percent of the PROs, 15 percent of the NEAs and, as hoped for validation purposes, 100 percent of the EAs reported having used and abused various drugs. In table 5, the proportions of counselors in each group reporting that they had ever used each substance are presented. Heavier use of a variety of drugs including heroin, barbiturates, cocaine, and alcohol was reported by NEAs compared to PROs. PROs, on the other hand, were more likely to report use of opiates and synthetics other than heroin and hallucinogens. It should be pointed out, however, that only 16 percent

Table 4. Topics of training, by counselor group
(Table presents percent answering "yes" for each item)

Q. 26. Considering all your training in school, on the job, or in special seminars or conferences, have you studied:

	Professional	Non-ex-addict paraprofessional	Ex-addict paraprofessional
a. The physical and psychological effects of specific drugs?	90.3 (28)	85.0 (17)	77.4 (24)
b. Individual or group counseling techniques?	93.5 (29)	95.0 (19)	87.1 (27)
c. Specific therapy methods; for example, directive therapy, client-centered therapy?	90.3 (28)	85.0 (17)	74.2 (23)
d. Laws relating to drug abuse?	77.4 (24)	85.0 (17)	67.7 (21)
e. Administration of drug treatment programs?	45.2 (14)	60.0 (12)	45.2 (14)
f. Client control and enforcement procedures?	67.7 (21)	85.0 (17)	61.3 (19)
g. Outreach counseling, or counseling in the community?	51.6 (16)	70.0 (14)	58.1 (18)
h. Clerical function of counselors, such as, how to fill out admission forms, take treatment progress notes?	93.5 (29)	95.0 (19)	90.3 (28)
i. Vocational guidance or counseling techniques?	80.6 (25)	60.0 (12)	61.3 (19)
N	100.0 (31)	100.0 (20)	100.0 (31)

Note — No significant differences among groups in percentage studying each topic.

Table 5. Counselor experience with specific drugs, by counselor group[1]
(Table presents percent answering "ever used")

Q. 30. How often, if ever, have you tried each of the following drugs or groups of drugs?

	Professional	Non-ex-addict paraprofessional	Ex-addict paraprofessional
Heroin	9.7 (3)	20.0 (4)	96.8 (30)
Illegal methadone	0	0	42.0 (13)
Other opiates and synthetics (with morphinelike effects)	16.1 (5)	5.0 (1)	67.8 (21)
Barbiturates	19.3 (6)	35.0 (7)	61.3 (19)
Other sedatives, hypnotics, or tranquilizers	19.5 (6)	20.0 (5)	35.5 (11)
Amphetamines	32.3 (10)	35.0 (7)	61.3 (19)
Cocaine	22.6 (7)	40.0 (8)	90.3 (28)
Marihuana/hashish	45.2 (14)	50.0 (10)	96.8 (30)
Hallucinogens	35.4 (11)	20.0 (5)	35.4 (11)
Inhalants	6.5 (2)	5.0 (1)	32.3 (10)
Alcohol to excess	9.7 (3)	30.0 (6)	48.4 (15)
N	100.0 (31)	100.0 (20)	100.0 (31)

[1]Seventeen PROs (55 percent) and 9 NEAs (45 percent) reported no drug use in any of the categories.

of PROs and 5 percent of NEAs reported such use. In general, except for the greater frequency of use of almost all substances (with the exception of hallucinogens) among EAs, there were no statistically significant group differences. The low estimates for "alcohol" may be due to interpretations of the term "in excess"--for example, the counselor may have taken that to mean a series of many days or weeks of drinking.

When EA counselors were asked about their treatment histories, if any, 29 of the 31 reported having been in treatment. Both EAs who had not been in treatment had been addicted to heroin. Regarding other drugs listed, both these EAs reported substantial use only of marihuana/hashish and cocaine.

Given the definitions of the other counselor groups, no histories of addiction were anticipated, and the data confirmed this. However, with respect to treatment, one of the PROs had spent 4 months in a work-release therapeutic community following an arrest for possession of marihuana some years ago. This was not seen as invalidating his status as a PRO counselor for purposes of the study.

For those among the ex-addicts who had been in treatment, length of time spent in various modalities was seen as germane to roles, and functioning as a counselor. As expected, a number of EA counselors (10) had been in more than 1 treatment modality--in total, 20 had been in drug-free programs, 14 had been in chemically supported detox, and 12 had been on methadone treatment. Of those who had been in drug-free programs, the median time spent in such programs was about a year. For those who had been in detox, the median number of months in detox was 16 1/2. The corresponding figure for those who had been treated with methadone was 20 months. In each case the mean number was more than twice the median, since a few counselors in each modality had been in treatment for long periods of time. In all, the median number of months in treatment across all modalities for the 29 ex-addicts who had received treatment was 22.

The EAs, then, have brought to their current jobs substantial drug and treatment histories and experiences. While sizable proportions of the PROs and NEAs had used a variety of drugs, only one of them had spent even a short time in treatment.

It is apparent that many of the general beliefs among researchers and workers in the field regarding background and demographic differences between paraprofessionals and professionals are true for the current sample. As expected, greatest contrast is between PROs and EAs. However, it is also noteworthy that the EAs and NEAs are much closer to each other demographically, indeed are virtually indistinguishable, than either is to the PRO group. As has been pointed out, PROs are much more likely to be white/Anglo, to be female, and to be younger than EAs and NEAs. It would seem justifiable to conclude that the paraprofessional groups do, in fact, reflect the community served, whereas the professionals do not.

The EAs differ, by definition, from NEAs and PROs in amount and quality of experience with drugs. The amount of drug use, however, is considerable among all counselor groups with about half of the PROs and NEAs reporting use (at least once) of one or more drugs listed. About a third of both groups report some use of amphetamines, while substantial use of hallucinogens and cocaine is also reported. Heroin use by NEAs and PROs, though less frequent, is not uncommon. There is some evidence, then, that counselors, professional as well as paraprofessional, may be at least tenuously associated with the "drug culture" when they decide to become counselors, or that they develop such an association through their working environment.

The counselor groups also differ in the amount of education, training, and experience as counselors. PROs, by definition here, have the most education. They have, however, the least experience and the least inservice training as counselors. NEAs, on the other hand, have the most experience as counselors, more education than EAs, and more specific inservice training as counselors.

It is of particular interest that, as shall be seen in the next section, all counselor groups perform pretty much the same activities. One may conclude, then, that experience with drugs, education, counseling experience, and inservice training as counselors are seen by program administrators as compensatory assets which are in some way capable of substituting one for another. That is, there seems to be an unspoken assumption that the formal course work and some inservice training for the PROs is equivalent to the counseling experience and extensive inservice training of the NEA, which is, in turn, equivalent to the addiction experience and some inservice training for the EAs.

4. RESULTS OF QUESTIONING ON FUNCTIONS AND ACTIVITIES

Free-Answer Questions

Hours Worked Per Week and Income

On the basis of the literature, it was expected that paraprofessionals might work longer hours than professionals and for less pay. This expectation was supported. On the average, the EA counselors worked significantly more hours per week than did PRO counselors, $F(2,79)=3.67$, $p<0.05$, with mean number of hours worked per week of 40.4, 41.7, and 44.4 for the PRO, NEA, and EA groups, respectively (table 6). This difference was accounted for by the overtime work of the EAs which exceeded that of PROs, $F(2,79)=3.35$, $p<0.05$. Median annual incomes of the three groups were highly similar--$10,934, $10,500, and $10,068 for the PRO, NEA, and EA groups, respectively. However, while 23 percent of the PRO group earned $15,000 or more per year, this was true of only 13 percent of the EA group and 5 percent of the NEA group.

Caseload and Hours Devoted to Counseling

It might be expected that professionals with their more extensive training in counseling and psychotherapy would be more heavily involved in direct counseling of clients than paraprofessionals. On the other hand, there are copious examples in the literature of the involvement of paraprofessionals in individual and/or group counseling. The heavy involvement of paraprofessionals in direct counseling is evident in the present sample.

Caseloads did not differ significantly in size across groups, ranging from just under 32 clients per NEA counselor to 34 per EA counselor and 43 per PRO counselor. The higher mean of the PROs is mostly accounted for by one counselor who stated he had 121 clients. (As seen from table 6, items c, e, and f, EAs but not NEAs spend proportionally less of their workweek in counseling sessions, with proportions of 0.52, 0.49, and 0.40 of total hours worked in all spent in counseling sessions by the PRO, NEA, and EA groups, respectively.) The PRO counselors tended to spend slightly more time in counseling sessions with individual clients than did EAs, $F(2,79)=2.60$, $p<0.10$. In contrast, EAs spent significantly more time than PROs in group counseling sessions $F(2,79)=3.31$, $p<0.05$. The NEA group fell between the PRO and EA groups in both individual and group counseling times.

Job Activities Other Than Direct Counseling

Counselors were asked to describe the main job activities, other than direct counseling sessions, on which they spent their time. As expected from the range of activities reported for professionals and paraprofessionals in the literature, a variety of activities which overlapped across counselor groups were reported by this sample of counselors. The many activities reported were classified into 12 areas which were mentioned in order of frequency of occurrence from highest to lowest across all groups as follows: clerical and service, counseling services,[6] counseling in the community, administration of clients, administration of the program, socializing with clients, personal aid to clients, control and enforcement, staff training, interagency relationships, psychological assessment, and finally community education. The groups were remarkably consistent in the activities mentioned. Spearman rank order correlations of the frequencies of mentioning activities in each category across counselor group were 0.97 for PROs versus EAs, 0.97 for PROs versus NEAs, and 0.98 for NEAs versus EAs.

The majority of the responses of each counselor fell into three categories. Clerical and service duties of one sort or another comprised 33 percent of all activities mentioned by PROs; 36 percent for NEAs, and 37 percent for EAs. For counseling services the corresponding percentages were 16 percent, 24 percent, and 17 percent for the PROs, NEAs, and EAs, respectively. Counseling in the community comprised 13 percent, 22 percent, and 14 percent of all activities mentioned by PROs, NEAs, and EAs.

In sum, the activities of the counselors in the present sample reflected the breadth of activities reported in the literature. Moreover, the three counselor groups reported

[6]Counseling services included services performed by counselors other than direct counseling of the client, for example, setting up job interviews, arranging for medical care, and seeing other members of the client's families. This area replaces counseling in the treatment center as used in the literature review and the activities list, since activities other than counseling per se were requested here. With this exception and the omission of the research category mentioned by no one in response to this question, the category list is the same as that used in the literature review.

Table 6. Mean response value to questions describing counselor functions and activities, with standard errors given in parentheses, by counselor group:

	Professional	Non-ex-addict paraprofessional	Ex-addict paraprofessional	p[1]
a. Total regular hours worked each week	38.45 (.43)	37.75 (1.42)	39.16 (.46)	NS
b. Average hours worked overtime per week	1.90 (.61)	3.90 (1.17)	5.26 (1.14)	0.05
c. Total hours worked per week	40.35 (.75)	41.65 (1.37)	44.42 (1.31)	0.05
d. Number of clients for whom respondent is primary counselor	43.03 (5.36)	31.75 (4.56)	34.00 (3.69)	NS
e. Average hours per week in individual counseling	19.55 (1.59)	18.55 (2.07)	14.74 (1.30)	0.10
f. Average hours per week in group counseling	1.23 (.29)	1.90 (.52)	2.94 (.62)	0.05

[1]Significance level of F test in one factor ANOV.

highly similar involvement levels with the various activities. These findings are corroborated in the more extensive data set gathered from the activities list, which data are reported below.

Counselors' Desire for Activity Modification

Counselors were also asked how, if at all, they would modify their work activities to be in line with what a counselor should ideally do. One-fifth of the PROs and NEAs suggested no modification while fully a third of the EAs made no suggestions for change. Of all modifications suggested, the most frequently suggested in each group was a decrease in paperwork, comprising 25 percent, 23 percent, and 24 percent of the suggestions made by PROs, NEAs, and EAs, respectively. The complete elimination of clerical and other services not associated with client contact comprised another 8 percent, 15 percent, and 19 percent, of the suggestions made by PROs, NEAs, and EAs, respectively. Members of all groups suggested increased contact with clients, with mentions of generally more involvement with clients (23 percent, 19 percent, 19 percent for PROs, NEAs, and EAs, respectively), increased time for counseling and therapy (20 percent, 23 percent, 14 percent for PROs, NEAs, and EAs, respectively), and decreased caseloads in order to see patients more often and for longer periods of time (18 percent, 15 percent, 17 percent for PROs, NEAs, and EAs, respectively). These percentages are again quite similar for all three groups for the most part, with no statistically significant differences in evidence.

Activities List

If differences did exist among the three counselor groups in their job activities, it was on the comprehensive activities list that a picture of such differential functioning would be most likely to be observed. The list had been devised to tap a broad range of potential activities of counselors. On the one hand, activities were included which placed the counselor in a caregiver role, e.g., helping clients with housework or cooking. On the other hand, activities were included which covered the highest administrative functions in the program, e.g., making up budgets, hiring and firing staff members, or which required high levels of training, e.g., the interpretation of psychological tests.

Each activity was considered separately. Responses of counselors were examined in a series of one factor analyses of variance with counselor group as the independent variable and the rank of the response as the

dependent measure.[7] To summarize the items in each area, a multiple discriminant analysis was also run, with the three counselor groups as the criterion groups and the scores on the activities in one area as the predictors. (Results of the one factor ANOVs are given in table 7).

There were six areas for which no differences among groups were found in either the univariate ANOVs or the multivariate test. These were areas in which no differences would be expected, either because of the high involvement of all counselors, e.g., in clerical tasks, or the uniform low involvement of all counselors, e.g., in psychological assessment. The high involvement areas in which there were no differences were clerical and service duties, control and enforcement, and counseling in the treatment center. The relatively low involvement areas in which there were no differences were psychological assessment, staff training, and administration of the program (for all univariate F tests on individual activities, $p>0.20$; for all F approximations to Wilk's Lambda, the overall multivariate test of differences among groups on the set of predictors, $F<1$).

In two areas, administration of clients and personal aid to clients, there was a suggestion of a difference among counselor groups. In the area of administration of clients, one item tended toward significance. This item was attending staff meetings that deal with client treatment, $F(2,78)=2.33$, $p=0.10$. The PRO counselors reported doing this slightly less frequently than either paraprofessional group. This was not corroborated by administrators who reported equal high attendance for all groups. It is reasonable that professionals might attend such staff meetings slightly less frequently than paraprofessionals, since these staff meetings may be part of the inservice training provided by programs to paraprofessionals, as was reported in the literature. The area of personal aid to clients provides a similar result. There was a tendency for PROs to report that they accompanied clients to community resource agencies slightly less often than did either paraprofessional group, $F(2,77)=2.38$, $p<0.10$. In this case, the percentages of clients who reported their counselors did this were 2.6 percent, 8.6 percent, and 7.2 percent for clients of PROs, NEAs, and EAs, $\chi^2(2)=3.56$, $p>0.10$. Among administrators, 38 percent reported none of their counselors did this. Of those mentioning the involvement of a counselor group, 62 percent mentioned PROs as involved, 55 percent mentioned NEAs, and 55 percent mentioned EAs.[8]

Where clear differences were found among counselor groups, these differences were invariably in activities which took the counselor out of the program. In the area of community education, EAs were significantly more frequently involved than were professionals in giving talks to community groups, $F(2,79)=5.19$, $p<0.01$. Administrators corroborated this; 82 percent mentioned the involvement of EAs, while only 39 percent mentioned the other two groups.

In the area of socializing with clients, EAs reported meeting clients on their own time in public places for socializing, for example, having lunch with a client, going to a ball game with a client, significantly more often than did professionals, $F(2,79)=6.52$, $p<0.01$. Administrator reports corroborated this in that only one administrator (3.5 percent) indicated that PROs did this, only three administrators (10.3 percent) indicated that NEAs did this, while 31.0 percent of administrators reported that EAs did this. Client responses were in the same direction: 8.8 percent, 7.1 percent, and 17.0 percent of clients of PROs, NEAs, and EAs reported meeting their counselors at least once a year to socialize in a public place. On a second item in this area, that of counselors' meeting clients on their own time to socialize in their own homes or the clients' homes, clients of EAs reported this happened significantly more often than did clients of PROs, $F(2,293)=4.01$, $p<0.05$ (3.5 percent, 10.0 percent, versus 14.3 percent of clients of PROs, NEAs, versus EAs reported that this happened at least once a year). The corresponding percentages as reported by PROs (6.5 percent), NEAs (10.0 percent), and EAs themselves (17.2 percent); as well as those reported by the administrators (3.5 percent, 3.5 percent, and 17.2 percent for PRO, NEA, and EA groups, respectively) corroborate the clients' reports.

[7]Data were coded as follows: 0=never, 1=once or twice a year, 2=three or four times a year, 3=once or twice a month, 4=once or twice a week, 5=just about every day.

[8]Administrators responded for each group of counselors in their program.

Table[1]7. Mean participation level of counselors in activities, by counselor group. (0 = never, 1 = once or twice a year, 2 = three or four times a year, 3 = once or twice a month, 4 = once or twice a week, 5 = just about every day)

ACTIVITY	PRO	NEA	EA	ANOV	Tukey A(0.05)
I. Community education					
01. Give talks about drug abuse to community groups?	0.74	0.95	1.81	$F(2,79)=5.19^{1}$	P < E
02. Inform community groups about the services your program provides?	1.67	1.70	2.26	F(2,78)= .87	---
II. Clerical and service duties					
03. Fill out forms which deal with client admission, progress, and/or discharge?	4.58	4.50	4.40	F(2,78)=0.24	---
04. Carry out clerical tasks such as filing, typing letters, covering the telephone switchboard?	4.16	3.80	3.90	F(2,78)= .33	---
05. Do maintenance tasks in the agency such as cleaning, making repairs?	1.42	1.65	1.32	F(2,79)= .21	---
06. Perform messenger services between the treatment center and other centers or offices?	1.87	2.11	1.90	F(2,78)= .11	---
III. Control and enforcement					
07. Discipline clients when necessary, by keeping down noise, breaking up fights, or removing verbally abusive clients from the center?	2.61	2.35	3.13	F(2,78)=1.31	---
08. Inform police of drug-dealing activities, either dealing by clients or by others?	.26	.30	.16	F(2,79)= .20	---
09. Take responsibility for coordinating and controlling traffic at the center?	3.76	3.45	3.30	F(2,73)= .37	---

[1] $p < 0.01$

Table 7 (Continued)

ACTIVITY	PRO	NEA	EA	ANOV	Tukey A(0.05)
IV. Socializing with clients					
10. Provide social activities for clients under the auspices of the program, for example, a picnic for clients of the program?	1.23	1.15	1.39	F(2,79)=0.15	---
11. Meet clients on their own time in public places for socializing, for example, having lunch with a client, going to a ball game with a client?	.42	1.40	1.71	F(2,79)=6.52[1]	P < E
12. Meet clients on their own time to socialize with them in their own homes or the clients' homes?	.06	.20	.34	F(2,77)=1.53	---
V. Counseling in the community					
13. Visit clients at their place of employment in the community?	0.42	1.00	0.55	F(2,79)=1.71	---
14. Accompany clients into the community when they have job interviews?	.29	0.30	.28	F(2,77)= .01	---
15. Go into the community and visit a client in the hospital if he has become hospitalized?	1.03	1.18	1.93	F(2,72)=4.93[1]	P < E
16. Go into the community to appear in court on a client's behalf if the client is called to court?	.77	1.50	1.52	F(2,75)=2.99[2]	P < N = E (0.10)
17. Spend time becoming familiar with community resource agencies in order to know exactly where to send clients for these services in the community?	2.77	3.10	2.97	F(2,78)= .26	---

[1] $p < 0.01$
[2] $p < 0.10$

Table 7 (Continued)

ACTIVITY	PRO	NEA	EA	ANOV	Tukey A(0.05)
VI. Personal aid to clients					
18. Accompany clients to community resource agencies where the clients can get help, for example, a social work agency, a daycare facility?	0.71	1.35	1.41	$F(2,77)=2.38^2$	P < E (0.10)
19. Give personal care to clients, for example, helping them with housework or cooking, buying food for them?	.42	.55	.40	F(2,78)= .10	---
20. Go into a client's neighborhood to help him deal with people with whom he may be having problems, for example, someone who is leaning on him to repay a loan?	.03	.25	.30	F(2,78)=1.51	---
21. Go into the clients' homes to discuss their problems with other members of their families?	.73	.70	1.17	F(2,77)=1.09	---
VII. Administration of clients					
22. Decide whether a client will be accepted into your treatment program?	1.19	2.11	1.61	F(2,78)=1.21	---
23. Assume responsibility at the center for deciding whether clients should remain in the program?	2.29	2.21	2.47	F(2,77)= .14	---
24. Attend staff meetings that deal with client treatment?	3.71	4.05	4.00	$F(2,78)=2.33^2$	---
25. Make the decision about support services (e.g., vocational training or psychiatric workups) for clients?	3.68	3.74	3.48	F(2,74)= .21	---

$^2p < 0.10$

Table 7 (Continued)

ACTIVITY	PRO	NEA	EA	ANOV	Tukey A(0.05)
VIII. Administration of program					
26. Supervise other workers, for example, assigning clients, making out work schedules?	1.61	1.11	1.35	F(2,78)=0.38	---
27. Carry out tasks that have to do with money matters of the agency, for example, keeping track of costs of the agency, making up budgets?	.29	.26	.06	F(2,78)= .58	---
28. Participate in tasks that have to do with the staffing of the agency, for example, finding people to work, deciding who should be hired or fired?	.58	.63	.57	F(2,77)= .02	---
29. Participate in reviewing and revising policies of the program?	1.65	1.68	1.55	F(2,78)= .05	---
30. Evaluate the effectiveness of services provided by the treatment program?	2.19	1.80	1.77	F(2,79)= .48	---
IX. Counseling in treatment center					
31. Tell clients about the programs, services, and kinds of help your agency can give them?	4.48	4.67	4.48	F(2,77)=0.43	---
32. Discuss with the client problems his family and friends may be having with regard to drugs?	3.84	4.11	4.03	F(2,77)= .34	---
33. Conduct group counseling sessions?	1.90	1.50	1.68	F(2,79)= .27	---
34. Talk to clients about their childhood?	4.00	3.47	3.57	F(2,74)=1.19	---
35. Explain the advantages and disadvantages of methadone and abstinence to clients?	3.90	3.85	3.90	F(2,78)= .01	---
36. Review urine results of clients regularly?	4.16	3.89	4.19	F(2,78)= .45	---
37. Thoroughly discuss the specific reasons and circumstances that led the client to drug use?	3.71	3.60	4.06	F(2,79)= .61	---
X. Psychological assessment					
38. Administer psychological tests and examinations to clients, for example, personality tests, job preference tests?	0.68	0.45	0.35	F(2,79)=0.49	---
39. Interpret psychological tests and examination results, and make recommendations on the basis of their outcomes?	.87	.35	.83	F(2,78)= .87	---

Table 7 (Continued)

ACTIVITY	PRO	NEA	EA	ANOV	Tukey A(0.05)
XI. Staff Training					
40. Explain to new counselors the procedures and rules of the program, for example, how to fill our forms used by the program?	1.59	1.85	1.50	$F(2,72)=0.33$	---
41. Participate as instructors in training programs which deal with drug abuse counseling?	.87	1.05	.63	$F(2,78)= .64$	---

Again in the area of counseling in the community, EAs report themselves to be more active than PROs. The EAs report visiting hospitalized clients significantly more often than do PROs, $F(2,72)=4.93, p<0.01$, with 58.1 percent, 70.6 percent, and 89.9 percent of PROs, NEAs, and EAs reporting doing this at least once a year. Administrators corroborate this ordering of counselor groups with 75 percent of administrators reporting that the PROs visit clients, and 78.6 percent and 85.7 percent of administrators report this for NEAs and EAs, respectively. Client reporting for this item provides the one inconsistent picture across all functions and activities examined. There were 27, 16, and 26 of the 116, 71, and 115 clients of PRO, NEA and EA counselors who were hospitalized since having become clients of their current counselors. These clients were asked whether their counselors had visited them in the hospital. Only 14.8 percent of clients of PROs and 19.2 percent of clients of EAs responded that their counselors had visited them, while 62.5 percent of the clients of NEAs reported that this was so, $\chi^2(2)=12.89$, $p<0.01$. The disagreement of clients with counselors and administrators may stem from several sources. First, relatively few clients in the sample had been hospitalized, an average of less than one client per counselor. Second, counselors and administrators responded about their general behavior patterns, while clients responded about their particular experiences. Whether particular clients were visited in the hospital might well have been related to the nature of the ailment and the length of the stay. For these reasons, the counselor and administrator reports are taken as the more accurate reflections of counselor functioning.

There was also a trend toward a difference among counselor groups in the counseling in the community activity of appearing in court in the client's behalf if the client is called into court. The PRO group tended to report doing this less often than either paraprofessional group, $F(2,75)=2.99, p<0.10$. In the PRO, NEA, and EA groups, 45.2 percent, 60 percent, and 70.4 percent of counselors reported having done this at least once a year. Administrator percentages for these three groups, respectively, were 65.5 percent, 72.4 percent, and 75.9 percent. Of the 28, 15, and 29 clients of PRO, NEA, and EA counselors who had had a court trial since having become clients of their current counselors, 10.7 percent, 20 percent, and 17.2 percent, respectively, reported that their counselors had come to court to testify, $\chi^2(2)=0.67$, $p>0.20$.

Overall, the main difference noted among counselor groups was the greater activities of EAs over the PROs outside the treatment program. This difference was found in three areas of counselor functioning: community education, socializing with clients, and counseling in the community.

Discriminant analyses applied to the set of activities in each of these areas corroborated the univariate analyses. In all three cases, the F approximation to Wilk's Lambda for overall significance of discrimination among groups reached the 0.05 level of significance, with EAs distinguished from PROs on each of the three sets of items in question, $p<0.05$ in all three cases.

While these significant differences emerged, it is important to note the differences among counselors within groups. Not all EAs gave talks to community groups. Fully a third of the EAs had never done so and in this regard were similar to the 58 percent of PROs who had never done so. The difference between the groups emerged in that there was a substantial percentage of EAs who spoke at least once or twice a month (36 percent), while far fewer professionals (10 percent) spoke to community groups with this frequency.

In the area of socializing with clients, a similar result emerged. Slightly over half (55 percent) of EAs reported never socializing with clients in public places in contrast with three-quarters (77 percent) of PROs who never did so. It is the 42 percent of EAs versus the 6 percent of PROs who socialized with clients at least once a month who led to the overall difference between the groups.

What is being suggested here is that some but not all EAs exhibit a unique pattern of concentrating their efforts in the community. A large percentage, however, were more like the PROs who more heavily concentrated their efforts within the treatment program. This notion of two types of EA roles was supported by the statistical classifications of EAs in the context of the discriminant analyses for the community education and socializing with clients items. In such classification analyses, a substantial subset of EAs were classified as being statistically more similar to the PROs than to other EAs.

Counselor-Category-Independent Correlates of Functions and Activities

As previously suggested, it was possible that there were correlates of counselor involvement in activities, over and above counselor group. To explore this possibility, partial correlations of counselor characteristics with involvement levels in activities were examined; counselor group was dummy-variable coded and then partialed out of these correlations. Simply stated, these correlations answer the following questions: Does one know more about the activities in which a counselor engages by knowing about his particular background as well as his counselor group membership than one knows by just having his counselor group membership?[9]

For example, there was no overall difference among counselor groups in involvement in psychological assessment. In general, few in any group were involved in administering psychological tests. In this sense, knowing the group to which a counselor belonged gave no information as to whether he was more likely to be involved in assessment than a member of any other group. Yet in each counselor group there were a few counselors who reported involvement in this activity at least once or twice a month. The significant partial correlation of number of counseling courses with this activity of 0.37, $p<0.01$, suggests that those counselors with more training in counseling courses did the testing, independent of the particular counselor group into which they fell. A similar significant partial correlation between number of counseling courses and involvement in interpreting psychological tests of $r = 0.36$, $p<.0.01$, suggests that those same counselors who had had a relatively large number of counseling courses were also the ones who did test interpretation, regardless of their counselor group. In the area of staff training, there is again a significant partial correlation of number of counseling courses with having participated as an instructor in training about drug abuse counseling, $r = 0.27$, $p<0.05$. This variable is also correlated with deciding whether a client would be accepted into the treatment program, $r = 0.25$, $p<0.05$; and supervising other workers, $r = 0.24$, $p<0.05$. In sum, the number of counseling courses, an index of the relevance of coursework to the counselor role, accounts for involvement of counselors in counselor training, psychological assessment, staff supervision, and intake decisionmaking over and above their designation as members of PRO, NEA, and EA group.

There are apparently seniority and/or experience effects in the functions counselors perform. With counselor group partialed out, the number of months in present position was correlated with frequency of supervision of other workers, $r = 0.28$, $p<0.05$, as was the total number of months of previous counseling experience, $r = 0.32$, $p<0.01$. Experience was also correlated with engaging in activities outside the treatment program. The number of months in present position was significantly correlated with visiting a client in the hospital, $r = 0.39$, $p<0.001$. Similarly, the total months of previous experience was correlated with a counselor's going into clients' neighborhoods to help them with problems, $r = 0.24$, $p<0.05$. In contrast, the number of months in present position was negatively correlated with the psychologically oriented counseling activity of talking to clients about their childhood, $r = -0.25$, $p<0.05$. Surprisingly, it was the counselors with little previous experience in drug abuse counseling who were involved in explaining procedures and rules of the programs, e.g., how to fill out forms used by the program, to the counselors, $r = -0.24$, $p<0.05$.

These correlations of activity with experience seem consistent with other correlations of activity with training. Breadth of

[9]These analyses should be considered as exploratory in nature, due to the absence of a cross-validation sample.

inservice training, measured by the number of different topics covered by counselors in all training courses was positively related to visiting clients at work, $r = 0.27$, $p<0.05$, and with spending time becoming familiar with community resource agencies, $r = 0.24$, $p<0.05$. The greater the number of "relevant courses" to counseling, e.g., deviance, abnormal psychology, taken by the counselor, the less likely the counselor was to appear in court on a client's behalf, $r = -0.23$, $p<0.05$. What emerges here is a picture of more experienced counselors and/or those with heavy inservice training being more oriented toward counseling in the community, in visiting clients at work, in the hospital, and in their neighborhoods, and in concerning themselves with community resource agencies, while those with less experience but more relevant course work are oriented to psychological approaches to counseling in the treatment program.

It may be that experience and/or inservice training as opposed to formal course work encourages the development of sufficient confidence on the part of the counselor to undertake a role in the community. The lack of such experience or training, on the other hand, may lead to greater program-centered activity in which the individual feels more comfortable. It may also be that formal course work by traditional tutors encourages the view that the program is a more appropriate setting for counselor functioning.

In any case, the fact that different counselor types place different emphasis on counseling in the community, socializing with clients, etc., elicits more questions than answers. For example, one would wish to know not only why differing roles are undertaken, but what is accomplished thereby in terms of client performance and what is implied about differences in client-counselor relationships. Since the implications may be expected to be of some magnitude, these areas are in need of further investigation and clarification in future studies.

Administrators' Views of Counselor Functions

Another perspective on the functions and activities performed by the different counselor groups was gained from interviews with administrators. Specifically, each of 41 activities was inquired about with the following question: "Of the three counselor groups in which we are interested--that is, professionals, non-addict paraprofessionals, and ex-addict paraprofessionals--which group, if any, is more involved in (activity)?" In addition, administrators were asked which groups they thought should be involved more than the others in each activity. Reasons for administrator views on who should be more involved were then cross-tabulated with the question on who should be more involved. In the following paragraphs, the results of the cross-tabulations of those questions for the 41 activities are discussed.

Table 8 presents a list of the 41 activities with number of administrators reporting all counselor groups or none are involved and/or should be involved with each activity. The logic of this presentation is that administrators divided their responses to most activities into those two categories--that is, they tended to say that the activity was either performed by all groups with equal frequency, or that no group was performing it. Further, administrators usually felt that this arrangement was most appropriate. Individual tables for activities are only presented when some marked departure from this tendency or some meaningful difference among groups was seen--i.e., when one counselor group or another was viewed as more involved than others or more appropriate for such involvement.

It should be remarked that while administrators differed in their educational and experiential background, and also in age, race, and sex, viewpoints about counselor groups measured by these questions were not differentiated by such background differences. Also, a general caveat concerning small numbers--only 28 administrators were interviewed in the study--is, of course, appropriate here. Indeed, in some cases the number answering the questions is less than 28 due to item nonresponse.

The activities are discussed below in categories for efficient summarization and individually as seems warranted.

In the first category, community education, are two items, one of which concerns giving talks about drug abuse to community groups and the other of which involved informing community groups about program services. The pattern of response to both items is about the same, with about half of the administrators feeling that either all or no counselor groups are involved, and that this should indeed be the case. As will be seen with many of these items, there is a tendency for more administrators to report a desire for participation by all counselors than to report that the activity is currently being performed by all counselors. For example, nine adminstrators say all their counselors are giving talks to community groups, while 13 say all groups should be doing it. Also,

Table 8. Administrators' views of counselor activities, by who <u>does</u> perform activities and by who <u>should</u> perform activities

Activity	All do	None do	All should	None should
I. Community education				
01. Give talks about drug abuse to community groups?	9	3	13	0
02. Inform community groups about the services your program provides?	9	6	10	2
II. Clerical and service duties				
03. Fill out forms which deal with client admission, progress, and/or discharge?	26	0	25	0
04. Carry out clerical tasks such as filing, typing letters, covering the telephone switchboard?	19	7	14	10
05. Do maintenance tasks in the agency such as cleaning, making repairs?	3	23	9	19
06. Perform messenger services between the treatment center and other centers or offices?	11	14	12	15
III. Control and enforcement				
07. Discipline clients when necessary, by keeping down noise, breaking up fights, or removing verbally abusive clients from the center?	15	6	18	5
08. Inform police of drug-dealing activities, either dealing by clients or by others?	0	25	4	20
09. Take responsibility for coordinating and controlling client traffic at the center?	22	4	22	4
IV. Socializing with clients				
10. Provide social activities for clients under the auspices of the program, for example, a picnic for clients of the program?	10	8	20	2
11. Meet clients on their own time in public places for socializing, for example, having lunch with a client, going to a ball game with a client?	10	14	7	13
12. Meet clients on their own time to socialize with them in their own homes or the clients' homes?	1	15	6	13

Table 8 (Continued)

Activity	All do	None do	All should	None should
V. Counseling in community				
13. Visit clients at their places of employment in the community?	6	17	16	7
14. Accompany clients into the community when they have job interviews?	9	14	17	4
15. Go into the community and visit a client in the hospital if he has become hospitalized?	21	2	23	1
16. Go into the community to appear in court on a client's behalf if the client is called to court?	18	5	20	2
17. Spend time becoming familiar with community resource agencies in order to know exactly where to send clients for these services in the community?	20	2	21	2
VI. Personal aid to clients				
18. Accompany clients to community resource agencies where the clients can get help, for example, a social work agency, a daycare facility?	16	10	18	5
19. Give personal care to clients, for example, helping them with housework or cooking, buying food for them?	2	20	8	12
20. Go into a client's neighborhood to help him deal with people with whom he may be having problems, for example, someone who is leaning on him to repay a loan?	0	24	6	14
21. Go into the clients' homes to discuss their problems with other members of their families?	10	15	15	7
VII. Administration of clients				
22. Decide whether a client will be accepted into your treatment program?	9	13	14	5
23. Assume responsibility at the center for deciding whether clients should remain in the program?	25	3	24	2
24. Attend staff meetings that deal with client treatment?	27	1	27	1
25. Make the decision about support services (e.g., vocational training or psychiatric workups) for clients?	18	5	22	2

Table 8 (Continued)

Activity	All do	None do	All should	None should
VIII. Administration of program				
26. Supervise other workers, for example, assigning clients, making out work schedules?	5	11	12	7
27. Carry out tasks that have to do with money matters of the agency, for example, keeping track of costs of the agency, making up budgets?	1	26	6	16
28. Participate in tasks that have to do with the staffing of the agency, for example, finding people to work, deciding who should be hired or fired?	8	17	11	12
29. Participate in reviewing and revising policies of the program?	18	7	25	2
30. Evaluate the effectiveness of services provided by the treatment program?	15	9	18	2
IX. Counseling				
31. Tell clients about the programs, services, and kinds of help your agency can give them?	24	1	25	1
32. Discuss with the client problems his family and friends may be having with regard to drugs?	25	2	25	1
33. Conduct group counseling sessions?	14	6	18	1
34. Talk to clients about their childhood?	14	1	19	0
35. Explain the advantages and disadvantages of methadone and abstinence to clients?	20	0	22	0
36. Review urine results of clients regularly?	27	1	28	0
37. Thoroughly discuss the specific reasons and circumstances that led the client to drug use?	20	1	20	0
X. Psychological testing				
38. Administer psychological tests and examinations to clients, for example, personality tests, job preference tests?	2	19	6	9
39. Interpret psychological tests and examination results, and make recommendations on the basis of their outcomes?	0	22	2	10

Table 8 (Continued)

Activity	All do	None do	All should	None should
XI. Training				
40. Explain to new counselors the procedures and rules of the program, for example, how to fill out forms used by the program?	17	5	19	3
41. Participate as instructors in training programs which deal with drug abuse counseling?	4	14	17	3

while three administrators say no group is doing it, no administrator feels that the activity is inappropriate for all groups.

The responses of the other half of the administrators--that is, those who gave answers other than "all equal" or "none" to the question of participation in community education--then, should be examined.

Table 9 shows the detailed results of cross-tabulating administrators' views on who is more involved and who should be more involved in giving talks on drug abuse to community groups. Twelve of the 28 administrators said that EAs were more involved in doing this. Seven of these 12 administrators plus 3 others felt that EAs should be more involved than the other counselors. A somewhat similar pattern was found for the other community education item--informing community groups about program services (table 10). However, here PROs (named by five administrators) as well as EAs (named by four administrators) are seen as most appropriate to inform the community. In fact, the advocacy here is so spread among counselor groups that there is little agreement as to the appropriateness of a specific group. In both items, those advocating the EAs see them as having special credibility resulting from direct experience with drugs and from conquering the problem. This credibility is seen as especially important in counseling in the community. For those advocating the involvement of only PROs, speaking ability and educational credentials are cited.

Four clerical and service duties were also included in the questioning (table 8). Administrators were emphatic that tasks such as filling out forms should be shared equally by all counselor groups, that this task was "part of the job." Filing and typing, etc., was also viewed this way. Messenger services, on the other hand, were more often judged inappropriate (e.g., no counselor should do it) than appropriate for all groups. Maintenance tasks, such as cleaning and making repairs, were seen by the great majority as not performed by their counselors, and as inappropriate for them.

Control and enforcement was the subject of three items. Taking responsibility for coordinating client traffic at the center was seen as evenly and appropriately distributed across counselor groups by the administrators. As far as disciplining clients is concerned, although several administrators thought that this was not particularly appropriate as a counseling function, they also thought that if it had to be done it should be shared by all the groups. Informing police of drug-dealing activities, however, was seen as inappropriate for all counselors, and no administrator thought the counselors were doing this.

Socializing with clients is often cited in the literature as the special province of the paraprofessional counselor[10] (American Personnel and Guidance Association 1967; Ellsworth 1968; Euster 1971; Fo and O'Donnell 1974; Hallowitz and Riessman 1967; Lytle 1964). In the present data, it is true that when one group is picked out by administrators as doing more socializing with clients outside the program, it is most often the EAs (tables 11 and 12). However, most administrators feel there is very little such socializing. Specifically, administrators were asked about meeting clients on one's own time in public places and also in the homes of the client or counselor. One administrator thought meeting clients in public places was being done by all groups, while 14 thought it wasn't being done at all. The corresponding numbers for meeting in homes were

[10]Virtually no consistent distinctions are made in the literature between paraprofessionals who are ex-addicts and those who are not.

Table 9. Of the 3 counselor groups--who is more involved in giving talks about drug abuse to community groups?--by who should be more involved

Who is more involved?	Who should be more involved? None	All Equally	NEA	EA	PRO and EA	NEA and EA	
None		0	1	1	0	1	3
All equally		6	1	2	0	0	9
PRO		0	0	0	1	0	1
NEA		0	1	0	0	0	1
EA		5	0	7	0	0	12
PRO and EA		1	0	0	0	0	1
NEA and EA		1	0	0	0	0	1
Total		13	3	10	1	1	28

Table 10. Of the 3 counselor groups--who is more involved in informing community groups about program services?--by who should be more involved

Who is more involved?	Who should be more involved? None	All Equally	PRO	NEA	PRO and NEA	EA	PRO and EA	NEA and EA	
None	1	1	1	0	0	2	0	1	6
All equally	0	6	3	0	0	0	0	0	9
PRO	1	0	0	1	1	0	0	0	3
NEA	0	1	0	1	0	1	0	0	3
PRO and NEA	0	0	0	0	2	0	0	0	2
EA	0	2	1	0	0	1	0	0	4
PRO and EA	0	0	0	0	0	0	1	0	1
Total	2	10	5	2	3	4	1	1	28

Table 11. Of the 3 counselor groups--who is more involved in meeting clients on their own time in public places for socializing?--by who should be more involved

Who is more involved?	Who should be more involved? None	All equally	PRO	EA	
None	10	3	1	0	14
All equally	0	1	0	0	1
EA	3	1	0	1	5
NEA and EA	0	2	0	0	2
Total	13	7	1	1	22

Table 12. Of the 3 counselor groups--who is more involved in meeting clients on their own time to socialize with clients in their own homes or the clients' homes?--by who should be more involved

Who is more involved?	Who should be more involved? None	All equally	EA	
None	11	3	1	15
All equally	0	1	0	1
EA	2	2	0	4
Total	13	6	1	20

one and 15. In each case, 13 administrators thought socializing should not be done at all. About one-quarter of the administrators thought socializing should be done--but that it should be distributed equally among the counselor groups, rather than vested in the EAs (tables 8, 11, and 12). Reasons for the equal distribution were that "It's part of the job," and "All counselors are capable of doing this. You don't need to be an ex-addict to help an addict." A question was also asked about providing social activities for clients within the program. Here 10 administrators reported that all counselors were doing this, while 20 thought all counselors should be doing this. While eight administrators said none were doing it now, only two thought that it was inappropriate for counselors to do.

To sum up administrators' sentiments regarding socializing with clients outside of the program, about half of the administrators see public socializing as inappropriate and not currently performed by counselors. Of those who think it appropriate, almost all would like to see it distributed equally among the counselor groups. Providing social activities within the program is most often seen as a legitimate counseling function for all counselor groups.

Counseling in the community was inquired about with five items, the first two of which were related to client employment. On these items--visiting clients at their place of employment and accompanying them into the community for job interviews--a majority of administrators thought that no counselors were doing it now, but that all should be doing it equally. Seven felt that visiting clients at work was not appropriate. In a previous section of this report, it was found that this activity was considered highly inadvisable by about 25 percent of the clients.

The other three items relating to counseling in the community involved visiting clients in the hospital, appearing in court, and becoming familiar with community agencies. These were regarded as quite appropriate and as frequent counselor activities.

Providing personal aid to clients with household chores or by helping them with a neighborhood loan repayment problem were seen as very infrequent counselor activities (table 8). In addition, almost half the counselors thought these to be inappropriate activities, with most of the rest feeling all groups should do it. Going to clients' homes to discuss their problems with family members was more often approved and seen as more frequent. Most prevalent of all and also most approved was accompanying clients to community resource agencies. Even for this activity, however, ten of the administrators saw the activity as never performed.

Counselors evidently are seen as frequently performing appropriate administrative duties relative to clients. These duties involve assuming responsibility for deciding whether clients should remain in the program, attending meetings dealing with client treatment, and deciding whether support services are advisable. Decisions about client acceptance are viewed as less frequent contributions, but half the administrators think all counseling groups should be involved in this decision process.

Program administration items for which counselor participation is seen as prevalent are policy review and revision, and evaluation of services. In addition, administrators clearly would prefer even more counselor participation. On the other hand, progressively less frequent and desirable are tasks associated with staffing, supervising other workers and, finally, budgeting, where 16 of the 25 administrators answering the question think no counselor should be involved. Incidentally, PROs and EAs are seen as doing more supervision than other groups by five administrators each--however, when it comes to who should be doing it, once again, equal assignments are advocated because all have the skills and "it's part of the job."

Counseling functions were judged appropriate for all groups by most administrators. PROs were seen, however, as more likely and more appropriate to discuss clients' childhood with them by seven administrators, and eight administrators felt they should be more involved with group counseling than the other groups (tables 13 and 14). In contrast, four administrators felt that EAs were more involved than other groups in group counseling, while only one felt this should be the case. Reasons given for these discrepancies had to do with the superior academic credentials of the PRO, and the specific experience some PROs have had in therapeutic counseling.

Psychological testing was sometimes seen as the province of the PRO counselor. For example, for interpreting psychological tests, 15 administrators felt that PROs should do it, while only two thought that all groups should do it. Ten thought that no counselor should be involved (tables 8 and 14). In administering the tests, about the same number (13) thought that PROs should be involved more than other groups, while six others thought all

Table 13. Of the 3 counselor groups--who is more involved in administration of psychological tests?--by who should be more involved

Who is more involved?	Who should be more involved? None	All equally	PRO	
None	9	3	7	19
All equally	0	2	0	2
PRO	0	1	6	7
Total	9	6	13	28

Table 14. Of the 3 counselor groups--who is more involved in interpretation of psychological tests?--by who should be more involved

Who is more involved?	Who should be more involved? None	All equally	PRO	
None	10	2	10	22
PRO	0	0	5	5
Total	10	2	15	27

groups should be involved equally, and nine thought no counselors should be involved (table 13). Once again, the reasons given where PROs are chosen is the strength of their academic background. Those who think no counselor should perform the task largely see it as a support service to be handled by specialists from outside the program.

With regard to training of new staff, all counselors are thought to be appropriately involved by most administrators with explaining procedures and rules of the programs. However, while participation of counselors as instructors in drug abuse counseling was seen as desirable by 17 administrators, such participation was actually observed only by four. Four administrators felt that PROs are, and the same number feel they should be, more involved in training because of their general experience in the classroom as students, and in specific courses. Two others felt the same way about EAs because of their direct experience with drug use. In general, as in so many of these items, there is a desire expressed on the part of the administrators for more participation by all counselor groups.

5. SUMMARY OF FINDINGS

The sex and ethnic distribution among the counselors mirrored that in the college-education non-opiate-abusing versus non-college-educated heroin-abusing populations. White/Anglo females were most prevalent among PROs; black males among EAs, with NEAs more closely resembling the EAs.

The average age of the EAs was about 10 years greater than that of the PROs, with NEAs closer to the age of the EAs.

The PROs also had briefer tenure in their present positions than the other groups.

EAs had somewhat more previous counseling experience in drug abuse programs per se, while NEAs had more counseling experience in other settings such as the Criminal Justice System.

The picture that emerges from the above is one in which PROs come to their jobs directly from the schools, while NEAs of similar rank have filtered through counseling positions in a variety of settings. The EAs have arrived after experiencing addiction and cure.

PROs by definition had more education with NEAs next and EAs last, although both the latter groups had a considerable number of college credits on the average. PROs educational advantage was not so much in counseling courses per se, but in the number of related courses such as abnormal psychology and deviance.

EAs had the least training by current and previous programs, while NEAs had most. However, there were few group differences in number of topics covered in training, since most counselors reported training in almost every area. With regard to specific areas, training in clerical activities was most frequently reported, while training in outreach or counseling in the community was relatively infrequent.

In all, there is a striking resemblance of the NEAs and EAs in a variety of aspects: their ethnic mix, age, counseling experience, and academic training. That NEAs appear to resemble the populations served by the programs more than they resemble the PROs is consistent with the model of the indigenous, community-based paraprofessional promulgated in the literature.

EAs, as expected, reported significantly more drug use than the other groups in virtually every area--with hallucinogens the only exception--and all but two of the EAs had treatment experience. The NEAs reported somewhat more drug use than the PROs, although histories of treatment were present in neither of these two groups. The EAs included many who had experienced more than one treatment modality.

The groups differed somewhat in working conditions. EAs worked more overtime hours, and had somewhat lower salaries, while the caseloads in the three counselor groups were about the same.

The wide variety of functions and activities of the counselors was consistent with the findings in the literature. Further, when activities were categorized, the counselor groups were quite similar for the most part in their levels of involvement with each category. This similarity was associated both with generally high levels of participation (e.g., in clerical tasks) and with low levels of participation (e.g., in psychological assessment).

Significant differences in participation levels were found only in those activities which led counselors out of the program--community education, socializing with clients, and counseling in the community. Even here, however, it was clear that some EAs, like PROs, were involved in few of these outside activities, while another group was very much involved with them.

Counselors within each of the three groups varied among themselves in their levels of both academic and inservice training and in their previous experience. This variation, over and above counselor group membership, was related to involvement in a number of activities. Across counselor groups, counselors who had taken a large number of counseling courses were relatively more involved in psychological assessment and test interpretation, in training and supervising other counselors, and in making intake decisions. More experienced counselors were involved in supervision of other counselors and in working with clients outside the treatment program. Breadth of inservice training was also associated with counseling in the community. Independent of counselor group, more experienced counselors and those with broad inservice training seemed more oriented to counseling outside the program. Less experienced but more academically trained counselors in all groups seemed more traditionally oriented to psychological approaches in the treatment program. A rational approach to the employment of the talents of individuals is evident here, one which emphasizes the specific abilities, training, and experience of the counselor in addition to traditionally defined group membership.

In regard to the administrators' points of view, in most cases the various activities were seen as appropriate either for all counselor groups or, to a lesser extent, none of the counselor groups. As far as the disparity between what counselors do and what they should be doing is concerned, administrators often expressed the feeling that all counselor groups should be more and equally involved especially in tasks which were now being performed more often by one group or by no groups.

Regarding group differences in the case of community education, PROs were seen as somewhat more involved and appropriately so, and the same is true of psychological testing. While EAs were viewed as participating somewhat more currently in public socializing with clients, it was thought that all counselor groups should be equally involved to the extent that socializing was to take place at all.

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APPENDIX

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II

Professional and Paraprofessional Drug Abuse Counselors: Attitudes of Counselors and Their Clients

Executive Summary

This report is based on a NIDA-funded study of three groups of counselors working in drug abuse treatment programs: (1) professional counselors who hold at least a bachelor's degree and who do not have addiction histories; (2) ex-addict paraprofessionals who do not usually hold a bachelor's degree; and (3) non-ex-addict paraprofessionals who neither hold a bachelor's degree nor have an addict background. Data were collected in drug-free and methadone maintenance programs located in five major SMSAs--New York; Washington, D.C.; Chicago; Los Angeles; and San Francisco--during the winter of 1976 and the spring of 1977. Personal interviews were conducted with counselors from each of the three groups, with administrators of the programs in which the counselors were employed, and with clients of the respective counselors.

One objective of the study was to explore the attitudes of the three counselor groups toward clients and their expectations regarding client success in treatment. Another objective was to consider clients' attitudes toward and their expectations of counselors in the three groups and clients' expectations regarding their own success in treatment. Since these attitudes and expectations were complementary, they were combined into one report and constitute the focus of this monograph.

Attitudes of the three counselor groups toward drug abuse and drug abusers were found to be quite similar. For example, they viewed clients as reachable, capable of real and permanent change, and not criminal by nature. They tended to agree that peer group pressures are most important in understanding why drug abuse starts, and that social factors such as poverty and discrimination are less important. They also agreed that the client himself is the most important factor in treatment success, that the counselor plays only a secondary role, and that supporting drugs are least important of all. In regard to modes of interaction with clients, all counselors felt that certain strategies were more appropriate than others. There was also an indication of some ambivalence or uncertainty on the part of each counselor group about the utility of their particular backgrounds for dealing with clients.

Clients' views of counselors were somewhat better differentiated by counselor groups than were counselors' attitudes. For example, ex-addict counselors were rated as significantly more knowledgeable about drugs and the street and, perhaps related to that, their clients more often claimed to profit from counseling sessions. The most general finding, however, was a relatively high level of trust, respect, and liking for all counselors. Clients expressed great willingness to discuss a variety of issues with counselors and saw their counselors as extraordinarily willing to help them in situations ranging from counseling to personal help with household chores. Clients of all counselor groups were approximately equal in their willingness to request help from counselors. In every case, however, their desire for help from the counselor was somewhat less than the perceived willingness of the counselor to give it.

Clients' expectations for the future were more optimistic across a variety of potential outcomes than were counselors' expectations for clients. The patterns of response though were much the same for counselors and clients. For example, both thought it would be easier for clients to secure employment than to become and remain drug free.

On the average, client-counselor relationships were good. This was evidenced by remarks of the clients themselves and was corroborated by the view of administrators--i.e., that clients complain relatively little about any particular counselor group.

CONTENTS

PROFESSIONAL AND PARAPROFESSIONAL DRUG ABUSE COUNSELORS:

ATTITUDES OF COUNSELORS AND THEIR CLIENTS

BY

Leonard A. LoSciuto
Leona S. Aiken
Mary Ann Ausetts

1. ORGANIZATION OF THIS REPORT

The report opens with a review of the literature concerned with the attitudes of clients and counselors toward each other and toward the treatment process. This review is followed by a presentation of the methodology of the study. Here, particular emphasis is given to the backgrounds of the three counselor groups and to the backgrounds of their clients. The results follow, reported in two major subsections, dealing with: (1) the attitudes of counselors toward clients, toward drug abuse itself, and toward drug abuse treatment; and (2) the attitudes of clients toward their primary counselors and toward the treatment process, as well as their expectations for their own lives following treatment. The views of administrators were also investigated in order to gain an alternative perspective. The final section of this report includes a restatement of major findings, a summary, and conclusions.

2. LITERATURE REVIEW

Before presenting a review of the literature describing counselor and/or client attitudes toward one another and toward the treatment process, a number of concerns should be discussed. First, the majority of this literature is relatively subjective--i.e., it is derived generally from the personal experiences of individuals who are working or who have worked in treatment settings or in the general treatment area. It is often in the form of an essay, a policy statement, or a conference report, and may be expected to reflect personal orientations if not biases. Many empirical studies in this area are also reported, however, and it is these which will constitute the focus of this literature review. When the relatively subjective reports support, contradict, or further explain empirical findings, the appropriate supplementary information will be included.

It should be noted also that even the empirical investigations conducted in the area of counselor and client attitudes are generally exploratory in nature. Consequently, there are attendant methodological problems--e.g., convenient and small samples were used and the results often provide indirect measures or indications of the variables and relationships of interest in this study. The literature reviewed, therefore, cannot provide confident generalizations, but only possible indications concerning counselor and client attitudes. Sample sizes are reported here when presented in the original publication.

Another concern to be noted in regard to a review of the relevant literature is the lack of consistent classification of counselor groups. For example, a counselor who had earned a bachelor's degree is classified as a professional in some programs or agencies, while in others he may be classified as a paraprofessional. For the purposes of this study, professional counselors will be those who hold at least a bachelor's degree and who do not have an addict, offender, alcoholism, and/or patient background; paraprofessional counselors will be those who do not hold a bachelor's degree. Paraprofessional counselors will also be classified, wherever the literature permits, according to their background experience with addiction, incarceration, alcoholism, and/or mental health problems. Therefore, when possible, a distinction will be made between counselors who have such background experiences (ex-addict, ex-offender, ex-alcoholic, or ex-patient paraprofessionals) and those who lack such background experience (non-addict, non-offender, non-alcoholic, or non-patient paraprofessionals).

Finally, although the data presentation to follow deals with counselor attitudes and client attitudes in separate sections, in the literature the topics are not always so readily divisible. Therefore, in this review, they are discussed concurrently within context or setting--i.e., drug abuse, alcoholism, corrections, and mental health.

At the outset, it might be noted that perhaps the most prevalent finding across treatment areas regarding counselor or client attitudes in the literature is that counselors perceive clients as difficult to treat. This finding has been reported in literature dealing with drug abuse (Ball et al. 1974; Monroe and Astin 1961; Balder 1973; Scher et al. 1973; Chappel 1973; Snyderman 1974; Chappel et al. 1974), corrections (Beless et al. 1972; Lytle 1964; Snyderman 1974; Gordon 1976; Benjamin et al. 1966), and alcoholism (Chappel et al. 1974; Chappel 1973; Pattison 1973; Mitnick 1974; Mandell 1974; Clement and Notaro 1975; Burnett 1977).

Other findings are discussed below within the four treatment areas already delineated.

Drug Abuse

The empirical literature concerned with counselor attitudes toward drug abuse clients gives some evidence of differential attitudes toward clients depending upon the clients' assignment to one of three categories: (1) addicts using heroin; (2) addicts maintained on methadone; or (3) abstinent addicts. Brown et al. (1972) reported that the staff members participating in their study (n=23) perceived addicts using heroin to be relatively nonachieving, irresponsible, dependent, aggressively antisocial, and unconcerned about others. In contrast, abstinent addicts were perceived to be achievement-oriented, persevering, dependable, aggressively independent, and eager for new experiences. Addicts maintained on methadone were characterized as falling between these two extremes.[2] A subsequent study (Brown et al. 1974) revealed similar results despite an analytical distinction made among staff groups: (1) administrators and supervisors (n=25); (2) ex-addict counselors maintained on methadone (n=21); (3) abstinent ex-addict counselors (n=22); and (4) non-addict counselors (n=20).

In the area of drug abuse, no empirical studies were found to substantiate differential attitudes toward clients among counselor groups. Subjective evaluations, however, have tended to characterize professional and paraprofessional counselors and their orientations toward clients in dichotomous terms. Professional counselors were reputed to be formal, impersonal, and calculating (Chappel et al. 1974; Scher et al. 1973; Suchotliff and Seligman 1974; Chappel 1973), while paraprofessionals, and especially ex-addict paraprofessionals, were said to be empathic, understanding, and spontaneous (Reinstein 1973; Dash 1973; Zimmerman and Coghlan 1972; Suchotliff and Seligman 1974; Brown and Thompson 1973; Social and Rehabilitation Service 1974). Professionals were said also to be moralistic and rejecting of drug abuse clients (Chappel, 1973) in contrast to paraprofessionals who were considered more comfortable with their clients and more optimistic about their clients' prognosis (Reinstein 1973). Paraprofessionals were characterized also as dedicated to their clients (Gay et al. 1972) and yet suspicious of their clients' motives for seeking treatment (Sloboda 1972).

Subjective evaluations of counselor groups also indicated attitudinal differences related to treatment. Professionals allegedly apply counseling techniques or skills acquired through academic training regardless of client or program characteristics, while

[2] It is interesting to note that client attitudes (n=55) toward the three addict groups were similar to those of the staff.

paraprofessionals prefer to confront clients directly and/or to apply the treatment technique to which they attribute their own "cure" (Chappel et al. 1974; Suchotliff and Seligman 1974; Social and Rehabilitation Service 1974).

Indirect and partial support for the above subjective evaluations can be derived from a study conducted by Kozel and Brown (1973). The study provides empirical evidence regarding the "ideal counselor role" as viewed from the perspectives of ex-addict (n=28) and non-addict (n=20) counselors, program administrators (n=24), and clients in treatment (n=30). The authors reported that administrators, in contrast to both counselor groups and clients perceived the ideal counselor role as involving little responsibility for community education; they also differed from ex-addict counselors in perceiving less responsibility (ideally) for counseling in the community. Client perceptions of the ideal counselor role assigned less value to counseling in the treatment center than did the other groups and less responsibility for policymaking than did non-addict counselors. These results indicate that counselor and client perceptions of treatment priorities were aligned with perceptions of client needs, while program administrators appeared to use some other criteria, possibly their academic training or exigencies of the treatment policy, to determine priorities.

Other empirical studies measuring client attitudes appeared to support the inference that the perceptions of client needs held by the paraprofessional, and especially the ex-addict, match most closely the perceptions of the clients themselves.

For example, Ball et al. (1974) asked the 224 randomly selected addict clients in their sample: "Are the professional staff helpful in treatment?" (Ball et al. 1974, p. 93). Forty-two percent responded affirmatively to this question. In contrast, 60 percent of the respondents stated that the ex-addict counselors were helpful.

Another indication of possible perceived differential effectiveness of professional and paraprofessional counselors is provided by Sinnett et al. (1975). These researchers asked 23 black heroin addicts in treatment to rate 46 sources of information about street drugs on a scale of 0 to 100 percent. These ratings were then averaged to obtain a "mean credibility rating." The results of this study indicated that these addicts placed considerably more confidence in their own experience (90 percent), in the ex-addict (89 percent), and the ex-user (88 percent) than they did in sources which could be representative of professional counselors--i.e., a doctor (70 percent) a drug educator (69 percent), a psychologist (49 percent), a psychiatrist (47 percent), and a social worker (41 percent). "Credibility" so defined here, of course, may not be directly related to perceived effectiveness.

The tendency on the part of clients to hold more favorable attitudes toward paraprofessionals, and especially the ex-addict, in contrast to their attitudes toward professionals oftentimes was explained by citing the existence of a cultural conflict. That is, individuals whose background experiences include a ghetto environment, racial or ethnic discrimination, and poverty find it difficult to understand, to communicate with, and to trust professionals who have an upper-middle or middle-class background, who tend to perceive addicts as physically and psychologically impaired, and who are held responsible, at least representatively responsible, for the inequities suffered by most drug abuse clients. (Baider 1973; Baldwin et al. 1973; Ball et al. 1974; Berzins and Ross 1972; Brown and Thompson 1973; Chappel 1973; Chappel et al. 1974; Dash 1973; DeBruce 1975; Jackman 1973; Monroe and Astin 1961; Reinstein 1973; Scher et al. 1973; Sinnett et al. 1975; Social and Rehabilitation Service 1974; Suchotliff and Seligman 1974; Wolf et al. 1973; Zimmerman and Coghlan 1972).

Alcoholism

In the area of alcoholism treatment, most indications of counselor and/or client attitudes in general are reported in subjective literature. Empirical studies in this area tended to be concerned with particular aspects of attitudes--i.e., changes in attitudes due to training, attitudes toward elements of an alcoholism treatment program, etc. Consequently, the subjective literature, in summary form, will precede empirical evidence in this section of the literature review.

Even the subjective literature concerned with client attitudes toward counselors in the area of alcoholism treatment was found to be extremely sparse. Furthermore, it indicated little agreement among the various authors. For example, Clement and Notaro (1975) stated that the alcoholic person often perceives professional counselors as "rescuers who solve crises" and "accept responsibility" for the alcoholic's behavior. Mandell (1974), on the other hand, asserted that alcoholics have a great deal of superficial respect for professional counselors, while they harbor feelings of resentment based on frustrating experiences with professionals who have

failed to provide what they consider to be needed care. Mcinerney (1973) contended that ex-alcoholic paraprofessional counselors are respected by patients entering treatment programs, but are not necessarily liked; when recovery is in process, however, clients were said to indicate appreciation for the counselors' care and their reduction of the clients' anxieties.

Subjective reports of attitudes held by professionals toward alcoholic persons indicated that professionals are reluctant to treat this "deviant" population (Mandell 1974; Clement and Notaro 1975; Strachan 1973; Burnett 1977; Weisman 1973; Pattison 1973; Chappel et al. 1974; Chappel 1973; Mitnick 1974). The alcoholic person was characterized as a hedonist (Clement and Notaro 1975); as reluctant to seek or accept treatment (Mitnick 1974; Burnett 1977; Finlay 1975); as fragmented, isolated and frightened (Fox 1975; Maxwell 1973); as a "con artist" (Burnett 1977; Maxwell 1973); as having a low self-concept (Finlay 1975; Maxwell 1973).

In contrast to these general characterizations of the alcoholic person, Pattison (1973) argued that specific types of treatment facilities provide specific services and consequently attract different types of alcoholic persons. As noted in regard to drug abuse clients, then, professional counselors working in the area of alcoholism treatment may hold different attitudes toward their clients dependent upon particular client conditions or characteristics. Pattison indicated that the range of these conditions or characteristics attributed to the alcoholic person runs the full gamut. That is, the alcoholic person may be perceived as socially oriented, experiencing little disruption of his social and vocational life, and accepting a view of alcoholism as a medical disease rather than as a reflection of some personality disorder within himself. At the other extreme is the alcoholic person perceived as an "institutional drifter," one who is totally alienated from society, who exhibits psychopathic qualities, nonconformity, overt hostility and yet despair and depression, and who is motivated only to seek the temporary relief from alcoholism obtained by living in a care-taking institution. With such reported diversity among clients, therefore, it might be considered unlikely to expect that alcoholism counselors hold a general attitude toward their clients.

As mentioned above, the relevent empirical studies conducted in the area of alcoholism treatment deal with specific elements or aspects of counselor and/or client attitudes.

One such study is that conducted by Ludwig et al. (1970). These investigators asked the psychiatric therapists (n=13) participating in their study to complete a Bias Questionnaire. An analysis of the responses indicated that the majority of these professional counselors had "no special feelings" in regard to alcoholic persons, that they perceived alcoholic persons to be suffering from underlying psychological disturbances, and that total abstinence should be the major treatment goal for these clients.

Bailey (1970) conducted a comparative study of family caseworkers' (n=71) attitudes toward alcoholic persons and alcoholism before and after training. Her results indicated that these professionals perceived alcoholism to be a psychosomatic disease and alcoholic persons to be suffering from underlying emotional problems. Despite these attitudes, however, only 65 percent of the professionals agreed that a majority of alcoholics could recover with treatment. Furthermore, failure to stay in treatment was perceived to be the responsibility of the alcoholic person (47 percent) more often than that of the professional counselor (18 percent). While Bailey stated that considerable changes in these attitudes occurred as a result of training, she also reported that the more closely the attitude statements related to actual casework practice, the less responses changed. Furthermore, when the respective responses were changed after training, it was sometimes in a direction opposite to that desired by training directors. Perhaps this increased divergence from "ideal" attitudes is similar to that reported by Kozel and Brown (1973) in regard to drug abuse program administrators--i.e., that some factor(s) other than client needs appeared to determine treatment priorities or orientations.

Goby et al. (1974) conducted a study which appears to support this interpretation. These investigators attempted to measure client (n=60) and counselor (n=31; predominantly professionals) perceptions of effective components of an alcoholism treatment program. Their results indicated little concensus between clients and counselors. In fact, client-counselor agreement was reported in regard to only one element of the treatment program, while marked disagreement was reported in regard to items intended to reflect the key underlying philosophy of the treatment program.

Corrections

An early empirical attempt to account for the discrepancy between professional expectations for success or failure of offenders

on probation and actual outcomes (Lytle 1964) provides an indication of professional, paraprofessional, and client attitudes.

In studying a large urban probation office, Lytle found that "unpromising clients," offenders judged by professional officers as unlikely to benefit from psychotherapeutic treatment and therefore unsuccessful probationers, were assigned to the less expensive, "untrained officers" rather than to professionals. He attributed this decision, as well as the unexpected client successes, to differential counselor attitudes.

Lytle stated that the professionally trained officers assumed an attitude of resignation mingled with resentment toward unpromising clients and felt uncomfortable in providing the close control and supervision deemed necessary. In contrast, the untrained officers were said to be concerned primarily with the positive rather than pathological elements of their clients' behavior. As a result of this orientation, the paraprofessionals were reported to find their clients more likable, attractive, and worthy of respect than did their professional counterparts. Lytle also stated that the untrained officers' attitudes tended to promote an atmosphere "in which the client looked upon his officer as a father, friend, brother and confidant as well as a representative of the court" (Lytle 1964, p. 133).

Snyderman (1974) also provided indications of counselor and client attitudes in his report of a study conducted in 1971-72 by the Special Placement Service Staff of the Public Offender Program (POP). Snyderman stated that clients, as perceived by staff, tended to frustrate easily; to be uncooperative; to exhibit negativism, secretiveness and hostility (also, Clements 1972); to be burdened with a variety of educational, vocational and psychosocial failures; and to rationalize these failures. He stated also that counseling, testing, and ancillary services were perceived by clients as hoaxes when they failed to result in a suitable job placement, but that successful attempts resulted in favorable community evaluations. Increasing numbers of addicts and ex-addicts were reported to voluntarily seek assistance from the POP staff because the staff "listen, we talk and don't get chewed out or get jive talk" (Snyderman 1974, p. 710).

More rigorous empirical literature relevant to counselor and client attitudes in the area of corrections was derived from the Probation Officer-Case Aide (POCA) Research Project, an attempt to examine the effects of utilizing indigenous paraprofessionals, ex- and non-offenders, as assistants to probation and parole officers. Phase I of this Project (1968-1971) was conducted in the U.S. Probation Office in Chicago and involved 26 professional officers, 30 non-offender Probation Officer Assistants (POAs), and 22 ex-offender POAs (Beless et al. 1973). Phase II (1971-1972) was conducted on a broader geographical scale but involved only 19 POAs, four of whom were ex-offenders (Gordon 1976).

Beless et al. (1973) asserted that a long-standing, severe shortage of professionally trained manpower and the relatively low success rates of available professional officers prompted a rapid expansion of the utilization of indigenous paraprofessionals to provide direct client services in probation and parole. The decision to employ indigenous paraprofessionals, rather than adopting an alternative manpower source, largely reflected commonly held professional attitudes toward clients, paraprofessionals, and the rehabilitative process.

Beless et al. (1973) reported that most professional corrections officers perceived clients as hard-to-reach, unmotivated, mistrustful, and resentful of authority (also, Clements 1972; Neil 1972), as subscribing to their own norms, values, and lifestyles, and, therefore, as being alienated from the mainstream of society--i.e., alienated from the middle-class society which professionals represent (also, Sigurdson 1969). This social distance was believed to "inhibit the development of a working relationship between client and professional to the point of client non-engagement in the rehabilitative process" (Beless et al. 1973, p. 10).

The utilization of indigenous paraprofessionals appeared to provide solutions for these problems in that professionals perceived them as having experienced life situations and problems similar to those of clients, as having proximity to and familiarity with clients and clients' environments, and as having ethnic or racial affinity with certain offender populations (also, Beless et al. 1972; Gordon 1976; Sigurdson 1969).

In her report of Phase II of the POCA Project, Gordon (1976) asserted that the POAs were remarkably client oriented (also, Lytle 1964), devoting considerable amounts of time to clients on an emergency basis, and providing services not usually offered by professional officers. In support of this statement, she reported that professional officers and POAs both responded positively to the question "Have you ever felt cynical about the services probation officers offer clients?" (Gordon 1976, p. 77) but that professionals

and POAs cited different reasons for their responses.

Professional officers generally cited the frustration accompanying attempts to "get anything done" for clients and occasionally cited the clients themselves as the reason for their cynicism. In contrast to these professional attitudes, POAs generally cited the ineffective organization of the probation system relative to the accomplishment of its promulgated goals and their frustration with the lack of career opportunities in the POA position as responsible for their cynicism. No POA mentioned disillusionment or frustration with clients as the reason for responding positively to the above question.

Glaser (1964) reported a study which investigated many aspects of the prison and parole system. As part of this undertaking, 454 inmates at five different prisons were interviewed in an attempt to assess their attitudes toward the prison staff. An analysis of their responses revealed that friendliness of manner and fairness of treatment were used by the inmates as criteria for liking or disliking officers. It was reported that, of all prison officers, the inmates most liked the work supervisors and least liked custodial officers.

Additionally, work supervisors primarily and then chaplains and their auxiliary religious workers were perceived as being major influences among successful releases who stated that their change from criminal interests occurred while they were in prison. Reasons given for these perceptions included friendliness and fairness rather than permissiveness or leniency; the personal interest and encouragement provided; and postrelease gestures such as transportation when leaving the prison and letters written to the former inmates.

Brown et al. (1971a,b) conducted a study which provides indications of staff attitudes toward inmates and of staff and client perceptions of the average inmate. To measure staff perceptions of inmates (Brown et al. 1971b), the following subjects and settings were selected: (1) 89 custodial personnel from a rehabilitative setting; (2) 12 treatment personnel from a rehabilitative setting; (3) 26 custodial personnel from a custodial setting; and (4) 18 treatment personnel from a custodial setting. An analysis of responses to the Adjective Check List revealed several significant findings.

The custodial staff employed in that setting were reported to perceive inmates as more active and antisocial than did the respective treatment staff and the custodial staff in the rehabilitation setting. The reverse, however, appeared to be true of the rehabilitative setting--i.e., the treatment staff in this setting perceived the inmates to be more antisocial than did the respective custodial staff and more active and agressive than the treatment staff in the custodial setting.

A brief followup study which measured personnel attitudes toward the "ideal" (as opposed to the "average") inmate was conducted in an attempt to further explain the above findings. The investigators reported at least partial support for the following hypotheses: (1) treatment staff in the custodial setting, perceiving a need to view themselves as real or potential change agents, try to dissociate themselves from the attitudes expressed by custodial officers; and (2) treatment staff in the rehabilitative setting, perceiving more overall acceptance of themselves and their philosophy, attempt to align themselves with the custodial staff by adopting attitudes toward inmates similar to those expressed by their custodial counterparts.

To study staff and inmate attitudes (Brown et al. 1971a), 25 inmates from the rehabilitative setting and 37 from the custodial setting were selected for comparison with the staff groups described above. Perceptions were measured by the Adjective Check List in terms of the "average" inmate. Again, several significant findings emerged from an analysis of the data.

The investigators reported that both staff groups in the rehabilitative setting perceived the average inmate to be more outwardly aggressive and yet more dependent upon others than did the respective clients. The clients, on the other hand and in contrast to both staff groups, perceived the average inmate to be concerned with taking responsible social action. In contrast to the treatment staff, these clients attributed more interest and concern for others to the average inmate.

In the custodial setting, staff and client perceptions generally paralleled those found in the rehabilitative setting, but it was the clients who perceived the average inmate to be more individualistic and more aggressive. In contrast, the treatment staff were reported to view the average inmate as more socially responsible, more concerned about others, and more deferential.

A comparison of client attitudes at the different institutional settings also revealed significant differences. Custodial clients

attributed traits of orderliness, deference, self-criticism, and dependence to the average inmate, while rehabilitative clients respectively attributed greater assertiveness, achievement, leadership, affiliation, and heterosexual interest.

Mental Health

Most of the literature relevant to client and counselor attitudes was found in the area of mental health. Due to the volume of this material, the literature will be presented selectively, but all references pertaining to the topic at hand will be included in the bibliography.

Andrade and Burstein (1973) conducted a study of client (n=102) perceptions of social congruence (the ability of an individual to identify with another on the basis of perceived similarities in family background, peer status position, communication skills, etc.), empathy (understanding), and helpfulness in regard to professional and paraprofessional counselors. The authors reported that perceptions differed with particular characteristics of the clients: (1) blue-collar workers and clients with less than a high school education perceived paraprofessionals as more socially congruent than professionals, but professionals as more understanding and more helpful than paraprofessionals; (2) white-collar workers perceived equal degrees of social congruence with both counselor groups, but perceived professionals as more understanding and more helpful than paraprofessionals; (3) clients with a high school education or more and male clients perceived professional and paraprofessional counselors to be equal in social congruence and in helpfulness, but perceived professionals to be more understanding than paraprofessionals; and (4) female clients perceived both counselor groups as equal in social congruence and understanding, but perceived professionals as more helpful than paraprofessionals.

Verinis (1970) was concerned with client assessments of differential members engaged in group counseling. He investigated the perceptions of 15 psychiatric patients in regard to qualities attributed to 12 specific group members: three professional counselors, three ex-patient lay therapists, three outpatients, and three inpatients. The researcher reported that professional counselors and lay therapists were selected significantly more often than the patient groups on each "positive" index--i.e., "most helpful to me," "most helpful to others," "best leader" and "most liked as a friend." Professional counselors were perceived more favorably than lay therapists in the "most helpful to me" and "best leader" categories, while lay therapists were selected slightly more often as the individual "most liked as a friend." Professionals and lay therapists were selected equally as the individual "most helpful to others."

Verinis (1970) further analyzed his data in an attempt to account for the relatively favorable evaluations of the lay therapists. He reported that the lay therapists, like professionals, were selected as the person "most helpful" because patients perceived them as willing to listen, as honest and sincere, as involved, as caring about the patient. Additional patient perceptions of professionals included their ability to help patients understand problems, and their ability to provide valuable advice, suggestions, and constructive criticism. Patients additionally perceived the lay therapists as having dealt successfully with problems similar to those of patients, and therefore as providing hope and as setting a good example.

Goldman and Singer (1974) investigated paraprofessionals' attitudes (n=14) toward patients diagnosed as psychotic (n=256). They reported that paraprofessionals relied upon logical, rather than clinical, indices for judging a patient's competence and prognosis--i.e., degree of mental disorganization, severity and awareness of problems, and quality of interaction with other patients and staff. They perceived the patients to be incapable of caring for themselves in general if they appeared disheveled. Paraprofessionals were reported also to judge the likelihood of aggressive behavior in terms of patients' case histories, compliance with ward rules, and relationships with the staff. Goldman and Singer concluded that the judgments or perceptions of the paraprofessionals were based on sharing a reasonably common frame of reference with patients and that the information sought by the paraprofessionals appeared to be appropriate. Whether or not this infers agreement with professional perceptions of clients cannot be determined.

Three studies which attempted to relate specific demographic characteristics of clients to their attitudes toward counselors and to their treatment expectations are worthy of note.

The first of these studies was that conducted by Warren et al. (1973). These investigators attempted to assess the effect of clients' race on the dependent variables mentioned above. They reported several differences between the perceptions of the 22 black and 22 white families interviewed. For example, 85 percent of the white parents felt

that their therapist (white and assumed to be a professional) understood them and their ethnic background, while only 55 percent of the black parents expressed the same perception. Both parent groups expected some relief of their children's problems, but black parents defined their expectations in behavioral terms, while white parents employed emotional terms. A third salient finding was that 75 percent of the white parents felt that their treatment expectations had been fulfilled, while only 38 percent of the black parents expressed the same positive attitude toward the therapeutic experience.

Overall and Aronson (1963) selected socioeconomic status as the client characteristic to be investigated in their study, and further concentrated their efforts by the selection of 40 outpatient psychiatric clients of lower socioeconomic status (Classes IV and V). The results reported indicated that these clients expected the counselor to express an interest in their physical as well as emotional well-being and to provide advice and solutions for their problems. The therapeutic experience did not appear to be perceived as interactional nor as self-exploratory, but rather as a situation in which the client expected to relay his problem to the counselor and receive a solution in return.

Balch and Miller (1974) also were concerned with the relationship between clients' (N=236) socioeconomic status and their treatment expectations. They compared these relationships to the attitudes or assessments of professional counselors as well. Their findings revealed that professional perceptions of client problems and their treatment recommendations generally agreed with those of middle- and upper-class clients, but considerable disagreement was reported in regard to lower-class clients.

Regardless of the symptoms presented, the professional counselors perceived most clients as suffering from similar social and psychological problems, treatable by one global form of psychological intervention. These counselors were reported also to have perceived all clients as needing advice and supportive counseling. The perceptions of middle- and upper-class clients also included presenting problems of a social and/or psychological nature and the expectation of self-exploration therapy. Lower-class clients, however, generally perceived their problems to be physical in nature and, therefore, expected to receive medication. All client groups, in agreement with the professional counselors, expected some form of advice and support.

Summary

The literature in all four areas of concern--drug abuse, alcoholism treatment, corrections, and mental health--indicated that counselors held different attitudes toward their clients dependent upon particular client conditions or characteristics. Clients who more closely approximated middle-class norms and values generally were perceived more favorably than other clients. Professionals were not well differentiated from paraprofessionals in their attitudes toward clients, especially as experience with treatment programs increased.

Counselor perceptions of their appropriate roles and services to be provided clients generally divided professionals from paraprofessionals. Professionals tended to orient themselves toward their academic training and the program or agency and its policies in determining the appropriateness of counselor roles and services to be offered clients. Paraprofessionals, on the other hand, tended to orient themselves toward their background experiences and perceived client and community needs in determining these factors. Client perceptions of appropriate counselor roles and needed services tended to be aligned more closely with those of paraprofessionals rather than with those of professional counselors.

There appears to be some consistency among the studies cited in regard to client attitudes toward counselors. First, clients appear to hold favorable attitudes toward both professional and paraprofessional counselors, but perceive each group as having distinct abilities or qualities. Professional counselors were valued for their academically acquired expertise and the advice they offered clients. Paraprofessionals, on the other hand--and especially the ex-addict, the ex-alcoholic, the ex-offender, and the ex-patient--were valued for the ease with which clients can relate to them and the similarity of client-paraprofessional orientations towards life and the social context. This is so particularly for clients belonging to ethnic or racial minorities and those of lower socioeconomic status (also, Banks 1972; Carkhuff 1968; Graff et al. 1971; Pasewark et al. 1970; Ruiz and Padilla 1977; Toban 1970).

Second, the major area of attitudinal divergence appears to be between the predominantly middle-class professional counselors and these clients with differing racial/ethnic backgrounds and with lower socioeconomic status. When divergence in attitudes and

treatment expectations between clients and professionals was reported, it was generally attributed to a cultural conflict--i.e., a discrepancy between the professionals' middle-class lifestyles and orientations and the clients' predominantly working- or lower-class lifestyles and orientations.

Addendum

Because the reader may be interested in research and opinion related to areas other than drug abuse, corrections, alcoholism treatment, and mental health, the following references pertaining to client and counselor attitudes and expectations are provided.

A. Client attitudes and expectations

Brager (1967)
Brager and Barr (1967)
Brager and Specht (1967)
Buchanan and Makofsky (1970)
Cloward and Epstein (1967)
Davis (1966)
Gartner and Riessman (1974)
Goldberg (1967)
Grosser (1967b)
Normandia (1967)
Piven (1967)
Pomeroy (n.d.)
Riessman (1967)
Taylor (1974)

B. Counselor attitudes and expectations

Barr (1967)
Billingsley (1964)
Brager (1967)
Brager and Barr (1967)
Brager and Specht (1967)
Buchanan and Makofsky (1970)
Cloward and Epstein (1967)
Cowin (1970)
Davis (1966)
Fanshel (1958)
Gartner (1969)
Gartner and Riessman (1972, 1974)
Goldberg (1967)
Gould et al. (1969)
Grosser (1967b)
Normandia (1967)
Piven (1967)
Riessman (1967)
Social and Rehabilitation Service (1968, 1974)
Taylor (1974)

3. METHODOLOGY

Study Design and Procedures

The Sample

Counselors were included in this study only if they were full-time workers with a caseload of approximately 25 or more clients for whom they had primary responsibility for the treatment regimen. Interviews were conducted with either all or a random sample of counselors in given treatment programs, a number of randomly selected clients of each counselor, and with the top program administrators in order to gather different perspectives on various areas of counselor functioning. In all, 82 counselors were interviewed along with 302 of their clients (see table 1), and 29 administrators of their programs. These individuals were from nine methadone maintenance and six drug-free programs within five major cities or surrounding areas--New York; Washington, D.C.; Chicago; Los Angeles; and San Francisco. The 16th program had both a methadone and a drug-free unit.

Criteria for Selection

These cities were chosen in part to insure geographic spread across the country. Another consideration was that major programs from large urban areas seemed desirable since they have relatively large client and counselor populations. This, in turn, insured that sufficient numbers of counselors and clients would be interviewed from each program. When possible, programs were chosen which had all three types of counselors. In only two programs in the sample was a counselor group missing.

Table 1. Distribution of counselors and clients by counselor group

	Number of counselors	Number of clients
Professional	31	116
Non-ex-addict paraprofessional	20	71
Ex-addict paraprofessional	31	115
Total	82	302

It was thought ideal to choose about the same number of methadone maintenance programs as drug-free programs in order to control for the effects of treatment modality. This was not possible, however, since there was a smaller proportion of drug-free, as compared to methadone maintenance, programs in the SMSAs surveyed who employed non-ex-addict paraprofessionals. Therapeutic communities were excluded because clients are not often assigned to particular counselors in those settings. Detox units were excluded because their short-term nature, among other factors, discourages the establishment of client-counselor relationships.

Procedures

The procedures used to select and recruit these programs involved initial screening for eligibility using the NDATUS file and several followup letters and phone calls to gather more program information and request cooperation. Professional interviewing staff from Creative Socio-Medics Corp. conducted the interviews during the winter of 1976 and the spring of 1977. Each of these interviewers was a professional in the area of drug abuse research and had experience in dealing with studies of addicts.

Each of the interview forms was designed to contribute information to each of the overall study objectives. That is, questions relevant to counselor functions and activities, client-counselor attitudes and interactions, and the progress of clients in treatment were included in each form. The three major questionnaires are described below, emphasizing those items most germane to the study of counselor and client attitudes.

Client interview. A structured client interview form required about one hour to administer. Clients were asked to estimate how often their counselor actually performed each of a number of activities or services for them. The items ranged from those associated with testifying for clients in court to giving clients personal help such as cooking or cleaning. Clients then reported how willing they thought their counselors were to perform each of 11 such activities. These items are presented on pages 44-46 of the report. In addition, clients were asked how desirous they were that counselors perform such services for them. Clients were also asked how likely they would be to discuss certain personal (e.g., neighborhood and domestic) problems with counselors and/or ask for counselors' help. Clients' perceptions of their counselors' views about the nature of, and expectations for, drug abuse clients were also sought, as well as some overall opinions on client relationships with their counselors. Data on client's own expectations and quality of life were also collected. Finally, background information was solicited for each client regarding education, work, criminal and drug use histories.

Counselor interview. The counselor interview form lasted about 1 1/2 hours on the average. Since this questionnaire was partly devoted to items concerning individual clients of each counselor, the time varied depending upon the number of clients in the counselor's caseload. Among other things, counselors were asked how willing they would be to perform a number of services for their clients--the same services described above and contained in the client questionnaire. Other topics were counselors' definitions of, and expectations for, treatment success, counselors' views of the nature of drug abuse clients, counselors' ideas about appropriate interactions with clients, counselors' attitudes toward methadone and toward alternate drug abuse treatment schemes. Counselor background items (e.g., education, work, drug histories) were also asked.

Administrator interview. The semi-structured interview for program administrators required 1 1/2 hours to administer. For the purposes of this attitudes study, administrators were asked for their views of counselor-client relationships, whether one counselor group or another received and/or issued more complaints with regard to clients, and whether these complaints were justified in the administrator's view. Background information on administrators was elicited, including education and work history.

Background of Counselors

Beginning with this section, results of the present study are presented. Counselor background is considered first, followed by client background, and then by counselors' and clients' attitudes.

It seemed reasonable to expect that variation in background and experience of counselors apart from their classification into the three groups might play a part in determining their roles, attitudes, and accomplishments. Therefore, counselor sex, ethnicity, and age were recorded, as well as amount and content of formal education and of training experience in drug treatment programs. Abbreviated histories of substance abuse and associated treatment were also taken. Descriptions of the counselors in terms of background are presented here, while in a later section attempts are made to relate these characteristics and variables to

counselors' attitudes toward, and expectations for, their clients.

For convenience to the reader, professionals will henceforth be noted as PROs, ex-addict paraprofessionals as EAs, and non-ex-addict paraprofessionals as NEAs.

Demographics: Sex, Ethnicity, and Age

With regard to sex and ethnicity, Chi-square analyses show that the three groups were quite different in composition. PROs were much more likely to be white/Anglos ($\chi^2(8)=23.64$, $p<0.01$) and female ($\chi^2(2)=7.08$, $p<0.05$) than EAs. NEAs as a group were somewhat more like the EAs than they were like the PROs on these demographic dimensions. Table 2 shows that more than half the PROs were female and about two-thirds of them white/Anglos, while only one-fifth of the EA group was female and only one-fifth was White/Anglo. Viewing ethnicity and gender together, only 13 percent of PROs were black males, while they constituted more than 60 percent of the EA group. Only six of all counselors were neither black nor white/Anglo. They were distributed evenly among the counselor groups. Five of the six were of Spanish descent, either Mexican or Puerto Rican; and four of the six were males.

Generally speaking, it seems that the ethnic and sex composition of the three counselor groups was not discordant with previous knowledge of the levels of education and rates of drug addiction among males and females of various ethnic groups in the population. With regard to ethnicity in particular, one might hypothesize that the composition of the groups also reflects the job opportunities that are available to different ethnic groups in our society and the abilities of different groups to have access to higher and lower level staff positions.

Another background item significantly differentiating counselor groups was age. Analysis of variance indicated that PROs with a mean age of 29.87 years were significantly younger than either NEAs with a mean age of 36.48, or EAs with a mean age of 39.40 ($F(2,78)=11.12$, $p<0.001$). The age differences are not surprising since PROs often come straight from college graduation to counseling positions, while NEAs have often pursued other early careers before coming to drug counseling. EAs must, of course, run the gamut of addiction and cure before becoming counselors.

Work Experience

The younger age of the PROs is also consistent with the average time they had spent in their current positions, compared to the other groups. PROs averaged about a year and a half tenure in their current positions, compared to slightly more than two years for EAs and three years for NEAs ($F(2,79)=3.74$, $p<0.05$). In addition to age, another possible explanatory variable for job tenure is the more limited job mobility of the paraprofessional, which may contribute to job stability.

The NEAs were most likely to have previous experience as counselors, even if that experience was not directly in drug treatment programs. Although the differences among groups did not reach statistical significance here ($\chi^2(2)=4.61$, $p<0.10$), they are of interest as a possible indication of the way the groups are viewed by program administrators and other employment decisionmakers. That is, since only 61 percent of EAs had previous counseling experience compared to 81 percent of the PROs and 85 percent of the NEAs, one might hypothesize that the EAs experience as addicts has often been seen as equal to or more valuable than direct counseling experience when selecting counselors.

It is also true, however, that the EAs had somewhat more cumulative experience on the average in drug counseling per se (16 months) than did the NEAs (13 months) or the PROs (7 months), although the differences were not significant. This in itself, of course, might lead to favorable views of the EAs by program administrators compared to other groups. The greater experience of the NEAs was acquired in two other counseling environments--mental health and, especially, the criminal justice system. The PROs had somewhat more experience in counseling in schools, in which environments the experience of the other groups was quite limited.

Education and Training

Given the definitions of counselor groups, few unexpected responses to questions on education could be found. The PROs, of course, all had bachelor's degrees; 42 percent of them had master's degrees and 29 percent of the rest had at least some graduate training. In contrast, 95 percent of the NEAs and 84 percent of the EAs had high school diplomas, post high school certificates, or at most some college training. The remaining 5 percent of the NEAs and 16 percent of the EAs had less than a high school education.

With the idea that area or field of degree might have some impact on PRO counselors' activities, attitudes, and achievements, their college majors and majors at the master's level were examined individually and together.

Table 2. Counselor sex and ethnicity, by counselor group

	Ethnicity			
	Black	White/Anglo	Puerto Rican	
1. Professional Counselors				
Male	26.7 (4)	66.7 (10)	6.7 (1)	48.4 (15)
Female	25.0 (4)	68.8 (11)	6.3 (1)	51.6 (16)
	25.8 (8)	67.7 (21)	6.5 (2)	100% (31)

	Black	White/Anglo	Mexican American	Philipine Chinese	
2. Non-ex-addict Paraprofessionals					
Male	75.0 (9)	16.7 (2)	8.3 (1)	---	60.0 (12)
Female	62.5 (5)	25.0 (2)	---	12.5 (1)	40.0 (8)
	70.0 (14)	20.0 (4)	5.0 (1)	5.0 (1)	100% (20)

	Black	White/Anglo	Puerto Rican	Mexican American	
3. Ex-addict Paraprofessionals					
Male	76.0 (19)	16.0 (4)	4.0 (1)	4.0 (1)	80.6 (25)
Female	50.0 (3)	50.0 (3)	---	---	19.4 (6)
	71.0 (22)	22.6 (7)	3.2 (1)	3.2 (1)	100% (31)

By far the most popular college major was psychology (40 percent) with sociology second (16 percent) and other social science areas next (another 20 percent). The remainder of majors represented a cross section of general liberal arts and allied subjects. Areas of concentration for master's degrees among the 13 counselors who had them were much the same--with psychology, social work or criminology, and sociology the most frequent choices. Relatively little switching of fields was observed from bachelor's to master's work. Only one of the 13 master's degrees was in a nonsocial science field--student personnel services. However, it is of some interest that not one of the master's degrees was in counseling per se.

When the paraprofessional groups were asked to enumerate their completed college credits, if any, the NEAs counted an average of 41 credits, and the EAs averaged 21 ($F(1,49)=8.00$, $p<0.01$). The above credit averages show that both groups have had substantial opportunity for exposure to relevant course work. Indeed when the paraprofessional groups are compared to the PROs in number of counseling courses, PROs report an average of only four more courses (PROs averaged eight in toto) than either paraprofessional group. The difference does not reach statistical significance. It should be kept in mind, however, that these courses may have been high school, college, or graduate school courses--or even weekend seminars, so long as they were

offered "in school." When other courses relevant to counseling were inquired about--such as abnormal psychology, personality theory, social deviance--PROs reported significantly more courses (9.72) than either NEAs (5.55) or EAs (2.13) ($F(2,76)=7.70$, $p<0.001$). Generally, while completed study units were certainly more prevalent among the PROs, a fair amount of relevant course work also showed up in the histories of the NEAs, and even the EAs.

Most would agree that many of the appropriate learning experiences for the drug counselor are encountered outside the classroom, in formal or informal training situations within treatment programs. It is noteworthy, then, when training by the current and previous drug program was examined, the EAs were much less likely than NEAs to have had such training. This is especially true for training by a previous program in which only 42 percent of the EAs compared to 58 percent of the PROs and 80 percent of the NEAs had received such training ($\chi^2(2)=7.71$, $p<0.05$).

This again suggests the value, indeed the "mystique," of the addict experience as a selection factor in employment and as an accepted substitute for counseling training and experience. NEAs, having neither the education of the PROs nor the addiction experience of the EAs, may be viewed as requiring compensatory amounts of program training and/or previous experience with counseling.

Despite differences among the groups in the amount of training each has received, on the average, from current and previous jobs as well as in school, significant differences did not appear for individual training topics. The EAs report less frequently that they have been trained on a number of topics, but not consistently so. Indeed, of the nine topics, listed in table 3, EAs reported having been trained, on the average, in 6.23, while the corresponding numbers for the PROs and the NEAs were only 6.90 and 7.20 respectively. These differences do not approach statistical significance. Table 3 shows that across topics ranging from the physical and psychological effects of specific drugs to outreach counseling and specific approaches to therapy, a majority of counselors had studied each one, with the exception of program administration which had been studied by only 40 of the 82 counselors.

One quite frequently studied topic, as might be expected, was counseling techniques along with specific therapy methods. More interesting perhaps is the emphasis apparently placed on clerical functioning in the training of these counselors--more than 90 percent of each group claimed to have studied it, making it the most common subject of training. This is perhaps some indication that the typical counselor complaint against the omnipresent concern with paperwork has some justification.

Overall, the data show similarity among the groups in amount of training on most topics--or at least inconsistent differences among the groups from topic to topic--with the EAs somewhat, though not significantly, less often trained. Perhaps the most salient finding is the relatively high frequency of training for all the groups across almost all training areas. The training results from on-the-job training and other settings as well as formal course work. The relative equality of the groups in areas studied may therefore be due to, for example, a balance of heavier formal course work among PROs, inservice training for the NEAs and somewhat less heavy input in both areas for the EA. Another implication is that while the counselor groups have different backgrounds and different images, the areas in which they are expected to perform and their roles and functions within those areas may be largely the same.

Counselor Drug and Treatment Experience

Another aspect of counselor experience which may be associated with counselor roles, activities, and attitudes is type and extent of substance abuse on the part of the counselor. Forty-five percent of the PROs, 15 percent of the NEAs and, as hoped for validation purposes, 100 percent of the EAs reported having used and abused various drugs. In table 4, the proportions of counselors in each group reporting that they had ever used each substance are presented. Heavier use of a variety of drugs including heroin, barbiturates, cocaine, and alcohol was reported by NEAs compared to PROs. PROs, on the other hand, were more likely to report use of opiates and synthetics other than heroin and hallucinogens. It should be pointed out, however, that only 16 percent of PROs and five percent of NEAs reported such use. In general, except for the greater frequency of use of almost all substances (with the exception of hallucinogens) among EAs, there were no statistically significant group differences. The low estimates for "alcohol" may be due to interpretations of the term "in excess"--for example, the counselor may have taken that to mean a series of many days or weeks of drinking.

When EA counselors were asked about their treatment histories, if any, 29 of the 31

Table 3. Topics of training, by counselor group

(Table presents percent answering "yes" for each item)

Q. 26. Considering all your training in school, on the job, or in special seminars or conferences, have you studied:

	Professional	Non-ex-addict paraprofessional	Ex-addict paraprofessional
a. The physical and psychological effects of specific drugs?	90.3 (28)	85.0 (17)	77.4 (24)
b. Individual or group counseling techniques?	93.5 (29)	95.0 (19)	87.1 (27)
c. Specific therapy methods, for example, directive therapy, client-centered therapy?	90.3 (28)	85.0 (17)	74.2 (23)
d. Laws relating to drug abuse?	77.4 (24)	85.0 (17)	67.7 (21)
e. Administration of drug treatment programs?	45.2 (14)	60.0 (12)	45.2 (14)
f. Client control and enforcement procedures?	67.7 (21)	85.0 (17)	61.3 (19)
g. Outreach counseling, or counseling in the community?	51.6 (16)	70.0 (14)	58.1 (18)
h. Clerical function of counselors, such as, how to fill out admission forms, take treatment progress notes?	93.5 (29)	95.0 (19)	90.3 (28)
i. Vocational guidance or counseling techniques?	80.6 (25)	60.0 (12)	61.3 (19)
N	100.0 (31)	100.0 (20)	100.0 (31)

Note — No significant differences among groups in percentage studying each topic.

Table 4. Counselor experience with specific drugs, by counselor group[1]

(Table presents percent answering "ever used")

Q. 28. How often, if ever, have you tried each of the following drugs or groups of drugs:

	Professional	Non-ex-addict paraprofessional	Ex-addict paraprofessional
Heroin	9.7 (3)	20.0 (4)	96.8 (30)
Illegal methadone	0	0	42.0 (13)
Other opiates and synthetics (with morphinelike effects)	16.1 (5)	5.0 (1)	67.8 (21)
Barbiturates	19.3 (6)	35.0 (7)	61.3 (19)
Other sedatives, hypnotics, or tranquilizers	19.5 (6)	20.0 (5)	35.5 (11)
Amphetamines	32.3 (10)	35.0 (7)	61.3 (19)
Cocaine	22.6 (7)	40.0 (8)	90.3 (28)
Marihuana/hashish	45.2 (14)	50.0 (10)	96.8 (30)
Hallucinogens	35.4 (11)	20.0 (5)	35.4 (11)
Inhalants	6.5 (2)	5.0 (1)	32.3 (10)
Alcohol to excess	9.7 (3)	30.0 (6)	48.4 (15)
N	100.0 (31)	100.0 (20)	100.0 (31)

[1]Seventeen PROs (55 percent) and nine NEAs (45 percent) reported no drug use in any of the categories.

reported having been in treatment. Both EAs who had not been in treatment had been addicted to heroin. Regarding other drugs listed, both these EAs reported substantial use only of marihuana/hashish and cocaine.

Given the definitions of the other counselor groups, no histories of addiction were anticipated, and the data confirmed this. However, with respect to treatment, one of the PROs had spent four months in a work-release therapeutic community following an arrest for possession of marihuana some years ago. This was not seen as invalidating his status as a PRO counselor for purposes of the study.

For those among the ex-addicts who had been in treatment, length of time spent in various modalities was seen as germane to roles, and functioning as a counselor. As expected, a number of EA counselors (10) had been in more than one treatment modality--in total, 20 had been in drug-free programs, 14 had been in chemically supported detox, and 12 had been on methadone treatment. Of those who had been in drug-free programs, the median time spent in such programs was about a year. For those who had been in detox, the median number of months in detox was 16 1/2. The corresponding figure for those who had been treated with methadone was 20 months. In each case the mean number was more than twice the median, since a few counselors in each modality had been in treatment for long periods of time. In all, the median number of months in treatment across all modalities for the 29 ex-addicts who had received treatment was 22.

The EAs, then, have brought to their current jobs substantial drug and treatment histories and experiences. While sizable proportions of the PROs and NEAs had used a variety of drugs, only one of them had spent even a short time in treatment.

It is apparent that many of the general beliefs among researchers and workers in the field regarding background and demographic differences between paraprofessionals and professionals are true for the current sample. As expected, greatest contrast is between PROs and EAs. However, it is also noteworthy that the EAs and NEAs are much closer to each other demographically, indeed are virtually indistinguishable, than either is to the PRO group. As has been pointed out, PROs are much more likely to be white/Anglo, to be female, and to be younger than EAs and NEAs. It would seem justifiable to conclude that the paraprofessional groups do, in fact, reflect the community served, whereas the professionals do not.

The EAs differ, by definition, from NEAs and PROs in amount and quality of experience with drugs. The amount of drug use, however, is considerable among all counselor groups, with about half of the PROs and NEAs reporting use (at least once) of one or more drugs listed. About a third of both groups report some use of amphetamines, while substantial use of hallucinogens and cocaine is also reported. Heroin use by NEAs and PROs, though less frequent, is not uncommon. There is some evidence, then, that counselors, professional as well as paraprofessional, may be at least tenuously associated with the "drug culture" when they decide to become counselors, or that they develop such an association through their working environment.

The counselor groups also differ in the amount of education, training, and experience as counselors. PROs, by definition here, have the most education. They have, however, the least experience and the least inservice training as counselors. NEAs, on the other hand, have the most experience as counselors, more education than EAs, and more specific inservice training as counselors.

It is of particular interest that, as shall be seen in the next section, all counselor groups perform pretty much the same activities. One may conclude, then, that experience with drugs, education, counseling experience, and inservice training as counselors are seen by program administrators as compensatory assets which are in some way capable of substituting one for another. That is, there seems to be an unspoken assumption that the formal course work and some inservice training for the PROs is equivalent to the counseling experience and extensive inservice training of the NEA, which is, in turn, equivalent to the addiction experience and some inservice training for the EAs.

Background of Clients

The present study explored the attitudes and expectations of clients in treatment with three counselor groups. Clients were sampled from the ongoing caseloads of counselors as they existed at the time of the first interview. It was therefore possible that biases in the assignment of clients with varying backgrounds to one or another counselor might have occurred, which would confound measures of client attitudes. For example, there might have been a bias within programs to assign clients with heavier drug use histories to one type of counselor. Such a selection bias, in turn, might be expected to affect the clients' attitudes toward their counselors and their expectations regarding treatment. Such effects, though not attributable to the impact

of the counselor group, would be confounded with counselor group effects. For this reason, i.e., the possible confounding of client assignment biases with counselor group effects, it was vital to explore the backgrounds of clients assigned to each counselor group. This exploration is accomplished in the present section. First, a brief description of the demographic characteristics of the clients is presented. This is followed by a summary of the background dimensions on which clients of the three counselor groups were contrasted, and a summary of differences found.

Demographic Characteristics

The demographic characteristics of clients are summarized in table 5. Clients in each group were approximately two-thirds male. Half the clients in each group were black, with another third white and the remainder Spanish-American. Clients of PROs were significantly, though only three years, younger, on the average than clients of NEAs.

Areas of Client Background Explored in the Present Study

Five areas of client background in addition to demographics were explored in the present study. These areas were drug use history, treatment history, educational history, employment history, and criminal history. An overview of the background of the client in each area was considered. In addition, in each area, the recent background was considered in detail by examining the year before treatment entry, as well as just the 30 days prior to treatment entry.

All measures in each area on which clients of the various groups were contrasted are enumerated in table 6. The outcomes of these measures for this client sample are given in the appendix. Analyses of variance or χ^2 tests were used to examine differences among counselor groups on each measure given in table 6. The counselor group differences found are highlighted below. For drug use and treatment history, modality effects and their interaction with counselor group effects were also considered. Modality effects are summarized in appendix tables A-1 and A-2 for drug use and A-3 for treatment history.

Differences Among Clients in the Various Counselor Groups

In two of the five areas, educational history and employment history, no counselor group effects were found.

In the area of drug abuse, there was only one counselor group effect. In the drug-free modality only, there was significantly greater use of alcohol to excess by clients of PROs than by clients of NEAs in the 30 days prior to treatment entry; for the simple effects, $F(2,290)=3.48$, $p<0.05$; for Tukey A contrast, $p<0.05$. Even with this effect, however, clients of PROs reported low levels of alcohol use, i.e., less than once a month to excess (see appendix, table A-2).

There was only one counselor group effect in the area of treatment history. In the drug-free modality only, clients of PROs had, on the average, about one more treatment episode than clients of NEAs; for the simple effect, $F(2,295)=4.65$, $p<0.05$; for Tukey A contrast, $p<0.01$ (see appendix, table A-3).

Finally, in the area of criminal history, there was again only one counselor group effect. More clients of EAs than of PROs or NEAs had been in jail in the year prior to treatment entry, $\chi^2(2)=6.28$, $p<0.05$ for overall test; $z=1.98$, $z=2.16$ for EA versus PRO and NEA, respectively, $p<0.05$ in both cases.

Conclusions

In the main, the demographics, drug use and treatment histories, the educational and employment histories, and criminal histories were substantially the same across the clients of the three counselor groups. On this basis, it was concluded that any differences in attitudes of clients, their expectations for progress in treatment, or their actual progress in treatment would not be confounded with counselor group.

4. RESULTS

Attitudes of Counselors Toward Clients

In this section, data on counselor attitudes toward drug abuse clients and their treatment are presented. Included in the analyses are the opinions of each counselor group on how drug abuse starts; the meaning of treatment success to the counselors and the factors seen as instrumental to it; expectations about client outcomes; counselor views about the average drug abuse client's physical and mental health, as well as other characteristics; notions of how counselors should interact with clients; and counselor attitudes toward methadone. In order to gain a different perspective, comments of program administrators on counselor attitudes are then examined. Finally, counselor background items are correlated with each attitudinal item to see whether such information helps significantly

Table 5. Demographic characteristics of the three client groups

Characteristics	Client groups[1] PRO	NEA	EA	Test for difference among groups
1. Sample size	116	71	115	
2. Sex (percent male)	61.2	64.8	63.5	$\chi^2(2)=0.14$, $p>0.20$
3. Mean age in years: $\bar{X}$	28.7	31.9	30.4	$F(2,299)=3.70$, $p<0.05$
S.E.	.67	.99	.81	
4. Ethnic identity (percent):				
Black	43.6	52.9	49.6	
White	35.5	32.9	36.3	$\chi^2(4)=2.83$, $p>0.20$
Spanish-American	20.9	14.3	14.2	

[1]PRO: Professional counselors
NEA: Non-ex-addict paraprofessional counselors
EA: Ex-addict paraprofessional counselors

Table 6. Background measures on which clients of the three counselor groups were contrasted

A. Drug history

1. Drugs or drug categories considered

   a. Marihuana/hashish
   b. Drug store items containing drugs, like cough sirup with codeine
   c. Inhalants such as glue
   d. Hallucinogens such as LSD
   e. Barbiturates such as phenobarbital, secobarbital (Seconal), pentobarbital (Nembutal)
   f. Sedatives or tranquilizers such as chlordiazepoxide (Librium), diazepam (Valium), chloral hydrate
   g. Cocaine
   h. Heroin
   i. Illegal methadone
   j. Opiates or drugs with the same effect such as codeine, morphine, opium, meperidine (Demerol)
   k. Amphetamines and other stimulants
   l. Alcohol to excess

2. Measures taken on each drug or category of drugs

   a. Number of years of any use
   b. Number of years of continuing use (once a week or more often)
   c. Frequency of use of each drug in year prior to treatment entry
   d. Frequency of use of each drug in 30 days just prior to treatment entry

B. Treatment history

1. Percent ever in treatment before current treatment episode
2. Number of prior treatment episodes
3. Number of attempts to detox
4. Number of times in chemical support modality (methadone maintenance, propoxyphene napsylate [Darvon N])
5. Number of years in treatment
6. Number of heroin-related treatment episodes
7. Number of court-related treatment episodes

C. Educational history

1. Highest grade completed in school
2. Percent of clients receiving any schooling in year before treatment

   a. Percent receiving vocational training
   b. Percent receiving other than vocational training

3. Number of months in school in year before treatment

   a. Number of months in vocational training in year before treatment
   b. Number of months in school in year before treatment

4. Percent of clients receiving any schooling in the 30 days before treatment

   a. Percent of all clients receiving any vocational training in 30 days before treatment
   b. Percent of all clients receiving any schooling other than vocational training in 30 days before treatment

Table 6 (Continued)

D. Employment history

1. Employment of males and females

   a. Percentage of clients who ever held a legal job, one for which they got paid and paid taxes
   b. Percentage of clients who held at least one job in the year prior to treatment entry
   c. Number of months employed in year prior to treatment entry
   d. Percentage of clients who worked at least one day in the 30 days prior to treatment entry
   e. Number of days worked, including Saturdays and Sundays, at a legal job in the 30 days prior to treatment entry
   f. Percentage of clients employed at entry into treatment

2. Time as housewives for female clients

   a. Percentage who had ever been a housewife
   b. Percentage who had been a housewife in the year prior to treatment entry
   c. Number of months mainly a housewife in year before entry into treatment
   d. Percentage mainly housewives in the 30 days prior to treatment entry

E. Criminal involvement

1. Percent ever arrested
2. Number of arrests in year prior to treatment entry
3. Percent of all arrests which were drug-related in year before treatment
4. Number of days in jail in year before treatment
5. Percent arrested in 30 days prior to treatment entry
6. Number of days in jail in 30 days before treatment entry
7. Percent of clients in treatment due to an arrest

in prediction of counselor attitudes beyond that prediction provided by knowledge of counselor status as PRO, NEA, or EA.

The actual questions were mainly structured with some of the free answer variety and they are described individually below. Regarding analysis, each item of the attitude scales was examined in a one factor analysis of variance with counselor group as the factor of interest. These ANOVs, where significant, were followed by Tukey A tests of differences among groups. Groups of items from individual attitude scales were also considered together in multiple discriminant analyses of the three counselor groups. In such analyses, a test (Wilk's Lambda) is performed to examine whether there are differences among the groups on the set of items when the items are considered simultaneously. In addition, the differences between pairs of groups on the set of items are examined.

Counselor Beliefs About How Drug Abuse Starts

To begin with, one fundamental attitudinal area investigated here was that of counselor beliefs about the way drug abuse starts. When counselors were provided with six possible causes or reasons and asked to rank them, all groups chose "peer group pressures" as most important and "poverty" followed by "being discriminated against" as least important. The three factors in the middle range of importance are "personality problems," "curiosity," and "bad home life." (See table 7.)

It is notable that despite the public stereotype of the addict as the product of economic disadvantage, all counselor groups see the social pressure of the particular peer group and not the larger socioenvironmental vicissitudes of poverty and discrimination as of primary importance in drug abuse etiology. Just as notable is the consistency among the counselor groups in judging those factors associated with deviance or individual pathology as of middling importance. As is the case with subsequent questions, the similarities in responses of PROs, NEAs, and EAs are much more impressive than are the differences. Indeed, the likeness is often remarkable, considering the disparities in demographic, educational, and experiential backgrounds just examined. Friedman's two-way analysis of variance of ranks was employed to see whether counselor groups each ranked the items in about the same pattern. This was indeed the case, with statistically significant overall differences among ranks in evidence for each group. This was due mainly to the low rank given by each group to "discrimination" as a potential reason for initial drug abuse, compared to the other reasons provided.

When the counselors were asked to supply other factors just as important or more important than the six provided, virtually no new information was gained.

Factors Perceived by Counselors as Important to Treatment Success

Counselor groups were also in very substantial agreement when asked to rank four factors in order of their importance in accounting for treatment success or failure. Each group feels that the client is most important, while supporting drugs are least important, with the counselor and client's family and friends somewhere in between. Friedman's two-way analysis of variance for ranked data was again employed, this time to see whether significant differences occurred among perceived treatment success factors for the different counselor groups. It was found that all counselor groups were alike in ranking the client as significantly more important than any other factor and in ranking supporting drugs as significantly less important than any other factor. In a free-response question, taking action in changing to a more middle-class lifestyle and getting into the "mainstream" was also seen as important by all counselor groups. The emphasis of the counselors is on placing major responsibility for treatment outcome on clients and encouraging them to change their behavior in a variety of ways.

Whatever the perceived causes or correlates of treatment success, it seemed likely that definitions of treatment success might vary considerably. Therefore, counselors were asked to supply their own definitions of treatment success. Once again, responses do not differ greatly among the groups. (See table 8.) The most commonly mentioned definition involves becoming and remaining drug free (reflected in the definitions of 29 percent, 31 percent, and 23 percent of PROs, NEAs, and EAs, respectively). About the same percentage of mentions for each group are given to changing from drug-oriented and nonproductive lifestyles to those more mainstream-oriented and productive. While the specific Federal criteria of becoming employable and/or employed, and staying away from crime receive only about 14 percent and five percent of the mentions, respectively, these criteria may be included by implication in many of the counselors' remarks concerning improvements of lifestyle. The only group difference of note is that EAs tend to mention much more frequently internal states of adjustment--e.g., coping, feelings of self-sufficiency, self-awareness (16 percent, 15 percent, and 32 percent for the mentions of PROs, NEAs, and EAs, respectively), while the other counselor groups are

Table 7. Counselors' beliefs about the causes of drug abuse, by counselor group

Q. 39. Here are some potential reasons why drug abuse starts. Please rank them in order, from (1) most important, to (6) least important.

Reason		Professional (PRO)	Non-ex-addict paraprofessional (NEA)	Ex-addict paraprofessional (EA)	ANOV
1. Curiosity	$\bar{X}$ [1]	3.58	3.05	2.81	F(2,79)=1.46
	S.E.	.32	.37	.35	
	N	31	20	31	
2. Bad home life	$\bar{X}$	3.03	2.63	3.25	F(2,74)=1.48
	S.E.	.21	.24	.26	
	N	30	19	28	
3. Poverty	$\bar{X}$	4.40	4.63	3.89	F(2,74)=1.74
	S.E.	.24	.31	.29	
	N	30	19	28	
4. Being discriminated against	$\bar{X}$	5.27	5.33	5.17	F(2,74)=0.13
	S.E.	.23	.20	.18	
	N	30	18	29	
5. Peer group pressures	$\bar{X}$	2.03	2.15	2.53	F(2,77)=1.26
	S.E.	.19	.32	.24	
	N	30	20	30	
6. Some personality problems	$\bar{X}$	2.77	3.25	3.07	F(2,77)=0.66
	S.E.	.26	.34	.29	
	N	30	20	30	

[1]Data presented are mean ranks.

Table 8. Counselor definitions of treatment success, by counselor group (in percent)[1]

Q. 43. Please explain in your own words what treatment success means to you.

	Professional (PRO)	Non-ex-addict paraprofessional (NEA)	Ex-addict paraprofessional (EA)
Being and remaining drug free	29 (22)	31 (12)	23 (15)
Becoming employable and/or employed	15 (11)	15 (6)	12 (8)
Staying away from crime	7 (5)	3 (1)	4 (3)
Changing lifestyles, adopting normal, "mainstream" lifestyle	29 (22)	26 (10)	20 (13)
Coping, improving self-sufficiency, awareness, and ability to handle problems	16 (12)	15 (6)	32 (21)
Other	4 (3)	10 (4)	8 (5)
Total	75	39	65

[1]Base of table is total number of reasons mentioned by each counselor group.

more likely to emphasize changing lifestyles or the Federal criteria. It may be that the PROs' and NEAs' middle-class values are not shared equally by the EA. Also, the EA may not be as convinced that the middle-class lifestyle is either necessary or sufficient evidence for improvement in the addict's life.

Counselor Expectations of Treatment Outcomes

Another important dimension of counselor attitudes is expectations regarding treatment outcome. When counselors were asked to judge how well off their clients were likely to be within a year or two after leaving the treatment program, here too, few differences among the counselor groups emerged. For example, the average counselor thinks it neither particularly likely nor unlikely that clients in their program will remain drug free, get and hold legal jobs, be healthy mentally and physically, have good lives in general, and have no need for treatment. (See table 9.) EA counselors tend to be somewhat more likely to feel that their clients will remain drug free ($F(2,77)=2.90$, $p<0.10$). When the Federal criteria items of employment, drug-free and crime-free status are used as a battery in a multiple discriminant analysis, there is significant discrimination among groups (F approximation to Wilk's Lambda of $F(8,146)=2.16$, $p<0.05$) with EAs differentiated from both other groups ($p<0.05$ in both cases). Interestingly, in the four-item battery, only the item of remaining drug free is a significant discriminator, $F(1,73)=5.23$, $p<0.05$.

Looking for trends, the NEAs are more pessimistic about outcomes on seven of the 11 items used to measure counselor expectations, an outcome which would be expected by chance alone with probability of only 0.037. NEAs are most pessimistic compared to the other groups in believing that their clients are unlikely to achieve good mental health ($F(2,77)=3.10$, $p<0.05$).

It is intriguing to note, however, that the EAs are somewhat more pessimistic than either PROs or NEAs with regard to two Federal criteria--employment and crime-free status. Since these differences are not statistically significant, it is not profitable to discuss them in depth--however, this result is not dissonant with the previously offered interpretation that these two criteria may be of somewhat lesser importance to EAs than to the other counselor groups. Further study is needed to clarify this particular issue.

Table 9. Counselor expectations for client outcomes, by counselor group

Q. 44. Think of drug abusers who have spent some time in treatment in your program, whether or not they have completed treatment. For all these clients, within a year or two <u>after</u> they leave treatment, how likely is it that they will remain drug free on the average? Is it (1) very likely, (2) somewhat likely, (3) somewhat unlikely, or (4) very unlikely that they will:

Client outcome		Professional (PRO)	Non-ex-addict paraprofessional (NEA)	Ex-addict paraprofessional (EA)	ANOV
a. Remain drug free?	$\bar{X}$	2.73	2.89	2.32	$F(2,77)=2.90^{1}$
	S.E.	.16	.21	.16	
	N.A.	1	1	0	
	N	30	19	31	
b. Get legal jobs?	$\bar{X}$	1.87	1.95	2.67	$F(2,77)=1.71$
	S.E.	.12	.19	.19	
	N.A.	0	1	1	
	N	31	19	30	
c. Hold legal jobs?	$\bar{X}$	2.32	2.21	2.43	$F(2,77)=0.44$
	S.E.	.09	.20	.19	
	N.A.	0	1	1	
	N	31	19	30	
d. Stay away from crime?	$\bar{X}$	2.19	2.36	2.43	$F(2,77)=0.73$
	S.E.	.11	.16	.18	
	N.A.	0	1	1	
	N	31	19	30	
e. Have good physical health?	$\bar{X}$	2.23	2.32	2.25	$F(2,77)=0.09$
	S.E.	.11	.19	.16	
	N.A.	1	1	0	
	N	30	19	31	
f. Have good mental health?	$\bar{X}$	2.20	2.63	2.19	$F(2,77)=3.10^{2}$
	S.E.	.07	.17	.14	
	N.A.	1	2	0	
	N	30	19	31	

Table 9 (Continued)

Client outcome		Professional (PRO)	Non-ex-addict paraprofessional (NEA)	Ex-addict paraprofessional (EA)	ANOV
g. Have good family lives?	$\bar{X}$	2.21	2.53	2.39	F(2,76)=1.20
	S.E.	.09	.18	.15	
	N.A.	2	1	0	
	N	29	19	31	
h. Have good lives in general?	$\bar{X}$	2.21	2.58	2.42	F(2,76)=1.48
	S.E.	.09	.19	.16	
	N.A.	2	1	0	
	N	29	19	31	
i. Be productive members of society?	$\bar{X}$	2.30	2.53	2.16	F(2,77)=1.14
	S.E.	.12	.23	.15	
	N.A.	1	1	0	
	N	30	19	31	
j. Have no need for treatment?	$\bar{X}$	2.70	3.16	2.94	F(2,77)=1.83
	S.E.	.12	.19	.17	
	N.A.	1	1	1	
	N	30	19	31	

[1] $p<.10$

[2] $p<.05$

Counselors' Perceived Characteristics of Drug Abuse Clients

Counselors were also asked whether they agreed or disagreed with each of 19 statements about the current status of the average drug abuse client in their program--including statements about mental and physical illness, environmental forces acting on the addict, addict personality, and addict behavior. As table 10 shows, the only item on which a difference even approaching statistical significance occurs among groups is on the topic of discrimination--EAs tend to be more likely to agree that drug abuse clients are discriminated against unfairly ($F(2,75)=2.75$, $p<0.10$).[3] When multiple discriminant analysis techniques are employed, a combination of four items, including the discrimination item, emerge as differentiating the groups (F approximation to Wilk's Lambda of $F(8,136)=2.54$, $p<0.01$), with EAs differentiated from both other groups ($p<0.05$ in both cases). The three items, in addition to the discrimination item, are those describing a sort of "ego weakness" or helplessness on the part of the addict--unawareness of mental problem, moral weakness, and childishness. On the one hand, EAs are most likely to agree that addicts are unaware of their problems. However, NEAs are most likely to feel that addicts are childish and morally weak. It should be emphasized at this point that the level of agreement here among the counselor groups, as in previously discussed areas, is much more remarkable than the differences observed.

In the main, there was no clear position taken by a group of counselors on a particular item. Typically, counselors in each group were relatively evenly divided between agreeing and disagreeing on any given item, leading to mean responses falling between two (agree) and three (disagree) on a four-point scale. There were three items, however, on which counselors in all groups expressed more polarized views. Two of the three statements to which mean scores for all three groups indicated strong positive feelings are those reflecting directly on potential for change. Apparently, all three groups see the addict as reachable and as capable of real and permanent change. The third item with which there is strong agreement shows that counselors do not believe the addict is criminal by nature. The answers to these three items show somewhat more optimism than responses to the other questions concerning current state and prognosis would predict. It seems that there is a belief in the capability of the addict for improvement which transcends his obvious liabilities and even his high perceived risk of recidivism (at least in the short run) with regard to drugs.

Counselor-Client Interactions

Counselors were also asked for their opinions about the proper nature of interactions with drug abuse clients. (See table 11.) Ten statements were presented to the counselors, each attempting to measure perceived appropriate or necessary levels of: educational and experiential factors, including addict background; development of trust and personal relationships with clients; and, in addition, control to be exercised over clients and over counselor relationships with clients. Strong differences do not often surface here either, although the EAs clearly and predictably disagree less often with the statement "You can't really understand a client's problems unless you've had the same problems yourself." ($F(2,79)=8.37$, $p<0.001$). Despite the statistical significance, it should be pointed out that while the other groups disagree most vehemently with that statement, the mean score of the EAs also indicates more disagreement than agreement. Interestingly, EAs also tend to agree more often than the other groups that clients will take advantage if one is not careful ($F(2,79)=2.93$, $p<0.10$). This may, of course, reflect EAs' recall of themselves as untrustworthy during their own periods of involvement with drugs, and an extension of these feelings to the client. Alternatively, these findings may indicate that some ambivalence exists in the EAs' thinking about the true value of his addict experience vis-a-vis the more personal relationships this experience permits him to establish with clients. More positively, the score may reflect consideration of the contributions of those counselors without a history of addiction. Consistent with this notion of uncertainty regarding proper interactions with clients is the fact that few statements elicited either strong approval or strong disapproval from any of the groups. In fact, univariate testing on other items showed no significant differences among the groups, though many of the small differences that emerged were in the direction one would predict. For example, EAs are more likely to advocate going into the clients' communities and socializing with them. When multiple discriminant analysis techniques were used, items measuring the perceived importance of

[3] This difference is, of course, confounded by ethnicity, since EAs are predominantly black in our sample.

Table 10. Attitudes held about the average drug abuse client, by counselor group

Q. 47. Please circle whether you (1) strongly agree, (2) agree, (3) disagree, or (4) strongly disagree with each word or phrase as it applies to the average drug abuse client in your program.

Word or phrase		Professional (PRO)	Non-ex-addict paraprofessional (NEA)	Ex-addict paraprofessional (EA)	ANOV
a. Mentally ill	$\bar{X}$	2.90	2.79	2.58	F(2,78)=1.16
	S.E.	.14	.16	.17	
	N.A.[1]	0	1	0	
	N	31	19	31	
b. Physically ill	$\bar{X}$	2.39	2.11	2.43	F(2,77)=1.14
	S.E.	.13	.19	.15	
	N.A.	0	1	1	
	N	31	19	30	
c. Unfortunate victims of society	$\bar{X}$	2.52	2.56	2.45	F(2,77)=0.42
	S.E.	.11	.19	.15	
	N.A.	0	2	0	
	N	31	18	31	
d. Unaware of mental problems	$\bar{X}$	2.23	2.17	1.90	F(2,76)=2.05
	S.E.	.09	.17	.14	
	N.A.	1	2	0	
	N	31	18	30	
e. Criminals by nature	$\bar{X}$	3.52	3.39	3.30	F(2,76)=0.75
	S.E.	.10	.18	.14	
	N.A.	0	2	1	
	N	31	18	30	
f. Morally weak	$\bar{X}$	2.79	2.37	2.48	F(2,76)=1.39
	S.E.	.14	.26	.17	
	N.A.	2	1	0	
	N	29	19	31	
g. Basically no better or worse than other people	$\bar{X}$	2.19	2.26	2.23	F(2,78)=0.042
	S.E.	.15	.21	.14	
	N.A.	0	1	0	
	N	31	19	31	

Table 10 (Continued)

Word or phrase		Professional (PRO)	Non-ex-addict paraprofessional (NEA)	Ex-addict paraprofessional (EA)	ANOV
h. Capable of real and permanent change	$\bar{X}$	1.77	1.53	1.87	F(2,77)=1.49
	S.E.	.12	.12	.14	
	N.A.	0	1	1	
	N	31	19	31	
i. Hostile	$\bar{X}$	2.60	2.56	2.23	F(2,76)=1.68
	S.E.	.13	.22	.17	
	N.A.	1	2	0	
	N	30	18	31	
j. Reachable	$\bar{X}$	1.80	1.79	1.87	F(2,77)=0.19
	S.E.	.07	.10	.10	
	N.A.	0	1	1	
	N	31	19	30	
k. Culturally disadvantaged	$\bar{X}$	2.27	2.22	2.26	F(2,76)=0.02
	S.E.	.10	.19	.15	
	N.A.	1	2	1	
	N	30	18	31	
l. Smarter than most people	$\bar{X}$	2.74	2.67	2.60	F(2,76)=0.32
	S.E.	.10	.18	.14	
	N.A.	0	2	1	
	N	31	18	30	
m. Discriminated against unfairly	$\bar{X}$	2.38	2.68	2.13	F(2,75)=2.75[2]
	S.E.	.14	.19	.16	
	N.A.	2	1	1	
	N	29	19	30	
n. Likely to steal	$\bar{X}$	2.13	2.21	1.86	F(2,76)=1.80
	S.E.	.10	.20	.13	
	N.A.	0	1	2	
	N	31	19	29	
o. Likely to be dangerous	$\bar{X}$	2.84	2.47	2.55	F(2,78)=1.68
	S.E.	.10	.21	.15	
	N.A.	0	1	0	
	N	31	19	31	

Table 10 (Continued)

Word or phrase		Professional (PRO)	Non-ex-addict paraprofessional (NEA)	Ex-addict paraprofessional (EA)	ANOV
p. Resistant to treatment	$\bar{X}$	2.48	2.16	2.27	F(2,77)=1.43
	S.E.	.11	.18	.14	
	N.A.	0	1	1	
	N	31	19	30	
q. Just needing a break	$\bar{X}$	2.67	2.47	2.45	F(2,77)=0.76
	S.E.	.12	.18	.14	
	N.A.	1	1	0	
	N	30	19	31	
r. Likely to become alcoholic if drugs aren't available	$\bar{X}$	2.29	1.89	2.16	F(2,78)=1.79
	S.E.	.12	.19	.12	
	N.A.	0	1	0	
	N	31	19	31	
s. Childish	$\bar{X}$	2.29	1.95	2.40	F(2,77)=2.23
	S.E.	.12	.16	.16	
	N.A.	0	1	1	
	N	31	19	30	

[1]No Answer

[2]$p<.10$

Table 11. Counselors' views as to how counselors should interact with drug abuse clients, by counselor group

Q. 48. Here are some statements that some counselors have agreed with, while others have disagreed, about the way counselors should interact with drug abuse clients. Again, please circle whether you (1) strongly agree, (2) agree, (3) disagree, or (4) strongly disagree with each statement.

Statement		Professional (PRO)	Non-ex-addict paraprofessional (NEA)	Ex-addict paraprofessional (EA)	ANOV	Tukey A
a. Clients will take advantage of you if you get too friendly with them.	$\bar{X}$	2.58	2.30	2.13	$F(2,79)=2.93^{2}$	E<P
	S.E.	.11	.21	.13		
	N.A.[1]	0	0	0		
	N	31	20	31		
b. Unless you have a lot of education, most clients think you can't help them.	$\bar{X}$	3.13	3.20	3.10	$F(2,79)=0.19$	___
	S.E.	.06	.16	.13		
	N.A.	0	0	0		
	N	31	20	31		
c. You can't really understand a client's problems unless you've had the same problems yourself.	$\bar{X}$	3.35	3.50	2.74	$F(2,79)=8.37^{3}$	E<P=N
	S.E.	.12	.14	.15		
	N.A.	0	0	0		
	N	31	20	31		
d. You've got to get to know a client personally before you can really help him.	$\bar{X}$	2.29	2.25	2.39	$F(2,79)=0.25$	___
	S.E.	.11	.18	.14		
	N.A.	0	0	0		
	N	31	20	31		
e. It is important to build up trust with family and friends of clients so that they won't be afraid to give information about the client.	$\bar{X}$	2.55	2.63	2.45	$F(2,78)=0.30$	___
	S.E.	.12	.19	.17		
	N.A.	0	1	0		
	N	31	19	31		
f. You've got to keep tight control over your clients or they will walk all over you.	$\bar{X}$	2.93	2.68	2.71	$F(2,78)=0.80$	___
	S.E.	.11	.22	.16		
	N.A.	0	1	0		
	N	31	19	31		
g. It's good to get out and socialize with the clients in their own neighborhood if you want to help them.	$\bar{X}$	2.97	2.84	2.61	$F(2,77)=2.16$	___
	S.E.	.12	.18	.11		
	N.A.	1	1	0		
	N	30	19	31		

Table 11 (Continued)

Statement		Professional (PRO)	Non-ex-addict paraprofessional (NEA)	Ex-addict paraprofessional (EA)	ANOV	Tukey A
h. There is no substitute for course work in counseling or social work for learning how to deal with clients.	$\bar{X}$	3.00	3.00	2.97	F(2,79)=0.02	___
	S.E.	.13	.15	.13		
	N.A.	0	0	0		
	N	31	20	31		
i. Going places informally with clients, such as to ball games or picnics, is important.	$\bar{X}$	2.39	2.21	2.03	F(2,78)=2.15	___
	S.E.	.12	.16	.12		
	N.A.	0	1	0		
	N	31	19	31		
j. It is the counselor's job to help his client at the program site, not to go out in the community.	$\bar{X}$	2.87	3.25	3.13	F(2,79)=1.67	___
	S.E.	.13	.14	.16		
	N.A.	0	0	0		
	N	31	20	31		

[1]No Answer

[2]$p<.10$

[3]$p<.001$

socializing with clients in and especially outside the counseling setting tended to distinguish the EAs (higher socializing) and PROs (lower socializing) to some extent (F approximation to Wilk's Lambda of F(6,148) =1.81, $p=0.10$; difference between EAs and PROs, $p<0.10$). Also, in answering a free-response question about how counselors should interact with drug abuse clients, EAs and PROs showed the same differences in points of view. Of all interaction modes mentioned by EAs as appropriate, 31.5 percent (compared to 19.6 percent and 19.1 percent for PROs and NEAs, respectively) concerned socializing with clients, helping them informally in and outside the program. On the other hand, maintaining a professional, detached approach is seen in 11.8 percent of mentions by PROs as important and only 4.8 percent and 5.6 percent for the NEAs and EAs, respectively. It is of interest to note that in a previous report (see A Study of Professional and Paraprofessional Counselors: Functions and Activities), the EAs reported working outside the treatment program, socializing with clients, etc., much more than did the PROs or NEAs. Attitudes in this area, while in the same direction, differentiate the groups much less well and, as mentioned, perhaps indicate some uncertainty on the part of the EAs as to the value of such close personal interaction.

Given the differences in educational backgrounds, the virtual absence of differences among counselor groups is especially surprising on questions concerning the value of education and course work and views of clients' perceptions of their value. For example, all three groups disagree just about equally with the notion that there is no substitute for course work in counseling in learning how to deal with clients. Even stronger disagreement is voiced by all three groups with the idea that clients feel that only counselors with a lot of education can help them. This may reflect counselor doubts about the validity of their educational backgrounds, or simply a tolerance and appreciation for the appropriateness and unique contributions of the backgrounds of other counselors.

Counselors' Choice of Methods for Withdrawing from Heroin

Counselors were also asked to choose one of four ways (or to suggest an alternative) as best for the long-term user to stop using heroin. As with other questions, differences among the groups are not pronounced. About half of all counselors feel that chemically supported detoxification followed by counseling or therapy is best, while almost a quarter feel that "cold turkey" is the most successful method. A fifth or fewer of counselors in all groups chose methadone maintenance followed by detoxification. A fourth choice provided--slow withdrawal on one's own--drew very few choices.

Perhaps most interesting of the above findings is the relatively high number of choices for "cold turkey"--often thought of as harsh and generally unsuccessful--and the lower number of "methadone maintenance followed by detox." "Methadone maintenance" implies long-term chemical support, while the other methods mentioned have more immediate results. Perhaps counselors responded in terms of the time dimension. It is also quite possible that, to some counselors, "methadone maintenance followed by detox" implied chemotherapeutic support only, and no counseling support. It is interesting in any case that very few other methods were suggested as better than those listed.

Counselors' Attitudes Toward Methadone

The final set of attitude questions in this section was not associated directly with feelings about clients--rather it consisted of measures of opinions about methadone. It was felt that EAs might hold different attitudes than non-EAs here regardless of treatment history or program of employment. The results, however, show no such differences--once again, the similarities among the groups are remarkable.

In addition to univariate analyses of variance with counselor group as the independent variable, two-factor ANOVs of modality (methadone maintenance, drug free) by counselor group were performed. These analyses revealed only the strong effect of modality of current program--i.e., those counselors who work in methadone programs are, of course, much more favorably disposed to methadone than those who work in drug-free programs. No interaction effects with counselor groups are seen for any item, and main effects of counselor groups are virtually absent. Multiple discriminant analyses essentially confirm that the groups are very similar in their views about methadone. Moreover, the items do not elicit a great range of responses across counselor groups. There does tend to be more agreement in general for the point of view that methadone helps with the crime problem than for most other questions. Likewise, there is relatively heavy disagreement with the notion that methadone represents an oppression of blacks by whites, and that methadone has done more bad for society than good. However, for the most part, answers reflect mild agreement, mild disagreement or neutrality, as has been the case for so many

of the items on previous scales presented in this section.

Perhaps most interesting of these methadone items are those in which the methadone counselors themselves are not particularly enthusiastic about their treatment modality. For example, on two items worded so that they are favorable toward methadone--"Methadone has proven to be the best way of quitting heroin," and "People would not stay off heroin if they did not take methadone"--the average score falls in the neutral category--neither agreement nor disagreement--for all three counselor groups working in methadone programs. Likewise, equally neutral average scores are obtained to the negative items: "Methadone will become more of a problem than heroin ever was" and "Methadone has been used more to stop crime than to help addicts." Neutral response to the positive items may express some uncertainty among methadone counselors as to the efficacy of their treatment modality. Neutral response to the negative items may reflect ambivalence regarding the proper role of methadone in a larger societal sense.

Administrators' Views of Counselors' Attitudes Toward Clients

To investigate another perspective on counselor-client interactions, program administrators were questioned about their observations of these interactions. In particular, administrators were asked which of three counselor groups voiced most complaints about clients, what the nature of these complaints was, and whether or not the complaints were legitimate. Remarks from the administrators lend some corroborating evidence that counselors are for the most part favorably disposed to their clients. The comments indicate few negative feelings, and these feelings are not well differentiated by counselor group. Over half of the administrators see no differences between the counselor groups regarding their complaints about clients. While a few more administrators see PROs as complaining more than NEAs or EAs, the differences are not impressive. The most frequent complaint to administrators of all counselor groups is that clients are "gaming" or conning and manipulative, that they are unreliable (e.g., in showing up for appointments), and that they will not live up to the rules of the program. The administrators see these complaints as largely legitimate, although they point out that it is sometimes the inability of the counselor to get through to the client which encourages such behavior.

The Relationship Between Attitudes and Counselors' Background

It was reasoned that counselors' educational and experiential background might affect their attitudes toward clients, above and beyond the effects of counselor group membership. For example, counselors who had many years of experience might differ in attitudes from those with little experience regardless of whether the counselors were PROs, NEAs, or EAs. Accordingly, the following six background variables were employed in a partial correlational analysis against all the attitude items under discussion in this section: number of school courses taken in counseling, number of other relevant school courses taken, such as abnormal psychology or deviance, number of topics relevant to drug abuse treatment covered in training, number of months in present position, total number of months' experience as a drug abuse counselor prior to the present position, and total number of months' experience in all counseling positions prior to the present position. When the analyses were completed, the number of statistically significant partial correlations for each attitudinal variable did not exceed the number expected by chance with one exception--attitudes toward methadone as related to job experience. While attitudes toward methadone are generally more favorable for those with more months in their present position, further analysis shows that this is due to the fact that methadone program counselors have been in their current positions longer. In sum, when we consider these six aspects of counselor background, no new information is given which would help predict counselor attitudes toward clients better than can already be done simply by knowing whether the counselor is a PRO, NEA, or EA.

As has been already noted, there is a high degree of homogeneity among the attitudes of the counselors in this study. This implies that the search for sources of variation may not be particularly fruitful. The attitudinal similarity of the three counselor groups, regardless of education, work, and life experience, and regardless of attitudinal area investigated, is most striking.

Attitudes of Clients Toward Counselors

In this section data are presented which indicate the feelings of clients for counselors in all three groups--PROs, NEAs, and EAs. It is important to note here that clients were asked questions only about their primary counselors, not counselors in general. For example, clients were asked about their primary counselors' drug and street knowledge, personal characteristics, and ability to counsel. They

were also asked about problems or situations which they would discuss with their counselors. In a previous part of this study (see A Study of Professional and Paraprofessional Counselors: Functions and Activities), counselors were asked whether or not they performed certain roles and activities with their clients. In the current effort, clients' perceptions concerning their counselors' willingness to participate in these activities and clients' desires for counselors to perform the activities are presented. Clients' perceptions of how their primary counselors view drug abusers were also sought, which made it possible to compare with the views actually expressed by counselors. Clients also reported on how well they get along with their counselors and why. They were then questioned about their expectations for their own lives after they leave treatment. Here too matching was possible, in this case between counselor and client expectations concerning treatment and the future lives of clients.[4] Lastly, the views of administrators on client attitudes toward counselors were investigated. (See p. 11 for a description of interview instruments.)

Clients' Views of Their Counselors

In the first series of client attitude questions, a number of different dimensions were tapped, including perceived knowledge of drugs and the street, intellective and nonintellective counselor characteristics, and degrees of comfort and communication the client experiences with his counselor. Clear differences are found among counselor groups on some of these dimensions. For example, of 30 items in this section, five were about knowledge of drugs and of the street. In all five, EAs are given significantly (at the 0.001 probability level) higher ratings than the other two groups. (See table 12.)

The EAs are also favored on one other item--clients of EAs agree more strongly that they really profit from counseling sessions. Perhaps perceived superior knowledge of the street and drugs gives the EAs some advantage in the minds of the clients when they consider what they get out of counseling. However, it is not easy to see meaning in this finding, since on the more than 20 remaining items centering around counselor-client interactions and perceptions of the value of the counselor, all three counselor groups are rated very highly, and the similarity of ratings for all groups is great. On the average, all counselor groups are about equally trusted, respected, seen as authentic or genuine, and thought to be helpful. Perhaps it is to be expected that the extra knowledge and street wisdom of the EA is not mirrored by extra helpfulness as viewed by clients, when one considers that the other counselor groups are also rated high on those same dimensions. The knowledge of NEAs and PROs concerning drugs and the street may be more than adequate as far as helpfulness to clients is concerned.

The only other difference of note is that the PROs seem most intelligent to the clients ($F(2,286)=3.12$, $p<0.05$).

Likelihood of Clients' Discussing, and Asking Help for, Problems

Clients were presented with a series of ten problems or situations and asked how likely it was that they would discuss the problem with their counselors. Further, if the client was likely to discuss the problem with the counselor, he was then asked how likely he would be to ask the counselor for help with the problem. At times, in the counseling context, of course, discussing the problem and asking for help might be one and the same. In other situations (e.g., needing money, family problems, problems with a landlord), direct counselor intervention in addition to discussion might be sought by the client.

The ten situations presented in table 13 covered a broad range from personal and family problems to those involving the three Federal criteria of drug-free, crime-free, and employment status. For the most part, answers to these questions parallel the finding that counselors in all three groups are equally liked, trusted, and seen as sources of support. In four of the ten situations, clients said, on the average, that they would be likely or very likely to discuss the situation with their counselor. Interestingly, three of these situations involved the three Federal criteria mentioned above. Presumably, problems with increased drug use by the client, legal problems, and a threat to the client's job are seen as situations which are clearly within the province of the counselor. The fourth situation seen as likely to be discussed is one in which a spouse or mate leaves

[4]One question which arises in this study is the extent to which clients knew that their counselors fell into one or another of the three counselor groups. While it was expected that the clients did have this information for the most part, especially with regard to ex-addict or non-ex-addict status, there is no hard evidence that can be offered at this point. Even with such knowledge, of course, only certain questions (e.g., counselors' knowledge of drugs) might be expected to be influenced by it.

Table 12. Clients' views of their counselors, by counselor group

Q. 80. Please check the box showing whether you (1) strongly agree, (2) agree, (3) disagree, or (4) strongly disagree with each item as it applies to your primary counselor.

			Professional (PRO)	Non-ex-addict paraprofessional (NEA)	Ex-addict paraprofessional (EA)	ANOV	Tukey A
a.	My counselor knows a lot about drugs.	$\bar{X}$	1.98	2.00	1.30	$F(2,293)=33.94^1$	E<P=N
		S.E.	.07	.10	.05		
		N.A.	4	2	0		
		N	112	69	115		
b.	My counselor knows a lot about the street.	$\bar{X}$	2.17	2.14	1.37	$F(2,291)=40.80^1$	E<N=P
		S.E.	.08	.10	.05		
		N.A.	6	2	0		
		N	110	69	115		
c.	My counselor understands people with drug problems.	$\bar{X}$	1.71	1.70	1.35	$F(2,297)=11.43^1$	E<P=N
		S.E.	.07	.07	.05		
		N.A.	1	0	1		
		N	115	71	114		
d.	My counselor knows how tough it is to get off drugs.	$\bar{X}$	1.87	1.89	1.31	$F(2,296)=19.84^1$	E<P=N
		S.E.	.08	.10	.05		
		N.A.	3	0	0		
		N	113	71	115		
e.	My counselor is intelligent.	$\bar{X}$	1.41	1.64	1.51	$F(2,294)=3.48^2$	P<N
		S.E.	.05	.08	.06		
		N.A.	3	1	1		
		N	113	70	114		
f.	My counselor knows how to handle problems on the street for his clients.	$\bar{X}$	2.08	2.00	1.68	$F(2,281)=9.36^1$	E<N=P
		S.E.	.07	.09	.07		
		N.A.	9	2	7		
		N	107	69	108		
g.	In counseling sessions, my counselor listens to my ideas and plans without putting me down.	$\bar{X}$	1.55	1.58	1.57	$F(2,290)=0.06$	—
		S.E.	.06	.08	.06		
		N.A.	1	2	6		
		N	115	69	109		

Table 12 (Continued)

			Professional (PRO)	Non-ex-addict paraprofessional (NEA)	Ex-addict paraprofessional (EA)	ANOV	Tukey A
h.	My counselor doesn't seem to understand me.	$\bar{X}$	3.41	3.26	3.31	F(2,293)=1.11	—
		S.E.	.07	.09	.06		
		N.A.	2	3	1		
		N	114	68	114		
i.	My counselor seems "uptight" when he talks to me.	$\bar{X}$	3.40	3.25	3.22	F(2,292)=1.87	—
		S.E.	.06	.10	.07		
		N.A.	4	2	1		
		N	112	69	114		
j.	I can talk with my counselor about deep, personal feelings.	$\bar{X}$	1.92	1.91	1.94	F(2,291)=0.02	—
		S.E.	.08	.11	.08		
		N.A.	3	2	3		
		N	113	69	112		
k.	My counselor makes things clearer for me.	$\bar{X}$	1.78	1.78	1.76	F(2,290)=0.02	—
		S.E.	.06	.08	.06		
		N.A.	3	4	2		
		N	113	67	113		
l.	I don't trust my counselor.	$\bar{X}$	3.35	3.24	3.41	F(2,291)=0.97	—
		S.E.	.07	.10	.08		
		N.A.	4	1	3		
		N	112	70	112		
m.	My counselor seems like a "real human being."	$\bar{X}$	1.46	1.51	1.43	F(2,295)=0.44	—
		S.E.	.05	.07	.06		
		N.A.	2	2	0		
		N	114	69	115		
n.	My counselor has a good sense of humor.	$\bar{X}$	1.61	1.65	1.62	F(2,292)=0.10	—
		S.E.	.05	.08	.06		
		N.A.	2	2	3		
		N	114	69	112		
o.	My counselor insists on always being "right."	$\bar{X}$	3.21	3.01	3.09	F(2,294)=1.42	—
		S.E.	.07	.10	.07		
		N.A.	3	2	0		
		N	113	69	115		

Table 12 (Continued)

			Professional (PRO)	Non-ex-addict paraprofessional (NEA)	Ex-addict paraprofessional (EA)	ANOV	Tukey A
p.	I have confidence in my counselor.	$\bar{X}$	1.52	1.63	1.61	$F(2,297)=0.84$	—
		S.E.	.05	.08	.06		
		N.A.	1	1	0		
		N	115	70	115		
q.	My counselor doesn't seem sure of himself.	$\bar{X}$	3.31	3.25	3.45	$F(2,295)=1.85$	—
		S.E.	.07	.10	.06		
		N.A.	1	3	0		
		N	115	68	115		
r.	My counselor makes me feel as though my problems are really important.	$\bar{X}$	1.76	1.76	1.71	$F(2,291)=0.22$	—
		S.E.	.06	.08	.06		
		N.A.	2	3	3		
		N	114	68	112		
s.	My counselor is very patient.	$\bar{X}$	1.76	1.74	1.72	$F(2,290)=0.11$	—
		S.E.	.06	.07	.06		
		N.A.	3	3	3		
		N	113	68	112		
t.	Talking with my counselor helps me to understand myself better.	$\bar{X}$	1.79	1.72	1.64	$F(2,290)=1.24$	—
		S.E.	.07	.08	.06		
		N.A.	3	3	3		
		N	113	68	112		
u.	I feel the counselor really wants to help me.	$\bar{X}$	1.51	1.64	1.46	$F(2,290)=2.03$	—
		S.E.	.05	.08	.06		
		N.A.	1	5	3		
		N	115	66	112		
v.	My counselor treats me as an individual.	$\bar{X}$	1.62	1.65	1.63	$F(2,294)=0.06$	—
		S.E.	.06	.08	.06		
		N.A.	1	2	2		
		N	115	69	113		
w.	I feel as though I really get something out of the counseling sessions.	$\bar{X}$	1.77	1.79	1.56	$F(2,286)=3.12^{2}$	—
		S.E.	.07	.09	.06		
		N.A.	3	5	5		
		N	113	66	110		

Table 12 (Continued)

			Professional (PRO)	Non-ex-addict paraprofessional (NEA)	Ex-addict paraprofessional (EA)	ANOV	Tukey A
x.	My counselor makes me feel more like a "case" than an individual.	$\bar{X}$	3.30	3.33	3.22	F(2,290)=0.53	—
		S.E.	.07	.08	.07		
		N.A.	2	4	3		
		N	114	67	112		
y.	I feel comfortable in talking with my counselor.	$\bar{X}$	1.67	1.70	1.63	F(2,294)=0.26	—
		S.E.	.06	.08	.06		
		N.A.	1	2	2		
		N	115	69	113		
z.	My counselor seems to look down on me.	$\bar{X}$	3.39	3.43	3.37	F(2,293)=0.17	—
		S.E.	.07	.07	.07		
		N.A.	3	3	0		
		N	113	68	115		
aa.	My counselor completely understands my feelings.	$\bar{X}$	2.14	2.04	2.07	F(2,290)=0.45	—
		S.E.	.07	.09	.07		
		N.A.	4	3	2		
		N	112	68	113		
bb.	My counselor's way of speaking confuses me.	$\bar{X}$	3.33	3.25	3.22	F(2,293)=0.80	—
		S.E.	.06	.09	.07		
		N.A.	2	3	1		
		N	114	68	114		
cc.	My counselor makes me feel as though he will jump on me if I say the wrong things.	$\bar{X}$	3.42	3.51	3.34	F(2,292)=1.37	—
		S.E.	.06	.07	.07		
		N.A.	1	4	2		
		N	115	67	113		
dd.	My counselor tries to help me make decisions about a job.	$\bar{X}$	2.14	1.97	1.97	F(2,288)=1.81	—
		S.E.	.08	.08	.07		
		N.A.	3	4	4		
		N	113	67	111		

[1] $p<0.001$

[2] $p<0.05$

Table 13. Problems that clients would and would not bring to their counselors, by counselor group

Q. 77. I am going to read to you a list of problems or situations that people run into. For each, please tell me how likely you would be to discuss this problem with (counselor) if you had the problem.

[(1) very likely; (2) likely; (3) unlikely; (4) very unlikely]

			Professional (PRO)	Non-ex-addict paraprofessional (NEA)	Ex-addict paraprofessional (EA)	ANOV	Tukey A
1a.	Your (wife/husband/girl-friend/boyfriend) left you.	$\bar{X}$	1.91	1.90	1.83	F(2,294)=0.17	—
		S.E.	.11	.13	.10		
		N.A.	1	3	1		
		N	115	68	114		
1b.	How likely is it that you would ask (counselor) to help you with this problem?	$\bar{X}$	1.88	1.94	1.89	F(2,206)=0.05	—
		S.E.	.12	.15	.10		
		N.A.	40	22	31		
		N	76	49	84		
2a.	Your mother or any other close relative was sick and needed medical attention.	$\bar{X}$	2.09	2.13	1.95	F(2,298)=0.86	—
		S.E.	.10	.12	.09		
		N.A.	0	0	1		
		N	116	71	114		
2b.	How likely is it that you would ask (counselor) to help you with this problem?	$\bar{X}$	1.91	1.95	1.86	F(2,194)=0.18	—
		S.E.	.12	.14	.10		
		N.A.	46	27	32		
		N	70	44	83		
3a.	Someone was threatening you because you couldn't pay off a loan.	$\bar{X}$	2.76	2.59	2.53	F(2,296)=1.43	—
		S.E.	.10	.12	.10		
		N.A.	0	2	1		
		N	116	69	114		
3b.	How likely is it that you would ask (counselor) to help you with this problem?	$\bar{X}$	2.37	2.07	2.04	F(2,117)=1.26	—
		S.E.	.17	.16	.15		
		N.A.	75	43	64		
		N	41	28	51		
4a.	Your landlord said he would evict you.	$\bar{X}$	2.05	2.08	2.05	F(2,296)=0.03	—
		S.E.	.09	.13	.10		
		N.A.	0	0	3		
		N	116	71	112		

Table 13 (Continued)

			Professional (PRO)	Non-ex-addict paraprofessional (NEA)	Ex-addict paraprofessional (EA)	ANOV	Tukey A
4b.	How likely is it that you would ask (counselor) to help you with this problem?	$\bar{X}$	2.04	1.80	1.90	F(2,198)=1.11	—
		S.E.	.10	.13	.10		
		N.A.	37	26	38		
		N	79	45	77		
5a.	You needed to borrow $100 quickly.	$\bar{X}$	2.97	3.03	2.59	F(2,293)=5.69[1]	E<P=N
		S.E.	.10	.11	.10		
		N.A.	2	1	3		
		N	114	70	112		
5b.	How likely is it that you would ask (counselor) to help you with this problem?	$\bar{X}$	2.18	2.44	2.08	F(2,87)=0.84	—
		S.E.	.16	.18	.16		
		N.A.	82	55	75		
		N	34	16	40		
6a.	You were about to lose a job that you liked.	$\bar{X}$	1.82	1.81	1.76	F(2,294)=0.16	—
		S.E.	.08	.11	.08		
		N.A.	2	1	2		
		N	114	70	113		
6b.	How likely is it that you would ask (counselor) to help you with this problem?	$\bar{X}$	1.87	1.71	1.71	F(2,234)=1.15	—
		S.E.	.09	.10	.09		
		N.A.	23	16	26		
		N	93	55	89		
7a.	You were having problems getting along with your family.	$\bar{X}$	2.28	2.20	2.03	F(2,293)=1.76	—
		S.E.	.10	.12	.09		
		N.A.	0	1	5		
		N	116	70	110		
7b.	How likely is it that you would ask (counselor) to help you with this problem?	$\bar{X}$	1.89	1.80	1.84	F(2,180)=0.16	—
		S.E.	.11	.13	.09		
		N.A.	50	31	38		
		N	66	40	77		
8a.	You had a problem with the law.	$\bar{X}$	1.55	1.56	1.38	F(2,294)=1.92	—
		S.E.	.07	.10	.06		
		N.A.	1	1	3		
		N	115	70	112		

Table 13 (Continued)

			Professional (PRO)	Non-ex-addict paraprofessional (NEA)	Ex-addict paraprofessional (EA)	ANOV	Tukey A
8b.	How likely is it that you would ask (counselor) to help you with this problem?	$\bar{X}$	1.55	1.60	1.44	F(2,267)=1.15	—
		S.E.	.07	.09	.06		
		N.A.	14	9	9		
		N	102	62	106		
9a.	One of your children was in trouble in school.	$\bar{X}$	2.58	2.34	2.46	F(2,274)=1.14	—
		S.E.	.10	.13	.10		
		N.A.	8	7	10		
		N	108	64	105		
9b.	How likely is it that you would ask (counselor) to help you with this problem?	$\bar{X}$	1.93	1.84	1.94	F(2,123)=0.14	—
		S.E.	.13	.16	.12		
		N.A.	71	39	66		
		N	45	32	49		
10a.	You were using drugs heavily again.	$\bar{X}$	1.58	1.63	1.68	F(2,294)=0.46	—
		S.E.	.07	.10	.08		
		N.A.	0	1	4		
		N	116	70	111		
10b.	How likely is it that you would ask (counselor) to help you with this problem?	$\bar{X}$	1.41	1.41	1.41	F(2,249)=0.00	—
		S.E.	.07	.10	.07		
		N.A.	14	13	23		
		N	102	58	92		

[1] $p<0.01$

the client. In other contexts, clients are somewhat ambivalent concerning their discussion with counselors, seeing these situations as neither particularly likely nor unlikely for discussion, on the average. In only one case do the counselor groups differ significantly--when the client needs to borrow money quickly ($100 in our item), the client is more likely to discuss it with the EA ($F(2,293)= 5.69$, $p<0.01$). Of all the situations, this may be the one in which an informal personal relationship is seen as most necessary for reaching a solution. When those who are likely to discuss each problem with the counselor are asked whether they would be likely to ask the counselor for help, the same general pattern is seen. In this case, no significant difference occurs among the three counselor groups.

Clients' Perceptions of Counselor Willingness to Help, and Clients' Desire for Help

Clients were also asked whether they thought their counselors would be willing to participate in certain activities with and for them, and then, whether the clients desired such participation (table 14). The results are striking in that well over half of all clients on each item think that their counselors would be willing to perform the activity in question, whether it is testifying in court or visiting in the hospital (95 percent think so), or even giving personal help with housework or socializing at home (60 percent think so). It is interesting that, in every case, the EA is seen as at least somewhat more willing to perform the activity--however, in only four cases are the group differences significant according to Chi-square tests. These differences occur concerning the counselor's willingness to give personal help; to come to the client's neighborhood; and to socialize with the client at home or in a public place. Statistically, the clients of EAs are also somewhat more interested than clients of the PROs or NEAs in getting the counselor's help in personal chores, paying hospital visits, and discussing the client's problems with family members at home or in the program.

Regardless of counselor group, clients consistently see their counselors as much more willing to help them, than they (the clients) are desirous of such help. The McNemar Test for detecting significance of changes was employed here to test these differences and, in almost every case, statistical significance was found. That is, for each counselor group and virtually every activity, clients perceived counselors as significantly more willing to help them than they (the clients) were willing to accept such help. Virtually the lone exception occurred because the vast majority of clients saw counselors as willing to testify in court for them, and these clients said they would want that to happen if the necessity arose. Once again, the similarities among groups are notable, especially in regard to perceived counselor willingness to help. It might be pointed out, for example, that even in areas in which the EA has traditionally been prevalent, such as socializing with the client and entering his community, the PROs and NEAs are thought by the client to be very willing to participate if asked.

Clients' Perceptions of Counselors' Views of Clients

It may be recalled that counselors were asked whether they agreed or disagreed, and how strongly, with 19 statements or terms describing the average drug abuse client in their programs. (See table 10.) For the most part, views were not well formulated with only three items eliciting either strong agreement or strong disagreement on the average. The items were: "criminals by nature" to which the average response is strong disagreement, "reachable" and "capable of real and permanent change" for which there is rather strong endorsement. In order to get a picture of how well clients understood their counselors' perceptions of them, clients were asked in their interview to estimate how their primary counselors would respond to those questions. Not surprisingly, the results showed that clients do not have well formed perceptions of counselors' views. (See table 15.) Counselors are perceived as likely to answer all questions, except the three mentioned above, with moderate rather than strong agreement or disagreement. As for the three items, clients' perceived average scores for counselors matched actual average scores quite well. In addition, clients' perceptions are not different for the three counselor groups, except that EAs are seen as more likely to agree that clients are likely to steal ($F(2,287)= 3.56$, $p<0.05$) and be dangerous ($F(2,283)= 3.13$, $p<0.05$). As for counselors' actual feelings, it may be remembered that EAs are indeed more apt to think clients are likely to steal, although not significantly so.

To investigate further this seeming agreement between client perceptions and actual counselor feelings, Pearson product-moment correlations were run between counselor score on each item and average score for each counselor's clients. The results show no greater number of significant correlations than might be expected on the basis of chance, indicating that individual counselors' feelings are not predicted well by their clients.

Table 14. Clients' perceptions of counselors' willingness to participate in activities and clients' desires that counselors do so, by counselor group

Activity	Group	Q. 76C. If the need arose, would (counselor) be willing to-- Percent of response Yes	No	(N)	Q. 76D. If the need arose, would you want (counselor) to-- Percent of response Yes	No	(N)
01. Visit you at work?	Professional	89.4	10.6	(104)	74.1	25.9	(112)
	Non-ex-addict paraprofessional	93.8	6.3	(64)	76.5	23.5	(68)
	Ex-addict paraprofessional	94.9	5.1	(98)	80.6	19.4	(103)
02. Go with you on a job interview?	Professional	85.6	14.4	(97)	63.0	37.0	(108)
	Non-ex-addict paraprofessional	83.3	16.7	(66)	55.9	44.1	(68)
	Ex-addict paraprofessional	91.9	8.1	(99)	66.4	33.6	(110)
03. Visit you in the hospital?	Professional	94.1	5.9	(101)	82.4	17.6	(108)
	Non-ex-addict paraprofessional	91.5	8.5	(59)	82.3	17.7	(62)
	Ex-addict paraprofessional	98.0	2.0	(101)	92.7	7.3	(109)
					$\chi^2(2)=6.00$[1]		
04. Go to court to testify for you?	Professional	92.1	7.9	(101)	92.8	7.2	(111)
	Non-ex-addict paraprofessional	95.5	4.5	(66)	90.8	9.2	(65)
	Ex-addict paraprofessional	95.1	4.9	(103)	94.3	5.7	(106)

Table 14 (Continued)

Activity	Group	Q. 76C. If the need arose, would (counselor) be willing to-- Percent of response Yes	No	(N)	Q. 76D. If the need arose, would you want (counselor) to-- Percent of response Yes	No	(N)
05. Go with you to an agency where you could get help?	Professional	84.2	15.8	(101)	67.9	32.1	(109)
	Non-ex-addict paraprofessional	82.3	17.7	(62)	68.8	31.3	(64)
	Ex-addict paraprofessional	87.5	12.5	(96)	69.5	30.5	(105)
08. Give you personal help, such as helping with housework or cooking or buying food for you?	Professional	48.9	51.1	(90)	34.3	65.7	(102)
	Non-ex-addict paraprofessional	56.1	43.9	(57)	42.2	57.8	(64)
	Ex-addict paraprofessional	73.3	26.7	(90)	49.5	50.5	(99)
		$\chi^2(2)=11.64^2$			$\chi^2(2)=4.76^3$		
09. Come to your neighborhood to help you deal with people with whom you are having problems?	Professional	56.7	43.3	(97)	30.8	69.2	(107)
	Non-ex-addict paraprofessional	70.0	30.0	(60)	40.0	60.0	(70)
	Ex-addict paraprofessional	73.5	26.5	(98)	43.8	56.2	(105)
		$\chi^2(2)=6.62^1$					
10. Come to your home to discuss your problems with you or people you live with?	Professional	78.0	22.0	(91)	48.1	51.9	(104)
	Non-ex-addict paraprofessional	87.7	12.3	(57)	64.2	35.8	(67)
	Ex-addict paraprofessional	87.2	12.8	(94)	66.3	33.7	(98)
					$\chi^2(2)=8.02^1$		

Table 14 (Continued)

Activity	Group	Q. 76C. If the need arose, would (counselor) be willing to-- Percent of response Yes	No	(N)	Q. 76D. If the need arose, would you want (counselor) to-- Percent of response Yes	No	(N)
11. Have members of your family come to this program for counseling about your problems?	Professional	73.1	26.9	(78)	42.9	57.1	(91)
	Non-ex-addict paraprofessional	78.9	21.1	(57)	45.3	54.7	(64)
	Ex-addict paraprofessional	82.3	17.7	(79)	64.3	35.7	(98)
					$\chi^2(2)=10.11^2$		
16. Meet you in a public place for socializing, e.g., to have lunch or go to a ball game?	Professional	60.0	40.0	(85)	47.5	52.5	(101)
	Non-ex-addict paraprofessional	71.7	28.3	(60)	44.4	51.6	(64)
	Ex-addict paraprofessional	77.0	23.0	(87)	55.0	45.0	(100)
		$\chi^2(2)=6.05^1$					
17. Socialize with you in your home or his home?	Professional	52.2	47.8	(92)	40.0	60.0	(105)
	Non-ex-addict paraprofessional	65.5	34.5	(58)	47.8	52.2	(67)
	Ex-addict paraprofessional	67.9	32.1	(81)	52.1	47.9	(94)
		$\chi^2(2)=5.13^3$					

Note--If χ^2 value is not given, then significance was not achieved.

[1] $p<0.05$

[2] $p<0.01$

[3] $p<0.10$

Table 15. Clients' perceptions of their counselors' views of drug abusers, by counselor group

Q. 81. Please check the box to indicate whether your primary counselors would (1) strongly agree, (2) agree, (3) disagree, or (4) strongly disagree with each statement about the average drug abuser.

		Professional (PRO)	Non-ex-addict paraprofessional (NEA)	Ex-addict paraprofessional (EA)	ANOV	Tukey A
1. Mentally ill	$\bar{X}$	2.68	2.51	2.74	F(2,290)=1.33	___
	S.E.	.08	.12	.09		
	N.A.	2	3	4		
	N	114	68	111		
2. Physically ill	$\bar{X}$	2.37	2.41	2.50	F(2,287)=0.62	___
	S.E.	.08	.11	.08		
	N.A.	3	3	6		
	N	113	68	109		
3. Unfortunate victims of society	$\bar{X}$	2.52	2.51	2.42	F(2,281)=0.41	___
	S.E.	.08	.10	.09		
	N.A.	6	4	8		
	N	110	67	107		
4. Unaware of mental problems	$\bar{X}$	2.39	2.52	2.31	F(2,282)=1.15	___
	S.E.	.09	.10	.09		
	N.A.	5	5	7		
	N	111	66	108		
5. Criminals by nature	$\bar{X}$	3.26	3.14	3.22	F(2,283)=0.59	___
	S.E.	.07	.10	.06		
	N.A.	7	5	4		
	N	109	66	111		
6. Morally weak	$\bar{X}$	2.77	2.59	2.63	F(2,278)=1.23	___
	S.E.	.08	.11	.08		
	N.A.	5	7	9		
	N	111	64	106		
7. Basically no better or worse than other people	$\bar{X}$	2.25	2.25	2.09	F(2,281)=1.21	___
	S.E.	.08	.10	.08		
	N.A.	6	3	9		
	N	110	68	106		

Table 15 (Continued)

		Professional (PRO)	Non-ex-addict paraprofessional (NEA)	Ex-addict paraprofessional (EA)	ANOV	Tukey A
8. Capable of real and permanent change	$\bar{X}$	1.78	1.85	1.82	F(2,290)=0.29	—
	S.E.	.06	.08	.06		
	N.A.	3	3	3		
	N	113	68	112		
9. Hostile	$\bar{X}$	2.90	2.97	2.82	F(2,279)=0.81	—
	S.E.	.07	.08	.07		
	N.A.	7	6	7		
	N	109	65	108		
10. Reachable	$\bar{X}$	1.89	1.90	1.90	F(2,288)=0.00	—
	S.E.	.06	.07	.06		
	N.A.	3	3	5		
	N	113	68	110		
11. Culturally disadvantaged	$\bar{X}$	2.60	2.66	2.54	F(2,276)=0.45	—
	S.E.	.08	.10	.10		
	N.A.	9	7	7		
	N	107	64	108		
12. Smarter than most people	$\bar{X}$	2.80	2.80	2.79	F(2,281)=0.00	—
	S.E.	.07	.08	.07		
	N.A.	5	5	8		
	N	111	66	107		
13. Discriminated against unfairly	$\bar{X}$	2.59	2.72	2.54	F(2,281)=1.03	—
	S.E.	.07	.09	.08		
	N.A.	3	7	8		
	N	113	64	107		
14. Likely to steal	$\bar{X}$	2.47	2.43	2.21	F(2,287)=3.56[1]	E<P
	S.E.	.08	.08	.07		
	N.A.	4	3	5		
	N	112	68	110		
15. Likely to be dangerous	$\bar{X}$	2.79	2.68	2.54	F(2,283)=3.13[1]	E<P
	S.E.	.07	.08	.08		
	N.A.	4	5	7		
	N	112	66	108		

Table 15 (Continued)

		Professional (PRO)	Non-ex-addict paraprofessional (NEA)	Ex-addict paraprofessional (EA)	ANOV	Tukey A
16. Resistant to treatment	$\bar{X}$	2.69	2.72	2.63	F(2,283)=0.29	—
	S.E.	.07	.09	.07		
	N.A.	3	4	9		
	N	113	67	106		
17. Just needing a break	$\bar{X}$	2.35	2.31	2.25	F(2,280)=0.43	—
	S.E.	.08	.10	.08		
	N.A.	2	6	11		
	N	114	65	104		
18. Likely to become alcoholic if drugs aren't available	$\bar{X}$	2.71	2.61	2.58	F(2,280)=0.66	—
	S.E.	.08	.11	.09		
	N.A.	5	5	9		
	N	111	66	106		
19. Childish	$\bar{X}$	2.92	2.91	2.79	F(2,281)=0.79	—
	S.E.	.08	.08	.08		
	N.A.	6	4	8		
	N	110	67	107		

[1] $p<0.05$

One reason for this lack of correlation was found by inspecting frequency distributions for each statement by counselors and clients. These show the prevalence of fairly severe range truncation, that is, more than 80 percent of the answers to virtually all questions fell in two of the four possible response categories. For the most part, the two categories were "agree" or "disagree" rather than "strongly agree" or "strongly disagree." Thus, there is not enough variation in counselor response to any of the items to expect high correlations between individual counselor points of view and clients' perceptions of these points of view. However, clients seem to be generally in touch with the points of view of counselors in that they are able to mirror group patterns of response to the statements and terms in question.

Clients' Expectations for the Future

Another question asked of clients paralleled one asked in the counselor's interview concerning treatment expectations. It may be remembered that counselors were asked how well off they thought clients would be on a variety of dimensions within a year or so after leaving treatment. (See table 9.) Clients were then asked about their own expectations on the same dimensions. One obvious point of interest here is the expectations of the clients themselves, while another is the extent to which the prognostications of counselors and clients coincide.

Regarding the views of the clients, the most outstanding feature is the general optimism expressed. (See table 16.) Across all items ranging from those concerning the Federal criteria or drug-free, crime-free, and employment status to "having good lives in general," clients report great expectations. Clients feel on the average that it is either very likely or at least likely that they will fare well on every dimension listed within a year or two after leaving the current treatment program. Although the range of responses across all items is small, clients are most optimistic about their ability to stay away from crime, while they are least optimistic about remaining drug free and having no need for further treatment. The patterns are much the same for clients and counselors with regard to which outcomes are most and least probable.

It is most interesting that for both clients and counselors, the clients remaining drug free and having no need for treatment are seen as less likely than all the other outcomes cited in the question. This may reflect the caution of drug treatment personnel in promising easy release from dependence on drugs. The frustration of the counselor's job is evident here in that treatment success is often defined by the counselors themselves, the clients, and the Federal Government, in terms of getting clients off drugs. (See table 8.)

Staying away from crime, another of the Federal criteria, is seen as more likely relative to other outcomes by clients than it is by counselors. In fact, clients view this outcome as more likely than any of the others. They are somewhat less optimistic about the third Federal criterion--legal employment. Counselors, on the other hand, regard legal employment of clients as more likely than any of the other outcomes, although they are less sanguine about the prospects of clients holding those jobs. Quite possibly counselors feel it is partly their responsibility to help the client get a job, but it is more the responsibility of the client to hold the job once gained. Also, of course, by definition, more clients will get jobs than will hold them.

The client data were further examined to see if differences in optimism among the various items were statistically significant. Analyses were performed separately for employed and unemployed clients since the question of getting a legal job was not asked of those who had jobs. First, it should be noted that comparison of means of these two groups reveals no differences in answers to each item asked of both groups except for the prospects of holding a legal job, as might be expected. Newman-Keuls tests for differences among means for the employed clients show that holding a legal job was seen as significantly more likely than every other item except staying away from crime and having a good life in general. Staying away from crime was seen as significantly more likely than remaining drug free and having no need for treatment. No other differences were significant. Newman-Keuls tests for unemployed clients revealed only that staying away from crime was seen as significantly more likely than any other outcome, and that having no need for further treatment was seen as significantly less likely than any other outcome.

Differences among clients of different counselor groups were not significant. Again, the most impressive feature of the client data is the apparent optimism of the clients with regard to expectations. All outcomes listed--and all listed were favorable--were seen as likely.

This degree of optimism is not shared by their counselors. On the average, as pointed out in the Attitudes of Counselors Toward

CONTINUED

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Table 16. Clients' expectations for their own lives after they leave treatment, by counselor group

Q. 79. Think about how you yourself expect to be within a year or two after treatment. For example, how likely is it that you will:

[(1) very likely; (2) likely; (3) unlikely; (4) very unlikely]

		Professional (PRO)	Non-ex-addict paraprofessional (NEA)	Ex-addict paraprofessional (EA)	ANOV
1. Remain drug free?	$\bar{X}$	1.64	1.72	1.70	F(2,285)=0.21
	S.E.	.08	.11	.08	
	N.A.	4	6	4	
	N	112	65	111	
2. Get a legal job?	$\bar{X}$	1.58	1.75	1.59	F(2,289)=0.04
	S.E.	.09	.14	.10	
	N.A.	2	3	5	
	N	114	68	110	
3. Hold a legal job?	$\bar{X}$	1.55	1.49	1.50	F(2,285)=0.14
	S.E.	.08	.09	.08	
	N.A.	1	6	7	
	N	115	65	108	
4. Stay away from crime?	$\bar{X}$	1.37	1.37	1.40	F(2,289)=0.05
	S.E.	.06	.09	.07	
	N.A.	1	4	5	
	N	115	67	110	
5. Have good physical health?	$\bar{X}$	1.56	1.68	1.65	F(2,287)=0.72
	S.E.	.06	.10	.07	
	N.A.	2	5	5	
	N	114	66	110	
6. Have good mental health?	$\bar{X}$	1.53	1.58	1.51	F(2,290)=0.19
	S.E.	.06	.09	.06	
	N.A.	1	5	3	
	N	115	66	112	

Table 16 (Continued)

		Professional (PRO)	Non-ex-addict paraprofessional (NEA)	Ex-addict paraprofessional (EA)	ANOV
7. Have a good family life?	$\bar{X}$	1.59	1.58	1.67	F(2,287)=0.41
	S.E.	.07	.09	.08	
	N.A.	3	4	5	
	N	113	67	110	
8. Have a good life in general?	$\bar{X}$	1.50	1.58	1.55	F(2,286)=0.31
	S.E.	.06	.09	.07	
	N.A.	3	5	5	
	N	113	66	110	
9. Be a productive member of society?	$\bar{X}$	1.61	1.60	1.56	F(2,287)=0.16
	S.E.	.07	.09	.07	
	N.A.	2	6	4	
	N	114	65	111	
10. Have no need for treatment?	$\bar{X}$	1.84	1.76	1.81	F(2,286)=0.18
	S.E.	.09	.11	.09	
	N.A.	1	5	7	
	N	115	66	108	

Clients section of this report, the counselors are neither optimistic nor pessimistic regarding client outcomes. In order to see whether these levels of optimism are different statistically for counselors and clients, two-way analyses of variance were run for each expectation using the average response of each counselor's clients as the client data. Without exception, client optimism is significantly greater than counselor optimism for each expectation.

Whether these high client expectations will lead to eventual frustrations or whether they will constitute a self-fulfilling prophecy is, at this point, in the realm of speculation.

Clients' Relationships with Counselors

In a previous section, it was found that clients thought their counselors willing to help them in a great number of situations, from testifying in court to helping with household chores. Further, most of the clients felt they would want their counselors to help them with these services and activities if the need arose. In view of these findings and others presented here, it is not surprising that clients, when asked how well or poorly they get along with their counselors, give very favorable responses. The extent of the favorability, however, is overwhelming. Of the 300 clients responding, more than 95 percent offered positive or very positive views of the relationships with their primary counselors (table 17). Each counselor group was viewed positively, with more clients of PROs (64 percent) than of NEAs or EAs (55 percent each) giving very positive comments. The enthusiasm for counselors is largely accounted for by three factors suggested in a free-answer question. First, counselors are seen as understanding the client's problem. Second, the counselors' characteristics or personalities are seen as good--they are nice people who are open-minded, supportive, and nonjudgmental. Finally, the clients report that their counselors and they have good relationships, typified by understanding and honesty.

Administrators' Views of Clients' Attitudes Toward Counselors

Program administrators were questioned about their observations of client-counselor interactions. Specifically, administrators were asked which of the three counselor groups were the object of most complaints from clients, what the nature of these complaints was, and whether or not they (the administrators) saw these complaints as legitimate. Administrators were also asked to describe in their own words how the different counselor groups work with clients and the differences, if any, between the groups in their attitudes toward clients.

The results of this questioning generally corroborate what has already been seen--that clients and counselors seem to get on very well. It should be emphasized here that the complaint questions were designed to elicit relative rather than absolute frequencies of complaints for purposes of comparing counselor groups. However, when administrators were asked to identify the most frequently complained about group, no one group stood out as receiving more complaints than another. When administrators were asked to identify the most frequent client complaint about EAs, it was that they are seen as too often using themselves as a central reference and not allowing for the individual characteristics and needs of the client. The most frequent complaint by clients about PROs, on the other hand, is that the PROs are sometimes rather distant and removed from the clients because they themselves have not been addicted. Administrators report that the number of such complaints about either group is small, however. Also, administrators tended to think that these few complaints were not particularly well justified, and that the groups work equally well with clients.

In general, the group differences are quite small, and the overall level of satisfaction with counselors in each group by clients seems quite high if one uses complaints to administrators in conjunction with administrator observations as an index.

5. MAJOR FINDINGS

The sex and ethnic distribution among the counselors mirrored that in the college-educated nonopiate abusing versus non-college-educated heroin abusing populations. White/Anglo females were most prevalent among PROs; black males among EAs, with NEAs more closely resembling the EAs.

The average age of the EAs was about 10 years greater than that of the PROs, with NEAs closer to the age of the EAs.

The PROs also had briefer tenure in their present positions than the other groups.

EAs had somewhat more previous counseling experience in drug abuse programs per se, while NEAs had more counseling experience in other settings such as the criminal justice system.

Table 17. Clients' feelings about how well they get along with their counselors, by counselor group (in percent)

Q. 82. Finally, please tell me in your own words how well or poorly you feel you get along with (name of counselor) [and why?]

Counselor Group	Very positive comments	Somewhat positive comments	Somewhat negative comments	Very negative comments	N
Professional	64.3	28.7	4.3	2.6	115
Non-ex-addict paraprofessional	54.9	42.3	1.4	1.4	71
Ex-addict paraprofessional	55.3	41.2	3.5	0.0	114

The picture that emerges from the above is one in which PROs come to their jobs directly from the schools, while NEAs of similar rank have filtered through counseling positions in a variety of settings. The EAs have arrived after experiencing addiction and cure.

PROs by definition had more education with NEAs next and EAs last, although both the latter groups had a considerable number of college credits on the average. PROs educational advantage was not so much in counseling courses per se, but in the number of related courses such as abnormal psychology and deviance.

EAs had the least training by current and previous programs, while NEAs had most. However, there were few group differences in number of topics covered in training, since most counselors reported training in almost every area. With regard to specific areas, training in clerical activities was most frequently reported, while training in outreach or counseling in the community was relatively infrequent.

In all, there is a striking resemblance of the NEAs and EAs in a variety of aspects: their ethnic mix, age, counseling experience, and academic training. That NEAs appear to resemble the populations served by the programs more than they resemble the PROs is consistent with the model of the indigenous, community-based paraprofessional promulgated in the literature.

EAs, as expected, reported significantly more drug use than the other groups in virtually every area--with hallucinogens the only exception--and all but two of the EAs had treatment experience. The NEAs reported somewhat more drug use than the PROs, although histories of treatment were present in neither of these two groups. The EAs included many who had experienced more than one treatment modality.

With regard to counselor attitudes toward clients, our most general conclusion was that the three counselor groups are very similar--confirming the findings of many smaller and local studies reported in the literature. Further, opinions and expectations tended to be moderate rather than strong across virtually all of the attitudinal areas investigated. More specific results are summarized below.

PROs, NEAs, and EAs tended to agree that peer group pressures are most important in understanding why drug abuse starts, and that larger social factors such as poverty and discrimination are less important. The three counselor groups also agree that the client is the most important factor in treatment success, that the counselor plays only a secondary role, and that supporting drugs are least important of all. The meaning of treatment success does not differ much by counselor group, with freedom from drug abuse and achievement of middle-class lifestyles offered most commonly as components of such success. As far as the likelihood of achieving treatment success is concerned, all counselor groups were neither particularly optimistic nor pessimistic concerning specific outcomes. Most counselors either mildly agreed or mildly disagreed that the average clients, within a year or two after leaving treatment, will remain drug free, get and hold a legal job, be healthy mentally and physically, have a good life in general and have no further need for treatment. Yet each of the counselor groups perceived as common client characteristics that they are reachable, capable of real and permanent changes, and not at all criminals by nature.

In order to bring about treatment success, all counselors felt that certain modes of interaction with clients were more appropriate than others. Thus, while EAs were somewhat more in favor than PROs of going out into the community, and of socializing with clients, the differences were not large. Also while EAs disagreed significantly less often than PROs or NEAs, that an addiction history is necessary to understand clients, the point is that they too did disagree. Just as surprisingly PROs disagreed as much as did NEAs and EAs with the idea that there is no substitute for course work in learning how to deal with clients. These findings and others were regarded as indicating some ambivalence or uncertainty on the part of each group about the utility of their particular backgrounds for dealing with clients. With regard to treatment modality, similar uncertainty prevailed--except that counselors in methadone programs naturally held much more positive views about methadone than drug-free counselors. Administrators' view of counselor attitudes were that clients complain relatively little about any particular counselor group.

Because of the apparent homogeneity of counselor attitudes toward clients, little variation exists to be explained. Perhaps for that reason, partial correlational analysis using counselor background variables did not contribute significantly to predicting attitudes of counselors toward clients over and above group membership.

Clients' views of counselors are somewhat better differentiated by counselor groups, although a generally high level of trust,

respect, and liking for all counselor groups is the most general finding. The biggest advantage any one counselor group has over another with regard to perceived counselor characteristics may well be the history of addiction of the EA. They are rated as significantly more knowledgeable about drugs and the street and, perhaps related to that, their clients more often claim to profit from counseling sessions. However, regarding the latter point, the counselor groups were not differentially perceived on some 20 other items reflecting more or less directly on aspects of those counseling sessions and the counseling situation in general. Clients generally expressed great willingness to discuss a variety of issues with counselors and were significantly more likely to turn to one group more than another in only one situation--to the EA, if the need was to borrow money quickly. Clients saw their counselors as extraordinarily willing to help them in situations ranging from counseling to personal help with housework. The EA was seen as more willing, but only a little more, to be helpful on most tasks. Clients of all counselor groups were about equal in their willingness to ask for help from the counselors concerning each issue. Their desire for help from the counselor in every case is somewhat less than the perceived willingness of the counselor to give it.

Average scores for clients' perceptions of counselors' views of them matched actual average scores from counselors very well for almost all client characteristics. However, correlations between client-perceived counselor scores and actual counselor scores were virtually zero, indicating that clients were unable to predict ratings of their own capabilities and characteristics by their primary counselors.

Clients' expectations for the future were more optimistic than counselors' expectations for them across a variety of potential outcomes. The patterns of response though were much the same for counselors and clients--e.g., both thought it would be easier to get a job than to become and remain drug free.

Clients' relationships with counselors on the average were shown to be good by remarks of the clients themselves, and indirectly through observations of administrators. While the EA is looked upon somewhat more favorably than PROs or NEAs, the support, trust and helpfulness of members of each counselor group is apparently appreciated.

Summary and Conclusions

With regard to counselor attitudes toward clients and client attitudes toward counselors, it is apparent that there are surprisingly few differences among the counselor groups. All counselor groups are favorably disposed toward clients. For example, the EAs are predictably viewed by clients as more knowledgeable about drugs, drug problems, and the street scene than are PROs and NEAs--but these latter groups are also seen as quite knowledgeable in these areas. To take another example, clients of PRO counselors are statistically more likely to strongly agree with the statement "My counselor is intelligent" than are clients of the other groups. However, the great majority of clients of both paraprofessional groups also strongly agree with that statement. This may account for the fact that neither the drug and street experience of EAs nor the perceived intellectual advantage of the PROs are predictors of perceived helpfulness to the clients. Indeed, the NEAs, who have neither the advantage of the addiction experience nor the formal course work of the PRO, seem to fare as well in the view of clients as either of these groups.

Counselors say they are willing to help and to intervene in a great variety of situations depicted on an activities list, and clients generally perceive that this is true. Further, most of the clients reacted positively to the prospects of such help. Overall, clients are extremely positive in their descriptions of their relationships with their counselors. Regardless of counselor group, counselors are generally seen as open-minded, supportive individuals who understand the clients' problems and who interact with them honestly and authentically.

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APPENDIX

CLIENT BACKGROUND DATA

Table A-1. Mean years of any client use and years of continuing client use of drugs prior to treatment entry as a function of counselor group (Modality effects are noted where significant at at least α=0.05. There were no effects of counselor group.)

Drug or drug category		Years of any use				Years of continuing use			
		PRO	NEA	EA	(Modality effect)	PRO	NEA	EA	(Modality effect)
Marihuana/hashish	MM	9.59	11.14	11.66	NS	6.72	7.60	9.28	NS
	DF	10.71	11.31	10.17		6.51	6.56	6.81	
Drugstore items containing drugs	MM	1.73	1.68	1.39	NS	1.05	.98	.50	NS
	DF	1.71	1.47	2.80		.73	.88	1.09	
Inhalants such as glue	MM	.39	.19	.27	DF>MM	.24	.09	.10	NS
	DF	.65	.12	.88		.23	.12	.33	
Hallucinogens such as LSD	MM	1.65	1.54	1.49	DF>MM	.74	.63	.84	NS
	DF	3.03	2.06	2.16		1.53	.59	1.16	
Barbiturates	MM	3.96	2.68	3.60	DF>MM	1.92	1.43	2.09	DF>MM
	DF	5.35	5.71	4.73		2.25	3.76	3.55	
Sedatives and tranquilizers	MM	2.21	2.55	3.19	NS	1.11	1.06	1.42	NS
	DF	3.76	4.06	3.25		2.33	2.24	1.77	
Cocaine	MM	4.38	3.89	5.72	NS	2.43	1.43	2.71	NS
	DF	4.87	4.18	4.12		2.32	1.29	1.56	
Heroin	MM	8.91	11.61	11.20	MM>DF	8.08	10.22	10.35	MM>DF
	DF	7.36	6.88	7.88		5.38	5.06	6.00	
Illegal methadone	MM	1.92	1.56	1.51	MM>DF	.75	.76	.60	NS
	DF	.95	1.12	1.23		.30	.18	.66	
Opiates or drugs with the same effect	MM	2.51	3.51	3.13	NS	1.48	.96	1.37	NS
	DF	2.53	2.06	2.02		1.27	.53	1.74	
Alcohol to excess	MM	2.05	2.51	2.93	NS	1.16	1.83	2.30	NS
	DF	3.61	1.88	2.91		2.55	1.18	1.68	
Amphetamines	MM	.53	1.17	.39	NS	.20	.63	.39	NS
	DF	.95	1.00	.88		.55	.59	.33	

Table A-2. Mean frequency of client use drugs in the year prior to treatment entry and in the 30 days prior to treatment entry as a function of couns or group (There were no effects of counselor group. Modality effects are noted where significant at at lea t α=0.05.) [1 = not at all; 2 = less than once a month; 3 = less than once a week; 4 = once a week; 5 = several times a week; 6 = daily]

Drug or drug category		Use in the year before treatment entry				Use in the 30 days before treatment entry			
		PRO	NEA	EA	(Modality effect)	PRO	NEA	EA	(Modality effect)
Marihuana/hashish	MM	2.71	2.32	2.48	DF>MM	2.86	2.38	2.35	DF>MM
	DF	3.43	3.06	3.30		3.23	2.47	3.29	
Drugstore items containing drugs	MM	1.26	1.20	1.23	NS	1.15	1.08	1.25	NS
	DF	1.11	1.06	1.25		1.28	1.00	1.21	
Inhalants such as glue	MM	1.04	1.00	1.00	NS	1.00	1.00	1.00	
	DF	1.02	1.00	1.07		1.00	1.00	1.00	—
Hallucinogens such as LSD	MM	1.03	1.06	1.01	DF>MM	1.03	1.06	1.03	NS
	DF	1.25	1.41	1.37		1.10	1.00	1.20	
Barbiturates	MM	1.50	1.20	1.35	DF>MM	1.26	1.22	1.23	DF>MM
	DF	1.89	1.47	2.02		1.76	1.44	1.93	
Sedatives and tranquilizers	MM	1.88	1.74	2.18	NS	1.85	2.00	2.13	NS
	DF	2.71	1.40	2.10		2.31	1.13	2.07	
Cocaine	MM	1.90	1.42	1.91	NS	1.94	1.31	1.68	NS
	DF	1.62	2.25	1.80		1.28	1.47	1.54	
Heroin	MM	4.57	4.51	4.57	MM>DF	4.46	4.39	3.66	MM>DF
	DF	3.49	3.18	3.24		2.98	2.88	2.98	
Illegal methadone	MM	1.83	1.62	1.75	MM>DF	1.77	1.48	1.67	NS
	DF	1.43	1.31	1.29		1.17	1.00	1.18	
Opiates and synthetics	MM	1.46	1.50	1.35	NS	1.43	1.35	1.18	DF>MM
	DF	1.58	1.47	1.45		1.60	1.35	1.77	

Table A-2 (Continued)

Drug or drug category		Use in the year before treatment entry				Use in the 30 days before treatment entry			
		PRO	NEA	EA	(Modality effect)	PRO	NEA	EA	(Modality effect)
Alcohol to excess	MM	1.17	1.49	1.39	DF>MM	1.29	1.62	1.30	(Interaction of group by modality
	DF	1.83	1.41	1.73		1.73	1.00	1.57	
Amphetamines	MM	1.07	1.25	1.06	NS	1.11	1.28	1.00	NS
	DF	1.28	1.35	1.18		1.22	1.00	1.07	
Opiate index[1]	MM	4.66	4.62	4.73	MM>DF	4.72	4.41	4.08	MM>DF
	DF	3.91	3.31	3.15		3.15	3.12	3.27	

[1]The Opiate index is an overall measure of the use of heroin, illegal methadone, and/or any other opiate which leads to eligibility for methadone maintenance. It is calculated as the greatest frequency of use among heroin, illegal methadone, or other opiates and synthetics with morphine-like effects.

Table A-3. Summary of treatment history of clients as a function of counselor group and modality. (Modality effects significant at at least α=0.05 are noted. There were no group main effects.)

Measure		Counselor Group PRO	NEA	EA	(Modality effect)
1. Percentage ever in treatment before the current treatment episode.		75.0	70.0	73.9	
2. Mean number of prior treatment episodes.	MM	1.77	1.70	2.13	MM>DF
	DF	1.71	.59	.91	
3. Mean number of attempts to detox.	MM	.71	.57	1.01	MM>DF
	DF	.63	.06	.41	
4. Mean number of times in chemical support modality (methadone maintenance, Darvon N).	MM	.77	.85	.76	
	DF	.29	.24	.27	MM>DF
5. Mean number of years in treatment.	MM	1.54	1.56	1.61	MM>DF
	DF	1.37	.76	.78	
6. Mean number of heroin related treatment episodes.	MM	1.65	1.51	2.06	MM>DF
	DF	1.41	.35	.82	
7. Mean number of court related treatment episodes.	MM	.23	.26	.17	NS
	DF	.39	.41	.20	

Note — Data are based on 301 of the 302 clients (99.7 percent). In 38.9 percent of treatment episodes, the dates of entering and/or leaving treatment were incomplete. In such cases, the mean length of time of treatment of all clients who received the same modality of treatment and had complete data was used to estimate the length of that treatment episode. If a client had not been in treatment before, he was scored zero (0) on indices 2 through 7 above.

Table A-4. Educational history of clients as a function of counselor group

	Counselor group		
	PRO	NEA	EA
1. Highest grade completed in school (percent):			
- 8th grade or less	6.9	9.9	7.0
- 9th, 10th, 11th grade	36.2	40.9	45.2
- High school or GED	33.6	25.4	26.9
- Some college	20.7	22.5	20.0
- BA/BS degree or beyond	2.6	1.4	1.7
N	116	71	115
2. Percent of clients receiving any schooling (vocational or otherwise) in the year before treatment.	32.8	23.9	22.6
a. Percent of all clients receiving vocational training	17.2	11.3	13.0
b. Percent of all clients receiving schooling other than vocational training	19.0	12.9	11.3
3. Mean number of months in school in the year before treatment.			
a. In vocational training	.91	.70	.85
b. In schooling other than vocational	1.15	1.11	.58
4. Percent of clients receiving any schooling (vocational or otherwise) in the 30 days before treatment.	9.5	11.3	8.7
a. Percent of all clients receiving any vocational training	3.5	2.8	7.0
b. Percent of all clients receiving any schooling other than vocational training	7.0	9.9	2.6

Note — Data are based at least on responses of 301 out of the 302 clients (99.7 percent).

Table A-5. Employment history of clients as a function of counselor group

		Counselor group		
		PRO	NEA	EA
I. All Clients - Males and Females Considered Together				
1. Percentage of clients who ever held a legal job, one for which they got paid and either paid taxes or had taxes taken out of their pay.		94.8	94.4	95.7
2. Percentage of clients who held at least one job in the year prior to treatment entry.		54.3	51.4	55.7
3. Mean number of months employed in the year prior to treatment entry.	ALL	4.89	5.02	4.59
	MM	4.79	4.75	4.25
	DF	5.06	5.85	5.14
4. Percentage of clients who worked at least 1 day in the 30 days prior to treatment entry.		31.3	30.0	40.7
5. Mean numbers of days worked, including Saturdays and Sundays, at a legal job, in 30 days prior to treatment entry.		5.28	6.29	5.89
6. Percentage of clients employed at entry into treatment.		29.3	29.6	27.8
II. Female Clients - Time as Housewives				
7. Percentage who had ever been a housewife.		81.8	88.0	77.5
8. Percentage who had been a housewife in the year prior to treatment entry.		50.0	44.0	57.1
9. Mean number of months mainly a housewife in year before entry into treatment.		4.93	4.24	5.98
10. Percentage mainly housewives in the 30 days prior to treatment entry.		45.5	48.0	52.5

Note — Data are based on at least 300 of the 302 respondents.

Table A-6. Criminal involvement of clients as a function of counselor group

	Counselor group		
	PRO	NEA	EA
1. Percent ever arrested.	83.6	87.3	90.4
2. Number of arrests in year prior to treatment entry (percent):			
None	56.9	62.9	55.7
Once	19.8	22.9	21.7
2 to 4 times	19.0	8.6	17.4
More than 4 times	4.3	5.7	5.2
3. Mean number of arrests in year prior to treatment entry.	1.07	.80	1.11
4. Percent of all arrests which were drug related in the year before treatment.	42.4	42.9	54.9
5. Number of days in jail in year before treatment (percent):			
None	61.2	64.3	47.8
1 to 10 days	18.1	10.0	20.9
11 to 100 days	8.6	10.0	17.4
Over 100 days	12.1	15.7	13.9
6. Mean number of days in jail in year before treatment.	32.2	48.5	45.5
7. Percent arrested in the 30 days prior to treatment entry.	4.35	5.71	8.85
8. Number of days in jail in the 30 days before treatment entry (percent):			
None	93.1	91.4	87.8
1 to 10 days	3.45	5.7	5.2
More than 10 days	3.45	2.9	7.0
9. Percent of clients in treatment due to an arrest.	17.2	21.1	20.9

Note — Data presented in this table are based on at least 99.3 percent of the full sample of clients.

III

Professional and Paraprofessional Drug Abuse Counselors: The Progress of Clients in Treatment

Executive Summary

This report is based on a NIDA-funded study of three groups of counselors working in drug-abuse treatment programs: (1) professional counselors who hold at least a bachelor's degree and who do not have addiction histories; (2) ex-addict paraprofessionals who do not usually hold a bachelor's degree; and (3) non-ex-addict paraprofessionals who neither hold a bachelor's degree nor have an addict background. Data were collected in drug-free and methadone maintenance programs located in five major SMSAs--New York; Washington, D.C.; Chicago; Los Angeles; and San Francisco--during the winter of 1976 and the spring of 1977. Personal interviews were conducted with counselors from each of the three groups, with administrators of the programs in which the counselors were employed, and with clients of the respective counselors.

One objective of the study, and the topic of this monograph, was to consider the progress of clients in the course of treatment in an attempt to identify any unique strengths and emphases of the three counselor groups in working with clients. First, the backgrounds of clients were investigated to assess the possibility of differential assignment of clients with special problems to one type of counselor or another. It was found that clients of professional counselors were slightly younger than clients of non-ex-addict paraprofessionals. Also, clients of professional counselors in the drug-free modality reported more excessive alcohol use and an average of one more drug treatment episode than clients counseled by non-ex-addicts. Finally, more clients of ex-addict counselors spent time in jail in the year prior to treatment entry than did clients of professional and non-ex-addict paraprofessional counselors. These few differences must be viewed against an overwhelming number of measures on which clients of the three counselor groups were strikingly similar. In general, there seemed little reason to suspect a systematic bias or orientation in the treatment field in selecting particular types of counselors to treat one or another type of client.

A broad investigation of the progress of these clients in treatment revealed no real differences in the attainment of treatment goals as a function of counselor group. Clients of the three groups had been in treatment equal lengths of time, suggesting equivalent retention levels across counselor groups; and, clients of all counselor groups exhibited drastic reductions in overall levels of substance use as well as very low levels of arrest and time spent in jail following entry into treatment. With regard to education and employment, it was found that more clients of professionals were in school during the course of treatment than were clients of paraprofessionals; that slightly more clients of non-ex-addict counselors held jobs at followup than clients of the other two counselor groups; and that slightly more female clients of ex-addict paraprofessionals reported being mainly housewives. The few differences were again overridden by a plethora of similarities among clients in these endeavors across all counselor groups. This contributed to the conclusion that the various counselor groups hold common goals and stress common outcomes when working with clients.

An investigation of the quality of life of clients supported the conclusion that clients of the three groups fared equally well in the course of treatment. Across groups, clients participated in ordinary chores, tasks, and recreational activities with equal frequency, showed equal levels of social interaction in their lives and equal satisfaction with people with whom they lived. They rated their health as slightly less than good on the average, and expressed a good deal of dissatisfaction with their homes and neighborhoods.

Overall, clients seemed to progress equally well in the care of a variety of counselor types. Whether or not there are philosophical conflicts among these counselor groups, virtually no evidence was found here of differential impact on clients, whether individual dimensions of treatment or overall progress of clients is taken as the criterion of counselor quality.

CONTENTS

PROFESSIONAL AND PARAPROFESSIONAL DRUG ABUSE COUNSELORS:

THE PROGRESS OF CLIENTS IN TREATMENT

By

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Mary Ann Ausetts

1. ORGANIZATION OF THIS REPORT

The report opens with a review of the sparse literature concerned with the evaluation of the impact of professional and paraprofessional counselors in a number of service delivery systems. This review is followed by a presentation of the methodology of the study. Here particular emphasis is given to the backgrounds of clients of the three types of counselors and to counseling input to these clients prior to the onset of the present study. Also considered in the methodology section are validity data on the convergence of counselor and client responses to questions of client progress in treatment. The results follow, reported in five subsections, dealing, respectively, with the drug use, education, employment, criminality, and quality of life of the clients. For the first 4 of these subsections, client functioning is considered for all time between treatment entry and the time of the first interview, and then for just the 30 days prior to the first interview. In addition, the data of a 4-month followup of clients are presented. In a final section, differences in client progress across counselor groups are summarized against a backdrop of the previously reviewed literature.

2. LITERATURE REVIEW

As previously indicated, the concern of the present report is the progress through treatment of clients of three types of counselors. Literature relevant to this concern is sparse, even when considered across the areas of drug abuse, mental health, corrections, and alcoholism. Literature which addresses the quality of task performance of counselors, as rated by their administrators, is, overall, far more prevalent than that which considers the client in treatment as an indicator of the quality of counselor performance. A likely reason for the dearth of literature concerning client outcomes as a function of counselor group is that the goals of paraprofessional-counselor oriented research often have been to determine whether or not newly developed or defined job descriptions or task allocations between the counselor groups were operationally feasible for the program or agency under investigation.

The sparse literature on counselor impact on clients as a function of counselor group has a major limitation vis a vis the present investigation. This is the inconsistency of classification of counselor groups across studies. For example, a counselor who has earned a bachelor's degree is classified as a professional in some programs or agencies, while in others he may be classified as a paraprofessional. For the purposes of the current study, professional counselors will be those who hold at least a bachelor's degree and who do not have an addict, alcoholism, patient, and/or offender background; paraprofessional counselors will be those who do not hold a bachelor's degree. Whenever possible, these definitions will be adhered to in the literature review; when no

distinction is made in a particular study or report, this will be pointed out. Paraprofessional counselors also will be classified, wherever the literature permits, according to their background experience with addiction, incarceration, alcoholism, and/or mental health problems. For example, when possible, a distinction will be made between counselors who were formerly drug addicted (ex-addict paraprofessionals) and those who lack such background experience (non-ex-addict paraprofessionals.

A second limitation is the lack of generalizability of findings from one area of service delivery to another. That paraprofessional student counselors have been found, for example, to be effective in teaching study skills to other students tells us perhaps little about what to expect in the drug abuse treatment area.

With these considerations in mind, studies which attempted to measure counselor impact across counselor groups through observed changes in client progress in or out of treatment are presented. The studies are presented according to the treatment area, (i.e., drug abuse, mental health, and corrections[2]) in which the research was conducted.

Drug Abuse

Only one study attempting to measure the comparative impact of drug abuse counselors via client progress was found--that conducted by Brown and Thompson (1976). These researchers compared the functioning of addict-clients (n=52) assigned to non-addict counselors (n=29) with that of addict-clients (n=84) assigned to ex-addict counselors (n=30). One-year evaluations of counselor impact were made on the bases of (1) the percentages of clients who were retained in or who had completed treatment; (2) the mean number of months that clients spent in treatment; (3) the percentage of clients who had been arrested; (4) the mean number of client arrests; and (5) the percentage of retained clients who were employed. Brown and Thompson reported no significant differences between ex-addict and non-addict counselors on any of the above criteria.

While the counselor groups in this study were not dichotomized as professionals or paraprofessionals, the distinction made is of considerable importance to the project at hand. Furthermore, sufficient sample description was provided to allow professional-paraprofessional classification by inference if desired. Non-addict counselors had significantly more education and were expected to have at least some previous counseling experience, indicating that this counselor group was likely to include professionals. Ex-addict counselors, on the other hand, were selected on the bases of intelligence and sensitivity and were not expected either to have earned academic credentials nor to be experienced counselors, indicating that this group was likely to consist generally of paraprofessionals.

Mental Health

Three studies conducted in the mental health treatment area which provide an indication of the comparative impact of professional and paraprofessional counselors are those conducted by Poser (1966), by Zunker and Brown (1966), and by Ellsworth (1968).

Poser compared the impact of professional (n=15) and paraprofessional (n=11) counselors working with male chronic schizophrenics (n=295) over a period of 5 months. During the experiment, each counselor was free to conduct therapy as he desired. Six psychological tests were administered to patients pretherapy and posttherapy to assess client change relative to a control group.

Poser reported that patients treated by professional counselors, as compared with the control group, performed significantly better on 2 of the 6 tests. Patients treated by paraprofessional counselors, as compared with the control group, performed significantly better on 4 of the 6 indices. Poser also reported that, in a direct comparison of patients treated by the respective counselor groups, patients treated by paraprofessionals performed significantly better than patients treated by professionals on 3 of the 6 tests. He also noted, however, that the standard deviation on every test was smaller for the group of patients treated by professional counselors, perhaps indicating more consistent treatment effects.

Zunker and Brown (1966) compared the responsiveness of college freshmen (n=320) to professionals (n=4) and paraprofessionals (n=8) who provided academic adjustment counseling. The professionals participating in this study were at least 10 years older than the typical college freshman, had earned at least a master's degree, and had at least 5 years of teaching and/or counseling experience. The

[2]No studies concerned with counselors' comparative impact in the area of alcoholism were found.

paraprofessionals, in contrast, were college sophomores and juniors, and only one had previous counseling experience.

A series of precounseling and postcounseling educational tests were administered to the participating students in an attempt to measure gains attributable to the counseling experience. Analyses of these test scores revealed no significant differences between counselor groups in their ability to communicate information about effective study procedures. Students counseled by paraprofessionals, however, were found to have retained significantly more of the information transmitted and to have earned higher grades than students counseled by professionals.

In addition to the educational tests administered, Zunker and Brown asked the students participating in their study to complete a "Counseling Evaluation Questionnaire." An analysis of the students' responses revealed that most believed they had received more useful information when it was provided by paraprofessional counselors. This indication that students held more favorable attitudes toward paraprofessional counselors could also be expected to reflect upon the overall performance evaluations reported above. That is, the greater change demonstrated by paraprofessional counseled students may be due, at least in part, to the apparent similarities between them and the paraprofessionals and to the dissimilarities between the students and the professional counselors. The students' test scores, then, could be expected to reflect not only effects attributable to the competence and skills of their respective counselors, but also effects attributable to peer interaction (e.g., the students' projection of empathy, relative lack of inhibition in the counseling interaction).

Ellsworth (1968) attempted to measure and compare the impact of professionals and of professional-paraprofessional teams engaged in psychiatric rehabilitation. At the Veterans Administration Hospital, Fort Meade, S. Dak., only professionals had been involved traditionally in counseling and patient interaction, while paraprofessionals, or psychiatric aides, had been expected to maintain a custodial relationship with their male schizophrenic charges. For the purposes of this study, however, and in an attempt to develop a more effective treatment model, two nonexperimental units were maintained (professionals acting in a treatment capacity and paraprofessionals in a custodial capacity) while an experimental unit (both professionals and paraprofessionals acting in a treatment capacity), focusing on the development of a high level of aide-patient interaction, was instituted. The research project was continued for 30 months, at which time the treatment outcomes of 119 patients assigned to the experimental unit and those of 208 patients assigned to the nonexperimental units were evaluated and compared. Measures and comparisons of counselor impact on patient behavior were reported for both in-hospital and community functioning.

In regard to in-hospital treatment outcomes, Ellsworth reported: (1) that the behavioral adjustment of patients treated in the experimental unit was significantly better than that of patients treated in nonexperimental units; and (2) that the experimental unit not only released more patients than its nonexperimental counterparts, but the experimental patients also spent less time in the hospital prior to release than nonexperimental patients.

An analysis of community treatment outcomes revealed that return rates of patients assigned to the experimental unit were generally lower than those of patients maintained in nonexperimental units. Since more patients treated in the experimental unit were released and these releases were effected in less hospital treatment time, the above finding suggested that experimental patients were released in better condition than their nonexperimental counterparts. Furthermore, significantly more of the experimental patients achieved a 1-year community stay, and this despite the fact that significantly more of them were placed on their own rather than in the care of spouse or relatives, or in some type of supervised living arrangement.

As might be expected in light of the above findings, the community social adjustment outcome of experimental patients was significantly better than that of nonexperimental patients. In addition, however, Ellsworth reported that the greatest differential impact of experimental and nonexperimental units was evidenced in the more chronically hospitalized schizophrenic patients. Also, significantly more of the experimental patients, in contrast to nonexperimental patients, were employed full time at both 3 and 12 months postrelease.

Ellsworth also conducted a followup evaluation of the 327 patients who participated in the original study. He reported that 6 years after completion of the project, an overall higher proportion of experimental patients was on discharge status, while a higher proportion of nonexperimental patients was on "trial visit" or "currently hospitalized" status. Furthermore, this difference

was especially prevalent among the more chronic patients.

Corrections

Beless et al. (1973) conducted phase 1 of the Probation Officer Case Aide (POCA) Project, an attempt to examine the effects of utilizing indigenous paraprofessionals, ex- and non-offenders (n=22 and n=30, respectively), as assistants to probation and parole officers (n=26). While both types of counselors participating in this demonstration project were assigned individual caseloads (clients = 285), professional officers maintained ultimate decisionmaking and service-delivery authority. They also functioned in consultative and supervisory capacities for the paraprofessionals working under them.

Beless et al. reported noteworthy, although not statistically significant, differences in terms of recidivism and social adjustment between clients supervised by professional officers and those supervised by POAs.[3] More open and more direct relationships were found between clients and POAs than between clients and professional officers. This finding was attributed to the far greater frequency and regularity of contact between clients and POAs than was evident between clients and professional officers. They also reported a lower conviction rate among clients supervised by POAs. Rather than attributing this finding to the innocence of clients, however, Beless et al. cited the POAs' role as court advocate as an explanation of the lower conviction rate.

Conclusion

The studies reviewed primarily yield no evidence of difference in impact of paraprofessional and professional counselors on their clients. While clients may identify more highly with their paraprofessional counselors, who may be demographically more similar to them than are professionals, clients of professional and paraprofessional counselors, when contrasted, are often not significantly different from one another in outcome. In one major study, in fact, it was the type of program, rather than the type of counselor, which differentiated client outcomes. In sum, the literature yields little evidence that the clients of any one type of counselor fare better than the clients of any other type of counselor.

3. METHODOLOGY

Study Design and Procedures

The Sample

Counselors were included in this study only if they were full-time workers with a caseload of approximately 25 or more clients for whom they had primary responsibility for the treatment regimen. Interviews were conducted with either all or a random sample of counselors in given treatment programs, with a number of randomly selected clients of each counselor, and with the top program administrators in order to gather different perspectives on various areas of counselor functioning. In all, 82 counselors were interviewed along with 302 of their clients, and 29 administrators of their programs. These individuals were from 9 methadone maintenance and 6 drug-free programs within 5 major cities or surrounding areas--New York; Washington, D.C.; Chicago; Los Angeles; and San Francisco. The 16th program had both a methadone and a drug-free unit.

Criteria for Selection

These cities were chosen in part to insure geographic spread across the country. Another consideration was that major programs from large urban areas seemed desirable since they have relatively large client and counselor populations. This, in turn, insured that sufficient numbers of counselors and clients would be interviewed from each program. When possible, programs were chosen which had all three types of counselors. In only two programs in the sample was a counselor group missing.

It was thought ideal to choose about the same number of methadone maintenance programs as drug-free programs in order to control for the effects of treatment modality. This was not possible, however, since there was a smaller proportion of drug-free, as compared to methadone maintenance, programs in the SMSAs surveyed who employed non-ex-addict paraprofessionals. Therapeutic communities were excluded because clients are not often assigned to particular counselors in those settings. Detox units were excluded because their short-term nature, among other factors, discourages the establishment of client-counselor relationships.

[3]While both ex- and non-offender POAs participated in this demonstration project, the results of analysis were presented only in terms of a control group (clients supervised by professional officers) and an experimental group (clients supervised by POAs).

Procedures

The procedures used to select and recruit these programs involved initial screening for eligibility using the NDATUS file and several followup letters and phone calls to gather more program information and request cooperation. Professional interviewing staff from Creative Socio-Medics Corporation conducted both initial and followup interviews during the winter of 1976 and the spring of 1977, respectively.

Content of first data collection episode.[4] Data were gathered from clients actively in treatment with their current counselors for at least 1 month at the time of the interview. The clients varied in the length of time in treatment prior to this interview, and also in whether they had received counseling input from different counselors over the course of their treatment.

Data gathered from clients reflected upon aspects of their lives prior to treatment entry: demographic information, drug use history, treatment history, educational history, employment history, and criminal history. Questions were specifically asked about the year before entry into the current treatment program and the 30 days just before treatment entry. With regard to client progress in treatment up to the interview, clients were asked about their drug use, education, employment, and criminality in the whole time since entry into treatment and also in the 30 days prior to the interview. In addition, they were asked about their lifestyles in an assessment of the quality of their lives.

Concurrent with client interviewing, data about each client were gathered also from counselors. Counselors were asked specifically about the drug use, education, employment, and criminality of clients in the 30 days prior to the interview. The information gathered from counselors was compared with that of clients to validate client interviews. In addition, counselors reported on counseling input to each client during the course of the current treatment episode. If a client had had one or more primary counselors prior to the current counselor, the counselor reported the counselor group of each such counselor, as well as the duration of counseling by each such counselor. In addition, if clients were receiving any current input from other than the primary counselor, such input was documented.

Content of second data collection episode. The second data collection episode, referred to as the followup study, occurred 4 months after the initial interviewing. Each counselor in the study who was still working at the same program was asked to document the progress of each of the clients who had been interviewed previously, whether or not the client remained in treatment. Data were gathered about those clients who had, in the main, remained with their primary counselors between the first and second data collection periods. If the counselor in question had left the program since the first interview, his clients were omitted from followup. If a client in question had switched to another primary counselor in the time between the first and second data collection episodes, then the data of this client were omitted from followup.

Counselors reported on the current treatment status (in or out of treatment) of each client. For clients who had left treatment, counselors reported on the time and reason for the clients' leaving as well as on the drug use, employment, education, and criminality of these clients in their last 30 days in treatment. For clients who were still in treatment, counselors were asked about the same areas, but with reference to the 30 days just prior to the followup.

The counselor portion of the followup was handled in part by mail. Each counselor was mailed a separate followup form for each client in question. The counselor was asked to complete the forms and to hold them until an interviewer came to collect them. At the time the forms were collected from counselors, interviewers attempted to conduct a validation interview with one of each counselor's clients who remained in treatment. Clients were asked about their own drug use, education, employment, and criminality during the preceding 30 days. These responses were compared with those of counselors as a second means of data validation.

Of the 302 clients originally interviewed, followup questionnaires were obtained for 259, and 34 clients were reinterviewed for validation purposes. Counselors were each paid $10 for completing the forms; clients received $3 each for the brief followup interview.

[4] The content described here is relevant to the present report of client progress. Other data relevant to counselor functions and activities, counselor and client attitudes, and administrators' views of counselor functioning were also gathered and are reported elsewhere.

Background of Clients

The present study explored the progress in treatment of clients of three counselor groups. Clients were sampled from the ongoing caseloads of counselors as they existed at the time of the first interview. It was therefore possible that biases in the assignment of clients with varying backgrounds to one or another counselor might have occurred, which would confound measures of treatment progress. For example, there might have been a bias within programs to assign clients with heavier drug use histories to one type of counselor. Such a selection bias, in turn, might be expected to affect the client's expectation for his own treatment outcome, or even his actual progress in treatment. Such effects, though not attributable to the impact of the counselor group, would be confounded with counselor group effects. For this reason, i.e., the possible confounding of client assignment biases with counselor group effects, it was vital to explore the backgrounds of clients assigned to each counselor group. This exploration is accomplished in the present section. First, a brief description of the demographic characteristics of the clients is presented. This is followed by a summary of the background dimensions on which clients of the three counselor groups were contrasted, and a summary of differences found.

Demographic Characteristics

The demographic characteristics of clients are summarized in table 1. Clients in each group were approximately two-thirds male. Half the clients in each group were black, with another third white, and the remainder Spanish-American. Clients of PROs[5] were significantly, though only 3 years, younger on the average than clients of NEAs.

[5]Throughout the report, the abbreviations PRO, NEA, and EA will be used to represent professional, non-ex-addict paraprofessional, and ex-addict paraprofessional counselors, respectively.

Table 1. Demographic characteristics of the 3 client groups

Characteristics	Client groups[1] PRO	NEA	EA	Test for difference among groups
1. Sample size	116	71	115	
2. Sex (percent male)	61.2	64.8	63.5	$\chi^2(2)=0.14$, $p>0.20$
3. Mean age in years:				
$\bar{X}$	28.7	31.9	30.4	$F(2,299)=3.70$, $p<0.05$
S.E.	.67	.99	.81	
4. Ethnic identity (percent):				
Black	43.6	52.9	49.6	
White	35.5	32.9	36.3	$\chi^2(4)=2.83$, $p>0.20$
Spanish-American	20.9	14.3	14.2	

[1]PRO: Professional counselors. NEA: Non-ex-addict paraprofessional counselors. EA: Ex-addict paraprofessional counselors.

Areas of Client Background Explored in the Present Study

Five areas of client background in addition to demographics were explored in the present study. These areas were drug use history, treatment history, educational history, employment history, and criminal history. An overview of the background of the client in each area was considered. In addition, in each area, the recent background was considered in detail by examining the year before treatment entry, as well as just the 30 days prior to treatment entry.

All measures in each area on which clients of the various groups were contrasted are enumerated in table 2. The outcomes of these measures for this client sample are given in appendix B. Analyses of variance or χ^2 tests were used to examine differences among counselor groups on each measure given in table 2. The counselor group differences found are highlighted below. For drug use and treatment history, modality effects and their interaction with counselor group effects were also considered. Modality effects are summarized in appendix tables B-1 and B-2 for drug use and B-3 for treatment history.

Differences Among Clients in the Various Counselor Groups

In 2 of the 5 areas, educational history and employment history, no counselor group effects were found.

In the area of drug abuse, there was only one counselor group effect. In the drug free modality only, there was significantly greater use of alcohol to excess by clients of PROs than by clients of NEAs in the 30 days prior to treatment entry; for the simple effects, $F(2,290)=3.48$, $p<0.05$; for Tukey A contrast, $p<0.05$. Even with this effect, however, clients of PROs reported low levels of alcohol use, i.e., less than once a month to excess (appendix table B-2).

There was only one counselor group effect in the area of treatment history. In the drug free modality only, clients of PROs had, on the average, about one more treatment episode than clients of NEAs; for the simple effect, $F(2,295)=4.65$, $p<0.05$; for Tukey A contrast, $p<0.01$ (appendix table B-3).

Finally, in the area of criminal history, there was again only one counselor group effect. More clients of EAs than of PROs or NEAs had been in jail in the year prior to treatment entry, $\chi^2(2)=6.28$, $p<0.05$ for overall test; $z=1.98$, $z=2.16$ for EA versus PRO and NEA, respectively, $p<0.05$ in both cases.

Conclusions

In the main, the demographics, drug use and treatment histories, the educational and employment histories, and criminal histories were substantially the same across the clients of the three counselor groups. On this basis, it was concluded that any differences in attitudes of clients, their expectations for progress in treatment, or their actual progress in treatment would not be confounded with counselor group.

Length of Time in Treatment, Counseling Input, and Client Status at Time of First Interview and Followup

Time in Treatment Prior to First Interview

As previously explained, clients were interviewed not at entry into treatment but rather at some time during the course of treatment. It was thus important to determine whether the clients sampled had had equal lengths of time in treatment across counselor groups within modalities. This was, in fact, the case. At the time of the first interview, methadone clients, on the average, had been in treatment for over a year and a half, while drug-free clients had been in treatment slightly over half a year (table 3). In a two-way ANOV of counselor group by modality with number of months of treatment prior to the first interview as the dependent measure, only the modality main effect reached significance, $F(1,296)=49.27$, $p<0.001$. There was neither a group main effect nor an interaction of modality with counselor group ($F<1$ in both cases).

Input from Previous Primary Counselors

As shown in table 3, a substantial percentage of clients in each counselor group, in the course of the current treatment episode, had been clients of primary counselors other than their present primary counselor. Thus, while the counselor group of a client for this study was that of his current primary counselor, often clients had received input previously from other counselors in their own or another counselor group. The mean number of months spent by clients of each counselor group with previous primary counselors in each counselor group is shown in table 3. These times are quite brief relative to the total lengths of time clients spent in treatment, i.e., at most a ratio of 3.13 months spent by current clients of NEAs with previous PRO primary counselors of a total of 23.9 months in treatment. When the

Table 2. Background measures on which clients of the 3 counselor groups were contrasted

A. Drug history

1. Drugs or drug categories considered

   a. Marihuana/hashish
   b. Drugstore items containing drugs, like cough sirup with codeine
   c. Inhalants such as glue
   d. Hallucinogens such as LSD
   e. Barbiturates such as phenobarbital, secobarbital (Seconal), pentobarbital (Nembutal)
   f. Sedatives or tranquilizers such as chlordiazepoxide (Librium), diazepam (Valium), chloral hydrate
   g. Cocaine
   h. Heroin
   i. Illegal methadone
   j. Opiates or drugs with the same effect such as codeine, morphine, opium, meperidine (Demerol)
   k. Amphetamines and other stimulants
   l. Alcohol to excess

2. Measures taken on each drug or category of drugs

   a. Number of years of any use
   b. Number of years of continuing use (once a week or more often)
   c. Frequency of use of each drug in year prior to treatment entry
   d. Frequency of use of each drug in 30 days just prior to treatment entry

B. Treatment history

1. Percent ever in treatment before current treatment episode
2. Number of prior treatment episodes
3. Number of attempts to detox
4. Number of times in chemical support modality (methadone maintenance, propoxyphene napsylate [Darvon N])
5. Number of years in treatment
6. Number of heroin-related treatment episodes
7. Number of court-related treatment episodes

C. Educational history

1. Highest grade completed in school
2. Percent of clients receiving any schooling in year before treatment
   a. Percent receiving vocational training
   b. Percent receiving other than vocational training
3. Number of months in school in year before treatment
   a. Number of months in vocational training in year before treatment
   b. Number of months in school in year before treatment
4. Percent of clients receiving any schooling in the 30 days before treatment
   a. Percent of all clients receiving any vocational training in 30 days before treatment
   b. Percent of all clients receiving any schooling other than vocational training in 30 days before treatment

Table 2 (Continued)

D. Employment history

1. Employment of males and females

   a. Percentage of clients who ever held a legal job, one for which they got paid and paid taxes
   b. Percentage of clients who held at least 1 job in the year prior to treatment entry
   c. Number of months employed in year prior to treatment entry
   d. Percentage of clients who worked at least 1 day in the 30 days prior to treatment entry
   e. Number of days worked, including Saturdays and Sundays, at a legal job in the 30 days prior to treatment entry
   f. Percentage of clients employed at entry into treatment

2. Time as housewives for female clients

   a. Percentage who had ever been a housewife
   b. Percentage who had been a housewife in the year prior to treatment entry
   c. Number of months mainly a housewife in year before entry into treatment
   d. Percentage mainly housewives in the 30 days prior to treatment entry

E. Criminal involvement

1. Percent ever arrested
2. Number of arrests in year prior to treatment entry
3. Percent of all arrests which were drug related in year before treatment
4. Number of days in jail in year before treatment
5. Percent arrested in 30 days prior to treatment entry
6. Number of days in jail in 30 days before treatment entry
7. Percent of clients in treatment due to an arrest

Table 3. Time in treatment variables for clients prior to the first interview

		Current counselor group		
		PRO	NEA	EA
1. Total length of time in treatment (in months) up to present interview	MM	19.15	23.89	20.34
	DF	5.76	6.94	7.20
2. Percent of clients who had counseling from previous primary counselors other than the present counselor	MM	38.7	45.3	31.0
	DF	20.5	0	31.8
3. Mean length of time spent with previous primary counselors other than the present counselor (in months):				
Previous professional counselors	MM	1.01	3.13	2.17
	DF	.56	0	.93
Previous non-ex-addict paraprofessional counselors	MM	.71	2.91	1.37
	DF	0	0	.55
Previous ex-addict paraprofessional counselors	MM	.91	.61	.30
	DF	.12	0	0
4. Mean length of time spent with the current primary counselor up to first interview	MM	16.52	17.24	16.51
	DF	5.07	6.94	5.73

Note--Data presented are based on a minimum of 99.7 percent (301 cases) of 302 clients.

amount clients have spent with their current counselors only is considered, the mean lengths of time again are quite similar across groups (table 3). Considered in a two-way ANOV, the results for length of time with the current counselor only are identical to those for the total length of time in treatment, i.e., a large modality main effect, $F(1,296)=37.39$, $p<0.001$ with neither a main effect of counselor group, nor an interaction of counselor group with treatment modality.

Simultaneous Input from Other Counselors

Only 17 percent, 7 percent, and 13 percent of clients of PROs, NEAs, and EAs, respectively, were receiving counseling from counselors in addition to their primary counselors at the time of the first interview (table 4). These percentages were stable across groups, $\chi^2(2)=2.62$, $p>0.20$. Of clients who received input from more than one other counselor, most frequently there was only one other such counselor. There was no particular bias for the additional counseling to come from one or another counselor group, with 6.6 percent, 2.4 percent, and 4.2 percent of the total sample receiving additional input from PROs, NEAs, and EAs, respectively. Of the clients who received counseling from at least one other counselor, about four-fifths of them (31 of the 38) received individual counseling from another counselor, while an overlapping 11 of the 38 (29 percent) received group counseling from another counselor.

Client Status at the Time of Followup

Followup data were available on 257 of the 302 or 85 percent of the clients, as shown in table 5. Of those clients in methadone maintenance for whom followup data were available, 85 percent remained in treatment; at the followup this value did not differ across groups, $\chi^2(2)=2.92$, $p>0.20$. Of those clients in drug free from whom followup data were available, 49 percent remained in treatment at the followup. Again, this value did not differ across groups, $\chi^2(2)=2.00$, $p>0.20$. Of those 71 clients in all who were reported to have left treatment by followup, the length of time they remained in treatment was given by counselors of 60 of them (85 percent). The mean lengths of time in treatment until leaving are given in table 6. In a two-way ANOV, these times were found to differ as a function of modality, as expected, $F(1,54)=15.08$, $p<0.001$, but not as a function of counselor group.

Summary

Within each modality, the length of time clients were in treatment prior to the first interview did not differ across counselor groups. Neither did the percentages of clients who had received input from another primary counselor prior to their current counselor. When only the length of time clients spent with their current counselors was considered, this value too was found to be stable across groups within each modality. A relatively small and approximately equivalent number of clients in each counselor group were receiving input from more than one counselor at the time of followup. Finally, at the time of client followup 4 months following the first interview, approximately equal percentages of clients of each counselor group within each modality had left treatment. In sum, an exploration of length of time in treatment variables and counselor input from previous and other current counselors revealed no differences among the groups which would serve to distort analyses of client progress as a function of the counselor group of the clients' current primary counselors.

Measures of Validity

Concerns about the validity of client self-reports are often voiced by critics of studies based on these self-reports alone. The concerns frequently stem from notions that clients are likely to distort such reports, either inadvertently because of memory failures, or deliberately because of some real or perceived advantage to them in appearing to be in better or worse condition or circumstances than they really are. However, concerns are also expressed about data based on counselor reports alone since these reports may also be faulty. The flaws may be due to inadequate recall or even insufficient initial knowledge of the clients' circumstances (e.g., drug usage patterns), or to counselors' conscious or unconscious wishes to make their clients appear to improve under their care.

With these considerations in mind, the present study utilized a design in which independent corroboration of self-reports was sought by asking identical questions of clients and counselors. These "validity" questions were asked about drug use, criminality, and employment status which were obtained during the 30 days prior to the first interview of counselor and client and in the 30 days prior to the followup study. In the present section, the results of matching

Table 4. Input from counselors other than the primary counselor at the time of the first interview

A. Number of other counselors from each group from whom clients received counseling. This table is summed across all current primary counselor groups but is partitioned by the counselor group of the other counselor group (sample sizes given in parentheses).

	Counselor group of other counselors				
	No other	PRO	NEA	EA	Overall
Number of other counselors:					
None	100.0 (251)	0 (0)	0 (0)	0 (0)	87.0 (251)
One	0 (0)	46.4 (13)	17.9 (5)	27.8 (10)	9.7 (28)
Two	0 (0)	55.6 (5)	22.2 (2)	22.2 (2)	3.1 (9)
Four	0 (0)	100.0 (1)	0 (0)	0 (0)	.3 (1)
Overall	86.9 (251)	6.6 (19)	2.4 (7)	4.2 (12)	100.0 (289)

B. Input from other counselors considered separately for each current counselor group.

1. Clients of professional counselors.

	Counselor group of other counselors				
	No other	PRO	NEA	EA	Overall
Number of other counselors:					
None	100.0 (91)	0 (0)	0 (0)	0 (0)	82.7 (91)
One	0 (0)	30.8 (4)	23.1 (3)	46.2 (6)	11.8 (13)
>One	0 (0)	50.0 (3)	33.3 (2)	16.7 (1)	5.5 (6)
Overall	100.0 (91)	6.4 (7)	4.6 (5)	6.4 (7)	100.0 (110)

Table 4 (Continued)

2. Clients of non-ex-addict paraprofessional counselors.

	Counselor group of other counselors								Overall	
	No other		PRO		NEA		EA			
Number of other counselors:										
None	100.0	(66)	0	(0)	0	(0)	0	(0)	93.0	(66)
One	0	(0)	60.0	(3)	20.0	(1)	20.0	(1)	7.0	(5)
>One	0	(0)	0	(0)	0	(0)	0	(0)	0	(0)
Overall	93.0	(66)	4.2	(3)	1.4	(1)	1.4	(1)	100.0	(71)

3. Clients of ex-addict paraprofessional counselors.

	Counselor group of other counselors								Overall	
	No other		PRO		NEA		EA			
Number of other counselors:										
None	100.0	(94)	0	(0)	0	(0)	0	(0)	87.0	(94)
One	0	(0)	60.0	(6)	10.0	(1)	30.0	(3)	9.3	(10)
>One	0	(0)	75.0	(3)	0	(0)	25.0	(1)	3.7	(4)
Overall	87.0	(94)	8.3	(9)	.9	(1)	3.7	(4)	100.0	(108)

Note--Row percents in cells of all tables are often based on Ns too small to support interpretations and are presented only for completeness. Data reported are based on 96 percent of the total sample.

Table 5. Status of clients at the time of followup (in percent)

A. Of clients on whom followup data were available, percentages in and out of treatment at the time of followup (sample sizes in parentheses).

Modality	Methadone maintenance	Drug free
	Clients of professionals	
Still in treatment	90.4 (47)	41.0 (16)
Left treatment	9.6 (5)	51.3 (20)
Transferred to another program	--	7.7 (3)
N	52	39
	Clients of non-ex-addict paraprofessionals	
Still in treatment	85.7 (42)	53.9 (7)
Left treatment	14.3 (7)	46.1 (6)
N	49	13
	Clients of ex-addict paraprofessionals	
Still in treatment	79.1 (53)	56.8 (21)
Left treatment	20.9 (14)	43.2 (16)
N	67	37

B. For clients who had left treatment at the time of followup, mean length of time in treatment in months as a function of modality and counselor group (sample sizes given in parentheses).

	PRO	NEA	EA
Methadone maintenance	16.33 (3)	8.80 (5)	12 (12)
Drug free	4.84 (19)	7.17 (6)	6.13 (15)

answers of clients and their counselors on these questions are summarized. A more complete description of the results of the validity study may be found in appendix A. It may be well to point out that this conception of validity is a bit strained since neither counselor nor client reports can be accepted as an external criterion, i.e., it is not known which, if either of them, is correct for each question. Rather, it is assumed that agreement between the two affords some evidence that capriciousness, arbitrariness, and memory failure are not operating here to any great extent. Bias may still exist, of course--for example, counselors may often base their reports largely on what clients tell them, although in this case other objective records were also used as will be seen. Another possible problem is that both clients and counselors may see an advantage in reporting certain conditions--for example, low current drug usage.

The evidence for validity is much the same whether one examines the initial interview or followup data. Given this finding and also the fact that only 34 counselor-client comparisons were possible for the followup, only the initial data set will be discussed here with regard to each of the Federal criteria. Also, since only small and inconsistent differences were found among counselor groups, as will be seen in the Outcome section, such differences are ignored in this summary.

Drug Use

The first validity check performed was the cross-tabulation of clients' and counselors' reports of frequency of client drug use during the 30 days prior to the interview. Five categories of response were possible for client and counselor from "not at all" to "daily." Table 6 shows the results of these cross-tabulations for the initial interview. The most prominent feature of the table is the high degree of agreement among clients and counselors across all counselor groups for almost all drugs. Percent agreement ranges from a low of 69 for marihuana/hashish use to 100 for inhalants. This variation might be expected since marihuana/hashish use is a higher probability event. Also, a difference of one scale category was accepted as agreement between client and counselor. In any case, counselor-client agreement is, for the most part, higher than 90 percent, giving good evidence for data credibility. Another feature of interest is that counselors on the average are about as likely to report more as they are to report less drug use than clients report.

Employment Status

Another set of questions which seemed important to validate were those concerned with employment status. In table 7, results are presented of cross-tabulating client and counselor responses regarding current legal employment status of the client. One view of the data shows that 27.4 percent of clients are employed according to self-report, while 32.5 percent are employed according to counselor reports. Another view is that of those clients who say they are employed, 85.4 percent had counselors who concurred. Similarly, of those clients who report not being employed, 87.5 percent had counselors who agreed.

Overall, 86.5 percent of clients' and counselors' reports agree. While this is a relatively high percentage, it is perhaps lower than one might hope given the rather simple nature of the question. The marginals show that clients tend to report somewhat less often than counselors that they are employed. This may indicate a lack of up-to-date information on the part of the counselor, influenced by high instability of employment among clients. Equally probable is confusion over the concept of legal employment. This confusion might result from clients' or counselors' failure to attend to the definition provided which involved getting paid and paying taxes--or even from uncertainty as to whether or not the client's employment meets that definition.

Criminality

Another Federal criterion for which validity was estimated was extent of criminal behavior and some correlates. First, clients and counselors were asked whether clients were in the program voluntarily or because the courts sent them or because of a legal situation of some kind (table 8). Another question asked of both clients and counselors concerned the number of times the client had been arrested in the last 30 days (table 9). Finally, clients and counselors were asked how many days in the last 30 the client had spent in jail. In general, all three questions show a high degree of counselor-client agreement.

Table 8 shows that 81.1 percent of clients and 80.5 percent of counselors say that the client is there voluntarily, not because of legal pressure. Further, of the clients who say they are in treatment

Table 6. Percent agreement and disagreement between clients and counselors in regard to the frequency of use of illicit drugs during the 30 days prior to the first interview[1]

	Total percent		
	=	CL>	CO>
Marihuana/hashish	69	18	13
Over-the-counter drugs	94	1	6
Inhalants	100	1	1
Hallucinogens	99	0	1
Barbiturates	97	1	2
Sedatives	85	10	5
Cocaine	96	3	0
Heroin	89	7	3
Illegal methadone	98	1	1
Opiates	91	1	7
Alcohol	84	4	12
Amphetamines	96	1	4
	N = 302		

[1]Percent agreement indicates either perfect agreement or disparities of no more than one category on scale.

Table 7. Relationship between client and counselor responses to the question of whether or not the client is employed at a legal job

Client report	Counselor report		
	Employed	Not employed	
Employed	85.4 (70)	14.6 (12)	27.4 (82)
Not employed	12.5 (27)	87.5 (189)	72.8 (217)
Total	32.5 (97)	67.2 (201)	100.2 (299)

voluntarily, 92.9 percent had counselors who agreed that this was the case. Interestingly, only 73.2 percent of counselors of clients who said that they were in treatment because of legal pressure agreed that this was so. Perhaps definitions are again problematic--clients were asked whether "the courts sent you" and counselors were asked about "some legal" situation. The word "sent" in this context could perhaps mean either "ordered" or "referred." It may also be that clients feel some pressure that the legal system exerts only indirectly, and that counselors do not feel this pressure is acting on their clients. In any case, overall agreement between client and counselor is 89.2 percent so that these speculations may not be particularly worthwhile. It should also be pointed out that differences among counselor groups were virtually nonexistent here.

Table 8. Relationship between client and counselor responses to question of whether client is in program voluntarily or because the courts sent him

Client report	Counselor report		
	Voluntarily	Pressured	
Voluntarily	92.9 (224)	7.1 (17)	81.1 (241)
Pressured	26.8 (15)	73.2 (41)	18.9 (56)
Total	80.5 (239)	19.5 (58)	100.0 (297)

The results of questioning on arrests are shown in table 9. Of those clients who report no arrests, 97.5 percent had counselors who agreed. For the clients who report being arrested once in the last 30 days, six counselors reported 0 and 1 arrests, respectively, with one counselor reporting two arrests. As the table shows, for over 95 percent of the clients, client and counselor reports agreed perfectly. The other 5 percent were off by no more than one arrest.

Clients and counselors were also asked how many days of the last 30 clients had spent in jail. Concurrence was extremely high here as in the previous question with few disparities of more than a day or two. Indeed, more than 94 percent of all clients were reported by the counselor as well as clients themselves to have had no arrests in the last 30 days. Of clients who reported no arrests (which was 95.5 percent of all clients), 98 percent of the counselors of these clients agreed.

For all three Federal criteria, then, client and counselor reports of current client behavior agree quite well, although slightly higher agreement might have been expected on the seemingly straightforward measures of employment status. The results are, of course, subject to the caveats mentioned at the beginning of this section.

Table 9. Relationship between client and counselor responses to question of number of days in last 30 that client had spent in jail

Client report	Counselor report			
	0	1	2	
0	97.5 (274)	2.5 (7)	0 (0)	95.6 (281)
1	46.2 (6)	46.2 (6)	7.7 (1)	4.4 (13)
Total	95.2 (280)	4.4 (13)	.3 (1)	100.0 (294)

4. OUTCOMES

Drug Use

Use Levels Following Entry into Treatment: First Interview

Clients were questioned about their use of 12 drugs or categories of drugs following entry into treatment. Specifically, they were asked how often they had used each drug or category of drugs during two overlapping time periods: all the time since entry into treatment and the 30 days just prior to the first interview. Client responses to these questions are presented in table 10 as a function of counselor group and treatment modality. For some drugs there was essentially no use following treatment entry: drugstore items containing drugs, like cough sirup with codeine, inhalants such as glue, hallucinogens such as LSD, and amphetamines.[6] For these drug categories, there was also very little use prior to treatment entry. There were substantial decreases following treatment entry in the use of heroin, illegal methadone, and other opiates. With the exception of marihuana and hashish, there were slight decreases in the use of all other drugs. Methadone-maintenance, but not drug-free, clients reported a slight increase in use of marihuana and hashish from the 30 days prior to treatment entry to the 30 days prior to the first interview.

With the exceptions noted in table 10, both measures of use of each drug or category of drugs were considered in two factor ANOVs of counselor group by modality. In no case was there a group main effect or a modality by group interaction when use during all the time since treatment entry was considered. However, when drug use was considered in the 30 days before the first interview, group main effects were found for use of marihuana/hashish, $F(2,277)=3.39$, $p<0.05$, with clients of PROs tending to use marihuana/hashish more frequently than clients of either NEAs and EAs ($p<0.10$ in both cases, by Tukey A analysis). In addition, a group main effect was found for use of barbiturates in the 30 days before the first interview, $F(2,288)=4.56$, $p<0.01$, with use by clients of EAs exceeding that by clients of NEAs ($p<0.01$ by Tukey A analysis).

Three drugs or classes of drugs, heroin, illegal methadone, and other opiates and synthetics with morphinelike effects, were also combined into an overall opiate index, to represent the use of any drugs which might result in eligibility for methadone maintenance. This index was calculated as the greatest frequency of use of any of the three aforementioned drugs. This index did not differ across counselor groups in either the time from treatment entry to the first interview or the 30 days prior to the first interview.

Partialing Out Preentry Levels and Other Counselor Input

The above analyses were based on drug use levels reported by clients during treatment. What was of more interest was the change in level of use following treatment entry. Two measures of change were available from data gathered: (1) change in use from the whole year prior to treatment entry to the whole time after treatment entry, and (2) change in use from the 30 days prior to treatment entry to the 30 days prior to the first interview. Of course, the magnitude of change is, in large measure, determined by the initial use level; hence, it was necessary to statistically control for or partial out the initial level from the change score in question, yielding a measure of amount of change which was independent of the pretest level. This was accomplished by performing analyses of covariance of change in drug use levels as a function of counselor group with initial use level as a covariate. A second set of covariates was also considered. While clients were nominally in the group of their current primary counselors, about a third of all clients had received input from previous primary counselors. Three measures were thus created for each client: the number of months the client had spent with previous primary counselors in each counselor group during the current treatment episode. These values were also partialed out of the change scores. This strategy of partialing out initial levels and input from other counselors and examining adjusted change was adopted throughout the present report.

Analyses of covariance were carried out separately in each modality. With change from the whole year prior to treatment entry to the whole time since treatment entry considered in the drug-free modality, for no-drug or drug category was the counselor group main effect significant. In methadone maintenance, there was a significant counselor group main effect

[6] The average frequency of use of amphetamines may be an underestimate since this drug was not asked of clients as a category but was rather coded from clients' volunteering the information. However, the use of amphetamines, as reported by clients, matches closely the reports of amphetamine use reported by their counselors, as described in Validation.

Table 10. Frequency of use of illicit drugs between time of entry into treatment and the first interview and in the 30 days prior to the first interview

[1 = not at all; 2 = less than once a month; 3 = less than once a week; 4 = once a week; 5 = several times a week; 6 = daily]

Drug		From treatment entry to first interview				30 days prior to first interview			
		PRO	NEA	EA	Modality effect	PRO	NEA	EA	Modality effect
Marihuana/Hashish	MM	2.97	2.74	2.57	NS	3.15	2.78	2.48[1]	NS
	DF	3.13	2.13	2.81		3.20	2.19	2.61	
Drugstore items containing drugs, like cough sirup with codeine	MM	1.04	1.00	1.03	NS	1.03	1.00	1.03	See note.[2]
	DF	1.08	1.06	1.14		1.00	1.00	1.05	
Inhalants such as glue	MM	1.00	1.00	1.00	See note.[2]	1.00	1.00	1.00	See note.[2]
	DF	1.00	1.00	1.00		1.00	1.00	1.00	
Hallucinogens such as LSD	MM	1.07	1.02	1.08	DF>MM	1.00	1.00	1.00	See note.[2]
	DF	1.08	1.06	1.18		1.00	1.12	1.20	
Barbiturates such as phenobarbital, secobarbital (Seconal), pentobarbital (Nembutal)	MM	1.28	1.14	1.45	NS	1.09	1.08	1.37[1]	NS
	DF	1.39	1.31	1.47		1.31	1.00	1.54	
Sedatives or tranquilizers such as chlordiazepoxide (Librium), diazepam (Valium), chloral hydrate	MM	1.77	2.17	2.06	MM>DF	1.67	1.80	1.93	NS
	DF	1.63	1.13	1.52		1.82	1.35	1.56	
Cocaine	MM	1.53	1.21	1.54	MM>DF	1.35	1.07	1.38	NS
	DF	1.28	1.24	1.20		1.28	1.41	1.14	
Heroin	MM	1.75	2.13	1.58	DF>MM	1.47	1.52	1.40	DF>MM
	DF	2.24	1.94	2.05		2.46	1.59	2.05	

Table 10 (Continued)

Drug		From treatment entry to first interview				30 days prior to first interview			
		PRO	NEA	EA	Modality effect	PRO	NEA	EA	Modality effect
Illegal methadone	MM	1.20	1.12	1.14	NS	1.03	1.08	1.06	NS
	DF	1.27	1.00	1.09		1.24	1.00	1.09	
Opiates or things with the same effect, such as codeine, morphine, opium, meperidene (Demerol)	MM	1.22	1.17	1.20	DF>MM	1.12	1.08	1.09	NS
	DF	1.33	1.29	1.58		1.15	1.41	1.32	
Alcohol to excess	MM	1.36	1.58	1.45	NS	1.26	1.56	1.40	NS
	DF	1.46	1.06	1.39		1.27	1.00	1.36	
Amphetamines	MM	1.07	1.15	1.00	NS	1.00	1.19	1.00	See note.[2]
	DF	1.07	1.06	1.07		1.04	1.00	1.06	
Opiate index[3]	MM	2.04	2.13	1.82	DF>MM	1.56	1.63	1.54	DF>MM
	DF	2.50	2.25	2.34		2.55	1.76	2.07	

Note--Response rates for all time since treatment entry vary from 90.4 to 99.3 percent.
Response rates for 30 days prior to first interview vary from 93.7 to 99.0 percent.

[1]Group main effect was significant.

[2]Use is so infrequent (not at all in at least one cell) that ANOV was not performed.

[3]The most frequent use among three drug categories: heroin, illegal methadone, and other opiates or things with the same effect.

for heroin, $F(2,158)=4.14$, $p<0.05$ with mean adjusted decreases in use being the least for clients of NEAs, i.e., adjusted mean decreases of -2.73, -2.28, and -2.90 for clients of PROs, NEAs, and EAs, respectively. However, this effect did not hold for the use of other opiates. For use of illegal methadone, clients of NEAs decreased use as much as those of the other groups, i.e., adjusted mean decreases of -0.35, -0.42, and -0.43 for clients of PROs, NEAs, and EAs, respectively. In fact, for the use of other opiates and synthetics with morphinelike effects, clients of NEAs showed the greatest adjusted decrease, i.e., adjusted mean decreases of -0.19, -0.29, and -0.20 for clients of PROs, NEAs, and EAs, respectively. When the opiate index which measures use of any opiate leading to methadone eligibility including heroin, illegal methadone, and other opiates was considered, adjusted decreases were equivalent across groups, $F<1$. The smaller decrease in heroin use by clients of NEAs was counterbalanced by equivalent or greater decreases in the use of other opiates.

With change from the 30 days prior to treatment entry to the 30 days preceding the first interview considered in the drug-free modality, the only counselor group effect found was for the use of marihuana/hashish, $F(2.89)=3.60$, $p<0.05$, with clients of PROs showing a very slight increase of 0.06 on the six-point scale of use, while clients of NEAs and EAs exhibited slight adjusted decreases in use of -0.84 and -0.57, respectively. In methadone maintenance, a counselor group effect was found for barbiturates, $F(2,181)=4.51$, $p<0.01$, with clients of PROs and NEAs showing a slight decrease in use, while clients of EAs showed a slight increase in use. It should be noted that the adjusted increase was very small, 0.15 on the six-point scale of use; the adjusted decreases for the other two counselor groups was of the same slight order of magnitude as the adjusted increase, -0.13 and -0.17 for clients of PROs and NEAs using barbiturates, respectively.

Since a vital concern of this study was the impact of counselors in the three groups on drug use levels in treatment, the three small but significant counselor group effects were further explored at the level of individual responses. For each significant effect, crosstabulations of drug use frequency by counselor group at four time periods are given in tables 11a-c. An examination of the crosstabulation in table 11a for heroin use in methadone maintenance in the year prior to treatment versus all the time following treatment entry clarifies the significant effect. In the year prior to treatment entry, 70 percent, 70 percent, and 72 percent of clients of PROs, NEAs, and EAs, respectively, used heroin at least several times a week. During treatment, these percentages dropped dramatically to six, nine, and zero percent, respectively. Indeed, the drop outweighs the difference in heavy use during all treatment, particularly when one considers that in the 30 days prior to the first interview, 85 percent, 82 percent, and 83 percent of clients of PROs, NEAs, and EAs were no longer using heroin at all.

Use of barbiturates by maintenance clients, given in table 11b, shows that there is almost no use of barbiturates either in the 30 days prior to treatment entry or the 30 days prior to the first interview. In terms of actual numbers of clients, only 12 clients reported any use of barbiturates in the 30 days prior to the first interview, 7 of whom were clients of EAs. In fact, the use of barbiturates is so low that assumptions of normality of the distribution of frequency of use required for analysis of covariance are clearly not met; the results of the analysis of covariance for barbiturates should thus be considered descriptive at best. The very low overall use of barbiturates far overrides the slight differences in use among clients of the counselor groups.

The use of marihuana/hashish by clients in the drug-free modality is presented in table 11c. In the 30 days before treatment, clients of PROs and EAs used marihuana/hashish somewhat more frequently than did clients of NEAs, i.e., used at least several times a week by 37.5 percent, 26.7 percent, and 41.5 percent by clients of PROs, NEAs, and EAs, respectively. These figures had dropped for clients of NEAs and EAs but not PROs by the 30 days prior to the first interview, i.e., used at least several times a week by 36.6 percent, 12.5 percent, and 29.5 percent of clients in the three groups, respectively. While the use levels did drop for clients of NEAs and EAs, what is striking about the data is that a substantial percentage of clients persisted in the use of marihuana/hashish once they entered treatment.

In sum, at the time of the first interview, only slight, if any, differences in change in levels were found among counselor groups. The few differences identified were minute relative to the more striking overall decrease in use in one case, lack of use in a second case, and stability of use in the third case. At the time of the first interview, then, it appeared that the three counselor groups had had equivalent impact on

Table 11a. Frequency of use of heroin at various times as a function of counselor group in the methadone maintenance modality, as reported by clients

	30 days prior to first interview			30 days prior to entry into treatment		
	PRO	NEA	EA	PRO	NEA	EA
Not at all (1)	85.3 (64)	81.5 (44)	82.9 (58)	26.8 (19)	27.3 (12)	44.1 (30)
Less than once a week (3)	26.3 (5)	31.6 (6)	11.4 (8)	2.8 (2)	4.5 (2)	2.9 (2)
Once a week (4)	0 (0)	1.9 (1)	1.4 (1)	1.4 (1)	2.3 (1)	0 (0)
Several times a week (5)	6.7 (5)	3.7 (2)	2.9 (2)	8.5 (6)	6.8 (3)	4.4 (3)
Daily (6)	1.3 (1)	1.9 (1)	0 (0)	60.6 (43)	59.1 (26)	48.5 (33)
N	75	54	70	71	44	68

	During all treatment			In the year prior to entry into treatment		
	PRO	NEA	EA	PRO	NEA	EA
Not at all (1)	58.2 (39)	42.2 (19)	62.5 (40)	22.4 (15)	20.9 (9)	22.1 (15)
Less than once a month (2)	23.9 (16)	26.7 (12)	21.9 (14)	1.5 (1)	9.3 (4)	1.5 (1)
Less than once a week (3)	9.0 (6)	17.8 (8)	10.9 (7)	3.0 (2)	0 (0)	2.9 (2)
Once a week (4)	3.0 (2)	4.4 (2)	4.7 (3)	3.0 (2)	0 (0)	1.5 (1)
Several times a week (5)	6.0 (4)	6.7 (3)	0 (0)	10.4 (7)	7.0 (3)	14.7 (10)
Daily (6)	0 (0)	2.2 (1)	0 (0)	59.7 (40)	62.8 (27)	57.4 (39)
N	67	45	64	67	43	68

Note--Clients who reported no use of heroin prior to treatment entry were either transfers from other maintenance programs or were abusers of illegal methadone or other opiates.

Table 11b. Frequency of use of barbiturates at various times as a function of counselor group in the methadone maintenance modality, as reported by clients

	30 days prior to first interview						30 days prior to entry into treatment					
	PRO		NEA		EA		PRO		NEA		EA	
Not at all (1)	95.9	(71)	96.2	(51)	89.6	(60)	91.4	(64)	94.1	(48)	92.8	(64)
Less than once a week (3)	2.7	(2)	3.8	(2)	3.0	(2)	4.3	(3)	2.0	(1)	4.3	(3)
Once a week (4)	1.4	(1)	0	(0)	1.5	(1)	0	(0)	0	(0)	0	(0)
Several times a week (5)	0	(0)	0	(0)	3.0	(2)	4.3	(3)	2.0	(1)	0	(0)
Daily (6)	0	(0)	0	(0)	3.0	(2)	0	(0)	2.0	(1)	2.9	(2)
N	74		53		67		70		51		69	

	During all treatment						In the year prior to entry into treatment					
	PRO		NEA		EA		PRO		NEA		EA	
Not at all (1)	87.3	(62)	92.2	(47)	84.1	(58)	82.4	(56)	91.8	(45)	85.5	(59)
Less than once a month (2)	4.2	(3)	5.9	(3)	4.3	(3)	4.4	(3)	4.1	(2)	5.8	(4)
Less than once a week (3)	4.2	(3)	0	(0)	2.9	(2)	2.9	(2)	0	(0)	2.9	(2)
Once a week (4)	1.4	(1)	0	(0)	1.4	(1)	2.9	(2)	2.0	(1)	2.9	(2)
Several times a week (5)	2.8	(2)	2.0	(1)	5.8	(4)	5.9	(4)	0	(0)	0	(0)
Daily (6)	0	(0)	0	(0)	1.4	(1)	1.5	(1)	2.0	(1)	2.9	(2)
N	71		51		69		68		49		69	

Table 11c. Frequency of use of marihuana-hashish at various times as a function of counselor group in the drug-free modality, as reported by clients

	30 days prior to first interview			30 days prior to entry into treatment		
	PRO	NEA	EA	PRO	NEA	EA
Not at all (1)	36.6 (15)	62.5 (10)	52.3 (23)	35.0 (14)	60.0 (9)	41.5 (17)
Less than once a week (3)	14.6 (6)	12.5 (2)	15.9 (7)	22.5 (9)	6.7 (1)	9.8 (4)
Once a week (4)	12.2 (5)	12.5 (2)	2.3 (1)	5.0 (2)	6.7 (1)	7.3 (3)
Several times a week (5)	29.3 (12)	6.3 (1)	25.0 (11)	25.0 (10)	20.0 (3)	19.5 (8)
Daily (6)	7.3 (3)	6.3 (1)	4.5 (2)	12.5 (5)	6.7 (1)	22.0 (9)
N	41	16	44	40	15	41

	During all treatment			In the year prior to entry into treatment		
	PRO	NEA	EA	PRO	NEA	EA
Not at all (1)	28.2 (11)	53.3 (8)	38.1 (16)	21.6 (8)	31.3 (5)	35.1 (13)
Less than once a month (2)	15.4 (6)	6.7 (1)	14.3 (6)	18.9 (7)	25.0 (4)	10.8 (4)
Less than once a week (3)	12.8 (5)	20.0 (3)	14.3 (6)	8.1 (3)	0 (0)	5.4 (2)
Once a week (4)	10.3 (4)	13.3 (2)	2.4 (1)	5.4 (2)	6.3 (1)	2.7 (1)
Several times a week (5)	25.6 (10)	6.7 (1)	23.8 (10)	37.8 (14)	25.0 (4)	29.7 (11)
Daily (6)	7.7 (3)	0 (0)	7.1 (3)	8.1 (3)	12.5 (2)	16.2 (6)
N	39	15	42	47	16	37

clients' drug usage.

Drug Use Between First Interview and Followup

In the followup study, counselors were asked to indicate, for clients still in treatment, how often they had used 12 drugs or categories of drugs in the 30 days just prior to the followup. For those who had left treatment by the time of followup, counselors reported frequency of use in the last 30 days of that treatment. The drug categories were the same as those in the initial interview. Counselors had also reported analogous information at the time of the first interview. Mean use levels as reported by counselors at the time of the first interview and the followup are presented in tables 12a-d for clients who remained in and had left methadone maintenance and drug-free treatment, respectively. As a rough overview of the change in use levels of drugs from initial interview to followup, in any subgroup of clients represented in 1 table, the number of drug categories of the 12 in which a decrease in use was noted at followup was counted. For only one group of clients, those who remained in drug-free treatment, did a drop in use level occur in more categories than would be expected by chance alone; there was a decrease in use in 10 of the 12 categories, $p<0.02$ by binomial probability. There was no similar effect for any of the remaining groups of clients. At the followup, it should be noted that use was very low for all drugs. The highest use was obtained for marihuana/hashish. Even here, the frequency-of-use rating averaged only slightly higher than "less than once a week" in two of the four instances.

Table 12a. Mean drug-use levels in the 30 days prior to the first interview and the 30 days prior to the followup interview as reported by counselors, and the correlation between these use levels for those clients who remained in treatment in the methadone maintenance modality

[1 = not at all; 2 = less than once per week; 3 = once per week; 4 = several times a week; 5 = daily]

Drug	Mean level, 30 days prior to first interview		Mean level, 30 days prior to followup interview		Correlation
	$\bar{X}$	N	$\bar{X}$	N	
Heroin	1.31	137	1.32	127	0.31[1]
Illegal methadone	1.01	138	1.01	116	---
Other opiates	1.18	140	1.09	128	0.37[1]
Alcohol to excess	1.52	136	1.45	122	0.75[1]
Barbiturates	1.16	139	1.25	126	0.44[1]
Other sedatives	1.35	137	1.40	122	0.38[1]
Amphetamines	1.16	139	1.25	129	0.42[1]
Cocaine	1.14	135	1.07	122	0.15
Marihuana/hashish	2.03	118	2.02	91	0.54[1]
Hallucinogens	1.00[2]	140	1.00[2]	117	---
Inhalants	1.00[2]	140	1.00[2]	117	---
Over-the-counter drugs	1.25	124	1.15	102	0.03

[1] $p<0.001$

[2] No use of the drug reported by any counselor. Correlation cannot be computed.

Table 12b. Mean drug-use levels in the 30 days prior to the first interview and the 30 days prior to the followup interview as reported by counselors, and the correlation between these use levels for those clients who remained in treatment in the drug-free modality

[1 = not at all; 2 = less than once per week; 3 = once per week; 4 = several times a week; 5 = daily]

Drug	Mean level, 30 days prior to first interview		Mean level, 30 days prior to followup interview		Correlation
	$\bar{X}$	N	$\bar{X}$	N	
Heroin	1.43	44	1.20	39	0.45[3]
Illegal methadone	1.00[1]	44	1.00[1]	38	---
Other opiates	1.86	42	1.19	36	0.40[4]
Alcohol to excess	1.61	41	1.59	39	0.60[2]
Barbiturates	1.02	43	1.05	39	1.00[2]
Other sedatives	1.20	44	1.10	39	0.15
Amphetamines	1.05	44	1.08	39	0.90[2]
Cocaine	1.05	44	1.03	38	-0.04
Marihuana/hashish	2.03	40	1.64	39	0.55[2]
Hallucinogens	1.14	44	1.00[1]	39	---
Inhalants	1.00[1]	44	1.00[1]	39	---
Over-the-counter drugs	1.28	43	1.00[1]	36	---

[1]No use of the drug reported by any counselor. Correlation cannot be computed.

[2]$p<0.001$

[3]$p<0.01$

[4]$p<0.05$

Table 12c. Mean drug-use levels in the 30 days prior to the first interview and the 30 days prior to the followup interview as reported by counselors, and the correlation between these use levels for those clients who had left treatment in the methadone maintenance modality

[1 = not at all; 2 = less than once per week; 3 = once per week; 4 = several times a week; 5 = daily]

Drug	Mean level, 30 days prior to first interview		Mean level, 30 days prior to followup interview		Correlation
	$\bar{X}$	N	$\bar{X}$	N	
Heroin	1.84	25	1.75	24	0.60[4]
Illegal methadone	1.00[1]	25	1.00[1]	21	---
Other opiates	1.48	23	1.52	23	0.58[4]
Alcohol to excess	1.64	25	1.96	25	0.38[2]
Barbiturates	1.35	23	1.52	25	0.38[2]
Other sedatives	1.30	23	1.33	21	0.49[3]
Amphetamines	1.27	22	1.39	23	0.10
Cocaine	1.00[1]	21	1.18	22	---
Marihuana/hashish	2.20	20	1.78	18	0.91[5]
Hallucinogens	1.00[1]	25	1.10	20	---
Inhalants	1.00[1]	24	1.00[1]	19	---
Over-the-counter drugs	1.05	20	1.33	21	-0.07

[1]No use of the drug reported by any counselor. Correlation cannot be computed.

[2]$p<0.10$

[3]$p<0.05$

[4]$p<0.01$

[5]$p<0.001$

Table 12d. Mean drug-use levels in the 30 days prior to the first interview and the 30 days prior to the followup interview as reported by counselors, and the correlation between these use levels for those clients who had left treatment in the drug-free modality

[1 = not at all; 2 = less than once per week; 3 = once per week; 4 = several times a week; 5 = daily]

Drug	Mean level, 30 days prior to first interview		Mean level, 30 days prior to followup interview		Correlation
	$\bar{X}$	N	$\bar{X}$	N	
Heroin	1.48	42	1.66	32	0.40[2]
Illegal methadone	1.07	42	1.00[1]	30	---
Other opiates	1.54	41	1.33	30	0.16
Alcohol to excess	1.44	41	1.72	32	0.59[4]
Barbiturates	1.20	41	1.20	30	0.47[3]
Other sedatives	1.71	42	1.15	26	0.16
Amphetamines	1.14	42	1.07	28	0.49[3]
Cocaine	1.05	42	1.04	26	-0.06
Marihuana/hashish	2.20	40	2.44	27	0.10
Hallucinogens	1.10	42	1.08	25	0.60[3]
Inhalants	1.02	42	1.08	26	-0.04
Over-the-counter drugs	1.10	39	1.00[1]	24	---

[1]No use of the drug reported by any counselor. Correlation cannot be computed.

[2]$p<0.05$

[3]$p<0.01$

[4]$p<0.001$

Table 13a. Percentages of clients reported by counselors to have any use of drugs in the followup study as a function of counselor group in the methadone maintenance modality[1]

	Clients remaining in treatment				Clients who left treatment			
	PRO	NEA	EA	χ^2	PRO	NEA	EA	χ^2
Heroin	25.6 (43)[2]	17.1 (35)	18.4 (49)	NS	--- (5)	42.9 (7)	40.7 (12)	NS
Illegal methadone	2.3 (43)	--- (36)	--- (37)	NS	--- (5)	--- (7)	--- (9)	--
Other opiates	7.0 (43)	8.3 (36)	6.1 (49)	NS	--- (5)	57.1 (7)	9.1 (11)	NS
Alcohol to excess	14.6 (41)	27.8 (36)	20.0 (45)	NS	--- (5)	33.3 (6)	42.9 (14)	NS
Barbiturates	--- (42)	5.6 (36)	27.1 (48)	.01	20.0 (5)	14.3 (7)	23.1 (13)	NS
Other sedatives	14.6 (41)	18.2 (33)	18.7 (48)	NS	--- (5)	20.0 (5)	9.1 (11)	NS
Amphetamines	4.7 (43)	20.0 (35)	7.8 (51)	NS	--- (5)	29.6 (7)	19.2 (11)	NS
Cocaine	--- (37)	5.7 (35)	4.0 (50)	NS	--- (4)	--- (7)	9.1 (11)	NS
Marihuana/hashish	48.4 (31)	33.3 (27)	36.4 (33)	NS	50.0 (4)	25.0 (4)	30.0 (10)	NS
Hallucinogens	--- (43)	--- (33)	--- (41)	--	--- (4)	16.7 (6)	--- (10)	NS
Inhalants	--- (43)	--- (33)	--- (41)	--	--- (4)	--- (5)	--- (10)	NS
Over-the-counter drug	16.1 (31)	--- (33)	7.9 (38)	NS	25.0 (4)	--- (5)	8.3 (12)	NS
Opiate index	23.8 (42)	20.0 (35)	75.7 (26)	NS	--- (5)	57.1 (7)	33.3 (9)	NS

[1]Dash indicates no use reported.

[2]Number in parentheses is total number on which percentage is based.

While mean use levels are informative, it was also of interest to examine the drug use data at followup of individual clients by considering the percentage of clients in a particular group (modality by treatment status) who had any use of each drug. The time frames were the same as those above, i.e., 30 days prior to followup for clients in treatment, and final 30 days in treatment for clients who left treatment. These data are given in tables 13a and 13b for methadone maintenance and drug free, respectively. Chi-squares were computed on the use of each drug by clients in the three counselor groups, separately for clients in and out of treatment in each modality. In one instance was significance found. The instance occurred for use of barbiturates among clients remaining in methadone treatment. Use of barbiturates was reported by EA counselors for 27.1 percent of these clients, NEA counselors for 5.6 percent of these clients, and by PRO counselors for none of these clients, $\chi^2(2)=17.66$, $p<0.001$.

Analyses similar to those used in examining the drug use data from the first interview, i.e., two-way analyses of variance of use as a function of counselor group and modality, and analyses of covariance of use as a function of counselor group with initial use level and previous counselor input were also performed. These analyses, however, are of dubious value; in most cases there was at least one cell of subjects for whom there was no use. This exceptional violation of assumptions renders the analyses of descriptive utility at best. These effects completely mirror those of the χ^2 tests, showing only elevation of barbiturate use of clients of EAs who remained in methadone maintenance at beyond the $\alpha=0.05$ significance level. Given the curiosity of this barbiturate effect, the actually reported use levels by individual clients are presented in table 14. The effect is clearly due to a small group of heavy barbiturate users among the clients of EAs, rather than due to a generalized use of barbiturates among all or even a majority of these clients.

It is interesting that the heavy barbiturate use of clients of ex-addicts (several times a week or daily) reported at followup was in 6 of 7 instances not associated with equally as heavy use at the time of the first interview. Of the 5 clients who at followup were reported to use barbiturates several times a week, 3 had used no barbiturates at the time of the first interview; 1, less than once a week, and the other, once a week. Of the 2 clients reported to use barbiturates daily at followup, one had also done so at the original interview; the other, however, had used barbiturates less than once a week.

Clients' Views of Aid from Counselors

During the first interview, clients were asked, in open-ended fashion, what their counselors had done to help them become and remain drug free. Clients were permitted to indicate as many ways of being helped as they wished; about 45 percent of clients mentioned only one way; another 35 percent mentioned two ways; while 20 percent mentioned three different ways. The mean number of ways mentioned by clients was constant across counselor groups. First-mentioned responses, one per client, and then all responses summed across clients, are given in table 15.

About an eighth of all the clients stated that their counselors had done nothing; these clients often further explained that they themselves felt fully responsible for their own progress, and that they believed that no one else could help them with their drug problems. Such responses were made slightly more often by clients of PROs than by clients in the other groups, $\chi^2(2)=6.20$, $p<0.05$ for the first mention. In contrast, clients of EAs reported a bit more frequently than clients in the other two groups that their counselors had pointed out the negative aspects of the life associated with drug abuse and the positive alternatives to such a life, $\chi^2(2)=6.43$, $p<0.05$ for the first mention. It is interesting that support given through encouragement, friendship given through just talking, and insight were first, second, and third most frequently mentioned in all counselor groups. Moreover, it is of interest that when all mentions were considered, PROs were no more likely to be credited with providing insight than were nonprofessional counselors.

Summary

Overall, there were few differences found in drug use as a function of counselor group. There were four such differences, all in methadone maintenance: (1) adjusted decrease in use of heroin from the year before treatment to all time after treatment was smaller for clients of NEAs than for other clients; (2) adjusted change in use of marihuana/hashish from the 30 days before entry into treatment to the 30 days before the first interview was toward slightly more use by clients of PROs and slightly less use by other clients; (3) from the 30 days before entry into treatment to the 30 days prior to the first interview, clients of EAs increased their use of barbiturates slightly while other clients' use decreased; and (4) in the

Table 13b. Percentages of clients reported by counselors to have any use of drugs in the followup study as a function of counselor group in the drug-free modality[1]

	Clients remaining in treatment				Clients who left treatment			
	PRO	NEA	EA	χ^2	PRO	NEA	EA	χ^2
Heroin	18.2 (11)[2]	14.3 (7)	19.0 (21)	NS	44.4 (18)	--- (3)	19.2 (11)	NS
Illegal methadone	--- (11)	--- (7)	--- (20)	--	--- (16)	--- (5)	--- (9)	NS
Other opiates	--- (10)	--- (5)	14.3 (21)	NS	21.4 (14)	--- (5)	19.2 (11)	NS
Alcohol to excess	17.3 (11)	14.3 (7)	28.6 (21)	NS	30.2 (16)	20.0 (5)	45.5 (11)	NS
Barbiturates	--- (11)	--- (7)	4.8 (21)	NS	7.1 (14)	20.0 (5)	9.1 (11)	NS
Other sedatives	9.1 (11)	--- (7)	4.8 (21)	NS	9.1 (11)	--- (5)	10.0 (10)	NS
Amphetamines	9.1 (11)	10.0 (7)	4.8 (21)	NS	8.3 (12)	--- (5)	9.1 (11)	NS
Cocaine	9.1 (11)	--- (7)	--- (20)	NS	--- (11)	--- (5)	10.0 (10)	NS
Marihuana/hashish	17.3 (11)	--- (7)	33.3 (21)	NS	68.2 (13)	75.0 (4)	50.0 (10)	NS
Hallucinogens	--- (11)	--- (7)	--- (21)	NS	10.0 (10)	--- (5)	10.0 (10)	NS
Inhalants	--- (11)	--- (7)	--- (21)	NS	--- (11)	--- (5)	10.0 (10)	NS
Over-the-counter drug	--- (11)	--- (7)	--- (18)	NS	--- (9)	--- (5)	--- (10)	NS
Opiate index	10.0 (10)	--- (5)	30.0 (20)	NS	50.0 (14)	--- (3)	11.1 (9)	NS

[1]Dash indicates no use reported.

[2]Number in parentheses is total number on which percentage is based.

Table 14. Frequency of use of barbiturates by methadone maintenance clients who were still in treatment at the time of the followup

	Use in 30 days prior to first interview			Use in 30 days prior to followup		
	PRO	NEA	EA	PRO	NEA	EA
Not at all	93.3 (42)	95.2 (40)	86.5 (45)	100.0 (42)	94.4 (34)	72.9 (35)
Less than once a week	2.2 (1)	2.4 (1)	7.7 (4)	---	5.6 (2)	12.5 (6)
Once a week	2.2 (1)	---	3.8 (2)	---	---	---
Several times a week	2.2 (1)	2.4 (1)	---	---	---	10.4 (5)
Daily	---	---	1.9 (1)	---	---	4.2 (2)
N	45	42	52	42	36	48

$\chi^2(2)=17.66$, $p<0.001$ for no use versus any use.

Table 15. What counselor has done to help client become and remain drug free, as reported by clients

	First mention			Sum of 3 mentions		
	PRO	NEA	EA	PRO	NEA	EA
Nothing	19.8 (23)	12.7 (9)	8.7 (10)	13.1 (26)	8.1 (10)	6.1 (12)
Encouragement, help with coping	25.9 (30)	25.4 (18)	20.0 (23)	27.8 (55)	30.6 (38)	26.4 (52)
Talking, just talk	26.7 (38)	23.9 (17)	27.0 (31)	19.2 (38)	17.7 (22)	19.3 (38)
Gives insight	13.8 (16)	21.1 (15)	20.0 (23)	15.7 (31)	16.9 (21)	17.3 (34)
Constant availability whenever client needs counselor	.9 (1)	2.8 (2)	.9 (1)	3.0 (6)	3.2 (4)	2.0 (4)
Helped reduce drug dosage, helped client detox	0 (0)	2.8 (2)	2.6 (3)	2.5 (5)	3.2 (4)	3.6 (7)
Pointed out negativity of drug life and positive alternatives to drug abuse	1.7 (2)	4.2 (3)	10.4 (12)	6.6 (13)	7.3 (9)	13.2 (26)
Gave services to client to improve the quality of life of the client, e.g., transportation to drug program, getting medical care for client, helping him find a job	10.3 (12)	5.6 (4)	7.8 (9)	11.6 (23)	10.5 (13)	10.2 (20)
Specific counselor characteristic was helpful to client, e.g., Spanish speaking, calm, had used drugs and understood drug problem	0 (0)	0 (0)	.9 (1)	0 (0)	1.6 (2)	1.5 (3)
Client not at this point in therapy	.9 (1)	1.4 (1)	1.7 (2)	0.5 (1)	0.8 (1)	1.0 (2)
N	116	71	115	198	124	197

Note--Ns at the bottom of the columns for the first mention only are the numbers of clients; Ns at the bottom of the columns for the sum of 3 mentions are the total numbers of responses given by all clients over 3 mentions.

subsequent time period, i.e., 30 days before the first interview to 30 days before the followup interview, clients of EAs who remained in treatment used barbiturates more heavily than did other clients.

As pointed out throughout this section, the differences among counselor groups in these four instances were very small. In the case of heroin, it was previously pointed out that when the use of any opiates was considered, i.e., the opiate index, there was no difference among reduction in use across the three counselor groups. In all, the likeness of drug use by clients of the three types of counselors was far more striking than the four significant effects found in the course of 96 different analyses. In fact, the number of differences found were what would have been expected by chance alone at the 0.05 level of significance. It was thus concluded that the three groups of counselors had not had differential effects on the drug use of their clients.

Education

Schooling from Treatment Entry to First Interview

Clients were questioned about both vocational and academic schooling during all the time since treatment entry and specifically during the 30 days prior to the first interview. Slightly over 30 percent of clients had received some schooling between the time of entry into treatment and the time of the first interview (table 16). Of these clients, more had received academic than vocational training. The percent of clients who did receive some schooling tended to depend upon counselor group, $\chi^2(2)=4.89$, $p<0.10$, with significantly more clients of PROs (38.8 percent) having received schooling than clients of EAs (25.8 percent), $z=2.27$, $p<0.05$. It was possible that this difference was attributable to some differences in schooling in the year before treatment entry. There was a close relationship between having received schooling in the year prior to treatment and since treatment, $\chi^2(1)=10.20$, $p<0.001$. Of those clients who had been in any form of school in the year prior to treatment entry, 47 percent had also received schooling after treatment entry. In contrast, of those clients who had received no schooling in the year before treatment entry, only 27 percent had received schooling following entry into treatment. The percentage of these latter clients who received schooling after but not in the year before treatment entry also tended to be associated with counselor group, there being 34.6 percent, 24.1 percent, and 21.3 percent of clients of PROs, NEAs, and EAs, respectively, in this category, $z=1.92$, $p=0.06$ for clients of PROs versus EAs, respectively.

While these counselor-group-associated differences existed in the percentage of clients receiving any vocational training, the groups did not differ in the amount of time spent in school. The mean number of months during treatment in which clients had received vocational training did not differ over groups, $F(2,298)=0.28$, $p>0.20$. Neither did groups differ in mean number of months in treatment during which clients had received schooling other than vocational training, $F(2,298)=1.10$, $p>0.20$. This lack of difference across groups in proportion of time devoted to schooling was retained when the time spent in school in the year before treatment and measures of input from other counselors were partialed out.

The pattern of percentages of clients receiving any schooling in the 30 days prior to the first interview followed those for all the time in treatment. These percentages tended to be associated with counselor group, $\chi^2(2)=5.08$, $p<0.10$, with significantly more clients of PROs (22.4 percent) than clients of EAs (11.3 percent) having received any schooling in the 30 days before the first interview, $z=2.28$, $p<0.05$.

Of those clients receiving academic schooling in the 30 days prior to the first interview, over half were attending college. This value was stable across counselor groups. The types of vocational training received during this time were widely varied and not associated with counselor group.

Schooling at the Time of Followup

Of those clients who were still in treatment at the time of the followup, approximately equal percentages of each group were enrolled in vocational school, $\chi^2(2)=0.84$, $p>0.20$. However, a substantially higher proportion of clients of PROs (29.5 percent) than either NEAs (8.2 percent) or EAs (9.6 percent) were enrolled in academic programs, $\chi^2(2)=12.85$, $p<0.01$. For clients who had left treatment by the followup, the percentage of clients enrolled in vocational school when they left also tended to be associated with counselor group, $\chi^2(2)=4.63$, $p< 0.10$, with clients of PROs more often in vocational school than other clients. There was no association between counselor group and attendance in academic schooling for these clients, $\chi^2(2)=2.35$, $p>0.20$.

Table 16. Schooling (vocational and other than vocational) from treatment entry to the first interview, and at followup

A. Schooling from treatment entry to the first interview

	Counselor group		
	PRO	NEA	EA
1. Percentage of clients receiving any vocational training since treatment entry	18.1	9.9	12.2
2. Percentage of clients receiving any schooling other than vocational training since treatment entry	28.4	25.4	16.5
3. Percentage of clients receiving any schooling (vocational or otherwise) since treatment entry	38.8	32.4	25.8
4. Mean number of months of vocational training since treatment entry (percents of total time in treatment in which client received training are given in parentheses)	.71 (5.68)	.68 (2.31)	.47 (3.57)
5. Mean number of months of other schooling since treatment entry (percents of total time in treatment in which client received schooling are given in parentheses)	1.48 (12.19)	1.49 (14.0)	.89 (8.73)
6. Percentages of clients receiving any vocational training in 30 days before first interview	8.6	2.8	3.5
7. Percentage of clients receiving any schooling other than vocational training in 30 days before first interview	14.7	15.5	7.8
8. Percentage of clients receiving any schooling (vocational or otherwise) in the 30 days prior to the first interview	22.4	18.3	11.3

Table 16 (Continued)

B. Schooling at time of followup for clients remaining in treatment and at time of leaving treatment for clients who left treatment before followup

	Counselor group		
	PRO	NEA	EA
9. Clients in treatment--percentages receiving vocational training at time of followup	9.7	6.1	11.0
10. Clients in treatment--percentages receiving schooling other than vocational training at time of followup	29.5	8.2	9.6
11. Clients who left treatment--percentages receiving vocational training at time of leaving treatment	21.7	7.7	3.4
12. Clients who left treatment--percentages receiving schooling other than vocational training at time of leaving treatment	17.4	23.1	6.2

Note--Data reported at time of first interview are based on at least 99.7 percent of the full sample. Data reported at time of followup are based on 95.8 percent of the sample on whom any followup data were available, or 60.9 percent of the original sample of 302 clients.

Education at Initial Interview Versus Followup

An interesting comparison among counselor groups can be made by considering the educational status at followup of clients not in school at the time of the first interview. Examining clients still in treatment at followup who had not been receiving vocational training at the time of the first interview, 5.4 percent, 2.2 percent, and 7.6 percent of the clients of PROs, NEAs, and EAs, respectively, were receiving vocational training at followup. For those clients who had left treatment at followup, analogous percentages were 23.8 percent for clients of PROs and zero percent for clients of NEAs and EAs. With regard to academic schooling of clients who had not been in school at the time of the first interview and who remained in treatment, 9.2 percent, 2.2 percent, and 1.6 percent of the clients of PROs, NEAs, and EAs were in school at the time of followup. For those clients who had left treatment at followup, analogous percentages were 13.6 percent, 14.3 percent, and 3.8 percent, for clients of PROs, NEAs, and EAs, respectively.

An explanation was sought for the consistent finding that more clients of PROs received schooling than did clients of the other two counselor groups in the time following entry into treatment. One possibility was that this finding was due not to the unique emphasis of one counselor group on education but rather to the eligibility of clients to attend school based on their ages and previous academic achievement. To explore this, indices of eligibility for high school and college were created. For the high school eligibility index, a client was scored "1" if he were between the ages of 12 and 20 and held neither a high school degree nor a GED; zero otherwise. For the mutually exclusive college eligibility index, a client was scored "1" if he were between the ages of 16 and 25 and held either a high school degree or a GED. The percentages of clients who were high school eligible were uniformly low across groups, i.e., 4.3 percent, 1.4 percent, and 2.6 percent for clients of PROs, NEAs, and EAs, respectively, $\chi^2(2)=1.37$, $p>0.20$. However, more clients of PROs than of the other two groups were college eligible, i.e., 18.1 percent, 5.6 percent, and 12.2 percent for clients of PROs, NEAs, and EAs, respectively, $\chi^2(2)=6.18$, $p<0.05$. These proportions differed significantly for clients of PROs versus NEAs, $z=5.29$, $p<0.01$.

The college eligibility results suggest that demographic characteristics of clients might well account for the greater rate of school attendance by clients of PROs than by clients of the other counselor groups. This seems partially but not entirely the case. Substantially, more clients in the PRO and NEA counselor groups actually attended school during treatment than would be expected from the high school plus college eligibility indices. Moreover, the difference in rates of school attendance across counselor groups is greater than would be expected from differences in eligibility. In sum, then, some portion, but not all, of the difference in school attendance by clients of the three groups is attributable to demographic differences among clients in age and prior academic achievement. Even with eligibility considered, there are still further differences in favor of clients of PROs attending school.

Summary

Clients of professional counselors tended to be in vocational or academic school more often than clients in the other two groups. This was so for clients of PROs over EAs considered in all the time between treatment entry and the first interview, as well as in the 30 days just prior to the first interview. At followup, clients of PROs who remained in treatment were enrolled in school at a higher rate than were clients in the other two groups. For those clients who had left treatment at the time of followup, a similar tendency existed for enrollment in vocational school.

A hypothesis was explored to account for these effects: that clients of PROs were more likely to be eligible for school in terms of age and previous academic achievement than clients of other counselors. This hypothesis was supported; the extent to which it was so in part accounted for the counselor group effect.

Employment

Employment from Treatment Entry to First Interview

Over half the clients in each counselor group had held at least one legal job since entering treatment, $\chi^2(2)=0.51$, $p>0.20$ (table 17). Clients, on the average, had been employed for one-third or more of their total time in treatment. The percentage of all treatment time during which clients were employed did not differ over modality, $F(1,295)=1.20$, $p>0.20$, or as a function of counselor group, $F(2,295)=0.23$, $p>0.20$. Further, there was no relationship between counselor group and amount of change in proportion of total time spent employed from the year before treatment to all the time following treatment entry, with initial level and

Table 17. Employment from treatment entry to first interview, and at followup

A. Employment from treatment entry to the first interview

		Counselor group		
		PRO	NEA	EA
1. Percent who held at least 1 job since entering treatment		56.9	57.7	53.0
2. Mean number of months employed since entered treatment (percentage of all time in treatment in which client employed given in parentheses)	MM	5.75 (32.6)	8.01 (33.4)	6.84 (33.15)
	DF	1.93 (41.2)	3.21 (41.4)	2.39 (34.6)
3. Percent employed as of day of first interview		25.0	33.8	26.1
4. Mean number of days worked in past 30 days		4.50	6.13	5.51
5. For female clients only, mean number of months mainly a housewife since entry into treatment (percentage of all time in treatment in which mainly a housewife given in parentheses)		3.43 (21.48)	4.94 (20.90)	3.51 (22.30)
6. For female clients only, percent who were mainly housewives in the 30 days before the first interview		66.7	68.2	77.4

B. Employment status at followup

1. Percentages of clients still in treatment at followup who were employed full time, part time, or not at all at followup:			
Full time	29.0	44.9	28.8
Part time	21.0	14.3	9.6
Not at all	50.0	40.8	61.6
2. Percentages of clients who had left treatment at followup who were employed full time, part time, or not at all at followup:			
Full time	25.0	38.5	34.5
Part time	16.7	0	10.3
Not at all	58.3	61.5	55.2

other counselor input partialed out.

At the time of the first interview, slightly over a quarter of all clients were employed. This value did not differ as a function of counselor group, $\chi^2(2)=1.89$, $p>0.20$. Groups did not differ in the mean number of days worked in the 30 days prior to the first interview, $F(2,298)=0.79$, $p>0.20$. Again, with previous counselor input and number of days employed in the 30 days before treatment entry partialed out, change in number of days employed from 30 days prior to treatment entry to 30 days prior to first interview did not differ across counselor groups. Considered another way, McNemar tests of significance of change in employment in the 30 days prior to treatment entry versus the time of the first interview performed separately for clients in each counselor group indicated no gain in rate of employment over this time period in any group.

For women only, their status as housewives was considered. Fully 70.8 percent had been mainly housewives in the 30 days prior to the first interview. This percentage was stable over counselor groups, $\chi^2(2)=1.03$, $p>0.20$. Neither did female clients in the three counselor groups differ in the proportion of all time since treatment entry during which they had been mainly housewives, either with or without pretreatment level and other counselor input partialed out ($F<1$ in both cases). In fact, McNemar tests of significance of gain in rates of housewife status within each counselor group indicated no change in these rates from the 30 days prior to treatment entry to the time of the first interview, $p>0.20$ in all cases.

Employment at Followup

Of clients who remained in treatment at followup, there tended to be a relationship between being employed and counselor group, $\chi^2(2)=5.27$, $p<0.10$. Significantly more clients of NEAs held jobs than did clients of EAs, $z=2.32$, $p<0.05$. Of those clients who had left treatment at followup, equal percentages were employed across counselor groups, $\chi^2(2)=0.16$, $p>0.20$.

Employment Before Versus After Treatment, and from First Interview to Followup

As would be expected, there was a substantial relationship between employment of clients at entry into treatment and at the time of the first interview. Of particular interest were those clients who were not employed at entry into treatment but were employed at the time of the first interview. There were 13.4 percent, 22.0 percent, and 12.0 percent of clients of PROs, NEAs, and EAs who fell into this category, $\chi^2(2)=2.70$, $p>0.20$. A similar test for relationship examined the percentage of clients not employed in the whole year before treatment entry who became employed after treatment entry. There were 24.5 percent, 32.4 percent, and 21.6 percent of clients of PROs, NEAs, and EAs who fell in this category, $\chi^2(2)=5.22$, $p<0.10$. While there was a tendency for an association between counselor groups and these latter percentages, no pair of groups differed at least at the 0.05 level of significance.

A second period of examination was the time between the first and followup interviews. Of clients not employed at the time of the first interview, of those still in treatment at followup, 27.4 percent, 22.2 percent, and 18 percent of clients of PROs, NEAs, and EAs, respectively, were employed at the time of followup, $\chi^2(2)=1.42$, $p>0.20$. For clients who had left treatment by followup, analogous percentages were 20 percent, 18.2 percent, and 24 percent for clients of PROs, NEAs, and EAs, respectively, $\chi^2(2)=0.21$, $p>0.20$. In all, there appeared to be no difference among clients of the three counselor groups in their levels of legal employment through the course of treatment.

While there were no differences among counselor groups in rates of employment of their clients, there was an optimistic outcome with regard to gains in employment between the first and followup measurement for clients who remained in treatment. In each counselor group, there was a significant gain in employment rate as shown by McNemar tests of changes, $\chi^2(1)=11.25$, $p<0.001$; $\chi^2(1)=13.07$, $p<0.001$, and $\chi^2(1)=3.50$, $p=0.06$ for clients of PROs, NEAs, and EAs, respectively.

Clients' Perceptions of Counselor Input in Finding and Keeping Jobs

In the first interview, clients were asked about what their counselors had done to help them find and/or keep jobs. Of clients employed at the time of the first interview, 57 percent had had their current jobs when they started being counseled by their current counselors. These clients were asked what their current counselors had done to help them keep their jobs. In all, 16, 9, and 20 clients of PROs, NEAs, and EAs responded. Of these clients, 44 percent, 67 percent, and 25 percent of clients in the three groups responded that their counselors had done nothing, $\chi^2(2)=4.65$, $p<0.10$. The remainder indicated that their counselors had primarily provided emotional support and encouragement. One client of a PRO, and two clients of EAs

mentioned that the counselor had done something specifically related to the job, e.g., writing excuses for clients' tardiness.

Those employed clients who did not have present jobs when they started being counseled by their current counselors were asked what their counselors had done to help them find and keep their present jobs. Of the 12, 13, and 10 clients of PROs, NEAs, and EAs who fell into this category, 58 percent, 23 percent, and 50 percent, respectively, said that their counselors had done nothing, $\chi^2(2)=3.45$, $p>0.10$. Another 17 percent, 39 percent, and 40 percent, respectively, indicated that their counselors had given them emotional support. Only 6 clients, 2, 3, and 1 of the three groups, respectively, indicated that their counselors had gotten them job leads or had arranged job interviews.

Finally, the 79, 38, and 72 clients of PROs, NEAs, and EAs who were unemployed at the time of the interview were asked about what their counselors had done to help them find jobs. In all, 30.4 percent, 31.6 percent, and 31.9 percent of clients of PROs, NEAs, and EAs, respectively, indicated that their counselors had done nothing. Fully, 29 percent, 37 percent, and 36 percent of clients of PROs, NEAs, and EAs, respectively, indicated that their counselors had gotten them job leads, arranged for job interviews, or arranged for clients to meet with people who had access to jobs. Another 15 percent, 21 percent, and 18 percent of clients of PROs, NEAs, and EAs, respectively, indicated that their counselors had helped them prepare psychologically for jobs. In addition, 11 percent, 5 percent, and 8 percent of clients in the three groups indicated that their counselors had arranged for them to get job counseling or relevant schooling.

Of unemployed clients, over 85 percent stated that they planned to get legal jobs; this value was stable across groups, $\chi^2(2)=3.78$, $p>0.10$. Of those clients who stated that they planned to get legal jobs, 87 percent, 78 percent, and 89 percent of clients of PROs, NEAs, and EAs indicated that they were certain or pretty sure that they would get regular jobs. Fewer than 10 percent of the clients in each counselor group expressed any trepidation about whether they could handle jobs.

Client Sources of Income

Substantial numbers of clients were unemployed in the 30 days prior to the first interview. It was of interest, then, to determine what sources of income they had had during these 30 days. All clients were asked about six sources: work, welfare, unemployment compensation, a spouse, parents, and other relatives. They were also asked to specify any other sources. The most frequent single source mentioned was, in fact, work (table 18), uniformly indicated across all counselor groups. Welfare or food stamps was next often mentioned. The frequency with which clients mentioned this source tended to be associated with counselor group, with clients of NEAs mentioning this source least often. It is of interest to note that in contrast with the many legal sources mentioned, illegal sources were mentioned only very infrequently. The use of illegal sources, as well as the many other sources listed in table 18, did not differ in terms of frequency of mention across counselor groups. Overall, then, it was concluded that sources of income were substantially the same across counselor groups.

Summary

The percentage of clients in each counselor group who were employed at the time of the first interview, and who had held any job prior to entry into treatment, was equivalent across counselor groups. Slightly over a quarter of clients were employed at the time of the first interview. Among women, over two-thirds reported being mainly housewives in the 30 days prior to entry into treatment; again, this value was stable over counselor groups. At followup, there was no difference as a function of counselor group in the percentage of clients employed at the time they left treatment. For clients remaining in treatment at followup, there tended to be more clients of NEAs who were employed. When clients who had not been employed in the whole year prior to treatment were examined at the first interview, there was a tendency ($p<0.10$) for more of such clients of NEAs to have been employed since entering treatment. Clients did not differ substantially across groups in what they perceived their counselors had done to help them find and/or keep their current jobs. Clients who were unemployed at the first interview were optimistic about their finding and holding legal jobs. Finally, groups did not differ in the variety of their sources of income in the 30 days prior to the first interview.

Composite Measure of Productivity

Two aspects of productive activity have been considered, i.e., schooling and employment. For women, the fact of being a homemaker was also considered. It was of interest to summarize these several aspects of productive activity in one index, and to examine whether there were differences among counselor

Table 18. Sources of income for clients during the 30 days prior to the first interview

Q. 73. During the last 30 days, which of the following were sources of income to you: work? welfare? unemployment compensation? your spouse? your parents? other relatives? anything else? (Client mentioned all sources that applied)

	Counselor group			
	PRO	NEA	EA	χ^2
Work	34.8%	39.1%	36.6%	NS
Welfare or food stamps	38.3	23.2	34.8	0.10
Unemployment compensation or other government sources	9.6	11.6	7.1	NS
Your spouse	9.6	14.5	15.2	NS
Your parents	11.3	8.7	6.3	NS
Other relatives	7.8	5.8	3.6	NS
SSI disability	9.6	11.6	11.6	NS
Friend/girlfriend/boyfriend	8.7	10.1	7.1	NS
Illegal sources, e.g., gambling, drug sales, hustling, copping	1.7	4.3	1.8	NS
School grants	3.4	--	4.3	--
Savings or retirement property	.9	--	4.3	--
Child support[1]	.9	--	.9	--
Loans	.9	1.4	--	--
No source	--	1.4	.9	--
N	16	71	115	

Note--χ^2 tests omitted where expected frequencies are inappropriately low.

groups in the overall productive activity of the clients. Toward this end, a binary index was created in which a client was scored "1" if he or she were either attending school, or working at a legal job, or being a housewife; "zero" otherwise. This index was considered for the 30 days before entry into treatment and 30 days prior to the first interview. For followup, only schooling and legal employment were considered since housewife-related data had not been gathered. Clients of the three counselor groups were equivalent on this productivity index at all three measurement points, $\chi^2(2)=0.04$, 0.05, 1.47, $p>0.20$ for the 30 days prior to treatment entry, 30 days prior to the first interview, and prior to followup, respectively. At each point, half the clients were considered productive on this index.

The finding of no difference among counselor groups on the overall index needs to be reconciled with the finding of greater school involvement of clients of PROs than particularly clients of EAs. The resolution is quite simple. When each measure of productivity was considered separately, there was a slight though often nonsignificant difference among clients of the three counselor groups in one or another direction. For example, female clients of EAs were somewhat more often housewives than were female clients in the other groups. Clients of NEAs tended to be more frequently employed at followup than clients of the other groups. These slight advantages in one direction or another balanced out over groups when all measures of productivity were combined into one index.

Criminality

Criminality from Treatment Entry to First Interview

Overall, there was remarkable similarity among clients of the three counselor groups in arrests and time spent in jail from entry into treatment (table 19). Around a quarter of the clients of each counselor group had been arrested at least once in the period between entry into treatment and the time of the first interview, $\chi^2(2)=0.37$, $p>0.20$. Slightly over 20 percent of each counselor group had spent at least 1 day in jail during the same period, $\chi^2(2)=0.19$, $p>0.20$. Clients who had been arrested reported the charges for their arrests; somewhat more drug-related arrests were reported by clients of NEAs than in the other two groups, $\chi^2(2)=5.46$, $p<0.10$, though no pair of groups differed in this percentage in at least the 0.05 level of significance.

Fewer than 5 percent of clients had been arrested or had spent time in jail in the 30 days prior to the first interview. In fact, there were so few such cases in each group that conventional statistical tests such as χ^2 or the analysis of variance were completely inappropriate.

Criminality at Followup

Of clients who remained in treatment until the followup, fewer than 5 percent had been arrested between the first and followup interview. Fewer than 2 percent had been arrested in the 30 days prior to the followup. Fewer than 4 percent of the clients had spent any time in jail between the initial interview and the followup. For only the 30 days prior to the followup, 2 percent had spent any time in jail.

Of clients who had left treatment by followup, none of the 23 clients of PROs, 1 of the 13 clients of NEAs, and 4 of the 28 clients of EAs had been arrested in the time between the first interview and the followup. By Fisher exact test of the PRO versus EA groups, the arrest rates of the clients of EAs tended to be higher than those of PROs ($p=0.08$) though not at conventional significance levels. For percentages of clients who had been in jail between the time of the first interview and treatment followup, a Fisher exact test of the PRO versus EA groups did not even approach significance ($p=0.16$).

Summary

Arrest rates during treatment were uniformly low across counselor groups. Further, clients of all counselor groups were jailed with very low frequency. Overall, there was clear evidence of equal progress in treatment of clients of the three groups with regard to freedom from criminality.

Quality of Life

During the initial interview, an attempt was made to assess some dimensions of "quality of life" for clients apart from their specific levels of drug abuse, legal employment status, and criminality as measured by number of days in jail and number of arrests. It was felt that while these "Federal criteria" items were of prime importance, other factors associated directly with them in some cases but only indirectly in others should be examined to get some idea of how the addict perceives his life. Clients were asked to fill out a self-administered questionnaire (SAQ) which has the advantage of

Table 19. Arrests and time spent in jail from treatment entry to followup

	Counselor group		
	PRO	NEA	EA
A. Criminality from treatment entry to the first interview			
1. Distribution of arrests in all time between entry into treatment and the time of the first interview (percent):			
None	74.1	76.0	72.2
One or two times	18.1	14.1	21.7
More than twice	7.8	9.9	6.1
2. Percentages of all charges mentioned which were drug-related, for all arrests from time of entry into treatment to time of first interview	36.4	61.3	39.0
3. Distribution of number of days in jail in all time between entry into treatment and the time of the first interview (percent):			
None	79.3	77.1	77.2
One to 10 days	13.8	12.9	18.4
More than 10 days	6.9	10.0	4.4
4. Percentage of clients arrested in 30 days prior to the first interview	4.3	1.4	6.1
5. Percentage of clients spending at least 1 day in jail in 30 days prior to first interview	3.4	2.9	5.2
B. Criminality at followup			
6. Clients in treatment, percentage arrested since first interview	3.2	6.1	2.9
7. Clients in treatment, percentage arrested in 30 days prior to followup	1.6	4.1	0
8. Clients in treatment, percentage who spent any time in jail between first interview and followup	3.3	6.1	4.2
9. Clients in treatment, percentage who spent any time in jail in 30 days prior to followup	1.6	4.1	1.4
10. Clients who left treatment, percent who had been arrested between first interview and time left treatment	0	7.7	14.3
11. Clients who left treatment, percent who had been in jail between first interview and time left treatment	0	7.7	10.3

relative privacy without having the low response rate disadvantage associated with mail questionnaires. In cases where particular respondents could not read, or had difficulty in filling out the SAQ, interviewers helped them by reading the questions to them.

The areas of questions asked in the SAQ fell into five general categories of self-report:

1. Participation in ordinary chores, tasks, and activities, social and otherwise, in which many non-addicted individuals regularly indulge;

2. Indices of physical health such as appetite and sleep, and a general question about perceived state of health;

3. Measures of social isolation or nonisolation such as number of and relationship to persons lived with, opposite-sex friendships, number of meals eaten alone, and other specific indicators of social life;

4. Level of satisfaction of clients with their relationships with those they live with, satisfaction with home and neighborhood. For those who expressed dissatisfaction with the state of these important sources of social support, reasons for dissatisfaction were sought; and

5. Activities, largely of a socially unacceptable nature, often related to the drug and street scene such as pimping and prostitution.

Interestingly, as will be seen, when all these indices are examined, the overall quality of life for most addicts in this study is not perceived by the clients themselves as universally or even predominantly disparate or intolerable.

No attempt was made in this section to take into account the effect of other variables besides counselor group on these indices. Nor were they inquired into in the followup study. A primary reason for this is that these social indicators or quality-of-life measures were not designed to be measures of client progress in this study. They were included merely to give further insight into the client's own current views of his world--views which would seem necessary to examine whether one considers them legitimate therapeutic targets or merely as social and psychological contexts within which behavioral change must be set.

Participation in Ordinary Activities and Chores

A large number of routine activities, including a range of recreational pursuits, hygiene, health, and what might be termed "maintenance" chores, were asked about in the SAQ. The aim as stated above was to see the extent to which addicts led normal lives with regard to these rather mundane, common endeavors. While quantitative comparison to the general population is not practicable, some notions of "quality of life" may be acquired by examining responses to the items presented in table 20. Scanning this table, two results are immediately apparent. First, no differences are observed among the clients of the three counselor groups. No one group of clients seems to be better or worse off; no F ratio comes close to statistical significance in the ANOVs run for each item. One rough way of summarizing table 20 is to say that about half of the items had a mean score of between (2) several times a week and (3) once or twice a week. This group included many of the positive, socially reinforced items such as eating breakfast and lunch, working for money, fixing the house, playing sports and exercise, and caring for children. More frequent still with average scores between (1) every day and (2) several times a week were other socially desirable activities such as doing household chores, hygiene factors including bathing and brushing teeth, and reading. Two other items in this category characterized by less social desirability, but certainly thought of as socially acceptable and reflecting the norm, were watching television and partying. About one-quarter of the items fell into this frequency category. The remaining one-quarter of the activities were those least reported as occurring between (3) once or twice a week and (4) less often or never. These included two items of high social desirability but which one might expect to be in this category because of the natural timing of such activities and the demographics of this population. These items are going to church or synagogue, and spending time in school. The infrequently reported items also included the least socially desirable items in the list--gambling, drinking, and using prescription drugs. Social desirability may, of course, be operating as a response set here, and respondents may be distorting their answers accordingly. However, taking the answers at face value, it seems that this particular addict population responds much like one might intuitively expect the public at large to respond to these questions.

Indices of physical health also fail to reveal either differences among counselor

Table 20. Client responses to quality of life indices for the 30 days prior to the first interview

[1 = every day; 2 = several times a week; 3 = once or twice a week; 4 = less often or never]

		PRO	NEA	EA	ANOV	Tukey A
a. Eat breakfast	$\bar{X}$	2.33	2.06	2.15	F(2,293) = 1.39	--
	S.E.	.11	.14	.14		
	N	115	70	111		
b. Work for money	$\bar{X}$	2.96	2.78	2.96	F(2,284) = .57	--
	S.E.	.11	.16	.12		
	N	112	68	107		
c. Shower, bathe	$\bar{X}$	1.42	1.34	1.40	F(2,291) = .71	--
	S.E.	.06	.07	.05		
	N	113	70	111		
d. Do household chores	$\bar{X}$	1.95	1.86	1.82	F(2,290) = .44	--
	S.E.	.10	.13	.09		
	N	113	70	110		
e. Repair or fix up your house	$\bar{X}$	2.43	2.31	3.43	F(2,292) = .28	--
	S.E.	.10	.14	.11		
	N	113	70	112		
f. Wash dishes	$\bar{X}$	2.30	2.26	2.41	F(2,292) = .39	--
	S.E.	.11	.15	.11		
	N	114	69	112		
g. Gamble	$\bar{X}$	3.80	3.64	3.75	F(2,287) = 1.31	--
	S.E.	.05	.10	.06		
	N	112	69	109		
h. Brush teeth	$\bar{X}$	1.10	1.22	1.17	F(2,290) = 1.41	--
	S.E.	.04	.07	.05		
	N	114	68	111		
i. Eat lunch	$\bar{X}$	2.06	1.84	1.92	F(2,293) = 1.10	--
	S.E.	.10	.13	.10		
	N	115	70	111		

Table 20 (Continued)

		PRO	NEA	EA	ANOV	Tukey A
j. Watch television	$\bar{X}$	1.46	1.30	1.42	F(2,290) = 1.13	--
	S.E.	.08	.07	.06		
	N	114	68	111		
k. Play sports or exercise	$\bar{X}$	2.72	2.86	2.81	F(2,292) = .41	--
	S.E.	.10	.14	.10		
	N	113	70	112		
l. Spend time on hobbies	$\bar{X}$	2.93	2.88	2.97	F(2,288) = .14	--
	S.E.	.10	.14	.10		
	N	114	68	109		
m. Hang out with old friends	$\bar{X}$	2.89	2.91	2.82	F(2,288) = .24	--
	S.E.	.10	.12	.10		
	N	114	68	109		
n. Care for or spend time with children	$\bar{X}$	2.34	2.12	2.25	F(2,291) = .65	--
	S.E.	.11	.15	.13		
	N	115	68	111		
o. Visit with family members	$\bar{X}$	2.58	2.50	2.39	F(2,294) = .82	--
	S.E.	.11	.13	.10		
	N	115	70	112		
p. Drink wine, beer, or liquor	$\bar{X}$	3.34	3.16	3.16	F(2,289) = 1.03	--
	S.E.	.09	.13	.10		
	N	113	69	110		
q. Study or spend time in school	$\bar{X}$	3.18	3.41	3.38	F(2,292) = 1.24	--
	S.E.	.11	.12	.10		
	N	114	69	112		
r. Use prescription drugs	$\bar{X}$	3.28	3.11	3.14	F(2,290) = .60	--
	S.E.	.11	.15	.12		
	N	113	70	110		
s. Go to church or synagogue	$\bar{X}$	3.80	3.72	3.76	F(2,292) = .42	--
	S.E.	.05	.07	.05		
	N	115	69	111		

Table 20 (Continued)

		PRO	NEA	EA	ANOV	Tukey A
t. Take care of personal business like paying bills, going to bank, etc. —	$\bar{X}$	2.93	2.96	2.89	F(2,293) = .11	--
	S.E.	.08	.12	.09		
	N	114	70	112		
u. Read	$\bar{X}$	1.77	1.94	1.98	F(2,293) = 1.44	--
	S.E.	.08	.12	.10		
	N	115	69	112		
v. Party	$\bar{X}$	1.99	1.94	2.09	F(2,294) = .74	--
	S.E.	.08	.10	.08		
	N	115	71	111		

groups or evidence for extremely poor health in general (table 21). These clients on the average rate themselves as being in a little less than good health ($\bar{X}$ = 2.05, 2.08, and 2.13, respectively, for clients of PROs, NEAs, and EAs). Difficulties in sleeping are not particularly prevalent, nor are problems with appetite. While the clients are not reporting excellent physical condition, neither do they seem to perceive themselves as in poor shape on these crude health indicators.

Table 21. Clients' self-reports of their physical health during the 30 days prior to the first interview

a. Overall rating of physical health

Q. 61. During that 30 days, how would you rate your physical health: (1) very good, (2) good, (3) poor, (4) very poor?

	PRO	NEA	EA	ANOV	Tukey A
$\bar{X}$	2.05	2.08	2.13	F(2,295)=0.37	---
S.E.	.07	.08	.06	---	---
N	115	71	112	---	---

b. Difficulty with sleeping

Q. 60. During the last 30 days, how much difficulty have you had sleeping: (1) a lot, (2) some, (3) very little, (4) none at all?

	PRO	NEA	EA	ANOV	Tukey A
$\bar{X}$	2.48	2.72	2.53	F(2,295)=0.98	---
S.E.	.11	.14	.11	---	---
N	115	71	112	---	---

c. Quality of appetite

Q. 57. In general, during the last 30 days, how good has your appetite been: (1) very good, (2) good, (3) bad, (4) very bad?

	PRO	NEA	EA	ANOV	Tukey A
$\bar{X}$	1.99	1.94	2.09	F(2,294)=0.72	---
S.E.	.08	.10	.08	---	---
N	115	71	111	---	---

Social Isolation

One of the aims was to take at least a cursory look at client's degree of social isolation. The indicators seem to show that such isolation is relatively rare. In table 22, for example, it can be seen that only about 20 percent of the entire sample lived alone during the 30 days before the first interview. Further, about half of each counselor group's clients lived with opposite-sex partners, and for about 30 percent of the

sample, this was a marriage partner. Approximately 40 percent of the sample had their own children living with them. Among those not living with opposite-sex partners, many were living with parents.

Table 23 shows that of those not actually living with an opposite-sex partner, almost 50 percent had such partners whom they visited a number of times a week or more.

For none of the items dealing with social isolation are there statistically significant differences among clients of the three counselor groups.

Table 22. Who client lived with during the 30 days prior to the first interview, as reported by clients (in percent)

Who lived with	Counselor group PRO	NEA	EA	χ^2
No one	13.9	21.1	18.8	NS
Parents	21.7	22.5	22.3	NS
Friends	9.6	4.2	7.1	NS
Spouse	20.0	36.6	26.8	0.04
Children (other than own children)	5.2	5.6	4.5	NS
Other relatives	14.8	19.7	12.5	NS
Girlfriend	20.9	8.5	11.6	0.04
Boyfriend	14.8	4.2	10.7	0.08
At a crisis center, part of the program	--	--	1.8	NS
One's own children	36.5	42.9	39.3	--
N	115	71	112	--

Table 23. Steady opposite-sex relationships of clients in the 30 days prior to the first interview (in percent)

	Group PRO	NEA	EA
Lived with	54.8 (63)	49.3 (35)	49.1 (54)
Visit	24.3 (28)	22.5 (16)	22.7 (25)
None	20.9 (24)	28.2 (20)	28.2 (31)

$\chi^2(4)=2.00$; $p>0.20$

Satisfaction with Relationships with Living Partners

Table 24 shows that, on the average, clients were more satisfied than dissatisfied with their relationships with people they lived with during the past 30 days. Among those who were dissatisfied, the reasons for dissatisfaction were basically related to the general prevalence of arguing or fighting in the household, specific conflicts with particular individuals--usually nonfamily members, or the client's financial problems and pressure put upon the client to be self-supporting (table 25).

On this last dimension--reasons for dissatisfaction--the clients of counselor groups differed somewhat, with clients of PROs most likely to speak of general disagreement and clients of EAs most likely to talk of specific conflicts with individuals. However, the numbers of clients are quite small and the meaning of this difference is not immediately clear.

Level of satisfaction with home and with neighborhood were also examined, as well as reasons for dissatisfaction with either or both.

Table 24. Level of clients' satisfaction with people with whom they lived during the 30 days prior to the first interview

[1 = very satisfied; 2 = satisfied; 3 = dissatisfied; 4 = very dissatisfied]

	Professional (PRO)	Non-ex-addict paraprofessional (NEA)	Ex-addict paraprofessional (EA)	ANOV	Tukey A
$\bar{X}$	1.99	1.82	2.04	F(2,250)=1.44	---
S.E.	.08	.09	.09	---	---
N	102	57	94	---	---

Table 25. Reasons why clients were dissatisfied with the person(s) with whom they lived during the 30 days prior to the first interview (in percent)

Q. 65. In general, during the last 30 days, how satisfied or dissatisfied were you with your relationship with (person[s] R lived with)?

Q. 66. (Of those who were either dissatisfied or very dissatisfied) Why were you dissatisfied?

Reason mentioned	First and second mentioned reason		
	PRO	NEA	EA
General disagreement with people lived with--always arguing, not getting along	50.0 (11)	44.4 (4)	22.7 (5)
Specific conflicts, e.g., people R lived with were bad, stole from R, stupid or prevented R from elevating himself	31.8 (7)	22.2 (2)	63.6 (14)
Financial problems, pressure on R to get money, find a job	18.2 (4)	22.2 (2)	4.6 (1)
Crowding	0.0 (0)	11.1 (1)	9.1 (2)
N	22	9	22

CONTINUED

3 OF 4

Satisfaction with Home

It was found that most of the clients had lived at their current addresses for some time and few (less than 15 percent) had moved in the last 30 days (table 26). About two-thirds of the clients said they had done something in the last 30 days to fix up and decorate their homes (table 27). Table 28 shows that, on the average, clients were somewhat more dissatisfied than satisfied with their homes. Table 29 shows that those who were dissatisfied with their homes felt this way mainly because of problems with people lived with (as discussed above), with the neighborhood, or with the physical condition, crowding, or costs associated with the home. Once again, some group differences appear. For example, clients of NEAs are more likely to complain of lack of space and other comforts, while clients of PROs are more likely to cite needed repairs. These differences are not particularly impressive, however, given the lack of hypotheses associated with such differences and, of course, the small Ns.

Table 26. Clients' responses to question of whether or not they changed residences during the 30 days prior to the first interview

	Counselor group		
	PRO	NEA	EA
Percent yes	14.8 (17)	7.0 (5)	14.3 (16)
Percent no	85.2 (98)	93.0 (66)	85.7 (96)

$\chi^2(2)=2.74$, $p>0.20$

Table 27. Clients' responses to question of whether or not they fixed up or decorated their homes during the 30 days prior to the first interview

	Counselor group		
	PRO	NEA	EA
Percent yes	64.3 (74)	70.4 (50)	66.1 (74)
Percent no	35.7 (41)	29.6 (21)	33.9 (38)

$\chi^2(2)=0.74$, $p>0.20$

Table 28. Level of clients' satisfaction with their homes during the 30 days prior to the first interview

[1 = very satisfied; 2 = satisfied; 3 = dissatisfied; 4 = very dissatisfied]

	Professional (PRO)	Non-ex-addict paraprofessional (NEA)	Ex-addict paraprofessional (EA)	ANOV	Tukey A
$\bar{X}$	2.13	2.14	2.15	F(2,293)=0.02	---
S.E.	.08	.10	.07	---	---
N	114	71	111	---	---

Table 29. Reasons why clients were dissatisfied with their homes during the 30 days prior to the first interview (in percent)

Q. 67. In general, during the last 30 days, how satisfied or dissatisfied were you with your home?

Q. 68. (Of those who were dissatisfied) Why were you dissatisfied?

Reason mentioned	First and second mentioned reason		
	PRO	NEA	EA
Problems with people with whom living with, wants place of own	25.0 (8)	21.1 (4)	27.8 (10)
Place needs repairs, better maintenance, better cleaning	28.1 (9)	5.3 (1)	13.9 (5)
Neighborhood, people in building, neighborhood is bad, crime, social isolation	15.6 (5)	21.1 (4)	30.6 (11)
Lack of space, convenience, comfort, e.g., lack heat	15.6 (5)	42.1 (8)	19.4 (7)
Place is too expensive, economic considerations, or can't afford what he wants	9.4 (3)	5.3 (1)	5.6 (2)
Other reason, e.g., person is depressive in general, wants to move, was evicted	6.3 (2)	5.3 (1)	2.8 (1)
N	32	19	36

Satisfaction with Neighborhood

A factor associated closely with satisfaction with home is satisfaction with neighborhood. In general, clients felt about the same way about their neighborhoods as about their homes--a little more dissatisfied than satisfied (table 30). Neighborhood is, of course, one variable associated with dissatisfaction with homes, as seen above. Of those that professed dissatisfaction with neighborhood, a fair proportion felt that there are too many drugs and drug dealers in the area (table 31). [25.5 percent of the mentions by PROs' clients fall into this category, with 16.7 percent and 13.9 percent for NEAs and EAs, respectively.] Other negative factors of slightly more prevalence are conflicts with, or bad feelings about, the people in the neighborhood, poor living conditions, and crime and violence. With regard to group differences, PROs' clients are less likely to speak of poor living conditions, but more likely to mention drugs (as reported above) than NEAs or EAs. Once again, the bases here are too small to warrant speculation about possible reasons for this.

Table 30. Level of clients' satisfaction with their neighborhoods during the 30 days prior to the first interview

[1 = very satisfied; 2 = satisfied; 3 = dissatisfied; 4 = very dissatisfied]

	Professional (PRO)	Non-ex-addict paraprofessional (NEA)	Ex-addict paraprofessional (EA)	ANOV	Tukey A
$\bar{X}$	2.30	2.15	2.20	F(2,294)=0.82	---
S.E.	.08	.10	.08	---	---
N	115	71	111	---	---

Table 31. Reasons why clients were dissatisfied with their neighborhoods during the 30 days prior to the first interview (in percent)

Q. 71. In general, during the last 30 days, how satisfied or dissatisfied were you with your neighborhood?

Q. 72. (If dissatisfied or very dissatisfied) Why were you dissatisfied?

Reason mentioned	First and second mentioned reason		
	PRO	NEA	EA
Too many drugs which people influence you to use	25.5 (12)	16.7 (4)	13.9 (5)
Negative about the people in the neighborhood, conflict with neighbors	23.4 (11)	20.8 (5)	22.2 (8)
Poor living condition, including noise, abandoned buildings, poor schools	21.3 (10)	37.5 (9)	38.9 (14)
Crime and violence	29.8 (14)	25.0 (6)	25.0 (9)
Other unpleasantness, e.g., hassling by police, landlord			
N	47	24	36

Socially Unacceptable Behavior

Another set of indices utilized here to measure quality of life, which is more directly related to the kinds of behavior of central importance to this study, is that presented in table 32. Clients were asked how often on a four-point scale (1 = just about every day; 2 = 5 times or more; 3 = 1 to 5 times; 4 = never) they had participated in some activities which were for the most part illegal. The time frame inquired about was "the last 30 days." The answers indicate that in every case, clients had participated very infrequently in these activities. For each counselor group, average scores on each activity were between 3 (1 to 5 times) and 4 (never). Indeed, only one of the two legal activities--hanging out with friends who take drugs received an average score of less than 3.5--halfway between "never" and "1 to 5 times." While these answers may, of course, only reflect clients' desires to "fake good," it is felt that this is unlikely, especially given the high degree of agreement between counselor and client responses to some similar questions, as was indicated in the section on validity.

Summary

The drug abuse clients in this study were asked via a self-administered questionnaire about their activities, health, social or personal situations, and their levels of satisfaction with different aspects of their lives. It was felt that these measures of quality of life would give perspective to interpretations about the status of these clients in treatment.

In general, when all indices are summed up, these clients do not seem to see their lives as of particularly poor quality. Another general finding is that there are virtually no statistically significant or meaningful differences among the three counselor groups.

More specifically, when clients were asked about their participation in ordinary chores, tasks, and activities, it was found that responses grouped themselves into reasonable categories according to frequency. The activities reported as most frequent (i.e., at least several times a week) were the socially reinforced and routine behaviors such as brushing teeth and bathing, and doing household chores. Two less socially desirable yet ordinary routine items in this high frequency category were watching television and partying. Clients reported many other socially reinforced and positive items such as eating breakfast, working for money, and caring for children to be somewhat less frequent (i.e., once to several times a week). Least frequent were socially undesirable items (with the exception of church and school attendance) such as gambling, drinking, and using prescription drugs.

On questions of health, clients rate themselves as being in only a little less than good health on the average. This includes measures of difficulties with sleeping and appetite.

It was also found that social isolation is hardly a typical condition for this sample. Of about half the sample who were not living with an opposite-sex partner, most had partners they visited once a week or more. More than half the sample was living together with parents and/or children.

These clients were more satisfied than dissatisfied, on the average, with the people they were living with--a major element in life satisfaction.

Clients were more likely to be dissatisfied than satisfied with their homes and with their neighborhoods often because of the poor physical condition of the housing, and the presence of drugs, drug dealers, and other undesirable elements in the environment.

When asked questions specifically reflecting continued personal participation in the drug culture, clients reported such participation as very infrequent.

Regarding all the above findings, it is recognized that social desirability and the attempt to "fake good" for various reasons may be operating here. However, at least some tentative evidence to the contrary has already been presented in the section on validity.

5. SUMMARY AND CONCLUSIONS

In this study, clients from already existing caseloads of the three counselor groups were interviewed. A consideration of the backgrounds of these clients could then be used to infer any tendencies of program administrations to assign clients with especial problems to one type of counselor or another. Few differences were actually found in backgrounds of the clients in the three counselor groups. Clients of PROs were about 3 years younger on the average than clients of NEAs (29 versus 32 years); in the drug-free modality, clients of PROs reported slightly more excessive alcohol use than those

Table 32. Level of clients' participation in socially unacceptable behavior during the 30 days prior to the first interview

[1 = just about every day; 2 = 5 times or more; 3 = 1 to 5 times; 4 = never]

		Professional (PRO)	Non-ex-addict paraprofessional (NEA)	Ex-addict paraprofessional (EA)	ANOV	Tukey A
a. Hung out with friends who take drugs?	$\bar{X}$ S.E. N	3.11 .09 114	3.10 .13 69	3.13 .10 111	F(2,291) = 0.01	---
b. Sold drugs?	$\bar{X}$ S.E. N	3.76 .06 114	3.90 .05 69	3.81 .05 112	F(2,292) = 1.18	---
c. Copped for someone else?	$\bar{X}$ S.E. N	3.57 .07 115	3.67 .08 69	3.63 .07 112	F(2,293) = 0.40	---
d. Got into trouble with the law?	$\bar{X}$ S.E. N	3.90 .03 115	3.93 .04 70	3.88 .04 112	F(2,294) = 0.51	---
e. Used heroin?	$\bar{X}$ S.E. N	3.50 .08 115	3.67 .09 70	3.57 .07 111	F(2,293) = 0.98	---
f. Abused other drugs?	$\bar{X}$ S.E. N	3.67 .07 114	3.67 .08 69	3.49 .08 112	F(2,292) = 1.81	---
g. Stolen anything?	$\bar{X}$ S.E. N	3.85 .04 114	3.87 .06 70	3.87 .05 112	F(2,293) = 0.05	---
h. Pimped?	$\bar{X}$ S.E. N	4.00 0 115	3.94 .05 69	3.99 .01 112	---	---
i. Prostituted?	$\bar{X}$ S.E. N	3.96 .03 114	3.94 .04 68	3.92 .04 112	F(2,291) = 0.30	---

Table 32 (Continued)

		Professional (PRO)	Non-ex-addict paraprofessional (NEA)	Ex-addict paraprofessional (EA)	ANOV	Tukey A
j. Got drunk?	$\bar{X}$	3.64	3.61	3.56	F(2,294) = 0.41	---
	S.E.	.06	.08	.07		
	N	115	70	112		
k. Done something else against the law?	$\bar{X}$	3.69	3.72	3.68	F(2,289) = 0.07	---
	S.E.	.07	.08	.07		
	N	114	68	110		

of NEAs and also had had, on the average, one more treatment episode than clients of NEAs (1.71 versus 0.59 episodes on the average for PROs versus NEAs). Finally, about 15 percent more clients of EAs than clients of PROs and NEAs had spent any time in jail in the year prior to treatment entry.

These few differences among the groups of clients assigned to various types of counselors must be considered against an overwhelming number of measures on which clients of the three groups were strikingly similar. When the many similarities are considered, there seems little reason to suspect a systematic bias in the treatment field to select particular types of counselors to treat one or another type of client. This must reflect administrators' views, reported in the monograph dealing with counselor functions and activities, that all counselor groups are competent in what they do.

A broad investigation of the progress of these clients in treatment indicated no real differences in the attainment of treatment goals as a function of counselor group. Clients of the three counselor groups had been in treatment equal lengths of time suggesting equivalent retention levels across groups. In intensive questioning about drug use, it was found that clients of all groups exhibited drastic reductions in overall use levels following entry into treatment. As pointed out previously, the four significant counselor group differences in use of particular drugs across 96 different analyses are almost precisely the number one would expect by chance alone at the level of significance (0.05) employed. A striking lack of difference is also noted across groups in the levels of detected criminality, coupled with very low levels of arrest and time spent in jail in all groups since entry into treatment.

Three areas of potential client productivity were considered: the educational pursuits of clients; the legal employment of clients; and, for women, the assumption of responsibilities as homemakers. In these areas, there were hints of unique emphases by counselors of the various groups. More clients of PROs were in school during the course of treatment, though this finding was at least partially interpretable on the basis of age-related and educational-attainment-related backgrounds of clients. In contrast, slightly more clients of NEAs held jobs at followup, though there were significant gains for all counselor groups in the rate of employment during the followup period. Slightly more women clients of EAs reported being mainly housewives. These differences, while quite small, might be taken to suggest that different types of counselors emphasize different aspects of productive lifestyle during treatment. The paucity of differences, however, is overridden by a plethora of commonalities among clients which lead to the conclusion that counselors of the various groups hold common goals and stress common outcomes in counseling clients. Such a conclusion is supported by the similarity of comments by clients of the three groups about what their counselors have done for them in the course of treatment. Finally, what is important to note is that when all aspects of productivity are considered at once, clients of all groups are equally involved in productive pursuits.

An investigation of the quality of life of clients supported the conclusion that clients of the three groups fared equally well in the course of treatment. Across groups, clients participated in ordinary chores, tasks, and recreational activities with equal frequency, showed equal absence of social isolation in their lives and equal satisfaction with people with whom they lived, rated their health, on the average, as slightly less than good, and expressed some dissatisfaction with their homes and neighborhoods.

There is, unfortunately, only a sparse literature contrasting the clients of professional versus paraprofessional counselors in drug treatment. The results of the present study corroborate the previous findings of the one study which makes such a contrast, that of Brown and Thompson (1976). In that study, it will be recalled, the clients of ex-addict and non-addict counselors were contrasted on measures of retention in treatment, criminality, and employment. No differences were found as a function of counselor group.

What is the case, then, is that the existing findings in drug abuse treatment give evidence that clients progress equally well in the care of a variety of counselor types. Whether or not there are apparent philosophical conflicts between these counselor groups in the professional arena, in their work with their clients, there is no evidence, from the present work, of differential impact, whether individual dimensions of treatment or overall progress of clients is taken as the criterion of counselor quality.

6. SELECTED BIBLIOGRAPHY

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APPENDIX A.

VALIDATION

Measures of Validity

Concerns about the validity of client self-reports are often voiced by critics of studies based on these self-reports alone. The concerns frequently stem from notions that clients are likely to distort such reports, either inadvertently because of memory failures, or deliberately because of some real or perceived advantage to them in appearing to be in better or worse condition or circumstances than they really are. However, concerns are also expressed about data based on counselor reports alone since these reports may also be faulty. The flaws may be due to inadequate recall or even insufficient initial knowledge of the clients' circumstances (e.g., drug usage patterns), or to counselors' conscious or unconscious wishes to make their clients appear to improve under their care.

With these considerations in mind, the present study utilized a design in which independent corroboration of self-reports was sought by asking identical questions of clients and counselors. These "validity" questions were asked about drug use, criminality, and employment status which were obtained during the 30 days prior to the first interview of counselor and client and in the 30 days prior to the followup study. In the present section, the results of matching answers of clients and their counselors on these questions are presented. It may be well to point out that this conception of validity is a bit strained since neither counselor nor client reports can be accepted as an external criterion, i.e., it is not known which, if either of them, is correct for each question. Rather, it is assumed that agreement between the two affords some evidence that capriciousness, arbitrariness, and memory failure are not operating here to any great extent. Bias may still exist, of course--for example, counselors may often base their reports largely on what clients tell them, although in this case other objective records were also used as shall be seen. Another possible problem is that both clients and counselors may see an advantage in reporting certain conditions--for example, low current drug usage.

Drug use. Table A-1 shows the results of cross-tabulating clients' and counselors' reports of frequency of client drug use during the 30 days prior to the interview. Five categories of responses were possible for client and counselor from "not at all" to "daily." The table shows the percent agreement and percent and direction of disagreement between clients and counselors for each drug.

Perhaps the most prominent feature of the table is the high degree of agreement among the clients and counselors across all counselor groups for almost all drugs. Percent agreement ranges from a low of 69 for marihuana/hashish use to 100 for inhalants.

In general, one would expect lower degrees of probable usage to be associated with more agreement and this indeed is the case. For example, in the case of inhalants, all counselors and clients responded "not at all" for estimated usage in the past 30 days. Marihuana/hashish usage, on the other hand, was a higher probability event, allowing counselors more room for error in estimating client usage. It should also be pointed out that differences of one scale category between counselor and client were accepted as "agreement."

Given these restrictions, the counselor-client agreement may still be regarded as notable, and as evidence for data credibility. After marihuana/hashish, the next lowest degree of agreement is found for alcohol (84 percent of the average; 89 percent, 83 percent, and 80 percent for PROs, NEAs, and EAs, respectively). It is possible that the phrasing for the alcohol item, i.e., "used to excess," may have been too vague to encourage highest possible agreement. In any case, alcohol and marihuana may be the drugs of least interest for purposes of the current study.

Among the remaining drugs, only sedatives (85 percent) and heroin (89 percent) result in less than 90 percent agreement.

If one examines differences among counselor groups, most disparity is shown for opiates, where EAs and their clients reach only 80 percent agreement compared to 89 percent for PROs and their clients; and for alcohol, where EAs and clients reach 89 percent agreement compared to 98 percent for NEAs and their clients. Even these differences are not larger than one would expect by chance, however.

Also of interest is that there are no consistent overall differences in the direction of reports by counselor or clients. That is, counselors, on the average, are about as likely to report more, as they are to report less, client drug use than clients report. On the average, across counselor

Table A-1. Percent agreement and disagreement between clients and counselors in regard to the frequency of use of illicit drugs during the 30 days prior to the first interview[1]

	Total percent			PRO percent			NEA percent			EA percent		
	=	CL>	CO>	=	CL>	CO>	=	CL>	CO>	=	CL>	CO>
Marihuana/hashish	69	18	13	67	25	8	71	12	16	69	13	16
Over-the-counter drugs	94	1	6	93	0	7	92	0	8	96	1	4
Inhalants	100	1	1	100	1	1	100	0	0	100	1	1
Hallucinogens	99	0	1	99	1	0	100	0	0	100	0	0
Barbiturates	97	1	2	95	1	4	99	0	1	97	3	0
Sedatives	85	10	5	84	12	5	83	11	7	88	7	5
Cocaine	96	3	0	97	4	0	99	1	0	96	3	1
Heroin	89	7	3	87	11	2	87	5	7	90	5	5
Illegal methadone	98	1	1	98	2	1	100	0	0	98	2	0
Opiates	91	1	7	91	1	9	98	0	2	89	1	10
Alcohol	84	4	12	89	2	9	83	3	12	80	4	15
Amphetamines	96	1	4	91	1	7	96	1	3	97	0	3
	N = 302			N = 112			N = 66			N = 115		

[1]Percent agreement indicates either perfect agreement or disparities of no more than one category on scale.

groups there are 4 drugs for which clients report more use than counselors, 4 for which the reverse is true, and 4 for which the difference is 0 or 1 percentage point.

Regarding direction of differences, it is worth emphasizing that there are no consistent differences among counselor groups either. It is true that in the case of heroin, a drug of primary interest here, PROs are somewhat more likely than EAs to report less use than clients. The same is true to a lesser extent for sedatives, while the reverse is true for marihuana/hashish. However, differences such as these are to be expected on the basis of chance alone.

It is of some interest to note that counselors based their estimates of client drug abuse on a number of inputs, including urinalysis, conversations with clients, and less frequently, information from other sources. In table A-2a, it can be seen that most counselors in each group based their conclusions on information other than the urinalysis alone. Differences among counselor groups here are not statistically significant, although the NEAs seem to rely somewhat more heavily on urinalysis for their judgments. As has already been seen, the groups do not differ significantly in the level or accuracy of their estimates of drug use by clients, as measured by client-counselor agreement.

Table A-2a. Sources of information from which counselors know about clients' ongoing drug abuse, with counselors' responses for each client counted separately[1]

	Counselor group			
	PRO	NEA	EA	
Based solely on urinalysis	17.3 (18)	29.9 (20)	20 (21)	21.3 (59)
Based on other information as well	82.7 (86)	70.1 (47)	80.0 (84)	78.6 (217)
N	37.7 (104)	24.3 (67)	38.5 (105)	100.0 (276)

[1]Responses are only of those counselors who had urine test outcomes provided by the program.

Table A-2b shows that, apart from urinalysis, counselors most often rely on contact with clients, either self-reports or clinical observations, to make judgments about client drug use. While NEAs report more use of client self-reports and less often other contacts with clients, the distinction between these information sources may not be a clear one.

Employment status. Another set of questions which seemed important to validate were those concerned with employment status. In table A-3, results of cross-tabulating client and counselor reponses regarding current legal employment status of the client are presented. One view of the data shows that 27.4 percent of clients are employed according to self-report, while 32.5 percent are employed according to counselor reports. Another view is that of those clients who say they are employed, 85.4 percent had counselors who concurred. Similarly, of those clients who report not being employed, 87.5 percent had counselors who agreed.

Overall, 86.5 percent of clients' and counselors' reports agree. While this is a relatively high percentage, it is perhaps lower than one might hope given the rather simple nature of the question. The marginals show that clients tend to report somewhat less often than counselors that they are employed. This may indicate a lack of up-to-date information on the part of the counselor, influenced by high instability of employment among clients. Equally

Table A-2b. Sources of information, other than urinalysis, from which counselors know about clients' ongoing drug abuse, with counselors' responses for each client counted separately[1]

Q. 58b. (If responses to drug abuse items not based solely on program provided urinalysis) What other sources did you use?

Source	First-mentioned source			All mentioned sources		
	PRO	NEA	EA	PRO	NEA	EA
Contact with client, clinical observation of client	33.3	24.0	46.7	34.6	29.7	45.1
Client admission, self-report	57.0	70.0	29.1	43.4	60.9	35.9
Another professional organization or professional person, e.g., hospital, probation department, other program staff	6.5	4.0	0	8.1	4.7	2.8
A friend or relative of the client	0	0	3.3	3.7	0	4.9
Behavior of client, i.e., his direct request for medication, possession of drugs or a prescription for drugs, client's criminal activity	3.2	2.0	8.7	7.4	1.6	7.0
Urinalysis results provided by another agency	0	0	2.2	2.9	3.1	4.2
N	93	50	92	136	64	142

[1]For first-mentioned sources, percentages are of total number of respondents; for all mentioned sources, percentages are of total number of mentions.

Table A-3. Relationship between client and counselor responses to the question of whether or not client is employed at a legal job

Client report	Counselor report: Employed	Counselor report: Not employed	
Employed	85.4 (70)	14.6 (12)	27.4 (82)
Not employed	12.5 (27)	87.5 (189)	72.8 (217)
Total	32.5 (97)	67.2 (201)	100.2 (299)

probable is confusion over the concept of legal employment. This confusion might result from clients' or counselors' failure to attend to the definition provided involving getting paid and paying taxes--or even from uncertainty as to whether or not the clients' employment meets that definition.

Tables A-4a, b, and c are presented to show the similarities and differences among counselor groups in terms of agreement between client and counselor employment reports. The total levels of agreement for the three groups are 89.4 percent, 81.7 percent, and 87.0 percent for PROs, NEAs, and EAs, respectively.

Tables A-4a, b, c. Percent agreement and disagreement between clients and counselors in regard to whether or not the client is employed at a legal job

	Client report	Counselor report: Employed	Counselor report: Not employed	
A-4a PRO:				
	Employed	82.1 (23)	17.9 (5)	24.8 (28)
	Not employed	8.2 (7)	91.8 (78)	75.2 (85)
	Total	26.5 (30)	73.5 (83)	100.0 (113)
A-4b NEA:				
	Employed	87.5 (21)	12.5 (3)	33.8 (27)
	Not employed	21.3 (10)	78.7 (37)	66.2 (47)
	Total	43.7 (31)	56.3 (40)	100.0 (71)
A-4c EA:				
	Employed	86.6 (26)	13.3 (4)	26.1 (30)
	Not employed	11.7 (10)	87.1 (74)	73.9 (85)
	Total	31.3 (36)	67.8 (79)	100.0 (115)

Criminality. Another Federal criterion for which validity was estimated was extent of criminal behavior and some correlates. First, clients and counselors were asked whether clients were in the program voluntarily or because the courts sent them, or because of a legal situation of some kind.

Table A-5 shows that 81.1 percent of clients and 80.5 percent of counselors say that the client is there voluntarily, not because of legal pressure. Further, of the clients who say they are in treatment voluntarily, 92.9 percent had counselors who agreed that this was the case. Interestingly, only 73.2 percent of counselors of clients who said that they were in treatment because of legal pressure agreed that this was so. Perhaps definitions are again problematic--clients were asked whether "the courts sent you" and counselors were asked about "some legal" situation. The word "sent" in this context could perhaps mean either "ordered" or "referred." It may also be that clients feel some pressure that the legal system exerts only indirectly, and that counselors do not feel this pressure is acting on their clients. In any case, overall agreement between client and counselor is 89.2 percent so that these speculations may not be particularly worthwhile. We should also point out that differences among counselor groups were virtually nonexistent here.

Table A-5. Relationship between client and counselor responses to question of whether client is in program voluntarily or because the courts sent him

Q. 41. (To client) Are you now in this treatment program because of an arrest; that is, did the court order you to go to a program?

Q. 59. (To counselor) As of today, is (client) in treatment voluntarily or is he pressured into treatment by some legal situation?

Client report	Counselor report: Voluntarily	Counselor report: Pressured	
Voluntarily	92.9 (224)	7.1 (17)	81.1 (241)
Pressured	26.8 (15)	73.2 (41)	18.9 (56)
Total	80.5 (239)	19.5 (58)	100.0 (297)

Another question asked of both clients and counselors concerned the number of times the client had been arrested in the last 30 days. The results are shown in table A-6. Of those clients who report no arrests, 97.5 percent had counselors who agreed. For the clients who report being arrested once in the last 30 days, six counselors reported 0 and 1 arrests, respectively, with one counselor reporting 2 arrests. As the table shows, for the over 95 percent of the clients, client and counselor reports agreed perfectly. The other 5 percent were off by no more than 1 arrest.

When data for clients from the different counselor groups were examined separately, the same extremely high level of agreement was evident for each group.

Clients and counselors were also asked how many days of the last 30 clients had spent in jail. Concurrence is extremely high here as in the previous question with very few disparities of more than a day or two. Table A-7 shows that more than 94 percent of all clients were reported by the counselor as well as clients themselves to have had no arrests in the last 30 days. Of clients who reported no arrests (which was 95.5 percent of all clients), 98 percent of the counselors of these clients agreed. The other cell percentages in the table are based on Ns too small for interpretation.

For all three Federal criteria, then, client and counselor reports of current client behavior agree quite well, although slightly higher agreement might have been expected on

Table A-6. Relationship between client and counselor responses to question of number of days in last 30 that client had spent in jail

Client report	Counselor report			
	0	1	2	
0	97.5 (274)	2.5 (7)	0 (0)	95.6 (281)
1	46.2 (6)	46.2 (6)	7.7 (1)	4.4 (13)
Total	95.2 (280)	4.4 (13)	0.3 (1)	100.0 (294)

Table A-7. Relationship between client and counselor responses to question of number of days in last 30 that client had spent in jail

Client report	Counselor report				
	0	1	2	3 or more	
0	98.0 (252)	1.0 (3)	1.0 (2)	.3 (1)	95.9 (258)
1	66.7 (2)	33.3 (1)	0 (0)	0 (0)	1.1 (3)
2	100.0 (1)	0 (0)	0 (0)	0 (0)	.4 (1)
3 or more	14.0 (1)	0 (0)	14.0 (1)	71.0 (5)	2.6 (7)
Total	95.2 (256)	1.5 (4)	1.1 (3)	2.2 (6)	100.0 (269)

the seemingly straightforward measures of employment status. We turn now to validity measures in the followup study.

Validity as Measured in the Followup Study

As previously described, this study had a 4-month followup component in which counselors from each program except one (because of inability to make arrangements with that program) were interviewed via a mail form with the aim of obtaining updated information on each of their previously interviewed clients. Of the 302 clients originally interviewed, forms were returned for 259. Information on the forms consisted of the same questions as those previously asked about the clients' drug use, employment, and criminal experience during the 30 days preceding the current moment or preceding the point of leaving treatment.

Also, personal interviews were conducted with 34 of these clients who remained in treatment in order to see how clients' self-reports matched with counselor reports of client status on "Federal criteria" items. While it was attempted to interview one client of each counselor, restriction on funds and time precluded more than one revisit to each program, and many clients were not available in the program on that one day. In addition, in some cases, all of a particular counselors' clients at the time of the interview had left treatment.

In this section, the results of matching client self-reports to counselor reports for the 34 clients whom we interviewed in the followup study are presented. Thus the structure of their presentation, as well as its philosophy, is basically the same as that of the preceding section on validity of

initial data. The point here is to attempt to validate in the same manner, though less extensively, the followup information. Since the base is never larger than 34--in fact, it is usually somewhat less because of item nonresponse--this procedure must be regarded as providing the ground for only tentative information rather than firm conclusions.

Drug use. Table A-8 shows the percent agreement and percent and direction of disagreement between counselors and clients for each of the drugs of interest. It is comparable to table A-1 in the previous section on initial validity. In fact, direct comparisons show that the results are very similar. Marihuana/hashish and sedatives still show lower levels of agreement than other drugs--although even on these drugs concurrence is higher (79 percent for marihuana/hashish, 79 percent for sedatives) than in the original interview. Among other drugs, in only one case is there less than 90 percent agreement, and that is for cocaine usage (87 percent).

When there is lack of concurrence between client and counselor, there is more of a tendency in the followup than in the initial study for clients to report more use than counselors. This tendency approaches significant deviation from chance expectation according to binomial probability (α=0.07). It may be that the client who is further along in treatment now feels more free to report higher drug usage, or that the counselors of these clients are simply making overly optimistic assumptions. All in all, however, rates of agreement on client drug usage seem quite high between counselor and client, and quite consistent with data from the original interview.

Table A-8. Percent agreement and disagreement between clients and counselors in regard to the frequency of use of illicit drugs at the time of followup[1]

	=	CL>	CO>
Marihuana/hashish	74	22	4
Over-the-counter drugs	95	5	0
Inhalants	100	0	0
Hallucinogens	97	3	0
Barbiturates	93	3	3
Sedatives	79	21	0
Cocaine	87	13	0
Heroin	94	6	0
Illegal methadone	100	0	0
Opiates	97	3	0
Alcohol	90	7	3
Amphetamines	90	6	3

[1]Percent agreement indicates either perfect agreement or disparities of no more than one category on scale.

Employment status. In the followup study, counselors and clients were asked about clients' current employment status, just as in the initial interview.

As table A-9 shows, some 82 percent of clients and counselors agree on client employment status in the followup interview. Moreover, of the 11 clients who say they are employed, 10 had counselors who agreed. Of the 27 who said they were not employed, 17 had counselors who agreed.

As stated above, 11 of the 33 clients reinterviewed (33.3 percent) claimed to be employed. However, 14 of the counselors of these clients (45.5 percent) thought their clients were employed. The corresponding percentages for the initial interview data were 27.4 and 32.5. It may be that at the time of followup, counselors were more likely to overstate client employment--or perhaps, once again, the vagueness of recall or of definitions and understanding of "legal" employment led to somewhat lower agreement between client and counselor. In any event, these differences between counselor and client results are not statistically significant, given the small N (33) for the followup study.

Table A-9. Relationship between client and counselor responses to question of whether or not the client is employed at a legal job at the time of followup

Client report	Counselor report		
	Employed	Not employed	
Employed	90.9 (10)	9.1 (1)	33.3 (11)
Not employed	22.7 (5)	77.3 (17)	66.7 (22)
Total	45.5 (15)	54.5 (18)	100.0 (33)

Criminality. To see if the followup reports matched between clients and counselors on criminality, both groups were first asked about the number of times the client had been arrested since the last interview. In 31 of the 33 cases (93.9 percent), both counselor and client reported no arrests (table A-10). In two cases, clients reported arrests (one and two, respectively) which the counselor had not. As in the initial interviews, counselors and clients were also asked about number of arrests in the past 30 days. It may be recalled that over 95 percent concurrence was found in the initial interview--in the case of the followup interview, all counselors and clients answering the question agreed there had been no arrests in the past 30 days.

Very high agreement between client and counselor was also found for the followup validity study for number of days client had spent in jail. The counselors all said that none of their clients had been in jail since the last interview--however, one client reported he had been in jail for 5 days. Clients and counselors all agreed that none of the clients had been in jail during the last 30 days.

Table A-10. Relationship between client and counselor responses to question of number of times that client had been arrested between time of first interview and followup

Client response	Counselor response: None
None	(31)
1	(1)
2	(1)
Total	100 (33)

APPENDIX B.

CLIENT BACKGROUND DATA

Table B-1. Mean years of any use and years of continuing use of drugs prior to treatment entry

Drug or drug category		Years of any use[1]				Years of continuing use[1]			
		PRO	NEA	EA	(Modality effect)	PRO	NEA	EA	(Modality effect)
Marihuana/hashish	MM	9.59	11.14	11.66	NS	6.72	7.60	9.28	NS
	DF	10.71	11.31	10.17		6.51	6.56	6.81	
Drugstore items containing drugs	MM	1.73	1.68	1.39	NS	1.05	.98	.50	NS
	DF	1.71	1.47	2.80		.73	.88	1.09	
Inhalants such as glue	MM	.39	.19	.27	DF>MM	.24	.09	.10	NS
	DF	.65	.12	.88		.23	.12	.33	
Hallucinogens such as LSD	MM	1.65	1.54	1.49	DF>MM	.74	.63	.84	NS
	DF	3.03	2.06	2.16		1.53	.59	1.16	
Barbiturates	MM	3.96	2.68	3.60	DF>MM	1.92	1.43	2.09	DF>MM
	DF	5.35	5.71	4.73		2.25	3.76	3.55	
Sedatives and tranquilizers	MM	2.21	2.55	3.19	NS	1.11	1.06	1.42	NS
	DF	3.76	4.06	3.25		2.33	2.24	1.77	
Cocaine	MM	4.38	3.89	5.72	NS	2.43	1.43	2.71	NS
	DF	4.87	4.18	4.12		2.32	1.29	1.56	
Heroin	MM	8.91	11.61	11.20	MM>DF	8.08	10.22	10.35	MM>DF
	DF	7.36	6.88	7.88		5.38	5.06	6.00	
Illegal methadone	MM	1.92	1.56	1.51	MM>DF	.75	.76	.60	NS
	DF	.95	1.12	1.23		.30	.18	.66	
Opiates or drugs with the same effect	MM	2.51	3.51	3.13	NS	1.48	.96	1.37	NS
	DF	2.53	2.06	2.02		1.27	.53	1.74	
Alcohol to excess	MM	2.05	2.51	2.93	NS	1.16	1.83	2.30	NS
	DF	3.61	1.88	2.91		2.55	1.18	1.68	
Amphetamines	MM	.53	1.17	.39	NS	.20	.63	.39	NS
	DF	.95	1.00	.88		.55	.59	.33	

[1]Modality effects are noted where significant at at least $\alpha=0.05$. There were no effects of counselor group.

Table B-2. Mean frequency of use of drugs in the year prior to treatment entry and in the 30 days prior to treatment entry

[1 = not at all; 2 = less than once a month; 3 = less than once a week; 4 = once a week; 5 = several times a week; 6 = daily]

Drug or drug category		Use in the year before treatment entry[1]				Use in the 30 days before treatment entry[1]			
		PRO	NEA	EA	(Modality effect)	PRO	NEA	EA	(Modality effect)
Marihuana/hashish	MM	2.71	2.32	2.48	DF>MM	2.86	2.38	2.35	DF>MM
	DF	3.43	3.06	3.30		3.23	2.47	3.29	
Drugstore items containing drugs	MM	1.26	1.20	1.23	NS	1.15	1.08	1.25	NS
	DF	1.11	1.06	1.25		1.28	1	1.21	
Inhalants such as glue	MM	1.04	1	1	NS	1	1	1	--
	DF	1.02	1	1.07		1	1	1	
Hallucinogens such as LSD	MM	1.03	1.06	1.01	DF>MM	1.03	1.06	1.03	NS
	DF	1.25	1.41	1.37		1.10	1	1.20	
Barbiturates	MM	1.50	1.20	1.35	DF>MM	1.26	1.22	1.23	DF>MM
	DF	1.89	1.47	2.02		1.76	1.44	1.93	
Sedatives and tranquilizers	MM	1.88	1.74	2.18	NS	1.85	2.00	2.13	NS
	DF	2.71	1.40	2.10		2.31	1.13	2.07	
Cocaine	MM	1.90	1.42	1.91	NS	1.94	1.31	1.68	NS
	DF	1.62	2.25	1.80		1.28	1.47	1.54	
Heroin	MM	4.57	4.51	4.57	MM>DF	4.46	4.39	3.66	MM>DF
	DF	3.49	3.18	3.24		2.98	2.88	2.98	
Illegal methadone	MM	1.83	1.62	1.75	MM>DF	1.77	1.48	1.67	NS
	DF	1.43	1.31	1.29		1.17	1	1.18	
Opiates and synthetics	MM	1.46	1.50	1.35	NS	1.43	1.35	1.18	DF>MM
	DF	1.58	1.47	1.45		1.60	1.35	1.77	
Alcohol to excess	MM	1.17	1.49	1.39	DF>MM	1.29	1.62	1.30	Interaction of group by modality
	DF	1.83	1.41	1.73		1.73	1	1.57	

Table B-2 (Continued)

Drug or drug category		Use in the year before treatment entry[1]				Use in the 30 days before treatment entry[1]			
		PRO	NEA	EA	(Modality effect)	PRO	NEA	EA	(Modality effect)
Amphetamines	MM	1.07	1.25	1.06	NS	1.11	1.28	1	NS
	DF	1.28	1.35	1.18		1.22	1	1.07	
Opiate Index[2]	MM	4.66	4.62	4.73	MM>DF	4.72	4.41	4.08	MM>DF
	DF	3.91	3.31	3.15		3.15	3.12	3.27	

[1]There were no effects of counselor group. Modality effects are noted where significant at at least α=0.05.

[2]The Opiate Index is an overall measure of the use of heroin, illegal methadone, and/or any other opiate which leads to eligibility for methadone maintenance. It is calculated as the greatest frequency of use. Among heroin, illegal methadone, or other opiates and synthetics with morphinelike effects.

Table B-3. Summary of treatment history of clients as a function of counselor group and modality[1]

	Measure		Counselor group[2] PRO	NEA	EA	Modality effect
1.	Percentage ever in treatment before the current treatment episode		75.0	70.0	73.9	
2.	Mean number of prior treatment episodes	MM	1.77	1.70	2.13	MM>DF
		DF	1.71	.59	.91	
3.	Mean number of attempts to detox	MM	.71	.57	1.01	MM>DF
		DF	.63	.06	.41	
4.	Mean number of times in chemical support modality (methadone maintenance, Darvon N)	MM	.77	.85	.76	MM>DF
		DF	.29	.24	.27	
5.	Mean number of years in treatment	MM	1.54	1.56	1.61	MM>DF
		DF	1.37	.76	.78	
6.	Mean number of heroin-related treatment episodes	MM	1.65	1.51	2.06	MM>DF
		DF	1.41	.35	.82	
7.	Mean number of court-related treatment episodes	MM	.23	.26	.17	NS
		DF	.39	.41	.20	

[1]Data are based on 301 of the 302 clients (99.7 percent). In 38.9 percent of treatment episodes, the dates of entering and/or leaving treatment were incomplete. In such cases, the mean length of time of treatment of all clients who received the same modality of treatment and had complete data was used to estimate the length of that treatment episode. If a client had not been in treatment before, he was scored zero (0) on indices 2 through 7 above.

[2]Modality effects significant at at least α=0.05 are noted. There were no group main effects.

Table B-4. Educational history of clients as a function of counselor group[1]

	Counselor group		
	PRO	NEA	EA
1. Highest grade completed in school (percent):			
8th grade or less	6.9	9.9	7.0
9th, 10th, 11th grade	36.2	40.9	45.2
High school or GED	33.6	25.4	26.9
Some college	20.7	22.5	20.0
BA/BS degree or beyond	2.6	1.4	1.7
N	116	71	115
2. Percent of clients receiving any schooling (vocational or otherwise) in the year before treatment:	32.8	23.9	22.6
a. Percent of all clients receiving vocational training	17.2	11.3	13.0
b. Percent of all clients receiving schooling other than vocational training	19.0	12.9	11.3
3. Mean number of months in school in the year before treatment:			
a. In vocational training	.91	.70	.85
b. In schooling other than vocational	1.15	1.11	.58
4. Percent of clients receiving any schooling (vocational or otherwise) in the 30 days before treatment:	9.5	11.3	8.7
a. Percent of all clients receiving any vocational training	3.5	2.8	7.0
b. Percent of all clients receiving any schooling other than vocational training	7.0	9.9	2.6

[1]Data are based at least on responses of 301 out of the 302 clients (99.7 percent).

Table B-5. Employment history of clients as a function of counselor group[1]

		Counselor group		
		PRO	NEA	EA
I. All clients--males and females considered together				
1. Percentage of clients who ever held a legal job, one for which they got paid and either paid taxes or had taxes taken out of their pay		94.8	94.4	95.7
2. Percentage of clients who held at least one job in the year prior to treatment entry		54.3	51.4	55.7
3. Mean number of months employed in the year prior to treatment entry	All	4.89	5.02	4.59
	MM	4.79	4.75	4.25
	DF	5.06	5.85	5.14
4. Percentage of clients who worked at least 1 day in the 30 days prior to treatment entry		31.3	30.0	40.7
5. Mean number of days worked, including Saturdays and Sundays, at a legal job, in 30 days prior to treatment entry		5.28	6.29	5.89
6. Percentage of clients employed at entry into treatment		29.3	29.6	27.8
II. Female clients--time as housewives				
7. Percentage who had ever been a housewife		81.8	88.0	77.5
8. Percentage who had been a housewife in the year prior to treatment entry		50.0	44.0	57.1
9. Mean number of months mainly a housewife in year before entry into treatment		4.93	4.24	5.98
10. Percentage mainly housewives in the 30 days prior to treatment entry		45.5	48.0	52.5

[1]Data are based on at least 300 of the 302 respondents.

Table B-6. Criminal involvement of clients as a function of counselor group[1]

	Counselor group		
	PRO	NEA	EA
1. Percent ever arrested	83.6	87.3	90.4
2. Number of arrests in year prior to treatment entry (percent):			
None	56.9	62.9	55.7
Once	19.8	22.9	21.7
2 to 4 times	19.0	8.6	17.4
More than 4 times	4.3	5.7	5.2
3. Mean number of arrests in year prior to treatment entry	1.07	.80	1.11
4. Percent of all arrests which were drug related in the year before treatment	42.4	42.9	54.9
5. Number of days in jail in year before treatment (percent):			
None	61.2	64.3	47.8
1 to 10 days	18.1	10.0	20.9
11 to 100 days	8.6	10.0	17.4
Over 100 days	12.1	15.7	13.9
6. Mean number of days in jail in year before treatment	32.2	48.5	45.5
7. Percent arrested in the 30 days prior to treatment entry	4.35	5.71	8.85
8. Number of days in jail in the 30 days before treatment entry (percent):			
None	93.1	91.4	87.8
1 to 10 days	3.45	5.7	5.2
More than 10 days	3.45	2.9	7.0
9. Percent of clients in treatment due to an arrest	17.2	21.1	20.9

[1]Data presented in this table are based on at least 99.3 percent of the full sample of clients.

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