



NATIONAL DEVELOPMENT AND RESEARCH INSTITUTES, INC.

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Comprehensive Employment Supports (CES) Training Manual (V. 4.2)

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2003-2008

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PREFACE

CES is a “manualized theory-driven” program rather a “manual-driven” program. This means that this manual articulates the theoretical foundations and specific principles of the intervention, details the stages of the intervention, and gives examples of implementation. It does not, however, intend to direct counselors step-by-step or session-by-session. This is because vocational rehabilitation counseling with a challenging addiction treatment population requires a tailored, flexible approach to individual patients. Some patients may progress rapidly, others will take longer. Different elements of the model may have to be emphasized for different patients. For instance, some may benefit more than others from the “Fieldwork CES” component. For these reasons a Master’s-level vocational counselor is highly recommended for the CES counselor role.

Chapter 1: Importance of Work for Methadone Patients and Origin of Model

Importance of work for methadone maintained individuals

Substance users in treatment programs, including methadone patients, historically have had poor rates of workforce participation (Friedman et al., 1996; Lamb et al., 1996). Nationally, 76% of methadone patients are unemployed at admission, with virtually the same rate at discharge (72%) (Drug Abuse Treatment Outcome Study data, unpublished). Employment rates are appreciably lower and unemployment rates higher among substance users than in the general population (e.g., Friedman et al., 1996; Lamb et al., 1996; Harley & Hanley-Maxwell, 1994; Schottenfeld, 1992; Gardiner, 1978), leading to substantial losses of societal productivity.

An ongoing philosophical debate has surrounded the use of methadone maintenance since its development as a treatment method. While not a “cure” for opioid addiction, methadone treatment has been demonstrated to eliminate or reduce heroin use, HIV risk behaviors, and criminality, and to increase productive behaviors (e.g., French et al., 1992; Murray, 1998; Hubbard et al., 1997; Marsch, 1998; Payte, 1997; Rothbard et al., 1999). Whereas most drug abuse treatment modalities focus on achieving abstinence from all substances, methadone treatment has traditionally focused on rehabilitating clients so that they can become functioning members of society. Finding employment has always been considered an important part of this rehabilitation process (Platt & Metzger, 1987), although rarely achieved in practice.

There are three reasons that it is critical that effective vocational programs be offered within methadone treatment clinics. First, employment can enhance clinical outcomes. Because successful treatment outcomes are correlated with employment, treatment professionals view employment as a potential facilitator of recovery, a means to prevent relapse and an indicator of separation from a former drug-using lifestyle. (Hubbard et al., 1989; Platt, 1995; Platt et al, 1998; Room, 1998; Jenner, 1998; Fisher and Anglin, 1987; Magura et al., 2004). Specifically, employment is related to less drug use during treatment; better treatment retention, low rates of relapse and criminality; improved parole status and enhance abstinence and stability from relapse (Platt 1995). Similar to substance abuse in general, there is a strong consensus in the field that employment is associated with improved treatment outcome for opioid dependent outpatients receiving methadone (Kidorf et al., 2004).

Second, employment enhances the quality of life for methadone treatment patients. Currently, these individuals see themselves as inferior to others in the “regular” world because they come from the subculture of drug users, which is heavily stigmatized by society. This sense of being a second class individual is reinforced by the rigid hierarchy of the clinic setting that sharply regulates the behaviors of substance abusers. As a result, patients have low self-efficacy and low self-esteem operationalized on a daily basis by belief that they

deserve negative events and feelings (Hunt et al., 1985; Rosenblum et al., 1991). Holding a competitive job provides a means of changing social status and thus enhancing self esteem and self efficacy. A competitive worker is seen as a productive citizen. Work provides a sense of identity and accomplishment, allowing individuals in recovery to interact as equals with co-workers and others. In addition, work provides addiction treatment patients with an alternative method of spending time and socialization with non-substance-using people (Blankertz et al., 1998).

Third, for many patients, employment is becoming an economic necessity. Federal and state welfare reform legislation (e.g., the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996; The New York State Welfare Reform Act of 1997) requires that drug treatment clients achieve work readiness in specific time frames or lose public assistance, drug treatment subsidies, health insurance and other supports. In New York State, for example, individuals on public assistance (including “drug addicts and alcoholics”) are limited under the Safety Net Assistance Program to a lifetime maximum of two years of cash benefits. Rigorous criteria now define permissible exemptions for those permanently disabled with serious medical or psychiatric conditions; and addiction alone is no longer a sufficient criterion for eligibility. To ensure that individual work requirements are adhered to, states must meet yearly increasing minimum participation rates in order to be eligible for full federal funds in the following fiscal year. Given these welfare changes, many methadone patients will need employment to pay for living costs as well as treatment.

Development of the CES model

The CES model was stimulated by the documented success of supported employment models in mental health, specifically the Individual Placement and Support (IPS) model. This model was successful because of its positive emphasis on work as an organizing practice principle, a focus on rapid placement into competitive employment in a job chosen by the consumer, and the requirement that vocational and clinical staff be an integrated team. IPS has two fundamental unique features. First, unlike many vocational models, it focused on competitive as opposed to set aside or sheltered types of work. Second, rapid placement has been found to be more effective than the traditional extensive preemployment training models. Two additional strengths are that assessment is continuous and time-unlimited, long-term supports are provided either on or off the job site (Drake and Becker, 1996; Bond et al., 1997; Bond, 1998)

However, IPS could not be transferred entirely and directly to meet the needs of methadone patients and the methadone treatment system. Changes so significant were needed that essentially a new model was created, termed Comprehensive Employment Services (CES) [Blankertz et al., 2003]. This innovation departs from Individual Placement and Support Model in the following major respects:

No job development (e.g., working with an employer to carve out or created a special position for the patient)

Because of the strong negative stigma that society places on substance abusers and the behaviors correlated with substance abuse (e.g., criminality), CES patients and counselors cannot reveal the patient's status to potential employers. Thus, unlike IPS, counselors cannot work with employers to create jobs tailored to the needs of the patient or that use accommodations. Thus, CES patients must compete for jobs with other candidates, who may or may not be disabled. As a result, there is a strong focus in CES on preparing the patient to be self-sufficient in the labor market.

Focus on removing vocational and nonvocational barriers.

In IPS, counselors focus on finding a job that accommodates the strengths and deficits of the consumer rather than trying to work with the consumer to change behaviors or modify other areas of the consumer's life. However, in CES because patients must attain jobs through a competitive process, CES counselors need to work together with patients to minimize or manage vocational (e.g. lack of job skills, lack of employment history) and nonvocational barriers (e.g., housing, health, high levels of anxiety) as well as teach patients the skills needed to find and maintain jobs. Methadone patients come to vocational services often with multiple vocational and non-vocational barriers that must be managed so that they can gain employment. Such barriers include lack of job experience, lack of job search skills, lack of concrete knowledge about the world of work, criminal records. For example, many patients have never developed a resume. Other patients do not know how to take public transportation to go outside their neighborhood. Even though they may say that they want to work, many patients also do not have a concrete knowledge of what work is really like or how to search for a job. For example, the patient may think that all workers are always happy and anxious to be at work each morning. Tangible nonvocational barriers may include lack of stable housing, physical illness, psychiatric issues, lack of stable personal relationships. Such issues can be so enervating for the patient that he or she is distracted from the job search.

In additions, there are two related psychological factors that can severely hamper the job attainment process. First, most patients enter vocational counseling with low self-efficacy. This is caused by a series of repeated failures in their personal lives as well as the internalized stigma of substance abuse. Society regards the substance abuser as morally deviant and ranks them at the very bottom of society. As a result, substance abusers have low self-esteem and self-efficacy. Most patients have a negative cognitive filter which creates high levels of anxiety at the thought of any change in their lives. They tend to have developed a geographic and behavioral comfort zone in which they feel relatively safe. Because of low self-efficacy it is often difficult to leave this zone. This is one reason that job interviews are so difficult for patients. Not only must they leave a comfort zone, but also put themselves in a situation where their worth is being assessed. For individuals starting with low self-efficacy and self-esteem, with negative distortions, such a situation is daunting.

No integrated team to deliver services

One of the features of IPS that differentiates it from other models of supported employment is a team of case managers that is integrated with the IPS counselors. IPS vocational workers are responsible only for work-related rehabilitation issues. Other members of the team work on treatment, housing, and other areas. However, the team shares decision-making for the consumer, often meeting daily to discuss progress and problems.

Because of the large caseloads that primary counselors carry in methadone clinics, they do not have the time to work closely with CES counselors to minimize or eliminate non-vocational barriers or to make joint decisions about the patient on a regular basis. Thus, the CES counselor must take the lead on helping the patient cope with both vocational and non-vocational barriers to employment and develop job search skills. As a result, CES counselors must work intensely with a limited caseload of 15-18 “active” patients who are in the first six months of vocational service. (Additional patients who require less intensive maintenance and follow-up after the first six months may be concurrently served.) These may be patients newly enrolled in the methadone program or those in any stage of treatment.

Because of the unique characteristics of substance abusers and the methadone treatment system, new models need to be developed for vocational rehabilitation. This manual first presents “Clinic-based CES,” the original model, and then “Fieldwork CES,” a more recent innovation. Because Field CES is a modification of Clinic-based CES, they share the same core characteristics, but differ in the implementation of the stages of the vocational rehabilitation process and in the staffing patterns.

Chapter 2: Essentials of CES Model

Key characteristics of the CES model shared by Clinic-based CES and Fieldwork CES.

Competitive employment is the goal: Competitive employment is necessary for individuals with disabilities to attain full participation in society. Competitive employment is defined as work in integrated settings, for minimum wages or above, in a job which is controlled by the economic needs of the employer and the behaviors of the worker (e.g. a job that is open to everyone and not set aside for an individual with a disability). Because of the stigma associated with substance abuse that can lead to employer discrimination, jobs are not created or developed specifically for patients, a common practice in other disability areas. CES participants compete with other candidates to attain employment in the “open market.” The standard procedure recommended by treatment professionals for persons with histories of substance use/treatment is to not volunteer such information when applying for jobs, and it is in fact illegal for employers to ask it, pursuant to the Americans for Disabilities Act (ADA) and earlier legislation

Competitive employment in this model does not have to be continuous; maintaining a job for any period of time is in itself a success as well as a learning tool for future job experiences. The goal is to promote attachment to the labor force so that each job is held longer. Success even for a short period of work can help methadone patients and other substance users enhance their self-efficacy and self-esteem, both of which are necessary for further occupational successes and hopefully concomitant reduction of substance use.

The goal of the CES model is to help patients attain competitive employment in a job that matches their interests and strengths. However, attaining such jobs is often difficult for the patients. Not only must they actively compete with other individuals who do not have a background of disability, but also they must often restructure their lifestyle. Because the transition to competitive work is a major change, many patients first pursue intermediate outcomes like informal work or “off-the-books” employment. CES does not “endorse” the latter but must recognize it as a practical reality.

Eligibility: The CES model is designed primarily for methadone patients who are unemployed but want to work. Patients who used illicit opioids or cocaine in the past 30 days, or who had a serious mental illness that was not stabilized, were not eligible in the original implementation of CES due to the insurmountable barriers this might present (Magura et al., 2007). Patients had to demonstrate four consecutive weekly urines negative for cocaine and opioids before becoming eligible for CES. These eligibility criteria could be modified depending on the program context.

Service delivery: There are four aspects of CES service delivery that are unique for vocational rehabilitation programs for substance abusers.

Individuation. The CES counselors individualize the rehabilitation program for each patient and works with him/her on a one-on-one basis. Group activities are not part of the model.

Treatment intensity. Since many of the patients present with multiple non-vocational barriers, the CES model must be capable of delivering relatively intense intervention. Contact between counselor and patient may be frequent (e.g. three times per week) and multi-modal. Given the model's more intense interventions, caseloads should be limited to 15-18 "active" patients who are in their first six months of service. (Additional patients who require less intensive maintenance and follow-up after the first six months may be concurrently served.)

Client active participation. The CES model insists that participants actively participate in the process of attaining a job. Active participation is necessary if change is to occur. This insistence on a high level of patient-generated activity contrasts sharply with the passive "patient role" individuals are often expected to play in addiction treatment agencies, e.g., just attend group sessions. For example, when the participant first enters CES he/she is expected to choose an immediate work-related goal. In addition, the CES counselor should ask the participant to perform several small vocationally-relevant tasks in the first few meetings.

Client deferral. CES counselors can place patients "on deferral status" (i.e., not actively receiving services) for several reasons: lack of interest in vocational services as operationalized by not keeping appointments despite repeated outreach; severe health or family problems that impede any vocational activities. Deferred patients can be "reactivated" by mutual consent if there is a change in circumstances and they are able and willing to participate. ("Deferral" may be noted on the Weekly Vocational Activities Log.). This has the advantage of not placing patients in a continuous "non-compliant" status that only reinforces their already low opinion of themselves and may "force" the program to penalize them.

Change mechanisms (Program Theory). Both models posit that there are two psychological states that need to be enhanced if patients are to attain employment.

Develop increased self-efficacy. Social Cognitive Career Theory has recently been extended to individuals with disabilities by focusing on how self-efficacy beliefs predict and explain vocational performance (Fabian, 2000). Self-efficacy beliefs in patients with disabilities are affected not only by their disability and previous negative experiences but also by societal stigma, which often is internalized (Blankertz, 2001). Patients who enter the program often come with many years of living in the substance abuse subculture. They have few if any positive achievements in the "normal" world. When these individuals enter the treatment system, their identity becomes that of the stigmatized substance abuser, in essence a life failure. As a result, they develop a negative filter, interpreting all events, and even emotions negatively. To produce any positive changes, self-efficacy must be enhanced. Self-efficacy is modified in the CES model by helping a patient master new vocational skills, verbal persuasion, vicarious learning and minimizing emotional arousal, four techniques suggested by Bandura (1997).

Enhancing motivation to work. Since patients often come to the program ambivalent about leaving the substance-abusing lifestyle and entering the uncertain world of competitive employment, they often present initial behaviors that suggest they do not want to work (e.g. missing appointments, not bringing in necessary paperwork). A mark of success for CES is increasing work motivation as rehabilitation continues. As Social Cognitive Career Theory

suggests, the development of vocational self-efficacy is a critical prerequisite for work motivation.

Incremental vocational steps. Because of the range of barriers faced by each patient, rates of progress toward paid employment vary widely. Positive change is expected to be slow and incremental. It is recognized by CES counselors that non-competitive vocational activities. (i.e. volunteer work, training, self-employment “casual” work, working for a family member or neighbor) may be positive steps to a pro-social lifestyle and then eventually competitive employment. Any positive activity is valued as an achieved behavior to be built on in the counseling process and as a means of increasing self-efficacy and work motivation.

Stages of Service Delivery

There are six different stages in the delivery of services. Although they generally occur in a chronological fashion, many occur concurrently. It is in the implementation of these six stages that Clinic-based CES and Fieldwork CES differ. Before the differences in the two models are explained for these stages, the general goal and common challenges of each stage are explained below.

Engagement

Essential to helping individuals enter the employment domain is the difficult process of achieving a therapeutic alliance, in which counselors show patients they care about them and can help them improve their lives. When a counselor demonstrates that he/she is truly interested in assisting a patient, the patient’s demeanor often changes radically. The counselors’ actions communicate a basic philosophy that they value their patients’ lives, respect them, and recognize their daily battle just to survive.

This bonding and positive affirmation is central to the vocational rehabilitation process. It is the seed from which a positive self-concept can develop. Many patients view themselves as “losers.” They believe that they are considered failures by society, perhaps by some treatment staff, and by many of their conventional family relations and social contacts. Thus, substance users are often cynical and distrustful, and do not expect others to care about them as people. The stigma of being a methadone patient becomes an internalized part of the self (Lovejoy et al, 1995; Gray, 2001).

The treatment engagement process is often difficult. It is well-known but frequently undocumented that most methadone patients have poor attendance in routine counseling sessions and even greater difficulty attending more intensive schedules of psychosocial care (Kidorf et al., 2004). Many patients approach any clinical contacts warily; they believe they have experienced many broken promises in the past.

The CES counselor must devote special attention to and use specific techniques to demonstrate positive regard for the patient and demonstrate that he/she truly cares about the patient. The CES counselor certainly may not be the only person who cares, but the key is making such caring readily apparent to the patient, which can be achieved through the development of a therapeutic alliance. Because methadone patients are frequently ambivalent toward treatment in general (Rosenblum, Magura, & Joseph, 1991; Villano, Rosenblum, Magura, & Fong, 2002), and toward vocational rehabilitation specifically, CES counselors use the following assertive outreach or treatment engagement techniques to help patients

overcome resistance to accepting services: repeated contacts, even if the patient does not immediately respond; helping patients with basic need problems like housing; immediately reinforcing strengths, such as helping to draft a functional resume which lists skills rather than a career history; and helping the patient become compute-literate or learn another work-relevant skill.

Patients engaged in treatment appreciate their counselors doing everything possible to help them improve their lives. Counselors demonstrate through action, as well as verbally, that they genuinely care. The patients, in turn, are more willing to take a more active role in their own rehabilitation process (e.g., keeping appointments) and to attempt new endeavors suggested by the counselor. The importance of a therapeutic alliance has been well documented for patients receiving substance abuse treatment (Rosenheck, 1995; Belding, Iguchi, Morral & McLennan, 1997). Yet, less attention has been paid to establishing the relationship of trust and respect necessary for prospective patients to enter and benefit from treatment.

Assessment

As in the IPS model, assessment is continuous, and starts during the treatment engagement phase as the counselor gets to know the patient and observe his or her behavior. The CES counselor focuses on determining "where the patient is coming from." This involves direct observation of interpersonal behaviors as well as identifying employment-related strengths and deficits. In addition, together, the counselor and patient identify the barriers to employment. Because some individuals have fewer barriers than others, timing of this stage may vary.

It is especially important during assessment to discern the non-vocational barriers to employment that patients may have. These barriers, described in the introductory section above, can derail the attainment of employment unless they are recognized. However, this is often difficult until the patient is engaged and willing to converse freely. Especially important in this stage is the detection of co-occurring mental health problems. Many patients suffer from phobias, other anxiety conditions, or depression, which may undermine their efforts to find work. For example, patients may develop narrow geographic and behavioral worlds in which they feel psychologically "safe." It may take a long period of gradual desensitization and examination of unrealistic or inconsistent cognitions to help patients enter the "normal" world of work, even though they may be willing to take part-time, informal, "off-the-books" jobs that they consider comfortable or safe.

Enhancement of self-efficacy

The literature on addiction has linked self-efficacy to behavioral change and persistence in overcoming substance misuse (Reilly, Sees, Shopshire, Hall, Delucchi, Tusel, Banys, Clark & Piotrowski, 1995; Gossop, Green, Phillips & Bradley, 1990). Self-efficacy has also been linked to vocational outcomes for other disabled populations (Fabian, 1999; Reginold, Sherman & Fenzel, 1999). The CES model views the development of self-efficacy as critical to facilitating the attitudinal and behavioral changes needed to enter the world of work. As noted earlier, self-efficacy enables individuals to initiate behaviors to reach a desired goal and to exert efforts to cope with problems in attaining that goal. This is especially important for substance misusers since, unlike other disabled populations such as the mentally ill, they are expected to navigate the world of work on their own.

To develop self-efficacy, CES counselors use the following four techniques established in the literature: mastery, role modeling, persuasion, and minimizing emotional arousal (Bandura, 1997). Mastery is considered the most effective method of developing self-efficacy (Bandura, 1997). The CES model uses several different staged approaches to develop mastery so that the changing needs of patients can be met as they progress through the program. Each approach focuses on helping the patient to meet the program expectation that he/she actively participates in the vocational process. At each stage the CES counselor structures the task so that the patient assumes more responsibility, in order to progress towards independence.

When patients first enter the CES program, they are asked to perform small tasks that are usually set by the counselor and, when successfully completed, are reinforced with praise. These include activities like keeping appointments, filling out a simple questionnaire on job aspirations and strengths, and going to businesses to request an employment application. One CES counselor encouraged her patients to learn how to use a computer and increase their word-processing skills. With steady encouragement, many of her patients begin to focus on computer-related jobs or training, or use the feeling of accomplishment to tackle other types of jobs.

Second, as the patients continue in the program, the CES counselor works with them to help reduce their vocational and non-vocational barriers to employment. CES counselors provide patients with the tools and encouragement to work on these issues themselves. For example, if housing is a problem the counselor may provide the patient with a list of agencies and contacts that provide housing assistance. Patients are expected to seek this help themselves. However, counselors will help with the complexities of specific housing applications. Not only does this demonstrate that change is possible, but it eliminates distractions from the goal of employment that can impede motivation.

As treatment continues, patients are expected to master behaviors that are directly employment-related, such as looking for jobs or holding part-time work. Often the CES counselor asks patients to set their own vocational expectations. This empowers them, and encourages them to take responsibility for their own treatment. The CES counselor may operationalize this empowering approach by having the patient write his or her own vocational treatment plan which specifies concrete steps necessary to achieve his or her stated vocational goals.

These expectations not only aid mastery but also reinforce the stance of active participation. If, after several months there is no activity, counselors may remind patients that they are expected to make progress if they want to continue in the program. Such expectations are needed to help the patient maintain momentum. Often, patients are willing to “woodshed” (i.e., remain at a certain level of activity), rather than make steady progress because of the comfort level they attain.

The second method of developing self-efficacy is role modeling. CES counselors do this in several ways. One is by their own professional conduct. The counselors personify consistent and structured behaviors; they are honest and reliable. When they make an appointment with a patient, they make sure that they keep it or, in an emergency, contact the client to reschedule. Alternatively, a counselor may role model a specific task, such as finding housing lists or skills training courses. They discuss with the patient how to accomplish the task so that the patient learns the structure needed to attain goals. In addition, there are some tasks, such as looking for job leads or faxing resumes, which counselors

perform along with patients, while anticipating that patients will ultimately perform these tasks themselves.

The third technique for promoting self-efficacy is persuasion. One CES counselor characterized the techniques he used to address patient fears as a counseling “tool bag” containing empathy for the patient’s perception of the situation, gentle persuasion, cheerleading as well as cognitive techniques. Persuasion may enable a patient to initiate a mastery task. For instance, a CES counselor told a patient who was extremely anxious about working about a modeling job for a shampoo product which would only last a few hours. With gentle urging and support, the patient took the assignment and noted immediately how much better she felt about herself.

CES counselors also employ cognitive restructuring techniques in order to transform clients’ personal perceptions. Many patients have self-defeating cognitive schema of faulty beliefs concerning self-worth and ability to set and achieve goals. (Beck, 1979; Beck et al., 1993). The CES counselors work with the patient to modify these in several ways. First, the counselor may explain “automatic thoughts” and “core beliefs,” helping the patient to identify situations when these emerge (McMullin, 2000; Beck et al., 1979).

Second, the counselor may suggest certain job search activities that involve behaviors that challenge faulty beliefs. For example, with one anxious patient plagued by feelings of inadequacy, the counselor structured written assignments for her that involved performing “mock” job search activities before attempting a “real” search. The CES counselor accompanied this patient in asking for job applications, calling prospective employers, and attending employment interviews. Counselors also help their patients deal with the self-defeating anxieties about transitioning to the world of competitive employment by showing them how certain skills (behaviors) developed in the drug-using world can be applied in the “normal” world (Gysbers et al, 1990).

Another method to enhance self-efficacy is to minimize emotional arousal. This technique is often used when the patient is actively involved in job-seeking activities. Anticipatory anxiety can be reduced by using analogies or metaphors that can help the patient cognitively “reframe” the situation. Working with one patient who expressed intense anxiety about entering a place of business to ask for a job application, a CES counselor recalled that the patient was a baseball fan. While walking to the designated business, which the CES counselor had previously identified as displaying a “help wanted” sign, the counselor likened what the patient was doing to spring training: practicing for an intensive job search. Feeling that he had more than one try at bat, the patient became more relaxed and confident. For another patient who played the guitar, the counselor drew an analogy between going on an interview and learning a new chord, and asked the patient to reflect on his feelings of incorporating such a new element into his repertoire.

For patients about to attend a job interview, a useful strategy for reducing anticipatory anxiety is not to “prime” the patient for the interview, but rather to focus pre-interview discussions on the skills that the patient brings to the job. This accentuates the positive rather than the potentially negative and unknown.

Focused Employment Skills Teaching

Many patients when they enter CES have little concrete knowledge about the world of competitive employment. They do not have a realistic concept of job duties, how to dress and how people feel about their jobs. In addition they do not know how to conduct a job

search. Such patients either have not been employed for a long period of time, or have held only “off the books” work, which is often more unstructured and attained through personal contacts.

CES counselors need to work with patients on these issues. Lacking a job history, most patients also lack even the simplest practical skills needed for a successful job search. One place to start is helping them to prepare a resume. Next, counselors have to show them how to identify possible jobs. Counselors need to teach them how to use the Internet to look for jobs in various parts of the community. They also can discuss the value of walking along a street to look for help wanted signs, or going into a store that interests the client and asking if a position is open.

CES counselors stress to patients the importance of following-up on job applications. Lacking employment experience, patients often do not realize that employers judge applicants by their willingness to follow through assertively on an application in order to obtain an interview. Such a process differs from the substance-abusing subculture where the focus is on the “immediate score” and not on planning for future action.

Getting a job - the interview

Interviews provoke intense anxiety in patients. Patients realize that they will be assessed and evaluated by the prospective employer. Given their lack of vocational background, low self-esteem and self-efficacy, negative thought filters, and uneasiness at avoiding disclosure of their substance abuse history, this is an ordeal. It is important for counselors to enhance patients’ ability to cope with this situation because excessive nervousness can ruin an interview.

There are two general techniques that can be used. One is to provide patients with as much knowledge beforehand as possible. Sheets can be distributed listing what to wear for an interview and what manners and behaviors are appropriate and inappropriate. Counselors also can conduct mock interviews with patients so that they have experience in handling typical questions.

Second, before the actual interview, counselors should focus on highlighting to the patient the positive strengths and skills they can bring to the job. The goal is to actively remind the patient of these as he or she enters the interview. Focusing on the positive provides more self-confidence than attempting to worry about responses to potential interview questions.

Counselors sometimes use knowledge of a patient’s interests to draw metaphors that can help them relax on the way to the interview. For example, for a baseball fan, the counselor said that one interview was like one time up at bat – if you struck out, you could always try again. For another patient who played the guitar, the counselor mentioned that the interview process was like learning to play a new cord.

Job retention

Once patients have attained jobs, the counselor’s challenge is to help with job retention. A job affects many aspects of patients’ lives. In particular, jobs can affect patients’ family members’ views and expectations of them. In addition to having to master their job duties, patients may encounter problems developing and maintaining relationships with co-workers and supervisors. Transportation and clothing issues must also be addressed. Vigilance regarding substance use must never waiver

Because of this wide range of potential problems, any one of which could potentially cause job loss, it is essential for the CES counselor to stay in close contact with the patient after they have attained a job. This can be a challenge. Patients who are working, especially if this is the first job, want to minimize contact with the treatment clinic. First, going to the clinic to see a vocational counselor can interfere with the work schedule. Most employed methadone patients attend before normal work hours to get medication. The patient does not want to return later to see a counselor. Second, after they attain the first job, the patient is often in a rosy haze. After all, they have succeeded in obtaining a role as a productive worker in the “normal” world. Attribute it to “human nature:” Suddenly they do not want to be associated with a treatment facility that only links them to a negative, stigmatized period of their life, even if that facility helped made their progress possible!

Chapter 3: CES Implementation in the Clinic Environment (“Clinic-based CES”)

Essential differences between Clinic-based CES and Fieldwork CES

Each version of the model uses different methods to implement each of the six stages. Clinic-based CES follows what was used in the original CES model. Fieldwork CES uses different and more varied techniques which emanate from the environmental context, the changed relationships between the counselor and patient in the community, the modified self-perception of the patient in the community, the more powerful array of teaching tools that the CES counselor can use in the community, and the patient’s potentially powerful in vivo learning.

Stage 1: Engagement: establishing a worker/patient relationship with methadone patients who are distrustful and avoid CES counselors

To get initial contacts CES counselors have found they need persistence and patience. For example, they will visit the medication lines and suggest that the patient accompany them back to their office. Or they will find out when the patient sees his primary counselor and then just “happen” to be around.

During the first few contact with the patient, CES counselors try to do something positive for the patient, such as helping the patients find housing (maybe not the easiest) or better housing, or drafting a functional resume which lists skills rather than work experiences, or helping the patient begin learning how to use a computer. These positive actions convey the message, “I respect you and care about you.”

Stage 2: Assessment: occurs throughout the project with a focus on documenting non-vocational as well as vocational barriers, especially high levels of anxiety.

The CES counselor should help patients assess their vocationally-related strengths and barriers. These aspects include identifying their basic values about work, attainable vocational goals, self –assessment of skills, and recognition of vocational deficits. Since patients may not have practice in introspection, this self-assessment can be important. At 30 and 60 days, each patient is reassessed to ensure that all problems are recognized and to document positive changes in attitude or behavior. At 90 days a career plan is established, short and long-term goals and specific tasks for the next 30 days. At six months, a progress assessment is made. (Use the CES Vocational Assessment/Progress Form, at end of manual.)

CES counselors use observations and patient conversations to identify non-vocational barriers such as lack of housing, or health problems, or high anxiety that is often closely associated with low self-efficacy and low self-esteem.

Stage 3: Mitigation of non vocational barriers to employment and enhancement of self efficacy.

For tangible non-vocational barriers, such as lack of housing, CES counselors search for referrals that have a good chance of producing results and that the patient can access directly. They refer patients to medical care within the clinic (which in turn can

link with needed care in the community) and follow-up to make sure that the patient has sought an appointment

Clinic-based CES addresses low self-efficacy through cognitive techniques, such as helping the patients to recognize the usable skills they have developed in the drug-using world, or by helping them to master new work-related skills such as using the computer. Since the clinic is part of the “comfort zone” for patients, the CES counselor may be unable to discern anxiety until the patient must attempt a new behavior, such as a job search or interview, outside of the clinic.

Stage 4: Focused Employment Skills Teaching to overcome skill deficits and lack of concrete knowledge about the work world.

Clinic-based CES attempts to remedy these deficits through modeling skills, role-playing, discussion, and referrals. For example, counselors show patients how to develop resumes, demonstrate how to use the infrastructure (e.g. computers, faxes) for job search activities, discuss how to find job leads, and provide them with current leads which they have attained and then explain how they can generate their own job leads from signs in store windows, neighborhood job notices, lists from various agencies, hospitals, and civil service lists. They also role-play with patients how to approach an employer to ask for a job application, stressing the importance of correct nonverbal as well as verbal behavior. Many methadone patients are not aware of social conventions and will often stand too close to a stranger in a conversation.

Patients must generalize or transfer skills that they have learned in the clinic to a community context. The counselors will often give patients specific tasks to do, such as walking down a business street and count the help wanted signs, or enter a store and ask for a job application.

Stage 5: Getting a job: Patients must learn how to handles themselves in an interview situation that is perceived as intimidating.

CES counselors try to prepare patients in advance for the interview situation. They explain proper clothing and manners (e.g., eye contact, sitting up straight). They hold mock interviews with patients to provide practice in answering questions about work skills and background.

To help patients manage nervousness and anxiety on the day of the interview, they prepare “prep note” cards for patients to keep in their pocket to remind them of their strengths and skills before they enter the interview.

Stage 6: Job retention: Maintaining contact with working patients who want to avoid the “stigmatizing” clinic, yet need monitoring to prevent problems that could cost job loss.

Clinic-based CES workers must use phone calls, email and patient visits to the clinic to monitor and discuss such issues. Counselors must be persistent and inventive to maintain contact. Many patients want to minimize contact with the methadone clinic not only because they want to escape connection with this stigmatized institution, but also because returning to the clinic for non-medication appointments may conflict with job schedules. Although counselors attempt to be collegial, contacts often become embedded with questions aimed at detecting problems that could bombshell into dismissal.

Documentation of Vocational Activities and Results: Counselors should complete a Weekly Vocational Activities Log once a week for each “active” patient. These logs should also be discussed in scheduled supervision.

CHAPTER 4: CES Implementation in the Community ("Fieldwork CES")

Because Fieldwork CES is an enhancement of Clinic-based CES, it has the same core characteristics and the same stages. However, Fieldwork CES implements the six stages differently because it uses the techniques and modifications listed below.

Introduction to Fieldwork CES

The term "fieldwork" has been used in other disciplines to describe a wide variety of community-based activities. For example, in ethnography, fieldwork is a methodology used to attain information and knowledge about individuals in their natural surroundings. Fieldwork is also used to describe the in vivo practicum experiences associated with some professional education, such as social work. Delivering rehabilitative services in the community, as opposed to a medical facility, has been well-documented, but usually termed "outreach" instead of "fieldwork." HIV programs send workers out into the community for HIV education. Workers with homeless individuals with severe mental illness spend extensive time engaging clients on the streets; often initial conversations are brief. However, over time the workers discern the personal micro world occupied by the individual and are able to communicate more effectively. Success - leaving the street and for instance entering a low demand group home - occurs over time after a trusting relationship has been developed. (Blankertz et al., 2004).

Some models of community mental health focus on providing services primarily "in-vivo." One such model is the Program for Assertive Community Treatment (PACT or ACT). Teams of mental health workers, comprised of case managers, nurses, and a psychiatrist provide individualized treatment, medication management and rehabilitative supports (e.g., food shopping) to enable the consumer to live independently in the community. In some implementations of the model, vocational workers are members of the team. The evaluation literature indicates that PACT/ACT teams can be effective in preventing hospitalization and increasing employment (Lockwood and Marshall, 2000), although the model is quite expensive to implement.

In community mental health, supported employment vocational models develop community-based jobs for individuals with disabilities and provide coaching at the work site. Perhaps the best-known model is Individual Placement and Support (IPS) (Drake and Becker, 1996). This model is based on the following principles: competitive employment as a goal, rapid placement, continuous assessment, integration of clinical and vocational staff, attention to client preferences, and provision of post-employment supports. However, IPS, similar to other models of supported employment used for individuals with developmental disabilities, uses disability-focused methods to attain competitive employment. That is, vocational counselors frequently either develop (create) jobs for consumers through contacts with employers or negotiate reasonable accommodations. In addition, job supports are often provided on-site and employers know that they can contact the vocational counselor if there are work problems. In sum, the process of attaining and maintaining work in supported employment is not fully competitive.

Fieldwork-focused CES differs from these other models of community-based service delivery. CES counselors do not provide services **to** patients or do tasks **for** them. CES counselors and patients participate together in in-vivo targeted vocational activities imbued with teaching, assessment, and supportive techniques. Although CES was inspired by the IPS model, it has evolved into an innovative program based upon the unique characteristics of substance abusers and the substance abuse treatment system. Because of the stigma associated with substance abuse and associated behaviors (such as criminality), addiction patients cannot reveal their status to employers if they want to avoid discrimination. Thus, they must compete on an “equal basis” with non-disabled job candidates. To help patients attain jobs, CES must not only help teach patients the skills to find and keep employment, but also help them develop the self-efficacy that will enable them to accomplish this. Patients often enter CES with many non-vocational as well as vocational barriers that need to be managed or minimized if jobs are to be attained. Because of primary substance abuse counselors’ heavy caseloads, CES counselors must take on many of the roles of case managers and work with patients on non-vocational as well as vocational issues.

Community-based CES focuses on delivering services outside of the treatment facility, although services are also provided in the clinic according to patient needs. Community-based services use a common, everyday activity to deliver a targeted vocational intervention in which both counselor and patient actively participate as equal partners. Providing services outside of the clinic lets the patient step out from the stigmatized role of drug user or addiction patient. This speeds up the development of the working alliance and enhances the self-esteem and self-efficacy of the patient. The in vivo context permits the CES counselor to use a variety of proven teaching, training and counseling methods and to provide immediate feedback on behavior in a real world setting. For example, many patients do not know how to search for jobs. When a patient is ready to look for jobs, the counselor will accompany the patient into the business community to observe the type of work done in local establishments. The CES counselor models for the patient how to walk in and ask for a job application, supports him/her as he/she subsequently independently completes the task, and then provide immediate feedback.

The location of services in a community context as opposed to a treatment facility *changes the nature of the services delivered, as opposed to just changing the service context. The activities of vocational fieldwork are grounded in social psychological and educational theories of the client/worker dyad and the client’s percepts of the self (Bandura, 1997; Fabian, 2000; Kolb, 1984).* This makes available to the counselor a wide variety of teaching and supportive interventions and provides a rich environment for learning. These unique characteristics of Fieldwork CES change the delivery of vocational services that has the potential to enhance positive outcomes (Blankertz et al., 2005).

First, from the perspective of the client, working with the counselor in the community eliminates the hierarchical power difference that exists in the substance abuse treatment institution. On community turf, the counselor and patient are now equal contributors to the relationship. The fact that the CES counselor is willing to come into the community with the client on this basis demonstrates respect. This change in the dyad, recognized by both the client and counselor, can increase clients’ sense of trust in counselors.

Second, in the community the client no longer has to take on the role of the stigmatized drug abuser because this identity is not apparent. When counselor and patient interact jointly outside the methadone clinic, the patient can publicly escape the subordinate

and stigmatized role that unfortunately he/she often associates with treatment (Hunt et al., 1985; Rosenblum et al., 1991). The two are now on neutral turf and are viewed by the general public as equals.

Third, the community setting also expands the rehabilitative capabilities of the counselor, permitting the field counselor to use coaching, feedback on the spot, and immediate emotional support.

Fourth, the in vivo context enriches the learning process. Experiential learning, or learning through action in the social context in which the learning will be used, is the most effective method to teach adults new knowledge, attitudes, and behaviors (Kolb, 1984). Patients can learn firsthand about the world of competitive work, about which many patients are ignorant. Skills are taught in a reality-based environment so that the patient does not need to generalize from a purely didactic setting.

Fieldwork CES Stages of Service Delivery

Stage 1: Engagement: Establishing a worker/patient relationship with patients who are distrustful and avoid CES counselors

CES counselors have found that going out into the community, such as a walk through the local business district; can change the perspective of the patient who has been assiduously avoiding the counselor. When the counselor goes into the community with the client, the client receives a positive message that conveys to him/her the care and regard of the counselor. That is, the counselor is willing to leave the clinic, where he/she occupies a position of superiority in status and power relative to the client, and instead spend time with the client in the community, where they are on "equal turf." Such a practice is highly unusual for providers in the substance abuse treatment system. This action demonstrates to the client that the counselor sees him or her as a person, not as a stigmatized patient. As one patient said to his counselor during their first excursion into the community, "Walking down the street with you, I feel like a normal person."

This time in the field lets the patient step out of the core identity as a substance abuser. From casual conversations, the CES counselor begins to find out more about the likes, dislikes and potential strengths of the patient. In turn, the patient begins to see the counselor as a real person rather than just a "clinic fixture." Thus, the counselor-patient relationship becomes multifaceted. After initial field excursions, CES counselors often observe changes in patients' behaviors. Clients who were once reluctant to see the counselor now keep their appointments and begin to more freely talk about themselves. Counselors who have engaged in the field feel that the working alliance develops more quickly with these patients.

Stage 2: Assessment: Occurs throughout the service process with a focus on documenting non- vocational as well as vocation barriers to employment, especially high levels of anxiety.

Fieldwork lets counselors observe skills and deficits in real life situations that often involve job seeking activities. The variety and depth of the information that they learn in the field is far more extensive than can be recorded in the clinic. For example, a CES counselor may accompany the patient as he or she asks for a job application. While observing the patient, the counselor can determine their verbal skills and appropriateness of interpersonal behavior. The increased flow of patient conversation outside of the clinic also aids the assessment process. One CES counselor noted that he had completed an assessment in his

office and then re-assessed in the field; the information obtained in the two environments was very different.

In the field the CES counselor can more readily discern any anxieties that clients have about job search activities. For example, when a client enters a business establishment the counselor can assess the stress level by observing facial expressions, body language and speed of speech.

From the conversations in the field, the CES counselor can often discover early on any tangible barriers, such as housing difficulties or family issues. From *in vivo* observations, the counselor can also discover physical disabilities that may not be apparent in the office, such as inability to climb stairs without breathing difficulties.

Stage 3: Removal of non-vocational barriers and enhancement of self efficacy

CES counselors can use fieldwork to directly accompany a client on referrals to handle tangible problems such as housing, legal issues or health care. Often, the CES counselor has done some exploratory work with the agency/resource that the patient has been referred to. The counselor can then confirm that the patient has the necessary information (i.e., ID, benefit status, health records) as well as provide on the spot emotional support. Methadone patients, because of previous negative experiences, are often very fearful of bureaucratic structures. Fieldwork also provides the flexibility to model how a patient could handle a physical disability (which may only be discovered by *in vivo* assessment) that may hinder movement in the community (such as trouble climbing stairs). .

The most powerful method of enhancing self -efficacy is through positive changes in performance. However, the self-efficacy that needs to be developed for patients to attain employment should be work-specific (as opposed to global) to be most effective (Pereman, Bandura). Thus, the behavior changes and accomplishments should be directly related to the work environment. In the community, counselors can often suggest to clients that he/she undertake a small vocational task, such as entering a store to observe how the managers interact with customers. However, often the anxiety of the normal work world makes it difficult to attempt these new behaviors. Counselors in the community can immediately provide support, by cheerleading and coaching a client to attempt this new behavior. If the patient succeeds, the counselor can also provide immediate positive feedback, another influential factor in the development of self efficacy (Bandura). Such feedback also permits the patient to begin to feel that he/she has strengths to succeed. If the patient cannot complete the task, the flexibility of the community context allows the counselor to use systematic desensitization, such as having the patient look through the windows of a variety of different stores.

Stage 4: Focused Employment Skills Teaching to overcome skill deficits and lack of concrete knowledge about the work world.

The CES counselor gradually exposes the patient to different real life work situations, such as taking them into a store that he or she has never entered. Just by observing how the employees dress and what they do, patients begin to get a more concrete concept of what it means to be a worker.

Fieldwork counselors use a variety of methods to teach patients the skills and steps needed to attain employment. First, counselor can use coaching, which provides both direction and support. For example, coaching is useful for teaching patients how to navigate

employment-related systems such as getting identification for a driver's license or obtaining a birth certificate copy. Such tasks, which involve complex interactions with a rigid bureaucracy, are often intimidating. Patients are often reluctant to leave their physical comfort zones (e.g. neighborhoods). In addition, from previous experiences they anticipate that any dealings with a public agency will be punitive. CES counselors not only "walk" them through the step-by-step process and make sure that they have the appropriate documentation, but also go with them to the given bureau. This combination of advance direction and immediate support enables patients to cope with such situations.

Second. CES counselors use role modeling to teach both basic skills (e.g., how to ride public transportation) and the more complex behaviors needed to apply for a job. Direct observation of the client while he/she attempts these new behaviors gives the counselor the flexibility to not only use a third teaching method – feedback - but also to change tasks or methods of teaching. Immediate feedback is important. Patients often immediately negatively distort their actions and experiences because of insecurity. Patient learning is enhanced by practicing skills in the environment where they are needed.

Feedback is also important to help the patients learn appropriate interpersonal boundaries. Often in the community context, patients will touch the hand of the counselor, stand too close to an employer when asking for an application, or begin to raise their voice. Counselors will immediately point to the specific behavior and discuss why it is not appropriate for the workplace (and thus by inference in a public place).

Stage 5: Getting a job. Patients must learn how to handles themselves in an interview situation that is perceived as intimidating.

When a patient is likely to begin to have job interviews, the CES counselor begins in advance to discuss all of the various elements of this event (waiting, initial contact, correct posture during the interview) and to role-play how to handle specific questions.

On the day of the interview, the CES counselor may accompany the patient to the interview site and wait outside. During the walk or ride to the interview, the counselor may review the patient's skills and abilities. The counselor may draw analogies to other parts of the patient's life to provide a personally related perspective to help combat nervousness. This type of field experience also permits the CES counselor to immediately "debrief" the patient before any esteem-related cognitive distortions can develop and to determine what adaptations should be made for future interview encounters.

Stage 6: Job retention: Maintaining contact with working patients who want to avoid the perceived stigmatized clinic, yet need monitoring to prevent problems that could cost job loss.

The CES counselor goes out and meets patients near their place of work. Patients are much more willing to meet with counselors within a normalized context. This type of contact is especially important during the first few weeks of the job, when many patients want to avoid the clinic because they feel that “they made it” and don’t need treatment any more. In addition to monitoring many different aspects of work life, in the field the counselor can immediately process with the patient any work situations that are difficult or uncomfortable. For example, one patient was riding in the car with his boss who offered him alcohol and marijuana. The patient did not know how to respond. His CES counselor discussed refusal skills and also reviewed all of the potential legal hazards.

Documentation of Vocational Activities and Results: Counselors should complete a Weekly Vocational Activities Log once a week for each patient. These logs should also be discussed in scheduled supervision.

Essential Model Version Differences

| | Clinic-based CES | Fieldwork CES |
|---------------------------------|--|--|
| Client empowerment | Sees self as drug user | Sees self as normal person |
| Development of working alliance | Slow, often difficult to engage client | Develops quickly as trust is gained and information is given |
| Skill learning process | In clinic – must be generalized | In vivo; skills practiced in real situations |
| Job supports | Phone or clinic visits | Close to place of work |
| Teaching methods | Discussion, role modeling | Discussion, role modeling, coaching, immediate feedback |
| Stress/anxiety | Cognitive tactics | On the spot supports; desensitization |
| Learning about work | Discussion | Concrete experiences |

CHAPTER 5: CASE STUDIES OF CES FIELDWORK

EXAMPLES OF FIELDWORK IN THE STUDY

"Joan"

"Joan" is a Puerto Rican female who stated she has never really been out of her neighborhood because that is where she feels "comfortable." To alleviate some of "Joan's" anxiety about leaving her neighborhood a systematic desensitization plan was utilized. Each time the CES counselor engaged in field-work activities the location of the activities gradually increased away from the clinic. Two such field work activities were accompanying "Joan" to acquire a copy of her birth certificate and NYS non-driver's identification. With concrete evidence that "Joan" could leave her neighborhood without undergoing an inordinate amount of anxiety, "Joan" did begin job search activities on her own in close proximity to her neighborhood. When "Joan" was called for an employment interview her anxiety heightened. The CES counselor accompanied "Joan" to her interview all the while discussing the fact that "Joan" had in fact traveled from her neighborhood on job searches. Right up until "Joan" went through the door for her interview the CES counselor offered examples of "Joan's" prior job search activities that "Joan" believed she could not accomplish, but in fact had accomplished. Feeling "anxiety" in an interview situation was also discussed as a natural reaction when engaging in this type of unfamiliar activity, thereby normalizing the anxiety "Joan" was experiencing. "Joan" was offered the job as a telephone survey operator and verbalized her sense of accomplishment, and shock that she had actually been offered the job. The CES counselor was able to act as an on-the-spot source of self-worth and self-esteem for "Joan," who is lacking in both; to get immediate feedback from "Joan" regarding her interview; and also to conduct a first-hand functional assessment outside the clinic setting.

"Mary"

"Mary" is a 51 year old Caucasian women who sought vocational services because she is "unable too survive" on her SSDI benefits. Upon referral from Mary's primary counselor I was informed that "this is a true MICA client" who needed intensive vocational services. Mary was at first very apprehensive about her ability to actually find and secure employment. The severe anxiety/panic attacks, along with concurrent agoraphobia, that Mary experiences had left her practically a prisoner who never traveled outside of a comfort zone that included the MMTP, an outpatient mental health clinic where she receives treatment, and a local Christian based social service agency. So the primary task at hand was to first gain Mary's trust which was accomplished by acknowledging and validating that, yes, she was indeed experiencing real, frightful physical symptoms associated with her anxiety. Once Mary saw that the CES counselor understood this fact I began work on countering her set beliefs that were she to travel outside her normal safety zone terrible things would happen. Some of the methods used were countering techniques, such as, the use of alternative explanations, disputing irrational beliefs, challenging faulty assumptions and highlighting discrepancies between what Mary was saying, and the truth of what was actually happening.

I encouraged Mary to bring in local neighborhood newspapers so that we could begin exploring job opportunities in her familiar neighborhood, or that were very time limited. As

a result of this we came across an advertisement for individuals to participate as hair product testers, approximately a 3-4 hour commitment, for an international hair products company for which they would be paid \$75.00. The CES counselor had Mary, after much motivational counseling and positive reinforcement, telephone the company and ask for an interview. Mary was given an interview appointment. It should be noted that Mary does not use the telephone because she is “always scared” of what she might hear from the person on the other end of the call. This incident was used to challenge Mary’s belief that “only bad news comes over the phone” when the reality is that she just arranged an interview for paid work. On the day of the interview I asked Mary if she wanted me to accompany her to the interview, but she stated, “I want to try it on my own,” which she did, was offered the job, actually participated and was paid. We now had an actual real life experience to reference off, rather than the multitude of faulty beliefs that Mary has been living her life by. She did in fact travel, by herself, to an area of the city she has not been to in “a really long time,” nothing terrible happened. This turned out to be a very positive experience and was a time limited activity.

Since the above-mentioned activity Mary has been working on a temporary basis as a cat-sitter, anywhere from 2-3 days per month to 2 weeks per month, for which she travels to the Bronx from her apartment in lower Manhattan on the subway. Freelance graphic art work is another activity Mary performs for which she receives a small stipend. Mary has attained her vocational goal of acquiring part-time, very limited hours, on-the-books employment. Currently Mary is working a four hour shift one day per week, 4 hours per day as a receptionist at a local social service agency. Also as a result of fieldwork that has been done with Mary, she has traveled to apply for Section 8 housing in upper Manhattan, and we together have traveled to the local Medicaid office to have her benefits reinstated after they had been cut. By utilizing a collaborative approach, with a great deal of input from Mary’s primary counselor, we have been able to begin the process of reintroducing Mary to a productive life outside of the confines of the faulty beliefs which have held Mary captive for the past 6 years. The intensive vocational counseling provided to Mary has allowed her, as she puts it in her own words, “to reconnect with the world.”

“John”

“John” is a 44 year old Caucasian male who initially presented as a client that would need some fine tuning: resume update, interview skills, but overall would be an “easier” client to work with. There was a good work history present, although he had not worked in 14 months, a stable living situation and a supportive spouse. John was asked to handwrite a resume, bring it to his next voc counseling session and we would then format and refine the resume. This was done within the first week of our meeting. On my way to work I noticed a local copy center had a help wanted sign displayed in their window. When John arrived at the MMTP that day I informed him of the sign and he agreed to walk over to the store, I would accompany him, to ask about employment. Once we stepped outside the MMTP John began to perspire, became very clonic in his psychomotor movements, speak in a very pressured fashion and smoke a cigarette at a rapid rate. This was in contrast to the calm, self-assured John who had been in my office only moments before. The anxiety of actually having to follow through on this task brought John to a near panicked state. By speaking calmly with John, pointing out that we were only asking for an application and to consider this as a “spring training” exercise: John is a big baseball fan so I took the conversation into a

frame of reference he is familiar and comfortable with, John completed the task and stated, “that wasn’t so bad.”

Had I not been in the field with John the depth of his anxiety and fear of participating in social interactions outside of his familiar social network would not have been known to me. Within 3 weeks John had sent a resume to a job located in one of the major newspapers in the city. I received a frantic call from John because he had received a response and the prospective employer wanted to interview him the following day. We agreed to meet early in my office to review interview behaviors and techniques. We traveled to the interview, during which time there was a great deal of motivational counseling taking place: mainly reiterating that he was qualified for the position, once again talking about baseball and most importantly that this is only a job interview; that no matter what happened we would view this as a success and move on. The job was not offered. We now, though, had an actual real life, not perceived, experience to work off of. I spent a great deal of time in the field with John submitting resumes. It was during one of our days in the field that John stated, “this is really nice. I feel like a normal guy just walking down the street talking.” The covert purpose of these field activities was to desensitize John to making direct contact with potential employers, and help raise his level of self-esteem and self-efficacy.

John never missed an appointment, but also never followed up contacting potential employers to whom he had submitted his resume. As John stated, “I don’t want to bother them, they’ll think I’m a pain in the [butt].” Even in my office John would balk at placing follow-up calls. I tried explaining that a potential employer wants to see the qualities of assertiveness, following through on assigned tasks, and persistence in an employee before he/she is hired. These are some of the qualities he would be demonstrating by following-up after submitting his resume. I explained Albert Ellis’ A-B-C theory of faulty cognitions, because it was evident that John had thought himself, erroneously, out of the ballgame following the before game warm-up. Following this explanation John did more actively engage in an effective job search, which paid off. John interviewed, I accompanied him to the interview, and was offered employment which he accepted. The job only lasted 3 weeks at which time John said the employer was only going to keep one of the three workers he had hired, John was not that one. It appears that there is a family issue, along with John’s extreme passivity, that have greater influence on John than what I was able to offer him as a counselor, or maybe it just isn’t John’s time. After working intensely with John for a considerable length of time he has recently been put on a 60 day deferral following his failure to honor a 30 day vocational treatment plan we collaboratively had formulated. John stated, “I just can’t do this now.”

“Don”

“Don” is a 37 year old Caucasian male who acquired an administrative employment position while working with his CES counselor”. A major issue which “Don” and the CES counselor spoke about often, is relapse triggers at work. “Don’s” previous employment experience had been very unorthodox: working different hours on a day-to-day basis, irregular patterns of pay, long periods in which “Don” had too much “free time” which many times led to relapse. To handle this issue head on the CES counselor and “Don” worked on creating a work related relapse prevention plan that is applicable not only to work specific hours, but also to everyday life situations. A main component of this plan called meetings in the field during “Don’s” lunch hour, or at a time most convenient for “Don.” At

one such field session “Don” revealed his immediate supervisor had offered him beer and marijuana. “Don” did not know how to handle this situation and did have a beer . “Don” contacted his CES counselor the next day about this situation and they met near “Don’s” place of employment. Together “Don” and his CES counselor spoke about refusal skills, the pros and cons of drinking beer/smoking marijuana with his supervisor, the effect this could have on not only his job, but also “Don’s” goal of remaining abstinent from illicit substances. The next time “Don’s” supervisor asked “Don” to go out with him “Don” utilized some of the refusal skills his CES counselor had discussed with him, and since that time the supervisor has not asked “Don” to go out with him for non-work related activities. Here the CES counselor’s goal is to allow “Don” to not rearrange his work schedule in order to meet the CES counselor. Meeting in the field also gives the CES counselor the opportunity to assess “Don” as a worker rather than as a client in the clinic.

“Julie”

“Julie” is a 42 year old Puerto Rican woman who stated that her initial vocational goal was to acquire her GED. The last grade “Julie” completed was the ninth grade and has very spotty recent work history. “Julie” has a history of recurring major depression for which she is receiving medication and is engaged in psychotherapy at an outside agency. Another major health issue is that “Julie” is HIV and hepatitis C positive. Once the CES counselor began speaking with “Julie” about what steps would be needed to begin working towards eventual acquisition of her GED it became obvious that “Julie” did not have the proper identification needed to enroll in GED classes, nor the skills to prioritize such an endeavor. The CES counselor arranged for two field work sessions; one to acquire a copy of “Julie’s” birth certificate and the second to acquire a NYS non-driver’s identification. During vocational counseling sessions in the CES counselor’s office “Julie” had stated that her living arrangements were stable, but the CES counselor believed “Julie” was not revealing the full picture about how “stable” the living situation actually was. While in the field on the way to acquire “Julie’s” birth certificate, “Julie” revealed she is doubled-up with her sister and the sister has a serious illness which is progressing. With this new information the CES counselor was able to have “Julie” sign a release of information form allowing the CES counselor to contact “Julie’s” off-site psychotherapist. The psychotherapist verified that “Julie” is prone to anxiety attacks along with her recurring major depression. At this time “Julie” has also acquired her NYS non-driver’s ID, the CES counselor accompanied “Julie” in the field, and is currently enrolled in, and attending, a GED prep course five days per week. By accompanying “Julie” in the field at an early stage of the counseling relationship, only six days after the initial counselor/client contact, the CES counselor was able to acquire vital information, unstable living situation, and act on this information by forming an alliance with “Julie’s” psychotherapist, thereby leading to coordinated treatment that will best serve the client’s needs.

“Jack”

“Jack” had been struggling and becoming frustrated with his job search. “Jack” had been on numerous employment interviews, on his own, and not received an offer. Despite the CES counselor’s offer to accompany “Jack” in the field to offer support and encouragement, “Jack” had refused. The reason “Jack” finally stated is that he would feel like a “baby” having a counselor “hold his hand.” The CES counselor addressed “Jack’s”

concern by presenting himself more as a team member rather than a chaperone. “Jack” still resisted the CES counselor’s outreach efforts. One afternoon “Jack” arrived at the clinic in a panic because he had received a response asking him to come in for an interview that afternoon, and requesting the CES counselor accompany him to the interview. At that point the CES counselor closed up his office and accompanied “Jack” into the field. One of the CES counselor’s first observances was that “Jack” was perspiring heavily, and was having difficulty remaining still in his seat on the subway. The CES counselor began a conversation highlighting in a round about way some of “Jack’s” accomplishments to date, even revealing he was a bit nervous for the client, but emphasized the being nervous/anxious is a normal reaction to this type of situation. Normalizing feelings/emotions associated with employment related activities in vivo is a major goal of CES field work. Right before “Jack” was to enter for his interview the CES counselor used metaphor as a counseling tool. Knowing that “Jack” is a musician the CES counselor asked “Jack” how he felt when he is learning a new cord on his guitar, and “Jack” stated, “relaxed,” to which the CES counselor replied that an employment interview is the same as learning a new cord on his guitar. At that point he entered the business for his interview. “Jack” was offered the job of answering service operator and stated that having the CES counselor present in the field allowed him to focus on his overall goal of acquiring employment. By addressing “Jack’s” anticipatory anxiety immediately prior to the interview, the CES counselor is able to direct the client’s focus onto the actual task at hand, which is the interview.

CES VOCATIONAL ASSESSMENT/PROGRESS FORM

Today's date: ____/____/____

Patient ID: _____

Vocational counselor: _____

Initial Session:

A. Conduct the Vocational Outcomes Interview/Baseline - with the patient.

B. What qualities do you have that will help you to find and keep a job?

C. What things could make it difficult to find and keep a job?

D. Lets talk about a goal for the next month (30 days).

E. What will you do to make that happen?

F. What should I do to help you make that happen?

30-day Progress Report: Today's date: ____/____/____

(If applicable) Let's talk about a new goal for the next month (30 days):

60-day Progress Report: Today's date: ____/____/____

(If applicable) Let's talk about a new goal for the next month (30 days):

90-day Career Plan: Today's date: ____/____/____

A. Long-term goal:

B. Short-term goal:

C. Specific tasks for patient:

D. Specific tasks for vocational counselor:

Six-month Outcomes Report: Today's date: ____/____/____

A. Conduct the Vocational Outcomes Interview/Follow-up - with the patient.

B. Six-month progress – additional comments:

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