Efficacy of the Customized Employment Supports (CES) Model of Vocational Rehabilitation for Unemployed Methadone Patients: Preliminary Results

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ABSTRACT

This article presents initial efficacy data for an innovative vocational rehabilitation model designed for methadone-maintained patients—the Customized Employment Supports (CES) model. In this model, a CES counselor works intensively with a small caseload of patients in order to overcome the vocational as well as nonvocational barriers that hinder their employment, with the goal of attaining rapid placement in competitive employment. The CES model was implemented at two Manhattan methadone treatment programs as part of a randomized clinical trial comparing the model’s employment outcomes with those of standard vocational counseling. The study tested the hypothesis that patients in the experimental group will have better employment outcomes than those in the comparison group. The data were collected from May 2001 through September 2003. The sample consisted of the first 121 patients who had completed their 6-month follow-up interviews. The preliminary results supported the hypothesis for two indices of paid employment, i.e., the CES group was more likely to obtain both competitive employment and informal paid employment. The clinical trial is continuing.

Key Words: Customized Employment Supports model; Vocational counseling; Substance use; Methadone treatment; Randomized clinical trial; Competitive employment; Therapeutic alliance; Fieldwork.

INTRODUCTION

Because of personal barriers and the limited availability of vocational services, few unemployed methadone-maintained patients attain competitive employment. With recent federal and state policy reforms requiring substance users to obtain work or risk losing public benefits, it is imperative to develop and test innovative vocational rehabilitation models so that employment outcomes can be improved for patients enrolled in addiction treatment programs.

This article reports on an evaluation of an innovative vocational counseling model designed for unemployed methadone-maintained patients—the Customized Employment Supports (CES) model. The central idea is that a CES counselor works intensively with a small caseload of methadone patients to overcome the vocational as well as nonvocational barriers that hinder their employment. Counselors identify...
and focus on the strengths of each individual and use various techniques to increase patients’ self-efficacy for work. Patients are expected to participate actively in vocational activities and take responsibility for their vocational progress. This approach is designed to enable patients to attain rapid placement in suitable competitive employment.

The CES model was implemented at two New York City methadone programs. As expected, the original model needed to be further adapted to the characteristics of the methadone treated population during the implementation phase. Long-term heroin users tend to cut themselves off from informal support systems involving family members, significant others, and friends, as well as from the formal institutions and resources that most people take for granted. Even when they become patients in a treatment program, drug misusers distrust those who lead a more conventional lifestyle. To overcome that deep distrust, the model needed highly active engagement strategies to build the therapeutic alliance with patients on which counseling depends. One important engagement strategy consisted of fieldwork, that is, activities in which counselor and patient interact in the community rather than in the clinic. Vocationally relevant learning activities that take place on “neutral turf” help to normalize the counselor-patient relationship and accelerate the development of patient trust and openness. A full description of the CES model is presented in Blankertz et al. (2004), this issue.

A 5-year, randomized clinical trial initiated in is being conducted to compare the employment outcomes of the CES model with those of standard vocational counseling in methadone programs. The present study tests the hypothesis that patients in the experimental group will have better employment outcomes than those in the comparison group at 6 months after study entry. Six-month outcomes are relevant because rapid job placement is a goal of the model and also because the average length of services reported in the literature before individuals with disabilities attain their first job is 6 months (Cook et al., in press).

**METHODS**

**Study Setting**

The study is being implemented at two sites in Manhattan. One is a freestanding methadone clinic operated by Greenwich House, a nonprofit social services agency. The other methadone clinic is operated by Harlem Hospital but is located separately from the main hospital.
Subject Eligibility

The study used five eligibility criteria for the methadone patients at each clinic:

1. Unemployed (i.e., without any employment) or appreciably underemployed in terms of weekly hours worked, duration or continuity of employment, or job skill level. Work history (e.g., length of unemployment) did not affect eligibility (all study patients were in fact unemployed at study entry.).

2. Stabilized on an appropriate methadone dose (i.e., at least 30 days after entering the clinic).

3. Negative urine toxicologies for both opiates and cocaine for the clinic's last four weekly urine tests. Current abstinence from these two major illegal drugs was considered necessary for being able to engage patients and have them secure employment. However, longer-term abstinence (e.g., 6 months) from all substances, as is typically required for standard vocational counseling, was not needed for acceptance into CES.

4. Absence of any condition that would preclude working (e.g., serious mental illness, developmental disability, severe physical health problem, or time-intensive dependent care responsibilities).

5. Willingness to enter the research study and be randomly assigned to either the innovative vocational program or the clinic's existing vocational counseling program.

Subject Recruitment

Methadone patients generally attend the clinics daily for medication, although some are permitted “take-homes” allowing them to come to the clinics less frequently. Subjects who applied to enter the study were either referred by their primary methadone treatment counselors or were self-referred. Each applicant was screened by a research assistant according to the study’s eligibility criteria. Applicants who were screened out of the study by positive urinalysis results for opiates or cocaine were told that they could reapply once they had negative test results over a 4-week period.

Participation in the research study was entirely voluntary based on written informed consent. Information collected for the study was confidential. Participants who chose to participate in the interview process were paid $30 for their time for each interview. Patients were told
that they would be recontacted by the research staff, and invited to return for follow-up interviews at 6, 12, and 18 months after study entry. The study protocol was approved by the Institutional Review Boards of the collaborating organizations.

**Study Sample**

The study subjects, all of whom were in the study for at least 6 months, consisted of:

1. Seventy-nine patients who entered the study at Greenwich House’s methadone clinic in Manhattan’s East Village during the 23-month period from May 2001 to March 2003.
2. Fifty-six patients who entered the study at Harlem Hospital’s methadone clinic during the 14-month period from September 2001 to October 2002.

**Research Design**

The study used an experimental design in which eligible subjects at each site were randomly assigned to either the CES vocational model or the clinic’s standard vocational program. A total of 135 patients were randomized for the current study. To ensure consistency of the research protocol across the two sites, the procedures of a multisite, randomized field trial were used. Each site served the same target population and had the same standard measurement points and instruments (Chow and Liu, 1998).

Each site supplied data to a centrally managed location (National Development & Research Institutes, Inc. headquarters in Manhattan). Quality assurance focused on both clinical and research issues. Consistency in the manner in which the two CES counselors delivered the intervention was maximized by having counselors discuss their cases with each other, and also by close and partly joint clinical supervision. Consistency in the way in which the two research assistants conducted the interviews and recorded the data was maximized by frequent communication between them about problems encountered, monitoring by senior research staff of selected interviews at each site, and staff review of data transmission to the central office.
Staff Training

The two CES counselors each had over 20 years of clinical experience working with addiction treatment patients, primarily in methadone treatment, and had experience in vocational counseling. The counselor at the Harlem Hospital clinic was an African-American female, resulting in an almost 100% counselor-patient match on ethnicity. The counselor at the Greenwich House site was a Caucasian male, whose caseload was almost equally divided among African-Americans, Hispanics, and non-Hispanic Whites. To ensure that the intervention was delivered in the same manner at each site, both CES counselors received the same training and clinical supervision, and stayed in close contact with each other—sharing job leads and working collaboratively on clinical problems.

The two research assistants/interviewers had previous experience interviewing substance misusers and were further trained by the project director and assistant project director in the study research protocol. Training topics included interviewing pace, probing of open-ended items, coping with noncooperative patients, and using the Computer Assisted Personal Interview (CAPI). The interviewers practiced initially by administering the baseline interview and providing feedback to each other, next by interviewing other role-playing nonpatients, and finally by conducting pilot interviews with study-ineligible methadone patients. The trainers directly observed a third of these practice interviews.

Description of the Interventions

The research design called for subjects in the experimental and comparison groups to receive different vocational interventions.

Experimental Condition

Similar to other vocational rehabilitation models for individuals with disabilities, the project followed a manual theory-driven rather than a manual-driven approach (Bond et al., 1997). That is, the CES counselors were provided with a written theoretical framework for the intervention with key principles, phases, core activities, and examples to integrate into their work, as opposed to delivering services in a prescribed step-by-step method. This theory-driven approach enabled them to deliver the core intervention components without compromising their own counseling style or disrupting their working alliances with their patients. In the
example of fieldwork, instead of a requirement that all initial contacts take place in the office, counselors were encouraged to use a set of techniques such as assertive outreach and helping a patient meet a pressing need (e.g., to find housing). One counselor frequently accompanied patients out in the community; the other helped many patients learn to use a computer.

The CES model, described more fully in this issue (Blankertz et al. 2004), recognizes that barriers to patients’ employment extend beyond deficits in job attainment skills and vocational background. Problems in nonvocational areas must also be addressed (e.g., low self-efficacy, fear of leaving an unstructured lifestyle for the demands of competitive employment). The CES counselors worked with patients to minimize nonvocational barriers while helping them seek employment in a job of their choice, a difficult task given the paucity of opportunities in the labor market for “marginalized” job-seekers. The resulting individualized and intense interventions limited each CES counselor’s caseload to approximately 15 “active” patients at a time.

The CES counselors met face-to-face with patients up to three times per week, and often had further contact by phone or e-mail. As noted, some of the face-to-face contacts occurred in the community rather than in the office. Although funding constraints limited the clinical staffing to one CES counselor at each site, future implementation of the model could, as in the implementation of the mental health vocational models, encompass several CES counselors at one site.

The CES counselors blended in well with other clinical staff, with two exceptions. They encountered the customary tensions between primary counselors and vocational counselors, which seem linked to differences in salary, education, and caseload. Also, due to the experimental research design, it was perhaps inevitable that standard vocational counselors were inclined to see the CES counselors as competing with them.

The two CES counselors met separately with the clinical supervisor once a week and jointly once a month; there were also frequent telephone contacts. The counselors also met with the project director once a month to discuss the delivery of services, and to ensure that the model was being adhered to. In addition, the CES model’s fidelity was evaluated once a month to maintain convergence between the CES vocational programs across sites.

Comparison Condition

The existing services at each site offered nonintensive, individual vocational counseling, as well as the opportunity for participation in
vocationally oriented groups. The individual counseling activities were either prevocational (e.g., working with patients on hygiene issues, insuring that patients had appropriate documentation) or job-seeking (e.g., helping patients write a resume), depending upon the needs and desires of the patients. The group counseling activities included workshops on topics such as interviewing skills. Virtually all contacts with counselors occurred in the clinic. Some patients, however, were referred to independent job training and job placement agencies. Paralleling the CES staffing, there was one counselor offering standard vocational services at each site. These two comparison group counselors, who also provided the same standard services to other methadone patients not in the study, had study caseloads of 15, plus additional nonstudy caseloads of roughly the same size (e.g., at one clinic, the standard counselor had 14 study patients and 18 nonstudy patients in one period.). Their total caseloads were thus more than double their study caseloads, leaving them with substantially less time to spend with patients. It is noteworthy that “standard counselors” at many methadone clinics have even higher caseloads.

Data Collection Schedule and Procedures for Assessing Vocational Activities

The study collected data on patient employment and behaviors from several sources:

- **Baseline interviews:** As noted, participants were interviewed at baseline via CAPI before they were randomly assigned to the experimental or comparison group. Pretests of the data collection procedure were needed to train interviewers, determine interview length, and adjust to interview revisions. Once the baseline interview was finalized, the average time taken to complete it was 90 min. This structured psychosocial baseline interview included, among other topics, demographic and background factors, employment history, and current work and other vocational activities.
- **Follow-up interviews:** A follow-up version of the interview was administered 6, 12, and 18 months later using the same procedure as the baseline. Although the follow-up interview excluded measures of personal history, it retained the measures of recent vocational activity and added measures concerning the vocational
intervention, especially the perceived helpfulness of services (only 6-month follow-up data are available for this study.).

- **Vocational Activities Log**: In addition to the interview self-report data, both CES and standard counselors kept a log that recorded vocational services provided and patients’ vocational outcomes during the period of service.

- **Employment Documentation**: Counselors asked employed patients to supply documentation to verify their employment (e.g., a pay stub, a letter from an employer, permission to call the employer, or stationery with company letterhead). Counselors sometimes used alternative methods for verifying employment in cases of informal jobs—for example, walking unannounced past the place of employment to check if the patient was present and working as expected.

The employment measures drew on and integrated information from these various sources since no single source was complete. For instance, not every patient completed a follow-up interview, not every patient remained in counseling for 6 months so that the counselor could record all employment, and not every patient could present documentary verification of the employment he or she reported. All available data were used to compile each patient’s record of employment and other vocational activities.

- **Measures of Vocational Outcomes**: The major employment outcome was the attainment of a paid job. Competitive employment—obtained in the open market and on-the-books—was the preferred outcome, but other forms of paid employment included self-employment, temporary jobs, and additional alternatives available in the informal labor market.

Vocationally relevant activities other than employment were also viewed as an outcome measure because of their potential to serve as a conduit to future paid employment. Such constructive activities developed patients’ skill sets in fields to which they had not been exposed, or enhanced their experiences in fields they had been involved in prior to the onset of drug misuse. Examples of these activities, which could lead to employment, included additional schooling, job training/placement programs, internships, stipend work, and volunteer work. Table 1 provides examples of patients’ ‘‘on-the-books’’ and ‘‘off-the-books’’ jobs during their first 6 months of vocational counseling, as well as examples of their other vocationally relevant activities.
Four dichotomous measures of vocational activities, which constitute the outcome measures for this analysis, were obtained at baseline and at 6-month follow-up:

1. Whether the patient attained any paid job in the previous 6 months.
2. Whether the patient attained a competitive job in the previous 6 months.

**Table 1.** Examples of vocational activities reported at 6-month follow-up.

<table>
<thead>
<tr>
<th>Competitive employment</th>
<th>On-the-books jobs</th>
<th>Data input, security guard, message center operator, cashier, owner/operator deliveries, stock person, supermarket meat wrapper, maintenance worker, porter, telephone survey operator, fast food worker, flyer distributor, building permits expeditor, health care/aide worker, temporary NYC Parks Department park ranger, manager of newspaper legal ads classified section, computer sales and technical support, cook, general manager of restaurant, masonry, construction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Informal paid employment</td>
<td>Working for family</td>
<td>Cashier and stocking in family grocery store, helping brother with his moving company</td>
</tr>
<tr>
<td></td>
<td>Working for neighbor</td>
<td>Pet sitting, baby sitting, grocery shopping</td>
</tr>
<tr>
<td></td>
<td>Other self-employed</td>
<td>Selling clothes, jewelry, tools, Christmas trees on street; flea market vendor, apartment painting, babysitting</td>
</tr>
<tr>
<td></td>
<td>Other informal</td>
<td>Roofing, dancing in a club, handy/repair man, building maintenance</td>
</tr>
<tr>
<td>Other vocationally relevant activities</td>
<td>Internship</td>
<td>Cook at therapeutic community, medical assistant</td>
</tr>
<tr>
<td></td>
<td>Stipend work</td>
<td>Computer technician-desktop support, maintenance work at shelter or therapeutic community</td>
</tr>
<tr>
<td></td>
<td>Volunteers</td>
<td>Gardener, needle exchange, casework for Red Cross, soup kitchen, GED tutor, shelving at church library, read to children in school, set up dog runs in park, run counseling groups</td>
</tr>
<tr>
<td></td>
<td>Education</td>
<td>Culinary arts, computer programming, computer repair, medical assistant, HIV education, business school, GED Program, English as a second language</td>
</tr>
<tr>
<td></td>
<td>Job training</td>
<td>HIV/AIDS peer educator, computer training, office skills training, case management/outreach harm reduction</td>
</tr>
</tbody>
</table>
3. Whether the patient attained an informal job in the previous 6 months.
4. Whether the patient participated in any other socially constructive, vocationally relevant activity in the previous 6 months.

The three basic vocational measures (i.e., competitive, informal, constructive activity) were not significantly associated with each other ($p > 0.05$). To provide a single overall index of vocational outcomes, they were combined into a four-level, ordinal measure of highest level of vocational attainment:

1. Attained a competitive job (highest).
2. Attained an informal job.
3. Performed constructive activity other than paid employment.
4. None of the above (lowest).

Analysis Plan

Given the limited sample size currently available for analysis, the data were pooled from the two clinic sites. A total of 135 patients were randomized within the current study period. An efficacy sample for analysis was constructed as follows (Chow and Liu, 1998). Two patients (one experimental, one control) who died during the period of service were excluded. Two patients (one experimental, one control) who were found to be ineligible for the study after randomization were excluded. Ten patients who were assigned to the experimental group at the Harlem site during the study period were excluded. These patients received little or no counseling because the CES vocational counselor became ill, had extended medical leaves, and then left the study. This lack of service was involuntary, and not dependent on patients’ willingness to participate nor on their prognosis. The resulting efficacy sample consisted of 121 subjects (55 experimental, 66 control). Follow-up interviews were conducted with 92% of these study subjects. Employment information for subjects without follow-up interviews was obtained from the counselor logs.

Using the combined ordinal outcome measure, the initial analysis was a cross-tabulation of the highest level of vocational activity attained by study condition. Next, cross-tabulations were conducted between experimental condition and four separate indices of vocational outcomes. In all instances, Pearson chi square provided the tests of statistical
Because the hypotheses involving vocational outcomes were directional predictions (i.e., better outcomes were predicted for the experimental group), single-tailed significance tests are reported.

RESULTS

Sample Characteristics

The experimental group \( (N = 55) \) and comparison group \( (N = 66) \) were compared on measures of patient baseline characteristics selected from major life domains to assess the effectiveness of the randomization.

The measures used in the comparisons included demographic factors (e.g., gender, race/ethnicity, education, marital status, and age), employment history (competitive or informal job in last 6 months), living arrangements (living alone or not), health (overall health rating), physical limitations (problems with standing, climbing, or lifting), HIV status, welfare (received public assistance in the past year), family relationships (any lifetime physical or sexual abuse; any serious conflicts in the past 30 days with family members or other people), criminal involvement (any illegal activities in the past 30 days; ever arrested), treatment and treatment-like activities (any prior substance use or mental health treatment; any 12-step participation), psychological status (any ongoing emotional problems), and attitudes (attitudes to employment, work motivation, self-efficacy, and self-esteem). These bivariate analyses detected no significant differences between the two conditions.

Key characteristics of the overall sample at baseline included the following: male (58%); minority group (68%); mean age \( = 43.8 \) years (s.d. = 8.8 years); high school graduate/GED (65%); no paid job within last 6 months (60%); unemployed at study entry (100%); ever arrested (81%); rates own overall health as excellent, very good, or good (62%), but reports having trouble standing for long periods (67%), climbing stairs (73%) and lifting a medium weight (90%); received prior treatment for substance misuse (67%) and mental health problems (53%); has attended some form of 12-step program (79%); and has received public assistance benefits in the past year (82%).

Outcomes of CES Program

Consistent with the study’s main hypothesis, the experimental group achieved significantly higher levels of vocational activities than the
comparison group during the 6-month follow-up (Chi square = 7.78, df = 3, p < 0.05) (Table 2). Each of the four measures of vocational outcomes was also evaluated individually. Compared with the standard vocational services group, patients in the CES program were significantly more likely to have obtained any form of paid employment (65.5 vs. 40.9%, Chi square = 7.24, df = 1, p < 0.01), competitive employment (27.3 vs. 13.6%, Chi square = 3.51, df = 1, p < 0.05), and informal employment (56.4 vs. 27.3%, Chi square = 10.54, df = 1, p < 0.001). However, the two groups did not differ significantly on engaging in constructive vocational activities other than paid work (41.8 vs. 31.8%).

### DISCUSSION

Based on an initial 6-month follow-up period, this study’s findings provide preliminary support for the efficacy of an innovative vocational rehabilitation program designed for unemployed methadone patients that emphasizes intensive individual counseling, rapid job search, and therapeutic fieldwork. The Customized Employment Supports (CES) model was developed by adapting components from vocational models designed for seriously mentally ill patients (i.e., supported employment models) and modifying them for substance misusing patients in general and methadone patients in particular. The data supported the study’s hypothesis that patients randomized to the experimental (CES) condition would have better employment outcomes at follow-up than patients receiving standard vocational counseling. This was true for measures of any paid employment, competitive employment, and informal employment, but did not hold for a measure of other constructive vocational activities.

Although the existing literature on vocational programs provides some context for interpreting the study’s findings, it is difficult to compare...
these results with those of other vocational programs for this target population (see Magura et al., 2004). Such programs have invariably imposed more restrictive eligibility criteria and thus have been highly selective of patients served. Standard vocational programs may require patients to have 6 months of “clean time” (i.e., total abstinence from substances) before allowing them to pursue employment, thus confining job searching to a small group of long-term, abstinent methadone patients, which indeed may produce higher rates of job acquisition. Instead in the present study, patients were eligible even if they were misusing substances other than cocaine and heroin, and only four successive weekly urinalyses indicating no cocaine or heroin use were required.

Research involving other disability fields provides a more useful context. The CES model is a response to the dearth of established models of vocational rehabilitation in the addictions treatment field. When other disability fields were in a similar state, initial findings for innovative programs were quite modest, with approximately only one-third of study samples attaining employment despite the fact that counselors worked to develop jobs where employers offered accommodations (Drake and Becker, 1996).

Although the study provided significant support for the comparative advantage of the CES model over standard vocational counseling, the intervention’s success in achieving competitive jobs for methadone patients was modest in these preliminary results. Most CES patients did not attain such jobs within the first 6 months of the intervention. Furthermore, the measure of competitive employment adopted a low threshold, namely, any competitive employment in a 6-month period. In general, the patients receiving CES who obtained competitive employment did not make the shift from “welfare to work.” For the most part, they did not get steady, full-time jobs in the labor force that enabled economic self-sufficiency. Instead, they typically found jobs that were some combination of part-time, short-term, and/or minimum wage. Some got more than one such job in the period studied. “Legitimate employment episodes” would be one way of conceptualizing their accomplishments. In short, the first 6 months of participation in CES may have helped patients take the first step toward regular labor force participation.

Why were the effects of the CES intervention on competitive employment limited? Several factors seem relevant. First, unlike other vocational interventions in disability populations, it was not possible to use the proven model of supported employment because of the stigma of substance misuse and associated criminality. Patients attained jobs on their own merits without the aid of specific job development.
Employers generally knew nothing of the patients’ addiction histories, nor were there any on-the-job coaching activities.

Second, these unemployed, urban methadone maintained treatment patients entered the study at very low levels of vocational participation and readiness. They faced many personal barriers to the world of legitimate work, especially their poor job histories and low levels of education and job skills. In addition, they faced many personal nonvocational barriers to employment: a history of serious and chronic drug misuse, problems with physical and mental health, unstable finances and housing, criminal justice system involvement, conflictual family relationships (if they had families), and inadequate peer support for recovery. Such multiple impairments imply that unemployed methadone patients typically start further back vocationally than other disability populations, require counselors to address diverse barriers to employment, make slow and halting vocational progress, and may have to settle for less than competitive employment in the early stages of rehabilitation. Importantly, many of the patients expressed to their CES counselors great fearfulness at leaving a familiar but unproductive lifestyle and entering the competitive world of work, where their achievements would be judged in comparison with employees long in the social mainstream.

A third reason for patients’ limited competitive employment during the study concerned the deteriorating job market (2001–2003) during the initial 6-month follow-up period. It has been shown that, during periods of economic downturn, individuals with disabilities fare far worse than their nondisabled peers (Yelin and Katz, 1999). Counselors noted in their project logs that many patients sent out numerous resumes without any favorable results, and the counselors themselves noted that, for each succeeding year, there were far fewer “help wanted” notices in the community.

Fourth, only 6 months of the CES intervention, much of it devoted to the engagement or “working alliance” process, had been available to patients by the time of the 6-month follow-up interview. Other vocational studies involving individuals with disabilities have found that there is a substantial minority of patients that require extensive services (e.g., longer than 6 months) before employment is attained (Cook et al., in press). These individuals usually have more severe barriers to work that must be addressed before they can find employment. Counselors need to recognize this and work patiently to remove barriers and develop skills at the same time, while not allowing the patients to become discouraged.

It has been found in other disability fields that individuals in vocational programs may attain paid employment that is informal, i.e., not competitive in the sense of the “open” legitimate job market (Cook et al., in press). There are several reasons for this. First, even though
CES counseling may have helped unemployed methadone patients improve their vocational functioning, some patients may prefer not to work competitively. Welfare benefits may act as a powerful disincentive to seek or accept competitive employment. Patients may choose work that does not interfere with their public assistance, which may be more valued for its medical benefits than monetary assistance. This has been documented for individuals being treated for severe mental illness who, unlike substance users in treatment, still qualify for Social Security Disability Insurance (SSDI) (Polak and Warner, 1996).

Second, patients may opt for self-employment, temporary work, or other “off-the-books” jobs—certainly often short-lived, undependable, and poorly compensated—to increase their ability and confidence to eventually enter competitive employment in stepping-stone fashion. Indeed, during the first 6 months of the CES program, clinicians reported that some patients transitioned from the informal economy to the regular labor market. Counselors also documented that fear of employment in the “regular” labor market is a large obstacle for this population. The CES counselors found that off-the-books work could be a positive enabling factor in establishing work routines and expectations.

Vocational counselors who work in methadone programs, which usually receive substantial government subsidies, are not permitted to encourage informal employment. Counselors were thus required to act as if the most common form of employment obtained by patients did not exist; the best they could do if the topic came up was to be neutral.

It is unsurprising that a vocational model designed to help patients find competitive employment would have little impact on nonpaid constructive activities. Indeed, the absence of significant differences on this measure between study conditions supports the fidelity of the model’s implementation, in that the clinical emphasis of CES was on rapid search for and attainment of paid jobs rather than preemployment activities. However, this should not obscure the additional possibility of stepping stone transitions. Just as informal work may be a step toward competitive jobs, other constructive activities, such as job training or additional education, may lead to paid employment.

What programmatic or policy changes might increase further the rates of competitive employment? One approach would be to offer patients state-of-the-art vocational counseling the first time that they entered methadone-maintained treatment. Many patients in this study had been in methadone treatment programs multiple times. Repeated treatment episodes, which imply older patients with longer addiction careers, limit responsiveness to clinical interventions.
A more ambitious approach to improving employment outcomes would require practice changes in the methadone treatment system involving some additional expense. If the role of primary counselor were upgraded (i.e., more education/training, higher salaries, and smaller caseloads), methadone treatment counselors, vocational counselors, and other clinical staff could operate as professional teams that comprehensively manage individual cases. Shown to be successful in treating the seriously mentally ill, such teamwork would increase the strength, integration, consistency, and clinical wisdom of the overall addiction treatment intervention.

Absent such changes, the data as reported and discussed point to a compelling if disturbing conclusion. There exists a convergence of social policies and personal patient circumstances that undermines efforts to promote competitive employment among unemployed methadone patients. Factors inhibiting such employment include long-term patients’ poor employment prospects, their need to hide their personal histories, the disincentives to enter employment that threatens their public “safety net,” the impossibility of job development by counselors, and the availability of simpler informal alternatives to legitimate, on-the-books employment. The conundrum created by these multiple forces merits serious attention from policy-makers.

Study Limitations

1. A design weakness in this study is that results favoring the CES over standard vocational counseling could reflect counselor skill or personality rather than model superiority. This issue may be partially addressed when sample sizes permit separate analyses for each site, because a necessary, though not sufficient, condition for accepting a model-based interpretation will be replication of CES superiority at both sites. Still, such probabilistic evidence cannot eliminate the existence of a design flaw.

2. The research design is also vulnerable to the possibility that the results are historically or geographically specific. Nonetheless, the deterioration of New York City’s labor market throughout the study, and the resulting problems posed for a vocational program attempting to place patients in competitive jobs, suggest that any historical/geographical bias is likely to be conservative.

3. Since two study locations required separate staffing, the study could not arrange for two CES counselors to work as a team, a staffing arrangement found valuable in the supported
employment models developed for the seriously mentally ill (Drake et al., in press).

4. This preliminary report leaves several questions unanswered, especially the efficacy of the intervention when extended beyond 6 months. In addition, it does not consider possible nonvocational outcome measures—for example, level of substance use, psychological status, quality of relationships with family, friends, and significant others; nor does it assess the cost-effectiveness of the CES model that requires smaller caseloads than standard vocational counseling. Future articles from the continuing clinical trial will address these additional issues.

GLOSSARY

*Competitive employment*: On-the-books jobs in the open “legitimate” employment market.

*Informal employment*: Off-the-books jobs in what is sometimes termed the “underground economy.”

*Constructive activities*: Activities that are economically, socially, or personally productive, but for which the person is not paid (e.g., job training, volunteer work).

*Fieldwork*: Activities in which the counselor and client participate together in the community rather than in the counselor’s office.

*Methadone treatment*: A treatment for chronic opioid misusers that relies on methadone as opioid replacement, usually supplemented by counseling and other supportive services.

*Vocational rehabilitation*: Any service designed to prepare individuals for employment and/or to assist them in securing employment.

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REFERENCES


