Substance Abuse and Mental Health Services Administration

Center for Substance Abuse Treatment

Integrating Substance Abuse Treatment and Vocational Services

Treatment Improvement Protocol (TIP) Series

38

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment

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What Is a TIP?

Treatment Improvement Protocols (TIPs) are developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services (HHS). Each TIP involves the development of topic-specific best-practice guidelines for the prevention and treatment of substance use and mental disorders. TIPs draw on the experience and knowledge of clinical, research, and administrative experts of various forms of treatment and prevention. TIPs are distributed to facilities and individuals across the country. Published TIPs can be accessed via the Internet at http://store.samhsa.gov.

Although each consensus-based TIP strives to include an evidence base for the practices it recommends, SAMHSA recognizes that behavioral health is continually evolving, and research frequently lags behind the innovations pioneered in the field. A major goal of each TIP is to convey "front-line" information quickly but responsibly. If research supports a particular approach, citations are provided.

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Foreword

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

The Treatment Improvement Protocol (TIP) series fulfills SAMHSA's mission to reduce the impact of substance abuse and mental illness on America's communities by providing evidence-based and best practices guidance to clinicians, program administrators, and payers. TIPs are the result of careful consideration of all relevant clinical and health services research findings, demonstration experience, and implementation requirements. A panel of non-Federal clinical researchers, clinicians, program administrators, and patient advocates debates and discusses their particular area of expertise until they reach a consensus on best practices. This panel's work is then reviewed and critiqued by field reviewers.

The talent, dedication, and hard work that TIPs panelists and reviewers bring to this highly participatory process have helped bridge the gap between the promise of research and the needs of practicing clinicians and administrators to serve, in the most scientifically sound and effective ways, people in need of behavioral health services. We are grateful to all who have joined with us to contribute to advances in the behavioral health field.

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Executive Summary and Recommendations

Employment has been positively correlated with retention in treatment. By holding a job, a client establishes a legal source of income, structured use of time, and improved self-esteem, which in turn may reduce substance use and criminal activity. Years of research show that the best predictors of successful substance abuse treatment are

Gainful employment
Adequate family support
Lack of coexisting mental illness

Unemployment and substance abuse may be intertwined long before an individual seeks treatment. Although the average educational level of individuals with substance abuse disorders is comparable to that of the general U.S. population, people who use substances are far more likely to be unemployed or underemployed than people who do not use substances. According to the U.S. Census Bureau, employment rates for the non–substance-using population ranged from 72.3 percent in 1980 to 76.8 percent in 1991. However, employment rates of the population with substance abuse problems before admission or at admission to treatment have remained at relatively stable, low levels since 1970, ranging from 15 to 30 percent. Most of the research on the employment rates of persons with substance abuse disorders has focused on opiate-dependent persons (usually heroin), and employment rates for other substance users may vary. The data clearly indicate the need for interventions to improve employment rates among this population in treatment and recovery.

Two major reform efforts have affected the substance abuse treatment field: health care reform and welfare reform. Both of these reforms highlight the role of vocational training and employment services in substance abuse treatment. Under the cost-saving initiatives of health care reform (i.e., managed care), treatment providers face demands to reduce length of care and still produce cost-effective, positive outcomes. Treatment providers must also attempt to match a client's individual needs to an appropriate level of care. Recent welfare reform efforts, which limit benefits and impose strict work requirements, stress vocational rehabilitation for people with substance abuse disorders in an effort to move clients off welfare and into work.

Treatment providers will need to learn how to operate under the imperatives of these two major reform efforts. Because of their increasing emphasis on efficacy and outcomes, welfare and health care reforms promise to enhance the availability and provision of not only substance abuse treatment services but also necessary supporting services, including vocational rehabilitation. Substance abuse treatment that is cost-effective and shows verifiable positive

outcomes is the ultimate goal. However, this goal cannot be achieved unless all the client's service needs are met, and this will occur only through the integration of treatment and wraparound services, including vocational counseling and employment services. Vocational counseling is an effective way to refocus substance users toward the world of work. Employment subsequently serves as a means of (re)socialization and integration into the non–substance-using world.

This Treatment Improvement Protocol is intended for providers of substance abuse treatment services. However, it can also be of use to vocational rehabilitation (VR) staff, social service workers, and all who are involved in arranging for and providing vocational and substance abuse treatment services. The TIP introduces vocational issues and concepts and describes how these can be incorporated into substance abuse treatment. While the alcohol and drug counselor is not expected to achieve complete mastery of vocational counseling, she should acquire at least rudimentary skills in providing vocational services and be able to recognize when her client should be referred to a VR counselor.

The Consensus Panel for this TIP drew on its considerable experience in both the vocational rehabilitation and substance abuse treatment fields. Panel members included representatives from all aspects of vocational rehabilitation and substance abuse treatment: VR specialists, alcohol and drug counselors, academicians, State government representatives, and legal counsel.

The TIP is organized into eight chapters. Chapter 1 provides an overview of the need for vocational services and discusses how employment and substance abuse treatment are interconnected. Challenges to employing clients in substance abuse treatment and strategies for promoting employment are discussed. The chapter also contains an overview of Federal and State legislative reforms and trends that have a deep impact on substance abuse treatment and the need for integrating employment services into substance abuse treatment.

Chapter 2 introduces the elements of vocational programming, such as screening and assessment tools, vocational counseling, prevocational services, training and education, and employment services. The roles of the VR counselor and vocational evaluator are discussed. A section on resources provides an overview of the vocational resources that are available for substance abuse treatment clients.

Chapter 3 focuses on the clinical issues related to integrating vocational services into substance abuse treatment. This chapter helps the alcohol and drug counselor incorporate vocational components into a treatment plan for the client and actively involve the client in his rehabilitation by assessing strengths and interests, setting goals, and finding and maintaining employment. The chapter also discusses legal and social challenges to securing employment. Three case studies are presented to illustrate the concepts discussed in the chapter.

Chapter 4 provides information about integrating onsite vocational services into substance abuse treatment programs. The main premise is that the substance abuse treatment program should not operate alone but should be part of a collaboration of agencies that provide various services to clients. Information is provided about models, staff development and training, integrating services, and, depending on the type of program (e.g., high-structure program, low-structure program), outcomes assessment, and uniform data collection.

Chapter 5 discusses setting up a referral system among agencies. Counselors are introduced to the authentically connected referral network, which is an integrated system where agencies function as equal partners to best serve the various needs of their clients. In

an authentically connected network, a holistic view of the client is adopted. Barriers to collaboration, finding potential collaborators, the elements of effective referrals, and building an authentically connected network are discussed.

Chapter 6 offers guidance to administrators who are navigating in the new, unfamiliar funding environment created by recent Federal and State reforms. Funding strategies and sources are provided, and the steps for adapting to the new funding and policy climate are reviewed. Future considerations regarding Single State Agencies, flexible funding mechanisms, accountability and resource redirection, and the role of the Federal government are also discussed.

Chapter 7 provides an overview of legal and ethical issues for alcohol and drug counselors who are providing vocational services directly or through referral. Part I discusses discrimination, Part II discusses welfare reform, and Part III covers confidentiality issues.

Chapter 8 presents information on the impact of increased law enforcement activity on clients with substance abuse disorders. The chapter provides some specific strategies to help clients who are making the transition from incarceration to the community find needed employment.

The TIP also contains several appendices, including source information for various screening tools, Web sites, and other useful resources; a version of the Addiction Severity Index; a list of State employment agency addresses and Web sites; Federal and State funding sources; and a sample copy of an Individualized Written Rehabilitation Program.

Throughout this TIP, the term "substance abuse" has been used in a general sense to cover both substance abuse disorders and substance dependence disorders (as defined by the *Diagnostic and Statistical Manual of Mental Disorders,* 4th ed. [DSM-IV] [American Psychiatric Association, 1994]). Because the term "substance abuse" is commonly used by substance abuse treatment professionals to describe any excessive use of addictive substances, it will be used to denote both substance dependence and substance abuse. The term does relate to the use of alcohol as well as other substances of abuse. Readers should attend to the context in which the term occurs in order to determine what possible range of meanings it covers; in most cases, however, the term will refer to all varieties of substance use disorders as described by the DSM-IV.

The recommendations that follow are grouped by chapter. Recommendations that are supported by research literature or legislation are followed by (1); clinically based recommendations are marked (2). To avoid sexism and awkward sentence construction, the TIP alternates between "he" and "she" in generic examples.

Recommendations

The Need for Vocational Services

- Vocational services should be an integral component of all substance abuse treatment programs. (2)
- If work is to be sustained and enduring lifestyle changes made, the vocational services provided to clients must focus on pathways into careers, on job satisfaction, and on overcoming a variety of barriers to employment, as well as on the needed skills for maintaining employment. (2)
- A number of changes that are affecting today's workforce must be taken into account when delivering vocational services to substance abuse treatment clients. Because the world of work is dynamic and job obsolescence is a well-documented phenomenon, vocational services must reflect these changes. (1)
- There are several laws in the area of welfare reform with which alcohol and drug

counselors should be familiar. These laws must be monitored closely because they signal time periods when financial support will be terminated for clients. These laws are as follows: (1)

- The Personal Responsibility and Work Opportunity Reconciliation Act of 1996
- The Contract With America Advancement Act
- The Adoption and Safe Families Act of 1997
- The Workforce Investment Act of 1998
- The Americans With Disabilities Act

- In response to welfare reform efforts, substance abuse treatment programs should address the vocational needs of women and offer them a full range of vocational services. (1)

Vocational Programming And Resources

- Initial vocational screening can be done by an alcohol and drug counselor, and more in-depth assessment should be conducted by a VR counselor or vocational evaluator. (1)
- The vocational component of the treatment plan is a dynamic process and should be periodically evaluated to determine whether the stated goals are still viable and appropriate, further assessment is needed, or any adjustments in the plan are required. All professionals involved in the client's treatment plan should maintain a close working relationship and a dialog about the client's progress so that appropriate adjustments to the client's treatment plan can be made. (1)
- Screening allows the counselor to determine the kinds of vocational services the client may need and to develop an appropriate vocational component to the treatment plan. Screening should enable the alcohol and drug counselor to accomplish the following (although not to the degree of detail that would be provided through a followup assessment or counseling by a vocational specialist): (1)
  - Identify the client's major employment-related experience, as well as her associated capacities and limitations
  - Determine what referrals will help the client attain successful employment (if needed)
  - Identify the necessary resources to make employment feasible for the client (e.g., transportation, day care)
  - Determine whether further assessment is needed to develop the vocational component of the treatment plan
- The functional assessment should be performed by professionals well versed in how an individual's skills and interests lead to successful vocational outcomes. Normally the VR counselor or vocational evaluator fits this description; however, the alcohol and drug counselor often has vital information about a client's level of functioning. In complex cases, functional assessment can be accomplished with input from a multidisciplinary team. (1)
- The next step after assessment is to counsel clients about setting vocational goals and creating short- and long-term plans for achieving those goals. To develop a plan with a client, factors to consider include the results of assessments, employment opportunities in the local area, existing training resources in the client's area of interest, the feasibility of alternative goals when full-time employment is not an option, and client empowerment to make the necessary decisions. (2)
- For referral purposes, it is important for the clinician to be familiar with the local vocational resources available to clients. (1) Before referring clients to State VR agencies, the alcohol and drug counselor should first

develop a relationship with the assigned VR office. (2)

Clinical Issues Related to Integrating Vocational Services

- To help clients attain work-related goals that will also support their recovery, the alcohol and drug counselor should consider the cultural, sociopolitical, physical, economic, psychological, and spiritual circumstances of each client. This is known as the "biopsychosocial–spiritual" model of treatment. (1)
- To successfully incorporate vocational services into substance abuse treatment, the alcohol and drug counselor must first acknowledge that vocational training, rehabilitation, and employment are important areas of concern for clients. (2)
- Clinicians can best address vocational issues by considering their relevance at every stage in the client's treatment, including their incorporation into individualized treatment plans. Preliminary information on vocational needs should be collected and assessed at intake. (2)
- The Consensus Panel believes, based on its collective experience, that three key elements are essential to effectively address the vocational needs of clients in the recovery process. They suggest that clinicians: (2)
  - Use screening and assessment tools, specifically for vocational needs, when appropriate.
  - Develop and integrate a vocational component into the treatment plan.
  - Counsel clients to address their vocational goals and employment needs.
- Clinicians often play a mediating role between clients and employers and should take advantage of opportunities to educate the employer on substance abuse issues and how to address them in appropriate policies. (2)
- In defining the client's educational needs and exploring resources available to meet them, it is important to recognize that the client's past experience with the educational system may strongly influence work-related decisionmaking. (2)
- Clinicians should receive basic information about clients' medical and psychological condition at intake, since certain medical and psychological limitations may affect the type of employment for which they are best suited. (2)
- Clinicians should be alert to clinical and legal issues surrounding clients' past histories and recognize their implications for employment. (2)
- The counselor should be alert for the presence of relapse triggers that have affected the client in the past and help the client recognize and cope with them. The treatment plan should provide for effective management of all relapse triggers that are relevant to the individual. (2)
- To achieve therapeutic goals in the domain of employment, the clinician should develop a treatment plan that addresses the client's vocational training, rehabilitation, and employment needs. (2)

Integrating Onsite Vocational Services

- Employment and vocational services should be a priority in substance abuse treatment programs, and employment should be addressed as a goal in treatment plans. The Consensus Panel recommends that if possible, a substance abuse treatment program should add at least one VR counselor to its staff. Should the size of the program or other fiscal shortcomings prevent this, arrangements should be made to have a VR counselor easily accessible to the program. (2)

- Every treatment program should consider itself part of a collaborative interagency effort to help clients achieve productive work. (2)
- The treatment program must determine the parameters of what it can offer clients in terms of vocational services. (2)
- Programs must ensure that staff members have a thorough knowledge of the diverse populations represented in their treatment program and the particular challenges that different groups face in securing and maintaining work. It is also important to understand various cultural attitudes toward work. (2)
- Counselors should evaluate their clients' personal plans for change to determine whether the vocational goals they set are realistic (not too high or too low) and whether achieving the goals will allow them to make a sufficient living and support continued recovery. (2)
- Each substance abuse treatment program must define successful outcomes appropriate to the population it serves and ensure that funders understand the importance of these outcomes and the services necessary to achieve them. (2)

Effective Referrals and Collaborations

- Collaboration is crucial for preventing clients from "falling through the cracks" among independent and autonomous agencies providing disparate and fragmented services. Effective collaboration is also the key to seeing the client in the broadest possible context, beyond the boundaries of the substance abuse treatment agency and provider. (2)
- Programs must reflect the fact that it is not feasible or effective to provide everything that clients need "under one roof." A more fruitful approach is to collaborate with other agencies on the basis of client needs and overlapping client caseloads. (2)
- All collaborators, including those providing treatment for substance abuse, should be aware that their efforts are likely to be ineffective unless all the client's life areas are addressed. To that end, each agency must recognize the existence, roles, and importance of the other agencies in achieving their goals. (2)
- Building an integrated service model based on community partners must begin from the client's base, taking into account his values and building on the strengths of his culture to create referrals that are appropriate and effective for his particular needs. (2)

Funding and Policy Issues

- To maintain financial solvency in this new era of policy and funding shifts, alcohol and drug treatment agencies must forgo their traditional independence and focus on building collaborative partnerships to meet their clients' needs. (2)
- A requirement for system competency (specifically, an understanding of funding sources and strategies) should be incorporated into Certified Addiction Counselor training and certification. (2)
- Policymakers at the Federal and State levels should work together to create financial incentives for collaboration between substance abuse treatment providers and agencies that provide other services to an overlapping population. (2)

Legal Issues

- Alcohol and drug counselors providing VR services directly or through referral should be aware of legal and ethical issues in three areas: discrimination against recovering individuals, welfare reform, and confidentiality. (2)

- Counselors should be familiar with the Workforce Investment Act of 1998, which Congress passed to improve the workforce, reduce welfare dependency, and increase the employment and earnings of its participants. A major emphasis of this law is its "work first" approach, which strongly encourages the unemployed to find work before requesting training. (2)
- Counselors should be familiar with the Drug-Free Workplace Act and how it may affect their clients in recovery from substance abuse disorders. Counselors should help their clients prepare for interviews and help them deal with any employment discrimination issues that may arise. (2)
- Counselors should be familiar with confidentiality and disclosure issues and how these issues affect working with other agencies that are providing services to the client. (2)

Working With the Ex-Offender

- Substance abuse treatment programs that engage ex-offenders should offer clients respect, hope, positive incentives, clear information, consistency, and compassion. Counselors need to provide these clients with an understanding of a career ladder that they will be able to climb and help them to see how skills and talents that have served them in the past can help them succeed in legitimate occupations as well. (2)
- Programs can encourage and assist clients to acquire a General Equivalency Diploma (GED) by locating the GED classes in the treatment site. (2)
- VR staff should be invited to spend some time at the substance abuse treatment program site. In this way, clients will regard VR staff as part of the "treatment family." (2)
- Treatment programs can incorporate job and skills training by providing clients with opportunities to perform jobs at the treatment site. (2)
- Programs should provide clients with guidance on budgeting. Many ex-offenders have not learned how to budget money. (2)
- Counselors should assist clients who are ex-offenders in following through on referrals and assembling necessary documents, such as social security cards and school transcripts. (2)
- Programs can match clients to mentors/peers who will assist clients with all components of the vocational training or job placement tracks. (2)
- For female clients in particular, programs should include education in parenting skills and skills in finding child care. (2)
- Once released from incarceration, women with substance abuse disorders should go immediately to substance abuse treatment centers. Ideally, the treatment program would form a linkage to the prison so that counselors have the opportunity to "reach in" to women while they are still incarcerated. (2)
- Counselors should assess safety issues before women return to potentially violent environments, and a safety plan should be developed and implemented. (2)
- To increase retention of female clients, it is important to find or develop a gender-sensitive program that offers a continuum of care, including aftercare. (2)
- Counselors should help clients who are ex-offenders to focus their job search on occupations and employers who do not bar ex-offenders, develop realistic goals, clean up official criminal histories ("rap sheets"), know when to disclose information about a criminal record, and learn to see their employment situation from the perspective of potential employers. These clients need to prepare and practice a statement that

acknowledges a substance abuse and criminal history and offers evidence of rehabilitation, a statement explaining their interest, a statement about positive aspects of their backgrounds, and a method of responding to illegal questions such as "Have you ever been arrested?" (2)

- Treatment programs can assist clients who are ex-offenders by educating employers about the benefits of hiring such clients, educating clients about the work environments they can expect to encounter, and helping clients assess whether a potential job will provide a supportive environment for recovery from a substance abuse disorder. (2)

1 The Need for Vocational Services

Work as a productive activity seems to meet a basic human need to be a contributing part of a group. It is critical that the meaning of work be understood in the context of each individual's personal values, beliefs, and abilities; cultural identity; psychological characteristics; and other sociopolitical realities and challenges. But what is work exactly? This appears to be an obvious question, but the nature of work is a multifaceted concept. The most basic definition of work is that it is a purposeful activity that produces something of economic or social value such as goods, services, or some other product. The nature of work is varied and may include physical activities (e.g., laying bricks), mental activities (e.g., designing a house), or a combination of physical and mental activities (e.g., building a house). High- or low-paid, hard or easy, work is effort toward a specific end or finished product.

Many individuals in this country, however, are not in the workforce and do not hold regular jobs, including a large percentage of persons who have substance abuse disorders. Employment traditionally has not been a focus—or a stated goal—of treatment for substance abuse. The standard approach has been to take care of clients' addiction problems, and in doing so issues such as employment would take care of themselves because of clients' increased self-esteem and desire to succeed. Even in instances where employment has been a stated goal of substance abuse treatment, the vocational services to support such a goal have not been readily available for all clients.

Recent reforms in the public welfare system and other benefit programs stress even more the importance of work and self-sufficiency. Because substance abuse disorders can be a barrier to employment, it is imperative that vocational services be incorporated into substance abuse treatment. This is particularly important because these treatment programs must be ready to serve the many welfare recipients with serious alcohol- and substance-related problems who must find and maintain employment within a very short timeframe.

This TIP was developed to assist alcohol and drug counselors with the daunting task of addressing the vocational and employment needs of their clients, especially in light of legislative and policy changes. While the alcohol and drug counselor may not be able to achieve complete mastery of multiple disciplines, she must acquire at least rudimentary skills in the area of vocational services provision, as well as be prepared to function as a case manager who advocates for the needs of the client and calls on other expert professionals as needed to provide the services that support the treatment process.

This chapter discusses the rationale for integrating vocational services with substance

abuse treatment, given that work is necessary for the physical and emotional recovery of clients with substance abuse disorders. Chapter 2 describes vocational programs and resources and the role of the vocational rehabilitation (VR) counselor. Chapter 3 discusses the clinical issues related to integrating vocational services with substance abuse treatment services, and Chapter 4 continues that theme by describing how to incorporate onsite vocational services in substance abuse treatment programs. Chapter 5 discusses strategies for developing referral networks, and Chapter 6 provides information about seeking funding for these services. Legal issues and available resources are discussed in Chapter 7. Chapter 8 describes how to help clients in the criminal justice system address vocational issues.

After reading this TIP, alcohol and drug counselors should have a better understanding of the importance that the world of work has for helping clients recover from abusing substances and how to tap into the wealth of resources available to help their clients gain entry into this critical aspect of human society.

Employment as a Goal

Unemployment and substance abuse disorders may be intertwined long before an individual seeks treatment. The 1997 National Household Survey on Drug Abuse revealed that 13.8 percent of unemployed adults over age 18 were current substance users, compared with only 6.5 percent of full-time employed adults (Substance Abuse and Mental Health Services Administration, 1998). The unemployment rates of people with substance abuse disorders are much greater than those of the general population, even though the mean educational levels of the two groups are comparable (Platt, 1995).

A related finding from numerous research studies is that employment before or during substance abuse treatment predicts both longer retention in treatment and the likelihood of a successful outcome (Platt, 1995). A study of employment outcomes for indigent clients in substance abuse treatment programs in the State of Washington concluded that of the factors measured in this research to determine who was likely to be successful following treatment, pretreatment employment accounted for 50 percent of the reasons why they were successful. Client characteristics explained about 33 percent of the reasons, and treatment factors accounted for only 12 to 18 percent of differences in employment outcomes (Wickizer et al., 1997). Although employed clients who have a strong work history usually respond well to substance abuse treatment, other variables that measure functioning and stability can also influence treatment success, such as education and a positive marital relationship.

Employment also helps moderate the occurrence and severity of relapse to addiction (Platt, 1995; Wolkstein and Spiller, 1998). In addition, employment can offer the opportunity for clients to develop new social skills and make new, sober friends who can help clients maintain sobriety.

Another important impact of employment on clients is the development of positive parental role models for their children. Metzger found a correlation between parental employment during the childhoods of both African American and White methadone clients and these clients' subsequent work histories (Metzger, 1987). Work breaks the intergenerational patterns of unemployment and dependency on social services.

Clients have often indicated a desire for vocational services, although they seldom have received sufficient assistance to meet their needs or expectations (Center for Substance Abuse Treatment [CSAT], 1997; French et al., 1992; Harwood et al., 1981; Platt, 1995). However, clients who are interested in training and

employment services may have unrealistic goals and expectations about the kind of work they are qualified to do. Therefore, clients should be referred to educational programs where they can acquire the education or training they need to meet their employment goals. In an ongoing effort to develop model training and employment programs (TEPs) for treatment facilities in Connecticut, a 4 site survey of 337 clients found that 88 percent were actively interested in vocational services leading to full-time jobs paying $8 to $10 per hour. When asked what they hoped to do, however, 34 percent of these clients said they wanted a technical or professional occupation, and another 21 percent wanted a craft or skilled labor position. However, these were not realistic expectations for the skill levels possessed by these individuals (French et al., 1992).

Challenges to Employing Clients in Treatment

Unemployed clients in substance abuse treatment programs face many challenges and obstacles in obtaining and keeping jobs. Employed clients may need help finding more satisfying work or identifying and resolving stresses in the work environment that may exacerbate ongoing substance abuse or precipitate a relapse. The barriers clients face may exist within themselves, in interpersonal relations with others, or in coexisting medical and psychological conditions. Barriers also stem from society, scarcity of lower level jobs, and prejudice against employing people with substance abuse disorders. Comprehensive and individualized substance abuse treatment can help overcome existing barriers to employment but is often not sufficient by itself. Vocational services can help clients obtain marketable skills, find jobs, develop interviewing skills, and acquire attitudes and behaviors necessary for work, such as punctuality, regular attendance, appropriate dress, and responsiveness to supervision (Wolkstein and Spiller, 1998). Alcohol and drug counselors can help clients address work-related issues, even when VR counselors are not available. For example, a methadone or outpatient program where clients are required to report several times during the week presents a setting to help clients develop punctuality, regular attendance, and appropriate dress and behavior skills that could later be transferred to the work place.

Figure 1-1 presents common challenges faced by substance abuse treatment clients who are seeking work. These have been cited by Consensus Panel members and a many investigators and specialists in the area of vocational services. Employability appears to be inversely proportional to the number of coexisting disabilities and social disadvantages faced by each client (Platt, 1995; Wolkstein and Spiller, 1998).

Different investigators identified various hierarchies and combinations of obstacles that seem critical in predicting employability. The priority of barrier will vary by individual and the specific situation. In a review of the research, Platt notes that special disadvantages such as culturally distinct population status, physical disability, criminal record, mental instability, and a lack of a high school education or equivalency all decrease the likelihood of employment (Platt, 1995). The Urban Institute found a similar set of barriers to employment for welfare recipients, including substance abuse, physical disabilities, mental health problems, children's health or behavioral problems, housing instability, learning disabilities, and, most important, low basic skills (e.g., literacy, job skills, life skills) (Olson and Pavetti, 1996). A risk index for welfare recipients reaching State-defined and Federal time limits (60 months) without employment cites some female-specific, but similar, disadvantages.

Figure 1-1
Challenges to Employment

Client Obstacles

Personal

- Substance use (substances used, history and pattern of use, relapse, associated problems)
- Mental or physical disabilities (psychiatric comorbidity, physical or medical condition, neuropsychiatric disability, cognitive disabilities, HIV/AIDS)
- Deficits in education and skills (education level, learning disability, literacy, language, computer knowledge, obsolete or low-level job skills, little or no work experience)
- At-risk history (developmental, familial employment, employment, criminal, loss of parental rights)
- Unrealistic expectations and attitudes (toward job demands, work habits, authority, capability for self-sufficiency, personal competencies, change, failure, impulse control, delayed gratification)
- Inadequate income (for clothing, food, transportation, housing, child care, job-related equipment)
- Work disincentives (from welfare-based income, illicit activities, relatives)
- Discontinuation of health benefits
- Crisis lifestyle (illnesses, children's illnesses, violent community, numerous family tragedies and deaths, children's school problems)
- Learned helplessness or dependence taught to clients over the years
- "First things first" approach where the client is conflicted about seeking employment and instead encouraged to focus exclusively on sobriety (often this approach is used by 12-Step programs)

Attitudes

- Negative attitudes toward vocational rehabilitation
- Negative attitudes toward disability

Interpersonal

- History of violence or abuse (e.g., domestic, physical, sexual, and psychological abuse; criminal activity)
- Competing family responsibilities (e.g., child or elder care, disabled family members or relatives)
- Inadequate social supports (e.g., spousal, familial, peer group, community, institutional)
- Lack of positive modeling (e.g., peer group, familial/parental, societal)

Substance Abuse Treatment Program-Level Obstacles

Staffing

- No onsite VR counselor
- No staff knowledge about or use of available employment and vocational services
- No staff training in delivery of vocational services
- Lack of understanding about vocational issues

Client–Counselor Interactions

- Poor therapeutic relationship
- Discrepant expectations with respect to vocational goals and needed services
- Agency and counselor attitude about addressing substance abuse disorder before any other issues (e.g., vocational services)

Figure 1-1 (continued)
Challenges to Employment

Resources

- Inadequate funding for vocational services for clients, staffing, or staff training
- Inadequate networking with other service providers
- Fiscal disincentives brought about by clients' loss of Medicaid or other public assistance as a source of payment for treatment services

Policies

- Lack of commitment to vocational services
- Vocational services not integrated into substance abuse treatment
- Inflexible treatment schedules (e.g., not open on weekends or after 5 p.m. during the week)
- Lack of commitment to individualized planning and treatment

Structural Barriers

Employers and Businesses

- Biases against hiring persons in substance abuse treatment, with criminal records, on welfare, of particular gender, with disabilities (coexisting), of a certain ethnicity, or with co-occurring mental disorders
- Unfavorable work environment (see biases above)
- Inadequate on-the-job-training
- Inadequate pay scales, promotion policies, or benefit packages
- Lack of supportive services and information
- State-required caregiver background checks and inability to work in various jobs because of background regardless of employer's willingness to hire

Welfare to Work

- Unrealistic expectation regarding client's ability to work now without adequate time to resolve basic problems

Local Labor Market

- Few entry-level jobs at sufficient pay that offer the prospect of advancement and benefits
- Difficulties in matching clients to available jobs
- Lack of, or exclusion from, union membership
- Jobs located too far away for reasonable transportation time

Local Services

- Limited personal or public transportation
- Insufficient safe, affordable housing
- Inadequate regional or local resources (e.g., day care, schools, accessible medical care, libraries)

Local Employment Programs and Vocational Services

- Inadequate or out-of-date programs for current labor market needs
- Unsuitable programs and services (e.g., for clients in substance abuse treatment, women)
- Insufficient funding for long-term training

Figure 1-1 (continued)
Challenges to Employment

- No focus on job retention problems
- Premature job placement when client is not ready
- Waiting lists or other delays in obtaining services
- Insufficient attention to short-term training to accommodate welfare reform mandates
- Insufficient coordination between service systems to identify mutual goals, needed collaborative approaches, and means to eliminate structural programmatic behaviors

Funding

- Work is not a goal for managed care or other insurance and therefore is not funded

Sources: French et al., 1992; Platt, 1995; Wolkstein and Spiller, 1998; Woolis, 1998.

These disadvantages include being under age 22 when receiving first welfare check, never being married, not having a high school diploma, having little or no work experience, and having a child under the age of 3 (Duncan et al., 1997).

An important distinction to make is that clients may face different obstacles in acquiring or improving marketable skills, securing jobs, and maintaining employment. For example, a client may have difficulty securing a job if he has poor interviewing and job-seeking skills, no clear vocational goals, and a distorted perception of his skills, the job requirements, and the compatibility between these. Once on the job, he may encounter difficulties with supervisors and coworkers if he cannot accept criticism or direction, has poor work habits, fails to report problems, or is frequently late or absent from work without an adequate reason (Schottenfeld et al., 1992). Counseling and vocational services must be tailored to each individual and to his stage of employment or job readiness.

Further distinctions may be made between limitations to employment that are temporary and those that are chronic, and between those that can be resolved and those that cannot be changed. Some substance users, for example, have transitory memory or psychological problems (e.g., depression, anxiety, panic disorders) that improve spontaneously as recovery progresses or with specific medication. On the other hand, cognitive functioning may be permanently damaged as a consequence of long-term and excessive alcohol use or as a result of traumatic brain injury from a motor vehicle accident, or it may not ever have been within normal range as a result of birth trauma or other unknown causes. Some skill deficiencies may be resolved with additional training or education if the client is willing and capable of pursuing these remedies. All of these factors must be considered in deciding what remedies can be applied, by whom they can be applied, and with what likelihood of success they can be applied using the resources available (Wolkstein and Spiller, 1998).

Vocational Issues

Vocational Needs

Persons with histories of substance abuse will have varying vocational histories, ranging from being chronically or permanently unemployed to being continuously employed. It is important to note that the severity of the client's substance abuse does not necessarily correspond to substance-use–related problems, employment status, or the need for vocational services. For example, the chief executive officer of a large corporation may have serious alcohol use

problems that may not yet be directly affecting his job performance.

Substance users may be classified into a range of categories according to their functional limitations and related needs for vocational and other types of rehabilitative services (Wolkstein and Bausch, 1998; Wolkstein and Spiller, 1998). Clients with a strong work history require different forms of vocational services than those who have never worked and have a lifetime history of substance abuse and dependency.

Figure 1-2 provides strategies for promoting employment for individuals throughout the employment continuum (Nightingale and Holcomb, 1997).

Availability of Vocational Services

Even though vocational and employment services are needed and wanted by clients with substance abuse disorders, help of this type is generally not part of the substance abuse treatment package (Platt, 1995; Schottenfeld et al., 1992). Researchers from the Drug Abuse Treatment Outcome Study (DATOS) reported that there was a widening gap between clients' need for support services beyond substance abuse treatment and the availability of those services (National Institute on Drug Abuse [NIDA], 1997). These services included vocational services. The focus of substance abuse treatment has become more comprehensive in recent years, with some assessment of employment history and vocational functioning typically a part of the intake process (e.g., Addiction Severity Index) and often demanded by managed care and welfare reform. However, the provision of vocational services by substance abuse treatment programs still should be expanded.

Some of the major reasons for the lack of vocational services in treatment programs include the current emphasis on briefer forms of treatment (usually outpatient) that satisfy cost-efficiency concerns, the very short time many clients actually spend in treatment, and a treatment philosophy that is not vocationally driven. Although the effectiveness of treatment depends on meeting clients' multiple medical and social needs related to substance use, many programs have cut back on the services they offer. In a survey of 481 outpatient substance abuse treatment units, researchers found significant decreases between 1988 and 1990 in all services examined—physical, medical, and mental health care; special treatment for multiple substance use; and employment, financial, and legal counseling (D'Aunno and Vaughn, 1995). Of 24 methadone maintenance treatment programs surveyed in 1990 by the General Accounting Office, only four had onsite vocational services, and the clients were not required to use them (French et al., 1992). A similar comparison of resources available to clients in community-based treatment in the Treatment Outcomes Prospective Study (TOPS) and in DATOS (Ethridge et al., 1995) found a marked decrease over a decade in both the number and variety of services provided. The study participants reported that substance abuse counseling alone did not address their wide-ranging service needs.

Effectiveness of Vocational Services For Substance Abuse Clients

While research has been conducted on the effectiveness of vocational services and on substance abuse treatment, few studies have addressed the effectiveness of vocational services in substance abuse treatment settings. A few large-scale collaborative efforts and more focused client-specific interventions have been mounted over the last 20 years to increase clients' employment levels. These have included supported work demonstrations, job-seeking and placement services, personal competency and skill-building programs, and other vocational supports. Most have exhibited moderate success, but few have been widely

Figure 1-2
Strategies for Promoting Employment

Job Placement Strategies

- Job search assistance, either in a group setting or through one-on-one counseling or coaching, sometimes through "job clubs" with workshops, access to phone banks, and peer support.
- Self-directed job search, where individuals search and apply for jobs on their own. Sometimes individuals must submit a log of their job contacts.
- Job development and placement, where program staff members identify or develop job openings for participants. Counselors refer individuals to openings, often using computerized job banks. In more intensive models, staff members develop relationships with specific firms, gaining knowledge of potential job openings or commitments to hire through the program.

Job Training Strategies

- Classroom occupational training, by training or educational institutions such as community colleges or vocational schools, community-based organizations, or nonprofit or for-profit training centers. Training may include formal postsecondary programs leading to certification or licensing in a particular occupation.
- On-the-job training with public or private sector employers, who usually receive a subsidy to cover a portion of the wages paid during the training period. The employer subsidy may be drawn from welfare or food stamp payments that otherwise would have been paid to the individual recipient.
- Use of a mentor, who provides support to the client within the work setting. A mentor could be someone who went through substance abuse treatment and is now working.

Broad Education Strategies

- Remedial education, such as preparation for the general equivalency diploma (GED), basic skills instruction in reading and mathematics, or English-language classes for persons whose primary language is not English, and computer-skills building.
- Postsecondary degree programs (e.g., associate's or bachelor's degree), generally financed by grants, Federal loans, or scholarships.

Mixed Strategies

- Vocational training plus basic skills, either in the workplace or in instructional centers/classes.
- Supported work experience, with pre-employment preparation, assignment to public jobs, and gradually increasing hours and work responsibility combined with ongoing counseling, education, and peer support.

Source: Nightingale and Holcomb, 1997.

replicated, primarily because of cost factors and ties to federally sponsored job-training activities. Many of these programs did not demonstrate much long-term effect and did not decrease substance use, although the supported work efforts did decrease dependence on public assistance and increase employment (Hall, 1984). The mixed results from these studies are partly attributed to difficulties of research in this area and the lack of a standard methodology. As one researcher noted (Platt, 1995),

- There are different definitions of employment (i.e., point-in-time or period-of-time).
- The followup periods are varied.
- The case mix of the populations studied is not always defined.
- The components of the vocational services offered are not adequately explained.
- It is not clear how well client needs were matched to services offered.
- Study participants were mainly from publicly funded clinics that serve lower socioeconomic groups and did not include the full continuum of individuals with substance abuse disorders.
- In general, the research methodologies used in the large-scale studies were not rigorous. The treatment protocols were vague and changed over time and from site to site, and large dropout rates may have compromised random assignment (Hall, 1984).
- In general, there is a scarcity of research on the vocational services and employment needs of substance-using women, the variables that differentially affect racial and ethnic groups, the effects of parental modeling, the predictors of employability, and the determinants of who cannot benefit from vocational services.

Traditional vocational services emphasize esteem building, adjustment to social conditions, comprehensive assessment, skill building, and basic education. However, today's focus on *work first* and quick employment, which try to prevent clients from being left without financial support when public assistance ends, overlooks these traditional emphases. This strategy helps unemployed, low-skilled clients find work rapidly but does not help these individuals advance into higher paying and more satisfying jobs. Investigators are discovering that a combination of quick-employment strategies (also known as "rapid attachment") and basic education and training produces the best long-term impacts on continuing employment and advancement for low-skilled workers (Hanken, 1998). However, it is the intent of funding sources, such as the Welfare to Work Block Grant, to make available not only job retention support services but also training and other services to help clients advance to higher level employment (see Chapter 6, Funding and Policy Issues, for more information).

Treatment and Employment

A review of the literature on the impact of substance abuse in the workplace concluded that employees who abuse substances are costly to employers. This is because people who abuse substances

- Have twice as many lengthy absences as other employees
- Use more sick days and benefits
- Are tardy three times more frequently
- Are five times more likely to file workers' compensation claims
- Are more likely to be involved in accidents
- Are more inclined to steal property belonging to the employer or other employees
- Work at approximately 75 percent of their productive capability

Another literature review (Comerford, 1999) examined the similarities in the self-efficacy roots of substance abuse disorders and vocational dysfunction, along with the benefit of providing vocational services in conjunction with substance abuse treatment. Based on this review, Comerford recommended using client functionalities and level of care as a guide for vocational services, closely monitoring working clients, and providing long-term counseling to ensure that clients' developmental gains are not lost.

The misuse of psychoactive substances often compromises a person's work performance or in many cases becomes such a preoccupation itself that continued employment is impossible (Wolkstein and Spiller, 1998). A study from the Urban Institute found that welfare recipients who have substance-abuse–related problems are just as likely to work as other recipients (63 percent worked at some point during the current or previous year compared with 58 percent of those without substance use problems), but those with substance-abuse–related problems work less steadily—only 15 percent work full-time and year round compared with 22 percent of all recipients (Strawn, 1997).

Many studies have found that substance abuse treatment does increase employment rates, although the magnitude of the gains varies widely, and the results are mixed. These gains in employment have been reported for heroin addicts in methadone maintenance programs and therapeutic communities, for polysubstance users in outpatient substance-free clinics, for male and female clients in residential programs, for alcohol users in private hospital-based programs, and for White and Hispano/Latino individuals with substance abuse disorders in California. However, no readily identifiable factors are consistently associated with or predictive of these increases in employment (Platt, 1995).

Some of these studies (Pavetti et al., 1997; Young, 1994; Young and Gardner, 1997) have cited improvements in employment rates as great as 60 percent among certain groups as a result of treatment for California residents with substance abuse disorders, and 136 percent among Missouri clients. A study in Ohio found a 60 percent decline in absenteeism among working clients who were in treatment and a 15 percent reduction in the number of clients receiving public assistance (Johnson et al., 1998).

These investigators also noted that substance abuse treatment is not similarly successful for everyone with respect to employment gains. Evidence indicates that substance abuse disorder treatment increases both employment and earnings (Legal Action Center, 1997b; Young, 1994). The National Treatment Improvement Evaluation Study (NTIES) (CSAT, 1997b) reported an 18.7 percent increase in employment of 5,700 study participants in the year after treatment. In Oregon, clients increased weekly earnings from $154 to $278 in the 3 years after treatment; in Minnesota, full-time employment of clients in the public treatment system increased by 18.1 percent in the 6 months after treatment compared with the 6 months before treatment. In these studies, the welfare rolls were reduced (resulting in substantial savings), cost offsets were produced for other health care (e.g., hospitalizations, drug overdoses, detoxification, mental health admissions to psychiatric hospitals, treatment of in utero substance-exposed infants), and substance use also decreased.

Other data from Minnesota, Colorado, Florida, and Missouri reveal increases in employment rates for welfare recipients who completed a substance abuse treatment program. A study in Kansas showed that earnings for clients were 33 times higher after completing treatment, compared with before treatment (Young, 1996). A similar study in Oregon found that clients who completed treatment earned 65 percent more than counterparts who terminated prematurely (Young, 1996).

Substance abuse treatment also improves job-training effectiveness, according to a report issued by the Miami Coalition for a Safe and Drug Free Community (Rector, 1997). Because many participants in Federal job-training and skill-development efforts in this city were found

to be using crack, three Job Training Partnership Act (JPTA) programs added specially developed Training Assistance Programs (TAPs) to their activities from November 1994 to November 1995. All three sites saw increases in effectiveness (i.e., the percentages of adult and youth trainees completing training and their job placement rates) after incorporating TAPs that focused on preventing and reducing crack use.

If work is to be sustained and enduring lifestyle changes made, the vocational services provided must focus on pathways into careers, on job satisfaction, and on overcoming a variety of barriers to employment, as well as on the skills necessary for maintaining employment.

National Trends Affecting Employment

A number of changes affect today's workforce and must be taken into account when delivering vocational services to substance abuse treatment clients. Because the world of work is dynamic and job obsolescence is a well-documented phenomenon, vocational services must reflect these changes. Particularly noteworthy are shifts from a manufacturing to a service economy and advances in communications and other technologies that make computer literacy a valued and necessary skill.

Job growth has occurred in two areas at the opposite ends of the occupational spectrum: high-wage, high-skill technical and professional occupations, and low-wage, low-skill service jobs without many opportunities for advancement (Hanken, 1998). The greatest number of new jobs that have been generated pay $80,000 per year or more—or $15,000 a year or less. Few middle-income jobs have been created in recent years, and this overall wage inequality has been increasing in the United States for both men and women since the mid-1970s. Real wages in terms of buying power have fallen substantially for workers with the fewest skills, education, and experience, whereas those of professionals at the top of the pay scale have skyrocketed. Wages for entry-level jobs are low and declining; moreover, they are likely to decrease further as more unskilled work is conducted in foreign labor markets and as more welfare recipients are required to enter the labor force (Burtless, 1997).

In the U.S. economy, poorly paid, entry-level service work is widely available, although this varies enormously by locale, by skill or specialty area, and by transportation access to jobs (Burtless, 1997). In many places, new immigrants, unskilled and undereducated workers, and ethnic minority groups face daunting challenges. In making vocational decisions, these clients, unless counseled otherwise, may have widely discrepant expectations about what is desired and what is possible. These discrepancies can lead to treatment and job failure, especially if the client underestimates or overestimates his abilities, is not realistic about costs of employment and the challenges of financial independence, and is not prepared for ongoing work and additional training beyond the immediate satisfaction of having a job.

Moreover, in today's work world, few employees can expect to remain with one company for a complete career. Low-wage workers are particularly vulnerable in this new world of work as other publicly funded safety nets weaken. Going back and forth between work and welfare or other subsidies is no longer a long-term option for the chronically underemployed (Hanken, 1998). Lack of financial security can produce anxiety and substance use relapse unless clients are trained to be flexible and assertive in regard to work. Because most workers will change jobs and occupations several times in the course of a career, retraining and adaptability are critical. Work must be seen from the perspective of developing and advancing personal goals.

Vocational counseling and guidance can play a vital role in defining one's career path and making difficult work-related decisions.

Federal and State Reforms

Welfare reform and changes in child welfare laws

The combined effect of the new welfare reform requirements and changes in the child welfare laws greatly pressure parents involved with child protection service agencies to quickly comply with multiple demands for compliance with public system requirements. To avoid losing parental rights to their children, parents may be required to enter substance abuse treatment and achieve sobriety as well as meet other expectations of the child welfare system, all within a limited time period. At the same time, under Temporary Assistance for Needy Families (TANF), welfare authorities may impose work requirements and sanction those who fail to comply.

Those with substance abuse disorders, minimal work experience, and dubious parenting skills may feel overwhelmed by all these demands. Maintaining sobriety, by itself, is a difficult achievement for many. Complying with work requirements and parenting responsibilities at the same time may seem impossible. For some people, the response may be to deny that "the system" has changed. Others may be overcome by a feeling of hopelessness and the inclination to give up. Still other parents will relapse into substance abuse.

As welfare reform and changes in child protection laws are implemented, alcohol and drug counselors will see increasingly stressed parents in need of supportive counseling and services. Providing support while conveying to clients the urgency of their attaining or maintaining sobriety will be the challenge in the years ahead.

There are several laws in this area with which alcohol and drug counselors should be familiar:

- The Personal Responsibility and Work Opportunity Reconciliation Act of 1996
- The Contract With America Advancement Act
- The Adoption and Safe Families Act of 1997
- The Workforce Investment Act of 1998
- The Americans With Disabilities Act

These laws must be monitored closely because they signal time periods when financial support will be terminated for clients and delivery of vocational and employment services will be drastically modified. These changes will heighten the urgency for integration of treatment and vocational services as a means to provide clients with maximum opportunity for full rehabilitation. These laws are discussed in detail in Chapter 7; see also the TIP, *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues* (CSAT, 2000a) for discussion of these laws.

Medicaid and managed care programs

Although Medicaid has not been a major source of funding for substance abuse treatment, many States have negotiated coverage for screening services, inpatient detoxification, intensive outpatient day treatment, and some medical, methadone maintenance, counseling, and therapy services (Strawn, 1997). Most States now require that Medicaid recipients enroll in State-directed managed care programs. However, in many places, moving Medicaid reimbursements to managed care programs has created new obstacles to financing substance abuse treatment.

A primary tenet of managed care is based on "continuum of care" principles in substance abuse treatment. This concept argues that treatment needs change over time, often in a predictable fashion.

Managed care plans typically require the use of a comprehensive program having several levels of care, such as detoxification (inpatient, outpatient, or residential), hospital rehabilitation, nonhospital residential rehabilitation, structured outpatient rehabilitation, and individual or group outpatient rehabilitation (Anderson and Berlant, 1995). Matching the proper intervention with current patient needs should lead to more effective and cost-efficient service delivery.

Although the emphasis on cost efficiency is commendable, there is concern that the emphasis on savings might curtail treatment effectiveness. A focus on improved fiscal outcomes that ignores more satisfactory and enduring client outcomes could be counterproductive (Young and Gardner, 1997). Treatment barriers imposed by managed care programs under Medicaid in some States include refusal to approve appropriate treatment placements, failure to accurately diagnose substance abuse, referral to geographically inaccessible facilities, and retroactive denial of benefits (Legal Action Center, 1996). Providers should remain abreast of changes in Medicaid rules and regulations in order to access such financial reimbursements for their clients.

An existing Medicaid requirement has also complicated reimbursements for residential care for substance users. The Medicaid rules prohibiting reimbursement for residential services provided in a facility with more than 16 beds to anyone between the ages of 22 and 64 years have often discouraged special residential treatment for women and their dependent children.

Populations Most Affected by Legislative Changes

There are numerous concerns regarding the effects of the aforementioned legislative and policy changes on several populations. These populations include women on welfare, their children, noncustodial parents, former Supplemental Security Income (SSI) beneficiaries, and clients in the criminal justice system.

Women on welfare

Women on welfare have been the primary targets of reform efforts (particularly at the Federal level), which reflect changing societal attitudes about the expanded roles of women, their place in the workforce, and their capabilities for self-reliance. The sudden changes and multiple roles that women are expected to assume are a difficult balancing act. Without adequate support, women who are living in poverty with their children find it more difficult to assume full responsibilities as the head of the household and become productive outside the home. Unfortunately, the new emphasis on women does not necessarily consider the many disincentives and loopholes in the work requirements, such as lower wages from work than from welfare, lack of child care, and loss of Medicaid benefits after certain periods of work.

In response to welfare reform efforts, substance abuse treatment programs must address the vocational needs of women and offer them a full range of vocational services. A recent study of an experimental TEP for methadone clients in three facilities in the United States found significant variations in the types of vocational services offered to male and female clients (Karuntzos et al., 1994a). The women in the TEP were less likely to be involved in vocational activities or employed at admission compared with males. These women were also less likely to have received job preparatory services than male counterparts, who received more job support, job development, and job placement services. Although the investigators argued that differences in the vocational services provided reflect gender differences in vocational pressure

and readiness, women who are expected to enter the job market in the near future will need a comprehensive range of vocational services that are delivered intensively, as well as child care. Women on the TANF rolls must be alerted to the law's realities and the urgency to demonstrate work readiness and find employment rather than exhaust temporary benefits.

Indications are that the Welfare Reform Act has apparently stimulated a dramatic 37 percent overall drop in welfare rolls—with decreases in all States (Archer, 1998; U.S. Department of Health and Human Services [HHS], 1994a). Some welfare offices are now functioning as job placement centers. However, a current survey indicates that the numbers on the welfare rolls are declining in part because applicants are being diverted from enrollment by one-time cash payments, requirements to exhaust all assistance from relatives and charitable organizations before getting TANF benefits, and additional stipulations to engage in immediate job search activities and to provide evidence of a predetermined number of job applications as a condition of TANF eligibility. States are also discovering that necessary and appropriate services for hard-to-place welfare recipients are not available and are investing more resources in providing ancillary services, such as transportation to existing jobs and in developing day care for children (National Governors' Association [NGA], 1997).

Children of women on welfare

Children of women on welfare are affected by the requirement that their mothers rapidly enter the workforce, especially if their mothers take low-paying jobs. This is not a minor consideration because children are the largest group on the welfare rolls, representing approximately two-thirds of the recipients. Some mothers will not be able to provide basic necessities of food, shelter, clothing, and adequate day care if these items are costly in the local economy, if relatives are not nearby and cannot help, and if other government or charitable assistance is not forthcoming. These material hardships may increase the incidence of child abuse and neglect (HHS, 1999a). Access to health care also may be jeopardized if employers do not offer adequate insurance protections or if preexisting conditions are not covered. Although eligibility for Medicaid is still available for these children, most States rely on managed care efforts to keep Medicaid costs down, which may restrict available medical services. New funds, however, are now available from the Child Health Insurance Partnership (see Chapter 6) to provide insurance to children who are not eligible for Medicaid and not covered by private insurance.

High-quality child care often is unavailable at a reasonable cost for mothers with low-paying jobs. Employed mothers also have less time to spend with young children, and jobs may require lengthy commuting times, resulting in children's spending up to 12 hours a day or more in day care. As more mothers with infants begin to work, child care arrangements will affect these children's learning environments and responses, for better or worse. While there has not been much research, there is some that indicates that maternal employment does not harm and can help the development, maturation, and cognitive functioning of school-age children (Larner et al., 1997). A lack of adequate supervision, by contrast, could exacerbate behavioral problems in children and contribute to a punitive and dysfunctional family environment. Also, it is important to note that children with a parent or parents with substance abuse disorders are at higher risk of developing these problems themselves.

Noncustodial parents

Noncustodial parents, usually fathers, may need substance abuse treatment and vocational services as they try to become better providers. New policies in the TANF legislation also require that States try to collect child support

from absentee parents who have abandoned their families; this has contributed to an increase in child support payments retrieved by State and Federal government (Office of Child Support Enforcement, 1999). The mechanisms in place to identify fathers and garnish their wages can be punitive but, more important, are ineffective unless these fathers are working and paid enough to meet child support requirements.

Some investigators estimate that working noncustodial fathers could contribute as much as 40 percent of the amount previously received by mothers during the 18 years of Aid to Families With Dependent Children (AFDC) benefits while a child is dependent (Larner et al., 1997). Minnesota, Missouri, and Nevada are already implementing strategies to improve the earnings of noncustodial parents, usually by court-ordered referral of unemployed fathers to vocational and training services and threatened sanctions such as revocation of their drivers' licenses (NGA, 1997). These strategies could also include treatment for those identified as having a substance abuse disorder.

Former SSI beneficiaries

Former SSI beneficiaries who previously qualified for cash benefits because of substance-abuse–related disabilities are no longer eligible for this assistance or for food stamps unless they have another qualifying physical or mental health disability. Hence, comprehensive vocational services integrated into substance abuse treatment will be necessary now more than ever for this population. CSAT currently is funding studies on the impact of this benefit loss on this population.

Criminal justice system clients

Criminal justice system clients with drug-related felony convictions are no longer eligible for TANF benefits or food stamps unless States modify or opt out of this prohibition. This group is another target for vocational services and employment. In addition, clients in treatment as a condition of probation or parole may lose eligibility for TANF, food stamps, SSI, and public housing if they are found to be violating conditions of release during the period they received such funding, or have absconded. The definitions of violation and of duration of ineligibility must be defined, as must the procedures for reporting between welfare offices, treatment programs, and the criminal justice system. However, because a large percentage of substance abuse treatment clients have been criminally adjudicated, this legislation may be another avenue for termination of their financial support.

2 Vocational Programming And Resources

Awareness is growing about the importance of, and in most cases, the necessity of work in the recovery process. Work is central to the existence of adult functioning; in addition to providing the funds needed to live, work supplies status and security for an individual. In most substance abuse treatment models, recovery involves a shift away from substance abuse or dependence behaviors, attitudes, and beliefs to a focus on the establishment of positive life activities and attitudes. Traditionally this involves abstinence, reshaping the personality and cognitions, and developing a strong support network, all aimed at maintaining a recovery process free of relapse. Loss of or failure to adopt a positive vocational identity is a risk-laden situation for most individuals and often leads to depression, poor self-image and self-esteem, and relapse for many.

In addition to the obvious psychological implications of employment, legal and survival implications have emerged for many individuals. Welfare-to-work reforms at the State and national levels now mandate participation in gainful employment for nearly all adults; consequently, most individuals entering recovery must be prepared to seek and obtain employment. This can be a daunting task, both for individuals and substance abuse treatment agencies, many of whom may turn to vocational rehabilitation (VR) services for support and assistance.

This chapter introduces the field of vocational rehabilitation to alcohol and drug counselors and describes the services VR counselors are trained to provide, such as screening and assessment, vocational counseling, referral for training and education, and placement assistance. The chapter lists State and community resources that are useful in placing clients in jobs. In the absence of a VR counselor, the alcohol and drug counselor may have some ideas about what types of resources to use in providing vocational assistance to clients. Chapter 3 discusses issues in vocational rehabilitation from the clinical side.

Vocational Rehabilitation Counseling

Vocational rehabilitation counseling focuses on the process of improving an individual's functioning in primary life areas based on the person's values, interests, and goals. The VR counselor is trained to provide a wide range of vocational, educational, supportive, and followup services (Wolkstein and Spiller, 1998). These services include five essential functions (Schottenfeld et al., 1992):

1. Providing information to clients about the job market, the skills and experience

necessary to obtain and work successfully at a particular job, and the types of stressors and rewards associated with different jobs
2. Assisting the client with developing a realistic view of her skills, abilities, and limitations
3. Teaching the client basic problem solving and coping skills
4. Helping the client to develop or maintain motivation for vocational services and employment
5. Aiding the client in obtaining educational services, skills training, or the necessary entitlements to obtain education and training (case management)

VR counselors are professionals who have earned a master's degree in VR counseling in a rehabilitation counselor training program offered at nearly 100 universities and colleges across the country. They are trained as counselors with specialization in disability and vocational areas, and they work in a wide spectrum of school- or community-based VR programs. The VR field has long recognized the importance of its involvement in the treatment of substance abuse disorders. Consequently, in addition to their core studies, a significant percentage of rehabilitation counselor training programs include specialty studies in substance abuse disorders as an elective sequence in their programs (Benshoff et al., 1990).

Graduates of VR counselor training programs are eligible to become Certified Rehabilitation Counselors (CRCs) through the national certifying body, the Commission on Rehabilitation Counselor Certification (CRCC). The CRCC is the oldest counselor certification program in the United States, and in 1996 the connection between VR counseling and substance abuse disabilities was given more emphasis. In that year, the CRCC created the Master Addiction Counselor (MAC) certification, which is available to those who are already CRCs. As a result, universities often work with substance abuse treatment programs to cross-train with their students. Accredited rehabilitation counseling programs require their students to complete a minimum of 640 hours of supervised fieldwork under the supervision of a CRC. Students seeking a specialization in substance abuse counseling often complete practice and internships in substance abuse treatment settings.

Vocational evaluators are rehabilitation professionals specializing in assessment, vocational evaluation, and work adjustment, including prevocational readiness. Vocational evaluators may become certified as Certified Vocational Evaluators (CVEs), a national certification offered by the Commission on Certification of Work Adjustment and Vocational Evaluation Specialists (CCWAVES). To earn this certification, individuals must demonstrate proficiency in such areas as vocational interviewing, vocational assessment, and individualized vocational evaluation and planning. A bachelor of science degree in rehabilitation is the minimum qualification for a CVE, although many earn a master's degree in vocational evaluation, thus gaining preparation to provide more specialized services. In addition to learning about assessment, these professionals have studied such topics as assistive technology; group and individual counseling; counseling theories; case management; job analysis; types of disabilities; career planning; job placement techniques, testing, and evaluation; and rehabilitation issues related to particular disabilities, including substance abuse disorders.

Figure 2-1 illustrates how one agency combined vocational services with substance abuse treatment services in a residential treatment facility.

Both the Rehabilitation Act of 1973 and its Amendments and the Americans with Disabilities Act (ADA) of 1992 offer protections and eligibility for benefits and services to

Figure 2-1
Vocational Services Provided to a Residential Treatment Facility

The Virginia Department of Rehabilitative Services provides a full-time VR counselor (perceived by residents as a staff member) to support the integration of vocational strategies into residential therapeutic communities. The counselor works closely with the treatment provider, who collaborates in the development of a VR plan. Clients are referred to the counselor for planning and assessment, which include the administration of aptitude tests that often uncover learning disabilities. An array of services, listed below, is then provided based on the client's individual needs.

- Vocational evaluation, including aptitude, skill level, and interest testing
- Research on jobs of interest to clients and help in arranging informational interviews, along with career counseling
- Referral to training and education or apprenticeship programs
- A week-long program in job-seeking skills, including role-playing and videotaped interviews
- An informal job club with ongoing group sessions to support people looking for work; participants keep a log of their accomplishments and discuss the problems related to reentering the workforce
- Employer outreach and marketing to raise awareness of the availability of this pool of prospective employees
- Job placement services that allow for funding of on-the-job training experiences and tax credits for employers
- Assistance in purchasing work clothes or tools required for entry into a job
- After employment, a "reentry support" group that meets at night during a work adjustment period

individuals with substance abuse disorders. For example, the ADA considers individuals who are in recovery from dependence on alcohol or who are in recovery from illicit drug use to be individuals with disabilities who are entitled to the protections of the Act (Feldblum, 1991). Within certain limitations, these Federal laws entitle those with substance abuse disorders to receive VR services funded by Federal and State governments. (See Chapter 7 for a more detailed discussion.)

Screening and Assessment

Developing a vocational plan for a particular client begins with screening and continues, as necessary, with further assessment. Vocational screening is usually performed during the initial intake process and can be performed by an intake counselor, an alcohol and drug counselor, or a VR counselor. Screening is intended to provide a rough picture of the client's vocational history and potential. It includes a brief vocational and educational history, touching on employment experiences of the individual, including legal and other-than-legal employment, military history, and special skills possessed by the individual. Many individuals with substance abuse histories lack a legal, easily verifiable employment history, but they may have worked in jobs that paid "under the table" and have developed certain job skills in consequence.

In addition to background information, the screening should assess the client's psychological willingness and readiness to enter the workforce. Many individuals who are thrust into employment by welfare reform fail, but not because of poor work skills. More often they fail because they have a poor understanding of workplace rules, regulations, or behaviors.

Their failures are traced to absences, tardiness, or an inability to get along with supervisors and coworkers. In some cases, screening will reveal individuals with a positive work history and an ability to enter the workforce; in most other situations a more in-depth vocational assessment may be required. In either situation, the alcohol and drug counselor may wish to consult with a VR counselor in the development of the vocational portion of the treatment plan.

Vocational assessment is a longer, more intensive process aimed at identifying the most optimal vocational outcome for the individual (Power, 1991). It incorporates more in-depth evaluative procedures and examines the complex social, emotional, physiological, and vocational factors contributing to the individual's vocational potential. Vocational assessment should be performed by a trained VR counselor or a vocational evaluator.

When the findings from the screening and assessment process are analyzed, the services the client needs to gain "successful employment" can be identified. The meaning of successful employment is different for each client; it can mean anything from part-time to full-time employment or even volunteer work or vocational skills training. The clinician should not make assumptions and should work closely with the client to develop a treatment plan that includes a vocational component appropriate to the client's needs and abilities. For the plan to be successful, the client must be an active partner in establishing and maintaining the recovery process and must be accountable for his actions and behaviors.

As treatment progresses, the client's abilities and life circumstances can change. These changes can affect the client's capacity for employment, need, or eligibility for resources and her attitude toward employment. The vocational component of the treatment plan is a dynamic process and should be periodically evaluated to determine if (1) the stated goals are still viable and appropriate, (2) further assessment is needed, and (3) any consequent adjustments to the plan are needed. All professionals involved in the client's treatment plan should maintain a close working relationship and a dialog about the client's progress so that appropriate adjustments to the client's treatment plan can be made when necessary. Key clinical issues related to the development of vocational treatment are discussed in Chapter 3.

Screening

Screening allows the alcohol and drug counselor to determine the kinds of vocational services the client needs and to develop an appropriate vocational component to the treatment plan. Screening should accomplish the following (although not to the degree of detail that would be provided through a followup assessment or counseling by a VR counselor):

- Identify the client's major vocationally related experience and education, as well as associated capacities and limitations.
- Determine what referrals will help the individual attain appropriate vocational and educational outcomes.
- Identify the necessary resources to make employment feasible for the individual (e.g., transportation, day care, psychological adjustment, healthy self-esteem).
- Determine whether further assessment is needed to develop the vocational component of the treatment plan.

In most intake or screening processes, an important task is to review the client's medical records. If the client has not had a recent medical or psychiatric examination, these should be arranged as part of standard intake procedures since medical information has considerable relevance to a client's employability. These examinations can identify a client's limitations that are not otherwise

apparent, such as visual and hearing impairments, mental health problems, and hidden coexisting disabilities. It is important to remember that information from a medical or psychiatric examination is confidential and may not be shared with other providers without the client's written consent. See Chapter 7 for a discussion of confidentiality issues.

Screening instruments

An initial screening for vocational issues can be completed by the alcohol and drug counselor. Figure 2-2 contains a sample of the kinds of vocational information that the counselor can gather during this initial screen. Publicly funded alcohol and drug treatment providers are required to use the Federal Minimum Data Set (MDS), also called the Treatment Episode Data Set (TEDS), as part of their intake and discharge procedures. The MDS contains the minimum amount of data that States are required to submit to the Substance Abuse and Mental Health Services Administration (SAMHSA) each time a client enters or leaves publicly funded substance abuse treatment.

Figure 2-2
Vocational Information From Initial Screen

Educational History

Write a brief description of the client's educational history in order to evaluate current academic functioning and potential to engage in training that could range from remedial to advanced. The history should include the following information:

- Highest school grade completed, and when
- Client attitude toward education and possible future training (verbal report may differ from behavior with some clients)
- Favorite subjects, and why
- Extracurricular activities
- Potential for future education and/or training

Standardized achievement tests of math, reading, and general learning ability are often used to augment interview questions. The client's educational history can also be used to indicate vocation-related interests and values.

Vocational History

Write a brief description of the client's work history in order to estimate current and potential vocational functioning. Ask questions addressing the following:

- Types of occupations in which the client has worked
- Chronology of jobs within the last 15 years, including job title, name of employer, length of employment at each job, and primary job duties
- Reasons for leaving each job
- Client-identified work skills and any certifications or licenses held
- Client's perception of relationships with supervisors and coworkers
- Favorite and least favorite jobs, and why
- Work-related ambitions and goals

The TEDS asks about the client's education and employment status.

Assessment

The processes and instruments used for assessment are tailored to the needs of the individual client and should be administered by a trained VR counselor or vocational evaluator. They are based on established career development theories, and the instruments should be able to provide evidence of validation. They also vary according to the following:

- *Method of administration.* Some instruments use pen and paper or computer forms; others use more intensive forms of vocational assessment that require observation of the individual to assess skill level and areas of difficulty.
- *The time required for assessment*. An assessment can require anywhere from several hours for a typical case to 2 to 6 months for an extended work evaluation. For some clients, extended evaluation of work skills in a simulated work environment is necessary; for others, an evaluation can be accomplished using basic assessment instruments readily accessible to the counselor.
- *Timing of assessment.* Generally, extensive job readiness and assessment should be completed within the first 90 days following entrance to treatment; however, some clients need time to allow their bodies to recover from the effects of severe substance abuse.
- *Resources.* Assessment resources include both people and organizations with expertise in vocational assessment and are described later in this chapter. Various resources offer different types of assessment that may be helpful for particular individuals.

Functional assessment

Functional assessment is necessary to match clients with work they can perform successfully. Going beyond traditional models of diagnosis or client classification, functional assessment incorporates a broad range of assessment strategies. It aims to identify existing capabilities and limitations, along with the sociocultural or environmental conditions that impede or enhance success for the client. Sound treatment planning dictates that all of the assets and liabilities of the client be considered to develop a holistic plan. Functional assessment provides a more objective measure for evaluating client behaviors and for examining treatment planning outcomes. It is well documented that relapse and recovery failure are linked to vocational and educational failure. Functional assessment is a strategy designed to maximize success and minimize failure; it is not simply a tool to provide a diagnosis or a classification.

The term *functional capacities* denotes the job readiness of the individual, including skills such as the ability to read, write, relate well to supervisors and coworkers, or use a computer. *Functional limitations* are those deficiencies that should be addressed by a recovering person and VR counselor when planning to meet short- or long-term vocational goals. Identifying these limitations is important because the extent to which an individual's limitations are a barrier to employment depends in part on her work and living environment. For example, an individual with impaired mobility or who has a visual impairment may not drive and must travel to work by public transportation. But if the client's area is not served by public transportation, then this limitation presents a more serious barrier. Public VR services may assist individuals with impaired mobility or impaired vision to procure transportation for employment, including providing funds to purchase vehicles or convert existing vehicles to make them accessible.

The functional assessment should be performed by professionals well versed in how an individual's skills and interests lead to

successful vocational outcomes. Normally, the VR counselor or vocational evaluator fits this description; however, the alcohol and drug counselor often has vital information about a client's level of functioning. In complex cases, functional assessment can be accomplished with input from a multidisciplinary team.

Key functions

A functional assessment evaluates the client's performance of key functions in five areas: living, managing finances, learning, working, and interacting socially. Interventions can then be planned to help the client develop or apply the needed skills.

1. *Living*. An assessment in this area helps to determine whether the client has the individual and environmental resources to support the activities of daily living. What is the client's present living condition? Is the individual dependent on someone else to provide basic services such as cooking and cleaning?
2. *Managing finances*. Can the individual manage financial activities, such as handling a paycheck, opening a bank account, or living within a budget?
3. *Learning*. The purpose of an assessment in this area is to determine the client's educational level and, more important, the client's ability to process new information. Can the client concentrate, remain on task, comprehend spoken and written information, recall information, apply what has been learned, and express what has been learned clearly to others?
4. *Working*. The goal of an assessment of this area is to determine whether the client has the skills to maintain a job. Job-keeping behaviors include attendance, punctuality, grooming, response to coworkers, and response to supervision. These kinds of behaviors, rather than the ability to do the job, are a primary cause of job separation (i.e., being fired, quitting) for people with substance abuse disorders (Krantz, 1971).
5. *Interacting socially*. The assessment goal is to determine the individual's capacity to engage in functional interpersonal relationships. This includes an ability to accept authority, the willingness to conform to workplace rules and regulations as well as societal norms, and a sense of community responsibility.

Categories of functional limitations

People in recovery commonly have significant functional limitations, some as a result of substance abuse and some associated with coexisting disorders. These limitations can be physical, psychological, or social, and the categories may overlap.

- *Physical.* Physical limitations result from impairments of the individual's biological system, including deterioration of the body as a result of substance abuse. Some physical limitations, such as HIV/AIDS, hepatitis, and peripheral neuropathy, are often related to or the result of substance abuse, while others may predate substance abuse. Such conditions must be considered when determining the client's vocational goals. Some limitations may be partially reversible with abstinence.
- *Psychological or emotional.* Emotional problems, such as mood disorders, mental health problems, and anxiety, and neuropsychiatric conditions, such as learning disabilities, can affect a client's life functioning. These disorders may require psychopharmacological or behavioral interventions prior to or concurrent with vocational services (Barlow, 1988, 1993; Linehan, 1993).
- *Social.* Social limitations affect the individual's capacity to interact productively with others. The heavy use of substances at an early age, a dysfunctional family or

neighborhood environment, or neurodevelopmental disorders such as attention deficit/hyperactivity disorder can arrest an individual's social development and maturation. In general, the earlier the individual began using substances, the more likely limitations are to occur. Some recovering substance users also exhibit immature attitudes and behaviors not conducive to employment, such as a "short fuse" or a tendency to reject authority.

A limitation in any of these areas can be considered a *challenge to employment* or a *vocational challenge* if it affects the individual's capacity for successful employment.

Six-realm classification system

The areas of assessment have been further refined into a six-realm classification system for functional limitations and capabilities (Livneh and Male, 1993). Assessments using this sophisticated system should be performed by a trained VR counselor. The system can be used to identify and conceptualize limitations, consider remedial strategies, and help the client make an enlightened and appropriate career choice. The six realms are as follows:

1. *Cognitive–processing realm.* This realm includes brain dysfunction or diminished cognitive processes (i.e., information processing, memory, intelligence). Individuals with this type of impairment often do better at less complex and more routine jobs that do not require much independent judgment. Also, they can benefit from job coaching and supported employment.
2. *Cognitive–affective realm.* This realm includes impairments related to judgment, decisionmaking, motivation, concentration, and staying on task. Persons with serious impairments in this area may have difficulty functioning successfully on the job and are best suited for simple and routine jobs with a minimum of cognitive involvement.
3. *Social–affective realm.* Impairments in this area include a limited ability to form or maintain meaningful relationships, as well as problems with social and interpersonal adjustment. Because most jobs require at least some interpersonal relationships, limitations in this area make it very difficult for an individual to sustain employment. Consequently, therapeutic intervention to improve relationship skills is essential prior to placement.
4. *Social–structural realm.* Included in this realm are impairments that result from structural or environmental conditions (such as neurological disorders or speech impairments) that may interfere with the capacity to associate or communicate effectively with others. Most of these difficulties can be overcome if the focus is placed on the client's capabilities and appropriate use is made of applicable procedures and technology.
5. *Physical–structural realm.* This area is comprised of structural–physical abnormalities resulting from accidents, birth defects, diseases, and injuries. Limitations in this area require close collaboration with medical and physical rehabilitation providers to achieve a positive outcome.
6. *Physical–neurological realm.* This realm includes neurological impairments that affect physical functioning, such as those that result from birth defects or traumatic injury. It is important to focus on and use the client's remaining functional capabilities to secure appropriate employment.

Substance abuse can be a direct cause or a result of functional limitations in each of these realms. Because substance abuse is often a coexisting disability, the clinician should be aware of the possibility of impairment in any or

all six realms and ensure that adequate assessment has been done to identify such limitations. Because these areas require more comprehensive evaluation of a client's strengths and limitations in several specific functional areas, a trained psychological or VR counselor is needed to make these assessments.

Assessment instruments

A number of assessment instruments are available to gather more in-depth information related to vocational skills, interests, and aptitudes (see Figure 2-3). However, special training in the use of some of the instruments is needed to correctly administer the tests and interpret findings. Descriptions of some of the most commonly used and helpful instruments follow. See Appendix B for information about obtaining these resources.

Vocational interest tools for alcohol and drug counselors

A number of instruments are available to assist in determining vocational preferences and interests. These instruments are based on different theoretical approaches to career counseling. The following are commonly used and can be administered by alcohol and drug counselors to engage the client in the vocational exploration process. See Appendix B for information about where to obtain these resources.

- *The Self-Directed Search.* This tool addresses vocational interests in addition to client attributes (Holland, 1985a). It is easily administered and probes the client's dreams, interests, and abilities, yielding a three-letter code that corresponds to suitable occupations. It is available in a variety of languages and in a form for people with low reading levels. Although some training in its use can be helpful for the counselor, the manual provides sufficient instruction to interpret and use results. For the employed client, the tool helps the clinician determine whether the client's current job matches his skills and interests. For the unemployed client, it offers a sense of possible vocational directions.
- *Vocational Preference Inventory Interest Checklist.* This inventory considers possible occupations for a client by matching personality types with occupational examples (Holland, 1985b).
- *My Vocational Situation.* This tool addresses vocational identity and can be used to measure the effectiveness of career interventions. A simple paper-and-pencil test, it is easy to score and provides immediate feedback (Holland et al., 1980).

Psychometric vocational interest assessment tests

The following tests generally are administered by a trained VR counselor or vocational evaluator because of their complexity of administration or interpretation.

- *USES Interest Inventory (USES II).* This self-report instrument measures the respondent's relative strength of interests in 12 categories of occupational activity: artistic, scientific, plants and animals, protective, mechanical, industrial, business detail, selling, accommodating, humanitarian, leading/influencing, and physical performing. It consists of 162 items of three types: job activity statements, occupational titles, and life experiences. The inventory can be used with the general adult population 16 years of age and older (U.S. Department of Labor [DOL], 1981).
- *Work Temperament Inventory.* This is a self-report measure of 12 work temperaments and a person's adaptability to these temperaments. The 12 temperaments are directing others, performing repetitive work, influencing people, handling a variety of duties, expressing feelings, making judgments, working alone, performing under

Figure 2-3 Assessment Tools	
Screening Vocational Interests	**Measures/Approaches (not all-inclusive)**
Categories of interests	■ Geist Picture Interest Inventory ■ Kuder Occupational Interest Survey ■ Reading-Free Vocational Interest Inventory ■ The Self-Directed Search ■ Strong Interest Inventory ■ Vocational Preference Inventory Interest Checklist ■ Wide Range Interest Opinion Test
Vocational functioning	■ Addiction Severity Index ■ Career Attitudes and Strategies Inventory™ ■ Career Thoughts Inventory™ ■ My Vocational Situation ■ Wonderlic Basic Skills Test ■ Work Potential Profile
Functioning in particular areas related to employability	■ Addiction Severity Index ■ Employability evaluation ■ Employability plan ■ Interview information ■ Placement readiness checklist ■ Previous work experience ■ Readiness planning checklist
Emotional functioning	■ Interview information ■ Tennessee Self-Concept Scale ■ The Psychological Screening Inventory ■ Verified work history
Intellectual and aptitude functioning	■ Addiction Severity Index ■ Adult Basic Learning Examination (ABLE) ■ Educational experience and records ■ General Aptitude Test Battery (GATB) ■ Microcomputer Evaluation, Screening, and Assessment (MESA) ■ Minnesota Clerical Test ■ Peabody Picture Vocabulary Test ■ Revised Beta Examination ■ Slosson Intelligence Test ■ Wechsler Adult Intelligence Scale (WAIS-R) ■ Wide Range Achievement Test (WRAT)
Source: Adapted from Power, 1991.	

stress, attaining precise tolerances, working under specific instructions, dealing with people, and making decisions based on measurable data. It can be completed in about 20 minutes by hand or on a computer form. The computer-generated report will provide a percentile score profile on the 12 work temperament scales and list up to 12 worker trait groups for which the person is suited.

- *General Aptitude Test Battery.* DOL developed the GATB as an occupational aptitude test (DOL, 1970). First published in 1947, it measures nine aptitude factors with eight paper-and-pencil tests and four apparatus tests. The aptitudes measured are general learning ability, verbal aptitude, numerical aptitude, spatial aptitude, form perception, clerical perception, motor coordination, finger dexterity, and manual dexterity. Trained VR counselors can administer the entire test battery, which is available to nonprofit organizations through licensing agreements with the U.S. Employment Service (USES), in about 2½ hours. Either individuals or small groups can be tested. The GATB is part of a detailed career assessment and exploration system available to VR counselors. If it is used in conjunction with the USES-II (Droege, 1983) and the *Guide for Occupational Exploration* (GOE) (DOL, 1979), the VR counselor and client receive the most thoroughly researched occupation data file assembled for the U.S. labor market (Parker and Szymanski, 1998). Not only does it translate aptitude and interests into potential occupations, but it provides information on a series of critical job features, including physical demands, working conditions, specific preparation needed, and required mathematical and language skills. The results can be further organized via computer with the *Occupational Report*.

Work samples

Assessment approaches abstracted from actual job tasks can be performed to complement psychometric testing. Psychometric tests "are close simulations of actual industrial operation, no different in their essentials from what a potential worker would be required to perform on an ordinary job. Through performance on a work sample, tentative predictions about future performance can be made" (Power, 1991, p. xiv). A number of such systems are available, and they all measure performance across a range of basic job tasks.

An especially useful assessment approach is a computer-based system called the Microcomputer Evaluation Screening and Assessment System (MESA) (Brown et al., 1994; Valpar International Corporation, 1984). The MESA System is designed to "assist in identifying those individuals who are job or training ready, those who are in need of remediation, or those who may need a more comprehensive assessment" (Valpar International Corporation, 1984, p. 67). The MESA System was introduced in 1982, and the full and short forms of the system have been sold to thousands of rehabilitation facilities, schools, private practitioners, Federal programs, and other rehabilitation-related facilities in the United States. Thus, MESA System scores frequently are available to rehabilitation counselors whose clients have completed formal vocational evaluations.

Vocational Counseling

After assessment, individuals need counseling about setting vocational goals and creating short- and long-term plans for achieving those goals. To develop a plan with a client, the factors to consider include (1) the results of assessments, (2) existing training resources in the client's field, (3) employment opportunities in the local area, (4) the feasibility of alternative

goals when full-time employment is not an option, and (5) client empowerment to make the necessary decisions.

Client empowerment is a fundamental premise of rehabilitation; it implies an ability to shift away from dependence to independence, a notion consistent with recovery. The very notion of empowerment suggests both the availability of opportunity and the ability to move toward that opportunity through a sequential, developmental process aimed at creating further opportunity. Empowerment is not a foreign notion to drug and alcohol treatment and recovery. The peer self-help movement empowers individuals by focusing on control of what can be controlled and recognition and acceptance that some things (i.e., drugs, alcohol) cannot be controlled. In addition, it empowers clients by creating a mutual support system and by a philosophy of moving away from learned helplessness to taking responsibility for one's own actions and behaviors.

From a rehabilitation perspective, disabilities that disempower individuals are created by attitudes, beliefs, stereotypes, and actual physical barriers in the social, vocational, or personal environment of the individual and are not intrinsic to the person. Truly empowered individuals are as independent as possible across physical, psychological, intellectual, social, and economic dimensions. From a recovery perspective these individuals might be conceptualized as having learned strong recovery skills around impulse control and delayed gratification, self-advocacy, and assertiveness. Empowered individuals are capable of going beyond manipulation of systems and people to an open, honest style aimed at securing and enjoying basic entitled rights.

A five-step approach to career counseling has been described this way (Salomone, 1988):

1. Understand self.
2. Understand the world of work and other relative environments.
3. Understand the decisionmaking process.
4. Implement career and educational decisions.
5. Adapt to the world of work/school.

VR counselors are trained to assist clients through these or similar steps to determine vocational goals and plans.

Agreement With and Cooperation With the Plan Process

VR counselors are required to develop an individual plan for employment with each client. Formerly called the individualized written rehabilitation program (IWRP), this plan specifies the goals and objectives agreed to by the client and the agency and spells out the services the State agency will provide (see Appendix G for a sample IWRP). It is a formal document within the VR system and essentially represents the contract between the agency and the client. The principle of free choice strengthens the development and implementation of the plan—the client is presumed to have the ability to choose appropriate, realistic objectives and goals in concert with the VR counselor and is expected to meet specific and reasonable criteria for plan continuation. Consequently, a client enrolled in an educational program may be required to attend a specific number of classes and maintain a passing grade point average; a client enrolled in a vocational training program may be required to attend training regularly and on time. However, clients with substance abuse disorder–related disabilities may encounter policies or regulations not encountered by individuals with other disabilities. These dictates may be formal or informal (i.e., not contained in the agency administrative regulations) and may be operationalized at the State, regional office, or individual counselor

level. For example, some agencies may require an individual to demonstrate a period of abstinence prior to eligibility for service, a regional office may require an individual to participate in counseling at a particular counseling center, or a counselor may require participation in a specified number of Alcoholics Anonymous meetings during the rehabilitation process. While these policies and regulations are usually well intended, they often pose a bureaucratic barrier to rehabilitation services. Clients who feel they are being denied services or forced into unneeded service by unreasonable or unfair policies are guaranteed the right to appeal. Each State agency has established an impartial hearing process to resolve cases in dispute.

Other legal or regulatory factors may affect participation in employment plans and treatment plans. Some clients may be required or mandated to perform certain activities by the courts or probation and parole. Welfare-to-work regulations may impose other conditions the client must fulfill. Depending on legal or regulatory factors, alcohol and drug counselors and VR counselors may need to adopt specific strategies to support, guide, and encourage clients as they seek to comply with and meet the demands of the employment plan and external forces.

Prevocational and Ongoing Services

Prevocational services are those that are typically provided before an individual begins the job-seeking process (see Figure 2-4 for examples of prevocational counseling activities). Although some clients already have work-related skills that need to be recovered, updated, or refined through a training process (or *rehabilitation*), others have no job skills and need to develop them for the first time. Some clients need training in basic life skills, such as how to organize themselves to engage in learning, before they can benefit from vocational training. The term *habilitation* describes the process of helping these clients acquire the basic skills needed to perform effectively in the workforce. There are several types of services, including life skills training programs, job readiness, work adjustment, and mentoring.

Life skills training prepares clients who have never lived independently to manage the requirements of daily life. Residential programs or halfway houses offer opportunities to gain social and life skills such as cooking, cleaning, time management, money management, grocery shopping, and general household planning. Occupational therapists are frequently the professionals who provide life skills training, when they are available. Otherwise, community support workers or other team members can supply the training.

Job readiness programs help individuals gain the specific skills, attitudes, and motivation needed to obtain and maintain employment. For example, clients learn how to interview for a job and make a positive impression on an employer, how to apply for a job in writing, how to dress, and how to prepare a résumé or work history. These services are provided through job clubs, VR agencies (e.g., Goodwill Industries, State VR agencies), nonprofit or community agencies, federally funded job training programs, or consultants.

Work adjustment is a prevocational support program for people who have never had a job and who need help learning how to work effectively. Clients perform tasks in a simulated work environment with regular evaluations. A work adjustment program should be of limited duration, with a goal of eventual competitive employment. Such programs teach clients new skills and help them learn to tolerate criticism and work well with peers and supervisors. Most work adjustment programs are designed for clients who are mentally retarded, and they have

Figure 2-4
Prevocational Counseling Activities

Psychosocial–spiritual development

- Keep a diary of daily activities.
- Participate in role-playing exercises (e.g., for developing interpersonal communication skills, expressing needs and wants without appearing demanding).
- Complete values clarification, skills assessment, and personal traits exercises.

Career exploration

- Generate an autobiography on vocational and educational experiences.
- Visit community resources, including libraries, stores, businesses.
- Read newspapers for a specific purpose (e.g., employment trends, want ads).
- Watch educational and interactive programs to stimulate discussion and practice new behavior.

Structured activity

- Take a battery of vocational tests.
- Pursue and perform volunteer assignments.
- Take continuing education courses to determine and validate interests.
- Write a résumé.

Source: Adapted from Rehabilitation Research and Training Center on Drugs and Disability, 1996.

been criticized for frequent failure to lead to competitive employment. Some VR programs also provide specially trained job coaches to assist clients with work adjustment. Work adjustment needs of individuals with substance abuse disorders may be similar to the needs presented by individuals with other types of disabilities, but many substance abuse disorder clients may be offended by or resistant to participating in work adjustment programs. This is especially so if they perceive themselves as having been placed in a setting or with a disability group that is below their operational level. Both VR counselors and alcohol and drug counselors must be sensitive to these feelings in recommending a particular work adjustment site.

Training and Education

Many clients can only meet their employment goals through appropriate education or training. Some perhaps lack literacy. They may have dropped out of high school. Some have a history of chronic underemployment, and others have long-term plans that require advanced knowledge and skills.

The terms *education* and *training* are sometimes used interchangeably; however, providers of these services commonly make a distinction between the two. These services, or the referrals for them, are available through State employment services commissions, one-stop centers, schools, employers, VR centers, and colleges and universities.

In general, an *educational program* provides information and sometimes skills that the participant can use in a variety of settings; there is no clear and specific vocational application. At the end, the participant has learned a subject and may also have developed or honed skills—such as the ability to make a well-reasoned argument—that can be applied in many contexts. For example, a college program

leading to a bachelor of arts degree in history is an educational program.

In contrast, a *training program,* such as the Job Corps, shows the participant how to perform a task and in the process provides information to give the instruction a context. For example, a course where the individual learns to repair computers or to build a database using a particular kind of software is considered training.

It is possible to envision a continuum from "pure" education that has little to do with a particular job (e.g., history) to training that builds skills that can be applied in a variety of jobs (database development) or that is specific to the needs of a particular job (how to use custom-designed software to build a database for a specific job application). Which type of program is most applicable to meeting the client's needs will, of course, depend on the client's goals, timelines, and aptitude for engaging in learning under given conditions.
Most secondary school and adult education programs provide a combination of educational and training activities.

This section describes several of the most common kinds of training and education programs that are available to clients. These resources include school-to-work transition programs, on-the-job training, apprenticeship programs, technical schools and colleges, community-sponsored adult education, and colleges and universities.

School-to-Work Transition Programs

School-to-work transition programs provide opportunities for students to broaden their educational, career, and economic opportunities. These programs build on and expand other existing programs of several types, such as technical preparatory, cooperative education, youth apprenticeship, career academics, and schools within schools. These programs have several components:

- *Work-based learning*. This includes work experience, job training, workplace mentoring, and instruction in workplace competencies that occur on the worksite.
- *School-based learning*. This type of learning includes career counseling, career selection, major program of study, and integrating academics with vocational education.
- *Connecting activities.* These include matching students with employers, job placement, continuing education or further training assistance, and linkages with youth development activities and industry.

Most local school systems are directed to provide career exploration and support for all students, beginning in elementary school.

On-the-Job Training

Some employers offer their employees opportunities to gain the necessary skills for a specific job task in a supervised setting. On-the-job training, when available, clearly benefits the employee by providing useful training at no cost; it also benefits the employer by ensuring that the employee is familiar with the company's particular way of doing things.

Through networking with employers and tapping into the knowledge of employment professionals, the clinician can learn which employers in the area train their new employees and under what terms, and then make helpful suggestions to clients. Programs are sometimes available to assist in organizing these experiences, subsidizing the salary through the training period, or providing a tax credit. Alcohol and drug counselors should consult the Job Training Partnership Act (JTPA) and welfare-to-work agencies in their area to see if on-the-job training relationships have already been developed with local employers.

Apprenticeship Programs

Apprenticeship programs offer a structured process for mastering a particular profession, such as carpentry or plumbing. Individuals work side by side with a skilled person. All apprenticeship programs require some classroom work as well.

These programs are organized through unions and employment commissions. State agriculture departments often have apprenticeship programs suitable for farm and greenhouse management positions. An individual must meet certain criteria and often is required to take aptitude and interest tests upon application. It is important for the applicant to have references and experience in entry-level jobs in the field. Of course, a critical component is the employer's willingness to make a commitment to train the individual.

Technical Colleges and Schools

Some schools and colleges offer vocational training in which participants develop and practice the skills needed to meet the requirements of a particular job. Some examples of jobs include computer operator or repairperson, business manager, automotive service technician, nurse's aide, emergency medical technician, beautician, chef, welder, plumber, and veterinary assistant. Usually, technical colleges and vocational schools serve specific groups of occupations, such as technological or human services.

Some schools offer 2-year degree programs that lead to an associate's degree, 1-year diploma programs, or certifications that require less than 1 year. The degree programs often combine technical classes with general education requirements that focus on oral and written communications skills, math skills, research and computer skills, and social/interpersonal skills.

All technical colleges and schools operate under an admissions policy that outlines the requirements for attendance. Some require a high school diploma or general equivalency diploma (GED), whereas others offer remedial education that allows a person to obtain a GED. All such programs require tuition, paid by either the student or another funding source. Some offer financial aid and provide staff members to assist students in the pursuit of such funding. Referring a client prematurely to a technical school can be harmful if the client embarks on the program without the financial support to complete it successfully and defaults on the loan.

Community-Sponsored Adult Education

Some city or county school systems use public schools on evenings and weekends to deliver a range of programs for adults, recent graduates, and young persons who dropped out of school. Many regions have accessible, well-staffed community colleges. These programs often are attractive to young people who do not have enough money to enter extensive training programs. Public schools sometimes offer preparation for GEDs, remedial education programs, and basic courses for adults. Some community programs offer courses in word processing, graphic design, and other skills.

Programs available through community schools and community colleges are often reasonably priced and likely to be accessible by mass transit services. Alcohol and drug counselors should become familiar with the public educational opportunities provided by local schools to assist clients in using these resources.

Colleges and Universities

Colleges and universities offer programs that provide general knowledge and skills that are applicable to many different professions. State-supported schools are likely to have lower tuition fees and generally give priority to State residents.

Some clients who want to attend a college or university have poor academic records because of previous substance abuse or learning problems. Students who are unsure of their academic skills may want to take some courses on a pass/fail basis or register as special students rather than as degree candidates taking a full-time course load. For those who want to demonstrate their qualifications as students to a college or university before applying, taking courses at a less competitive school and doing well in them, then transferring, is a good strategy. Note, too, that clients may wish to pursue a 2-year associate's degree if it is difficult to commit to a 4-year program.

Colleges and universities are required by law to provide support services to students with disabilities, including learning disabilities. This might mean providing accommodations such as assistance in taking class notes or special arrangements for taking tests. However, to receive such services, the student must present documented evidence of a disability requiring the need for the accommodations requested.

Employment Services

The following sections review some of the most commonly used employment and vocational services that could benefit clients recovering from a substance abuse disorder who are seeking employment.

Job-Seeking Skills and Training

Some clients will need help learning how to secure employment because they have never looked for a job, are seeking a different kind of job, or have special problems to address in the job search (e.g., how to handle the existence of a criminal record). Many of the providers identified in this chapter offer assistance in numerous areas, such as the following:

- How to read and assess want ads. This includes how to determine whether a position is appropriate for the client's interests, skills, and background.
- How to obtain job leads. This includes using job development programs like those maintained by unions and unemployment offices, the Urban League, and the National Association for the Advancement of Colored People (NAACP), and finding alternative sources for job information, such as networking with friends, and checking job boards in public housing administrative offices, city halls, and the like.
- How to prepare a résumé that presents the client in the best possible light. Clients who have never written a résumé will need help in distinguishing among types of résumés, knowing which type is appropriate for their skill level, and determining employers' preferences.
- How to find job information provided on the Internet. The moderately sophisticated client will be able to use information from the Internet in locating suitable opportunities.
- How to contact employers and make appointments for job interviews. This could include developing a short introductory speech, role-playing its delivery, and learning what types of responses to expect from potential employers.
- How to fill out job application forms that are legible, highlight the client's skills, and provide the information requested. This also includes discussion of when and how to inform an employer about a substance abuse history.
- How to interview for a job, including how to dress and how to answer questions related to the client's substance use history, coexisting disability, gaps in employment, or criminal record (see Chapter 7 for more information). Different jobs require different degrees of formality of dress, but cleanliness, grooming, and manners are always important.

- How to organize and manage time during the job search process so that the client's time is structured and conducive to maintaining abstinence. Being systematic and organized in the job search pays off. This includes expectations for the number of contacts made each week, the best times to contact employers, and working out transportation.

Job clubs, which use a behaviorally based, group-oriented approach, are another source to help jobseekers (see Chapter 4 for more information about job clubs). Meeting daily or weekly, jobseekers help themselves and each other develop and pursue job leads, practice interviewing skills, and receive encouragement. These approaches have proven effective in helping many people achieve their job goals.

Another valuable source for jobseekers is the Internet. Figure 2-5 describes America's Job Bank (AJB), a Web site maintained by DOL in conjunction with State employment offices.

Job Development and Placement Approaches

Effective job development generally requires the VR counselor to provide multiple services, such as networking with employers, establishing relationships with them, and assembling information about employment opportunities for clients. The counselor locates jobs and also provides information to the employer about the client (within the confines of confidentiality). This addresses potential barriers to employment that result from biases and discrimination. VR counselors also conduct outreach to area

Figure 2-5
Job Search Resources: America's Job Bank on the Internet

America's Job Bank (http://www.ajb.dni.us) is a partnership between the DOL and State-operated employment services. This computerized network links State employment service offices to provide jobseekers with the largest pool of active job opportunities available anywhere, plus nationwide exposure for their résumés. For employers it provides rapid, national exposure for job openings and an easily accessed pool of candidates. The AJB Web site is available on computer systems in public libraries, colleges and universities, high schools, shopping malls, and other public places.

Every day, AJB receives new job listings from the States, and the Internet database is updated each night. On average, more than 5,000 new jobs are received daily from the States. Also, thousands of employers enter their jobs directly into the system in real time. Typically, more than 3,000 new jobs are received directly from employers daily.

In addition to the AJB, there are three other sections to explore on this Web site:

- **America's Talent Bank** (http://www.ajb.dni.us). This is a nationwide electronic résumé system. Jobseekers enter résumés into this national network, which is then searched by employers for workers who meet their needs.
- **America's Career InfoNet** (http://www.acinet.org). This is a comprehensive source of occupational and economic information. It contains information about general outlook, wages, trends, State profiles, and a resource library.
- **America's Learning eXchange** (http://www.alx.org). This is an online source for training and education resources. Jobseekers can find a myriad of training opportunities, including traditional classroom- based training, leading-edge distance learning, Web-based instruction, and multimedia instructional materials (e.g., CD-ROM, video).

employers to publicize the availability of individuals with the requisite skills for the job. Participating employers can receive certificates, publicity, or other recognition.

Job development also requires the counselor to become familiar with the local labor market to better guide clients about the types of employment that are available locally. For many States this information is available online. DOL regularly identifies the professions that it projects will expand in the future on its Web site and in its annual publication, *Occupational Outlook Handbook.* AJB has links to State employ- ment databases, and the Career InfoNet Web site also provides occupational growth projections. This information allows the client to make decisions about a career that will be viable both in the present and in the future.

In the act of job placement, the VR counselor can intervene with the employer on behalf of the jobseeker. The intensity of the placement services varies from case to case, depending on such factors as the client's level of motivation, openness on the part of the employer, and the status of the economy. It requires a skilled professional with the knowledge and abilities to counsel both the client and the employer effectively, as well as to understand the intricacies of recruitment, human resources issues, and job satisfaction (Parker and Szymanski, 1998). Research also indicates that when a job placement plan is developed separately (i.e., in addition to the primary substance abuse treatment plan), counselors are more likely to successfully place their client in a job (Zadny and James, 1977). This may be because separately developing a vocational plan places more emphasis on employment.

Job placement can be completed by an individual consultant or through a program or agency. Also, a number of national computerized services exist to help individuals identify prospective employment suitable to their skills (see Figure 2-5). Most States have online systems that work in a similar way: Employers post job openings, and respondents place résumés and cover letters on file for employers to review.

Supported Work Programs

Supported employment enables people with disabilities who have not been successfully employed to work and contribute to society. The locus of vocational rehabilitation in supported employment shifts from that of a sheltered setting to a real-world job setting. This approach is appropriate for clients with coexisting disorders (e.g., mental retardation, chronic mental illness, traumatic brain injury) that are so severe that they cannot maintain employment without intervention. Common forms of supported employment service delivery include the following:

- *Job coaching.* A life skills coach works with the client in a blended staff situation. The coach may go to the client's home or "shadow" the client to get him to work on time. Job coaching is usually used during early phases of employment (i.e., the first 90 days), then discontinued or reintroduced as needed.
- *Enclave or mobile crews*. Although this approach has been criticized for isolating rather than integrating workers with disabilities, it is still common. An *enclave* is a group of individuals who accomplish a set of work tasks at a specific place of employment, sometimes by sharing a single job as a group. Typically, the business pays the service provider, which in turn pays the enclave employees. A *mobile crew* forms contractual relationships with businesses to perform a service, such as grounds maintenance or housecleaning. A supervisor or counselor oversees a group of clients who perform a job together to ensure work quality.

- *Mentoring*. A mentor is an individual who provides support to the client within the work setting. For example, a mentor can be someone who has gone through treatment and now holds a job similar to the client's job. This arrangement is relatively easy for a residential treatment facility to arrange if the same employers hire clients from the facility. Mentoring can be extremely effective when linked to self-help support groups.
- *Wage subsidy programs.* These Federal and State programs provide a subsidy for sheltered employees to encourage employers in the competitive job market to hire them. Typically, they pay up to one-half the employees' salary for the first 90 days of a job.

Figure 2-6 provides an example of a rehabilitation facility that offers supported work.

Job Retention and Advancement

Once a client has a job, a different set of issues arises. The client needs assistance in identifying relapse triggers that exist on the new job and in resisting the impulse to celebrate by drinking or using drugs for having secured employment. If the client has a disability in addition to a substance abuse disorder, VR counselors may need to help him identify any reasonable accommodations and assistive devices needed to perform required job functions. Individuals sometimes find they need additional education to help them manage their paycheck and household budget or to address other life changes and responsibilities that occur as a result of employment. Counselors should encourage clients to take advantage of their employer's employee assistance program as needed. Treatment programs need to accommodate their newly employed clients by having evening counseling hours and providing onsite child care while clients attend treatment programs.

Some kind of support for the long term must be built into VR programs so that the client avoids boredom, takes advantage of opportunities to advance, and manages crises at work. In addition, today's job market demands that clients be prepared for the possibility of job loss. VR counselors can inoculate clients against the attendant dangers of despair and relapse by working with the clients to develop a career network that identifies alternative strategies and pathways clients can use in the event of job loss or new openings. (See Chapter 3 for additional discussion of clinical aspects of job retention and advancement.)

Overview of Vocational Resources

For referral purposes, it is important for the clinician to be familiar with the local resources available to clients. Some clients will need only education and training to help them prepare for a career or enhance existing qualifications. Others will require a variety of rehabilitation services in addition to training or education. Some will need counseling to help them choose an employment situation that will make the best possible use of their skills and satisfy their own criteria for "successful employment."

The following sections discuss the variety of resources and services that may be available to clients. There will be considerable differences from one region to another in what resources are available, how they are structured, and whom they serve.

However, this discussion is intended to suggest avenues that could be explored to find new sources of vocational assistance.

Figure 2-6
Vocational Opportunities of Cherokee, Inc.:
Rehabilitation Facility Providing Primarily Onsite Services

Vocational Opportunities of Cherokee, Inc., offers both supported and sheltered employment for Native Americans with severe disabilities. Clients are referred to the program by social welfare programs; alcohol and drug treatment providers; medical treatment providers; the Women, Infants, and Children Program; and other sources.

Following an assessment, the individual reviews job descriptions and chooses a field of work. Detailed evaluations of the individual's capabilities, if needed, can take up to 18 months. All clients receive a basic training program that includes commonly needed skills, such as conflict resolution and grooming. The client then receives appropriate training in the chosen field and to enhance his functional capabilities. He begins with jobs requiring lower dexterity and skill and moves up to more complex jobs as capabilities increase.

The program includes the following services:

- Evaluation
- Counseling and guidance
- Physical and mental restoration
- Culturally appropriate social activities for the client and her family
- Vocational and other training services
- Transportation
- Services to the family members of the client
- Interpreter and note-taking services for the deaf
- Readers, rehabilitation teachers, and note-taking for the blind
- Telecommunication, sensory, and other technological devices
- Recruitment and training services for public service employment
- Placement and suitable employment
- Postemployment services to enable the client to maintain, regain, or advance in employment
- Occupational licenses, tools, equipment, initial stocks, and supplies
- Rehabilitation engineering services; other goods and services

The program employs three counselors, a job coach, and three trainer/managers. It is funded by the State VR agency and by tribal funds. The industrial training floor is operated through contracts with private employers. Some clients also perform contract work, such as grounds care for Federal buildings.

Employment Resources

Workforce Investment Act

On August 7, 1998, President Clinton signed P.L. 105-220, the Workforce Investment Act of 1998, into law. This legislation consolidates more than 60 Federal programs into three block grants to States for employment, training, and literacy. This reform measure replaces programs currently under the Job Training Partnership Act, the Stewart McKinney Act, the Carl Perkins Act, and the Adult Education and Family Literacy Act. Statewide and local Workforce Investment Boards (WIBs), which will replace Private Industry Councils (PICs), are required to provide employment and training activities to help youths and adults facing serious barriers, such as disabilities (including substance abuse

disorders). The activities of the WIBs include disseminating lists of service providers and establishing one-stop delivery systems for the following services:

- Outreach, intake, and orientation to available services
- Assessment
- Job search and placement assistance
- Career counseling
- Provision of employment information and forecasts
- Assistance in finding funding and other support for training and education
- Followup services

These programs provide job training and other services that are intended to increase employment and earnings, increase educational and occupational skills, and decrease reliance on welfare. Alcohol and drug counselors should be aware of the eligibility requirements and locations of these programs in their areas and refer clients to these services as appropriate. (See Chapter 7 for further discussion of the Workforce Investment Act.)

State employment services commissions

A network of State employment agencies is funded by DOL to offer a variety of services to persons who are eligible to work in the United States. The agency names vary (see Appendix E for a list of the agencies in all States). A central office is usually established in the State capital, and field offices are dispersed in communities to serve people in specific geographic areas.

Typically, they offer the following types of services to those looking for jobs and to employers:

- *Jobseeker services.* Such services may include job referral and placement, referral to training, and activities to build skills in the job search process.
- *Job search support.* Many State programs have computer-assisted job search capability, which allows jobseekers to reach beyond their immediate community. These databases also can provide assistance with career information. Multimedia systems include computer programs, career information hotlines, microfiche, newspapers, and Internet listings.
- *Employer services.* Staff can assist employers by screening and referring applicants for job vacancies.
- *Labor market information.* The agency collects, analyzes, and publishes data relating to all aspects of the State's labor market. This information includes current employment statistics, wage information, unemployment rates, and data regarding occupation trends.
- *Unemployment insurance services.* The agency collects unemployment taxes from employers and pays unemployment benefits to eligible individuals who have lost a job through no fault of their own.

These State agencies work closely with local government and private employers. Some have WIBs and Employer Advisory Committees. Employer Advisory Committees are local conglomerates that have a function similar to WIBs and are charged, usually by "one-stop" legislation such as the Workforce Investment Act of 1998, with planning, coordinating, and implementing all public economic development and employment services. As a consequence, these organizations also often provide direct links to available Federal, State, and local government jobs. Two government-run case management programs are described in Figures 2-7 and 2-8. Figure 2-9 describes an employment program for ex-offenders in Texas.

Figure 2-7
The Michigan Drug Addiction and Alcoholism Referral and Monitoring Agency: A Case Management Model

The Michigan Drug Addiction and Alcoholism Referral and Monitoring Agency (DAARMA) operated under Michigan Rehabilitation Services of the Michigan Jobs Commission until it was eliminated by changes in Social Security and Medicaid. The program served clients receiving Supplemental Security Income who had substance use disorders in addition to other disabilities. Its purpose was to help these clients return to the workforce by ensuring that they had the tools necessary to achieve full rehabilitation and self-sufficiency. This program description is retained because it has many transferable elements.

The program was a three-way partnership between the alcohol and drug counselor, DAARMA, and the vocational rehabilitation services agency. The partners were cross-trained: the State treatment provider agency gave a 6-week intensive training program on substance use disorders for all staff and in turn received training on Medicare rules and on the counseling rehabilitation model. Written agreements documented the partnership. Collaborating agencies made joint decisions on the appropriate timing for the introduction of vocational rehabilitation services. Services generally were introduced as soon as the clients were "clean" and their condition stabilized. The time required for the referral and monitoring process in the Michigan program ranged from 2 to 5 years. The program operated on several principles:

- Careful, comprehensive recovery plans focusing on full rehabilitation and a return to the workforce are essential if the program is to be successful and cost-effective.
- The effectiveness of a recovery plan is only as good as the quality of partnership between the beneficiary's therapist and the referral and monitoring agency counselor.
- For the treatment plan to be successful, the beneficiary must be an active partner in the accomplishment of his own recovery and must be held accountable for his actions.

The case management program included the following elements:

- A preliminary intake to determine clients' needs. Based on the intake results, some clients were referred to a residential program for detoxification.
- Counseling to ensure that clients understood the program's benefits and the sanctions that could be imposed for noncompliance.
- Periodic progress reports involving the clinician and, for corrections clients, the corrections officer.
- Individualized referral to, and coordination of, all services needed to sustain the client's full recovery and rehabilitation (i.e., substance use, physical and/or mental health treatment, habilitation and rehabilitation services, other supportive social services).
- Tools to monitor compliance, including drug testing.

Compliance issues included the following:

- A distinction between noncompliance and relapse. A client who relapsed might continue to receive benefits while attempting to return to treatment, whereas a client who missed appointments regularly might have her cash benefits temporarily suspended. The ability to suspend benefits gave the program a high success rate.

Figure 2-7 (continued)
The Michigan Drug Addiction and Alcoholism Referral and Monitoring Agency: A Case Management Model

- Loss of 1 month's benefits the first time a client was noncompliant, 2 months of checks for the second noncompliance, and 3 months of checks for the third noncompliance (which seldom occurred).
- During the first year of the program, 53 percent of the participants were noncompliant; however, 72 percent of them returned within 30 days after losing their first checks.

Social Security funded the case management and monitoring function, Michigan Jobs Commission Rehabilitation Services funded the cost of rehabilitation services, and Medicaid funded treatment services. The DAARMA's case management cost per case was $350 per year. One month's benefit check for one individual without dependents was $457. Thus, successful rehabilitation saved the General Fund a minimum of $5,500 per year, per case, in cash benefits. In cases of noncompliance, 1 month's benefit suspension ($457) saved the cost of case management of a case for an entire year. The average cost of rehabilitation services for substance use disorder clients averaged about $1,200 per case.

State vocational rehabilitation agencies

The Rehabilitation Act of 1973, as amended, authorizes the allocation of Federal funds to establish State VR programs to assist individuals with disabilities in preparing for and securing employment.

Priority is given to people with the most severe disabilities. To be eligible for VR services from a State agency, a person must

- Have a physical or mental impairment (includes substance abuse disorder) that is a substantial impediment to employment
- Be able to benefit from VR services in terms of employment
- Require VR services to prepare for, enter, engage in, or retain employment

This type of agency exists in all States and Territories. Each agency has a central office, which is usually located in the State or Territory capital, and field offices throughout the State or Territory. Counselors may be assigned to specific geographic locations, particularly to ensure coverage in rural areas. Some specialize in providing certain services, such as job placement, or work with a specific population (e.g., those with substance abuse disorders or brain injuries).

State VR offices provide a wide range of services, including vocational counseling, planning, training, and job development and placement. The alcohol and drug counselor can refer a client to a State VR office after the initial assessment phase is completed and the client is ready to benefit from these services. Before accepting the client, the coordinating counselor arranges for further assessments to determine the client's readiness for rehabilitation.

The primary case management and counseling services for the State agency are provided by a rehabilitation counselor. The rehabilitation counselor's responsibilities include (1) assessing the client's needs, (2) developing programs and/or plans to meet identified needs, and (3) providing or arranging for the services needed by the client, which may include job placement and followup services (Parker and Szymanski, 1998).

Figure 2-8
Combating Alcohol and Drugs Through Rehabilitation and Education (CADRE)

Limited Case Management/Rehabilitation Support for a Public Housing Community

Fourteen CADRE centers provide prevention and intervention services, operating in 12 Chicago Housing Authority (CHA) developments. Each conducts intake assessment and makes referrals for substance abuse treatment for the community and helps residents to move toward self-sufficiency. As part of these services, residents may receive vocational services on a voluntary basis. Participants are self-referred as a result of flyers distributed door to door or are referred by various social service agencies that work with CHA residents. Each center has a director, one case manager (who is a State-certified alcohol and drug counselor), two prevention specialists, and a general clerk. Programs are funded by the U.S. Department of Housing and Urban Development's Public Housing Drug Elimination Program through a grant to CHA's in-house employment and training program.

The CADRE centers make available the following vocational services:

- Job readiness programs that teach participants how to write a résumé, how to look for a job, how to dress for a job, and similar skills
- Job fairs where local businesses take applications and résumés
- Recovery support groups (not geared specifically to employment)
- Access to job-hunting resources such as a telephone, fax machine, computers, and the Internet
- Job training provided through outside consultants

Once a client is accepted by the agency, rehabilitation legislation mandates the development of an individual plan for employment (IPE)—also known in some States as the IWRP—to identify goals and objectives for employment, as well as a timetable for achievement. It is important for the alcohol and drug counselor to review the plan with the VR counselor to support the client in achieving these goals and identifying potential difficulties. The vocational plan should reinforce the substance abuse treatment plan and make the interagency linkage work as well as possible for the client.

Before referring clients to this type of service, the clinician should first develop a relationship with the assigned VR office, which is likely listed in the phone book in the State government section. Because many VR staff members will need cross-training in substance abuse treatment, each office should have a supervisor who can help determine which counselor should receive the referral.

Clients referred to a State VR agency must call to make an intake appointment. It helps to have psychological and medical evaluations ready, as obtaining documentation of disability is the second step of the process and often the most cumbersome. These evaluations must be signed by appropriate professionals and indicate the type of disability and limitations. Also, any information about a client that is divulged to another agency must be accompanied by a release form signed by the client (see Chapter 7 for a detailed discussion on confidentiality issues). State VR agencies can place clients in precontracted job training programs or provide funding for eligible clients to attend technical or college programs. This funding can enable indigent clients to receive the higher education services that would have eluded them without this support.

Figure 2-9
The Texas Workforce Commission: Project RIO (Re-Integration of Offenders)

Project RIO is administered by the Texas Workforce Commission in collaboration with the Texas Department of Criminal Justice (TDCJ), the Windham School District, and the Texas Youth Commission (TYC). One goal of the project is to link education, training, and employment during incarceration with employment, training, and education after release from prison. Another goal is to reduce the rearrest rate through employment.

Program participants receive services both pre- and postrelease from prison. An individualized treatment plan is developed for each offender to identify a career path and to guide placement decisions. Before release, a comprehensive evaluation is conducted to assess the needs of the offender and to assist in the selection and placement in Windham, college, TDCJ, and TYC programs. The evaluation process is a multistep process that includes information gathering, goal setting, program placement, and offender assessment.

Project RIO staff members encourage participants to take advantage of the education and vocational services and assist offenders in obtaining the documents necessary for employment. Staff also provides placement services to give offenders practical work experience in their areas of training.

After release, program participants receive individualized services, including job preparation and job search assistance. Participants attend job search workshops that focus on basic skills, such as completing a job application, preparing a résumé, and building interview skills through mock job interviews. The most important goal of the Project RIO program is for ex-offenders to secure employment as soon as possible after their release.

Project RIO also involves employers in the community. Program staff ensures that potential employers are aware of the incentives for hiring ex-offenders. The staff certifies prospective employees for the Work Opportunity Tax Credit program, which provides a tax incentive to employers for hiring economically disadvantaged ex-offenders.

Seeking and Securing Funds for Vocational Services

Two recent pieces of legislation will strongly influence the ways that treatment programs seek and secure funds to meet their clients' vocational needs. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 dramatically transformed the means by which public assistance is provided (see Chapter 7 for details on this legislation). The Balanced Budget Act of 1997 provided additional resources to support the goals of the 1996 welfare reform legislation by authorizing DOL to provide welfare-to-work grants to States and local communities. These grants are to be used for transitional employment assistance to move hard-to-employ recipients of Temporary Assistance for Needy Families (TANF) into unsubsidized jobs offering long-term employment opportunities; clients with substance abuse disorders are specifically targeted. The program is mobilizing the business community (largely through local WIBs) to hire welfare recipients and is working with civic, religious, and nonprofit groups to mentor families leaving welfare for work.

Funds can be used by States, PICs, WIBs, and other entities to move eligible individuals into long-term jobs by a number of means, including job retention and supportive services such as substance abuse treatment. Although TANF (and therefore welfare-to-work) funds cannot be used for "medical services" such as detoxification under the care of a physician, a range of substance abuse treatment services can be provided under this funding. In some States,

TANF block grant funds have been allocated for substance abuse treatment services, including assessment, residential treatment, and less intensive outpatient programs.

The welfare-to-work legislation is implemented differently in each State, and there is a complex web of political and financial forces that must be understood to access this funding effectively. Scanning the environment to determine the relationships among the welfare agencies, PICs, WIBs, State substance abuse agencies, and other community-based organizations is critical. It is in this context—a complex landscape of shifting ideas about treating substance abuse disorders, changing funding streams, and the blurring of roles and responsibilities between public and private sectors and between Federal and State governments—that substance abuse treatment programs must seek to secure the funds that have been set aside to help chronically unemployed welfare recipients obtain and maintain work.

Program planners should look to the future and budget for one-time expenditure items that will improve vocational outcomes for clients. Such items might include a computer with a package of vocational assessment software. A VR library can be budgeted as a one-time expense although some updating is periodically needed (see Figure 2-10). Additional information on securing funding for expanding current programs and hiring is provided in Chapter 6.

Resources for Veterans

When eligible dependents and survivors are included, nearly one-third of the U.S. population is entitled to veterans' benefits (U.S. Department of Veterans Affairs, 1997). The huge job of administering these benefits belongs to the Veterans Benefits Administration (VBA). The VBA's mission, in partnership with the Veterans Health Administration, is to provide benefits and services to veterans and their families in a responsive, timely, and compassionate manner in recognition of their service to the nation. The benefits include compensation and pensions, housing loans, insurance, and vocational or educational counseling and training. The VBA's educational services have two objectives:

1. To enable veterans to pursue training or attain higher education for the purpose of adjusting to civilian life, restoring lost educational opportunity, and expanding economic capacity.
2. To provide educational opportunities to children whose education would be impeded by reason of death or disability of a parent incurred in the Armed Forces; these opportunities are extended to surviving spouses in preparing them to support themselves and their families at a level the veteran could have expected to provide.

Vocational Rehabilitation and Counseling Service programs (VR&C services) primarily serve veterans entitled to benefits under 38 U.S.C., §3100 et seq. VR&C services administer vocational training to certain nonservice-connected veterans awarded disability pensions and educational and vocational counseling to specified classes of beneficiaries (veterans, service members, spouses, widows, and children of disabled veterans). Alcohol and drug counselors should be aware of those clients who are entitled to these benefits and how to access these services. Persons eligible for veterans benefits must apply through the local or regional Veterans Administration office, which can be located through the Federal government pages of the telephone book.

Community-Level Providers

Almost every community has a host of agencies that provide VR services. They offer a variety of

Figure 2-10
Basic Materials for a Vocational Reference Library

VR counselors use a variety of resources to help clients find jobs. The following is a list of basic materials that a counselor should have available. Although not all programs can afford an Internet hookup to access online employment-related information, they should identify locations where clients can obtain Internet access, such as schools and public libraries.

DOL Documents

- *Guide for Occupational Exploration*
- *Dictionary of Occupational Titles*
- *Occupational Outlook Handbook*

Local Resources

- Local newspaper classified ads
- Local telephone directories
- Catalog of employer profiles
- Contact information (address, phone number of personnel department) of
  - The largest employers in the area
  - The employers who hire the largest number of local workers
  - The fastest growing local employers
  - Employee Assistance Programs
- Mentor lists by employer
- Public transportation routes and schedules
- Course catalogs describing majors and programs in local technical schools, community colleges, and universities

Employment-Related Publications

- *College Placement Annual*
- *National Business Employment Weekly*
- *The Professional and Trade Association Job Finder*
- *The National Job Market*
- *The National and Regional Job Bank*
- *Career Guide to Professional Associations*
- *What Color is Your Parachute: A Practical Guide for Job-Hunters & Career-Changers*

Other Resources

- Materials from the local Chamber of Commerce
- Materials from the local Job Service
- Access to Web sites such as America's Job Bank (http://www.ajb.dni.us)
- State economic development Web sites for access to State and national job bank databases

services, from job-seeking assistance to employment in a sheltered or supported environment. In some States these agencies are State-certified and funded. In other States they are funded and operated by counties or cities. In many instances, the agencies are private,

nonprofit groups funded from a variety of sources to serve a specific group of clients. Eligibility for the services varies according to the policies established by the specific organization and its funding sources. Some serve persons with disabilities who are unable to work in a competitive environment, whereas others focus on youths who are at risk for dropping out of school or need a second opportunity because they already dropped out. Particular populations, such as those in a public housing community, could also benefit from rehabilitation programs targeting their needs. The key is that these services are designed to meet the unique needs of the community.

These organizations receive funding from a number of funding streams—Federal, State, and private (including foundations). The Neighborhood Funders Group is a national association of grantmaking institutions. It has more than 150 member foundations that seek to improve the economic and social fabric of low-income urban neighborhoods and rural communities. Many of their programs fund employment projects that vary from community to community. The local social services agency is a starting point to learn more about these programs.

Community-based rehabilitation centers

Community-based rehabilitation centers offer a range of medical, social, psychological, and technological services to persons with disabilities. They serve a locality, allowing people to undergo rehabilitation and build supports in their own community. They receive funding from State agencies, insurance companies, and nonprofit agencies (e.g., Goodwill Industries). A community-based rehabilitation center's target population varies according to the center's mission but might include persons with a traumatic brain injury, spinal cord injury, and learning disabilities, among others. Referrals to this type of center require coordination with the funding source.

Mental health agencies

Some local mental health agencies have designed vocational services as part of their continuum of care for eligible clients. These services vary and require coordination through the mental health care center or office. Persons who have a mental illness and require supportive services to obtain and maintain employment may be eligible. Some examples of typical programs include job club programs as part of day treatment programs, job coaching for obtaining and maintaining appropriate work behaviors, and supportive employment onsite in a work setting. Alcohol and drug counselors have numerous avenues for finding out about local VR services:

- State VR department or a local office of the department in a city
- The Web site for the State VR department
- Single State Agency for substance abuse prevention and treatment
- State Department of Labor
- State or local Workforce Investment Board
- Local employment development department
- Private agencies, such as Goodwill Industries

3 Clinical Issues Related to Integrating Vocational Services

There are many compelling reasons for vocational components to be part of the substance abuse treatment plan for clients in recovery. For example,

- Achievements such as completing education or training, finding a job, and maintaining employment counter a sense of personal incapacity and provide a basis for increasing self-esteem. Many substance-using clients used drugs initially to avoid feelings of worthlessness and powerlessness.
- The work environment offers an opportunity for the client to apply recovery skills, such as building supportive relationships, learning to work within an authority structure, accepting responsibility, managing anger, and recognizing boundaries.
- As clients consider the possibility of entering or reentering the workforce, highly charged clinical issues may emerge. For example, some clients have painful memories of school and consider themselves failures, especially if they have specific learning difficulties. Other clients may have had limited social interactions during their periods of substance abuse and may find the complex relationship patterns of a new work environment mystifying or frightening. Clients' family histories will also affect their view of workplace authority figures.
- Meaningful progress toward employment can reduce the potential for relapse.

To help clients attain work-related goals that will also support their recovery, the alcohol and drug counselor should consider the cultural, sociopolitical, physical, economic, psychological, and spiritual circumstances of each client. This is known as the "biopsychosocial–spiritual" model of treatment. For example, clients who enter a workplace culture that contradicts their cultural values will face a particularly difficult challenge, and clinicians will need to help these clients mediate between the two opposing cultural realms.

This chapter discusses clinical issues related to the incorporation of vocational components into the substance abuse treatment plan and how to counsel clients to address their vocational goals and employment needs. Exploring options for appropriate training or education, finding and maintaining employment, and coping with environmental and legal challenges also are discussed. The chapter then addresses how to develop a treatment plan and at the end presents case studies using the principles discussed throughout the chapter.

Incorporating Vocational Services

To successfully incorporate vocational services into substance abuse treatment, the alcohol and drug counselor must first acknowledge that

vocational training, rehabilitation, and employment compose an important area of concern for clients. How clients handle work often is closely related to how they handle other aspects of their lives; therapeutic concerns such as poor self-esteem, feelings of inadequacy, hypersensitivity to criticism, and issues with authority tend to manifest themselves in relationships at work. Therefore, gainful employment can be a measure of a client's successful adjustment, social functioning, and community reintegration (Schottenfeld et al., 1992). Research also suggests that the occurrence and severity of relapse tend to be lessened in individuals who can develop positive self-images and raise self-esteem through employment (Arella et al., 1990; Deren and Randell, 1990). Employment also can help decrease criminal behavior and substance abuse (Schottenfeld et al., 1992). Realistically speaking, clients must be able to support themselves financially. These findings confirm the therapeutic importance of including employment as part of the substance abuse treatment process.

Clinicians can best address vocational issues by considering their relevance at every stage in the client's treatment, including their incorporation into individualized treatment goals. Preliminary information on vocational needs should be collected and assessed at intake. When the client's situation is stable, the vocational element of the treatment plan should be more fully developed. Additional assessments should be conducted if necessary, with referrals to vocational services as appropriate.

The Consensus Panel believes, based on its collective experience, that three key elements are essential to effectively address the vocational needs of clients in the recovery process. They suggest that clinicians

1. Use screening and assessment tools, specifically for vocational needs, when appropriate.
2. Develop and integrate a vocational component into the treatment plan.
3. Counsel clients to address their vocational goals and employment needs.

These recommendations are discussed in more detail below, except for screening and assessment, which are discussed in Chapter 2.

Developing and Integrating a Vocational Component Into the Treatment Plan

Regardless of the client's employment situation—employed, looking for better work, or unemployed—it is appropriate for the treatment plan to have a vocational component that specifies objectives developed jointly with the client. Goals should be set that can be achieved through counseling (such as improving relationships with coworkers, handling anger or stress appropriately in the workplace, improving attendance), or the client may require referral to vocational rehabilitation (VR) counselors. The following are situations in which a clinician should refer the client for vocational services:

- The client is asking questions about employment or vocational goals that the clinician has difficulty answering.
- The counselor and client cannot develop a clear and concise set of goals concerning vocational issues because of a lack of information or guidance.
- The client needs special vocational testing or training beyond the expertise of the counselor or has a disability that requires special accommodations to obtain employment.
- The client's vocational history is either nonexistent or has been so seriously affected

that another person with expertise in this area should be introduced to assist the client with vocational issues.

- The client clearly wants to accomplish something meaningful through work but needs help, for whatever reason, to make such a major life change.

Counseling Clients To Address Vocational Goals and Employment Needs

Research suggests that counselors can help clients progress by focusing on what clients feel is most important (Jongsma and Peterson, 1995; Linehan, 1993; Meyers and Smith, 1995). For many clients, employment is the primary concern. For women with children, their care is of primary concern, and employment is the means to obtain that goal. For clients coming from incarceration, employment may be a condition of their parole. For others, work may seem unrelated to their current needs and desires as they perceive them. Still, exploring vocational goals can help these clients attain other goals, such as increased financial independence or a more satisfactory living arrangement. By helping the client appreciate the benefits of work, expressing optimism about the client's ability to obtain work, and preparing the client for the work environment, the clinician can foster positive change in the client's sense of worth, increase hope for the future, and positively affect many other areas. Figure 3-1 presents a list of early-stage vocational issues to explore with clients.

Many persons in recovery share common internal and external challenges in regard to employment. These include out-of-control feelings, coexisting disorders or disabilities, low self-esteem and self-efficacy, poor work histories, fear of failure, fears and anxieties severe enough to block needed actions, deficiencies in life skills such as financial planning, and poor problemsolving or coping skills. As these challenges become clinical issues, the clinician should address them in an empathic but motivational style, building rapport and trust and practicing reflective listening skills. A solution-focused approach can be used to help clients recognize that although it feels as if there are no alternatives, they can choose from among a range of options. The timing of the introduction of elements of vocational services depends on a number of factors, which are presented below in the section on developing the treatment plan.

A treatment plan for substance abuse ideally includes professionals from a number of disciplines. This multidisciplinary approach is discussed in greater detail below. The roles assumed by two of the players—the alcohol and drug counselor and the VR counselor—differ from one program to another and sometimes even within programs from one client to another. If the alcohol and drug counselor is the only person addressing employment issues, this clinician's tasks will be different from the case where the client is engaged in a formal vocational program.

The clinician—either the alcohol and drug counselor or VR counselor—has important responsibilities in (1) activating and supporting the client's desire for change, (2) motivating the client to take the risk of seeking new or better employment when appropriate, (3) helping the client learn to anticipate and solve problems, and (4) referring the client to community resources that can provide support at various points on the employment continuum.

Appropriate therapeutic goals in the realm of employment include the following:

- Help the client establish a positive life vision. What were the client's childhood dreams? What kind of person does she want to be now?
- Establish life goals with the client that are consistent with this life vision and realistic in

Figure 3-1
Early-Stage Vocational Issues and Approaches

Psychosocial–Spiritual Values

- Explore alternatives to a substance-using lifestyle and personal value system.
- Explore goals, interests, abilities, strengths, weaknesses, and personal values.
- Learn to consider personal and spiritual needs.
- Identify and acknowledge specific talents.
- Develop the concepts of lifestyle change and psychosocial development.
- Have a stable home and intact family; receive regular paychecks.
- Examine the relationship of substance abuse to other life issues.
- Consider ways to achieve positive parenting, good health, and economic independence from welfare and other support systems.
- Revise one's self-concept in relation to independent functioning at home, school, and work.
- Develop a positive outlook.

Activities of Daily Living

- Learn effective socialization skills.
- Interact without the use of drugs, with people who have not used drugs.
- Engage in activities of daily living.
- Begin to incorporate more healthful habits into daily living.
- Learn appropriate dress, hygiene, walk, talk, and eye contact.
- Learn to manage money.
- Open and maintain bank accounts, budget, and save money.
- Change living situation, if necessary.
- Acquire stable housing away from people currently using drugs; reunite with spouse, parents, or children.
- Check for any outstanding arrests on the client's record and follow up on results.
- Clean up legal records.
- Increase independence and responsibility.
- Assume responsibility for managing money and solving problems.
- Improve communication.
- Talk to new people in new ways.
- Learn to structure and be responsible for time.
- Manage time, calendar, appointments.
- Organize documents, e.g., social security card, birth certificate, military discharge papers, driver's license, diploma, training certificates.
- Get credentials in order and ready to present.
- Consider spirituality as a part of daily living.
- Determine sources for spiritual expression.

Education

- Evaluate educational level, skills, and potential.
- Take tests, assess deficits, plan for remediation if required.
- Examine attitude toward school.

Figure 3-1 (continued)
Early-Stage Vocational Issues and Approaches

- Highlight positive points.
- Consider longer term educational and vocational goals.
- Consider benefits of further education.

Vocational Skills

- Evaluate vocational level.
- Take tests; engage in a situational assessment.
- Evaluate courses that have been taken; differentiate from courses that have been completed.
- Reexamine prior training and what is still current.
- Consider current vocational skills and their potential for employment.
- Perform skills assessment.
- Examine desires for training.
- Consider why further training is necessary; consider in the context of specific goals.

Employment

- Develop an understanding of the world of work.
- Read career literature; visit work sites.
- Adopt an identity as a worker.
- Explore opportunities to be productive.
- Examine work experiences for past successes and failures.
- Develop a realistic picture of accomplishments and problems.
- Consider potential for transferability of skills.
- Compare skills to job demands.

Source: Adapted from Rehabilitation Research and Training Center on Drugs and Disability, 1996.

terms of the client's knowledge, skills, and abilities

- Identify the objectives, resources, and specific steps needed to enable the client to meet those goals within an appropriate timeframe.

It is also important to have an understanding of the client's cultural and family values and beliefs about work. For example, many Asian Americans are likely to focus heavily on returning to work because of the strong work ethic within their culture and the shame associated with being out of work. Family members are likely to be pressuring the client (possibly not with great sensitivity) to return to work. However, the client may be reluctant to explore the reasons for job loss or to identify the specific steps needed to make a change.

In such cases, the clinician should validate and support the cultural value placed on the importance of work and acknowledge the client's sense of being pressured to return to work. In addition, it is sometimes helpful to frame the treatment as a rebuilding process similar to the body's healing and reconstruction after an injury.

It is important to recognize that all clients, not simply those who belong to cultural and ethnic minorities, approach work from a particular cultural framework. However, the clinician should beware of making assumptions about how clients' cultural backgrounds affect their perceptions and experience because individuals can differ significantly from the norms of their culture.

In addition, the clinician should maintain an awareness of his own values, attitudes, and biases that affect the view of work-related decisions and challenges and how these can negatively affect the client's ability to progress. The clinician who does not see in work the possibility for growth and a way to enhance recovery will inevitably communicate to the client a poor attitude regarding work.

Clinicians often play a mediating role between clients and employers, helping each understand the other's point of view. The clinician's grasp of the employer's view is essential to ensuring the client's smooth transition to the workplace. Clinicians should also take advantage of opportunities to educate the employer on substance abuse disorder issues and how to address them in appropriate policies. A service partnership or close collaboration with a VR counselor is especially valuable in mediating and facilitating client–employer relations. VR counselors work regularly with employers in their communities and are trained to negotiate win-win situations with clients and employers.

Competency Areas for Employment

As clients move toward planning for future work or addressing challenges in their current workplaces, many opportunities for personal growth and accomplishment arise. Competency areas applicable to clients in recovery who are concerned with vocational issues include

- Identifying vocational goals
- Seeking appropriate education or training
- Coping with medical and psychological challenges
- Coping with environmental challenges
- Coping with legal challenges
- Developing social and life skills
- Finding and maintaining employment
- Planning for a career and resilience
- Preventing relapse

The clinician should explore the client's developmental history and other pertinent facts in each competency area, including relevant life experiences and their positive or negative consequences. This section discusses these competency areas and addresses the clinical challenges that commonly arise in each area.

Identifying Vocational and Employment Goals

As clients envision the possibility of a vocation—purposeful work that is meaningful to them—they also have an opportunity to address important therapeutic goals such as increased self-sufficiency, self-trust, and a sense of efficacy in the world. Although employment accepted for the purpose of gaining money also addresses these goals, the sense of choice that is implied by the term "vocation" is especially powerful. Because of this, the clinician will want to help the client distinguish between short-term employment strategies and long-term strategies for developing a vocation. In guiding the client to address this important topic, the clinician should use appropriate pacing and timing and avoid a confrontational approach. A realistic vocational goal should be part of a positive and compelling life vision that truly belongs to the client.

If the client has a negative work history, the clinician can activate a positive self-image by asking the client about areas in her life in which she has been successful (e.g., helping parents or other family members, participating in a religious group or other community organization). The idea that skills acquired in one setting are often transferable to another is sometimes new and reassuring to many clients.

To assist the client with vocational planning, the alcohol and drug counselor or VR counselor will need reliable information about the client's

life experiences, especially past work and educational experiences, as well as his knowledge, skills, and abilities. If available, the clinician should review prior employment and vocational skills assessments and the results of prior aptitude testing. (Information relayed by the client about educational or VR agencies that have previously worked with the client should be verified and records obtained to ensure the accuracy of details.) With a work history, the counselor can perform a "transferable work skills analysis." Typically, this process involves the following steps:

1. Use the relevant job history, training, experience, skills learned, and responsibilities handled and identify the client's relevant characteristics (e.g., physical capabilities, working conditions, education).
2. Translate these characteristics into measurable traits and skills and assign a value or level to skill development.
3. Conserve the value of specific residual skills unaffected by disability (i.e., what the client has not lost because of disability).
4. Apply the residual traits and skill levels to the universe of potential jobs.

Salomone states that transferring skills from one job to another requires the assessment of (1) the worker-specific vocational preparation that classifies work as unskilled, semiskilled, or skilled; (2) the physical demands of previously performed jobs; (3) a medical determination of the client's current physical and mental status and ability; and (4) the identification of specific jobs that the client could perform given the three factors noted above (Salomone, 1996). There are computer-based programs such as the EZ-DOT, CAPCO, and RAVE (Brown et al., 1994) that can be used to assist the counselor in this process.

The client's work history will reveal the skills the client already has. However, some clients may have forgotten parts of their employment history, and many will not be able to articulate the knowledge, skills, and abilities they possess. To elicit this information, the clinician can ask about specific activities the client has done, such as using a jackhammer or cooking, as well as about the client's use of spare time. Hobbies and interests sometimes suggest possible career directions, as well as natural talents. To assess clients' vocational interests, the clinician can use the easy-to-administer Self-Directed Search, mentioned in Chapter 2. The results of this scale can then be discussed with the clients to determine realistic vocational choices to explore.

As previously noted, vocational issues are ideally introduced when the client is relatively stable, although there are situations where the need for employment is so compelling that it must be addressed immediately. Whenever this issue is raised, the counselor should tailor the strategy to the client's stage of "readiness to change." A well-known model of change, developed by psychologists James Prochaska and Carlo DiClemente, is relevant (Prochaska and DiClemente, 1982). This model envisions the process of change as a wheel in which the individual moves from a stage of not thinking seriously about change (precontemplation) to seriously contemplating the possibility of change, determining to undertake change, acting to make the desired change happen, maintaining the new behavior, dealing with possible relapse, and then around the circle from contemplation once more. Different skills are required on the part of the clinician when the client is at different stages (Miller and Rollnick, 1991; see also TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* [CSAT, 1999c]). As the client progresses through the cycle of change, it becomes possible to address new and more challenging dimensions of long-term planning.

Clients who are at a precontemplation stage in regard to work may need motivation to help them develop a positive attitude toward the prospect of work. Applicable clinical strategies

include encouraging positive "self-talk" and exploring both the benefits and the disadvantages associated with work in a motivational style that elicits "self-motivational statements" (Miller and Rollnick, 1991). The clinician can build on the client's desire to stay "clean" and show how work can support that objective by providing a legal means of income as well as the potential for developing relationships that support a substance-free lifestyle.

Some clients who have clear and pressing reasons to find work are nevertheless in denial about the necessity to make a transition. This condition may present itself as avoidance: "I'm doing 12-Step and that's it—I'm in recovery, and I just can't handle anything else." Some clients enjoy the sharing and social contact that a group offers so much that they want to make it fill their lives; finding or staying in jobs may seem a distraction from what feels most important. The challenge for the clinician is to help them appreciate the realities of the situation and envision the consequences of their decisions, while maintaining the primacy of recovery. Clinicians should be careful not to foster a belief in their clients' fragility that could lead to their being denied useful services. If clients are genuinely unsure of where they stand (e.g., in regard to welfare-to-work requirements), then accurate information should be provided to them, or the clinician should make relevant referrals as appropriate.

For many clients, the transition to work seems a daunting leap from their present situation. Some are used to thinking in terms of getting through 24 hours at a time, and the thought of how to plan for a year or more can be overwhelming. Such clients can benefit from encouragement and from a focus on short-term, specific, manageable goals within the context of a longer term strategy. Clinicians can help clients envision each step and prepare them to overcome the obstacles that each step presents. For clients who lack work experience, a positive framework for considering work issues needs to be built. It should be explained to them that work is sometimes difficult and may require sacrifice but that it offers the satisfaction of achievement. For some clients, a period of temporary work in a supervised and controlled setting is necessary to prepare them for more permanent full-time work. Certain residential programs, for example, have clients engage in mechanical work under the auspices of the program in order to ease the transition and build a positive work history (see Chapter 2).

Clients who must for the first time accept menial employment will have understandable difficulty with the transition to work. Reorienting their values and framing the new work world positively is usually a long-term and difficult task. The clinician will need to help clients develop reasonable job expectations given their skills and environment. It will also be important to emphasize the nonmonetary rewards of work such as no more fear of arrest for selling or using illegal drugs and the esteem from family for having "gone straight."

Clients must also learn to envision a ladder to more prestigious employment and accept a reasonable pace of progress. Use of metaphors that are meaningful to the client helps to illustrate stages of growth leading to the goal. For example, sports superstars start out by practicing, learning, developing, and demonstrating their talents before they can build a reputation. Or, the clinician might compare the injury caused by the substance abuse, and the recovery afterwards, to the time and effort needed to rebuild the strength in an arm or leg after a serious wound or fracture. These analogies can be effective with clients who relate more readily to physical symptoms than to psychological concepts.

Even for clients who are currently employed, a reconsideration of vocational goals is often advisable as part of the recovery process.

Some employed clients in recovery should consider a transition because their job exposes them to alcohol or drug use on the job. For example, a construction worker whose crew drinks or smokes pot at lunchtime or after work may not be able to maintain a substance-free life.

Assessing the Need for Education or Training

In defining the client's educational needs and exploring available resources to meet them, it is important to recognize that the client's past experience with the educational system may strongly influence work-related decisionmaking. For example, the client may have had an undiagnosed learning disability and may have experienced repeated failure within the educational system, or the client may have had poor experiences with teachers. Some clients are illiterate, although they may have concealed this fact even from some of their closest associates. Clients who are not native English speakers may have experienced difficulties from the language difference that have affected their education. It is important for the clinician to be aware of the client's history in these areas and to help the client recognize and reframe the impact of a negative learning history on the present situation.

To support the client in obtaining successful employment, the clinician should be able to answer the following questions:

- What are the client's functional limitations that influence the type of work that would be appropriate?
- What strengths and attributes does the client bring to the world of work?
- Is the client literate in any language?
- Does the client use more than one language?
- What is the client's language preference?
- Is improving language skills important to the client?
- What is the client's level of education?
- What level of education does the client want to have?
- What is the client's past experience with schooling or learning?
- What is the client's present attitude toward schooling or learning?
- What level of literacy or educational attainment is necessary to meet the client's current vocational goals?

The clinician can learn the answers to some questions indirectly by noticing cues from the client, assessing writing skills on the basis of the intake forms, and observing the client's patterns of communication. Other questions are best addressed by asking the client directly at an appropriate time in the treatment process. Typically, the clinician makes a preliminary estimate of the client's educational abilities at the outset, then refers the client to other resources as necessary for a more thorough assessment. Counselors working with clients who are ex-offenders also should be familiar with the educational resources available to those clients through the prison system so that appropriate referrals can be made if necessary.

When the clinician has the information about the client's educational history, needs, and interests, the clinician can then assist the client with identifying career goals and determining the education required to meet those goals. The clinician should help the client recognize when his goals may be either too high or too low. However, it is important to be sure the process is client-driven, emphasizing the client's responsibility for decisionmaking.

As the client demonstrates a capacity to engage in education and becomes more employable, the clinician can support the client by raising the bar of expectation and encouraging the client to take on more challenging educational and vocational objectives. It is important, however, that the pace of progress not exceed the client's ability to

experience success and handle whatever disappointments occur.

Finding and Maintaining Employment

The process of finding a job provides an opportunity for clients to grow in many areas important to recovery. It provides an opportunity to practice goal-setting and recognize achievement. Through a successful job search, the client can acknowledge the potential for positive change and movement in a direction of her own choosing.

To be successful, clients may need to grow in a number of different ways. Common growth areas include the following:

- *Overcoming the fear of change or the unknown*. Counseling can be a valuable resource in overcoming this fear, which can lead to relapse in a newly recovering substance user. This fear is also addressed by pointing the client toward a job club formed by others in a similar position or by helping the client find a peer or mentor who has traveled a similar path. Judicious self-disclosure by the clinician may also be appropriate. Moving toward desired goals may still be anxiety producing, and small steps will maximize success.
- *Developing job-seeking skills*. These skills include allocating an appropriate amount of time to job hunting, finding ways to compensate for the lack of a network of well-placed contacts, using the job search methods most likely to be successful, being available for employer contact, and mastering the "walk, talk, and dress" of an employable person.
- *Being patient*. Overcoming the desire for immediate gratification, learning to accept incremental progress, handling disappointments appropriately, and keeping things in perspective are all parts of a healthy approach to work.
- *Communicating effectively with the employer.* Clients must learn how to present facts about the past and any disabilities to employers in a positive framework as well as how to gauge a prospective employer's willingness to work with a person in recovery. Addressing gaps in employment that have resulted from being fired from previous jobs or from being incarcerated is also important. This provides an opportunity to frame the treatment experience as a transition, focusing on the client's views for the future—but without dishonesty or denial. It can be beneficial for clients to talk with their employer about treatment and the choices they are currently making, placing their past choices firmly in the past. For some, being employed will provide incontrovertible evidence of the changes they have made. Counselors should caution clients to be selective in self-disclosure. Some employers can be very judgmental. Figure 3-2 depicts a model for an appropriate dialog that the client could practice through role-playing exercises with the clinician or therapy group members (recognizing that interviews in the real world are not likely to be so straightforward).

Once the client has found employment, the work setting itself will present challenges and provide opportunities for growth. It provides an opportunity to learn appropriate boundaries and appropriate self-protection. The client may need help discerning when self-disclosure is appropriate and when it is not. Recovering clients who are newly employed—particularly those with criminal records—should be careful of being in vulnerable positions in which they could be accused of stealing or other illegal behaviors (e.g., avoid closing up a store alone). Work will also provide an opportunity for some to recognize and accept responsibility.

Workplace conflict is to be expected, and persons in recovery may find such conflicts powerful triggers for relapse.

Interviewer: I noticed that none of these jobs lasted more than 18 months, and most were only a few months.
Client: Yes, a couple of years ago I had problems at a couple of jobs. I think it was partly a question of immaturity. I just wasn't ready to take things seriously.
Interviewer: I also noticed that you haven't been working for the past year. What have you been doing?
Client: I decided I had to get my life together. I'd started using drugs and ended up getting arrested. The court gave me a choice and I took the opportunity to go into drug treatment. I learned a lot about myself and also about working. At the treatment program I volunteered to work in the office.
Interviewer: Do you have any convictions?
Client: Yes, one conviction for drug sale and possession while I was using drugs. I did have problems earlier, but at the drug treatment center I found that I really enjoyed working in the office doing data entry, filing, and answering the phones.

Source: Adapted from Englehart, 1993.

The workplace may evoke associations with the family of origin, intensifying and potentially distorting the client's sense of what is at stake in conflict situations. The clinician, alone or through a therapeutic group, can help the client get the distance needed to perceive the situation accurately. The therapeutic process will help the client become conscious of associations and better able to separate past and present issues. Impulse control, problemsolving skills, stress management, and conflict resolution skills may all require development. In addition, the client may need help recognizing the legitimate options open to her in the situation—for example, getting help from the human resource department or requesting a transfer.

Many persons in recovery experience problems with authority that can become clinical issues as they enter the work environment. Some mistrust authority and experience a great deal of stress when dealing with their supervisors. They may have an excessive fear of being fired or a too-quick response to perceived mistreatment. Some fail to manage anger and can explode when the boss is critical or inflexible. The clinician can help the client distinguish between appropriate and inappropriate behavior on the part of the supervisor, and, if this is a problem, help the client separate emotional reactions to the supervisor from feelings about a parent or other authority figure. Clients can work on seeing "the boss" as a person. In addition, clients should learn to recognize their personal power in dealing with the supervisor and notice opportunities to negotiate. These issues can be dealt with successfully in individual or group therapy, or the client may be referred to community resources for training in pertinent job and behavioral skills such as anger management.

Coping With Medical and Psychological Challenges

Some clients have medical and psychological needs and limitations that can affect the type of employment for which they are best suited. The clinician can help them consider how to present these needs and limitations to an employer and acquaint clients with their legal rights concerning accommodations.

Clinicians should receive basic information on the client's medical and psychological condition at intake. The Addiction Severity Index (ASI) can provide a brief history and description of the client's medical needs (See Appendix D). If a more in-depth vocational assessment is needed it should be done by a VR counselor or a vocational evaluator (see Chapter 2). Also, a physical examination is usually part of the intake procedure; the clinician should identify acute and chronic medical needs and identify a process to address them. In particular, clients should be screened for substance abuse-related disorders such as sexually transmitted diseases, HIV/AIDS, and hepatitis, at the initiation of the treatment process so that these disorders may be treated and stabilized prior to the client's vocational training or employment endeavor. The screening should include determining what accommodations might be necessary for a client with medical dysfunction in training or employment settings.

Similarly, at intake or as soon as possible thereafter, clinicians should determine whether the client has coexisting psychiatric disorders. ASI has a psychiatric domain that may be helpful. The client may have problems such as depression, anxiety, anger control, memory deficits, concentration deficits, or more severe symptoms such as hallucinations. In that case, the client should be referred to a psychiatrist for further evaluation and to determine whether medication is necessary (or if current medication is effective). Such disorders have implications for vocational planning and for the kinds of support the client needs from the clinician when actively seeking or trying to maintain employment. Keep in mind that diagnosis of a psychological disorder is impossible if the client is still using. The psychoactive effects of drugs or the manifestations of withdrawal may mimic the symptoms of mental conditions. Generally the client must have abstained from drugs for an extended period of time (6 to 12 months) before a differential diagnosis can be made.

Special issues arise for clients who are either reliant on opioid maintenance therapy (i.e., methadone) or dependent on prescribed medications. If a client is taking methadone, then she may fail drug tests mandated in some places of employment unless she has disclosed the fact to the employer's medical review officer. It can be beneficial for a methadone patient to transfer to treatment with LAAM (levo-alpha-acetyl-methadol) as LAAM cannot be detected in urine drug screens except for thin layer gas chromatography and gas chromatography/mass spectrometry. See TIP 22, *LAAM in the Treatment of Opiate Addiction* (CSAT, 1995d). Similar problems can arise with certain prescription drugs (see Chapter 7 for a discussion of associated legal issues). The clinician or another knowledgeable specialist should help the client manage appropriate self-disclosure in advance of the drug test so that his right to confidentiality is protected.

Medications can generate a variety of other work issues that, whenever possible, should be anticipated before the client seeks or accepts employment. Some psychotropic medications, for example, can cause side effects such as lethargy, dizziness, and nausea. It is essential that these side effects be considered when determining appropriate work situations for clients so that they are not placed in a dangerous situation or one that will ultimately lead to failure. The timing and conditions under which the medication must be consumed should also be taken into account. Some medications leave the body through sweat, reducing their effectiveness; clients in jobs involving physical exertion, such as construction, should make appropriate adjustments for this. In other cases, a job coach or other monitoring may be needed to help the client cope with coordination problems resulting from medication.

The clinician should also ensure that clients (particularly those with comorbid medical or psychiatric disorders) recognize the importance of finding a job with health insurance. A good number of clients will obtain jobs without benefits or with benefits that phase in after a probationary period. Those involved in treatment should coordinate their efforts to ensure the most positive blend of resources and services possible to assist clients. In addition, counselors should educate clients about their right to confidentiality and accommodation for disabilities (see Chapter 7; see also TIP 29, *Substance Use Disorder Treatment for People with Physical and Cognitive Disabilities* [CSAT, 1998c]).

Coping With Environmental Challenges

Many clients must overcome logistical challenges to securing and maintaining work. The clinician can play an important role in helping clients identify the most effective approaches to addressing these difficulties. The Consensus Panel suggests using solution-focused strategies, building on coping skills the client has already demonstrated, and applying them to new contexts. Clinicians should encourage the client to identify resources used to accomplish other objectives and determine how these strategies might be useful in negotiating work-related issues. The clinician also should know about community resources, particularly in the frequently troublesome areas of housing, transportation, and child care. Progress and difficulties in meeting employment goals should be discussed regularly.

Housing and other basic needs

The clinician should be aware of the client's basic living situation and be able to refer the client to community resources if needed. Is the client coming from a residential treatment setting? Is he homeless, just out of the hospital, or in a group home with substance users? The client's living arrangements will have implications not only for the availability of support during recovery, but also for the availability of job-related resources such as access to an answering machine or a reliable message taker. Clients can also be referred to one-stop career centers or employability centers for assistance. Clinicians should be familiar with what housing options are available, such as through local housing authorities and the U.S. Department of Housing and Urban Development (HUD).

Transportation

Many clients have transportation issues such as suspended or revoked driver's licenses, lack of public transportation, or geographic isolation. For people with children, long hours on public transportation and the ability to get to a sick child greatly influence the ability to stay employed. If transportation is known from the beginning to be a problem, the client should only explore job opportunities accessible by public transportation. Clinicians can help them review how they have arranged transportation in the past (e.g., to get to a methadone clinic), and brainstorm about alternatives, including carpooling. VR services, medical assistance programs, and public transportation systems often provide free or low-cost transportation for eligible clients.

Child care

Locating suitable, convenient, and affordable child care is a common problem. For clients involved with child protective services or welfare agencies, child care vouchers are available both for child care centers such as the YMCA and local Boys and Girls Clubs and for family day care arrangements. These programs are usually licensed and provide safe and developmentally appropriate services for children while parents are at work. Head Start and early intervention programs are also available for low-income families through local schools, religious organizations, and social

service agencies. Some child care voucher programs are initiated when employment begins. The resources clients used to care for their children when they were using substances are probably not the safest or best alternatives. However, the clinician can expand the client's repertoire of possibilities by making suggestions—for example, sharing caretaker responsibilities with friends or relatives who work different hours. Again, being familiar with local child care agencies and resources will allow the clinician to provide appropriate referrals in this area.

Coping With Legal Challenges

For some clients, eligibility for work can be affected by criminal records or by issues related to their immigrant or residency status. Clients are sometimes barred from specific jobs (such as child care worker) on the basis of prior convictions. In addition, many have records so complicated they are actually unaware of outstanding warrants; it is not unknown for a client to have rebuilt her life and be gainfully employed, only to be arrested for a crime committed some years ago. See Chapter 8 for more information about working with ex-offenders.

Recent immigrants often need assistance in collecting the documents needed to work and in accessing reliable information about legal requirements. The clinician should direct such clients to community resources for help in applying for legal residency, getting a work permit, or learning the process for becoming a U.S. citizen. Clients not familiar with the U.S. Immigration and Naturalization Service and State requirements will need help distinguishing between realistic concerns and those that should not be a deterrent in seeking and maintaining work (see Chapter 7).

Developing Social and Life Skills

The first task in helping a client move toward employment is motivating the client to want to join society rather than be on its fringes. Work is an opportunity to advance the client's progress toward this important goal. The newly employed client can practice effective communication skills in a new environment, including learning how to talk to persons in authority, manage anger, and raise issues effectively. Developing confidence in appropriate self-expression, especially when it leads to the desired result, can enhance the client's sense of self-efficacy. Researchers have demonstrated that when people believe that they are capable of performing a new behavior (i.e., have efficacy expectations) and know that the new behavior will get them what they want (i.e., have outcome expectations), they are likely to persist and be successful in their attempts for change (Bandura and Adams, 1977).

Clients returning to work, or those attempting to maintain employment for the first time after a period of withdrawal from society, may be deficient in the basic skills needed to function within an organizational culture, manage resources, and gain social acceptance. Specific skills that may be needed include

- Communication skills, including appropriate and inappropriate responses to supervisors and coworkers
- Cleanliness, personal hygiene, and appropriate dress
- Management of personal finances
- Healthy eating habits
- Management of time, including getting enough sleep and being at work on time, managing competing obligations to family, work, and treatment (especially regular attendance at AA or NA meetings)
- Coping with crises that can trigger relapse
- Responding to invitations to "happy hour" or office parties

- Recognizing and respecting unwritten "rules" of the work culture, such as not bringing friends or children to work

Although some transition skills may be effectively gained through referrals to other community resources, it is the clinician's responsibility to assure the client of the necessity for change and to engage the client in mastering the social skills that will support recovery. The clinician can use the group therapy format to give clients an opportunity to role-play responses in difficult social situations and receive feedback from the group. If the client is employed at a work site that pressures him to drink, the client may need help avoiding or managing ostracism—or finding a healthier work environment.

For clients moving into the work environment for the first time or after an extended period of withdrawal, family members' behaviors toward the client around work issues can either help or hinder the client's progress. It will be useful for the clinician to have some information on how family members are responding to the client's employment situation.

An understanding and encouraging family can provide much needed emotional support to the client. Unfortunately, however, many families may have covert reasons for not wanting to see the client recover fully in the area of work. For example, clients may fear losing disability benefits if they recover sufficiently to work or a wife may be ambivalent about her husband's return to work because she has grown accustomed to being the sole decisionmaker in family matters while her husband was disabled by his substance abuse. If these issues are not addressed, then family members might not support the client's attempts to return to the job market. In fact, the family members might actually sabotage the client's efforts to return to work, viewing work as competition. For example, a client's child may begin acting out at school to get his attention. Recognizing and dealing with family resistance to work is a complex and continuing task with some clients.

Planning for a Career and Resilience

Losing a job, which can trigger a profound sense of failure and self-doubt, has been highly correlated with relapse (Platt, 1995). Yet, few persons in this era can expect to retire from the job at which they first started work—either through their own choice or their employers'. As a result, the client is likely to have more than one opportunity to exercise job-seeking skills. Today, the "contract" between employer and employee is "short-term and performance based," and "the company's commitment to the employee extends only to the current need for that person's skills and performance" (Hall and Mirvis, 1996, p. 17). Because of this philosophy, the clinician should help prepare clients for the need to change and grow throughout their work life. Either directly or through referral, the clinician should help clients envision the next steps they might take after leaving their present job. This kind of preparation can make each job, regardless of its duration, a learning experience rather than a failure. Some job counselors envision an employment "web" in which the client can move laterally, up, or down to accomplish strategic objectives. Clients should be prepared to show resilience and exercise choice in their work lives.

Preventing Relapse

As discussed previously, job-seeking and employment present an opportunity for growth and stabilization that can support recovery. However, the process can also be stressful and present many potential triggers for relapse. For example, if a client witnesses substance abuse on the job, should he report it or try to be "one of the guys?" General assistance in managing stress effectively should be provided.

Even if the client can find employment that provides good support for a substance-free lifestyle, the workplace will almost inevitably present challenges that could trigger renewed use. The clinician should be alert for the presence of triggers that have affected the client in the past and help the client recognize and cope with them. For example,

- Losing a job may trigger relapse.
- Jobs that do not provide sufficient structure can lead to boredom—a common trigger for use. Time away from work, formerly structured by alcohol or drug-related activities, will also need to be structured.
- Some workplaces offer frequent invitations to socialize where alcohol or even, in some environments, drugs are consumed. The client may need help maintaining a substance-free lifestyle without becoming an outcast.
- Job finding will have a systemic impact on the family, especially when the "screw up" suddenly becomes the breadwinner and wants a major or leading role in family decisions. To help other family members cope with such changes, family therapy should be considered at an early stage of vocational counseling (if it is not already a component of substance abuse treatment). Family members are more likely to support the client's vocational goals if they understand the issues and feel included in the process.

Developing the Treatment Plan

To achieve therapeutic goals in the domain of employment, the clinician should develop a treatment plan that addresses the client's vocational training, rehabilitation, and employment needs. Typically, such plans cover a period of 90 days (although some treatment episodes do not allow for this length of time).

The case studies at the end of this chapter illustrate how vocational rehabilitation is integrated into treatment plans. Consensus Panel members suggest envisioning the clinical treatment process as intertwined with the client's cultural background and the client's "work identity." Work identity denotes the specific meaning of the concept of work to the individual client. This includes

- Why work is done ("Why do I work?")
- The degree of importance placed on work ("How much does work really matter to me?")
- The client's life goals ("Where will it get me?")

The client's goals can include the attainment of good pay, interesting work, job security, opportunity to learn, interpersonal relationships, variety in tasks, autonomy, opportunity for advancement, and other considerations (England, 1991). These motivational considerations will obviously influence the career path chosen. They are also integral to the treatment process, a way for the individual with a background of substance abuse to begin to create an identity as a person in recovery.

The following considerations, discussed in this section, are key to the formulation of a treatment plan:

- Multidisciplinary participation
- Timing of vocational training, rehabilitation, and employment services delivery in relation to substance abuse treatment service delivery
- Tailoring treatment plans for the different stages of the substance abuse disorder and recovery, as well as plans related to recovery from use of, or dependence on, different substances
- Consideration of external factors in treatment planning
- Maintenance of employment gains and relapse prevention

Multidisciplinary Participation

To provide adequate support to the client in gaining successful employment, multidisciplinary participation is often needed. The case manager, whether the clinician or another person, should identify people from a range of professional disciplines who are able to supplement the clinician's skills and meet the client's needs. Most should be involved at the time of intake, then consulted afterward as needed. The group will most likely not come together as a team, but members should recognize that they each have significant responsibilities toward the client. Because of their ability to help clients meet therapeutic goals in their domain of employment, the group frequently includes the following members:

- VR counselor
- State or local employment service representative
- Education specialist or special education person for school or transition programming
- Nurse, physician, mental health clinician, or psychiatrist (for coexisting disorders)
- Adult education consultant
- Vocational trainer or work adjustment trainer
- Social worker
- Disability specialist
- Job placement specialist

Some clinicians would include the client's new employer or a representative of the client's school as a member of the treatment recovery team. Advantages to this approach include the potential for educating this person, as a representative of an institution that will play a key role in supporting recovery, to understand potential triggers for relapse in the workplace and increase the likelihood that the client will receive appropriate support. However, even assuming the client's informed consent, issues related to confidentiality, boundaries, and stigma should be carefully considered. Conflicts of interest could arise. The employer or educator may treat the client differently and project a bias, consciously or unconsciously, that affects the individual's employment experience.

Timing of Vocational Training, Rehabilitation, and Employment Services

Unless a client needs time for detoxification or adjustment to sobriety, some aspects of prevocational counseling can begin in the early stages of treatment. If the client has an immediate need for employment and is capable of managing it successfully, the timetable can be accelerated to encourage the client to accept an available entry-level job.

Although treatment initially focuses on use issues, a brief discussion of long-term treatment goals, such as work, will lay groundwork for later therapy. The client should have, in the back of his mind, the notion that work will be an important component of recovery, and although not addressed directly at first, vocational issues will play an important role in his treatment. The time for introducing vocational services must be paced according to the client's specific situations. Among the factors that must be considered are

- The client's stage of recovery
- The client's stability
- Any external legal mandates
- Impending termination of public assistance benefits (for either the client or dependent children)
- Limits on duration of treatment
- The client's goals
- The identification of therapeutic goals that may be addressed through the vocational domain (such as the need to learn to structure time or respond appropriately to authority)
- Client recovery needs that can only be met through gainful employment (such as earning funds necessary to move from a house where people are using substances)

It is important to coordinate treatment services to avoid conflict with the client's current job or educational pursuits because both of these may be helpful in stabilizing the client and supporting a substance-free lifestyle.

Tailoring Treatment Plans

Stages of substance abuse and recovery

Vocational plans will differ according to the client's stage of substance abuse and recovery. The client's commitment to work and the appropriate type of work can only be projected on the basis of thoughtful analysis of his specific situation. This includes considerations related to the specific substance or substances the client has used, his pattern of use, the amount of time in recovery, relapse triggers, and the social and other support systems available to assist in his recovery. If ongoing effects from substance abuse are evident, the clinician should assess the level and nature of dysfunction the substance abuse is causing (or has caused). Clearly, the client's level of functioning will affect the type of work he can undertake successfully (see Chapter 2 for further information on functional assessment).

Substance abuse

If the client does not have medical complications or withdrawal, or if the client has used a substance that does not have long-term effects that continue into the period of initial withdrawal, vocational planning issues can be addressed earlier in the treatment process. Vocational issues should be discussed whenever the opportunity arises. Even if a client's prospects for obtaining employment in a competitive market are slim, volunteer or supported work activities can be an important adjunct to traditional treatment and can give structure and meaning to the individual's life.

Substance dependency

Short-term dependency

Individuals with short-term substance dependency are likely to have less severe functional limitations and therefore a potentially wider range of job options (if they are unemployed). They may have a positive work history and may even have maintained a job. If they do need employment, they usually will have fewer difficulties in gaining it. If other factors are equal, these individuals are generally capable of achieving higher goals.

Chronic dependency

Some individuals with chronic substance dependency (dependence for 2 years or more) can be employed, but the longer the dependency has continued, the more likely it is that the individual has lost her job and has experienced functional loss and other difficulties that will make her more difficult to employ. These individuals generally have more medical problems or issues. Also, as masked symptoms emerge, the clinician may encounter coexisting disorders such as depression and anxiety that will have ramifications in the workplace. These clients usually have fewer resources and may have burned more bridges during their period of dependency.

A special class of chronic users includes functional alcoholics, whose relatively ingrained dependency is usually time limited. These individuals have learned to abstain for short periods—long enough to maintain employment—then binge. In setting goals for individuals with chronic dependency, enough time must be allowed for the individual to adjust to abstinence. As use decreases, vocational challenges can be increased.

Clients in early recovery

Clients who have been abstinent for 90 days or less are at the greatest risk for relapse. Because

of this, modest vocational goals are more appropriate. However, some individuals have significant cognitive dysfunction and have difficulty making plans and structuring time. It is generally best to limit stress and make only gradual changes in life activities, keeping the client focused on the recovery process and the "here and now." If it is essential to address vocational goals prior to 90 days of abstinence, then strong supports will be needed to maximize the individual's chance of success.

Mid-range abstinence (3 months to 2 years)

Individuals who have maintained their abstinence for more than 3 months have a diminished risk of relapse and, in general, a greater success rate for engaging in new activities and tolerating stress. Their family lives and sense of self have moved toward stability, and they have an increased capacity for long-range planning and problemsolving. They are often ready to engage in active job seeking or to begin work toward long-term vocational goals by acquiring new skills and knowledge. The treatment provider should ensure that the vocational plan provides that resources will be in place should a crisis occur, with adequate aftercare and followup treatment.

Recovery from different substances

The type of substance or substances the client has used also has implications for employment planning or work toward long-range vocational goals. Although each client's situation will have unique elements, the following generalizations suggest common concerns that should be taken into account.

Alcohol

Because alcohol is a legal substance, clients who use alcohol have generally experienced more social acceptance and are less likely to have criminal records than persons who use illegal drugs. These clients may, in general, have greater functional ranges, fewer personality disorders, and less of an "up and down" cycle than those dependent on illegal substances. As a consequence, there tend to be fewer obstacles to employment, and the client may have succeeded in maintaining a job through the period of dependency.

Even when a client in treatment is employed, there can be obstacles in the vocational area. These clients are more likely to have coworker encouragement to use alcohol. For example, going out for lunch with others may be a trigger for use, or employees may get together at a bar after work on Fridays. As part of the "methods" section of the treatment plan, the clinician and client will want to consider how to change work-related habits that have encouraged alcohol use in the past; for example, the client may find a lunchtime 12-Step program meeting or take a book to lunch, following the standard process of changing "people, places, and things" associated with use.

It is usually possible to detoxify the client's system in a relatively short time, even for clients who have used alcohol intensively. It is important to consider the implications of detoxification for employment and manage the issue of work leave in the manner most likely to protect the client's job. The client's workplace may have an employee assistance program that can help with this task. Ideally, the client will have sick leave or annual leave that may be used to provide the time needed without endangering employment.

For clients whose alcohol use has affected their attendance at work and who have a negative reputation for reliability, the plan may appropriately include a quantitative objective, such as attending work for 28 out of the next 30 days. Pharmaceutical help may be available to the alcohol-dependent employee. Naltrexone (ReVia) is approved by the Food and Drug Administration as a treatment for alcoholism. Although its cost is prohibitive for some, naltrexone appears to reduce craving in many

abstinent patients and block the reinforcing effects of alcohol in many patients who continue to drink. The latter effect often enables patients who drink a small amount of alcohol to avoid full-blown relapse and lessens the likelihood of their return to heavy drinking. The mechanism of naltrexone's effect in alcoholism has yet to be conclusively demonstrated, but there is hope that combining this drug with "talk therapy" (i.e., cognitive–behavioral treatment) will reduce relapse and improve outcomes of traditional alcohol dependency treatment. For more information about naltrexone, see TIP 28, *Naltrexone and Alcoholism Treatment* (CSAT, 1998b).

Amphetamines

Depending on the length of time the client has used amphetamines, a longer period of abstinence may be required before vocational rehabilitation can begin in earnest. Long-term use may result in psychosis, making short-term employment impossible. Other common coexisting disorders include depression, anxiety, and panic attacks—all of which raise the possibility of relapse. Problems maintaining attention and concentration are also common. These difficulties, which should generally be dealt with through appropriate referrals, usually suggest the need for a relatively long period of abstinence before symptoms are controlled and vocational issues can be addressed.

Amphetamine users typically are excitement seekers who are used to performing when "up" and then crashing. During the "down" part of the cycle, they may have experienced a high rate of absenteeism from work. Therapeutic objectives can address the client's need to keep a steady pace throughout the day. Healthy nutrition, energy management, and sleep are all likely to be important areas in which behavioral changes are needed in order to sustain productivity.

In setting vocational objectives, a sensible balance is needed between jobs that require high levels of risk-taking behavior and those that offer too much sameness and predictability. High-excitement jobs feed the "up-and-down" cycle associated with amphetamine use and also may offer daily association with others who may use amphetamines, resulting in a high potential for relapse. Monotonous, clerical work is likely to result in relapse because of boredom; jobs that require creativity, flexibility, and movement are usually more successful. For example, an intelligent former amphetamine-using individual with computer skills might do well at designing computer games.

Cocaine

There is no pharmacological substitute for cocaine, as there is for heroin, and an intense subculture helps to maintain the cocaine-using lifestyle. During the period of active use, the user will typically have a spotty record of work attendance, sometimes leading to job loss. It is not uncommon for cocaine abusers to have borrowed against their next paycheck. This behavior should be addressed with arrangements to repay the company. Long-time users may have brain damage (neurochemical changes) and functional loss (Gawin and Ellinwood, 1988). Whether the client has used crack or powder cocaine, it is important to consider work that will help the client maintain the sober lifestyle because it is easy to become readdicted. Coexisting depression and anxiety disorders must be addressed with cocaine-dependent clients (as with other recovering substance users) because these negative emotional states readily lead to relapse.

It is important to have a plan for rapid intervention and excellent aftercare. Potential relapse may also be reduced by asking the employer to directly deposit paychecks into the employee's bank account. As with any recovering substance user, jobs that are especially likely to trigger relapse should be avoided—all night shifts at factories, routine jobs, unsupervised jobs such as late-night guard,

or jobs in industries that contain a high percentage of users (Budney and Higgins, 1998; Carroll, 1998). For more information on the treatment of cocaine, see TIP 33, *Treatment of Stimulant Use Disorders* (CSAT, 1999b).

Heroin

For recovering heroin users, an adequate period for detoxification before resuming work is critical. Clients experiencing withdrawal symptoms will be too ill to concentrate in a structured environment for any length of time. Intravenous injection of this drug can cause related medical problems that must be addressed before these clients can work. Such problems may include hepatitis, endocarditis, fatigue, and ulcers. Many clients will not be able to do a great deal of walking or handle physically demanding jobs during the recovery period.

As previously noted, clients who are in opioid maintenance therapy (i.e., methadone, LAAM) should have a plan to address the possibility of failing a urine test. It is also important to take the job requirements into account when the dispensing schedule is organized. Because work will mean relearning the rituals of maintaining relationships and acting appropriately within the work culture, the treatment plan may also include objectives related to reacquisition of social skills and their application in the workplace.

Prescription drugs and narcotics

Some clients use prescription drugs, including narcotics, to self-medicate to mask anxiety, depression, or pain. The treatment plan should include a process for addressing these underlying conditions. For example, national pain management organizations can perhaps suggest alternative ways to manage pain. In vocational planning, the clinician should bear in mind that pain saps energy, and individuals who suffer from chronic pain are unlikely to be able to manage high-energy jobs.

Polysubstance abuse

Individuals who have been polysubstance users may have cognitive impairments such as hyperactivity and concentration deficits that will limit their potential for employment. They may also have more complex triggers for use. The clinician should assess these triggers and, based on findings, identify comfortable, incremental steps that can be successfully achieved. Although difficult, it will be helpful to identify work environments that provide as few of the individual's primary triggers as possible.

Consideration of External Factors in Treatment Planning

Welfare-to-work issues

Clients who are required to have a job in order to maintain eligibility for welfare, or who are losing welfare support, may have to start work earlier in the recovery process than would ordinarily be advisable. Under these circumstances, the client should be assured that the job he has accepted, for which he may be overqualified, is a temporary choice that is appropriate to meeting the immediate need. In addition, the client's initial job may provide a forum for acquisition of job skills, social competencies, and recommendations requisite for higher education or employment.

Child custody issues

With individuals for whom child custody is an issue, whatever is required to regain or maintain custody is likely to be the client's top priority. The timelines and requirements related to this external constraint should be reflected in the vocational plan.

Lack of finances

In treating clients who lack funds for basic expenses—food, shelter, clothing, transportation, child care, and health care—the clinician's role is to help the client find community resources and social services to help

meet these basic needs. An entry-level job may be appropriate for meeting the immediate crisis. Therapeutically, the client's need for financial support may be a powerful motivator for positive change.

Discrimination in the labor market

Participation in the work world is, unfortunately, influenced by many factors other than an individual's interests and abilities. Segments of the labor market may be less accessible for some because of gender, race, ethnicity, culture, and disability. These differences are due to societal factors such as discrimination and unequal educational resources allocated to schools in lower income communities (Szymanski et al., 1996).

The clinician should maintain a realistic attitude when addressing clients' specific situations, ensuring that their goals are achievable and that they understand legal antidiscrimination protections. A number of legal protections exist to protect people from workplace-related discrimination (see Chapter 7 for more information on these protections). It is important to acknowledge the reality of discrimination that some clients face, while concurrently nourishing a drive to succeed and channeling it in promising directions.

Maintenance of Vocational/ Employment Gains and Relapse Prevention

When clients return to work, they are exposed to a number of potential relapse triggers (Rehabilitation Research and Training Center on Drugs and Disability, 1996). These include

- Active drinking or substance use by other employees
- Pay day (i.e., money management)
- Working a rotating, "graveyard," or night shift
- Seasonal work
- Lack of supervision
- Working excessive overtime
- Dealers near the job
- Access to marketable goods or petty cash
- Receiving cash tips
- Transportation issues
- Too much free time on the job
- Working two jobs
- Too much pressure on the job
- Job dissatisfaction or boredom
- Required business meetings, dinners, and parties where drinking alcohol is expected
- The other issues and crises that cannot be addressed because of time limits now that the person is employed

The treatment plan should provide for effective management of all relapse triggers that are relevant to the individual. The plan should establish a proactive strategy to avoid the loss of newly won ground. It is useful to consider in advance the possibility of job loss or demotion and to consider the moves that would then be open to the client. This will help to reduce the likelihood that either event will lead to despair and relapse.

Case Studies

The following case studies represent either particular or composite cases familiar to Consensus Panel members. They are intended to illustrate several ways in which clinicians have helped clients in recovery from substance abuse disorders achieve appropriate vocational goals consistent with the recovery process.

Case Study 1: "Kay"

Background

Kay was referred to outpatient substance abuse treatment 4 months ago by the criminal justice system when she and her boyfriend were convicted of possession with intent to sell illegal drugs. Her drugs of choice were cocaine and amphetamines. She has past convictions related to drugs and prostitution.

Kay is 22 years old and the mother of two young children who are living with her mother, an employed waitress. Kay's therapeutic goals include becoming economically self-sufficient and regaining custody of her children. Vocational concerns have become a large part of her focus in both individual and group counseling sessions. Kay consistently insists that "any job will do." What is important to her is to be employed so that the criminal justice system does not put her in jail and thereby prevent her from regaining custody of her children. However, in planning for her to become economically self-sufficient, the clinician recognizes that she must have a job that provides enough income to support two children. In addition, the job should have health benefits.

The clinician learns at intake that Kay attended school only through ninth grade. She dropped out when she gave birth to her first child. Her educational records show that she repeated first grade; she says this was because the teacher felt she wasn't mature enough and because she could not focus on her work. Her attitude about returning to school is that it is not an option "because I am dumb." However, her records include the results of recent aptitude testing that suggest that she is capable of pursuing her education beyond high school.

Kay has a very spotty work history. Her primary places of employment were fast food restaurants and nightclubs. The counselor learns that requirements of the probation and parole system pushed her into employment in at least two instances. None of her jobs lasted more than 4 months, and Kay does not believe she is capable of holding down a job. She reports being fired for not showing up to work when she overslept or had been out partying the night before. She also has been reprimanded for not grasping the work tasks quickly enough and for having poor customer relations skills. She was fired from one job when a customer told the nightclub manager that she had a criminal record. She feels inadequate in many ways; for example, she is concerned about her ability to read and to manage numbers, count change, and so on.

Therapeutically, it is important that Kay find employment that supports her recovery lifestyle; however, the pressure she is under to locate a job must also be acknowledged. In the group sessions, the clinician finds that Kay identifies with another woman who admits to being terrified to go to work. Exploring this, Kay reveals that her fear is associated with having to tell an employer about her criminal record and what she has done to get drugs, as well as her past employment experiences.

In summary, Kay presents a self-image of failure supported by her past experience in academics and work. Her options are limited by her lack of a high school diploma or general equivalency diploma (GED), yet she needs to obtain a job that provides an adequate income and includes benefits in order to provide a foundation for her children. She has no knowledge of what types of jobs are available beyond restaurants and other service-oriented industries, nor does she currently have the skills for many occupations.

Counseling strategy

The first step in responding to Kay's vocational needs was to identify who should serve on her team. In addition to the treatment staff, the team included a State VR counselor, her probation officer, a social worker, and a representative from the State employment service. She was referred for a vocational evaluation to assist her in making employment decisions.

Kay's vocational evaluation included a series of interest inventories, aptitude tests, and other assessments. At the exit interview with the evaluator, Kay reported not being able to remember anything except that she could

complete the requirements for a GED, if she wanted to do so. A followup meeting was scheduled with her VR counselor, social worker, and drug and alcohol counselor. By this time, a written report was available, and they reviewed it with Kay in detail. Her reading and math skills were both at the fifth-grade level. She showed the aptitude to complete her GED and pursue vocational training. The recommendations for an immediate employment objective included positions in the restaurant and hospitality industries or in a clerical position such as receptionist, file clerk or other entry-level position. Certain positions for which she had an aptitude were ruled out because of her criminal record.

During the discussion of vocational alternatives, Kay leaned toward choosing a job in a restaurant because that was the type of work she had done previously. In the joint counseling session, however, it was pointed out that the hours associated with this type of work and the environment would be likely to trigger a relapse. Kay's lack of interpersonal skills was another concern. Kay also received guidance about the problems frequently associated with some entry-level jobs: Coworkers are often younger and are inclined to "party," the hours are irregular, and alcohol is readily available. There was also a discussion about what her course of action would be if confronted with situations that might cause her to relapse.

Kay's final decision was to pursue employment in an office clerical position. She was nervous that she would be rejected if employers discovered her criminal past and that she would not fit in with the other workers. Because Kay lacked effective job-seeking and maintenance skills, it was decided that she would participate in a program that taught these skills and would address the concerns about interpersonal relations at the office, as well as how to handle issues related to her criminal past. The VR counselor also arranged for her to start in the Job Club program. The program provided assistance in completing applications, looking for job openings, developing interviewing skills, and writing a followup letter. She was told she could use the rehabilitation center's facilities to look for work because they had access to the State Employment Commission's job-opening database, maintained posted job announcements, subscribed to the newspaper, and provided job placement counselors to assist in the process.

Kay obtained a job in a company that had hired a number of persons with disabilities. Because the VR counselor had experience with the employer, he told Kay about the work setting and the benefits and support programs that were available. One of those was an employee assistance program. He explained that they could help if she felt that she was having problems that would interfere with her job (e.g., stress or transportation difficulties) or that were related to her recovery. The company also had medical benefits and paid vacations.

The company's human resources director was concerned about Kay's lack of skills and educational history. She thought Kay would be a good employee but would need extra training. To assist with this, the State VR Agency arranged an on-the-job training program. In exchange for the employer providing the extra training, the agency paid a portion of her salary for a preset period.

The alcohol and drug counselor and the VR counselor worked out a daily plan with Kay. They discussed transportation to and from work, lunch, breaks, and how to fit in her Narcotics Anonymous meetings, counseling sessions, and meetings with her probation officer. They also helped her plan a budget that would allow her to save money for an apartment. In the meantime, she would continue living in the supervised housing run by the substance abuse treatment program.

Kay also expressed concern about fitting in with her coworkers. She owned mostly T-shirts and jeans and did not have suitable office clothing. A local program that helped women going back to work provided her with enough outfits for one week of work. With her clinician, she role-played possible conversations with coworkers and what she would do if approached to go for drinks after work.

She started working and was successful. Her performance evaluations were good, but her supervisor indicated she needed to work on being assertive and asking questions. In her regular counseling sessions, the clinician talked to her about daily work-related issues that arose. The supervised housing provided a setting that allowed her to talk with other people in recovery. The support group helped her identify solutions and options to problems, which included her continuing difficulty in adhering to a budget.

Kay developed a long-term plan with her social worker and alcohol and drug counselor. She would continue to adhere to a daily recovery plan, and visits with her children would be allowed. If she continued to progress in recovery, she would be able to petition for custody. At the end of the on-the-job training period, Kay continued to work with the company. Her case with the VR agency was then closed, with the understanding that followup support could be provided if necessary. She continued in aftercare and met with her probation officer on a regular basis. Once her housing and work stabilized, Kay planned to pursue a GED.

Case Study 2: "Young-Hwa"

Background

Young-Hwa, a 40-year-old Korean male, had immigrated to the United States 15 years ago without proper documentation. He had a hard life because, despite his training as a chef in Korea, he had difficulty finding a well-paying job without proper documentation. After many years as a kitchen assistant and then as an assistant cook, he finally was hired as a chef in a Korean restaurant.

During his long quest for suitable employment, Young-Hwa used alcohol to handle the stress and feelings of frustration and disillusionment. The many years of hardship put a strain on his marriage and he had many arguments with his wife. He progressively increased the amount of alcohol he used. During these heavy drinking episodes he became verbally abusive to his wife and two young children. After 3 years of continued alcohol use and verbal abuse, his wife and children left him. One year later, he was fired from his job for being drunk at work.

Over the next 3 years, he became depressed and continued to drink heavily. Finally, he was arrested for driving under the influence of alcohol and was ordered by the court to an alcohol residential treatment program.

Counseling strategy

In treatment, the clinician helped Young-Hwa by activating his desire to have contact with his children as motivation for recovery. The clinician supported the idea that his children needed a caring, loving, and competent father. In addition, the counselor focused on Young-Hwa's strengths as a competent chef for many years and engaged him in a discussion of how he could regain that level of functioning.

The clinician referred Young-Hwa to an Asian American legal services organization, which helped him apply for the immigration residency amnesty program in effect at the time. This step would grant him legal residency status.

In the meantime, Young-Hwa needed to find employment as quickly as possibly, both to satisfy requirements for probation and to support himself. There was no separate VR counselor on site; also, the client was suspicious of non−Asian counselors and resisted the idea of

a referral to State or county rehabilitation agencies. Because of this, the Korean clinician performed some of these tasks. The clinician guided him in exploring job opportunities in the Korean community and recommended that he begin at a lower level than full chef. The client resisted this idea initially, but later agreed that he needed to rebuild his level of competence in a step-by-step fashion.

He found a job as an assistant cook. Because he was very interested in boxing and was a boxer when he was in high school in Korea, the clinician used that sport as an analogy. He reminded Young-Hwa that for a boxer to come back from an injury, he needed to rebuild slowly. This rebuilding involves a step-by-step process until he finally can become a "major contender" again.

Case Study 3: "Julia"

Background

Julia is a 27-year-old Italian American female. She was referred to a specialty residential program by the child protective services agency because her daughter was born with a toxicology screen that tested positive for heroin, cocaine, and marijuana. In order to keep her baby, she was required to participate in this program with her infant daughter. Julia was administered a battery of assessment measures during her intake interview for residential treatment. These measures included the ASI (which measured her functional status in seven domains) and the Self-Directed Search (which determined her vocational interests and skills).

Julia is an only child. She lives with her mother, a nurse, and her father, an electrician. Her parents were given temporary custody of her daughter while she was waiting for placement at the residential program. The clinician learned, however, that she and her parents have had several physical fights recently, of which the child protective services agency was not aware.

Julia has had 13 years of education. She had been a nursing major at the local community college 5 years ago but dropped out when she could no longer manage school due to her polysubstance use. Julia has been drinking to intoxication on Friday, Saturday, and Sunday since the age of 15. She has also injected heroin regularly (about three times per week over the last 5 years) and has been smoking or snorting cocaine on weekends. She often used more than one substance per day—usually cocaine and alcohol—when she could not get heroin.

Julia has been arrested for assault, breaking and entering, and robbery. However, she was not convicted and has never been incarcerated. Julia usually got her money for drugs by stealing or by giving sexual favors. Julia has several close male and female friends who are also using drugs. She has had serious conflicts over the last 30 days with her parents, sexual partners, and friends. She reports that her current sexual partner, who sells drugs and is the father of her child, has physically and emotionally abused her.

Julia has been hospitalized twice for suicide attempts. She says that periodically she becomes severely depressed, can't eat or sleep, cries a lot, can't sit still, and has trouble getting out of bed. She is easily irritated when she is depressed and sometimes has difficulty controlling her anger. Julia also has panic attacks and is, at times, fearful of crowds, stores, classrooms, and restaurants where she does not know people. She is also afraid they will see her having a panic attack and think that she is crazy. Julia has been prescribed imipramine (Tofranil), lithium (Lithonate), and diazepam (Valium), but none of these medications seem to help. She finds it easier to get herself out of bed after she has used heroin or cocaine. Julia admits that her drug use may be a form of self-medication because she "feels better" after she uses.

Julia's ASI composite scores reveal that she is most in need of treatment in the areas of alcohol

and drug use, employment, social relations, and psychiatric problems. Julia herself rates her need for treatment in the areas of alcohol and drugs and in psychological functioning as extreme, but she views her need for employment and social counseling as slight.

Julia's result from the Self-Directed Search matches her vocational dream of becoming a nurse (like her mother). Julia was surprised to learn that her summary code was also consistent with dietician, physical/occupational therapist, and psychiatric technician. She was particularly interested in the physical and occupational therapy fields because she thought these occupations would limit her access to drugs and thus eliminate the temptation to steal them, while still allowing her to work with people in a medical setting.

When Julia was approached about further vocational exploration, she said that the thought of going back to school made her highly anxious and that she did not think she could ever see herself getting up to go to work or performing adequately on the job. She felt that she had been using drugs too long and "hanging out" so long with other users that she did not even know how to talk to "straight people." She also felt humiliated about all her arrests and about "doing nothing with her life" all these years, so she couldn't imagine filling out an application to go back to school or interviewing for a job.

Counseling strategy

Aware of the close-knit structure of Italian American families and Julia's desire to move back with her parents when she leaves the residence, Julia's counselor initiated family sessions with Julia and her parents to deal with the family violence. Julia was also referred to a psychiatrist to evaluate her depression and anxiety. The psychiatrist prescribed the antidepressant fluoxetine hydrochloride (Prozac), which has just begun to help her feel somewhat more comfortable. Julia has begun to learn relaxation and coping skills so that she can manage her panic attacks more effectively and not continue to avoid public settings. Julia is also participating in an anger management and social skills group, in which she is learning the internal and external triggers for her anger. She has been role-playing new ways to cope with these anger triggers and learning how to express her feelings more effectively.

Julia has also been discussing her life plans and goals. She would one day like to marry and have a father for her child and work with people in a medical setting. In the meantime, Julia has been gathering information about potential careers in physical or occupational therapy. She has gone to the career section of her local library to find information about the specific duties and requirements for each job. Armed with this information, Julia developed a plan with her VR counselor concerning the next steps to take and how she will accomplish them. These steps included selecting and applying for school, finding the money for tuition, arranging for child care, and finally, starting the program.

4 Integrating Onsite Vocational Services

A key purpose of this TIP is to help treatment programs rethink their philosophies and restructure their services around the belief that productive activity (work) is crucial to the health and long-term recovery of clients. One way to ensure that clients receive the necessary vocational services is to provide them in-house as an integral part of the substance abuse treatment program, rather than by referral to outside agencies. Each program must decide to what extent it wants to and can provide onsite vocational services. This chapter is designed to guide programs in this important decisionmaking process. Even those programs that cannot offer a full range of vocational training and employment services within their program setting can benefit from the information in this chapter. The chapter also describes how programs in various treatment modalities, from therapeutic communities to low-intensity outpatient treatment, can begin to address the vocational needs of their clients.

Employment and vocational services need to be a priority in every treatment program and should be addressed as a goal in treatment plans. The Consensus Panel recommends that if possible, a substance abuse treatment program should add at least one vocational rehabilitation (VR) counselor to its staff. Should the size of the program or other fiscal shortcomings prevent this, arrangements should be made to have a VR counselor easily accessible to the program. No matter the treatment modality or level of service, inclusion of a vocational specialist who is cross-trained in or at least sensitized to substance abuse disorder issues will create a new dynamic in the program. Through both formal and informal interactions, this staff member will begin to raise the awareness level of other treatment staff members about vocational issues. The vocational specialist can identify ways in which the staff members are already addressing vocational issues but simply not thinking of their efforts in vocational terms. For example, when one therapeutic community hired a VR specialist to help its treatment counselors provide vocational services to residents, she pointed out that many aspects of the program already addressed clients' vocational needs. She demonstrated how the job assignments given to residents emphasized the development of prevocational skills and explained that they were really operating a work adjustment training program. However, a VR counselor can provide more intensive and specific counseling, assessment, resource development, and treatment planning.

Unfortunately, some programs do not have the resources for such a staff specialist. However, a consortium or network of programs may sometimes be able to share a specialist as a consultant who provides training and other staff development activities on an occasional basis and guides work with particular clients. At the

same time, it must be acknowledged that even the most comprehensive program cannot meet the treatment and vocational needs of all clients. Welfare reform, health care reform, and other funding pressures can overwhelm treatment programs because they must meet the vocational needs of all clients with less support and in shorter periods of time. Referrals to outside vocational service agencies are necessary for many clients.

Every treatment program should consider itself part of a collaborative interagency effort to help clients achieve productive work. For the purposes of this TIP, the onsite integrated services model is discussed separately from the integrated services through referral model (discussed in Chapter 5). In reality, most programs exist on a continuum with onsite programs making fewer referrals, but where referrals continue to be a key part of providing services to all clients.

Planning an Integrated Program

Any decision to integrate vocational services into a substance abuse treatment program must be supported by the board of directors, the administrative staff, and the alcohol and drug counselors. This level of support is necessary to effectively change the existing "culture" of the treatment program and ensure that vocational services are a core part of treatment and not just a supplementary service.

To effect this change, the mission statement should be modified to encompass vocational goals and to ensure that all staff members embrace these goals (see Figure 4-1). An important philosophy to articulate in the mission statement is the belief that work is crucial to the health and long-term recovery of clients and that implementing vocational services is in itself therapeutic. As discussed later in this chapter, outcome studies must consider employment as one of the key variables in measuring program success. It is important to be aware that work in the competitive market may not be possible for all clients. Moreover, people often seek to contribute to their community, either by volunteer work or by some other type of educational or similarly productive involvement with the larger world that enriches their interactions with others and their sense of self-worth. Thus, the concept of employment

Figure 4-1
Steps for Planning an Integrated Program

- Modify mission statement to incorporate vocational goals for clients.
- Encourage all administrative, support, and treatment staff to embrace vocational programming as an essential component for all clients—on an equivalent level of importance with abstinence.
- Perform a needs assessment of current and past clients to identify what vocational services are most needed.
- Use needs assessment results to identify, develop, and deliver vocational services that make the most sense for the agency, clients, and community.
- Hire a vocational specialist or retool/upgrade existing staff to handle vocational counseling responsibilities.
- Develop vocational counseling competencies in all treatment staff.
- Develop and provide necessary vocational support materials (e.g., employment library, computer with Internet access, training materials for job-seeking skills).
- Integrate vocational outcomes into accountability studies when following up with former clients.

"success" may need to be broadened when the outcomes of substance abuse treatment programs are evaluated.

Choosing a Program Model

The treatment program must decide the parameters of what it can offer clients in terms of vocational services. Many factors will enter into this decision. To begin the decisionmaking process, the program must address several questions:

- What type of substance abuse treatment does the program provide?
- Who are the program's clients and what are their vocational needs?
- What are the staff members' skills, experiences, and backgrounds that can influence how they learn and incorporate new ideas and approaches?
- What vocational training and employment programs are available in the local community, as well as funding sources for vocational services?
- What are the program's capabilities for providing vocational services?

The most important factors in choosing a program model are (1) the modality of the substance abuse treatment program and the intensity of services provided, and (2) the specific needs of clients. Treatment programs vary from the least intensive level of outpatient treatment to highly structured residential programs, such as therapeutic communities. The degree to which the program can structure the client's daily life and the length of time spent in the program significantly dictate the range of onsite vocational services that can feasibly be offered. A therapeutic community in which clients generally reside for several months can offer a much wider range of vocational services than a short-term (14- to 28-day) residential program whose main objectives are to stabilize clients and initiate the recovery process before discharge.

The vocational needs of the majority of the program's clients, as well as other client-related factors such as their values and the realities they face in finding employment, are other key factors to consider in deciding the parameters of the onsite services offered. The important issue of cultural competence is discussed more fully in Chapter 5. Suffice it to say here that programs must ensure that staff members have a thorough knowledge of the diverse populations represented in their treatment program and the particular challenges that different groups face in securing and maintaining work. It is also important to understand various cultural attitudes toward work.

In any program, clients' ability to work will vary greatly. Some clients who have never worked or who are chronically unemployed will need habilitative and prevocational training. Others with more regular work histories may need help learning new job skills, finding work, or recognizing work-related relapse triggers. Some programs treat a large number of clients with a high level of coexisting disorders (e.g., serious mental illness). Clients with extensive or special needs outside the program's vocational capacity should be referred to collaborating agencies. Collaboration is discussed in Chapter 5.

One approach to evaluating the vocational needs of the client population is to survey clients who are currently in the program. A series of focus groups is an effective way to understand the particular needs of a program's client population. In these groups clients can discuss their needs and support each other in articulating their problems, gaining confidence about themselves, exploring employment goals, and preparing for finding and maintaining work. Another approach is to follow up with former clients to document their current vocational status and ask them which services they received at the agency were most and least

helpful, and what services they would have wanted.

Training and Developing Existing Staff

As noted previously, hiring or contracting with a VR counselor familiar with substance abuse treatment issues is an effective strategy to begin addressing the vocational issues, awareness, and training needs of program staff. Another option is to collaborate with State VR agencies that offer inservice training on vocational issues to alcohol and drug counselors. Joint training of alcohol and drug counselors with VR specialists should be encouraged, when appropriate. Key resources for such training and education are State and Federal VR authorities, which are found in every State, as well as the Rehabilitation Research and Training Center (RRTC) on Drugs and Disabilities. Other resources include university-based rehabilitation continuing education programs located throughout the country. Whether an agency is large and multiprogrammed or smaller, appointing someone as case manager can help ensure efficient collaboration, both intra- and interagency.

Another strategy for bringing VR expertise into the program is to form linkages with undergraduate and graduate programs in VR counseling and to offer the treatment program as a training site for internships in which students in these programs can be cross-trained in substance abuse treatment issues—provided that supervision and support are adequate and appropriate.

Recruiting and Hiring New Staff Members

Integrating vocational services and ensuring that all staff members share the program's values and mission will involve examining and changing job descriptions to recruit staff with vocational experience and training. Advertising and recruiting efforts can be broadened to include journals and programs of interest to VR counselors. Again, linking with a university to provide an internship site is a highly effective strategy for recruiting permanent staff members who possess the necessary skills. As part of their professional service obligations, university faculty should be open to providing inservice training programs on VR topics for the agency's staff. In turn, treatment staff may be able to help university faculty by offering to give guest lectures on substance abuse issues, becoming a resource for the university's employee assistance program, or helping with student intervention services.

Developing Relationships With Employers

A key aspect of incorporating vocational services into a program is to develop relationships with both large and small local employers. Many mutual benefits can result from ongoing relationships with employers because programs develop an understanding of the types of workers these employers are seeking and employers begin to perceive the program as a good source of job applicants. In geographic areas where there are multiple treatment programs, consideration should be given to a collaborative effort to develop relationships with potential employers. A centralized clearinghouse can also lead to better matches between jobs and the applicants for them.

The VR field has developed several approaches to initiating and maintaining such relationships. Becoming familiar with a particular employer, researching its products and human resources, and using a businesslike approach (e.g., professional dress, business cards, promptness) can be effective approaches (Vandergoot, 1984). Another approach offers an employment service or pool of qualified potential workers to employers as an incentive

for establishing an ongoing relationship (Shafer et al., 1988). Documents describing these approaches can be obtained from the National Clearinghouse of Rehabilitation Training Materials (see Appendix C, "Published Resource Materials").

In addition, many large employers have on-the-job training programs. For example, a large hotel chain offered on-the-job training for entry-level positions as front desk clerks, housekeepers, and laundry and kitchen personnel that allowed them to advance in their chosen job areas. Large employers also usually provide some level of employee benefits, such as medical leave, insurance, and access to child care. Relationships with small family-owned businesses can also be an important source of ongoing employment for clients. One program placed a client several years ago in a family-owned carpet business as a warehouse worker. That individual is currently the warehouse supervisor and hires many of the program's clients, giving them a chance to return to or enter the workforce in a supportive work environment. Clients who have completed treatment and are successfully working are excellent resources for information about job opportunities and prospective employers.

Some cities have business advisory groups that assist with return-to-work programs. Another good resource may be the Welfare to Work Partnership, a nonpartisan, nationwide effort designed to encourage and assist private sector businesses with hiring people on public assistance. This network of both large and small employers is committed to hiring individuals with multiple barriers and little work history. The partners are committed to working with many social service agencies to find solutions and promote a healthy workforce.

Finding Employers for Ex-Offenders

Ex-offenders are one group for which it is often particularly difficult to find job placements; therefore, treatment programs that involve job placement activities will need to make a special effort to locate employers for this population. Providers should be proactive when possible, in order to convince potential employers of the reliability of their clients. It will take time to develop strong and lasting relationships with employers willing to hire ex-felons, and providers working with this population should not expect immediate success. Once relationships with employers are formed, providers should exert effort to maintain these relationships and ensure that employers are satisfied with clients they hire.

Programs should inform potential employers about any financial benefits for which they may be eligible if they hire an ex-felon. For example, under the Tax and Trade Relief Extension Act of 1998 (P.L. 105-277) employers who hire ex-felons from low-income families are eligible for a tax credit of up to $2,400. Funds are also available for States from the Federal government under the Job Training Partnership Act (29 U.S.C. §§201-206) as amended by the Workforce Investment Partnership Act of 1998 (P.L. 105-220), which States can use for a variety of services including on-the-job-training. Ex-offenders are one of the groups specifically covered in this legislation. These latter funds are distributed through the States, and individual State departments of labor should be contacted for more information on the funds available. There are also Federal funds, distributed through State employment services (also known as One-Stop Career Centers), to pay for bonding for ex-felons and people in recovery from substance abuse disorders. This bonding service is provided free-of-charge to employers who are willing to hire ex-felons.

Implementing and Operating the Integrated Program

The specific procedures that a program develops will depend on the scope of vocational services it decides to incorporate into its treatment protocol. However, in an integrated program, vocational services are regarded as therapeutic, and a client's attitudes toward work, work skills, work history, and work goals are clinical issues that have an impact on recovery. Even if clients pass through the program very quickly, vocational concerns can be introduced and addressed in individual or group counseling, through brief screening in the form of work-related questions as part of an intake interview, or as part of relapse prevention in discussing work-related triggers.

Once the treatment program has decided to integrate vocational services, the degree to which the program can structure the client's daily activities while in treatment and the length of time the client spends in the program dictate the range of onsite vocational services that can feasibly be offered. The following section describes three levels of treatment programs and the types of vocational services that can be incorporated into each setting. The three levels of programs include high-structure programs (therapeutic communities and day treatment programs), which can offer the broadest range of services; medium- and low-structure programs (intensive outpatient treatment, standard outpatient treatment); and short-term residential programs (programs shorter than 30 days). Strategies for other kinds of programs, such as detoxification programs, opioid management programs, and halfway houses, are also discussed.

High-Structure Treatment Programs

Clients in therapeutic communities both live and work in these facilities, and their daily lives are highly structured by the ground rules and operations of the program. The length of stay in these programs varies widely, ranging from 10 days to 1 year or more. Clients in day treatment programs may spend about 6 hours a day at the program facility. Compared with a therapeutic community, the length of stay in day treatment programs is generally shorter, ranging from 4 to 6 weeks to several months. Interactions among staff members and clients and their peers are potent aspects of these high-structure programs, in which clients tend to seek the approval and respect of other members of the circumscribed and structured community.

Many clients in high-structure programs have little or no work history. Many lack education, are not competitive for training or career-track positions, and lack the financial skills to handle a paycheck or control impulse spending. Few have experience in setting and achieving personal goals or successfully completing treatment for their substance abuse. Many have a personal or family welfare history, and many have a criminal record. Clients' low self-esteem and lack of appropriate role models, combined with distorted expectations and ideas of "success" and the lack of a positive vision for their lives, all strongly contribute to their difficulty in obtaining and maintaining stable employment.

Therapeutic communities and day treatment programs are ideal sites in which to establish vocational services based on a classic rehabilitation model (Rubin and Roessler, 1995; Wright, 1995). Such a model includes the following components:

- Prevocational stage testing and work skills evaluation
- Work adjustment training, including education about work
- Attention to activities of daily living
- Formal vocational training and services (both classroom and on the job)

- Goal setting and developing a personal plan
- Postplacement job retention strategies

Some of these vocational components and ways they can be integrated into high-structure programs are discussed in more detail below.

Work adjustment training

Work adjustment training, as described in Chapter 2, uses work in a structured environment to teach accepted employment practices (i.e., education about work—the workplace, employer expectations, etc.). Therapeutic communities provide a wide range of internal work adjustment opportunities in the form of chores or job functions that support the day-to-day operations of the program and facility. Day treatment programs also can create such opportunities by establishing client-operated departments or services that are important to the operation of the program.

In a work adjustment environment, clients are assigned various jobs after they enter the program. Early work assignments are designed to enhance clients' strengths and build self-esteem by helping clients "discover" skills they did not realize they had. These work assignments focus clients on the importance of completing a task, working as a team member, and developing a sense of pride and personal satisfaction in a job well done. Early work assignments usually are less complex, guarantee initial success for most clients, and offer an opportunity for advancement to more responsible positions in the structure. Later, as clients demonstrate a commitment to their treatment goals and an ability to handle work positions of increasing responsibility, assignments become more complex and are designed to address behavioral areas clinically identified as essential to progress in recovery.

Other work skills emphasized in work adjustment training are attention to details, successful task completion, frustration, tolerance, and accountability.

In addition to acquiring supervisory skills, clients learn how to handle on-the-job advancement and how to model appropriate work behavior for newer members of the program. For many clients in these programs, a key work-related issue is understanding and dealing with authority in constructive ways that will not jeopardize their job.

When vocational rehabilitation and treatment for substance abuse are integrated in this way, clients not only work at various tasks with peers but also encounter these same peers in substance abuse disorder group counseling. Thus, work-related issues are addressed by clients in clinical groups, and clinical themes arise in vocational activities. Substance abuse disorder recovery and "vocational recovery" are synchronized, and clients are afforded opportunities for insights into problems and the interrelatedness that occurs when services are so thoroughly integrated.

Activities of daily living

High-structure programs can establish groups that focus on job issues addressing positive workplace behavior such as appropriate grooming, dress, and proper socializing on the job, as well as self-defeating and negative behavior in the workplace. Work-related triggers for relapse, such as disappointments and frustrations, can also be addressed in recovery in vocationally oriented group and individual counseling and in work adjustment training. Financial management skills can be provided on both an individual and a group basis. Efforts to improve skills in activities of daily living should also focus on social supports: making friends, having hobbies, networking for job-related information, and structuring leisure time. The importance of a client's hearing the same messages in all aspects of her treatment and from both alcohol and drug and vocational staff members should not be underestimated.

Formal vocational services

Work adjustment training involves bringing all clients to a basic level of work readiness before actual job-seeking activities begin. All programs should establish specific criteria that a client must meet before beginning formal vocational counseling. These criteria will define the point in the treatment process when a client will begin receiving formal vocational services, which is dictated in part by the length of a given treatment program. Formal vocational services provided at this point can include assessment, counseling, planning, résumé and interview preparation, and teaching other job-seeking skills, as well as job placement and monitoring. These services are described in detail in Chapter 2. A comprehensive vocational program would also include a vocational library that both staff and clients could use as resources for vocational planning and job placement. Figure 4-2 provides information about job clubs.

Setting goals and developing a personal plan

Developing and implementing a personal plan for change is another key aspect of vocational rehabilitation. The client develops the plan in consultation with vocational and treatment staff. The plan lays out the direction in which a client wishes to go and demonstrates that the client understands the steps necessary to achieve his goals. The plan can address vocational, educational, social, familial (including children), and housing goals, as well as relapse triggers and ongoing needs for substance abuse treatment. It generally requires the client to anticipate obstacles and develop contingencies or alternative strategies for coping with them.

The idea of the plan may be introduced to clients early in the treatment process so that they can begin to think about it. However, clients in high-structure programs may not be ready to actually develop a plan until they have learned about the effects of substance abuse on all aspects of their lives and have learned about the world of work and their vocational strengths and deficits. The length of the individual's proposed treatment is again a factor, and clients in shorter term treatment programs may be encouraged to develop plans that are more focused on specific, immediate vocational goals. Plans can also be used effectively in counseling groups because "going public" with a plan often enhances the client's commitment to it.

Counselors should evaluate the client's plan to determine whether the vocational goals the client sets are realistic (not too high or too low) and whether achieving the goals will allow the client to make a sufficient living and support continued recovery. In many ways the process of developing the personal plan is more important than the actual content of the plan. Situations and goals change, but once clients have mastered the process, they can create new plans on their own as their future situations require. In any case, it should be emphasized that the plan will be most useful if both the goals and the timeframe for achieving them are as specific as possible.

High-structure programs that incorporate the development of a detailed personal plan may wish to encourage formal presentations where the client describes his plan to selected peers and staff and receives feedback from the group. This "approval committee" can also include outside professionals involved with the client, such as a probation officer or a child welfare worker. For clients from particular ethnic groups, the approval committee might also have representatives of the community to which the client is returning at discharge. The presentation can be done in a formal way that symbolizes a passage from the exploration and information gathering that characterize the early stage of the treatment to action. The committee evaluates the client's plan, makes suggestions, and, by approving it, endorses the plan and gives the client permission to carry it out.

Figure 4-2
Job Clubs

A job club can be established in most treatment settings—i.e., high-, medium-, or low-structure programs. However, outpatient programs may find them particularly useful for helping clients obtain jobs with a low investment of staff time. Some job clubs are run by a staff person, but most are organized and operated by clients with a staff person in the role of a consultant.

The job club is a behavioral approach to job finding that is based on research showing that the difficulties faced by most job seekers often involve problems of learning, motivation, and the maintenance of behavior—problems for which the behavioral approach should be most relevant (Azrin and Besalel, 1982). This multistep approach, in which job seeking is regarded as full-time employment, provides a systematic method for conducting a job search. The group context provides important social support to members engaged in the stressful process of finding a job.

To establish a job club, the substance abuse treatment program provides daily newspapers and other current sources of job information and office equipment (e.g., copy machine, typewriter, computer) and supplies. A phone line or lines reserved for job club members and an answering machine help them contact potential employers and allow them to receive messages. The program also can obtain a post office box for members' mail from prospective employers. It is important to remember that some clients may not have a permanent address or phone number and that the person who answers the phone at their home may give a poor impression to the employer or may fail to take messages reliably. Job club members thus use the facility as a home base for conducting their search. Job clubs tend to become part of the treatment milieu and to integrate themselves into programs. There is a natural confluence of substance use disorder and vocational issues in these groups.

The Internet has now become a good resource for job hunting. The cost of a computer and modem may no longer be prohibitive for most programs and may be a good investment if it improves clients' vocational outcomes. In addition, the computer skills that clients gain in their job search may help them on the job.

Medium- and Low-Structure Treatment Programs

According to the model developed by the American Society of Addiction Medicine (ASAM), clients in intensive outpatient treatment spend from 9 to 20 hours a week in the treatment program, and clients in standard outpatient treatment spend less than 9 hours a week (ASAM, 1996). Lengths of stay vary widely but can be 6 months or longer in outpatient treatment. Lengths of stay in short-term residential treatment have declined in recent years because of pressure to contain costs, from typical 28-day programs to programs as brief as 10 to 14 days. Clearly, the range of vocational services for clients in medium- and low-structure programs is narrower than the services offered in high-structure programs. However, even 1 hour of rehabilitation services a week for 24 weeks, or 1 hour a day for 14 days, can be a significant level of attention for clients with serious vocational needs.

Most substance abuse treatment is provided in outpatient settings—generally in the lowest intensity modality (i.e., less than 9 hours a week). Thus, finding innovative ways to address the needs of clients in these programs, for which funds are often limited, is critical. As noted earlier, the Consensus Panel recommends that outpatient programs either hire a VR counselor or obtain such services through a VR consultant.

The time devoted to VR issues in outpatient programs can be used in several ways; some are described below. (Vocational activities that can be undertaken by methadone maintenance programs, halfway houses, and short-term residential treatment programs are described in a separate section.)

Education about work and job seeking

A brief introductory presentation and a question-and-answer session on work, jobseeking, and daily living skills can be completed in an hour. Many topics related to the world of work may be helpful to discuss with clients. These include what work is, work values, career exploration, résumé development, job searching, job interviewing, the workplace, workers' and employers' rights, discrimination, and maintaining employment. A series of presentations could be developed, with one session devoted to each of these topics.

If staff time for these presentations is limited, the outpatient program should look to organizations in the community that can send volunteers to address client groups, such as the local Chamber of Commerce, the State employment service, or the State VR system. Private Industry Councils and local Workforce Investment Boards also have career counselors who could address client groups about the availability of education and training opportunities, local employment opportunities, and job readiness issues. For example, the director of human resources of a large corporation can provide a group with valuable information about how to make a good impression during an interview. Employers with whom the program has placed clients can be guests. In addition, alumni of the program who have unusual or interesting jobs or who have completed training courses for particular occupations (e.g., mechanic, electrician, beautician) can talk about what they do and the obstacles they faced in achieving their goals. Local entrepreneurs who have been successful at starting their own businesses often have motivational stories to tell. The emphasis at these presentations should not be on recruiting clients into specific occupations but on how ideas and motivation can be transformed into action to achieve desired goals.

Another tactic is for counselors to give homework assignments related to work issues. For example, clients can be asked to bring in five employment ads from a newspaper that describe jobs that appeal to them. Another homework assignment might be for the client to register with a local job search agency or visit the local library to explore references about career options.

Vocational assessment

During the intake interview, outpatient programs typically collect information about the client's vocational needs using various assessment tools. An example used by substance abuse treatment programs is the Addiction Severity Index (ASI) (McLellan et al., 1980, 1992), one domain of which assesses the client's education and employment skills, sources of financial support, and severity of problems at work. However, this is not an adequate substitute for an assessment done by a VR counselor.

Assessment tools that clients can use independently can be an efficient use of resources. For example, Holland's Self-Directed Search is an instrument that clients can complete themselves, and the results can be viewed as a form of vocational self-assessment (Holland, 1985a). A client may learn from the process that she likes to produce a tangible product and does not like to deal with more process-oriented tasks that involve "shuffling papers" and "crunching numbers." This information can also be highly useful from a clinical standpoint in addressing work-related stressors and substance use triggers. Clients can be encouraged to discuss in a group setting what they have learned, as well

as concerns they face about maintaining a job, returning to a job, or seeking a job while stabilizing in recovery.

Incorporating vocational issues into group counseling

Although many traditional outpatient programs are based on an individual counseling model, groups can be an effective way for clients to address work-related issues. Problems that clients have on the job may become more conspicuous in the context of the group than in the individual counselor's office. Group members who have job interviews can be helped by the group to role-play any problems they anticipate in the interview, such as questions about their substance abuse or criminal history. Group members who are working can provide valuable advice about on-the-job behavior.

Some outpatient treatment programs for substance abuse may hesitate to develop groups specifically for vocational rehabilitation because they receive reimbursement only for substance abuse treatment services. In the climate of welfare reform, they may be successful in convincing funding sources that VR issues are key to clients' recovery and to bringing Temporary Assistance to Needy Families (TANF) and welfare-to-work resources to the substance abuse treatment site (see Chapter 6 for more information about funding). However, even if funding is not available, a VR group can be set up with volunteer presenters and experts from the community.

Short-Term Residential Treatment

As noted previously, stays in short-term residential programs, formerly known as 28-day programs, have been greatly reduced. Typically, the focus is to stabilize the client and initiate recovery before discharge to outpatient care. Because of their limited timeframe, such programs are the most difficult in which to integrate VR services, and they probably do not have a VR counselor on staff. Historically, the alcohol and drug counselor sometimes helped clients find jobs, but financial squeezes on these programs make current staff involvement or vocational assessment unlikely.

However, staff members in short-term residential programs can do a vocation-oriented interview after program entry that includes some type of screen for vocational problems. Discharge planning around vocational issues is encouraged, as are referrals to outpatient VR services. The program staff should develop a knowledge of community resources for referral. Another way to incorporate vocational issues into these programs is to use self-report instruments, such as Holland's Self-Directed Search or Vocational Preference Inventory, because these involve little staff time (see Appendix B for information about these instruments).

Educational programs about work can also be woven into the curriculum of the short-term residential program. Typically, these programs are education-oriented and based on a revolving curriculum of modules about clients' substance abuse and the consequences of not arresting the addiction process. With a minimal level of consultation from a VR counselor, it should be simple for programs to build in a module about vocational issues and what vocational rehabilitation involves. This module could be targeted to the needs of the majority of clients in a given program. It should motivate clients to seek VR services upon referral to ongoing outpatient treatment and other community-based services.

Vocational Strategies for Different Types of Services

Detoxification

Detoxification facilities, which typically provide stabilization, will not be able to provide VR services. Because most programs will gather some information about the client's work history through a psychosocial interview and the

administration of the ASI or similar assessment, it is recommended that detoxification facilities address vocational needs as part of the discharge plan. In this way, the recovery program to which the client is referred will have information that gives a snapshot of the client's potential vocational issues.

Methadone maintenance programs

Some methadone maintenance programs have introduced vocational services. In a demonstration project sponsored by the National Institute on Drug Abuse, a vocational readiness screening instrument was developed for methadone maintenance clients that measured five dimensions: the client's vocational status, level of motivation, level of social support, ancillary needs, and barriers for vocational activity (Dennis et al., 1994; Karuntzos and Dennis, 1994). In this demonstration project, the screening instrument was administered by a VR counselor, but an alcohol and drug counselor with some vocational expertise could be trained to use it. An alcohol and drug counselor was trained to provide vocational counseling and build positive work attitudes and behaviors. The project hired a case manager to deal with barriers to employment such as transportation and child care. The project funded some clients' return to school and purchased tools for other clients pursuing vocational goals. One key program component—creating relationships with employers—was identified as a critical aspect of success.

The Opioid Maintenance Program of the University of New Mexico's Center on Alcoholism, Substance Abuse, and Addictions is developing the position of a transitional agent. The case manager is part of a multidisciplinary team whose approach is designed to be harmoniously inclusive of basic living needs. A networking system within the community provides referrals for vocational training, educational opportunities, employment resources, and housing needs. Welfare to Work is also coordinated through this resource.

A key component of these kinds of programs is teaching clients job readiness skills. For example, the frequent visits required (especially in the early stages of treatment) can be scheduled on an appointment basis, as opposed to a drop-in basis, to address punctuality, time management, and personal responsibility issues. For more information about methadone maintenance programs, see TIP 20, *Matching Treatment to Patient Needs in Opioid Substitution Therapy* (CSAT, 1995c).

Utilizing a vocational case manager can help greatly when the primary counselor is very involved in the vocational counseling aspects of the client. A specific person who is responsible for trying to reduce barriers that could prohibit clients from job training, continuing education, job placement, aftercare, and so forth is essential. The primary counselor may not have enough time to deal with those issues.

Halfway houses

Halfway houses or other reentry facilities are an important element in the continuum of care. To be eligible to live in most halfway houses, clients must be in a training program or a job during the day. Most halfway house residents are trying to stabilize themselves in many aspects of their lives, including work, before they move out to live on their own. Thus, a support group for maintaining both sobriety and employment is appropriate in this setting. Such a group, meeting in the evening, could address issues related to helping residents keep their jobs and become more effective employees. The staff can help group members recognize triggers in the work environment that alert them to a risk of relapse. It is most helpful when staff members in halfway houses see a client's job not as a "given," but as a set of newly acquired skills that need strengthening.

A halfway house or group of halfway houses can hire a VR counselor as a consultant to

conduct group sessions or hold educational seminars for staff. Community volunteers, including individuals who have completed the halfway house program, can be important resources for helping residents maintain employment and stabilize their recovery.

Outcomes

The measurement of treatment outcomes is no longer just a research issue. In the current health care environment and with recent reforms in the welfare system, all treatment programs must demonstrate to payors and other funders that clients are achieving the goals to which the program is dedicated—the goals by which the program defines "success." Demonstrating the program's success is also important for recruiting new staff members and for maintaining or improving the morale of the existing staff.

For many years, abstinence was the only successful outcome recognized by most substance abuse treatment programs. However, treatment programs have begun to recognize the many different criteria that can be used to define success. Examples of criteria include (but are not limited to)

- Abstinence or decreased substance use
- Decreased involvement with the legal system
- Success in employment
- Success in education or training
- Improved family relationships
- Enhanced psychological functioning
- Removal from welfare rolls
- Return or maintenance of child custody
- Improved physical health (e.g., decrease in emergency room visits)

A similarly flexible approach should be considered in defining a successful vocational rehabilitation outcome. Outcomes must be defined and measured within a realistic framework. For clients with significant disabilities and who have strong family support, doing part-time or volunteer work may be a realistic goal. In the case of a single woman with young children who has minimal social supports and will soon lose welfare benefits, achieving gainful employment is an important goal, but perhaps harder to achieve.

What, then, should be called a successful outcome in terms of vocational rehabilitation? Some vocational measures include

- Number of hours worked per week (or per month, or in the past 6 months)
- Entry into and/or completion of an educational or training program
- Temporary or permanent job
- Earning level and/or level of benefits
- Employment evaluations, promotions, raises
- Duration of employment
- Job satisfaction
- Return to school to pursue long-term vocational goals

As described in TIP 14, *Developing State Outcomes Monitoring Systems for Alcohol and Other Drug Abuse Treatment* (CSAT, 1995a), all programs must have mechanisms in place to ensure the ongoing collection of reliable data. For example, one State has enhanced a version of the ASI so that it assesses 10 domains and is more relevant to Native American populations and other groups. This and other assessment instruments that are administered at intake should be periodically readministered and linked to outcomes.

It is best to conceive of a continuum of outcomes, from part-time to full-time work, from volunteer work to full-time homemaker, all of which may be considered successful depending on what was realistic at baseline for the client. The personalized vocational goals that clients articulate in their rehabilitation plans may not fit the program's measurement categories. However, helping clients attain these goals may represent a significant investment of staff energy, and programs will find ways to measure and report these outcomes.

More data are needed on employment outcomes across the array of substance abuse treatment modalities. Until recently, research has tended to focus on clients in methadone maintenance programs and has used mostly simple outcome measures (e.g., job versus no job). Building databases on employment outcomes from treatment programs is critical to future understanding of the dynamic connection between these two areas. In general, the field has focused on whether substance abuse treatment results in improved employment. However, it is also important to determine whether implementing vocational services and focusing on clients' vocational needs result in better substance abuse treatment outcomes. Important work also remains to be done in identifying treatment-level and client-level variables (such as clients' satisfaction with services) that are related to good employment outcomes. Accurate outcome data can also support future funding requests to legislative and other decisionmaking bodies and help ensure the fiscal viability of integrated treatment and vocational services.

To understand long-term employment outcomes, it is important for programs to obtain followup data after clients leave treatment. Vocational outcomes can be better during the posttreatment period, when clients are farther along in the recovery process and can focus more energy and attention on job performance. Outside of formal research studies, followup data are often difficult to obtain because many clients are lost to the program when they complete treatment. One program that has a high rate of success in contacting clients for followup interviews makes sure that at discharge it obtains the names, addresses, and telephone numbers of two significant others in the client's life who are not in the same household. The program should have the client update his address and telephone number before leaving.

The program should also have the client sign an authorization for followup that allows the program to contact the significant others whose names the client provided. Each substance abuse treatment program must define successful outcomes appropriate to the population it serves and ensure that funders understand the importance of these outcomes and the services necessary to achieve them. There are many variations of employment success, including obtaining and maintaining a full-time job, one or more part-time jobs, seasonal jobs (in which clients are unemployed for part of the year), or sheltered employment making or selling hand-crafted goods.

Figure 4-3 provides information about a client outcomes initiative developed by CSAT.

Uniform Data Collection 1

It is not uncommon for different funding agencies to require substance abuse treatment programs to report different types of data or to report the same data but in different forms. Program administrators are beginning to call on agencies to standardize reporting categories, not just to ease the programs' reporting burden but to facilitate comparisons among data sets. Another significant problem is that funders generally ask for aggregate data that are not broken down by the severity of clients' substance abuse disorders or VR needs.

Interpretation of such data is difficult, and reported results can be misleading, especially when the outcomes of two programs with different case mixes are compared. However, Federal minimum data sets do require pre- and posttreatment status reports concerning client employment, and such data can currently be analyzed concerning client characteristics, type and intensity of substance abuse treatment, and the like that lead to success in the employment domain.

Figure 4-3
Focus on Client Outcomes:
The Future for Substance Abuse Treatment Providers

CSAT is developing client outcome evaluations that will be disseminated to State and local governments and treatment providers. With these tools, treatment programs can measure their effectiveness and make comparisons on a regional and nationwide basis. A substantial initiative by CSAT, the two Treatment Outcome Performance Pilots (TOPPS I and II), which involve 14 and 19 States, respectively, is developing and pilot testing instruments and measures of substance abuse treatment outcomes. These measures will examine changes in several domains including employment, substance use, health status, psychological function, legal status, and family and social relationships. These domains represent consensus among States on the areas where substance abuse treatment is expected to result in changes. Treatment providers will need to address these domains via on- or offsite programming or referrals in order to remain competitive for Federal funding for substance abuse treatment programs.

Substance abuse treatment agencies involved in providing vocational services must lobby strongly to have outcome indices related to employment inserted in such uniform data packages.

5 Effective Referrals and Collaborations

Adopting a holistic view of clients in substance abuse treatment is especially important for any service provider making referrals to other providers or agencies. At the point of referral, there is both an opportunity to address a client's unmet needs and a potential danger of losing the client. Collaboration is crucial for preventing clients from "falling through the cracks" among independent and autonomous agencies. Effective collaboration is also the key to serving the client in the broadest possible context, beyond the boundaries of the substance abuse treatment agency and provider.

This chapter explores the elements of integrated services using a community–collaborative model. This model is based on an agency's ability to make effective referrals within a network of numerous agencies, including vocational services, serving common clients. Only when these service providers are truly interconnected can they work together toward the common goal of successful client outcomes. The phrase *authentically connected* has been coined to describe an integrated network in which agencies function as equal players with each other and with the client to identify and address the complex interplay of needs that is typical of clients with substance abuse disorders.

Collaboration as the Cornerstone of Effective Referral

When the many agencies that work with clients who have substance abuse disorders work independently of each other, the result is that the client is subject to fragmented services, none of which might address the client as a whole person. One of the biggest challenges to any collaborative or network-based model occurs when each of numerous agencies wants to use a different assessment tool to gather the same information. At best, this produces a fragmented portrait of the client; at worst, it creates frustration and confusion for the client, who may drop out of treatment as a result.

A shared vision among potential collaborators facilitates strategies to achieve common goals (Nelson et al., 1999). The biggest benefit of collaboration among health agencies is the improved health of clients and therefore of the community. One study found that health is dependent on how people perceive the quality of their community. Leadership and vision among collaborative agencies can make a difference in the quality of a community health care system and in the cost-effectiveness of the care provided (Molinari et al., 1998).

Collaboration among agencies is the key to preventing fragmentation. In addition to reducing the likelihood of clients falling through the cracks between disparate and unconnected agencies, collaboration can foster a more holistic view of the client. Sometimes just a simple change of perspective can make the difference between circumstances being viewed as "needs" and being viewed as assets. For example, a single parent who cannot find a babysitter on a particular evening misses a treatment session. This client is then labeled "noncompliant" by one treatment provider, but another provider who focuses on child care and parenting skills recognizes the client's adherence to her parental responsibility as a positive asset. With effective collaboration, service providers will learn to recognize these differing viewpoints through their contact with professionals with expertise in different areas.

Another approach to prevent fragmentation is to designate one agency as the primary contact both for the client and for the other agencies. The primary agency provides a holistic assessment that accompanies the client throughout the referral process. The assessment must be comprehensive enough to satisfy all the agencies and organizations participating in the client's care and might include medical/psychiatric history and conditions, substance use patterns, work history, housing situation, physical/sexual abuse history, involvement in family violence and the criminal justice system, and other data about the client. In addition to decreasing paperwork and minimizing fragmentation, this process could help to strengthen linkages and communication among various agencies providing different services.

Barriers to Collaboration

The traditional referral system from substance abuse treatment programs to outside agencies can create obstacles to effective collaboration. Examples of obstacles are designation of which agency has major responsibility for a client, structural barriers driven by funding sources (e.g., payment to only one treatment agency), difficult-to-treat clients, and differing staff credentials.

The issue of which agency "takes credit" for a client is a difficult question arising from competition among different agencies, each of which has an interest in maintaining a certain "head count" to ensure continued funding. This barrier highlights the need to change the way that agencies are credited for their participation in a client's recovery. In many treatment systems, only one agency can receive credit for clients who are served by several service providers. It would be preferable to allow all participating agencies to take credit for these clients. For example, this happens in communities that have collaborative relationships based on shared outcomes negotiated across agencies. These cross-agency outcomes can occur across service systems (e.g., substance abuse treatment and social services) or across provider networks (e.g., residential and outpatient providers). Outcomes are negotiated both across agencies and with funders of services. Funders play a critical role because they must "change the rules" that allow only one agency to receive credit for a client. This change from a rules-driven system to a results-based system encourages all participating agencies to be recognized for their contribution to client outcomes. Also, it is important that each provider understand the role of the other providers so that it does not seem as if they are competing. Each provider must create an appropriate working relationship with the other providers so the client can benefit from all.

Structural barriers may also be posed by program policies that are determined by the program's primary funding source. Such policies may dictate, for example, that clients

cannot engage in concurrent activities, such as vocational training and treatment of substance abuse disorders. If the State or a managed care system does not allow clients to participate in concurrent services, then collaboration efforts will be difficult, or even impossible. However, in some cases, this is simply a program philosophy and not a formal policy, and efforts should be made to change this mode of operation. Another major barrier in the past has been confidentiality requirements. One answer to addressing this problem is joint training.

In the present system, there are no rewards for serving difficult-to-treat clients, and sometimes agencies set criteria under which only the clients with the greatest potential for success are accepted. Incentives are needed for programs to accept those clients who have the greatest problem severity or multiple needs. This is known as "case mix adjustment." The incentives should be based on three factors: (1) identification of difficult-to-treat clients based on analysis of differential outcomes and clients' characteristics, (2) analysis of the additional average costs of serving these clients, and (3) provision of either explicit incentives for serving these clients or a more equitable approach. A key element in a more equitable approach is for funders to recognize that serving difficult-to-treat clients is as valuable as serving clients with fewer risk factors, even though success rates will be lower as a result. Referring difficult-to-treat clients should be viewed not as a matter of "handing off" problematic clients, but rather as securing additional services to meet these clients' needs.

Staff licensing can sometimes be a barrier to collaboration because it is defined categorically. For example, sometimes the referring agency has a policy requiring that the staff members of the receiving agency have the same licenses and credentials as the referring agency's staff. In addition to requiring specific types of expertise, a referring agency sometimes requires the staff members of the other agency to be "professionals" with advanced degrees. The unfortunate consequence is that credentialing standards, rather than transdisciplinary collaboration, often dictate the services clients receive.

Finding Potential Collaborators

Programs must look at their clients with the assumption that it is not feasible or effective to provide everything that clients need "under one roof." A more fruitful approach is to collaborate with other agencies on the basis of client needs and overlapping client caseloads. This procedure is called data matching. Figure 5-1 provides an example of this process.

Agencies and organizations that provide vocational training in collaboration with substance abuse treatment programs can be divided into two levels—agencies providing specific training for employment (Level 1), and agencies with resources and services needed by clients at the same time they are receiving substance abuse treatment and employment rehabilitation services (Level 2). Examples of Level 1 resources include

- City-, county-, and State-operated vocational rehabilitation (VR) services
- Public and private employment and job placement services
- Public and private employers in the community
- Vocational–technical colleges
- Community colleges
- Privately owned VR facilities
- Criminal justice vocational training programs

Examples of Level 2 resources include

- Economic Development Centers (One-Stop or Workforce Development Centers)
- Shelters for survivors of domestic violence
- Mental health agencies
- Homeless shelters
- Child welfare agencies

Figure 5-1
Data-Matching Software

The use of data-matching tools such as unique client identifiers (e.g., the client's first and last name and middle initial and the last four digits of the client's Social Security number) can help agencies determine overlapping client caseloads. The software ArcView (Environmental Systems Research Institute, Inc., 380 New York Street, Redlands, CA 92373-8100) can aid in assessing the effectiveness of collaborative relationships among service providers by providing data on the numbers of clients being served by multiple agencies. Some of the locations in which data matching has been implemented include Chicago, San Diego, Los Angeles, and Alameda County, California. This software compares data from specific client populations with those from other populations. The user can then determine the proportions of clients receiving substance abuse treatment services who are counted in the caseloads of other agencies. This makes it possible to determine, for example, what percentage of clients who are receiving substance abuse treatment have children in remedial education. By identifying areas of overlap such as this, data-matching tools can influence decisions about the makeup of a multidisciplinary team, the coincidental needs of clients, and what types of collaborative relationships with other agencies are most likely to benefit a program's client population.

- Child care services
- Family services
- Housing authorities
- Evening adult education programs
- Alternative education programs
- Literacy programs
- Adult basic education programs and general equivalency diploma (GED) programs
- Young Men's Christian Associations (YMCAs), Young Women's Christian Associations (YWCAs), Young Men's Hebrew Associations (YMHAs), and Young Women's Hebrew Associations (YWHAs)
- Social service organizations
- HIV/AIDS programs
- Health and disability organizations
- Independent living centers
- Religious groups
- Self-help meetings
- Accessible meetings

Often, collaborating agencies must be educated about the nature of substance abuse disorders, including the cycles of relapse and recovery. Alcohol and drug counselors may also benefit from applying the relapsing and remitting model in areas other than substance abuse disorders. For example, clients may also "relapse" into and out of employment, medication management, or violent situations. The failure of any one of these supports can then be a trigger for failure of any of the others. All collaborators, including those providing treatment for substance abuse disorders, should be aware that their efforts are likely to be ineffective unless all the client's life areas are addressed. To that end, agencies must recognize the existence, roles, and importance of each other in achieving their goals. It is preferable to have formal written agreements that outline the responsibilities of each agency.

Although the prison population has grown substantially in the last several years, vocational training programs for inmates are limited. The vocational training programs that are available to incarcerated individuals will vary according to the setting of the incarceration, and treatment programs will need to be in contact with penal institutions in order to find out what particular types of substance abuse treatment and vocational training are available (see Chapter 8 for more information about working with ex-offenders). Providers interested in more information concerning the particular

procedures and problems involved in establishing service agreements with criminal justice agencies (including prisons, detention centers, and community supervision agencies for ex-offenders) should consult Chapters 1 to 4 in TIP 30, *Continuity of Offender Treatment for Substance Use Disorders From Institution to Community* (CSAT, 1998d).

Figure 5-2 summarizes the steps that substance abuse treatment providers can take to establish an authentically connected network with other agencies or to screen potential collaborators. The next section provides more detailed information about this process.

Multidisciplinary Teams

In its conventional sense, a multidisciplinary team is composed of members from different service areas (e.g., substance abuse treatment, vocational rehabilitation, mental health). This method of service, which is more common in programs that provide multiple services in-house, is just one way of functioning in a multidisciplinary manner. In an authentically connected referral network, however, members of the multidisciplinary team provide their services in different locations. Still, in an authentically connected network, a multidisciplinary team approach can be fostered by regularly scheduled case conferences.

In the authentically connected model, the agencies are interdependent. They cross-train their staffs in concepts and methodologies from different disciplines and promote awareness of resources that each agency might provide. Instead of being dependent on certification, learning about other disciplines, and becoming recertified every few years, service providers are taught how to learn on their own.

Careful consideration must be given to the formation of a multifocal treatment team. One approach is to view the team as a pie divided into sections, with the team members proportionally reflecting the needs of clients in areas such as coexisting mental disorders, job skills and employment, and child custody and care. The community must be considered as a whole throughout the treatment and referral process, and all available resources in the local geographic area should be considered to meet

Figure 5-2
Steps for Establishing an Authentically Connected Network

The Consensus Panel developed the concept of authentically connected networks, which include the following steps to their establishment:

1. Determine the services that are available in the local area by developing an updated inventory and by resource mapping.
2. Hold discussions with agencies identified as potential collaborators. Discussions can include topics such as the following:
   - Emphasis on the benefits of collaboration
   - Cross-training of staff
   - How the other agency conducts business (e.g., "turf" issues)
3. Develop working agreements or memorandums of understanding between collaborators to organize information sharing and communicate respective roles.
4. Determine the agency's criteria for accepting clients (e.g., what types of clients and levels of severity do they accept?).
5. If warranted, establish a partnership with the agency, as well as agreements regarding the flow of information and feedback between the agencies to ensure provider accountability.

client needs. Multidisciplinary teams can be composed of credentialed specialists as well as self-help and grassroots organizations. The more diverse the team, the more likely that the client will be viewed holistically.

True collaboration is a higher order of referral than either cooperation or coordination. *Referral* is a term that is used to mean many different things. Whereas a traditional referral is unidirectional (e.g., the client is sent for services to an outside agency), an authentically connected referral network is multidirectional and incorporates the ideals of collaborative relationships, accountability, cultural competence, client-centered services, and holistic assessment.

Authentically Connected Referral Networks

Integrating Cultural Competence Into Treatment and Referral

People live in different environments, and service providers have a responsibility to understand the contexts in which their clients operate. Client-focused treatment and referral must be based on an understanding of the family relationships, cultures, and communities of the clients. Culture can be broadly defined as incorporating demographic variables (e.g., age, sex, family), status variables (e.g., socioeconomic, educational, vocational, disability), affiliations (formal and informal), and ethnographic variables (e.g., nationality, religion, language, ethnicity). In many cases the client's belief system is intricately woven with culture, and providers must start where the client is and acknowledge the spiritual part of the work. Substance abuse treatment programs should be open to faith-based organizations in their communities, which can be valuable collaborative partners.

Throughout this chapter, the expression *cultural competence* refers to the capacity to view and understand individual clients within these contexts (Center for Substance Abuse Treatment [CSAT], 1999a). It is a core philosophy that must be integrated into and must guide the entire treatment and referral process. Too often, cultural competence is equated with the completion of a workshop, a multicultural staff, or proficiency in the language(s) spoken among the client population served. However, diversity of staffing does not ensure the cultural competence of the treatment program. Cultural competence is not achieved solely by attending workshops or by having a diverse, multilingual staff. When taken seriously, cultural competency is a continual learning process that is dynamic and is constantly expanded, refined, and defined by the community being served.

Building an integrated service model based on community partners must begin from the clients' base, taking into account their values and building on the strengths of their culture to create referrals that are appropriate and effective for their particular needs. Issues of culture can begin during the intake and assessment process, when clients are asked about their ethnic identification, their religion, and their participation in culturally based activities. Providers should feel comfortable discussing these issues with their clients and not make assumptions based on outward appearances, whether they are related to attire, complexion, or language. In programs working with highly diverse, multicultural populations, it may not be possible to be intimately familiar with all the details of each group's customs and culture. In any case, it is probably more important for providers to be aware of what they do not know and to have access to resources that can help, such as local community centers working in collaboration with their program.

Moreover, a delicate balance is needed between a client's current circumstances and the

historical and cultural issues that come into play. Some cultures may be relatively "closed" to nonparticipants. One must sometimes maintain a presence for years until he is accepted as a participant or observer. Although outwardly some groups may seem more approachable, gaining the trust of any client takes time.

Client-Centered Versus Agency-Centered Treatment and Referral

Substance abuse treatment that is both client-centered and client-focused is more likely to improve the lives of clients. Collaboration among agencies providing requisite services is an initial step toward client-centered care. Referral can be a way for agencies to hold each other accountable for getting results for clients. Referrals are necessary and appropriate when the substance abuse treatment program cannot provide special services needed by their clients. Some of the areas for which referrals may be needed include job readiness, job training, medical care, and ethnic/cultural expertise.

If the rationale for integrated treatment is a successful outcome for the client, there must be some way of measuring whether the referral is successful. From the referring provider's perspective, referral represents an act of faith, hope, and trust that the agency to which the client is referred will be accountable and will share the goal of client success along with the referring agency. Referrals also represent an opportunity for change, growth, and development. Far too often, however, a referral consists merely of handing a client a list of names and telephone numbers and assuming or hoping that the client will take the initiative to make the necessary contacts.

Distinct from this traditional model is one in which collaborations are fostered and maintained among agencies providing services to clients with overlapping needs, such as substance abuse treatment, employment, housing, education, and child care. In this context, the multidisciplinary team approach comes into play, but rather than coexisting under one roof, team members work within the various agencies engaged in collaboration. Referrals are negotiated among interlinked and interdependent agencies that share mutual goals and outcomes. These authentic connections and shared outcomes can then serve as an agreed-upon basis for the involved agencies to measure their results instead of merely going through the motions of collaboration. Figure 5-3 lists the characteristics of authentically connected referral networks.

Elements of Effective Referrals

In general, an authentically connected referral network is composed of a set of defined relationships formed as clients' needs dictate, using sound principles of case management and building in flexibility and adaptability to meet the needs of individual clients (see also TIP 27, *Comprehensive Case Management for Substance Abuse Treatment* [CSAT, 1998a]).

Although authentically connected referral networks share several features such as those listed in Figure 5-3, this similarity does not constitute a mandate for all treatment programs to form identical referral networks. Rather, in order for such an authentically connected network to be effective, each program must understand its own mission as well as those of the other agencies.

Mechanism for information dissemination

The authentically connected model calls for a communication mechanism that allows the timely dissemination of information to all agencies and stakeholders. An authentically connected network also includes continually updated information about available resources. For example, a network might use a Web site to post referral information, which can readily be updated (see the "Inventory" section later in this

Figure 5-3
Characteristics of Authentically Connected Referral Networks

- Multiple agencies work as equal partners with each other and with the client; referring agencies make the initial contact to the referral source and keep abreast of client progress.
- Clients and agencies have mutual responsibility and trust; interagency accountability and data sharing exists.
- Communication mechanisms for timely information dissemination are accessible to all agencies and stakeholders.
- The full range of stakeholders is identified, including local community services, and feedback is elicited from all of them.
- Relationships among providers are collaborative and flexible in the assumption of multiple job tasks related to client needs.
- The network is client-, vision-, and mission-driven.
- Change and growth of the referring organization are demonstrated as a result of the referral process; dynamic network.
- The network is open to new paradigms, approaches, use of technology on behalf of clients (e.g., electronic portfolios), and individualization of client treatment plans and services.
- There is ongoing provider training and involvement in continuing education and staff development.
- Shared assessment of network effectiveness is ongoing.
- Cross-training of staff among collaborating agencies is ongoing.
- Accountability is results- and progress-based, with interagency negotiation of shared outcomes.
- The referral process is concurrent.

chapter for more information about electronic communication).

Focus on communitywide outcomes

Focusing on communitywide outcomes allows community leaders and agencies, as well as clients, to set priorities based on client populations in individual communities. Authentically connected referral networks also educate the larger community about substance abuse in general. In so doing, they encourage responsiveness on the part of the community and the network as a whole, rather than from the agency only. The use of a community scorecard is one method to rate a community's responsiveness to treatment issues.

Vision-driven service provision

Authentically connected referral networks are vision driven and have client needs as the primary focus of the agencies' existence. The emphasis is on shared purpose while acknowledging the organizational "cultures" among collaborating agencies. In contrast, "rule-driven" systems are agency centered and tend to be focused on agency policies.

Provider credibility and consistency

Mutual provider credibility and trust are at the core of the referral relationship. In the absence of trust, even the most sophisticated system will fail. Clients' trust must be built on the reliability of the provider and the provider's ability to be a consistent, accessible presence for the client. To be otherwise is to risk reinforcing a history of repeated abandonment and disappointment. The need for trust speaks to the credibility of providers and whether they are truly client oriented or are merely protecting the status quo of the program.

A sense of uniformity and cooperation is fostered by effective referrals. In a well-coordinated referral system, providers have

some sense of being part of a systematic network rather than one of many disparate and independent agencies. Clients and providers alike find it easier to work through a collaborative, uniform system.

Building an Authentically Connected Referral Network

Fostering collaborative interagency relationships in the community is only one step in the development of an authentically connected network. Once the participants in the network are identified and information about them gathered, the collaborating agencies can then begin to develop an interconnected service system that reflects the needs of the local community. The next step is to form a focus group involving all the agencies. This group will develop a shared vision of the services the community needs in regard to substance abuse treatment. Lastly, the collaborators can then determine which provider is best equipped to offer which services; this step takes the form of resource mapping, which is discussed below.

Resource Mapping and Inventory

Resource mapping

Resource mapping consists of gathering information about agencies and programs in the community with which linkages can be made to provide collaborative services to clients. This mapping of available resources should include the funding sources of these programs. In a collaborative effort, money can be pooled from the various funding streams and then "decategorized" so that it no longer drives the roles of service providers. A proposal can be sent to Federal, State, and local funding sources for approval of small demonstration projects or experimental initiatives. If these efforts are successful, this model might be accepted on a more global level.

Inventory

Many agencies that are willing to make referrals find that they may not know of all the resources and services available to meet their clients' needs. To fill in knowledge gaps, some communities maintain a database or inventory of available resources and geographically map them with computer software to facilitate the logistics of referrals. Such an inventory needs to include not only programs and agencies but also collaboratives. One way to make this information useful is to create a directory that is updated periodically. This directory could be posted on the Internet and also include information on eligibility criteria and available slots. For substance abuse treatment providers, an inventory of the full range of vocational opportunities available in the surrounding area can be a useful resource. Another important source of information is the State Occupational Information Coordinating Committees (SOICCs), which can provide labor market information. Computer technology can be a valuable resource for managing and updating information and matching data across systems and agencies, within the limits of confidentiality (see Chapter 7 for discussion of confidentiality issues).

Organizational Alignment and Capacity Building

Organizational alignment means that a service provider's vision, structure, mission, and policies are all based on the same underlying philosophy. All the activities and services the organization provides must be evaluated to determine the degree to which they contribute to client success. Having a mechanism for measuring client outcomes is important; information systems that track referrals and fiscal responsibility play key roles in identifying successful referrals as well as troubleshooting for cases in which needs were not adequately met.

Capacity building is the process by which organizational alignment is achieved; it involves elements such as program assessment and staff development.

Program assessment

For substance abuse treatment programs, capacity building includes changing the way in which assessment is viewed. At the client level, assessment involves determining a client's needs and assets and viewing the individual within the concentric contexts of family, culture, and community. At the agency level, assessment means evaluating the collaborative network of service providers and determining how well they are serving clients. This allows the collaborating agencies to better understand their missions and how they overlap and support each other. There is a potential pitfall, however, that must be monitored. As an organization begins to engage in capacity building, it will find that its initial costs may be higher than under the old method. Programs and funders will need to be educated that in the short run, the new authentically connected referral model will be more expensive, and capacity building initially will incur more overhead costs. However, once the network is in place, it will maximize the use of funds by avoiding duplication of services and, most important, it will result in higher client rehabilitation success rates.

Staff development

Cross-training initiatives are key to building the capacity to serve clients more directly and efficiently. Communication mechanisms must be established among collaborative agencies to provide and receive feedback that can be used to improve services. For example, in the Substance Abuse Treatment Initiative in Sacramento County, California, the entire staff of the County Health and Human Services Department (about 1,500 people) completed training in addiction and recovery. In addition, it should be noted that alcohol and drug counselors should be cross-trained in VR issues. The initiative was intended to ensure that staff members conducting intake interviews in county health and human services agencies understood concepts related to substance abuse and were able to identify individuals and intervene when appropriate. The Child Welfare League of America has published a book (Young et al., 1998) reviewing the lessons learned from this and other projects across the fields of substance abuse treatment and child welfare services. Several other California counties and the State of Oklahoma have implemented cross-training based on the curriculum developed by Sacramento County.

Capacity building also affects staff hiring, promotion, and compensation practices, which must be geared toward enhancing client outcomes rather than based solely on an individual's credentials. Newly hired staff members should be informed that their responsibilities include becoming proficient in a sophisticated network of referral to and from other agencies with which collaborations have been formed.

6 Funding and Policy Issues

Public substance abuse treatment programs have traditionally relied on three funding streams: Federal substance abuse block grants, Medicaid reimbursement, and State general funds. These traditional funding sources have now been joined by new potential funding sources at both the Federal and State levels. Most of these provide funding for substance abuse treatment within the context of other services such as job training, child protective services, or criminal justice.

This chapter offers guidance for administrators and providers as they attempt to navigate through this changed funding environment. Because of the extreme complexity of this new environment, it is crucial that providers develop a strategic approach to obtain sustainable funding that supports the provision of client-centered services. The first question to ask before seeking funds from any funding source is, how would these funds help our agency to achieve our mission and meet our clients' needs?

The hidden costs involved in relying upon short-term grant funding are often not well understood. Not only is a cost incurred for every grant sought, but every grant obtained incurs costs to maintain, administer, and meet funders' reporting requirements. A strategic approach is to consider ways to reduce the burden of grant administration on a program's budget.

A client-centered funding strategy focuses on connecting clients with the services they need to achieve both recovery from substance abuse and self-sufficiency through sustainable employment—not necessarily with providing all these services within the substance abuse treatment program (as described in Chapter 5).

In addition to substance abuse treatment and vocational services, clients often need housing, child care, transportation, primary medical care, or protection from domestic violence before they can reasonably be expected to find and succeed in a job. As this section will show, public funds are available for all of these services through a variety of Federal, State, and local channels. Having first identified the services that their clients need, providers then should identify the funding streams for those services in their State and community.

The best way to obtain any of these services for clients may be to contract with an outside agency that specializes in the provision of that service. Such an agency may already have funding to provide services to individuals with substance abuse disorders or may be in a stronger position to obtain such funding than the substance abuse treatment program (see Chapter 5 concerning referral networking).

Managed Care Contracts As a Funding Source

The growth of managed care offers alcohol and drug counselors opportunities to contract to provide substance abuse treatment to the enrollees of managed care health plans. Such

contracts can be a sustainable, flexible funding source without the restrictions that often apply to grant funding.

For example, nonprofit providers that receive publicly funded grants may not carry funds over from year to year and are restricted in the extent to which they can switch funds among budget categories. However, no such restrictions apply to payments received through managed care contracts. Any savings that a provider can make on a contract, while providing the agreed-upon level of service, represent funds that can be spent on other program services or set aside for future use. In addition, managed care contracts usually do not carry the sometimes onerous reporting requirements that may apply to grants.

Alcohol and drug counselors who are interested in obtaining managed care contracts must have an understanding of how managed care works. Managed care evolved as a system of controlling health care costs. Costs are controlled by limiting the length of care that is reimbursed and by negotiating costs on a capitated (i.e., per-patient) or fee-for-service basis. Contracts are awarded through a competitive bidding process. To achieve economies of scale, managed care companies generally prefer to contract with a single service provider. Small providers can improve their competitive position by collaborating with other providers to submit a single bid. It is also in providers' interests to form a coalition to establish reasonable contractual rates, thus minimizing managed care companies' ability to shop for the lowest cost provider.

Impact of Policy and Funding Shifts

Thus far, this chapter has offered a snapshot (which is, of necessity, partial and incomplete) of the highly complex new funding environment that has been created as a result of these policy shifts and in which alcohol and drug counselors must now learn to operate. This new environment necessitates a radical rethinking of traditional approaches to the provision of substance abuse treatment. The field has traditionally been independent and focused on the goal of helping clients achieve abstinence from substance use. However, the imperatives of welfare and health care reform mean that this traditional narrow focus can no longer be sustained.

To maintain financial solvency in this new era of policy and funding shifts, alcohol and drug treatment agencies must forgo their traditional independence and focus on building collaborative partnerships to meet their clients' needs. Substance abuse treatment must become an integral component of a community-based, collaborative network of services, including welfare, primary health care, mental health, vocational, and family support services. Some of the public funding sources that treatment providers and their community partners can use to support the range of services that clients with substance abuse disorders need were described above. The potential of managed care contracts as a funding source was also discussed.

The transformation of substance abuse treatment from an independent service to an integrated element in a community-based collaborative service network cannot be expected to occur overnight; rather, it is a process of transition. This section describes how providers can begin to make the changes and develop the relationships necessary to enable them to serve their clients effectively in an environment that operates under assumptions fundamentally different from those under which they operated in the past.

It must be noted that existing categorical funding mechanisms do not provide incentives for collaboration. Both State and Federal governments need to make policy changes to provide such incentives in order to foster the

development of community-based collaborative service networks (see the subsection "Creation of Flexible Funding Mechanisms").

Like the process of recovery from substance abuse disorders, the process of change by providers in response to the imperatives of a new policy and funding climate can be broken down into a series of steps:

1. Learn to be flexible.
2. Understand the local implications of the new environment.
3. Orient the program's mission to clients' needs.
4. Assess the program's resources and those of the community.
5. Embrace collaboration as a strategy for meeting clients' needs.
6. Adopt a sustainable funding strategy.
7. Accept accountability for outcomes.
8. Advocate for substance abuse treatment services.

Step 1: Learn To Be Flexible

The defining feature of the new funding environment is change. Although the recent shifts in policy and funding are significant, there is no doubt that further change will occur in the future as new policies undergo further refinement and as States and localities embrace their devolved authority. For example, new Federal legislation affecting job-training reform was enacted shortly after the Consensus Panel convened for this TIP. The potential impact of this new legislation—the Workforce Investment Act of 1998—has not yet been assessed. Flexibility is a key attribute associated with success in an environment characterized by change.

Providers must accept not only the need to change in response to an altered environment, they must also accept the need to continually adapt. They must develop and implement flexible strategies that will continue to serve them as further change occurs. In addition, providers must learn to regard substance abuse treatment as a service that can be delivered in a variety of ways in a variety of settings rather than as a program characterized by a defined setting and defined, sequential components.

Step 2: Understand the Local Implications of the New Environment

A second defining feature of the new environment is local variability. Although certain features of new policies on welfare are, for example, federally mandated, in general States and localities have considerably more authority than they previously did to make decisions about policy implementation and funding that can significantly affect the provision of substance abuse treatment. One result of increased State and local discretion is that decisions implemented in one State or community may differ greatly from the choices made elsewhere.

As previously noted, in some States the Single State Agency (SSA) has been subsumed within a larger State agency, such as the department of community or behavioral health. Federal funds that are administered by the department of education in one State are the responsibility of the department of community health in another State and of the executive office of the governor in a third. In some States substance abuse treatment has become the responsibility of local communities, and it has become an optional service.

Given the extent of local variability, providers have no choice but to find out which agencies in their State and locality are making important policy and funding decisions that affect the delivery of substance abuse treatment. Contacts in the SSA may be a useful source of such information. Active involvement in a State or community providers association is another effective strategy for learning who the key "budget holders" are and where the key

decisions are made. Subscriptions to journals in the substance abuse treatment field can also be important sources of information. Examples of journals include *Alcohol and Drug Abuse Weekly, Substance Abuse Funding News, Substance Abuse Report,* and *Drug Abuse Monitor.* In addition, a great deal of information about policy changes and funding sources can now be obtained via the Internet; for example, The Welfare Information Network, and The Finance Project.

Providers should ask their SSA for a copy of the agency's annual plan for the allocation of substance abuse prevention and treatment block grant funds. This plan can provide crucial information about the State's funding priorities for substance abuse treatment. Some States, for example, have made a policy decision not to allocate block grant funds to methadone maintenance programs or to give such programs low funding priority.

Providers can also ask their SSA to publish an annual inventory of all funding sources for substance abuse treatment services. The annual inventory published by the State of Arizona is a model that other States could emulate (see the section titled "The Role of the SSA" later in this chapter).

Other important pieces of information for providers to know are the amount that their State allocates from its general funds to support substance abuse treatment and the level at which their State provides matching funds when required to obtain Federal funds. Some States contribute the minimum required in matching funds, whereas others have set higher levels. A local providers association or sources in the SSA may be the best places for providers to begin their search for this information.

Step 3: Orient the Program's Mission to Clients' Needs

To succeed in the new environment, providers must have a clear understanding of the demographic characteristics and service needs of their client population. They must know, for example, how many of their clients are on welfare, how many have children, and how many are involved with the criminal justice system. Armed with this information, they are able to clarify their mission—what they need to do to meet their clients' needs, who they need as partners, and what resources are needed from partner agencies.

Step 4: Assess the Program's Resources and Those of the Community

Having thoroughly assessed their client population and aligned their mission to focus on their clients' needs, providers next need to assess their existing capability and resources to meet those needs. A realistic appraisal of the program's strengths and limitations is a crucial part of this process. It is not necessary—indeed, it is not possible—for any program to meet all its clients' needs with in-house resources. Rather, a program should begin to identify potential collaborators in its community that are already providing services needed by its clients (see Chapter 5).

Figure 6-1 outlines a process by which programs can assess their clients, their mission, their strengths and limitations, and their community resources and relationships.

Step 5: Embrace Collaboration as a Strategy for Meeting Clients' Needs

It must be acknowledged at the outset that collaboration presents many challenges.

Figure 6-1 Agency Self-Assessment Categories			
Client	**Agency Mission**	**"Agency Fit"**	**Endpoints**
■ Demographics ■ Culture ■ Family ■ Trends ■ Focus groups ■ Client feedback ■ Inclusion of clients in planning ■ Disability issues	■ Capacity ■ Staffing ■ Cultural competence ■ Readiness for collaboration ■ Accountability ■ Resources ■ Technological capability ■ Desired outcome ■ Client centeredness ■ Service needs	■ Analyze agency's service delivery profile versus what clients need ■ Choose to provide services in-house or by referral ■ Identify community resources and partners ■ Build relationships ■ Changes in organizational structure ■ Specialization and market segmentation	■ Sustainable employment ■ Better client outcomes ■ Improved community conditions ■ Multiple access points

Collaboration is difficult for many reasons, not the least of which is that at some level it requires relinquishing control over certain processes.

Once a program has adopted an approach that is centered on meeting clients' needs and has realistically assessed its own strengths and limitations, collaboration becomes a strategy that enables it to meet its clients' needs more effectively than it otherwise could.

Collaborative relationships with providers of services whose clientele may overlap with that of the substance abuse treatment program (such as welfare, vocational rehabilitation, law enforcement, and public housing agencies) are also a strategy for ensuring that all individuals with substance abuse disorder problems—no matter what their point of entry into the human services system may be—have access to treatment.

Providers may also find it mutually beneficial to collaborate with other substance abuse treatment programs. For example, a coalition of several providers may be in a better competitive position when seeking a contract to provide substance abuse treatment services to a managed care organization. One partner whose strength is screening and assessment can undertake that function for the entire coalition, whereas a partner who already has a highly developed information system can perform the coalition's data collection and analysis. Similarly, a provider that has specialized culturally sensitive services for one ethnic population may be able to help another agency that does not have such services.

Collaboration can also be a strategy for obtaining services such as cost-effective staff training. For example, two or more providers could share the cost of holding a staff training workshop on vocational and substance abuse issues.

Step 6: Adopt a Sustainable Funding Strategy

Once a program's mission becomes client-centered, the next step is to adopt a client-centered funding strategy. This means that rather than pursuing all possible sources of

funding, a program focuses on seeking sustainable funds that will enable it to achieve its mission and meet its clients' needs.

Such an approach may initially seem counterintuitive. The experience of many substance abuse treatment programs is that competing for the largest and broadest range of funding is the key to success. However, this approach fails to take into account the hidden costs of reliance on short-term grant funding.

The U.S. Department of Housing and Urban Development (HUD) provides an example of collaboration encouraged by funding. To apply for funds to provide services for homeless individuals (many people in substance abuse treatment are homeless under HUD's definition), communities must form coalitions and work collaboratively toward implementing strategies aimed at eliminating homelessness. These collaborations must define how money will flow to ensure that clients receive the needed services, from substance abuse treatment and medical services to food, etc. HUD requires that these coalitions seek more involvement from the private sector, especially the business community. This holds tremendous potential for matching clients with jobs and pooling resources to ensure that clients are successful.

Adopting a sustainable funding strategy means identifying and pursuing institutional funding sources such as Title XIX of the Social Security Act (which covers Medicaid reimbursement), Title IV of the Social Security Act (which covers treatment for parents who are clients of child protective services agencies), private health insurance reimbursement, and contracts to provide substance abuse disorder services to managed care companies, welfare and public housing agencies, and so on.

Also part of a sustainable funding strategy is forging agreements with other agencies to provide services required by a substance abuse treatment program's clients. For example, clients on welfare who have substance abuse problems might be referred to a vocational services agency or a community-based organization (CBO) that has funding through the Department of Labor's Welfare-to-Work program. Such a strategy leverages nontreatment funds to meet clients' needs for services that will help them along the path to self-sufficiency through sustainable employment.

Before being ready to pursue sustainable funding mechanisms, an alcohol and drug administrator must understand how funding streams flow in its State and community (Step 2), must have identified potential collaborators that are providing services needed by the alcohol and drug agency's clients (Step 4), and must have accepted collaboration as a strategy for more effectively meeting its clients' needs (Step 5).

Step 7: Accept Accountability For Outcomes

There has been a trend in recent years toward demanding greater accountability by all kinds of publicly funded programs, including substance abuse treatment programs. Evidence of effectiveness is frequently a prerequisite for continued funding. Federal agencies such as the Department of Health and Human Services (HHS) are known to be interested in offering more grants that are linked to performance.

Providers who recognize the need to form collaborative partnerships to meet clients' needs must be prepared to be accountable for treatment outcomes. The collection of outcomes data at the community level serves two purposes:

1. Documentation of overlapping caseloads among substance abuse treatment, welfare, public housing, family services, criminal justice agencies, disability organizations, and health organizations.

2. Evidence of the effectiveness of substance abuse treatment for specific groups of clients such as welfare recipients, public housing residents, clients of child protective services, individuals involved in the criminal justice system, and individuals with coexisting disabilities (mental, physical, emotional, HIV, etc.).

Outcomes data serve to document the value substance abuse treatment adds to the services of other agencies; that is, how substance abuse treatment helps reduce costs and enhance client success for other agencies. For example, substance abuse treatment can enable former welfare recipients to sustain employment, which in turn might decrease drug-related violence and criminal activity in a public housing complex.

Providers have a responsibility to make resources available for the collection of outcomes data, whether or not such resources are earmarked by funders. It is not sufficient to collect data about the numbers of clients treated. Although many States collect outcomes data, it is in programs' interests to collect and analyze their own data. Computer technology now makes it easier for programs to do this.

In addition, programs can use their clients' experiences to provide powerful anecdotal evidence of the benefits of treatment to individuals and communities. Examples include a woman who regained custody of her children or a man with a history of incarceration for drug-related offenses who now works to prevent substance abuse among at-risk youth in a public housing complex.

In the postwelfare-reform environment, it is essential that the practical effects of work-first policies are documented. A great deal of evidence demonstrates that mandatory work programs are unlikely to succeed when they fail to take into account individuals' needs for substance abuse treatment, vocational rehabilitation, and family and workplace support services.

Step 8: Advocate for Substance Abuse Treatment Services

As noted earlier under Step 2, States and communities now have much greater discretion over policy implementation in welfare, substance abuse treatment, and other related services. Increased State and local discretion means that providers must put a great deal of effort into understanding how the new policies are being implemented in their community. It also presents the substance abuse treatment field with much greater opportunities for influencing the direction of State and local policies on substance abuse treatment. Decisions made at the State and community levels can be changed by advocacy. It is more important than ever, therefore, for providers to become actively involved in the policymaking process, providing concrete data to document the effectiveness of substance abuse treatment services.

State and community provider associations, in addition to being useful arenas for providers to share information about policy developments and funding sources, can also be effective advocacy organizations for substance abuse treatment. In several States and communities, provider associations have sponsored town hall meetings and other forums to educate community leaders and legislators about the benefits of substance abuse treatment. In communities where no providers' association exists, providers are strongly advised to form one. For example, Rhode Island's provider trade association offers multiple services for alcohol and drug treatment staff, including a forum for meeting and discussion, education/training, and a political power base for client and provider advocacy. In California, statewide advocacy groups represent the county substance abuse treatment agencies, providers, and other related organizations. These groups meet regularly

with the SSA in a policy forum that serves as an arena for exchanging information and providing the opportunity to influence policy decisions.

Providers have a responsibility to make their voices heard when States and communities set priorities that exclude or adversely affect substance abuse treatment. By presenting data on the extent of untreated substance abuse disorders among women on welfare, for example, they can draw attention to the shortage of publicly funded treatment slots for women and the need for support services such as child care that make it possible for women with children to obtain treatment.

The substance abuse treatment field in general has not advocated effectively for the benefits of treatment. Policymakers and many members of the public support reforms such as work-first initiatives because such policies are consistent with deeply held beliefs in mainstream American culture about personal responsibility for life choices, but also because they are often genuinely unaware of the substantial body of evidence that substance abuse treatment works.

Providers must become more actively involved in educating the public and community leaders about the effectiveness of substance abuse treatment. The ability to present compelling data that demonstrate the benefits of treatment not only to individuals but also to communities as well as to society in general is a prerequisite for effective advocacy. Thus, advocacy is strongly linked to accountability.

Future Considerations

Providers must clarify their mission, understand their clients' needs, develop a client-centered focus, and become full partners in a collaborative service network that endeavors to meet the multiple needs of clients recovering from substance abuse disorder. This represents nothing less than a transformation of the substance abuse treatment field.

State and Federal agencies have a responsibility to facilitate this transformation not only by adopting policies and procedures that encourage and reward collaboration, accountability, and client-centered approaches to care but also by embracing these principles in their own behavior. This final section examines the changes necessary at State and Federal levels to model the transformation of substance abuse treatment services at the provider level.

The Role of the SSA

The overarching message of this chapter is that substance abuse treatment services must cease to be a self-sufficient entity not engaged with the wider health and human services community and must become an integral part of a community-based service network. It follows, therefore, that the future role of the SSA must extend further outside the traditional boundaries of the substance abuse treatment field than has previously been the case for SSAs.

Welfare reform enacted by Congress in 1996 both created new Federal mandates for States to carry out and devolved to States many decisions about implementation of the new policy. Most of these mandates and decisions are not carried out by SSAs, yet their impact on both clients and providers of substance abuse treatment services is substantial. In addition, new funding streams controlled by other State agencies may be used to support the provision of substance abuse prevention and treatment services as well as vocational and other services needed by individuals with substance abuse disorders who are subject to the work requirements and benefit from time limits imposed by welfare reform.

As a result of State government restructuring, in many States the SSA is no longer a free-standing agency but a division within a larger department such as community

or behavioral health. Such restructuring should not, however, be an excuse for lack of outreach efforts. It could, indeed, facilitate outreach because at least other divisions within the same agency may provide some of the other services that deal with clients with a substance abuse disorder.

These changes make it necessary for SSAs to adopt a much broader view of substance abuse policy and their role in its implementation. Although Federal substance abuse block grant funds still represent an important funding source for substance abuse treatment services, substance abuse policy at the State level must transcend decisionmaking about the distribution of the SSA's "own" block grant funds and take into account the reality that clients with substance abuse disorders are also likely to be clients of the State's welfare, criminal justice, public housing, child protection, and community health services.

SSAs, like providers, must adopt a client-centered approach that focuses on ensuring that the multiple needs of clients with substance abuse disorders are met across a spectrum of fragmented agencies and services. Outreach to other government agencies that provide services to individuals with substance abuse disorders must become a key objective for SSAs.

SSAs also have a responsibility, in addition to collecting and analyzing data on the outcomes of substance abuse treatment, to ensure that lessons learned through data analysis are applied in ways that improve outcomes for clients. Data collection is only useful if it results in policy and program changes that benefit clients. For example, the fact that nationally only 27 percent of all publicly funded treatment slots are allocated to women has great consequences for links between employment programs for welfare recipients and treatment programs needed to make these clients self-sufficient while addressing the critical needs of their children at the same time. The data point of 27 percent is the beginning of such a policy discussion, but when a community does not focus on gender in its discussion of who receives treatment benefits or amalgamates both genders and their needs into a single group, it becomes more difficult to use existing data to support requisite system reforms.

Creation of Flexible Funding Mechanisms

Most funding mechanisms remain narrowly focused and fail to provide incentives for the interagency collaboration that is required to make the envisioned client-centered care network a reality. At the Federal level, it is likely that a multiplicity of categorical funding sources will remain for the foreseeable future, although there is a trend in some Federal agencies toward awarding more performance-driven grants. It is extremely cumbersome for providers to have to deal with such a vast number of funding sources, all of which operate under different procedures and rules.

One approach that may represent a way out of this dilemma is to promote mechanisms that permit flexible or "wraparound" funding that involves a shared fiscal responsibility at the local level. Simply put, shared fiscal responsibility involves empowering local multidisciplinary coalitions to tie together funds from a variety of categorical sources to support an integrated network of services. This approach also might be termed "bottom-up block grants."

Several States—including Georgia, California, Minnesota, and Oregon—have passed legislative incentives for funding that allow wraparound or shared fiscal responsibility at the local level. In some States, the branch may be able to use existing executive authority to create such incentives. Nonlegislative approaches are also possible.

The Washington, DC –based Finance Project has published a series of reports on shared fiscal responsibility outside the substance abuse treatment field.

At present, States that wish to provide incentives for some kinds of shared fiscal responsibility must obtain a waiver from the Federal government.

Family-Centered Treatment Strategies

The criminal justice orientation of the public substance abuse treatment system devalues the treatment of women and ignores the intergenerational effects of substance abuse on children. For example, as mentioned earlier, 27 percent of publicly funded admissions are women. Some treatment agencies and funders do not collect data on the children of their clients.

In addition to a reconsideration of the allocation of public treatment slots to women, there is a need to integrate prevention and treatment activities focused on families to recognize that substance abuse treatment for a mother represents substance abuse prevention for her children. Substance abuse treatment for the mother leads to better parenting skills, which in turn decreases the number of neglect and child abuse cases. Such prevention also may mean the difference between a child's continuing dependency on the social service and criminal justice systems or his becoming a contributing member of society.

Current categorical funding mechanisms and a traditional focus on clients over families serve as major disincentives to such integration.

Federal and State Funding Sources

While the major source of public funding for substance abuse treatment comes through the SSAs, a variety of funds useful to substance abuse treatment providers are also available from other sources. This chapter describes 12 major sources of public funding that may be of use to treatment programs. Different sources will pay for different types of services and many stipulate the specific population for which the funds can be used.

The agencies responsible for administering Federal funds at the State level vary enormously. For example, the department of economic development in one State, the department of education in another, and the department of health in a third may handle vocational rehabilitation (VR) funds. Also, in some States the SSA has been subsumed within another State agency.

Many States also offer their own funding sources that may be used to support substance abuse treatment and related services. However, State funding sources are too numerous, and the State-level administrative structures responsible for such funding too diverse, for a list to be useful. Providers need to become familiar with the organization of their State government and find out which divisions are responsible for which funds.

Federal sources of discretionary, time-limited project grants that may also be available are summarized in Appendix F.

Substance Abuse Prevention and Treatment (SAPT) Block Grant

The bulk of these funds, which support a full range of substance abuse prevention and treatment services, are awarded to States by formula (42 U.S.C. §300). Thirty-five percent of the SAPT block grant funds are earmarked for prevention and treatment activities relating to alcohol abuse and 35 percent for prevention and treatment activities relating to drugs. Twenty percent of the grant is to be used for primary prevention activities and 5 percent for the administration and support of the SSAs.

Other SAPT block grant "set asides" were established for programs that target special populations, such as services for women, especially for pregnant and postpartum women and their substance-exposed infants, and, in certain States, for HIV screening.

Each State's SSA is responsible for delivering these Federal funds to counties and individual providers. Treatment programs should contact the appropriate SSA for more information.

Medicaid

Title XIX of the Social Security Act (42 U.S.C. §§1396-1396v) provides funding for substance abuse treatment of Medicaid-eligible individuals as an optional benefit at the States' discretion. The availability of Federal Medicaid funds is conditional upon the provision of State matching funds; the level of matching funds required is variable based on a number of factors. Medicaid eligibility varies by State and is based on income, age, participation in other Federal programs (such as Supplemental Security Income [SSI] and adoption assistance/foster care), and pregnancy status. States have discretion over whether to provide a substance abuse treatment benefit to their Medicaid populations, and different States have different levels of coverage (e.g., residential, outpatient, day or night treatment). Many States have opted not to provide such services.

In most States, Medicaid funds do not flow to the SSA, and the agency administering the Medicaid program varies by State. Many States now require Medicaid-eligible individuals to enroll in a managed care program. Interested parties should contact their State's Department of Health and Human Services for further information.

Welfare-To-Work Initiatives

The Temporary Assistance for Needy Families (TANF) program has several purposes: (1) to provide assistance to needy families so that children may be cared for in their own homes or in the homes of relatives; (2) to end needy parents' dependence on government benefits by promoting job preparation, work, and marriage; (3) to prevent and reduce the number of out-of-wedlock pregnancies; and (4) to encourage the formation and maintenance of two-parent families. As discussed earlier (in Chapter 2), benefits are time-limited and work is mandatory; more information on TANF can also be found in Chapter 7.

Each State receives a block grant based on its previous level of spending on Aid to Families With Dependent Children (AFDC), the Federal welfare program that TANF replaces in accordance with the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. For many States, this block grant represents a financial windfall. Although TANF funds cannot be used to provide medical services, some substance abuse treatment (e.g., outpatient counseling, residential services) can be paid for by TANF funds. Providers need to know the amount of the grant in their State and whether any of those funds were set aside for substance abuse treatment services.

The U.S. Department of Labor's welfare-to-work program also awards grants to support employment services for TANF recipients and the noncustodial parents of children receiving TANF. Three-quarters of the funds go to States in the form of formula grants and one-quarter go to local communities in competitive grants. Any services that overcome barriers to employment, such as job training, transportation, child care, and substance abuse treatment, are eligible for funding. Formula funds are directed to Private Industry Councils (PICs) or Workforce Investment Boards (WIBs), Workforce Development Boards, and similar bodies at the State and community levels; the precise funding channels vary by State. This program's specific recognition of a substance abuse disorder as a barrier to employment is an innovation. As

previously noted, some States consider participation in substance abuse treatment to be a valid work activity, whereas others do not.

The Department of Labor also offers job training funding for economically disadvantaged individuals through the Job Training Partnership Act (JTPA) (29 U.S.C. §§201-206). Eligible services include basic and remedial education, job skills assessment, on-the-job training, job-search assistance, work experience programs, internships, school-to-work transition programs, and transportation and relocation assistance. Specific groups eligible for services include unemployed adults, youth, the disabled, dislocated workers, Native Americans, migrant and seasonal farm workers, and veterans. Funds are channeled to States, which oversee the planning and operation of local programs; programs can contact their State department of labor for further information. Alcohol and drug counselors should consider partnering with agencies receiving JTPA funds in their locality to offer vocational services to the substance abuse treatment agency's clients. However, the JTPA act is superseded by the Workforce Investment Act of 1998 (P.L. 105-220) and was repealed July 1, 2000.

The Workforce Investment Act consolidates more than 60 Federal programs into 3 block grants to States for employment, training, and literacy. This job training reform measure replaces programs currently under JTPA, the Stewart McKinney Act, and the Carl Perkins Act. Under this new law, States will receive block grants for adult employment, training for disadvantaged youths and families, and literacy. The legislation establishes a system of "one-stop" centers that are intended to provide job seekers with the information and advice they need to obtain training and employment. Individuals who seek services at the one-stops will be given vouchers with which to fund training. The current local decisionmaking entities—PICs or WIBs—will continue to exist under a new name but will have less stringent membership requirements with respect to union- and community-based representation.

The bill establishes State WIBs and requires States to submit a plan that outlines a 5-year strategy for their statewide workforce investment systems. States are required to designate local workforce areas, and local WIBs are to be appointed by the chief elected local officials. Functions of the local WIBs include, among other things, development of the local plan; designation, certification, and oversight of one-stop operators; identification of eligible providers of intensive and training services; and development and entry into memoranda of understanding with one-stop partners.

The one-stop delivery system in each local workforce investment area is to provide core services and access to intensive services, training, and related services. Included in those program elements for youth activities are comprehensive guidance and counseling, which may include drug and alcohol use counseling and referral. For adult training, the bill requires use of Individual Training Accounts but allows for use of contracts for training services for CAOs or other private organizations that serve "special participant populations," defined as those who face multiple barriers to employment.

Furthermore, with regard to vocational rehabilitation, the bill calls for evaluation activities on identifying what works well rather than continuing to seek to define the chronic problems connected to the employment of individuals with disabilities.

Treatment and Prevention in Public Housing

HUD offers funding for substance abuse treatment of public housing residents under the Public Housing Drug Elimination Program (42 U.S.C. §11901). HUD awards grants to Public Housing Authorities (PHAs), Tribes, or Tribally Designated Housing Entities (TDHEs) in order

to create programs to eliminate substance abuse and substance-abuse–related crime in their developments.

Services eligible for funding include substance abuse prevention, intervention, referral, and treatment as well as job training (aimed at assisting prevention efforts), and security improvements in public housing complexes. Funds are channeled to local public housing authorities, which contract with service providers.

Vocational Rehabilitation

These funds, administered by the U.S. Department of Education, support services to enable people with disabilities to participate in the workforce. Funds are provided according to the Workforce Investment Act of 1998 (P.L. 105-220 §106) and the Carl D. Perkins Vocational and Technical Education Act of 1998 (P.L. 105-220). Chapter 7 of this TIP provides further information on both of these Acts.

Services eligible for funding include substance abuse disorder assessment and treatment, prescription medications, equipment that enables disabled individuals to have access to and function in the workplace (such as wheelchairs, hearing aids, and adapted computers), and transportation. Vocational rehabilitation will also fund training and secondary education, as well as vocational testing and evaluation. Funds are channeled to State agencies with responsibility for vocational rehabilitation. The location of this agency within the State government varies by State.

Child Protective Services

Title IV of the Social Security Act (42 U.S.C. §1862) provides funding for foster care and services to prevent child abuse and neglect. Eligible services include substance abuse treatment for parents who are ordered by a court to obtain treatment and are at risk of losing custody of their children, and child care while a parent is in residential treatment. The estimated overlap between clients of child protective services agencies and parents with a substance abuse disorder is 60 to 80 percent (National Center on Addiction and Substance Abuse at Columbia University [CASA], 1999; Young et al., 1998). Title IV funds are usually administered by State social services departments.

Title IV funds represent a large, open-ended potential funding source for substance abuse treatment for women who are involved in the child welfare system, an underserved population. Women with children may be unlikely to enter residential treatment if the facility cannot accommodate their children, if adequate child care is not available, or if doing so means giving up their children to foster care (Strawn, 1997). For more information on child abuse and neglect issues and substance abuse treatment, see the TIP, *Substance Abuse Treatment for Persons with Child Abuse and Neglect Issues* (CSAT, 2000a).

Expanded Health Insurance Coverage for Children

Title XXI of the Social Security Act (P.L. 105-33 §4901a) provides Federal funding for the Children's Health Insurance Plan (CHIP), a public–private initiative to provide health insurance coverage for children who are ineligible for Medicaid and not covered by private insurance. Funds are awarded to States by formula, and States have considerable discretion in deciding what services to cover. In some States, substance abuse treatment for adolescents is a covered service. The agency administering CHIP funds varies by State; it may be a State agency or a private entity. Interested providers should contact their State's Department of Health and Human Services to find out what services are covered and who is the funding intermediary in their State.

Social Services Block Grant

Title XX of the Social Security Act (42 U.S.C. §§1397–1397f) provides flexible funding that States can use for child care, transportation, detoxification, and substance abuse treatment services, and social services for clients with substance abuse problems. This block grant is administered by HHS, and eligibility is State-determined. Providers should contact State Departments of Health and Human Services for further information.

Criminal Justice

The U.S. Department of Justice (DOJ) Weed and Seed program administered under P.L. 105-277 is intended to reduce drug activity in target communities. Substance abuse treatment for residents of the target communities is an eligible service. Funds are channeled through the offices of State attorneys general. Most grantees are law enforcement agencies that are working as part of a community coalition. Treatment providers should contact the Executive Office for Weed and Seed (EOWS) at the DOJ for further information on this program.

The DOJ Office of Justice Program's (OJP) Drug Courts Program Office (DCPO) administers the Drug Court Grant Program, which originated under Title I, Subchapter XII-J of the Omnibus Crime Control and Safe Streets Act, as amended by Title V of the Violent Crime Control and Law Enforcement Act of 1994 ("the 1994 Act").[1] This legislation authorized the Attorney General to make grants to States, State courts, local courts, units of local government, and Indian tribal governments to establish drug courts in response to the needs of increased numbers of nonviolent, substance-abusing adult and juvenile offenders. Congress has appropriated substantial sums of money for the Drug Court Grant Program each year since the program's inception. Most recently, in the Omnibus Consolidated and Emergency Supplemental Appropriations Act, 1999, of October 1998, Congress appropriated $40 million specifically for the Drug Court Grant Program, "as authorized by Title V of the 1994 Act."[2]

In January 1997, the DOJ released *Defining Drug Courts: The Key Components*, a report developed through a cooperative agreement between the OJP, DCPO, and the National Association of Drug Court Professionals, that describes the 10 key components of a drug court and specifies performance benchmarks for each component. This report was endorsed by the Conference of Chief Justices, Conference of State Court Administrators, and National Association of Pretrial Services Agencies. The 10 key components and their performance benchmarks provide the foundation for the guidelines available on the DCPO Web site for those completing grant applications. The report is available through the National Criminal Justice Reference Service Clearinghouse at (800) 421-6770, and on the DCPO Web site.

At its Web site, the DCPO specifies that drug courts funded under the grant program must be defined as "a specially designed court calendar or docket, the purposes of which are: to achieve a reduction in recidivism and substance abuse among nonviolent adult and juvenile substance abusing offenders; and to increase their likelihood for successful rehabilitation through early, continuous, and intensive judicially supervised treatment, mandatory periodic drug testing, and the use of graduated sanctions and other rehabilitation services. A separate or special jurisdiction court is neither necessary nor encouraged."[3] In addition, drug courts must include two specific critical elements:

1. Diversion, probation, or other supervised release involving the possibility of prosecution, confinement, or incarceration based on noncompliance with program requirements or failure to show satisfactory progress

2. Programmatic offender management and aftercare services[4]

Funds available for the treatment of clients making the transition from incarceration to the community vary from State to State. Chapter 4 of TIP 30, *Continuity of Offender Treatment for Substance Use Disorders From Institution to Community* (CSAT, 1998d) describes the ways in which funding practices differ between States. Providers seeking additional information concerning Federal funding opportunities (such as vocational training pilot programs for criminal offenders) should contact the Office of Correctional Education (OCE) in the Department of Education. The OCE coordinates all correctional educational programs in the department, and provides technical support relating to correctional education.

Education

The Rehabilitation Services Administration (RSA), which is housed under the U.S. Department of Education's Office of Special Education and Rehabilitative Services, oversees programs that help individuals with physical or mental disabilities obtain employment (Rehabilitation Act of 1973, 29 U.S.C. §701ff). Employment is obtained through the provision of such supports as counseling, medical and psychological services, job training, and other individualized services. RSA's major formula grant program provides funds to State VR agencies to provide employment-related services for individuals with disabilities, giving priority to individuals who are severely disabled.

In addition, general equivalency diploma (GED) programs are offered free of charge by many public school systems. High school equivalency or remedial programs for students with special needs may also be offered by some State education departments. Academic tutoring is offered at many libraries by literacy volunteers. Other private, nonprofit social services agencies such as Travelers Aid and vocationally oriented mental health programs (e.g., Fountain House in New York City), also offer educational remediation and GED preparation.

Transportation

Finding adequate transportation is a major challenge facing people who are making the transition from welfare to work. Two-thirds of new jobs are in the suburbs, but three of four welfare recipients live in rural areas or central cities. There are several programs that help to provide transportation for people transitioning to work (Federal Transit Administration, 1998). Under TANF, funds may be used for a range of transportation services as long as these expenditures reasonably accomplish a purpose of the TANF program, such as promoting job preparation and work.

The U.S. Department of Labor provides Welfare-to-Work (WtW) funds to States and local communities to help create additional job opportunities for the hardest-to-employ TANF recipients. WtW funds also can be used for transportation assistance to help these recipients move into unsubsidized employment.

The Federal Transit Administration, which is housed within the U.S. Department of Transportation, oversees the Job Access and Reverse Commute grant program. This program, funded under the Transportation Equity Act of 1998 (49 U.S.C. §5309), helps States and local communities develop flexible transportation services that connect welfare recipients and other low-income persons to jobs and other employment-related services. These projects are aimed at developing new or expanded transportation services, such as shuttles, vanpools, new bus routes, connector services to mass transit, employer-provided transportation, and guaranteed ride home programs. The Job Access and Reverse Commute grant program also is intended to

establish a collaborative regional approach to job access challenges and involves organizations such as transportation providers, agencies that administer TANF WtW funds, human services agencies, employers, metropolitan planning organizations, States, and affected communities and individuals.

Empowerment Zones and Enterprise Communities

The Empowerment Zone and Enterprise Community Initiative (26 U.S.C. §1391) provides tax incentives and performance grants and loans to create jobs and expand business opportunities in the 87 urban areas and 38 rural areas that have been designated as Empowerment Zones (EZs) or Enterprise Communities (ECs). The initiative also focuses on activities to support people looking for work, including job training, child care, and transportation. Within each EZ or EC, residents decide what projects and activities should occur in their own neighborhoods. Grants can be used for a wide range of activities that assist residents, including job creation efforts linked to welfare reform, job training, and substance abuse prevention. Although the authorizing legislation made clear that the provision of substance abuse treatment services should be a priority, grantees have considerable discretion over the kind of activities they wish to support and in many cases have not chosen to fund substance abuse treatment services.

HUD and the U.S. Department of Agriculture (USDA) designated the original EZs and ECs; originally there were 72 urban areas and 38 rural areas, and 1997 legislation authorized HUD to designate 15 more urban areas and USDA to designate 5 more rural areas. HUD reviews the strategic plan and annual performance reports from each EZ or EC. Providers can contact HUD for a list of designated EZs and ECs as well as more information about activities funded under this program.

Community Development Block Grants

Alcohol and drug counselors may apply for community development block grant funds to support capital improvements such as roof repairs and building renovations. These grants were authorized by the Housing and Community Development Act of 1974 (42 U.S.C. §5301). They are administered by HUD, are distributed by formula to qualifying cities and urban counties and, through the States, to small communities that do not qualify for direct entitlement grants. The program's objectives are to benefit low- and moderate-income persons, aid the elimination of slums or blight, and meet other urgent community development needs.

Funds may be used to carry out a wide range of community development activities directed toward neighborhood revitalization, economic development, and the provision of improved community facilities and public services.

Endnotes

1. Title I, Subchapter XII-J of the Omnibus Crime Control and Safe Streets Act, as amended by Title V of the Violent Crime Control and Law Enforcement Act of 1994 ("the 1994 Act"), 42 U.S.C. §§3796ii *et seq*. (1994 & Supp III 1998) (repealed 1996). U.S. DOJ regulations for the Drug Court Program can be found at 28 C.F.R.
2. Omnibus Consolidated and Emergency Supplemental Appropriations Act, 1999, P.L. No. 105-277, 112 Stat. 2681-63 (1998).
3. U.S. DOJ, Office of Justice Programs, Drug Court Program Office. FY 1998 Program Plan [Online].

4. U.S. DOJ, Office of Justice Programs, Drug Court Program Office. FY 1998 Program Plan [Online].

7 Legal Issues

Alcohol and drug counselors providing vocational rehabilitation (VR) services directly or through referral need to be aware of legal and ethical issues in three areas: discrimination against recovering individuals, welfare reform, and confidentiality.

Part I, Discrimination, examines

- The Americans with Disabilities Act (ADA) and the Rehabilitation Act, which protect individuals with disabilities, including individuals with substance abuse disorders (but not those who are currently engaged in illegal drug use and who are not in treatment)
- How those laws apply to individuals recovering from substance abuse disorders when they seek equal access to social service agencies and programs, including vocational and educational training programs
- The Workforce Investment Act of 1998, which reorganized the delivery of federally funded vocational training services, and how the Act might affect individuals in substance abuse treatment
- How the laws protecting individuals with disabilities apply to individuals recovering from substance abuse disorders when they seek equal treatment in the area of employment
- Remedies available to those who suffer discrimination

Part II, Welfare Reform, looks at the new Federal legislation governing public assistance and how it can affect individuals recovering from substance abuse disorders.

Part III, Confidentiality, outlines the requirements of the Federal confidentiality law and regulations and describes ways in which counselors can communicate with vocational training programs and employers.

Part I: Discrimination in Employment and Employment-Related Services

Clients in substance abuse treatment who are entering or are in the job market sometimes encounter employer rejection or discrimination because of a history of substance use. For example, a computer training program might refuse to accept an applicant with a substance abuse disorder history. Or, a business may fire a secretary when it discovers that her request for medical leave was to allow her to enter a treatment program for alcoholism.

The section below outlines the protections Federal law currently affords people with substance abuse disorders, as well as the limitations of those protections and the available legal remedies. It describes how counselors can help clients deal with the issue of discrimination as they enter the job market. Also discussed are the protections offered by State antidiscrimination laws, new legislation that reorganizes federally funded vocational training programs,

and how the Drug-Free Workplace Act may affect the employment of former illegal drug users.

Federal Statutes Protecting People With Disabilities

There are two Federal statutes that protect people with disabilities: sections 503 and 504 of the Federal Rehabilitation Act (29 United States Code [U.S.C.] §791 et seq. (1973)) and the ADA (42 U.S.C. §12101 et seq. (1992)). Together, these laws prohibit discrimination based on disability by private and public entities that provide most of the benefits, programs, and services an individual in treatment for a substance abuse disorder is likely to need in order to enter or reenter the world of work.[1] These statutes outlaw discrimination by a wide range of employers.

Agencies, establishments, programs, and services covered

Together, the Rehabilitation Act and ADA prohibit discrimination against individuals with disabilities in services, programs, or activities provided by

- State and local governments and their departments, agencies, and other instrumentalities (29 U.S.C. §794(b) and 42 U.S.C. §§12131(1) and 12132).
- Most public accommodations, including hotels and other places of lodging, restaurants and other establishments serving food or drink, places of entertainment (movies, stadiums, etc.), places the public gathers (auditoriums, etc.), sales and other retail establishments, service establishments (banks, beauty shops, funeral parlors, law offices, hospitals, laundries, etc.), public transportation depots, places of public display or collection (museums, libraries, etc.), places of recreation (parks, zoos, etc.), educational establishments, social service centers (day care or senior citizen centers, homeless shelters and food banks, etc.), and places of exercise and recreation (42 U.S.C. §§12181(7) and 12182).

Employers covered

The Rehabilitation Act and ADA provide protection against discrimination by a wide range of employers,[2] including

- Employers with Federal contracts worth more than $10,000
- Employers with 15 or more employees
- Federal, State, and local governments and agencies
- Corporations and other private organizations and individuals receiving Federal financial assistance
- Corporations and other private organizations and individuals providing education, health care, housing, social services, or parks and recreation
- Labor organizations and employment committees

Kinds of protection offered

Together, the Rehabilitation Act and ADA cover discrimination in an extraordinarily broad range of establishments, services, programs, and employers.

In public accommodations

The Rehabilitation Act and ADA prohibit discrimination on the basis of disability "in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation" (42 U.S.C. §12182(a)).[3] Public accommodations—including training programs—are prohibited from

- Denying a disabled person the opportunity to participate in or benefit from goods, services, facilities, privileges, advantages, or accommodations
- Affording a disabled person an opportunity to participate that is not equal to that afforded to others

- Providing a disabled person with a separate or different opportunity, service, benefit, etc. (unless it is necessary in order to provide an opportunity, service, etc. that is as effective as that provided to others)
- Imposing or applying eligibility criteria that screen out or tend to screen out individuals with disabilities
- Failing to make reasonable modifications in policies, practices, or procedures when modifications are necessary to afford disabled individuals equal services, etc. (unless it can be shown that such modifications would fundamentally alter the nature of the services, etc.)

Limitations

The Rehabilitation Act and ADA have two major limitations:

- They protect only an individual with disabilities who is "qualified," a term that is defined as someone "with a disability who, with or without reasonable modifications to rules, policies, or practices . . . meets the essential eligibility requirements for the receipt of services or the participation in programs…" (42 U.S.C. §12131(2)). For example, an organization that sponsors week-long bicycle trips for teenagers would be justified in refusing to enroll a 10-year-old hearing-impaired boy because he is under age. (Of course, if the organization has made previous exceptions, its position would be more doubtful.) On the other hand, a therapeutic treatment community that requires clients to perform work in the facility might be required to make modifications to its program for a substance user who had lost the use of his hands.
- They exclude from protection an individual with a disability who "poses a *direct threat to the health or safety of others*," defined as "a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures, or by the provision of auxiliary aids or services" [italics added]. Organizations running programs or offering services "must make individualized assessment, based on reasonable judgment that relies on current medical knowledge or on the best available objective evidence, to ascertain the nature, duration, and severity of the risk; the probability that the potential injury will actually occur; and whether reasonable modifications of policies, practices, or procedures will mitigate the risk" (28 Code of Federal Regulations [CFR] §36.208; Supplemental Information 28 CFR Part 35, Section-by-Section Analysis, §35.104; 45 CFR §84.3(k)(4)). For example, an organization that sponsors mountain-climbing vacation adventures might be justified in refusing to allow the participation of someone who is blind on the grounds that her inability to see could endanger other novices.

In employment

Employers may not

- Limit or classify a job applicant or employee because of a disability in a way that adversely affects that individual's opportunities or status
- Use standards or criteria that have the effect of discriminating on the basis of disability or that perpetuate discrimination by others who are subject to the employer's control
- Use qualification standards, employment tests, or other selection criteria (including medical examinations) that screen out or tend to screen out an individual with a disability, unless the standard, test, or criterion is shown to be job-related for the position in question and is consistent with business necessity
- Deny equal employment or benefits, including hiring, promotion, tenure, layoff,

rates of pay, job assignments and classifications, leaves of absence, sick leave, fringe benefits, selection and financial support for training, or employer-sponsored activities

- Deny equal employment or benefits because of the known disability of an individual with whom an applicant or employee has a relationship
- Fail to make reasonable accommodations to the known limitations of an individual with a disability, unless such accommodation would impose an undue hardship on business operations
- Deny employment opportunities to avoid having to make reasonable accommodations (42 U.S.C. §12112(a) and (b); 45 CFR §84.11(b))

An employer may not ask an applicant about a disability before making an offer of employment, but can ask about her ability to perform specific job functions. An employer may also make a job offer contingent on the applicant's passing a postoffer medical examination if such an exam is required of all applicants for the particular job category (42 U.S.C. §12112(d)); 45 CFR §84.14; 29 CFR §1630.13).

Limitations

In the employment context, the Rehabilitation Act and ADA have two major limitations:

1. They protect only a "qualified individual with a disability"; that is, someone "who, with or without reasonable accommodation, can perform the essential functions of the employment position that such individual holds or desires" (42 U.S.C. §12111(8)). "Reasonable accommodation" includes "job restructuring, modified work schedules, reassignment to a vacant position… and other similar accommodations…" (42 U.S.C. §12111(9)).
2. Employers are not required to hire or retain individuals who "pose a direct threat to the health or safety of other individuals in the workplace" (42 U.S.C. §12113(b)). A direct threat is "a significant risk to the health or safety of others that cannot be eliminated by reasonable accommodation" (42 U.S.C. §12111(3)).

The Rehabilitation Act explicitly adopts ADA's standards with regard to complaints of employment discrimination (29 U.S.C. §794(d)).

Range of disabilities protected

Both the Rehabilitation Act and ADA extend protection from discrimination[4] to individuals

- Who *have a physical or mental impairment that substantially limits one or more major life activities*. *Major life activities* are "functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working."
- Who *have a record of having an impairment that substantially limits one or more major life activities*, including "a history of such impairment or a misclassification of having such impairment."
- Who *are regarded as* having such an impairment: those with an impairment that does not substantially limit major life activities but that is treated by others as such, those whose impairment results solely from the attitudes of others toward the condition or disease, and those who have no impairments but are treated as though they have a disability. This includes persons who are denied services or benefits because of myths, fears, and stereotypes associated with a disability.[5]

Examples of the kind of discrimination covered by these laws include individuals who may be turned down from certain positions because of poor eyesight (such as piloting airplanes) in

spite of adequately corrective lenses; because of a past history of mental illness or substance abuse that an employer assumed will lead to trouble on the job; or because the individual is known to be HIV-positive, even though he has no symptoms that impair his ability to do the job.

Protections for individuals with substance abuse disorders

For those seeking benefits and services, an individual with a substance abuse disorder is included in the definition of "individual with a disability" in many, but not all, instances. The Federal regulations implementing ADA and the Rehabilitation Act make a distinction between individuals whose substance abuse disorder involves alcohol and those who use illegal drugs.

Alcohol abusers

In general, the Rehabilitation Act and ADA protect alcohol-dependent persons who are seeking benefits or services from an organization or agency covered by one of the statutes (29 U.S.C. §706(8)(C)(iii) and 42 U.S.C. §12110(c)), if they are "qualified" and do not pose a direct threat to the health or safety of others (28 CFR §36.208(a)). This means that an organization or program cannot refuse to serve an individual unless

- The individual's alcohol abuse is so severe, or has resulted in other debilitating conditions, that he no longer "meets the essential eligibility requirements for the receipt of services or the participation in programs… with or without reasonable modifications to rules, policies, or practices..." (42 U.S.C. §12131(2))
- The individual poses "a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures, or by the provision of auxiliary aids or services" (36 CFR § 36.208(b); Supplemental Information 28 CFR Part 35, Section-by-Section Analysis, §35.104)

For example, a hospital might take the position that an alcohol-dependent patient with dementia was not "qualified" to participate in occupational therapy because he could not follow directions. Or, an alcohol-dependent individual whose drinking results in assaultive episodes that endanger elderly residents in a long-term care facility might pose the kind of "direct threat" to the health or safety of others that would permit his exclusion.

The Rehabilitation Act also permits programs and activities providing services of an educational nature to discipline students who use or possess alcohol or illegal drugs (29 U.S.C. §706(8)(C)(iv)).

Users of illegal drugs

The Rehabilitation Act and ADA distinguish between former users of illegal drugs and current users.

Individuals who no longer are engaged in the illegal use of drugs and have completed or are participating in a drug rehabilitation program are protected from discrimination to the same extent as alcohol abusers (29 U.S.C. §706((8)(C)(ii) and 42 U.S.C. §12210(b)). In other words, they are protected so long as they are "qualified" for the program, activity, or service and do not pose a "direct threat" to the health or safety of others. Service providers may administer drug tests to ensure that an individual who formerly used illegal drugs no longer does so (28 CFR §36.209(c) and 28 CFR §35.131(c)). For example, if an applicant for a vocational training program claims he no longer uses illegal drugs and has completed a course of rehabilitation, the training program could administer drug tests to determine that he is no longer using illegal drugs.

Individuals currently engaging in the illegal use of drugs are offered full protection only in

connection with health and drug rehabilitation services (28 CFR §36.209(b) and 28 CFR §35.131(b)). (However, drug treatment programs may deny participation to individuals who continue to use illegal drugs while they are in the program (28 CFR §36.209(b)(2).) The laws explicitly withdraw protection with regard to other services, programs, or activities (29 U.S.C. §706(8)(C)(i) and 42 U.S.C. §12210(a)).

A hospital that specializes in treating burn victims could not refuse to treat a burn victim because he uses illegal drugs, nor could it impose a surcharge on him because of his addiction. However, the hospital is not required to provide services that it does not ordinarily provide, for example, drug treatment (Appendix B to 28 CFR Part 36, Section-by-Section Analysis, §36.302). On the other hand, a vocational training program could refuse to admit a user of illegal drugs, unless the individual had stopped and was participating in or had completed drug treatment.

The protections ADA provides to clients in substance abuse treatment are summarized in Figure 7-1.

The Workforce Investment Act of 1998

In 1998, Congress passed the Workforce Investment Act to improve the workforce, reduce welfare dependency, and increase the employment and earnings of participants (§106 of P.L. 105-220). The Act requires that local "one-stop delivery systems" be established for those looking for work, and it provides Federal funding for these programs.

A major emphasis of the legislation is its "work-first" approach, which strongly encourages the unemployed to find work before requesting training. The Act establishes three tiers of service (§134(c)(1) of P.L. 105-220) available through a "one-stop operator":

1. *Core services* (assessment, information, and job search help) are available to everyone.
2. *Intensive services* (specialized assessments, counseling, skills training) are available to those who (1) fail to find employment after receiving core services and (2) are determined by the one-stop operator "to be in need of more intensive services in order to obtain employment" (§134(d)(3)(A)(i) of P.L. 105-220).
3. *Training services* (including occupational and on-the-job training) are available to those who have been unable to obtain or retain employment after receiving core and intensive services. The one-stop operator must determine that the individual seeking services is in need of training and has the skills and qualifications to successfully participate in the selected training program. The training program must be directly linked to employment opportunities in the community (§134(d)(4)(A) of P.L. 105-220). Training must generally be run by certified providers and paid for through vouchers (called Individual Training Accounts), although there are some exceptions.

(See Figure 7-2 for a more detailed description of the three tiers of services.)

The Workforce Investment Act requires States to give recipients of public assistance and other low-income individuals priority in the allocation of intensive and training services (§134(d)(4)(E) of P.L. 105-220). It also recognizes that "low-income individuals with substantial language or cultural barriers, offenders,[6] the homeless, and other hard-to-serve populations as defined by the [State]… face multiple barriers to employment." Members of these "special participant populations" may sidestep the voucher system and take part in training "of demonstrated effectiveness" that is offered "by a community-based or other private organization to serve special participant populations that face multiple barriers to employment" (§§134(d)(4)(G)(iv) and (G)(ii)(III) of P.L. 105-220).

Figure 7-1
Americans With Disabilities Act and Rehabilitation Act Protections

	Alcohol		Illegal drugs	
	Current abuse	Recovering	Current abuse*	Recovering
Educational or Training Program	Individuals qualified for services are protected	Protected	Protection limited to health and rehabilitation services	Individuals qualified for services are protected
—Exceptions	Individuals are not protected if ■ Their alcohol abuse is so severe that they no longer meet the eligibility requirements. ■ They pose a significant risk to health or safety of others that cannot be eliminated by service modification or auxiliary aids/services.	No Exceptions	Substance abuse treatment programs may expel clients who continue to use illegal drugs while attending the program.	Individuals are not protected if they pose a direct threat to the health or safety of others. Service providers may administer drug tests to ensure that an individual with a history of illegal drug use is no longer using illegal drugs.
Employment	Individuals qualified for the job are protected if they can perform job duties without posing a threat to health, safety, or property.	Protected	No Protection	Individuals qualified for the job are protected if they ■ Participate in a supervised rehabilitation program and are no longer using illegal drugs ■ Have successfully completed treatment and are no longer using illegal drugs
—Exceptions	See box above.	No Exceptions	Not Applicable	Employer may administer drug testing to ensure that an individual with a history of illegal drug use is no longer using.

*Current abuse is defined as the illegal use of drugs that occurred recently enough to conclude that it is still a problem.

Figure 7-2
Services Provided Under the Workforce Investment Act of 1996

Core Services include

- Assessment of individuals' skill levels, aptitudes, abilities, and supportive service needs
- Job search and placement assistance and, where appropriate, career counseling
- Information about current job vacancies, the skills those jobs call for, and the kinds of jobs that are generally available in the community, including pay levels and skill requirements
- Information about training available through the one-stop delivery system
- Information about and referral to supportive services, including child care and transportation
- Assistance with establishing eligibility for welfare-to-work activities and financial aid programs for training and education not funded by the Act
- Followup services (including counseling about the workplace) for those placed in unsubsidized employment (§134(d)(2) of P.L. 105-220)

Intensive Services include

- Comprehensive and specialized assessments of the skill levels and service needs of individuals, including diagnostic testing and in-depth interviewing and evaluation to identify employment barriers and appropriate employment goals
- Development of individualized employment plans identifying employment goals, appropriate achievement objectives, and appropriate combinations of services required to achieve employment goals
- Counseling, including group, individual, and career
- Case management for those seeking training services
- Short-term prevocational services to prepare individuals for unsubsidized employment or training (including development of learning, communication, interviewing, and personal maintenance skills and instruction about punctuality and professional conduct) (§134(d)(3) of P.L. 105-220)

Training Services include

- Occupational skills training, including training for nontraditional employment
- On-the-job training
- Programs that combine workplace training with related instruction
- Training programs operated by the private sector
- Skill upgrading and retraining
- Entrepreneurial training
- Job readiness training
- Adult education and literacy activities
- Customized training conducted by an employer or group of employers committed to employing individuals upon successful completion of the training (§134(d)(4) of P.L. 105-220)

The effect on clients in substance abuse treatment

The work-first approach may result in additional barriers for clients seeking vocational training. The three-tier system will mean that clients in substance abuse treatment who lack job skills will have to go through the process of assessment and job search (part of the "core services") before they receive any individualized ("intensive") service such as testing, counseling,

development of an individualized employment plan, or prevocational services. Only those who are unable to obtain or retain employment after participating in both "core" and "intensive services" will be eligible for "training services." Clients seeking a training program must find one that is directly linked to employment opportunities in the community and must have the skills and qualifications to participate in the program successfully.

Those in substance abuse treatment (or with a history of substance abuse) may not be refused service because of their "disability." The Act explicitly incorporates current Federal antidiscrimination laws, including ADA and the Rehabilitation Act, as well as laws relating to wages, benefits, health, and safety (§188(a) and §181(a) and (b) of P.L. 105-220). However, as stated above, those currently using illegal substances are not protected by ADA. Recipients of public assistance and low-income individuals should be given priority for "intensive" and "training" services.

Clients who participate in services under the Act may be tested for illegal drugs. The Act permits States to test job training participants for the use of controlled substances. States may sanction individuals who test positive by banning them for up to 6 months from the program for a first positive test and for up to 2 years for subsequent positive tests. States that choose to test participants for the use of controlled substances must establish a procedure that ensures "a maximum degree of privacy" (§181(f) of P.L. 105-220).

Two final comments: The Workplace Investment Act is new, and it is not clear how different States will implement it. In addition, counselors should keep in mind that although federally funded programs may dominate this area, there are programs funded by private enterprise or nonprofits that offer more individualized and flexible services.

Protections in the area of employment

Alcohol-dependent and alcohol-using individuals

The Rehabilitation Act and ADA provide limited protection against employment discrimination to individuals who abuse alcohol but who can perform the requisite job duties and do not pose a direct threat to the health, safety, or property of others in the workplace (29 U.S.C. §706(8)(C)(v); 42 U.S.C. §12113(b); 42 U.S.C. §12111(3)). For example, the Acts would protect an alcohol-dependent secretary who binges on weekends, but reports to work sober and performs his job safely and efficiently. However, a truck driver who comes to work inebriated and unable to do her job safely would not be protected. Nor would the employee whose promptness or attendance is erratic, unless the employer tolerates nonalcoholic employees' lateness and absences from work (see Shaw et al., 1994).

ADA (42 U.S.C. §12114(c)) also permits an employer to

- Prohibit all use of alcohol in the workplace
- Require all employees to be free from the influence of alcohol at the workplace
- Require alcoholic employees to maintain the same qualifications for employment, job performance, and behavior that the employer requires other employees to meet, even if any unsatisfactory performance is related to the employee's alcoholism

Users of illegal drugs

Individuals who no longer are engaged in the illegal use of drugs and have completed or are participating in a drug rehabilitation program are offered some protection: The Rehabilitation Act and ADA (29 U.S.C. §706(8)(C)(ii) and 42 U.S.C. §12210(c)) protect employees and prospective employees who

- Have successfully completed a supervised drug rehabilitation program or otherwise have been rehabilitated and are no longer engaging in the illegal use of drugs
- Are participating in a supervised rehabilitation program and are no longer engaging in illegal drug use
- Are erroneously regarded as engaging in illegal drug use

Employers may administer drug testing to ensure that someone who has a history of illegal drug use is no longer using.[7] ADA (42 U.S.C. §12114(c)) also permits an employer to

- Prohibit all use of illegal drugs in the workplace
- Require all employees to be free from the influence of illegal drugs at the workplace
- Require an employee who engages in the illegal use of drugs to maintain the same qualifications for employment, job performance, and behavior that the employer requires other employees to meet, even if any unsatisfactory performance is related to the employee's drug abuse

The Drug-Free Workplace Act

Another Federal law, the Drug-Free Workplace Act (41 U.S.C. §701 et seq.), may also affect clients in recovery. The Act requires employers who receive Federal funding through a grant (including block grant or entitlement grant programs) or who hold Federal contracts to certify they will provide a drug-free workplace. The certification means that affected employers must

- Notify employees that "the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the workplace and specify the actions that will be taken against employees [who violate the] prohibition"
- Establish an ongoing drug awareness program to inform employees of the dangers of drug abuse in the workplace, the availability of any drug counseling or employee assistance program, and the penalties that may be imposed for violations of the employer's policy
- Take appropriate action against an employee convicted of a drug offense when the offense occurred in the workplace
- Notify the Federal funding agency in writing when such a conviction occurs

Individuals currently engaging in the illegal use of drugs have no protection against discrimination in employment, even if they are "qualified" and do not pose a "direct threat" to others in the workplace (29 U.S.C. §706(8)(C)(i) and 42 U.S.C. §12210(a)).

The protections offered to clients in substance abuse treatment are summarized in Figure 7-1.

State Laws

Most States have also enacted laws to protect people with disabilities (or "handicaps"). And some States' laws protect persons with substance abuse disorders. Each State's law is different and a treatment provider seeking help under State law should get in touch with the State or local agency charged with enforcing State civil rights laws.

Federal Law

An ounce of prevention

The old adage "an ounce of prevention is worth a pound of cure" is particularly applicable to the area of employment discrimination. It is always easier to persuade an employer to hire an applicant *before* he has made a decision to reject him. In a variety of ways, counselors of individuals in treatment for substance abuse disorders can help hard-to-employ clients enhance their chances for employment. Counselors should be prepared to help clients, whether directly or through referrals, with the following tasks.

Focusing on jobs for which clients can qualify

Clients in substance abuse treatment often lack perspective about the world of work. To many, there is a great divide between jobs with status (professional or high-visibility) and jobs that they believe have no status (e.g., fast food, other service industry jobs). Counselors can help clients understand and accept that there are many low-profile jobs that provide livelihood and satisfaction to millions of people. They can help clients develop realistic plans that could require starting at the bottom in order to attain a desirable goal. Such plans could include finding a training program that would lead to a good job. This kind of counseling will be increasingly important as the many aspects of welfare reform are implemented.

Helping clients avoid common pitfalls

- Clients should avoid volunteering information about their substance use histories. Job seekers should generally avoid volunteering information employers may view negatively. A substance abuse disorder history falls in that category. Unless it is likely to surface (if, for example, the client is in a methadone program and will be tested for drug use) or may benefit the client (who, for example, is applying for a job as a counselor), a substance abuse disorder history is not a subject the client should introduce.
- Clients should avoid outright lies. Although volunteering information that employers may view negatively is unwise, lying is not advisable either. If an employer asks about the client's education or experience, the client would be foolish to manufacture degrees or an impressive employment history. The employer is bound to discover the truth and fire the client, no matter how valuable the client believes he has become in the meantime. The law generally sides with the employer in this situation.
- Clients should have a strategy for dealing with "illegal questions." ADA prohibits employers from asking a job applicant about a disability—including a substance abuse disorder—before making an offer of employment. The employer can ask about the applicant's ability to perform specific job functions and may condition a job offer on the applicant's passing a postoffer medical examination all applicants must pass. How, then, should an individual with a substance abuse disorder history respond to the question, "Have you ever used any of the following: heroin, cocaine, marijuana, etc.?"

There are four ways to deal with this kind of question:

1. The client can answer "yes," and add that she has participated or is participating in a supervised rehabilitation program (or has otherwise been rehabilitated) and is no longer engaged in illegal drug use. This is the "correct" legal answer. If the client is rejected, she can pursue one of the remedies outlined below.
2. The client can answer "no," which is a lie, and run the risk of being found out later. If the lie is uncovered, the client will most likely be fired, no matter how well she performed the job. In these circumstances, the law offers no remedies.
3. The client can inform the employer that the question is illegal. However, no matter how diplomatically this is put, it will likely offend the employer and indicate that the applicant does have a substance abuse disorder history.
4. Sometimes, the client can try to address an illegal question by supplying the information the employer seems to be seeking. If it appears that the employer is

concerned about abuse of sick time, or employees who fall asleep on the job, the applicant may be able to offer the reassurance that she's rarely sick or is not a night owl.

The counselor can help the client sort through the alternatives. Failing to disclose a substance abuse disorder history is rarely an illegal act (unless an application form requires attesting to the accuracy of information). It is for the client to decide how she wants to handle this problem, for she is the one who has to live with the consequences.

Enforcement: the pound of cure

Discrimination against individuals with substance abuse disorders continues despite the existence of the Rehabilitation Act and ADA. However, these laws offer those who believe they have suffered discrimination a choice of remedies.

The alternatives listed below must be pursued within certain time limits established by State and Federal laws. An individual who is considering filing a complaint with any one of the agencies mentioned below should consult an attorney at an early date to determine when a complaint must be filed.

For discrimination by a program or activity

Filing a complaint with the Federal agency that funds the program, activity, or service (42 U.S.C. §12133; 29 U.S.C. §794(a); 28 CFR Part 35, Subparts F and G). For example, if the program is educational, it may receive funding from the Department of Education; if it involves health care, it may be funded by the Department of Health and Human Services. Once a complaint is filed, the agency is supposed to investigate and attempt an informal resolution. If a resolution is reached, the agency drafts a compliance agreement that is enforceable by the U.S. Attorney General. Federal agencies are required by ADA and sections 503 and 504 of the Rehabilitation Act to establish an appeals process and to designate the person in charge of compliance.

If no resolution is achieved, the agency issues a "Letter of Findings" that contains findings of fact, conclusions of law, a description of the suggested remedy, and a notice of the complainant's right to sue. A copy is sent to the U.S. Attorney General. The agency must then approach the offending program about negotiating. If the program refuses to negotiate or negotiations are fruitless, the agency refers the matter to the U.S. Attorney General with a recommendation for action.

Advantages: A complaint to the Federal funding agency may get the offending program's attention (and change its decision) because the funding agency has the power to deny future funding to those who violate the law. It is also inexpensive (no lawyer is necessary); however, if the complainant opts to be represented by an attorney, he may be awarded attorneys' fees if he prevails. *Disadvantage*: Depending upon the kind of complaint and which Federal agency has jurisdiction, this may not be the most expeditious route.

Filing a complaint with the State administrative agency charged with enforcement of the antidiscrimination laws (42 U.S.C. §12201(b)). Such State agencies often have the words "civil rights," "human rights," or "equal opportunity" in their title. *Advantage:* This route is inexpensive. *Disadvantages:* Some of these agencies have large backlogs that generally preclude speedy resolution of complaints. Depending upon the State, remedies may be limited.

Filing a lawsuit in State or Federal court. One can file a court case requesting injunctive relief (temporary or permanent) and/or monetary damages. The court has the discretion to appoint a lawyer to represent the plaintiff (42 U.S.C. §§12188 and 2000a-3(a); 28 CFR §36.501).

Disadvantages: Unless one can find a not-for-profit organization that is interested in the case, a lawyer willing to represent the aggrieved party pro bono (free of charge), or a lawyer willing to take the case on contingency or for the attorneys' fees the court can award the side that prevails, this may be an expensive alternative. It can also take a long time. *Advantages*: The complainant can ask for injunctive relief (a court order requiring the program to change its policy) and/or monetary damages. It may give the complainant a better sense of control over the process. A lawyer may produce results quickly: a lawyer's approach to an offending program can have prompt and salutary effects. No one likes to be sued. It is costly, unpleasant, and often very public. It is often easier to re-examine one's position and settle the case quickly out of court. The advantages and disadvantages of filing a case in State court will depend upon State law, State procedural rules, and the speed with which cases are resolved.

Requesting enforcement action by the U.S. Attorney General, who can file a lawsuit asking for injunctive relief, monetary damages, and civil penalties (42 U.S.C. §12188 and 2000a-3(a); 28 CFR §36.503).

For employment discrimination

Filing a complaint with the Federal Equal Employment Opportunity Commission (EEOC) (42 U.S.C. §12117) **or the State administrative agency charged with enforcement of the antidiscrimination laws** (42 U.S.C. §12201(b)). If the EEOC finds reasonable cause to believe that the charge of discrimination is true and it cannot get agreement from the party charged, it can bring a lawsuit against any private entity. If the offending entity is governmental, the EEOC must refer the case to the U.S. Attorney General, who may file a lawsuit. The complainant can intervene in any court case brought by either the EEOC or the Attorney General.

The EEOC or the U.S. Attorney General can also seek immediate relief by filing a case for a preliminary injunction in a Federal court. The court can order injunctive relief, including reinstatement or hiring, back pay, and attorneys' fees (42 U.S.C. §2000e-5).

Advantage: A complaint to the EEOC, the U.S. Department of Justice, or a State or local antidiscrimination agency or State Attorney General is relatively inexpensive because it does not require a lawyer. *Disadvantage*: Some of these agencies have large backlogs that generally preclude speedy resolution of complaints.

Filing a lawsuit in State or Federal court. After an aggrieved party has filed a complaint with the State administrative agency and/or the EEOC, she can file a lawsuit (42 U.S.C. §2000e-5(f)).

Disadvantage: This may be an expensive alternative and may also take a long time. *Advantage:* It can get fast results (see section above on discrimination by a program or activity).

Employment Discrimination Against People With Criminal Records

Many individuals with substance abuse disorder histories also have criminal records. Most employers are reluctant to hire people with criminal records. Although there are rulings that prohibit employers from asking applicants about arrests that did not result in convictions, there are few protections for ex-offenders who have been convicted of misdemeanors or felonies. As is the case for individuals with substance abuse disorder histories, the best strategy is to prepare for difficulties in advance. See Chapters 3 and 8 for more on this issue.

A Closing Note

For individuals in treatment for substance abuse, Federal law provides protection against

discrimination by programs, services, and employers. Many States have also adopted laws prohibiting discrimination against "individuals with disabilities" or "handicaps," and some of these statutes also protect those recovering from substance abuse disorders. Some States also offer limited protection to ex-offenders. To learn more about State law—the protections it offers and the available remedies—providers can call the State or local "human rights," "civil rights," or "equal opportunity" agency. Advocacy groups for individuals with disabilities are also a good source of information. Local legal services offices, law school faculties, and bar associations may also have information available or may be able to provide an individual lawyer willing to make a presentation to staff.

Part II: The Revolution in Rules Governing Public Assistance

In 1996, Congress enacted a major overhaul of welfare called "The Personal Responsibility and Work Opportunity Reconciliation Act." It transformed the Aid to Families With Dependent Children (AFDC) program, which "entitled" needy individuals with dependent children to assistance, into Temporary Assistance for Needy Families (TANF), a program offering limited relief. Unlike AFDC, TANF imposes work requirements on aid recipients, limits the amount of time an adult can receive benefits, and bars benefits to certain categories of persons, including individuals with felony drug convictions. States may screen recipients for alcohol and drug use and sanction those who test positive. TANF promises to have a major impact on clients who are also parents. Also in 1996, as part of the Contract With America Advancement Act, Congress amended the Social Security disability laws to eliminate benefits for any individual whose substance abuse disorder is or would be a contributing factor to an award of Supplemental Security Income (SSI) or Disability Insurance (DI) benefits (§105 of P.L. 104-121). Those receiving SSI or DI benefits are also generally eligible for food stamps and Medicaid; thus, the loss of SSI or DI benefits carries with it the possible loss of these benefits, including support for substance abuse treatment.

Finally, as part of the Adoption and Safe Families Act of 1997, Congress has required the States to shift the focus of child abuse prevention and intervention services from family reunification to children's health, safety, and permanent placement. There is now a 15-month limit on "family reunification services," which are provided when children have been removed from the home and placed in foster care. This limit applies to substance abuse treatment and mental health services; individual, group, or family counseling; and transportation to or from services (42 U.S.C. §675(5), as amended by §§103 and 305 of the Adoption and Safe Families Act of 1997). States must begin proceedings to terminate parental rights when children have been in foster care for 15 of the most recent 22 months (42 U.S.C. §675(5)(C), as amended by §301 of the Adoption and Safe Families Act of 1997).

These three pieces of legislation promise to put great pressure on clients in substance abuse treatment to regain and retain sobriety, find work, and assume responsible parenting, all within a relatively short period of time. The following section provides an overview of these changes and a brief discussion of the practical implications for substance abuse treatment clients.

Changes in the Rules Governing Public Assistance

Personal Responsibility and Work Opportunity Reconciliation Act

The Personal Responsibility and Work Opportunity Reconciliation Act (1996) affects clients receiving TANF in the following ways:

- *Mandatory work requirements*. With few exceptions, recipients of TANF must work within 2 years. Those who fail to comply with the work requirements will see their benefits reduced or eliminated. (States may not penalize single parents with a child under 6 who cannot find child care.) States may also cut Medicaid coverage to parents who do not comply with the work requirement (42 U.S.C. §607(e)).
- *Time limits.* No family may receive assistance for more than 5 cumulative years (or a lesser period of time, at the State's option). Once a parent has been on public assistance the allotted time, he or she may be cut from the rolls, although certain hardship exceptions can be made (42 U.S.C. §608(a)(7)).
- *Drug testing*. States may screen welfare recipients for alcohol and drug use and sanction those who test positive by reducing or eliminating their benefits.
- *Drug felony ban*. Those applying for public assistance must disclose any drug-related conviction of any household member. States can then deny public assistance and food stamps to people whose drug felony convictions occurred after August 22, 1996. States must take an affirmative step to opt out of this ban (§115 of P.L. 104-193, as amended by §5516 of P.L. 105-33).
- *Probation/parole violation ban.* Offenders who violate the terms of their probation or parole lose their public assistance and food stamps. In some States, offenders who have been mandated into treatment and leave treatment may be subject to this provision (42 U.S.C. §608(a)(9)).

Contract With America Advancement Act of 1996

The Contract With America Advancement Act of 1996 affects individuals who have been found disabled because of their substance abuse disorder and are receiving SSI or DI benefits.

- *Alcoholism and drug addiction removed as qualifying disabling conditions*. Individuals who might previously have been classified disabled and found eligible for SSI or DI because of their substance abuse disorder may no longer be found disabled if their substance abuse disorder "would (but for this subparagraph) be a contributing factor to the [Social Security] Commissioner's determination that the individual is disabled" (§105(a)(1) of P.L. 104-121, the "Contract With America Advancement Act of 1996"). However, if an individual who has previously been classified disabled because of substance abuse has another, coexisting mental or physical disability that qualifies as a disabling condition, he may still be eligible for these benefits.
- *Representative payee required*. The benefits of any individual who receives SSI or DI for another disabling impairment must be paid to a representative payee if "such payment would serve the interest of the individual because the individual also has an alcoholism or drug addiction condition (as determined by the Commissioner) and the individual is incapable of managing such benefits" (§105(a)(2) of P.L. 104-121).
- *Mandatory referral to treatment*. Individuals whose benefits are paid to a representative payee must be referred "to the appropriate State agency administering the State plan for substance abuse treatment services. . . " (§105(a)(3) of P.L. 104-121).

Changes in the Rules Governing Families Involved With Child Protective Services

Congress has established a series of programs to fund and support States' efforts to help families in crisis, including family preservation, family reunification, foster care, and adoption assistance.[8] These programs require States to adopt policies, timetables, and restrictions that may have the following results:

- *States may take a less tolerant view when children are living in households with one or more substance-abusing adults*. The Federal legislation requires a shift in focus from a concern with "family preservation" to children's health and safety as "the paramount concern" (42 U.S.C. §671(a)(15), as amended by the Adoption and Safe Families Act of 1997). This means that children may be placed in foster care more readily than before.
- *Parents will have a shorter time period to achieve sobriety if they are to retain their children*. Family reunification services are now limited to 15 months after the child has been removed from the family and placed in foster care. This time limit applies to any substance abuse treatment and mental health services; individual, group, or family counseling; and transportation services provided as part of family reunification services (Id. at §675(5)).
- *There may be speedier termination of parental rights.*
- *There is greater emphasis on permanent placement of children*. States must hold a "permanency" hearing within 12 months of a child's placement in foster care to determine whether to return the child, initiate proceedings to terminate parental rights, or place the child in another permanent living arrangement (Id. at §675(5)(C)).
- *There will be limits on how long children can remain in foster care*. States must begin the process of terminating parental rights or finding long-term foster care placement for children who have been in foster care for 15 of the most recent 22 months (Id. at §675(5)(C)).

Parents who are unable to achieve sobriety after a year of treatment will be at greater risk of losing their parental rights as States implement the 15-month time limit on family preservation services and enforce the requirements regarding prompt determinations about children's permanent placement.

Changes in the Rules Governing Immigrants

There are some new restrictions on benefits for immigrants. A lawful immigrant may or may not be eligible for benefits, depending on a variety of factors, including her immigrant status, the kind of benefit the immigrant applies for (e.g., TANF, SSI, DI, Medicaid, food stamps), when the immigrant arrived in this country, how long she has been here, her age, and other facts about her personal history (42 U.S.C. §602(a)(33); 42 U.S.C. §2115).

The changes in the rules governing public assistance, disability benefits, and immigrants are fairly new, and States have some choice in the way they implement them. To learn more about how the State is implementing these laws, programs can consult their agency's counsel, if one exists, or a board member who is an attorney. Or, they can seek help from a lawyer familiar with the State law and regulations in this area who works for the State's Department of Social or Human Services, the State Attorney General's office, the Single State Agency, the local Legal Aid Society or Legal Services office, a family law clinic (perhaps at a law school), or a private practice specializing in family law. Often bar associations have lists of attorneys who work pro bono on issues such as these.

Combined Impact of Welfare Reform and Changes in Child Welfare Laws

The combined effects of the new welfare reform requirements, the amendments to the disability laws, and the changes in the child welfare laws threaten to put clients who rely on public assistance or who are involved with a child protective services (CPS) agency under tremendous pressure. Clients will no longer receive disability benefits (SSI or DI) based on their substance abuse problems and may lose eligibility for food stamps and Medicaid as well. Clients with children may face reduction or elimination of their benefits if they fail to achieve and maintain sobriety, comply with work requirements, or enter the workforce within 5 years. Clients whose benefits are reduced or eliminated may have difficulty providing their children with the requisite level of food, clothing, shelter, and medical care. At the same time, clients involved with a CPS agency may be required to meet additional requirements within a limited time period.

Those with substance abuse problems, minimal work experience, and a lack of parenting skills can feel overwhelmed by these growing demands. Maintaining sobriety, by itself, is a difficult achievement for many. If they have to comply with work requirements and assume new parenting responsibilities, they may see all of this as impossible. For some, the response will be denial of the reality that "the system" has changed. Others may be overcome by hopelessness and be inclined to give up. Others will relapse.

As welfare reform, amendments to the disability laws, and changes in child protection laws are implemented, counselors will see increasingly stressed clients in need of supportive counseling and a web of support services. In these changed times, however, support will not suffice. If a client in substance abuse treatment is to emerge with a source of income and his family intact, the counselor must combine support with a firmness rooted in the understanding that the rules in this area have changed and become less forgiving. The challenge for counselors is to continue supporting clients while conveying to them the urgency of their attaining or maintaining sobriety and finding gainful employment.

Part III: Confidentiality Of Information About Clients

Programs providing treatment or VR services to individuals with substance abuse disorders frequently need to communicate with individuals and organizations as they gather information, refer clients to services the program does not provide, and coordinate care with other human service providers. This section outlines the laws protecting client confidentiality and examines how staff can protect clients' privacy while providing appropriate treatment or VR services.

Information about individuals applying for or receiving substance abuse prevention, screening, assessment, or treatment services is subject to a Federal statute and regulations that guarantee confidentiality (42 U.S.C. §290dd-2; 42 CFR, Part 2). State laws also protect information about individuals' health or mental health status or treatment, as well as information about certain diseases, and may restrict disclosure of information about substance abuse.[9] The Federal law, however, is generally more restrictive than State laws. Federal law preempts less restrictive State laws, but does not preclude enforcement of State law that is more restrictive.

This section describes what the Federal law and regulations require and examines their impact on substance abuse treatment programs. It details the rules regarding the use of consent forms to get a client's permission to release

information and examines how consent forms may be used to refer a client to or coordinate a client's care with another service provider. Situations that commonly arise when a client in substance abuse treatment is receiving VR services at the program or elsewhere are reviewed, including how a program can properly gather information about a client from collateral sources and how a program can communicate with vocational programs or clients' employers in a variety of circumstances. Also discussed are some exceptions in the Federal confidentiality rules, the notice clients must receive about the confidentiality regulations, clients' right to review their own records, and security of records.

Overview: Federal Law and Regulations Protect the Client's Right to Privacy

A Federal law and a set of regulations guarantee the strict confidentiality of information about all persons who seek or receive alcohol and drug abuse prevention, assessment, and treatment services. The legal citation for the laws and regulations is 42 U.S.C. §290dd-2 and 42 CFR Part 2. (Citations in the form "§2..." refer to specific sections of 42 CFR Part 2.)

The Federal law and regulations are designed to protect clients' privacy rights in order to attract people into treatment. The regulations tightly restrict communications about substance-abusing clients; unlike either the doctor–patient or the attorney–client privilege, the substance abuse treatment provider is prohibited from disclosing even the client's name. A counselor may not acknowledge to an outside party that a particular client is a participant in the program. Violating the regulations is punishable by a fine of up to $500 for a first offense or up to $5,000 for each subsequent offense (§2.4).

The Federal rules apply to any program that specializes, *in whole or in part*, in providing treatment, counseling, or assessment and referral services for people with alcohol or drug problems (42 CFR. § 2.12(e)). Although the Federal regulations apply only to programs that receive Federal assistance, this includes indirect forms of Federal aid such as tax-exempt status, or State or local government funding coming (in whole or in part) from the Federal government.

Whether the Federal regulations apply to a particular program depends on the kinds of services the program offers, not the label the program chooses. Calling itself a "prevention program" or "outreach program" or "screening program" does not absolve a program from adhering to the confidentiality rules.

The primary aim of confidentiality rules is to allow clients (and not the provider) to determine when and to whom information will be disclosed. Some may view these laws and regulations as an irritation or a barrier to achieving program goals. Most of the nettlesome problems that can crop up under the Federal law and regulations can be avoided through planning ahead. Familiarity with the rules will ease communication. It can also reduce the confidentiality-related conflicts among program, client, and outside agency or person to a few relatively rare situations.

General Rules

The Federal confidentiality law and regulations protect any information about a client who has applied for or received any alcohol or drug abuse–related service from a program that is covered under the law. Services applied for or received can include screening, referral, assessment, diagnosis, individual counseling, group counseling, or treatment. The regulations govern from the time the client applies for or receives services or the program first conducts an assessment or begins to counsel the client. *The restrictions on disclosure apply to any information that would identify the client as an individual with a substance abuse disorder, either*

directly or by implication. The rule also applies to former clients or patients. It applies whether or not the person making an inquiry about the client already has the information, has other ways of getting it, has some form of official status, is authorized by State law, or comes armed with a subpoena or search warrant.

When Confidential Information May Be Shared With Others Through Client Consent

Although the Federal law and regulations protect information about clients, they do contain exceptions. The most commonly used exception is the client's written consent. The Federal regulations' requirements regarding consent are strict, somewhat unusual, and must be carefully followed. A proper consent form must be in writing and must contain *each* of the items contained in §2.31:

1. The name or general description of the program(s) making the disclosure
2. The name or title of the individual or organization that will receive the disclosure
3. The name of the client who is the subject of the disclosure
4. The purpose or need for the disclosure
5. How much and what kind of information will be disclosed
6. A statement that the client may revoke (take back) the consent at any time, except to the extent that the program has already acted on it
7. The date, event, or condition upon which the consent expires if not previously revoked
8. The signature of the client
9. The date on which the consent is signed (§2.31(a))

A general medical release form, or any consent form that does not contain all the elements listed above, *is not acceptable*. (See sample consent form in Figure 7-3.) Most disclosures of information about a client in substance abuse treatment are permissible if the client has signed a valid consent form that has not expired or been revoked.[10]

Specific aspects of the client consent procedure are discussed further below: the purpose of the disclosure and how much and what kind of information will be disclosed; the client's right to revoke consent; and the expiration of consent forms. Two other issues are also considered: the required notice to the recipient that the information may not be disclosed and the effect of a signed consent form.

Purpose of the disclosure and how much and what kind of information will be disclosed

These two items are closely related. All disclosures, and especially those made pursuant to a consent form, must be limited to information that is necessary to accomplish the need or purpose for the disclosure (§2.13(a)). It would be improper to disclose everything in a client's file if the person making the inquiry only needs one specific piece of information.

A key step in completing the consent form is specifying the purpose or need for the communication of information. Once the purpose has been identified, it is easier to determine how much and what kind of information will be disclosed, tailoring it to what is essential to accomplish that particular purpose or need.

Suppose, for example, that a counselor wants to refer a client to a vocational training program to improve his work-related skills. The counselor perhaps simply wants to call the training program to set up an appointment for the client. Making this kind of call from a substance abuse treatment program will almost always mean disclosing, albeit indirectly, that the client is in substance abuse treatment. Therefore, the client must sign a consent form.

Figure 7-3
Sample Consent Form

Consent for the Release of Confidential Information

I, _____, authorize XYZ Clinic to receive from/disclose to
(name of client or participant)

_____

_____
(name of person and organization)

for the purpose of_____

_____
(need for disclosure)

the following information_____

_____
(nature of the disclosure)

I understand that my records are protected under the Federal and State confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that in any event this consent expires automatically on _____
unless otherwise specified below. (date, condition, or event)

Other expiration specifications: _____

_____

_____
Date executed

_____
Signature of client

_____
Signature of parent or guardian, where required

In this instance, the purpose of the disclosure would be "to set up an appointment with the Big Tree Training Program." The disclosure would then be limited to a statement that "Sam O'Neill (the client) is in treatment at a substance abuse treatment program." No other information about Sam O'Neill would be released.

On the other hand, if the treatment provider and the vocational training program want to coordinate care for the client, they will need to communicate over a longer period of time and the counselor will need to release more detailed information. In this case, the "purpose of the disclosure" would be "coordination of services

for Sam O'Neill" and "how much and what kind of information will be disclosed" might be "treatment status, treatment issues, and progress in treatment."

If the program is treating a patient who is on probation at work and whose future employment is contingent on treatment, the "purpose of disclosure" might be "to assist the patient to comply with the employer's mandates" or "to supply periodic reports about attendance" and "how much and what kind of information will be disclosed" might be "attendance" or "progress in treatment." Note that the kinds of information that will be disclosed to a provider with whom a program is coordinating the client's care will be quite different from the kind of information a program will disclose to an employer. The program might well share some clinical information about a client with a vocational training provider if that would assist in coordinating services. Disclosure to an employer should be limited to a brief statement about the client's attendance or progress in treatment. Disclosure of detailed clinical information to an employer would, in most circumstances, be inappropriate.

Client's right to revoke consent

The Federal regulations permit the client to revoke consent at any time, and the consent form must include a statement to this effect. *Revocation need not be in writing*. If a program has already made a disclosure prior to the revocation, the program has acted in reliance on the consent and is not required to try to retrieve the information it has already disclosed.[11] If clients have been mandated into treatment by the criminal justice system as a condition of probation or parole or of any proceedings against them, they should sign a "criminal justice system consent form." This form prohibits the client from revoking consent to disclosures to the criminal justice mandating agency (§2.35). For a full explanation of the differences between this and the usual consent requirements, see TIP 25, *Substance Abuse Treatment and Domestic Violence* (CSAT, 1997c), pages 104–105.

Expiration of consent form

The Federal rules require that the consent form contain a date, event, or condition on which it will expire if not previously revoked. A consent form must last "no longer than reasonably necessary to serve the purpose for which it is given" (§2.31(a)(9)). If the purpose of the disclosure can be expected to be accomplished in 5 or 10 days, it is better to fill in that amount of time rather than a longer period. It is best to individualize the ending date that the consent form is in effect rather than have all consent forms within an agency expire within 60 or 90 days. When uniform expiration dates are used, agencies can find themselves in a situation where there is a need for a disclosure, but the client's consent form has expired. This means at the least that the client must come to the agency again to sign a consent form. At worst, the client has left or is unavailable (e.g., hospitalized), and the agency will not be able to make the disclosure.

The consent form does not need to contain a specific expiration date but may instead specify an event or condition. In the example discussed above, if a counselor is calling a training program to set up an appointment for the client, the consent form could provide that it will expire after the client "has had his first appointment at the Big Tree program." On the other hand, if the counselor wants to coordinate services with the training program, it might be appropriate to have the consent form expire "when services by either agency end." A consent form permitting disclosures to an employer might expire at the end of the client's probationary period. However, a program that continues to provide services after a client has revoked a consent authorizing disclosure to a

third-party payor does so at its own financial risk.

Somewhat different rules may apply when a client comes for assessment or treatment as an official condition of probation, sentence, dismissal of charges, release from detention, or other disposition of a criminal justice proceeding. A consent form (or court order) is still required before a program can disclose information about a client who is the subject of a referral from the criminal justice system (CJS). However, the rules concerning the length of time that a consent is valid and the process for revoking the consent are different (§ 2.35). Specifically, the regulations require that the following factors be considered in determining how long a criminal justice consent will remain in effect:

- The anticipated duration of treatment
- The type of criminal proceeding
- The need for treatment information in dealing with the proceeding
- When the final disposition will occur
- Anything else the client, program, or justice agency believes is relevant

These rules allow programs to draft the consent form to expire "when there is a substantial change in the client's justice system status." A substantial change in justice status occurs whenever the client moves from one phase of the criminal justice system to the next. For example, for a client on probation, a change in status would occur when the probation ends, either by successful completion or revocation. Until one of those events occurs, the program could provide periodic reports to the client's probation officer and could even testify at a probation revocation hearing, since no change in status would occur until after that hearing.

The Federal regulations also permit the program to draft the consent form so that it cannot be revoked until a specified date or condition occurs. The regulations permit the CJS consent form to be irrevocable so that a client who has agreed to enter treatment in lieu of prosecution or punishment cannot then prevent the court, probation department, or other agency from monitoring her progress. Note that although a CJS consent may be made irrevocable for a specified period of time, that time period must end no later than the final disposition of the juvenile or criminal justice proceeding. Thereafter, the client may freely revoke consent.

Signature when the client is a minor (and the issue of parental consent)

A minor[12] must always sign the consent form in order for a program to release information, even to his parent or guardian. The program must get the parent's signature in addition to the minor's signature only if the program is required by State law to obtain parental permission before providing treatment to minors (§2.14). ("Parent" includes parent, guardian, or other person legally responsible for the minor.)

In other words, if State law does not require the program to get parental consent in order to provide services to a minor, then parental consent is not required to make disclosures (§2.14(b)). If State law requires parental consent to provide services to a minor, then parental consent is required to make any disclosures. *The program must always obtain the minor's consent for disclosures and cannot rely on the parent's signature alone*. Substance abuse treatment programs should consult with their Single State Agency or a local lawyer to determine whether they need parental consent to provide services to minors. The Federal confidentiality regulations do permit the director of a substance abuse treatment program to communicate with a minor's parents without the minor's consent, when

- The minor is applying for services
- The program director believes that the minor, because of extreme substance abuse or medical condition, does not have the capacity

to decide rationally whether to consent to the notification of her parents or guardian

- The program director believes that the disclosure is necessary to cope with *a substantial threat to the life or well-being of the minor or someone else*

Thus, if a minor applies for services in a State where parental consent is required to provide services, but the minor refuses to consent to the program's notifying her parents or guardian, the regulations permit the program to contact a parent without the minor's consent, only if those conditions are met. Otherwise the program must explain to the minor that while she has the right to refuse to consent to any communication with a parent, the program can provide no services without such communication and parental consent (§2.14(d)). The regulations add a warning, however, that such action might violate a State or local law (§2.14(b)).

Required notice against redisclosing information

Once the consent form has been properly completed, there remains one last requirement. Any disclosure made with client consent must be accompanied by a written statement that the information disclosed is protected by Federal law and that the person receiving the information cannot make any further disclosure of it unless permitted by the regulations (§2.32). This statement, *not the consent form itself*, should be delivered and explained to the recipient at the time of disclosure or earlier.

The prohibition on redisclosure is clear and strict. Those who receive the notice are prohibited from rereleasing information except as permitted by the regulations. (Of course, a client may sign a consent form authorizing such a redisclosure.)

Note on the effect of a signed consent form

The fact that a client has signed a proper consent form authorizing the release of information does not *require* a program to make the proposed disclosure, unless the program has also received a subpoena or court order (§§ 2.3(b); 2.61(a)(b)). The program's only obligation is to refuse to honor a consent that is expired, deficient, or otherwise known to be revoked, false, or invalid (§2.31(c)).

In most cases, the decision whether or not to make a disclosure when a client has signed a consent form is within the discretion of the program, unless State law requires or prohibits disclosure once consent is given. *In general, it is best to follow this rule: disclose only what is necessary, for only as long as is necessary, keeping in mind the purpose of the communication.*

Sharing Information: Strategies for Dealing With Common Situations Requiring Communications With Others

This section discusses the kinds of questions that affect the operations of programs offering vocational services, either directly or through referral—bearing in mind the rules regarding consent discussed above. These questions include

- How can alcohol and drug counselors obtain information from collateral sources about clients they are screening, assessing, or treating?
- How should programs handle communications with vocational and training programs
  - When the vocational services are part of the substance abuse treatment program?
  - When the vocational services are offered by an outside agency?
  - When the vocational services are offered by an outside agency onsite at the program?
- How should programs handle communications with employers
  - Who have referred employees/clients to treatment?

- Who do not know their employees are in treatment?
- When a client's relapse may pose a threat to fellow employees or others at the workplace?

Seeking information from collateral sources

When a client is referred to a program by an employer, a training program, or a physician, the program may, at some point in the intake and assessment process, need to ask the person or organization making the referral some questions. Or, a program may want to communicate with an outside person or organization to verify information about a client. Making inquiries of employers, schools, training programs, family members, doctors, and other health care entities might, at first glance, seem to pose no risk to a client's right to confidentiality. But it does.

When a program asks a family member, employer, training program, doctor, or mental health professional to supply information about a client or verify information it has obtained from a client, it is making a patient-identifying disclosure that the client has sought its services. In other words, when program staff seek information from other sources, they are letting those sources know that the client has asked for substance abuse treatment services. *The Federal regulations generally prohibit this kind of disclosure unless the client consents*, even if the person or organization already knows the client is in treatment.

The easiest way to proceed in this situation is to get the client's consent to contact the employer, training program, family member, school, health care facility, and so on. Or, the program could ask the client to sign a consent form that permits it to make a disclosure for purposes of seeking information from collateral sources to any one of a number of entities or persons listed on the consent form. Note that this combination form must still include "the name or title of the individual or the name of the organization" for each collateral source the program may contact. Whichever method the program chooses, it must use the consent form required by the regulations, not a general medical release form.

Communicating with vocational/training programs

As discussed in the first part of this chapter, the Rehabilitation Act and ADA generally protect individuals in substance abuse treatment when they seek vocational or training services from a provider covered by either Act. Nevertheless, communications with a vocational or training program must comply with the Federal confidentiality rules. For example, if a program refers a client to a vocational program by making an appointment for her, it would need to get the client to sign a consent form. Figure 7-4 sets out the different ways a referral can be handled.

How the program communicates with a vocational or training program depends in part on whether the vocational or training services are part of the substance abuse treatment program or offered by a separate agency.

When vocational or training services are part of the treatment program

The Federal regulations permit some information to be disclosed to staff within the same program:

> The restrictions on disclosure in these regulations do not apply to communications of information between or among personnel having a need for the information in connection with their duties that arise out of the provision of diagnosis, treatment, or referral for treatment of alcohol or drug abuse if the communications are (i) within a program or (ii) between a program and an entity that has direct administrative control over that program (§2.12(c)(3)).

Figure 7-4
Making a Referral to a Vocational or Training Program

When a substance abuse treatment program refers a client to an outside agency providing vocational services, it has three choices:

1. A counselor can give the client the agency's name, address, and telephone number and urge her to make an appointment.
2. A counselor can call the agency for the client and set up an appointment.
3. The program can invite the agency to interview clients and/or provide services on its premises.

The first option requires no communication between the program and the vocational or training agency; thus, no consent is required. However, the first option does require the client to take the initiative, something she may have difficulty doing. The second option requires the client to sign a consent form permitting the counselor to call the agency and set up an appointment. The third option provides the path of least resistance for the client—she need only present herself to the outside agency on the day it schedules services at the program. By appearing to request services from the outside agency, the client is making a disclosure about her participation in treatment and no consent form is required. However, if the program sets up appointments for clients beforehand, it will need a consent form signed by the client before it can present the list of applicants for services to the vocational or training program. And, as noted above, the substance abuse treatment program must have a proper, signed consent form if it and the vocational or training agency are to communicate in the future about any client they both serve.

In other words, staff members who have access to information about clients because they work for or administratively direct the program—including full- or part-time employees and unpaid volunteers—may consult among themselves or otherwise share information if their substance abuse treatment work so requires (§2.12(c)(3)).

This is the second most commonly invoked exception to the Federal confidentiality rules (after consent). While the exception may apply to an in-house vocational or training program, two cautions must be noted. First, the exception does not permit unfettered communications among staff within a substance abuse treatment program. Only staff members "having a need for the information in connection with their duties that arise out of the provision of [substance abuse treatment services]" may receive information about the client without consent. Second, once information about a client is communicated to an in-house vocational or training program, information about that client that is held by the vocational or training program becomes subject to the confidentiality rules. Thus, the vocational or training program staff would have to learn and agree to abide by the Federal confidentiality rules.

When vocational or training services are offered by an outside agency

In order for a substance abuse treatment program to communicate with a vocational/training program operated by an outside agency, it must have a valid consent form signed by the client. As noted above, the form must satisfy all the requirements of §2.31; it must include a statement of the need or purpose of the communication and the kind and amount of information to be disclosed. If the communication is to be ongoing, it is

appropriate to have the consent form expire "when services by either agency end."

When an outside agency provides vocational or training services on program premises

When a substance abuse treatment program invites an outside agency to provide vocational or training services on program premises, it may communicate information about a client to that agency and its staff only after the client signs a valid consent form. The fact that the staff of an agency operating on program premises presumably knows that the clients it is serving are in substance abuse treatment does not mean that the program can dispense with the consent requirements. Moreover, the substance abuse treatment program must take steps to protect the confidentiality of clients who are not using the onsite vocational or training services. Nonparticipating clients should receive notice about when such "outsiders" will be at the program and where they will be. The vocational or training program should occupy space at the program that can be avoided by clients not receiving those services so that they can protect their own identities.

Communicating with employers

As discussed in the first part of this chapter, the Rehabilitation Act and ADA offer limited protection against employment discrimination to individuals participating in substance abuse treatment. Whether and how the program should communicate with an employer depends on a variety of factors, including whether the employer referred the employee to treatment, whether the employer is likely to be understanding or hostile when he learns that an employee has sought substance abuse treatment, and what kind of job the employee holds.

When the employer has referred the client

When an employer refers a client to treatment as a condition of keeping his job, the employer may well require periodic reports from the substance abuse treatment program about the employee's attendance and/or progress in treatment. Although the employer clearly knows in this situation that the employee is in treatment, a consent form is necessary for the program to communicate with the employer. As mentioned above, the program should limit the kind and amount of information it reports to the employer; with few exceptions, employers do not need detailed clinical information.

When the employer does not know an employee needs or is in treatment

When an employed client is self-referred or referred by someone other than her employer, there may be little or no reason for the program to communicate with the employer. However, circumstances may arise that appear to require communication. For example, suppose that a counselor believes that a client needs intensive treatment, available only in another county or at a residential facility? Someone must notify the client's employer that she will be gone for a period of time. The counselor and the program should consult the client about how she wants to handle this situation. The client should gather preliminary information, such as the following:

- *What is the employer's policy?* Does the client know what the employer's policy is with regard to medical leave? How much medical leave will the employer grant? Is there a procedure that must be followed to request a medical leave of absence? Is there a written personnel policy or a human resources department the client can consult?
- *Will the employer learn about the treatment through the insurance plan?* How will the client pay for treatment?

If her job benefits include health insurance, does that insurance cover the type of substance abuse treatment the client needs? If she uses the insurance, is her employer likely to find out about her treatment?

- *Can the client ask for time off herself?* If the client can simply tell the employer she needs time off for medical treatment, then that is probably the most prudent course to follow. (However, the client should ascertain whether, on her return, she would have to submit a medical report.) Or, perhaps the client can use her accumulated vacation time to pursue treatment.

If the client does not need to involve a health care provider to get medical leave, the safest course might be for her to ask for medical leave herself or take vacation time. If a health care provider must certify that the client needs medical leave, what are the likely repercussions if the employer learns she is entering a program for treatment of a substance abuse disorder?

- If the client believes *the employer will be sympathetic*, the program could inform the employer directly, so long as the client signs a proper consent form.
- If the client believes *there will be negative repercussions* if her employer learns she has a substance abuse problem:
  - *She could ask her medical doctor* to write a letter requesting a medical leave without revealing the substance abuse problem.
  - *If the program is part of a larger health care agency* that is not identified as an agency providing substance abuse treatment, it could write a letter requesting medical leave, using the umbrella agency's stationery. The letter would not mention substance abuse disorders. This is not an option that is practical for a free-standing program (or a program that is part of a larger agency that is identified as a substance abuse treatment provider), since writing to inform the employer that the client needs treatment will disclose the diagnosis to the employer.

An astute counselor can help the employed client navigate the sometimes perilous path leading to treatment and back to employment. It is critical for the counselor and the program to listen to a client's concerns about her employer's attitude. Remember that protections for those recovering from a substance abuse disorder are limited, and enforcement of those protections is uncertain and can be expensive. If a program communicates with an employer without a client's consent, and in doing so directly or indirectly reveals that the client has a substance abuse disorder, the program may find itself facing an unpleasant lawsuit if the client loses her job.

Communicating with an employer or vocational program when a client's relapse may pose a threat to others

Does a program have a "duty to warn" an employer or training program when it knows that a client it is treating has relapsed? When would that "duty" arise? Even when no duty exists, should a substance abuse treatment program warn those who may be put at risk about a client's relapse? How can others be warned without violating the Federal confidentiality regulations?

Successful substance abuse treatment depends on the willingness of clients to expose powerful feelings and shameful things about themselves to program staff. The news that the program has, without a client's consent, "warned" a training program or employer or someone else that a client has relapsed will spread quickly among the client population. It may have the effect of destroying clients' trust in the program and its staff. Any counselor or program considering "warning" someone of a client's relapse without the client's consent should carefully analyze whether there is, in

fact, a "duty to warn" and whether it is possible to persuade the client to discharge this responsibility himself or consent to the program's doing so.

Is there a duty? The answer is a matter of State law. This question does not usually arise in the employment or vocational training context. The "duty to warn" issue usually arises when a client makes a verbal threat to cause physical harm to himself or another person. In such cases, in order for a "duty to warn" to exist, a counselor generally must be able to identify a particular potential victim. For example, if a client makes a statement that he intends to shoot his boss, and the counselor believes he means it, then the counselor would have a duty to warn either the potential victim or law enforcement.[13]

There are obvious differences between the "verbal threat" and the threat that a relapse may present: because the client is not *intending* to hurt anyone in the training program or at work, it is not clear that his going to the training program or to work inebriated or "high" will actually result in physical harm to another. There are circumstances when individuals are in safety-sensitive positions, such as pilots, medical personnel, and child care workers, where harm to others may be an issue. However, there are always workers in such jobs whose performance seems unaffected by substance use. And, unlike the verbal threat scenario, the potential consequences are not so clear.

There appears to be no consensus that substance abuse treatment programs have a duty to warn an employer or training program of a client's relapse. The program has to make a judgment in a situation where it has conflicting moral obligations: On the one hand, no program would want to prompt a training program or employer to dismiss its client. On the other hand, it would be tragic if the client's condition resulted in death or injury to someone. How should treatment providers address this dilemma?

Reaching a decision: factors to consider

The process of reaching a decision concerning whether to warn an employer or training program about a client's relapse will be easier if programs develop a protocol about "duty to warn" cases in this context. A protocol gives staff guidelines to follow in making a decision. The protocol should require the client's primary counselor to consult with her clinical supervisor (and perhaps the program director) and should include the following steps:

1. Evaluate the threat.
2. If the threat is serious, determine if there is a way to avoid disclosure about the client's substance abuse disorder.
3. If the threat is serious and it is not possible to avoid a disclosure about the client's substance abuse disorder, determine how the program should warn an employer without violating the Federal confidentiality rules.
4. Document the incident.

Evaluate the threat

Safety sensitivity. The first question to consider is whether the client has the kind of job in which a relapse would be a problem. For example, if the client is a file clerk, being inebriated or "high" on the job would not pose a danger to others' physical welfare. If, on the other hand, the client works as a truck driver or on a fast-paced assembly line, going to work inebriated or "high" might well pose a danger to others.

The seriousness of the relapse. The program should determine whether the client's relapse and resulting substance use pattern is a threat to himself or others on the job or at the training program. If the client binges on weekends, for example, he may not pose a threat to others at the workplace even if he holds a safety-sensitive position.

The client's employment status. If the client has relapsed and is not keeping appointments at the

program, it may also be that the client has also stopped going to work. The program could try to find out whether the client is still employed, so long as it does not disclose that the client has a substance abuse disorder or is in treatment.

Determine if there is a way to avoid disclosure about the client's substance abuse disorder

If the threat is serious, determine if there is a way to avoid disclosure about the client's substance abuse disorder.

Will the client take responsibility? The program should make an effort to convince the client to take steps to avoid putting others at risk. This may require the client to call in sick during a relapse or request medical leave or temporary reassignment to a job that is not safety-sensitive.

Can the program give a warning without disclosing the client's substance abuse disorder? For a program that is part of a larger non–substance-abuse treatment facility, this can be accomplished by giving a warning in the larger facility's name. For example, a counselor employed by an alcohol treatment program that is part of a general hospital could phone the employer in question, identify herself as "a counselor at the New City General Hospital," and state that John Smith (the client) is not fit to work. (The counselor may not mention that the employee has a substance abuse problem or that he is impaired by drugs or alcohol.) This kind of warning would convey the vital information without identifying the client as someone in substance abuse treatment. Counselors at free-standing alcohol or drug programs cannot give the name of the program but could give a warning to the employer without identifying themselves (often called an "anonymous" warning). (This "non-patient-identifying disclosure" exception is discussed more fully below.)

Determine how the program should warn an employer without violating the Federal confidentiality rules

If the threat is serious and it is not possible to avoid a disclosure about the client's substance abuse disorder, determine how the program should warn an employer without violating the Federal confidentiality rules. *Is there a consent form?* For a client in a safety-sensitive position, the program should have on hand a consent form permitting it to inform the employer or training program about a relapse that poses a threat to others. This may be easier to obtain from a client who has been referred by an employer or whose vocational program knows he is in substance abuse treatment. Even then, the client can revoke his consent.

If the client will not give consent, the program can seek a court order authorizing the disclosure. The program should try to educate the court about the "court order" requirements of the Federal confidentiality regulations (which are discussed below in detail).

Document the incident

A program that decides to warn an employer or training program should document the factors that impelled its decision. If the decision is later questioned, notes made at the time showing that the program made a good-faith effort to determine the need to make the disclosure, to persuade the client to take responsibility himself, and to determine an appropriate way to issue the warning could prove invaluable.

The program's "duty to warn" protocol should be supplemented with ongoing training and discussions to assist staff in sorting out what should be done in any particular situation. Programs should also keep abreast of developments in this area. The circumstances under which the law imposes a "duty to warn" or "duty to notify" are changing, as States adopt

new statutes and their courts apply statutes to new situations. Although a duty to warn in the vocational training and employment contexts does not fit neatly into the classic model, developments in other areas of liability law may foreshadow shifts that will result in imposition of liability in this area, too. In some States, for example, bar owners and even hosts at private parties have been held liable for serving alcohol to inebriated customers or guests who injured or killed other motorists on their way home. In these cases, the bar owner's or host's knowledge that a customer or guest was drunk and about to drive his car is viewed as imposing a duty to protect innocent third parties. On the other hand, in some cases, courts have refused to impose liability on alcohol treatment programs that failed to get clients to stop drinking or driving. How any individual case will be decided will depend on the particular facts of the case (how egregious it appears in hindsight that the program failed to warn someone), what kind of damage was caused by the relapsed client, and the legal precedents in the State in which the case is brought.

Exceptions That Permit Disclosures

The Federal confidentiality regulations' general rule prohibiting disclosure of patient-identifying information has a number of exceptions. Some of these exceptions have already been mentioned: consent, disclosures that do not identify someone as a client in substance abuse treatment, communications within a program, and disclosures authorized by a special court. The rules governing these exceptions are described below. Other exceptions are listed at the end of this section, with references to other TIPs where they are explained more fully.

Communications that do not disclose patient-identifying information

The Federal regulations permit programs to disclose information about a client if the program reveals no patient-identifying information. A program may only disclose information about clients if it does not identify them as alcohol or drug abusers or support anyone else's identification of them as such.

Obviously, a program can report aggregate data about its population (summing up information that gives an overview of the clients served in the program) or some portion of its populations. Thus, for example, a program could tell the newspaper that in the last 6 months it screened 43 clients, 10 female and 33 male. Or, as mentioned above, a program can communicate information about a client in a way that does not reveal the client's status as a substance abuse treatment patient (§2.12(a)(i)). For example, a program that provides services to clients with other problems or illnesses as well as a substance abuse disorder may disclose information about a particular client as long as the fact that the client has a substance abuse problem is not revealed. Or, a program that is part of a general hospital could have a counselor call a training program to inform them that the client may be unable to perform adequately. However, the counselor may not disclose that the client has a substance abuse problem or is a client of the substance abuse treatment program.

Programs that provide only alcohol or drug services cannot disclose information that identifies a client under this exception, since letting someone know a counselor is calling from the "Capital City Drug Program" will automatically identify the client as someone who received services from the program. However, a free-standing program can sometimes make "anonymous" disclosures, that is, disclosures that do not mention the name of the program or otherwise reveal the client's status as an alcohol or drug abuser.

Disclosures authorized by court order

A State or Federal court may issue an order that will permit a program to make a disclosure

about a client that would otherwise be forbidden. A court may issue one of these authorizing orders, however, only after it follows certain special procedures and makes particular determinations required by the regulations. *A subpoena, search warrant, or arrest warrant, even when signed by a judge, is* not *sufficient, standing alone, to require or even to permit a program to disclose information* (§2.61).[14]

Before a court can issue a court order authorizing a disclosure about a client, the client about whom a disclosure will be made must be given notice of the application for the order and some opportunity to make an oral or written statement to the court. If the program is not the party requesting the order, then the program, too, must be given notice and an opportunity to be heard.[15] Generally, the application and any court order must use fictitious names for any known client, and all court proceedings in connection with the application must remain confidential unless the client requests otherwise (§§2.64(a), (b), 2.65, 2.66).

Before issuing an authorizing order, the court must find that there is "*good cause*" for the disclosure. A court can find "good cause" only if it determines that the public interest and the need for disclosure outweigh any negative effect that the disclosure will have on the patient, or the doctor–patient or counselor–patient relationship, and the effectiveness of the program's treatment services. Before it may issue an order, the court must also find that other ways of obtaining the information are not available or would be ineffective (§2.64(d)).[16] The judge may examine the records before making a decision (§2.64(c)).

There are also limits on the scope of the disclosure that a court may authorize, even when it finds good cause. The disclosure must be limited to information essential to fulfill the purpose of the order, and it must be restricted to those persons who need the information for that purpose. The court should also take any other steps that are necessary to protect the client's confidentiality, including sealing court records from public scrutiny (§ 2.64(e)).

The court may order disclosure of "confidential communications" by a client to the program *only* if the disclosure

- Is necessary to protect against a threat to life or of serious bodily injury
- Is necessary to investigate or prosecute an extremely serious crime (including child abuse)
- Is in connection with a proceeding at which the client has already presented evidence concerning confidential communications (for example, "I told my counselor that…") (§2.63)

Other Exceptions

Disclosures to an outside agency that provides services to the program

If a program routinely needs to share certain information with an outside agency that provides services to the program, it can enter into what is known as a Qualified Service Organization Agreement (QSOA).[17]

Medical emergencies

A program may make disclosures to public or private medical personnel "who have a need for information about a patient for the purpose of treating a condition which poses an immediate threat to the health" of the patient or any other individual. The regulations define "medical emergency" as a situation that poses an immediate threat to health and requires immediate medical intervention (§2.51).[18]

Research, audit, or evaluation

The confidentiality regulations also permit programs to disclose patient-identifying information to researchers, auditors, and evaluators without patient consent, provided certain safeguards are met (§2.52,2.53).[19]

Crimes committed on program premises or against program personnel

When a client has committed or threatens to commit a crime on program premises or against program personnel, the confidentiality regulations permit the program to report the crime to a law enforcement agency or to seek its assistance. The program can disclose the circumstances of the incident, including the suspect's name, address, last known whereabouts, and status as a patient at the program (§2.12(c)(5)).[20]

Child abuse and neglect

The Federal confidentiality regulations permit programs to comply with State laws that require the reporting of child abuse and neglect. While many State statutes are similar, each has different rules about what kinds of conditions must be reported, who must report, and when and how reports must be made. This exception to the general rule prohibiting disclosure of any information about a client applies only to *initial* reports of child abuse or neglect. Programs may not respond to followup requests for information or subpoenas for additional information, even if the records are sought for use in civil or criminal proceedings resulting from the program's initial report, *unless* the client consents or the appropriate court issues an order under subpart E of the regulations.[21]

Other Rules Regarding Confidentiality

Client notice

The Federal confidentiality regulations require programs to notify clients of their right to confidentiality and to give them a written summary of the regulations' requirements. The notice and summary should be handed to clients when they begin participating in the program or soon thereafter (§2.22(a)). The regulations contain a sample notice.

Client access to records

Programs can use their own judgment to decide when to permit clients to view or obtain copies of their records, unless State law grants patients the right of access to records. The Federal regulations do not require programs to obtain written consent from patients before permitting them to see their own records.

Security of records

The Federal regulations require programs to keep written records in a secure room, a locked file cabinet, a safe, or other similar container. The program should establish written procedures that regulate access to and use of clients' records. Either the program director or a single staff person should be designated to process inquiries and requests for information (§2.16).

The push toward computerization of medical and treatment records will complicate the problem of keeping sensitive information private. Currently, there is protection afforded by the cumbersome and inefficient way many, if not most, medical, mental health, and social service records are stored (on paper) and make their way from one provider to another. When records are stored in computers, retrieval can be far more efficient. Computerized records allow anyone with a disk and access to the computer in which the information is stored to instantly copy and carry away vast amounts of information without anyone's knowledge. Modems that allow communication about patients among different components of a managed care network extend the possibility of unauthorized access to anyone with a modem, the password(s), and the necessary software. The ease with which computerized information can be accessed can lead to "casual gossip" about a client, particularly one of importance in a community, making privacy difficult to preserve.[22]

A Final Note

The legal and ethical issues that affect clients and staff of programs providing VR services are complex and interrelated. Welfare reform has reduced the support system upon which many clients relied and given greater urgency to programs' efforts to help clients enter the world of work. Federal and State laws offer some protection to those clients as they participate in training and seek employment. As programs help clients deal with the new welfare rules and find training and employment, they must keep in mind the Federal confidentiality rules, which affect every communication programs make about clients to welfare agencies, vocational training programs, employers, and others.

Endnotes

1. For a discussion of how these laws apply to persons living with HIV/AIDS, see the TIP, *Substance Abuse Treatment for Persons With HIV/AIDS* (CSAT, 2000b).
2. *Rehabilitation Act and key implementing regulations*: 29 U.S.C. §793 and 29 CFR Part 1630; §794(a), (b)(1), (b)(3)(A), and 45 CFR Part 84; *Americans with Disabilities Act and key implementing regulations*: 42 U.S.C. §§12111(2) and (5) and 12112 and 28 CFR Part 35, Subpart C, and 29 CFR Part 1630.
3. *Rehabilitation Act and key implementing regulations*: 29 U.S.C. §794 and 45 CFR Part 84; *Americans with Disabilities Act and key implementing regulations*: 42 U.S.C. §12182(b)(1)(A), 42 U.S.C. §12182(b)(2), and 28 CFR Part 35 and Part 36.
4. 42 U.S.C. §12102(2), 29 U.S.C. §706(8)(A), and, e.g., 28 CFR §§35.104 and 36.104.
5. Supplemental Information 28 CFR Part 35, Section-by-Section Analysis, §35.105 and Appendix B to 28 CFR Part 36, Section-by-Section Analysis, §36.104.
6. The Act defines "offender" as "any adult or juvenile (A) who or has been subject to any stage of the criminal justice process, for whom services under this Act may be beneficial; or (B) who requires assistance in overcoming artificial barriers to employment resulting from a record of arrest or conviction" (§101(27) of P.L. 105-220).
7. 29 U.S.C. §706(8)(C)(ii), 42 U.S.C. §12210(b), 28 CFR §36.209(c), and 28 CFR §35.131(c).
8. For a more detailed description of these changes, see the TIP, *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues* (CSAT, 2000a).
9. For a discussion of these kinds of State confidentiality laws, see TIP 24, *A Guide to Substance Abuse Services for Primary Care Clinicians* (CSAT, 1997a), Appendix B. For a discussion of confidentiality issues for those with HIV/AIDS, see the TIP, *Substance Abuse Treatment for Persons With HIV/AIDS* (CSAT, 2000b).
10. However, no information that is obtained from a program (even if the client consents) may be used in a criminal investigation or prosecution of the client unless a court order has been issued under the special circumstances set forth in §2.65 (42 U.S.C. §§290dd-2 and 42 CFR §2.12(a), (d)).
11. The regulations state that "acting in reliance" includes the provision of services while relying on the consent form to permit disclosures to a third-party payor. (Third-party payors are health insurance companies, Medicaid, or any party that pays the bills other than the patient's family or the treatment agency.) Thus, a program can bill the third party-payor for past services provided before the consent was revoked.
12. Minors are those individuals, under a certain age, who do not have all the rights and privileges of adults. The specific age

varies according to State law and also according to the "right" or "privilege" at issue—e.g., serving in the Army, drinking.

13. For a discussion of "duty to warn" when a client threatens violent harm to another person, see TIP 19, *Detoxification from Alcohol and Other Drugs* (CSAT, 1995[b]), Appendix F, Legal and Ethical Issues for Detoxification Programs, pp. 82, 84–85.
14. For an explanation about how to deal with search and arrest warrants, see TIP 19, *Detoxification from Alcohol and Other Drugs* (CSAT, 1995[b]), Appendix F, Legal and Ethical Issues for Detoxification Programs, pp. 84–85. For advice about dealing with subpoenas, lawyers, and law enforcement, see TIP 24, *A Guide to Substance Abuse Services for Primary Care Physicians* (CSAT, 1997[a]), Appendix B, Legal and Ethical Issues, pp. 111–112.
15. If the information is being sought to investigate or prosecute a patient for a crime, only the program need be notified (§ 2.65). If the information is sought to investigate or prosecute the program, no prior notice at all is required (§ 2.66).
16. If the purpose of seeking the court order is to obtain authorization to disclose information in order to investigate or prosecute a patient for a crime, the court must also find that (1) the crime involved is extremely serious, such as an act causing or threatening to cause death or serious injury; (2) the records sought are likely to contain information of significance to the investigation or prosecution; (3) there is no other practical way to obtain the information; and (4) the public interest in disclosure outweighs any actual or potential harm to the patient, the doctor–patient relationship, and the ability of the program to provide services to other patients. When law enforcement personnel seek the order, the court must also find that the program had an opportunity to be represented by independent counsel. (If the program is a governmental entity, it *must* be represented by counsel. [§2.65(d)].
17. For a description of the rules governing Qualified Service Organization Agreements, see TIP 19, *Detoxification from Alcohol and Other Drugs* (CSAT, 1995[b]), Appendix E, Legal and Ethical Issues, pp. 87–88.
18. For a description of the rules governing communications in medical emergencies, see TIP 19, *Detoxification from Alcohol and Other Drugs* (CSAT, 1995[b]), Appendix E, Legal and Ethical Issues, p. 87.
19. For a more complete explanation of the requirements of §§2.52 and 2.53, see TIP 14, *Developing State Outcomes Monitoring Systems for Alcohol and Other Drug Abuse Treatment* (CSAT, 1995[a]), Chapter 6, Legal Issues in Outcomes Monitoring, p. 58.
20. For a description of what and how programs may report crimes on program premises or against program personnel, see TIP 19, *Detoxification from Alcohol and Other Drugs* (CSAT, 1995[b]), Appendix E, Legal and Ethical Issues, p. 85.
21. For a comprehensive discussion of how programs should handle reporting child abuse or neglect to State authorities, see the TIP, *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues* (CSAT, 2000a).
22. For a brief discussion of the issues computerization raises, see TIP 23, *Treatment Drug Courts: Integrating Substance Abuse Treatment with Legal Case Processing* (CSAT, 1996), pp. 52–53.

8 Working With the Ex-Offender

Over the past two decades, as law enforcement has become a front-line response to substance abuse, many people with substance abuse disorders have entered the criminal justice system. The increase in the number of people in the criminal justice system for drug-related crimes is startling. Between 1980 and 1997, drug arrests tripled to 1,584,000; 80 percent were for possession (U.S. Department of Justice, 1999b). In 1980, 6 percent of the offenders in State prisons and 25 percent of the offenders in Federal prisons had been incarcerated for drug offenses. By 1996, there had been an elevenfold increase in the number of inmates in State prisons on drug offenses, and drug offenders constituted 23 percent of the State prison population. For Federal prisons, the increase over the 15-year period was twelvefold, with drug offenders constituting 60 percent of the prison population.

This astronomical increase does not take into account the high number of individuals with substance abuse disorders who are arrested and incarcerated for drug-related crimes (e.g., property crimes, robbery, assault). In 1997, 57 percent of State prison inmates had used drugs in the month prior to arrest, and one-sixth committed their offense to obtain money to buy drugs (Mumola, 1999).

The "war on drugs" has had a disproportionate impact on African Americans as a result of three overlapping policy decisions: the concentration of drug law enforcement in inner cities, harsher sentencing policies, and the emphasis on law enforcement at the expense of prevention and treatment (The Sentencing Project, 1999a). Given the shortage of substance abuse treatment options in many inner cities, substance abuse in these communities is more likely to receive attention as a criminal justice problem than as a social problem (The Sentencing Project, 1999a). As a result, African Americans who use illicit substances are arrested, convicted, and imprisoned at greater rates than other groups. While Federal surveys show that 13 percent of those who reported using drugs within the previous month are African American, this group constitutes 35 percent of those arrested for possession, 55 percent of those convicted, and 74 percent of those sentenced to prison (Mauer and Huling, 1995; SAMHSA, 1998a). According to current data, the Department of Justice estimates that 28 percent of African American males will enter a Federal or State prison at least once during their lives; the rates are 16 percent for Hispano/Latino males and 4.4 percent for White males (U.S. Department of Justice, 1999a).

The exponential increase in the number of individuals arrested and convicted of drug offenses and the disproportionate representation of African Americans in that group means that many drug and alcohol counselors are working with ex-offenders and that a large proportion of these ex-offender clients are African American. A criminal record is an additional barrier to employment for anyone recovering from a substance abuse disorder. African Americans

and members of other minorities (including individuals without substance abuse and criminal histories) also experience employment discrimination, sometimes subtle, sometimes not. Counselors should be aware that the ex-offenders among their clients will have more difficulty finding work and that clients' experiences with discrimination may diverge along racial and ethnic lines.

This chapter describes the barriers ex-offenders seeking employment face and suggests ways for substance abuse treatment programs and counselors to help offenders overcome these barriers. These barriers tend to fall into two categories: internal (i.e., attitudes and characteristics ex-offenders bring to the process) and societal (i.e., the attitudes society has toward those with criminal records and the means it uses to exclude ex-offenders from the workplace). Both types of barriers can be difficult, although not impossible, to overcome.

Barriers to Employment: What the Offender Brings To the Process

Each ex-offender is a unique individual; yet as a group, ex-offenders tend to bring the following common characteristics or attitudes to the process of vocational rehabilitation:

- *Offenders face feelings of failure and hopelessness.* Ex-offenders tend to have a long history of failure behind them and may feel that there is little they can do to change their lives. They may have failed at school, at relationships, and at crime, and may have little faith that they will find a job or that employment will make a difference in their lives.
- *Offenders often feel alienated from mainstream institutions.* Offenders' experiences with school, health care facilities, welfare and child welfare offices, lawyers, police, and courts have been primarily negative. Their roles while involved with these institutions tend to be those of supplicant or "wrongdoer." Most often, they are told—rather than asked—what their needs are and how those needs will be met. With overwhelming caseloads, human service workers are often too pressed for time to listen to offenders or answer questions. Offenders may perceive this as a lack of respect. As they enter substance abuse treatment and vocational rehabilitation, ex-offenders might expect to face more of the same: requirements laid down by overworked people who believe they know best and who do not care whether the "help" they are offering meets clients' real needs or concerns. Offenders often expect to be treated with contempt and hostility; their sensitivity to the attitudes of others can make them seem "touchy" to counselors.
- *Offenders learn to be cynical and to manipulate the system.* From the perspective of an ex-offender, the most sensible way to deal with people assigned to provide "help" he may not want or believe he needs may be to find and exploit the system's weaknesses. The objective is to avoid compliance with burdensome requirements but retain whatever benefits the system offers. Often, in the offender's experience, passive resistance works because the system does not have the capacity to follow through and enforce rules with sanctions.
- *As a group, offenders tend to be less educated, less skilled, and less mature than the general population.* Those who spent their youth abusing substances probably did poorly in school and may never have had the opportunity to learn work-related skills or to mature.
- *Some studies have shown that offenders tend to have higher rates of attention deficit/hyperactivity disorder (AD/HD) and other learning disabilities than the general population*

(Eyestone and Howell, 1994; Mannuzza et al., 1989; U.S. Department of Justice, 1998). Offenders may have had considerable difficulty in school because of problems with concentration, comprehension, ability to plan, and ability to sustain effort. When these problems are not addressed in school, they lead to further skill deficits.

Offenders who have served time face additional barriers, and the more time someone has served, the more serious are the barriers to employment. The following points can help the substance abuse treatment counselor better understand the experience that ex-offenders may have had in prison.

- *Offenders' educational, mental, and social problems are not addressed in prison*. In many jurisdictions, these services were casualties of the explosive growth in prison population or never were available except at a minimal level.
- *Incarceration widens the educational and social gap.* Incarceration leads to "disculturation"—that is, inmates lose or "fail to acquire some of the habits currently required in the wider society" (Goffman, 1961). The very nature of an all-encompassing institution like a prison is incompatible with the development of the social skills needed to succeed in society at large. The prison inmate undergoes a total loss of autonomy. Others determine every detail of his life—from where he will live and when he wakes up in the morning, to what he will eat and how he will spend his time. Successful adaptation to prison requires accepting this loss of autonomy.

  Successful adaptation to prison also requires the individual to accept that the everyday rules of cause and effect and reward and punishment have been suspended. Correction officers can (and do) punish groups of inmates because of the actions of individuals. They can (and do) arbitrarily single out and punish an offender for no reason other than personal dislike. Searches of cells frequently result in destruction of inmate property, including treasured possessions such as photographs and valuables such as typewriters and legal papers. Any privilege earned with good behavior can be revoked at a moment's notice on a trumped-up charge. After years in one facility, an inmate can find herself on a bus to another without notice.

  Living in a place where the logic of cause and effect is suspended and justice occurs only by chance can create despair and anger. This, combined with the loss of autonomy, can cause an inmate to stop believing that he is responsible for his life or that anything he does can ever matter. He learns that it is useless to try to control his environment or what happens to him; attempts to plan for the future are almost always futile and frustrating. Yet taking responsibility, making decisions, planning for the future, and following through are precisely the social skills that the released offender needs in order to successfully function in the community, especially in the world of work.
- *Survival in prison and survival outside prison require two vastly different sets of skills*. To survive in prison, the offender must get along with other inmates, many of whom are angry and hostile and some of whom are dangerous. Because inmates have no privacy, battle over "turf" is common. Because inmates have no autonomy, power struggles are frequent. Survival in this environment calls on some of the behavior that the offender may have learned before he entered prison (and that may have contributed to being in prison). In some ways, the prison experience reinforces some of the offender's more undesirable social and personal attitudes.

- *After release, offenders may experience emotional shock.* Life in prison can be brutal. From the prisoner's perspective, the world outside can take on a rosy glow. The disappointments and difficulties the offender experienced prior to incarceration are often forgotten. As she counts the days to release, her expectations may be high that life on the other side of the wall will be good, if not carefree.

  However, reality rarely lives up to such expectations. After release, many ex-offenders are overwhelmed by personal and financial troubles. Some have difficulty adjusting to relationships with spouses and families who have changed and learned to live with greater independence while the ex-offenders were away. Others may return to old relationships that were built on the ex-offender's (or mutual) drug use. Still others, who are struggling to comply with substance abuse treatment and vocational requirements, may face hostility from family and friends who may not like the "new" person the ex-offender is being asked to (or has) become. The ex-offender can experience crushing disappointment at how difficult life is and how much adjustment is required. Having learned early in his life to deal with stress by drinking alcohol and using illicit substances, the ex-offender may be tempted by the pull of the streets and old friends or relatives who still abuse substances.
- *Release from prison can bring culture shock.* Offenders leaving prison may find themselves in an unfamiliar world. Simple things such as ordering from a menu can seem alien and anxiety-provoking. For those who have served long terms, the shock can be intensified by the pace of technological change during their incarceration. Offenders may be ashamed of their lack of familiarity with things other people take for granted.

Overcoming Barriers Resulting From Offender Alienation

Overcoming the formidable barriers offenders bring to vocational rehabilitation (VR) requires engaging offenders in services. Substance abuse treatment programs that engage ex-offenders should offer the following:

- *Respect.* Drug and alcohol counselors should strive to treat each person as an individual with a unique set of positive and negative qualities. Treatment staff should respect ex-offenders' autonomy, asking what *they* view as their primary needs and offering help in meeting those needs. When an ex-offender resists meeting program requirements, staff should not assume that the cause is willful disobedience. Resistance may arise from a variety of sources, including fear, anxiety, ignorance, lack of social skills, or the "lessons" learned in prison. Respecting the client means working with her to locate the reason for her resistance and then helping her overcome it.

  Counselors can also demonstrate respect by holding conversations with clients privately, looking at clients directly and asking, "How are you?" before launching into "business." An attractive and clean waiting area also conveys respect for clients. Program staff can demonstrate respect and cultural competence by explaining why certain questions need to be asked. For example, when asking about school and work experiences during which the client may have repeated failures, program staff should introduce the questions by stating, "In order for us to work together to find the best career path for you, I need to ask you some questions about school and work that may seem upsetting to you. Please let me know if there is a better way to ask you about this information, because that will help both of us."

- *Hope*. Offenders accustomed to failure and feelings of hopelessness need contact with positive role models—people who have come through prison and substance abuse treatment and found a job. Employing program graduates as counselors is one way to offer role models; moreover, program graduates are often effective in breaking through clients' denial and cutting through manipulation. Bringing graduates in to speak to groups of participants and compiling a book of letters from graduates who benefited from vocational services are other ways of providing role models.
- *Positive incentives*. Offenders need to experience achievement rather than failure. Programs should emphasize and build upon clients' small successes. This principle is in operation in many "drug courts," where judges take the time to praise the accomplishments of offenders, however small these accomplishments may seem. Some programs mark advancement through program phases with ceremonies or small tokens of achievement.
- *Clear information*. Offenders need to know what they can expect from substance abuse treatment and vocational counseling and what will be expected of them. Counselors should orient clients to the process they are beginning: what the steps or stages are, how long each lasts, what happens during each stage, and what the program rules are, as well as the consequences of violating them.
- *Consistency*. When ex-offenders fail to comply with program requirements, consequences under the program's control must be enforced swiftly and consistently. Offenders quickly learn whether the "system" is taking itself seriously. If there are inconsistent or delayed responses to rule violations, the rules might simply be disobeyed.
- *Compassion*. Counselors should be aware that the ex-offender may be juggling many demands. Requirements laid down by the substance abuse treatment counselor may be competing with criminal justice reporting requirements (e.g., to a parole officer) or family obligations. From the ex-offender's perspective, it may seem that everyone trying to "help" her is piling on competing demands that are impossible for her to meet and that make failure inevitable. Counselors should ask the client what other requirements she faces and offer to help her master the skills to manage everything.
- *Information about the career ladder*. Many ex-offenders believe that if they do obtain employment, it will be in a low-paying, "dead end" job. It is important for program staff to introduce and reinforce the concept of a career ladder. Clients need to develop a vision of increasing job skills and increasing job complexity, leading to increased pay and responsibility.
- *Assistance in transfer of skills*. Often counselors overlook some of their clients' "special talents" that may have served to bring about negative outcomes in the past but that can be used in a new way when the ex-offender is clean and sober. For example, an ex-offender who was a leader of gang activity and showed management abilities (under negative circumstances) can be assisted to see that those same skills could be used to lead a work crew.

Program strategies for overcoming barriers

There are many strategies that substance abuse treatment programs can institute on a program

level to help clients who are ex-offenders overcome barriers to employment. Following are some suggested strategies.

- Programs can encourage and assist clients to acquire a General Equivalency Diploma (GED) by providing GED classes at the treatment site. In this way, clients can feel that education and GED classes are an important part of treatment. If this is not feasible, then program staff should attempt to enroll a group of ex-offender clients together at an outside GED classroom site and work with the instructor on an ongoing basis to sensitize her to the multiple needs of the clients.
- VR staff should be invited to spend some time at the substance abuse treatment program site. In this way, clients see VR staff as part of the "treatment family," and staff have the opportunity to see the clients in another setting. In addition, this provides the substance abuse treatment program with an opportunity to cross-train staff.
- Treatment programs can include job and skills training by providing clients with opportunities to perform jobs at the treatment site. When clients are expected to perform (and assisted in performing) important job functions at the treatment site, they (1) learn time management, problemsolving, and many of the unwritten rules of employment, such as not being distracted by friends; (2) are allowed the gradual development of work skills within a known, safe environment; and (3) can try different types of jobs (e.g., receptionist, carpenter, child care aide, gardener, transportation coordinator).
- Programs should provide clients with guidance on budgeting. Many ex-offenders have not learned how to budget money. Programs should consider providing a skills-building group on budgeting and money management. Counselors can also work with clients to establish bank accounts and review and plan for monthly expenses.
- Counselors should assist clients who are ex-offenders in following through on referrals and assembling necessary documents, such as social security cards and school transcripts.
- The program can match clients to mentors or peers who can assist clients with all components of the vocational training or job placement tracks. Peers and mentors who are ex-offenders and have been employed successfully can assist in facilitating skills-building groups and job clubs (see Figure 4-2 in Chapter 4), providing support to appointments, facilitating support groups postemployment, and providing ongoing support. Workplace conflict is to be expected, and peers and mentors can assist the ex-offender in coping with these situations.
- If the offender's emotional readiness to return to work is poor, substance abuse treatment programs can offer empowerment workshops to help clients increase their readiness. Peer-run or peer-cofacilitated workshops based on stages of change and motivational interviewing strategies can be effective in increasing clients' readiness and help them to feel that they have some control over their vocational choices (see TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* [CSAT, 1999c] for more information on this topic).
- Participation in 12-Step programs provides clients with peer support for remaining abstinent, handling daily problems, and developing a healthy social network. Substance abuse treatment programs can form linkages with local 12-Step programs to provide clients with information about joining these programs.

Women's Issues

Between 1986 and 1991, the number of women in State prisons for drug offenses increased by 433 percent, compared with a 283 percent increase for men in the same time period (LeBlanc, 1996). The number of African American women incarcerated for drug offenses in State prisons increased by 828 percent from 1986 to 1991 (Mauer and Huling, 1995).

Women in prison differ from their male counterparts in several significant ways: (1) they are less likely to have committed a violent offense; (2) they are more likely to have a dual diagnosis (substance abuse disorder and a psychiatric disorder); (3) they are more likely to have experienced multiple incidents of physical and sexual abuse; and (4) they are more likely to be responsible for their children's support (Morash et al., 1998; Teplin et al., 1996).

In a study of women in California prisons (Bloom et al., 1994), 31 percent reported experiencing sexual abuse as a child and 23 percent as adults, and 29 percent reported physical abuse as a child and 60 percent as adults, usually by partners. Domestic violence may continue to be a risk for women when they return to the community.

Economic self-sufficiency is a challenge for ex-offenders who have not developed employment skills, particularly for women faced with supporting themselves and their children. Women who were involved in drug dealing generally had low-ranking roles, and many women have been forced by economic need to participate in sex work or prostitution. In addition, educational opportunities and job training in prison may have been different for men than for women. A 1980 General Accounting Office study found that women within the Bureau of Prisons had access to only 13 prison industry jobs, while men had access to 84 (Miller, 1990).

Women with substance abuse problems who were incarcerated are more likely to be unemployed or underemployed than their male counterparts (Wellisch et al., 1993). In a large survey of incarcerated female prisoners conducted by the American Correctional Association, only 18 percent of the women indicated that they were qualified to obtain satisfactory employment following release from incarceration (American Correctional Association, 1990).

Female ex-offenders are extremely vulnerable to recidivism and relapse if they cannot sustain themselves economically through lawful employment. This has become even more critical since passage of the Federal Welfare-To-Work legislation (see Chapter 1 for more information).

Program strategies for female clients

Substance abuse treatment programs can institute strategies on a program level to help address the special needs and considerations of female clients who are ex-offenders. Following are examples of such strategies (see also Figure 8-1 for an example of a program that addresses women's issues).

- Programs should incorporate the teaching of parenting skills and skills in finding child care. Program staff need to help mothers improve their parenting skills and assist them in finding affordable, safe child care when they do find employment. Many women are so concerned about losing their children or reuniting with them after incarceration that they have difficulty focusing on job preparedness. Staff should help clients see that preparing for work will help them care for their children adequately.
- Once released from incarceration, women with substance abuse disorders should contact substance abuse treatment centers. The treatment program may need to provide transportation to the treatment site as well as make arrangements for child care. Ideally, the substance abuse treatment program

Figure 8-1
A Program That Addresses Women's Issues

California has been a pioneering State in allowing women inmates with children under the age of 6 to live in community-based facilities. The California Department of Corrections Community Prisoner Mother Program (CPMP) is an innovative program that allows women inmates to strengthen bonds with their children and to reintegrate back into the community as productive and self-reliant individuals. As part of the community re-entry programming, women receive vocational training, job preparedness training, job placement services, referrals, and aftercare services.

should form a linkage to the correctional facility so that substance abuse treatment counselors have the opportunity to "reach in" to women while they are still incarcerated. This prerelease connection helps to establish relationships with these women.

- Address safety issues—women who have been in abusive situations may be returning to an abuser. Counselors should assess safety issues when women return to potentially violent environments, and a safety plan should be developed and implemented (see TIP 25, *Substance Abuse Treatment and Domestic Violence* [CSAT, 1997] for information on how to do this). Many women may be prevented from implementing vocational plans by an abusive partner, and this possibility should be addressed. In addition, it is important for the counselor to assess the safety of the client's working environment or potential working environment.
- Poor retention of women clients in community treatment programs is a widely reported problem. To increase retention, it is important to find or develop a gender-sensitive program that offers a continuum of care, including aftercare.

Barriers to Employment: What Society Brings to The Process

Employers who are reluctant to hire people with histories of substance abuse can be even less enthusiastic about substance abusers with criminal records. Ex-offenders may be viewed as unreliable and morally deficient and feared as volatile and dangerous. When this attitude is combined with the lack of marketable skills and scant work experience common to many ex-offenders, there seems to be little to recommend ex-offenders as employees.

There is no Federal statute like the Americans with Disabilities Act (see Chapter 2) to protect ex-offenders against employment discrimination. Although there are rulings that prohibit employers from asking applicants about arrests,[1] employers are free to ask about convictions. In fact, some employers have access to offender criminal records. For example, applicants' criminal records may be screened by employers at any level in the public sector, by licensing agencies (and employment in a great number of occupations requires obtaining a license), by child care agencies, by educational institutions, by health care institutions, and by

financial institutions. In fact, some employers may be required to ask about criminal history and to verify the information the offender supplies by checking official records. Which employers can (or must) obtain the criminal records of job applicants varies by State. Counselors and their clients should learn such information about prospective employers ahead of time so they can formulate strategies for addressing employers' concerns (see Chapter 3 for more information).

There are ways employers can obtain information about applicants' criminal records other than by obtaining official records. Employers can develop relationships with law enforcement officials and receive information "under the table." Employers can also pay consumer reporting (or "credit" reporting) agencies for information about applicants' criminal records and work histories. The Federal Fair Credit Reporting Act prohibits such agencies from reporting negative information that is more than 7 years old when an applicant has applied for a job paying less than $20,000 a year. Some States have Fair Credit Reporting laws that provide additional protections.

Some States, such as New York, offer ex-offenders explicit statutory protection against employment discrimination.[2] New York's statute (Article 23A of the Correction Law) makes it illegal to deny an ex-offender employment because of his criminal history unless the offender's convictions are directly related to the job he seeks or his employment would create an unreasonable risk to the safety of people or property. The statute requires the employer to consider each ex-offender as an individual, weighing factors such as the specific duties and responsibilities of the job and the bearing, if any, that the offender's criminal history has on his fitness to fulfill the duties and responsibilities of the job; the seriousness of the offense(s) committed; how long ago the offense(s) occurred and the individual's age at the time; and any evidence of rehabilitation. While the statute is well drafted, in practice employers have wide latitude to reject ex-offenders on the ground that their convictions are directly related to the jobs they seek or that their employment would pose an unreasonable risk to people or property.

Unfortunately, once an ex-offender has been rejected by an employer, there is seldom legal recourse, even when statutory protections exist. It will be the rare ex-offender who can demonstrate that she was clearly the superior applicant for a particular job. Therefore, for the ex-offender, as for the person recovering from substance abuse disorders, the best strategy is similar to the "Ounce of Prevention" strategy outlined in Chapter 7. Counselors should help clients who are ex-offenders to

- *Focus on occupations and employers who do not bar ex-offenders.* A job-seeker with two strikes against him (inexperience and a substance abuse history) should not make his search more difficult by targeting a job for which his criminal history will be a barrier. Counselors should be alert to the kinds of jobs that will be particularly difficult for clients to obtain. A client with a felony record who insists on seeking a job in law enforcement, for example, probably needs help recognizing that his quest is unattainable. He may also benefit from counseling that will help him understand that his focus is self-defeating.
- *Develop realistic goals.* Clients with limited work experience often have unrealistic expectations about the kinds of jobs they can obtain. Often, they need exposure to the long view—the notion that people can start at a level commensurate with their current skills and experience history and work their way up to greater pay and responsibility as their skills increase and their work history accumulates.
- *Clean up official criminal histories ("rap sheets").* If an employer will have access to the ex-

offender's criminal record, it is a good idea for counselor and client to take a look at it before the prospective employer does. Offenders' records frequently include mistakes that make their criminal histories look far more serious than they are. For example, the number of the statute the offender violated may be incorrect; a single digit can turn an assault into a conviction for bombing a building. A single offense may also be entered multiple times—when the offender was first arrested, when she was convicted, and when she was sentenced and incarcerated. Multiple entries for the same offense will appear to the employer to be entries for a series of crimes. Multiple entries can sometimes be combined, "shortening" the offender's record. Finally, in some States, offenders can "seal" parts of their criminal records, so that some employers with access will not see the offenses. For example, arrests that did not result in a conviction can sometimes be expunged from a criminal record. The process for obtaining an offender's criminal history, correcting errors, and "sealing" portions of the record varies by State. This process of cleaning up the ex-offender's record can also help the counselor engage her in developing a positive attitude toward counseling, as the process not only demonstrates the counselor's interest in the client's improved job prospects but also can yield immediate and tangible results.

- *Develop "smarts" about when to disclose a criminal record.* Clients looking for a job should not volunteer negative information unless the employer has some other way to get it. For example, if a job applicant will be fingerprinted, it is usually a good idea for him to disclose his criminal record *before* the employer obtains it.
- *Learn and practice a statement that acknowledges a substance abuse and criminal history and offers evidence of rehabilitation.* The statement that the client develops should address three important parts:

1. *An acknowledgment that the client has a criminal record.* The simple statement, "Yes, I have been convicted of drug possession," is sufficient unless the employer asks for more. If the employer asks for more, the client should offer a brief but accurate summary of the facts. An employer does not usually need to know the full details.
2. *The details of the criminal offense(s) (should the employer request them) without "letting it all hang out" and losing the employment opportunity.* Counselors and clients alike should keep in mind that there is a difference between describing a criminal history to a 12-Step group and describing it to a prospective employer.
3. *A brief explanation (should the client be asked) of her record that does not try to excuse it.* A client should not profess innocence or claim she was unjustly convicted. Such statements are red flags for an employer, signaling that the client is not honest with herself or others. On the other hand, if the criminal record dates to the offender's youth, she can mention that or other circumstances that might "explain" (but not excuse) the criminal behavior.

The statement should then offer evidence that the ex-offender has overcome his problems and changed his life. The client should be prepared to provide facts to support the claim that he has mended his ways. For example, a client with a criminal record for drug possession could point out that he has been sober for a year, that his criminal activities were limited to the period he was abusing drugs, that he has successfully completed a rehabilitation program, and that his drug use history and criminal activities are behind him. A client who served

time for robbery could point to the efforts she made while in prison to prepare for a different future, such as taking academic or vocational courses, earning a degree, or participating in substance abuse treatment. Or, a client can tell the employer that since his release he has become active in his church choir or that he shovels snow for the elderly man next door. Evidence of change could also include written recommendations from community members, such as a minister, parole officer, or counselor. (Note that if the counselor at a substance abuse treatment program is asked to provide a reference, the client must sign a proper consent form, as discussed in Chapter 7.)

- *Develop a "statement of interest."* Job seekers who are competing with others who do not have criminal records should be prepared to tell an employer why they are particularly interested in a job and why they are qualified for it. For example, a client who is interviewing for a job as a stock-room clerk might say that she is interested in the employer's business (be it hardware or toys), that she likes working in an environment where she is responsible for keeping track of inventory, and that she hopes, in time, to move up in the organization. Or, a client applying for a job as a car mechanic might mention that he has always been fascinated with cars and helped at a neighborhood repair shop when he was a teenager. The client making this kind of statement should avoid clichés and pat answers. To make the statement believable, the client must believe in the statement. A counselor can be particularly helpful to clients struggling to formulate goals and develop statements of interest.
- *Develop statements about other positive aspects of a client's background.* Counselors can help clients sift through their histories to uncover interests, skills, and experience to offer a particular employer. Perhaps a client applying for a food-handling job has worked in a program's kitchen during treatment. Another client seeking work with a landscaper might have earned money gardening during school vacations. A client who can offer enthusiasm, talent, or some related background is more likely to get a job than someone who simply presents herself as needing one.
- *See the problem from the employer's point of view and learn to address the employer's concerns.* An employer may never have knowingly hired an ex-offender. The employer may feel that someone with a substance abuse and criminal history is, by definition, a "bad" person, someone who cannot be relied on to show up regularly, who cannot be trusted with money, who probably still uses drugs or alcohol, or who will inevitably relapse into drug use and criminal activity.

  During an interview, a client may have the opportunity to acknowledge that he is asking the employer to "take a chance" on him and to address the employer's concerns directly. For example, an ex-offender could say, "I know this job carries a lot of responsibility and that you are probably concerned about whether I can handle it or whether I will start using drugs again. Well, I went into treatment and have been drug free for 2 years. Once I entered treatment, I stopped getting into trouble." Perhaps the client can offer a concrete example that shows that once she became sober her attitudes and actions changed; for example, she volunteered to work in a soup kitchen. Such steady work is evidence that she will reliably show up for work and pitch in. A reference letter from the organization running the soup kitchen could reduce a potential employer's negative view of the ex-offender.
- *Deal with illegal questions such as "Have you ever been arrested?"* Counselors can tell a client whose record includes both arrests and

convictions to respond by answering, "Yes," and listing his convictions. A client who has been arrested but never convicted can respond in one of these ways:

- "I have never been convicted of a crime."
- "No," but this is a lie and, for reasons mentioned in Chapter 7, not a good idea.
- "That's an illegal question." This is bound to antagonize the employer and raise the suspicion that the answer is "yes."

Program Strategies for Overcoming Barriers With Employers

The following are strategies that substance abuse treatment programs can implement to help clients who are ex-offenders overcome barriers to employment.

- *Educate employers.* Some treatment providers are implementing education programs for employer groups to help them understand some of the positive aspects of hiring ex-offenders. Some providers have established Business Advisory Committees.
- *Provide job coaching on an employer's site.* If possible, substance abuse treatment programs should consider providing staff as job coaches to assist new employees in adapting to a new work culture (see Chapters 2 and 3 for more information about job coaching).
- *Help clients to evaluate work environments.* When an ex-offender is offered a job, counselors should help the client to assess whether the job provides a supportive environment for recovery from substance abuse disorders.

Program Examples

A report (Finn, 1999) described four programs across the country that prepare inmates and parolees for employment by providing intensive educational and life skills services, social support, and postemployment followup, in addition to traditional job preparation and placement assistance. These programs are (1) the Safer Foundation in Chicago, (2) the Center for Employment Opportunities (CEO) in New York City, (3) Project RIO (Reintegration of Offenders) in Texas, and (4) the Corrections Clearinghouse (CCH) in Washington State. Although each program is unique, they share program components that can be replicated by others. Basic services include life skills training, job preparation skills, job placement, social support, and followup assistance. With regard to providing support services and followup, all four programs devote resources to helping ex-offenders address substance abuse, affordable housing, child care, emotional difficulties, and other barriers to securing and maintaining employment. These programs also follow up with clients after placement. See Figure 8-2 for a summary of the four programs.

Endnotes

1. Title VII of the Civil Rights Act (29 U.S.C. §2000e–2000e-17), which prohibits employment discrimination based on race, has been interpreted to outlaw questions about an applicant's arrests. This ruling is based on two premises: (1) Members of minority racial groups are arrested more often than whites, which means that this question tends to disqualify a disproportionate number of minority applicants, and (2) an arrest that has not resulted in conviction of a crime has little value as a test of character. A few States, such as New York, have adopted legislation that offers limited protection to ex-offenders from employment discrimination. Unlike the Federal laws protecting individuals with disabilities, however, the law permits employers to weigh an individual's

convictions against a set of factors in determining whether to hire him. Employers can weigh the disability in terms of whether or not the employer believes it means that the applicant cannot fulfill the "essential functions" of the job (and perhaps also that changes to the job situation would fundamentally alter management prerogatives).

2. To learn more about State law—the protections it offers and the available remedies—providers can call the State or local "human rights," "civil rights," or "equal opportunity" agency. Local legal services offices, law school faculties, or bar associations may also have information available or may be willing to provide a lawyer to make a presentation to staff.

Figure 8-2

Summary of Program Examples

	Safer Foundation (Chicago)	Center for Employment Opportunities (CEO) (New York)	Project RIO (Texas)	Corrections Clearinghouse (CCH) (Washington State)
Original Objectives	To provide vocational training to inmates and to assist them in entering into unions and private industry after release	To develop work crews that could offer day labor employment in neighborhoods where offenders were living	To provide specialized employment services to ex-offenders to reduce recidivism	To coordinate job search activities for adult offenders being released from prison
Program Components	(1) 200-bed work release centers where residents attend nine 90-minute minicourses and basic reading and math skills courses using a small-group, peer-learning approach. (2) The PACE (Programmed Activities for Correctional Education) Institute, a private school that provides basic education and life skills courses (3) A coordinator closely supervises 200 trained volunteers who provide literacy tutoring and 65 who facilitate groups.	(1) CEO assigns ex-offenders to day labor work crews. (2) Orientation includes four all-day job readiness classes and a 90-minute orientation to the work crews.	(1) Funds for a prison school district for life skills courses, job readiness counseling, and help assembling needed documents (e.g., birth certificates, social security cards, school transcripts) (2) A 30-minute orientation to the RIO hotline number and the program that inmates attend on their release day (3) Assessment, placement, and followup services (4) Arrangements for employers to spend a day in prison talking to inmates about job opportunities	(1) Several prerelease job-related courses as well as vocational assessment (2) At the Corrections Center for Women, CCH offers two transition-to-trades initiatives for women (3) CCH contracts with six community agencies and one employment service center to provide job search assistance to adult and juvenile ex-offenders, including ongoing postplacement services ("Ex-O" Program) (4) A college program for ex-offenders in recovery for substance abuse problems
Data/Results	(1) Improved GED scores by an average of 12.5 percent (2) Ninety-one percent of inmates improved basic skills test scores (3) Fifty-nine percent of those who found jobs remained on the job for at least 30 days	(1) Average placement rate of 70 percent (2) Half of those who remained on the job for 1 month were still on the same job at 6 months (3) In 1996, the average hourly wage of placed participants was nearly 50 percent higher than minimum wage	(1) In 1995, almost 74 percent of clients were employed at an average of 21 percent above minimum wage. (2) At 1 year after release, 69 percent were employed, compared with 36 percent of non-RIO parolees. (3) Of minority clients, 66 percent found employment compared with 30 percent of African Americans and 36 percent of Hispanos/Latinos who were not enrolled. (4) Forty-eight percent of RIO clients were rearrested during the year after release, compared with 57 percent of non-RIO parolees.	(1) In 1997 and 1998, 3,082 inmates completed a CCH program. (2) Ex-O contractors enrolled 1,312 ex-offenders, 59 percent of whom found work and 68 percent of whom were still employed after 45 days. (3) Recidivism rate for the Ex-O clients after 1 year was 3 percent, compared with 10 percent for all releasees; after 5 years, recidivism rate was 15 percent for Ex-O clients, compared with 30 percent for all releasees.

Appendix A
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Appendix B
Resources: Tools and Instruments

Title:	**Addiction Severity Index Package**
Purpose:	To evaluate client functioning in seven life areas: employment, medical, alcohol use, drug use, legal, family/social, and psychiatric; often used as an outcome measure before and after treatment.
Target Population:	Substance abuse disorder and mental health clients (adult version)
Administration:	Both clinician-administered and client self-administered forms; paper and pencil and software versions are available.
Test/Scoring Time:	Approximately 60 minutes
Price:	$63 (kit includes 240-page manual and 2-hour VHS video)
	Some ASI materials may be distributed without cost. See Appendix D for one version of this instrument.
Available From:	National Technical Information Service (NTIS) Order Desk 5285 Port Royal Road Springfield, VA 22161
	(888) 584-8332 Fax: (703) 605-6900
	www.ntis.gov. E-mail: info@ntis.fedworld.gov
	Also available from: Delta Metrics 2005 Market Street, Suite 1120 Philadelphia PA 19103 (215) 665-2880, (215) 665-2892
	For SOFTWARE versions of ASI (Adult and Adolescent versions, and Treatment Plans), contact: Accurate Assessments 183 Harney, Ste. 101 Omaha, NE 68102 (800) 324-7960

Title:	**(ABLE)**
Authors:	Bjorn Karlsen, Eric F. Gardner
Purpose:	Measures adult learning in a variety of adult education programs, including Tech Prep programs, GED programs, and adult literacy programs.
Target Population:	Adults
Administration:	Designed for classroom use. Consists of 3 levels: level 1 for adults who have completed 1–4 years of formal education; level 2 for adults with 5–8 years of schooling; level 3 for adults with at least 8 years of schooling and who may or may not have graduated from high school. A Spanish version of level 2 is available as well. Related products are available.
Test/Scoring Time:	Untimed; each level averages 2 hours, 40 minutes. ABLE Screening Battery averages about 1 hour.
Price:	$55.75 (kit includes level 1, 2, 3 test booklets, directions for administering, group record, hand-scorable answer sheet, READY SCORE answer sheet, and Selectable READY SCORE answer sheet)
Available From:	The Psychological Corporation 555 Academic Court San Antonio, TX 78204 Attn: Clinical Sales (800) 211-8378 Fax: (800) 232-1223 www.psychcorp.com

Title:	**Career Attitudes and Strategies™ (CASI): An Inventory for Understanding Adult Careers** (1994)
Authors:	John L. Holland, Ph.D.; Gary D. Gottfredson, Ph.D.
Purpose:	Assesses attitudes related to career, identifies career problems and obstacles in employed and unemployed adults.
Target Population:	Adults
Administration:	Self-administered; individual
Test/Scoring Time:	35 minutes
Price:	$75 (introductory kit includes manual, 25 inventory booklets, 25 hand-scorable answer sheets, and 25 interpretive summary booklets)
Available From:	Psychological Assessment Resources, Inc. P.O. Box 998 Odessa, FL 33556 (800) 331-TEST www.parinc.com

Title:	**Career Thoughts Inventory™ (CTI)** (1996)
Authors:	James P. Sampson, Jr., Ph.D.; Gary W. Peterson, Ph.D.; Janet G. Lenz, Ph.D.; Robert C. Reardon, Ph.D.; Denise E. Saunders, M.S.
Purpose:	Assists in career problemsolving and decisionmaking; assesses for and alters negative career thinking.
Target Population:	Adults, college students, and high school students
Administration:	Individual or group
Test/Scoring Time:	7–15 minutes
Price:	$89 (kit includes CTI professional manual, 5 workbooks, 25 test booklets)
Available From:	Psychological Assessment Resources, Inc. P.O. Box 998 Odessa, FL 33556 (800) 331-TEST www.parinc.com

Title:	**Crawford Small Parts Dexterity Test (CSPDT)**
Author:	John Crawford
Purpose:	Tests manual dexterity.
Administration:	The two-part, pegboard-type test uses a wooden board with separate wells for pins, collars, and screws.
Test/Scoring Time:	3 minutes for part 1; 5 minutes for part 2.
Price:	Kit: $564.10 (Canadian) Manual: $22.44 (Canadian)
Available From:	M.D. Angus & Associates Ltd. 2639 Kingsway Avenue, 2nd floor Port Coquitlam, BC V3C 1T5 Canada (604) 464-7919 Fax: (604) 941-1705 www.psychtest.com

Title:	**Geist Picture Interest Inventory**
Author:	Harold Geist, Ph.D.
Purpose:	Identifies vocational and avocational interests, especially with culturally different and educationally deprived persons.
Target Population:	Grade 8 through adult
Administration:	Individually or to groups
Test/Scoring Time:	Scoring takes a few minutes.
Price:	$78.50 (kit includes test booklets for males and females, and manual)

Available From:	Western Psychological Services 12031 Wilshire Blvd. Los Angeles, CA 90025 (800) 648-8857 Fax: (310) 478-7838

Title:	**General Aptitude Test Battery (GATB)**
Purpose:	Measures 9 aptitudes with 12 separate tests. The last five tests involve pegboards.
Target Population:	Grade 9 to adult
Administration:	Comprises two test booklets with four separately sold answer sheets and two pegboards (small parts and gross motor). May be administered to small groups, except for the small parts and gross motor test. The pegboards are expensive and relatively difficult to administer. Their use may be warranted if residual neurological impairment is suspected (e.g., in recovering alcoholics).
Test/Scoring Time:	1 hour
Price:	Test booklets: $71.50 each Prices of answer sheets and pegboards may be viewed in online catalog.
Available From:	M.D. Angus & Associates Ltd. 2639 Kingsway Avenue, 2nd floor Port Coquitlam, BC V3C 1T5 Canada (604) 464-7919 Fax: (604) 941-1705 www.psychtest.com

Title:	**Kuder Occupational Interest Survey (KOIS)**
Author:	Frederic Kuder
Purpose:	Assesses interest of students and adults in areas related to higher education and occupations.
Target Population:	Grade 10 through adult
Price:	$135.10 (package includes 20 books with items and response section, complete scoring, individual narrative reports, counselor's narrative reports, instructions; manual sold separately)
Available From:	CTB/McGraw-Hill 20 Ryan Ranch Road Monterey, CA 93940 (800) 538-9547 Fax: (800) 282-0266

Title:	**System 2000 (formerly Microcomputer Evaluation Screening and Assessment [MESA] System)**
Purpose:	A modular software system for IBM-compatible personal computers, including a career planner, census database, computerized assessment, competencies database, dictionary of occupational titles (DOT), and more. Modules can be purchased separately.
Price:	Varies by module (e.g., system manager, $300; computerized assessment, $3,875; DOT database, $1,015)
Available From:	Valpar International Corporation P.O. Box 5767 Tucson, AZ 85703-5767 (800) 528-7070 Fax: (520) 292-9755 www.valparint.com

Title:	**Minnesota Clerical Test (MCT)** (1979)
Authors:	Dorothy Andrew, et al.
Purpose:	Measures aptitude for office work such as bookkeeping, filing.
Price:	Examination kit: $41.67 (Canadian) Booklets (25): $102.56 (Canadian) Manual: $35.26 (Canadian) Scoring key: $32.05 (Canadian)
Available From:	M.D. Angus & Associates Ltd. 2639 Kingsway Avenue, 2nd floor Port Coquitlam, BC V3C 1T5 Canada (604) 464-7919 Fax: (604) 941-1705 www.psychtest.com

Title:	**My Vocational Situation (MVS)**
Authors:	John L. Holland, Ph.D.; Denise Daiger; Paul G. Power
Purpose:	Helps determine lack of vocational identity, lack of information or training, or emotional or personal barriers.
Target Population:	Adults
Administration:	Self-administered
Test/Scoring Time:	Less than 10 minutes; can be tabulated "at a glance"
Price:	$25 (kit includes manual and 50 questionnaires)
Available From:	Psychological Assessment Resources, Inc. P.O. Box 998 Odessa, FL 33556 (800) 331-TEST www.parinc.com

Title:	**Peabody Picture Vocabulary Test (PPVT-III)**
Purpose:	Measures listening comprehension for spoken words in standard English, provides a screening test of verbal ability.
Target Population:	2.5–90+ years
Administration:	Individually administered
Test/Scoring Time:	11–12 minutes
Price:	$149.50 for basic kit; other related products available at various prices.
Available From:	AGS/American Guidance Service 4201 Woodland Road Circle Pines, MN 55014-1796 (800) 328-2560 or (612) 786-4343 Fax: (800) 471-8457 or (612) 786-9077 E-mail: agsmail@agsnet.com

Title:	**Psychological Screening Inventory**
Author:	Richard I. Lanyon, Ph.D.
Purpose:	Provides brief, nonthreatening mental health screening. Identifies people who might benefit from more extensive examination.
Target Population:	Adults and adolescents
Administration:	Individual or group
Test/Scoring Time:	15 minutes
Price:	$49 (includes manual, question and answer sheets, scoring templates, and profile sheets)
Available From:	Sigma Assessment Systems, Inc. 511 Fort Street, Suite 435 P.O. Box 610984 Port Huron, MI 48061-0984 (800) 265-1285 Fax: (800) 381-9411

Title:	**Reading-Free Vocational Interest Inventory (R-FVII)**
Author:	Ralph L. Becker, Ph.D.
Purpose:	Measures vocational interests, likes, and dislikes of special populations.
Target Population:	Learning disabled, mentally retarded, and disadvantaged individuals ages 13 and older
Administration:	Individual or group
Test/Scoring Time:	20 minutes
Price:	$84 (introductory kit includes manual, occupational title lists, and 20 test booklets)

Available From:	Psychological Assessment Resources, Inc. P.O. Box 998 Odessa, FL 33556 (800) 331-TEST www.parinc.com

Title:	**Revised Beta Examination (Beta II)**
Authors:	C.E. Kellogg, N.W. Morton
Price:	$153.85 (Canadian) (kit includes booklets, key, manual)
Available From:	M.D. Angus & Associates Ltd. 2639 Kingsway Avenue, 2nd floor Port Coquitlam, BC V3C 1T5 Canada (604) 464-7919 Fax: (604) 941-1705 www.psychtest.com

Title:	**Self-Directed Search® (SDS®)** (several versions available)
Author:	John L. Holland, Ph.D.
Purpose:	Assesses vocational interests and long-term career planning.
Target Population:	Individuals on the career-development track
Administration:	Self-administered; individual or group
Test/Scoring Time:	15–25 minutes
Price:	$133 (for Form CP: Career Planning) (introductory kit includes professional user's guide, technical manual, 25 form CP assessment booklets, 25 career options finders, and 25 exploring career options booklets)
Available From:	Psychological Assessment Resources, Inc. P.O. Box 998 Odessa, FL 33556 (800) 331-TEST www.parinc.com

Title:	**Slosson Intelligence Test-Revised (SIT-R)**
Authors:	Richard L. Slosson, Ph.D. Revised by Charles L. Nicholson, Ph.D., Terry L. Hibpshman, Ph.D.
Purpose:	Provides a quick, reliable measure of intelligence to determine if further, in-depth evaluation is needed. **Slosson Full-Range Intelligence Test (S-FRIT)** (1993) is also available from source listed below ($119/kit).
Target Population:	Ages 4 years and older
Administration:	Individual
Test/Scoring Time:	10–30 minutes

Price:	$91 (introductory kit includes manual, norm tables, and 50 score sheets)
Available From:	Psychological Assessment Resources, Inc. P.O. Box 998 Odessa, FL 33556 (800) 331-TEST www.parinc.com

Title:	**Strong Interest Inventory**
Purpose:	Measures interest in a broad range of occupations, work activities, leisure activities, and school subjects.
Target Population:	Clients interested in career development or job change, as well as students exploring careers
Administration:	Licensed therapist or other professional trained in testing administration
Test/Scoring Time:	30–40 minutes (317 items)
Price:	Several versions available ranging from $69 to $135. Applications and technical guide: $57.75
Available From:	Consulting Psychologists Press, Inc. (CPP) 3803 East Bayshore Road Palo Alto, CA 94303 (800) 624-1765 Fax: (650) 969-8608

Title:	**Tennessee Self-Concept Scale (TSCS:2)**
Authors:	William H. Fitts, Ph.D.; W.L. Warren, Ph.D.
Purpose:	Measures self-concept in adolescents, adults, and children.
Target Population:	Adolescents, adults, children
Administration:	Individual or group
Test/Scoring Time:	10–20 minutes
Price:	$130 (kit includes manual, answer forms, and 4 prepaid mail-in answer sheets)
Available From:	Western Psychological Services 12031 Wilshire Boulevard Los Angeles, CA 90025 (800) 648-8857 Fax: (310) 478-7838

Title:	**Vocational Preference Inventory™ (VPI)** (1985)
Author:	John L. Holland, Ph.D.
Purpose:	Assesses career interests through a brief personality/interest inventory based on the RIASEC personality theory.
Target Population:	Adults and older adolescents
Administration:	Self-administered

Test/Scoring Time:	15–30 minutes
Price:	$44 (introductory kit includes manual and 25 test booklet/answer sheet/profile combinations)
Available From:	Western Psychological Services 12031 Wilshire Boulevard Los Angeles, CA 90025 (800) 648-8857 Fax: (310) 478-7838

Title:	**Wechsler Adult Intelligence Scale (WAIS-III)**
Author:	David Wechsler
Purpose:	The most widely used ability assessment instrument; results reflect age and abilities of today's population.
Target Population:	Ages 16–89
Administration:	Individual
Price:	$625 (complete set includes administration and norms manual, technical manual, stimulus booklet, record forms, response booklets, object assembly subtest, block design subtest, picture arrangement subtest, and scoring templates)
Available From:	The Psychological Corporation 555 Academic Court San Antonio, TX 78204 Attn: Clinical Sales (800) 211-8378 Fax: (800) 232-1223 www.psychcorp.com

Title:	**Wide Range Achievement Test 3 (WRAT3)**
Author:	Gary S. Wilkinson, Ph.D.
Purpose:	Measures development of reading, spelling, and arithmetic skills. New standardization of this widely used test yields all new grade ratings.
Target Population:	Ages 5–75
Administration:	Individual or group
Test/Scoring Time:	15–30 minutes
Price:	$142 (introductory kit includes manual, 25 blue test forms, 25 tan test forms, 25 profile/analysis forms, plastic word list cards, and soft canvas carrying case)
Available From:	Psychological Assessment Resources, Inc. P.O. Box 998 Odessa, FL 33556 (800) 331-TEST www.parinc.com

Title:	**Wide Range Interest-Opinion Test (WRIOT) (1979)**
Author:	Joseph F. Jastak, Ph.D.; Sarah Jastak, Ph.D.
Purpose:	Culturally and sexually unbiased pictorial interest test for vocational career planning and counseling. No reading or language understanding required.
Target Population:	Ages 5 through adult
Administration:	Individually or in groups (individual administration is necessary for those too limited by age, mental ability, or physical limitations to complete the answer sheet). Self-loading IBM scoring package available.
Price:	$150 (starter set includes manual profile/report, picture book, answer sheets, scoring stencils, attaché case)
Available From:	Wide Range, Inc. 15 Ashley Place, Suite 1A Wilmington, DE 19804-1314 (800) 221-9728 Fax: (302) 652-1644

Title:	**Wonderlic Basic Skills Test™ (WBST)**
Purpose:	Measures job-related math and language skills to identify basic skill levels of job applicants and employees.
Target Population:	Teenagers and adults
Administration:	Individual
Test/Scoring Time:	20 minutes
Price:	$115 (introductory kit includes user's manual, 25 verbal tests, 25 quantitative tests, and scoring diskette with 25 uses for each test)
Available From:	Psychological Assessment Resources, Inc. P.O. Box 998 Odessa, FL 33556 (800) 331-TEST www.parinc.com

Title:	**Work Potential Profile (WPP)**
Purpose:	Identifies current characteristics and dispositions of older adolescents and adults seeking employment. Provides a criterion-referenced profile for the initial assessment of long-term unemployed persons and persons who have difficulty finding employment.
Target Population:	Adolescents and adults
Administration:	Individual or group; self-administered
Test/Scoring Time:	Untimed
Price:	$150 (introductory kit includes manual, 10 WPP questionnaires, 10 WPP answer sheets, 10 WPP group summary forms, 10 individual summary forms, and 8 score keys)

Available From: Psychological Assessment Resources, Inc.
P.O. Box 998
Odessa, FL 33556

(800) 331-TEST

www.parinc.com

Appendix C
Published Resource Materials

Bolles, R.N. *The 1999 What Color Is Your Parachute: A Practical Manual for Job-Hunters and Career-Changers.* Berkeley, CA: Ten Speed Press, 1998.

Brown, C.; McDaniel, R.; Couch, R.; and McClenahan, M. *Vocational Evaluation Systems and Software: A Consumer's Guide*. Menomonie, WI: University of Wisconsin-Stout, 1994.

Farley, R.C. *Developing and Enhancing Interview Skills: A Supplemental Manual for the Interviewing Skills Training Workshop*. Hot Springs, AR: Arkansas Research and Training Center on Vocational Rehabilitation, 1983.

Hinman, S.; Means, B.; Parkerson, S.; and Odendahl, B. *Manual for the Job-Seeking Skills Assessment*. Hot Springs, AR: Arkansas Research and Training Center on Vocational Rehabilitation, 1988.

Holland, J.L. *Self-Directed Search (SDS) Form R*, 4th ed. Tampa, FL: Psychological Assessment Resources, Inc. 1997.

Kapes, J.T.; Mastie, M.M.; and Whitfield, E.A. *Counselor's Guide to Career Assessment Instruments*, 3rd ed. Alexandria, VA: American Counseling Association, 1994.

Matrix Research Institute. (many publications) 6008 Wayne Avenue, Philadelphia, PA 19144. Tel: (215) 438-8200; Fax: (215) 438-8337; TDD: (215) 438-1506.

National Institute on Drug Abuse. *Assessing Client Needs Using the ASI: A Handbook for Program Administrators.* Washington, DC: U.S. Government Printing Office, 1995.

Power, P.W. *A Guide to Vocational Assessment,* 2nd ed. Austin, TX: PRO-ED, 1991.

U.S. Department of Labor. *Manual for the General Aptitude Test Battery, Section III: Development*. Washington, DC: U.S. Government Printing Office, 1970.

U.S. Department of Labor. *Guide for Occupational Exploration*. Washington, DC: U.S. Government Printing Office, 1979.

U.S. Department of Labor. *Instructions for Administering and Using the Interest Check List.* Washington, DC: U.S. Government Printing Office, 1979.

U.S. Department of Labor. *Manual for the USES Interest Inventory*. Minneapolis, MN: Intran Corporation, 1982.

Software

Open Options for Windows. Order from Career Planning Specialists Software, Inc., 362 S. Harvey St., Plymouth, MI 48170. Voice: (313) 459-7348. Fax: (313) 459-9833.

Center for Substance Abuse Prevention (CSAP) Prevention Works! Software.

Appendix D
Addiction Severity Index

GENERAL INFORMATION

G1. Client ID: _____

G2. Social Security Number: _____

G3. Provider Number: _____

G4. Date of Admission: _____

G5. Date of Interview: _____

G6. Time Begun: _____

G51. Who referred you for an evaluation? _____

1 Attorney
2 Probation/Parole Officer
3 Presentence Investigator
4 Self
5 Judge or Court
6 Other

G52. The referral source's name: _____

G53. Address: _____

_____

_____

Phone number: _____

G54. Why are you receiving this assessment? (1–6) _____

1 OWI or DWI
2 Court ordered
3 Attorney recommended
4 Other criminal arrest
5 Self interest
6 Other

G55. BAC: _____

G56. By whom was it ordered (1-4)? _____

1 Judge
2 Probation
3 Presentence
4 Parole

Specify other: _____

G8. Class: _____

1 Intake
2 Followup

G9. Contact code: _____

1 In person
2 Phone
3 Mail

G57. Interviewer's initials: _____

G10. Gender: _____

G12. Special: _____

1 Terminated 2 Refused
3 Unable to respond X Not applicable

Client first name: _____

Client middle name: _____

Client last name: _____

Client's address: _____

Address: _____

Address: _____

Phone number: _____

G15. Is this address owned by you or your family? (Y/N): _____

G16. Date of birth: _____

G17. Of what race do you consider yourself? _____

1 White (Not of Hispanic Origin) 2 Black (Not of Hispanic Origin)
3 American Indian 4 Alaskan Native
5 Asian or Pacific Islander 6 Hispanic – Mexican
7 Hispanic – Puerto Rican 8 Hispanic – Cuban
9 Other Hispanic

G18. Religious preference: _____

1 Protestant 2 Catholic
3 Jewish 4 Islamic
5 Other 6 None

G58. Specify other religion: _____

G19. Have you been in a controlled environment in the past 30 days? _____

1 No 2 Jail
3 Alcohol or drug treatment 4 Medical treatment
5 Psychiatric treatment 6 Other

G20. How many days? _____

MEDICAL STATUS

M1. How many times in your life have you been hospitalized for medical problems? _____
Include ODs, DTs, exclude detox.

M2. How long ago was your last hospitalization for a physical problem? _____ years _____ months

M51. What was it for? _____

M3. Do you have any chronic medical problems that continue to interfere with your life? (Y/N) ____
Specify: _____

M4. Are you taking any prescribed medication on a regular basis for a physical problem? (Y/N) ____

M52. What is it? _____

M53. What is it for? _____

M5. Do you receive financial compensation (pension, disability, etc.) for a physical disability? (Y/N)
____ Specify: _____

M6. How many days have you experienced medical problems in the past 30 days? _____

M7. How troubled or bothered have you been by these medical problems in the past 30 days? _____
0 – Not at all 1 – Slightly 2 – Moderately 3 – Considerably 4 – Extremely

M8. How important to you now is treatment for these medical problems? _____
0 – Not at all 1 – Slightly 2 – Moderately 3 – Considerably 4 – Extremely

The questions below are to be answered by the interviewer only.

M9. How would you rate the patient's need for medical treatment? _____
0 – None necessary, to 9 – Treatment needed to intervene in life-threatening situation
Is the **medical status** information significantly distorted by:

M10. Patient's misrepresentation (Y/N)? _____

M11. Patient's inability to understand (Y/N)? _____

EMPLOYMENT/SUPPORT STATUS

E1. Education completed (GED = 12 years): _____ years, _____ months

E2. Training or technical education completed: _____ months

E3. Do you have a profession, trade, or skill? (Y/N): _____

E4. Do you have a valid driver's license? (Y/N): _____

E5. Do you have an automobile available? (Y/N): _____
Answer "No" if no valid driver's license.

E6. How long was your longest full-time job? _____ years, _____ months

E7. Usual (or last) occupation: _____

1 1. a. Higher Executives
2 1. b. Large Proprietors (Value over $180,000)
3 1. c. Major Professionals
4 2. a. Business Managers
5 2. b. Proprietors of Medium-Sized Businesses
6 3. a. Administrative Personnel
7 3. b. Proprietors of Small Businesses (less than $55,000)
8 3. c. Minor Professionals
9 3. d. Farmers (Owners $41,000 to $60,000)
10 4. a. Clerical and Sales Workers
11 4. b. Technicians
12 4. c. Proprietors of Little Business (less than $10,000)
13 4. d. Farmers (Owners $21,000 to $40,000)
14 5. a. Skilled Manual Employees and Small Farmers
15 5. b. Small Farmers (Owners less than $20,000)
16 6. a. Machine Operators and Semi-Skilled Employees
17 6. b. Small Farm Tenants
18 7. Unskilled Employees

Specify: _____

E8. Does someone contribute to your support in any way? (Y/N) _____
Specify: _____

E9. Does this constitute the majority of your support? (Y/N): _____

E10. Employment status: _____

1	full time (35 hrs/week)	2	part time (reg. hrs)
3	part time (irreg., daywork)	4	student
5	service	6	retired/disability
7	unemployed	8	in controlled environment

E11. How many days were you paid for working in the last 30 days? _____ days

How much money did you receive from the following sources in the past 30 days?

E12. Employment (net income) _____

E13. Unemployment compensation _____

E14. Welfare _____

E15. Pension, benefits, or social security _____

E16. Mate, family, or friends _____

E17. Illegal _____

E51. What was your gross income last year? _____

E18. How many people depend on your for the majority of their food, shelter, etc.? _____

E19. How many days have you experienced employment problems in the past 30 days? _____

E20. How troubled or bothered have you been by these employment problems in the past 30 days? _____

0 – Not at all 1 – Slightly 2 – Moderately 3 – Considerably 4 – Extremely

E21. How important to you now is counseling for these employment problems? _____

0 – Not at all 1 – Slightly 2 – Moderately 3 – Considerably 4 – Extremely

The questions below are to be answered by the interviewer only.

E22. How would you rate the patient's need for employment counseling? _____

0 – None necessary, to 9 – Treatment needed to intervene in life-threatening situation

Is the **employment/support status** information significantly distorted by:

E23. Patient's misrepresentation (Y/N)? _____

E24. Patient's inability to understand (Y/N)? _____

DRUG/ALCOHOL USE

D51. At what age did you first try alcohol or drugs? _____

D52. What was it? _____

		Past 30 Days	Lifetime Yrs.	Route of Administration
D1.	Alcohol—any use at all	_____	_____	_____
D2.	Alcohol—to intoxication	_____	_____	_____
D3.	Heroin	_____	_____	_____
D4.	Methadone	_____	_____	_____
D5.	Other opiates and analgesics	_____	_____	_____
D6.	Barbiturates	_____	_____	_____
D7.	Other sed/hyp/tranq	_____	_____	_____

Route of Administration:
1 – Oral
2 – Nasal
3 – Smoking
4 – Non IV injection

D8.	Cocaine	_____	_____	_____	5 – IV injection
D9.	Amphetamines	_____	_____	_____	
D10.	Cannabis	_____	_____	_____	
D11.	Hallucinogens	_____	_____	_____	
D12.	Inhalants	_____	_____	_____	
D13.	More than one per day (including alcohol)	_____	_____	_____	

D53. Have you ever used a needle to administer any of these drugs? (Y/N) _____

D54. Are you an I.V. drug user? (Y/N) _____

D14. According to the interviewer, which substance(s) are the major problem (0–16)? _____

00—No problem	08—Cocaine
01—Alcohol any use	09—Amphetamines
02—Alcohol to intox	10—Cannabis
03—Heroin	11—Hallucinogens
04—Methadone	12—Inhalants
05—Opiates/analgesics	13—Alcohol and one or more drugs
06—Barbiturates	14—More than one drug
07—Other sed/hyp/tranq	

D15. How long was your last period of voluntary abstinence from this major substance (substance identified in D14)? _____ months, 00—never abstinent

D16. How many months ago did this abstinence end? _____ months, 00—still abstinent

How many times have you:

D17. Had alcohol DTs? _____

D18. Overdosed on drugs? _____

How many times in your life have you been treated for:

D19. Alcohol abuse? _____

D20. Drug abuse? _____

How many of these were for detox only?

D21. Alcohol? _____

D22. Drug? _____

D55. How long ago were you last in treatment? _____ years, _____ months

D56. Name of center: _____

D57. Address: _____

D58. Type of treatment: _____ 1—Inpatient, 2—Outpatient

D59. How long did it last? _____days

D60. Did you complete it successfully? (Y/N) _____

D61. Have you been evaluated for alcohol or drugs before today? (Y/N) _____

D62. Where? _____

When? _____

How much money would you say you spent during the past 30 days on:

D23. Alcohol? _____

Drugs? _____

D25. How many days have you been treated in an outpatient setting for alcohol or drugs in the past 30 days (include NA, AA)? _____ days

D26. Alcohol problems? _____

D27. Drug problem? _____

How troubled or bothered have you been in the past 30 days by these:

0 – Not at all 1 – Slightly 2 – Moderately 3 – Considerably 4 – Extremely

D28. Alcohol problems? _____

D29. Drug problems? _____

How important to you now is treatment for these:

0 – Not at all 1 – Slightly 2 – Moderately 3 – Considerably 4 – Extremely

D30. Alcohol problems? _____

D31. Drug problems? _____

The questions below are to be answered by the interviewer only.

How would you rate the patient's need for treatment for

0 – None necessary, to 9 – Treatment needed to intervene in life-threatening situation

D32. Alcohol problems? _____

D33. Drug problems? _____

Is the **drug/alcohol status** information significantly distorted by:

D34. Patient's misrepresentation (Y/N)? _____

D35. Patient's inability to understand (Y/N)? _____

LEGAL STATUS

L1. Was this admission prompted or suggested by the criminal justice system (judge, probation/parole officer, etc.)? (Y/N) _____

L2. Are you on probation or parole? _____ 0 – Neither 1 – Probation 2 – Parole

How many times in your life have you been arrested and charged with the following:

			Under the influence at the time (Y/N)
L3.	Shoplifting/vandalism/theft?	_____	_____
L4.	Parole/Probation violations?	_____	_____
L5.	Drug charges?	_____	_____
L6.	Forgery?	_____	_____
L7.	Weapons offense?	_____	_____
L8.	Burglary, larceny, B&E?	_____	_____
L9.	Robbery?	_____	_____
L10.	Assault?	_____	_____
L11.	Arson?	_____	_____
L12.	Rape/sex-related crimes?	_____	_____
L13.	Homicide, manslaughter?	_____	_____
L14.	Prostitution?	_____	_____
L15.	Contempt of court?	_____	_____
L16.	Other?	_____	_____

L17. How many of these charges resulted in convictions? _____

How many times in your life have you been charged with the following:

L18. Disorderly conduct? _____ _____
Vagrancy? _____ _____
Public intoxication? _____ _____
L19. Driving while intoxicated? _____ _____
L20. Major driving violations? _____ _____
L51. MIP (minor in possession)? _____ _____
L21. How many months were you incarcerated in your life? _____ months
L22. How long was your last incarceration? _____ months
L23. What was it for? _____

03 – Shoplifting/vandalism/theft
04 – Parole/probation violation
05 – Drug charges
06 – Forgery
07 – Weapons offense
08 – Burglary, larceny, B&E
09 – Robbery
10 – Assault
11 – Arson
12 – Rape/sex-related crimes
13 – Homicide/manslaughter
14 – Prostitution
15 – Contempt of court
16 – Other
18 – Disorderly conduct, vagrancy
19 – Driving while intoxicated
20 – Major driving violations

L24. Are you presently awaiting charges, trial, or sentencing? (Y/N) _____
L25. For what? _____
L26. How many days in the past 30 days were you detained or incarcerated? _____ days
L27. How many days in the past 30 days have you engaged in illegal activities for profit? _____ days
L28. How serious do you feel your present legal problems are (exclude civil problems)? _____
0 – Not at all 1 – Slightly 2 – Moderately 3 – Considerably 4 – Extremely
L29. How important to you now is counseling or referral for these legal problems? _____
0 – Not at all 1 – Slightly 2 – Moderately 3 – Considerably 4 – Extremely

The questions below are to be answered by the interviewer only.

L30. How would you rate the patient's need for legal services or counseling? _____
0 – None necessary, to 9 – Treatment needed to intervene in life-threatening situation
Is the **legal status** information significantly distorted by:
L31. Patient's misrepresentation (Y/N)? _____
L32. Patient's inability to understand (Y/N)? _____

FAMILY HISTORY

Have any of your relatives had what you would call a significant drinking, drug use, or psychological problem—one that did or should have led to treatment?

Y – Yes N – No X – Not applicable Z – Not answered

Mother's side:		Alcohol	Drug	Psych
H1.	Grandmother	_____	_____	_____
H2.	Grandfather	_____	_____	_____
H3.	Mother	_____	_____	_____

H4.	Aunt	_____	_____	_____
H5.	Uncle	_____	_____	_____

Father's side:		Alcohol	Drug	Psych
H6.	Grandmother	_____	_____	_____
H7.	Grandfather	_____	_____	_____
H8.	Mother	_____	_____	_____
H9.	Aunt	_____	_____	_____
H10.	Uncle	_____	_____	_____

How many siblings do you have?

H53. Brothers: _____

H54. Sisters: _____

Have any of your siblings had what you would call a significant drinking, drug use, or psychological problem—one that did or should have led to treatment?

Y – Yes N – No X – Not applicable Z – Not answered

		Alcohol	Drug	Psych
H11.	Brother #1	_____	_____	_____
H51.	Brother #2	_____	_____	_____
H12.	Sister #1	_____	_____	_____
H52.	Sister #2	_____	_____	_____

FAMILY/SOCIAL RELATIONSHIPS

F1. Marital Status: _____

1 Married 2 Remarried
3 Widowed 4 Separated
5 Divorced 6 Never married

F2. How long have you been in this marital status (If never married, then since age 18)?
_____ years, _____ months

F3. Are you satisfied with this situation (0–2)? _____ 0 – No 1 – Indifferent 2 – Yes

F51. How many children do you have? _____

F4. Usual living arrangements for the past three years: _____

1 With sexual partner and children 2 With sexual partner alone
3 With children alone 4 With parents
5 With family 6 With friends
7 Alone 8 Controlled environment
9 No stable arrangements

F5. How long have you lived in these arrangements (If with family or parents, since age 18)?
_____ years, _____ months

F6. Are you satisfied with these arrangements (0–2)? ___ 0 – No 1 – Indifferent 2 – Yes

Do you live with anyone who:

F7. Has a current alcohol problem (Y/N)? _____

F8. Uses nonprescribed drugs (Y/N)? _____

F9. With whom do you spend most of your free time? _____

1 – Family 2 – Friends 3 – Alone

F10. Are you satisfied spending your free time this way? _____ 0 – No 1 – Indifferent 2 – Yes

F11. How many close friends do you have? _____

Would you say you have had close, reciprocal relationships with any of the following people in your life? Y – Yes N – No X – Not applicable Z – Not answered

F12. Mother _____

F13. Father _____

F14. Brothers/Sisters _____

F15. Sexual Partner/Spouse _____

F16. Children _____

F17. Friends _____

Have you had significant periods in which you have experienced serious problems getting along with: Y – Yes N – No X – Not applicable Z – Not answered

		Past 30 Days	In Your Life	Affected by Alcohol or Drugs
F18.	Mother	_____	_____	_____
F19.	Father	_____	_____	_____
F20.	Brothers/Sisters	_____	_____	_____
F21.	Sexual Partner/Spouse	_____	_____	_____
F22.	Children	_____	_____	_____
F23.	*Other significant family	_____	_____	_____
F24.	Close friends	_____	_____	_____
F25.	Neighbors	_____	_____	_____
F26.	Coworkers	_____	_____	_____

F23. *Specify other relative: _____

Did any of these people abuse you:

00 – None	21 – Sexual partner	25 – Neighbors
18 – Mother	22 – Children	26 – Coworkers
19 – Father	23 – Other family	27 – Yes-does not know who or chooses not to identify person
10 – Brother/sister	24 – Close friends	

		Past 30 days	In your life
F27.	Emotionally (make you feel bad through harsh words)?	_____	_____
F28.	Physically (cause you physical harm)?	_____	_____
F29.	Sexually (force sexual advances or sexual acts)?	_____	_____

How many days in the past 30 days have you had serious conflicts:

F30. With your family? _____ days

F31. With other people (excluding family)? _____ days

How troubled or bothered have you been in the past 30 days by these conflicts:

0 – Not at all 1 – Slightly 2 – Moderately 3 – Considerably 4 – Extremely

F32. Family problems? _____

F33. Social problems? _____

How important to you now is treatment or counseling for these problems?
0 – Not at all 1 – Slightly 2 – Moderately 3 – Considerably 4 – Extremely

F34. Family problems? _____

F35. Social problems? _____

The questions below are to be answered by the interviewer only.

L30. How would you rate the patient's need for family and/or social counseling? _____
0 – None necessary, to 9 – Treatment needed to intervene in life-threatening situation
Is the **family/social relationships** information significantly distorted by:

L31. Patient's misrepresentation (Y/N)? _____

L32. Patient's inability to understand (Y/N)? _____

PSYCHIATRIC STATUS

How many times have you been treated for any psychological or emotional problems:

P1. In a hospital or inpatient setting? _____

P1. As an outpatient or private patient? _____

P2. Do you receive financial compensation for a psychiatric or emotional disability (include pension, SSI, SSDI, etc.) (Y/N)? _____

Have you had a significant period (that was not a direct result of drug/alcohol use) in which you have: Y – Yes N – No X – Not applicable Z – Not answered

		Past 30 days	In your life
P3.	Experienced serious depression—sadness, hopelessness, loss of interest, difficulty with daily functioning?	_____	_____
P4.	Experienced serious anxiety/tension—uptight, unreasonably worried, unable to feel relaxed?	_____	_____
P5.	Experienced hallucinations—saw things or heard voices that others did not see or hear?	_____	_____
P6.	Experienced trouble understanding, concentrating, or remembering?	_____	_____
P7.	Experienced trouble controlling violent behavior including episodes of rage or violence?	_____	_____
P8.	Experienced serious thoughts of suicide?	_____	_____
P9.	Attempted suicide?	_____	_____
P10.	Been prescribed medication for any psychological or emotional problems?	_____	_____

Note: for questions P7 through P9, include incidents that occurred when the person was under the influence of substances.

P11. How many days in the past 30 days have you experienced these psychological or emotional problems? _____ days

P12. How much have you been troubled or bothered by these psychological or emotional problems in the past 30 days? _____
0 – Not at all 1 – Slightly 2 – Moderately 3 – Considerably 4 – Extremely

P13. How important is it to you now is treatment for these psychological or emotional problems?
____ 0 – Not at all 1 – Slightly 2 – Moderately 3 – Considerably 4 – Extremely

The questions below are to be answered by the interviewer only.

At the time of the interview, is the patient: Y – Yes, N – No

P14. Obviously depressed/withdrawn? _____
P15. Obviously hostile? _____
P16. Obviously anxious/nervous? _____
P17. Having trouble with reality testing, thought disorders, paranoid thinking? _____
P18. Having trouble comprehending, concentrating, remembering? _____
P19. Having suicidal thought? _____
P20. How would you rate the patient's need for psychiatric/psychological treatment? _____
0 – None necessary, to 9 – Treatment needed to intervene in life-threatening situation
Is the **psychiatric status** information significantly distorted by:
P21. Patient's misrepresentation (Y/N)? _____
P22. Patient's inability to understand (Y/N)? _____

P22. Time begun: _____
P22. Time ended: _____

INTERVIEWER'S ASSESSMENT
DIAGNOSTIC IMPRESSION

Interviewer's Assessment Comments _____ SASSI-3
RAP? _____
FVA? _____
FVOD? _____
SYM? _____
OAT? _____
SAT? _____
DEF? _____
SAM? _____
FAM? _____
COR? _____

DSM-IV

AXIS I: _____
_____
Description: _____

AXIS II: _____
_____
Description: _____

AXIS III: _____

AXIS IV: _____

AXIS V: _____

RECOMMENDATIONS FOR TREATMENT

Recommendation for Treatment: _____
Level of Care Recommendation: _____

Appendix E
State Employment Agencies

ALABAMA
Alabama State Employment Service
649 Monroe St, Room 266
Montgomery, AL 36131
Phone: (334) 242-8003; Fax: (334) 242-8012

ALASKA
Alaska Career Information System
Alaska Department of Education
801 West 10th Street, Suite 20
Juneau, AK 99801-1894
Phone: (907) 465-2980; Fax: (907) 465-2982

ARIZONA
Employment and Rehabilitation Services
Arizona Department of Economic Security
1831 W. Jefferson
Phoenix, AZ 85007
Phone: (602) 542-4941 or (602) 542-5216

ARKANSAS
Arkansas Employment Security Department
#2 Capital Mall, Room 506
ESD Building
Little Rock, AR 72201
Phone: (501) 682-2121; Fax: (501) 682-2273

CALIFORNIA
The California State Job Training Coordinating Council
800 Capitol Mall, MIC 67
Sacramento, CA 95814
Phone: (916) 654-6836; Fax: (916) 654-8987

COLORADO
Colorado Department of Labor and Employment
Attn: Public Relations
1515 Arapahoe Street, Tower 2, Suite 500
Denver, CO 80202-2117
Phone: (303) 620-4718

CONNECTICUT
Employment Training/Connecticut Works
Connecticut Department of Labor
200 Folly Brook Boulevard
Wethersfield, CT 06109
Phone: (888) 289-6757 [(888) CTWORKS]

DELAWARE
Delaware Department of Labor
Division of Employment and Training
First Floor
4425 North Market Street
Wilmington, DE 19806

DISTRICT OF COLUMBIA
Department of Employment Services
Training, Referral and Assessment Office
500 C Street, NW, Room 300
Washington, DC 20001
Phone: (202) 724-2300

FLORIDA
Florida Department of Labor & Employment Security
Division of Vocational Rehabilitation – Bldg A
2002 Old Augustine Road
Tallahassee, FL 32399
Phone: (850) 488-6210 or (850) 488-4398 (general information)

GEORGIA
Georgia Department of Labor
Suite 642
148 International Boulevard N.E.
Atlanta, GA 30303-1751
Phone: (404) 656-3032

HAWAII
Department of Labor and Industrial Relations
Workforce Development Division
830 Punchbowl Street
Honolulu, HI 96813
Phone: (808) 586-8842; Fax: (808) 586-9099

IDAHO
Idaho Department of Labor
317 Main Street
Boise, ID 83735-0600
Phone: (208) 334-6252; Fax: (208) 334-6300

ILLINOIS
Illinois Department of Employment Security
Field Operations
401 S. State Street, 7th North
Chicago, IL 60605
Phone: (312) 793-2713; in Springfield: (217) 785-5069

INDIANA
Department of Workforce Development
10 N. Senate Avenue
Indianopolis, IN 46204
Phone: (317) 232-7670; Fax: (319) 233-4793

IOWA
Iowa Workforce Development
1000 East Grand Avenue
Des Moines, IA 50319-0209
Phone: (515) 281-5387, 800-JOB-IOWA

KANSAS
Kansas Department of Human Resources
1430 SW Topeka Boulevard
Topeka, KS 66612-1897
Phone: (785) 296-1715; Fax: (785) 296-1984

KENTUCKY
Workforce Development Cabinet
Department for Employment Services
275 East Main Street
Frankfort, KY 40621
Phone: (502) 564-5331

LOUISIANA
Louisiana Department of Labor
735 St. Charles Avenue
New Orleans, LA 70130-3713
Phone: (504) 568-7111; Fax: (504) 568-7195

MAINE
Department of Labor
Job Service
Bureau of Employment Services
55 State House Station
Augusta, ME 04333-0055
Phone: (207) 624-6390; Fax: (207) 624-6499

MARYLAND
Maryland Job Service
Division of Employment and Training
Phone: (800) 765-8692

MASSACHUSETTS
Massachusetts Division of Employment and Training
19 Staniford Street
Boston, MA 02114
Phone: (617) 727-6560

MICHIGAN
Michigan Department of Career Development
[*formerly* Michigan Jobs Commission]
201 N. Washington Square
Victor Office Center, 4th Floor
Lansing, MI 48913
Phone: (517) 373-9808

MINNESOTA
Minnesota Department of Economic Security
390 N. Robert Street
St. Paul, MN 55101
Phone: (888) 438-5627

MISSISSIPPI
Mississippi Employment Security Commission
P.O. Box 1699
Jackson, MS 39215-1699
Phone: (601) 354-8711; Fax: (601) 961-7405

MISSOURI
Workforce Development Transition Team
P.O. Box 1928
Jefferson City, MO 65102-1928
Phone: (573) 751-7039; Fax: (573) 751-0147

MONTANA
Montana Department of Labor and Industry
Job Service Division

NEBRASKA
Nebraska Department of Labor
550 South 16th Street
Lincoln, NE 68509-4600
Phone: (402) 471-2600; Fax: (402) 471-9867

NEVADA
Nevada Department of Employment, Training and Rehabilitation
Information Development and Processing Division
Research & Analysis Bureau
500 E. Third Street
Carson City, NV 89713
Phone: (702) 687-4550

NEW HAMPSHIRE
New Hampshire Employment Security
Web site: www.nhworks.state.nh.us

NEW JERSEY
New Jersey State Employment & Training Commission
P.O. Box 940
Trenton, NJ 08625-0940

NEW MEXICO
New Mexico Department of Labor
Employment Security Division
401 Broadway NE
Albuquerque, NM 87102

NEW YORK
Workforce Development and Training
New York State Department of Labor
State Campus, Building 12
Albany, NY 12240
Phone: (518) 457-0380; Fax: (518) 457-9526

NORTH CAROLINA
North Carolina Division of Employment & Training
441 N. Harrington Street
Raleigh, NC 27603
Phone: (919) 733-6383

NORTH DAKOTA
Job Service North Dakota
P.O. Box 5507
Bismarck, ND 58506-5507
Phone: (800) 732-9787 or (701) 328-2868;
Fax: (701) 328-4193

OHIO
Ohio Bureau of Employment Services
145 S. Front Street
Columbus, OH 43215

OKLAHOMA
Oklahoma Employment Security Commission
Will Rogers Office Building
2401 North Lincoln Blvd.
P. O. Box 52003
Oklahoma City, OK 73152-2003
Phone: (405) 557-0200

OREGON
Oregon Employment Department
875 Union Street, N.E.
Salem, OR 97311

PENNSYLVANIA
Career Development Marketplace Unit
c/o Department of Labor and Industry
412 Labor and Industry Building
7th & Forster Streets
Harrisburg, PA 17120

RHODE ISLAND
Rhode Island Department of Labor and Training
101 Friendship Street
Providence, RI 02903
Phone: (401) 222-3625

SOUTH CAROLINA
South Carolina Employment Security Commission
1550 Gadsden Street
Columbia, SC 29202

SOUTH DAKOTA
South Dakota Department of Labor
700 Governors Drive
Pierre, SD 57501-2291
Phone: (605) 773-3101; Fax: (605) 773-4211

TENNESSEE
Tennessee Department of Employment Security
Davy Crockett Tower - 11th Floor
500 James Robertson Parkway
Nashville, TN 37245-1200
Phone: (615) 741-213

TEXAS
Texas Workforce Commission
101 E. 15th Street
Austin, TX 78778-8001

UTAH
Utah Department of Workforce Services
P.O. Box 45249
Salt Lake City, UT 84145-0249
Phone: (801) 526-WORK (9675);
Fax: (801) 536-7420

VERMONT
Vermont Department of Employment and Training
5 Green Mountain Drive
P.O. Box 488
Montpelier, VT 05601-0488
Phone: (802) 828-4000; Fax: (802) 828-4022

VIRGINIA
Virginia Employment Commission
5520 Cherokee Avenue, Suite 100
Alexandria, VA 22312- 2319
Phone: (703) 813-1300; Fax: (703) 813-1380

WASHINGTON
Washington State Employment Security Department
Commissioner's Office
212 Maple Park Drive
P.O. Box 9046
Olympia, WA 98507-9046
Phone: (360) 902-9301; Fax: (360) 902-9383

WEST VIRGINIA
West Virginia Bureau of Employment Programs
112 California Avenue
Charleston, WV 25305-0112
Phone: (304) 558-2630

WISCONSIN
Wisconsin Department of Workforce Development
201 E. Washington Avenue
P.O. Box 7946
Madison, WI 53707-7946

WYOMING
Wyoming Department of Employment
122 West 25th Street
Cheyenne, WY 82002
Phone: (307) 777-7672

Appendix F
Federal Funding Sources

The information about Federal and State funding sources in Figures F-1 and F-2 is intended to illustrate the range of potential Federal funding sources available and should not be regarded as comprehensive. Although every effort was made to ensure that the information was as up-to-date as possible, some information may no longer be current. The information is arranged in the same order as it was presented in the section "Federal and State Funding Sources" in Chapter 6.

Each of the funding sources listed in Figure F-1 has its own eligibility and reporting requirements and funding cycle. Some programs are competitive, whereas others award funding by formula. Although substance abuse treatment programs may not be able to compete directly for some of these funds, they may be able to subcontract with a funded agency. They can also have a crucial advocacy role in deciding funding priorities.

The following acronyms are used in Figure F-1.

- CHIP = Child Health Insurance Plan
- HHS = Department of Health and Human Services
- DOE = Department of Education
- DOJ = Department of Justice
- DOL = Department of Labor
- DOT = Department of Transportation
- EZ/EC = Enterprise Zone/Empowerment Community
- HCFA = Health Care Financing Administration
- JTPA = Job Training Partnership Act
- SAPT Block Grant = Substance Abuse Prevention and Treatment Block Grant
- SSA = Single State Agency (i.e., the primary State agency responsible for publicly funded substance abuse treatment services)
- TANF = Temporary Assistance to Needy Families
- USDA = United States Department of Agriculture
- VR = Vocational Rehabilitation

Figure F-1
Federal Funding Sources

Services Provided	Federal Agency	Enabling Rule	Target Populations	Eligibility Requirements for Target Populations	Grantee	Contacts
Alcohol abuse prevention and treatment Substance abuse prevention and treatment Primary prevention activities Administrative costs	HHS	SAPT Block Grant formula (42 U.S.C. §300)	People with alcohol and substance abuse disorders Special populations (e.g., women)	Substance abuse disorders Pregnant/postpartum women	SSA	SSA
Funding for substance abuse treatment of Medicaid-eligible individuals. This is an optional benefit at the State's discretion.	HHS/ HCFA Medicaid	Title XIX of the Social Security Act (42 U.S.C. §§1396– 1396v)	Medicaid-eligible individuals	Medicaid Income Age Participation in other Federal programs Pregnancy status	State departments of health and social services	DOL State HHS
Some substance abuse treatment services if State sets funds aside Job training Transportation Child care	HHS	Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193)	TANF recipients	TANF receipt	Three-quarters of formula funds go to States; one-quarter of formula funds go to local communities	HHS and welfare contracting
Support services for "hardest to employ" TANF recipients Transportation assistance	DOL	Welfare-to-Work grant provisions of Title IV, Part A of the Social Security Act (P.S. 105-33)	Hardest to employ TANF recipients	TANF receipt	State driven	DOL State HHS
Basic and remedial education Job skills assessment On-the-job training Job search assistance Work experience programs Internships School-to-work transition programs Transportation and relocation assistance	DOL	JTP (29 U.S.C. §201– 206) (Note: JTPA is superseded by the Workforce Investment Act of 1998 and will be repealed on 7/1/00.)	Unemployed adults Youth Disabled persons Dislocated workers Native Americans Migrant and seasonal farm workers Veterans	Disadvantaged and disabled individuals	Funds are channeled to States, which oversee the planning and operation of local programs	State DOL

Figure F-1 (continued) Federal Funding Sources						
Services Provided	**Federal Agency**	**Enabling Rule**	**Target Populations**	**Eligibility Requirements for Target Populations**	**Grantee**	**Contacts**
States receive block grants for adult employment, training for disadvantaged youths and families, and literacy Grant establishes a system of "one-stop" centers for job seekers	DOL	Workforce Investment Act of 1998 (P.L. 105-220) consolidates more than 60 Federal programs into 3 block grants to States for employment, training, and literacy	Disadvantaged adults and youth	Disadvantaged adults and youth	85% of funds go to local areas; the remainder for Statewide activities	DOL Employment and Training Division
Substance abuse prevention, intervention, referral, and treatment Job training (to assist prevention efforts) Security improvements in public housing complexes	HUD	Drug elimination, "back to work" efforts Public Housing Drug Elimination Program (42 U.S.C. §11901)	Public housing residents	Public housing residence	Local public housing authorities, which contract with service providers	HUD regional office State and local public housing authorities
Substance abuse disorder assessment and treatment Prescription medications Equipment and accommodation for disabled Transportation Training and secondary education Vocational testing and evaluation	DOE	Vocational Rehabilitation Act (29 U.S.C. §720– 728a, 730, 731) Workforce Investment Act of 1998 (P.L. 105-220, §106)	People with disabilities People receiving Supplemental Security Income	People with disabilities; Supplemental Security Income	VR agency designated by State	Varies by State

Figure F-1 (continued)

Federal Funding Sources

Services Provided	Federal Agency	Enabling Rule	Target Populations	Eligibility Requirements for Target Populations	Grantee	Contacts
Foster care Services to prevent child abuse and neglect Substance abuse treatment (often court-ordered) Child care	HHS	Title IV of the SSA (42 U.S.C. §1862)	Parents in child welfare system (often TANF)	TANF-eligible and those in the child welfare system	State or county child welfare services	Child welfare agency or contractors
State determines benefits package; in some States, adolescents and teen mothers are included	HHS	Title XXI of the Social Security Act (P.L. 105-33 §4901a) CHIP	Uninsured children (as defined by State)	Uninsured children; sometimes more narrowly defined	Varies by State	State HHS
Child care Transportation Detoxification Substance abuse treatment services Social services	HHS	Title XX of the Social Security Act (42 U.S.C. §§1397–1397f)	State determined	State determined	State HHS or subcontractor	State HHS
Substance abuse treatment services Tear down housing Move drugs out, services in	DOJ	"Weed and Seed"	Residents in designated neighborhoods	Law enforcement agencies with local community coalitions	Law enforcement agencies working as part of a community coalition	Executive Office for Weed and Seed of the DOJ
Substance abuse treatment at every point of entry in the criminal justice system Substance abuse treatment services for adjudicated and non adjudicated individuals	DOJ, Office of Justice Programs, Drug Courts Program Office	Violent Crime Control and Law Enforcement Act of 1994 (28 CFR §93)	Adjudicated and non adjudicated individuals	Adjudicated and non adjudicated individuals	Local criminal justice system	DOJ Office of Justice Programs

Figure F-1 (continued)
Federal Funding Sources

Services Provided	Federal Agency	Enabling Rule	Target Populations	Eligibility Requirements for Target Populations	Grantee	Contacts
Counseling Medical and psychological services Job training	DOE, Office of Special Education and Rehabilitative Services, Rehabilitation Services Administration	Rehabilitation Act of 1973 (29 U.S.C. §701ff)	Individuals with physical or mental disabilities (priority given to severely disabled)	Individuals with physical or mental disabilities (priority given to severely disabled)	State VR agency	State VR agency
Help States and local communities develop flexible transportation services that connect welfare recipients and other low-income persons to jobs and other employment-related services	DOT	Transportation Equity Act of 1998 (49 U.S.C. §5309)	Welfare recipients, low-income persons	Welfare recipients, low-income persons	States, local communities	DOT Federal Transit Administration
Loans and grants to create jobs, expand business opportunities Support activities for job hunting, such as job training, child care, transportation	HUD, USDA	Empowerment Zone and Enterprise Community Initiative (26 U.S.C. §1391)	Designated EZs or ECs	Within area with local discretion	EZ/EC local coalitions	HUD
Aid in the elimination of slums and blight Meet other urgent community development needs Neighborhood revitalization Economic development Improvement of community facilities and public services	HUD	Housing and Community Development Act of 1974 (42 U.S.C. §5301)	Low- and moderate-income people	Low- and moderate-income people	Entitled communities (metropolitan cities and urban counties)	HUD

Figure F-2
Federal Sources of Discretionary, Time-Limited Project Grants

Note: This list is not intended to be comprehensive.

Department of Education
- National Institute on Disability and Rehabilitation Research
- Office of Special Education and Rehabilitative Services, Rehabilitation Services Administration

Department of Health and Human Services
- Administration for Children and Families
- Health Care Financing Administration
- Health Resources and Services Administration
- National Institutes of Health
  - National Institute on Alcohol Abuse and Alcoholism
  - National Institute on Drug Abuse
  - National Institute of Mental Health
- Substance Abuse and Mental Health Services Administration
  - Center for Substance Abuse Prevention
  - Center for Substance Abuse Treatment
  - Center for Mental Health Services

Department of Housing and Urban Development

Department of Justice
- Executive Office for Weed and Seed
- National Institute of Justice
- Office of Justice Programs
- Office of Juvenile Justice and Delinquency Prevention

Department of Labor

Department of Transportation
- Federal Transit Administration

Appendix G
Sample Individualized Written Rehabilitation Program

Notice: This form is voluntary. You are not required to give us personal information as part of the joint development of your IWRP and there is no penalty if you do not provide the information requested. However, if you choose not to provide this information, we may not be able to provide goods or services we had discussed as part of your rehabilitation program. *The IWRP is a plan of services jointly developed by my counselor and myself to assist me in reaching my employment outcome and/or long-term rehabilitation goal. The services will be provided in the most integrated environment*.

Name	**ID Number**
Jane Doe	***7321***

This IWRP is for services in the program checked below

VR employment outcome

(X) Independent living
( ) Other (specify)
( ) Extended evaluations for VR Services
( ) Rehabilitation Teaching

Employment objective and/or long-term rehabilitation goal:

Obtain and maintain employment in the clerical field.

(X) Full time
( ) Part time Weekly hours of work (SE only)

Rehabilitation technology services: ( ) needed (X) Not needed at this time

Personal assistance services: ( ) needed (X) Not needed at this time

Postemployment services: (X) anticipated ( ) Not anticipated at this time

IWRP Intermediate Objective

Maintain recovery. Meet responsibilities of drug treatment center, establish VR goals.

Individual Counseling*	**Substance abuse counselor tx center**	**1/98**	**1/99**	**Drug treatment**
NA and/or AA Meetings*	***Local meeting sites***	***1/98***	***1/99***	"
Vocational Rehabilitation*	***VR Counselor, tx center***	***1/98***	***1/99***	"
Group Counseling*	***Relapse prevention counselor***	***1/98***	***1/99***	"
Vocational Rehabilitation*	***State VR counselor***	***1/98***	***1/99***	***State VR***

Began before inception of this plan. Had been in substance abuse treatment since 3/97

Progress toward meeting this intermediate objective will be measured by and reviewed:

( ) Annually ( ) Every 90 days (X) Monthly
( ) Weekly ( ) School term ( ) Other Specify:

Intermediate Objective

Attain skill through training

Services	Providers	Start	End	Funded By
Training/education	***Outside provider***	***4/98***	***10/98***	***DVR***
On-going counseling	***VR counselor, tx center***	***4/98***	***10/98***	***Tx center***
On-going counseling	***DVR counselor***	***4/98***	***10/98***	***DVR***
Books and supplies	***Training program***	***4/98***	***10/98***	***DVR***
Transportation	***Client***	***4/98***	***10/98***	***DVR***

Progress toward meeting this intermediate objective will be measured by and reviewed:

Attendance at school/program. Participation in counseling sessions.
And reviewed:
( ) Annually ( ) Every 90 days (X) Monthly
( ) Weekly ( ) Every school term ( ) Other:

Intermediate Objective:

Secure a job.

VR Counseling	***Tx center VR counselor***	***10/98***	***5/99***	***Tx center***
Placement	***State VR counselor***	***10/98***	***5/99***	***DVR***
	Training program	***10/98***	***5/99***	***DVR***

Progress toward meeting this intermediate objective will be measured and reviewed:

Attendance at all services. Involvement in counseling and placement.

And reviewed:

( ) Annually ( ) Every 90 days (X) Monthly

( ) Weekly ( ) Every school term ( ) Other Specify:

This is how I was involved in determining my employment objective or long-term rehabilitation goal. ***I was unsure about my career goals, but had interests in clerical work. My counselor gave me an assessment to see if I had the aptitude for this career and if my interests were similar to people in the field. Volunteering was a good way to determine whether the goal I want to pursue was realistic.***

This is how I was informed about and involved in choosing the intermediate objectives, the service providers, and the schedule of frequency for progress measures. ***I was an active participant in my career planning. I was present at team meetings and I felt my opinion counted as a member of the team.***

……

Signature (client or representative) Date:

DVR Approval Signatures-Original Approval

…….

Counselor/Teacher Signature Date

……..

Dist Dir/Asst Dir Signature Date

……..

Reg Adm Signature Date if required

A copy of this IWRP was sent or given to you on: (date and initials)……

Appendix H
Resource Panel

Note: The information given indicates each participant's affiliation during the time the panel was convened and may no longerreflect the individual's current affiliation.

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Appendix I
Field Reviewers

Note: The information given indicates each participant's affiliation during the time the review was conducted and may no longer reflect the individual's current affiliation.

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