An outline of vocational rehabilitation of the ex-addict is presented, with emphasis placed on the development of treatment plans, counselor inservice training, and clinical procedures. Discussion is based on the Beth Israel Medical Center (BIMC) programs of Methadone Maintenance Treatment and Alcohol Treatment. Section 1, Proceedings, defines goals for vocational rehabilitation and discusses the ex-addict counseling techniques and counseling forms developed by the BIMC program. The needs of the patient are stressed in planning systematic treatment, and a summary of sources of influence on the client-counselor relationship are provided. Section 2, Clinical Profiles, examines three cases in terms of the impact clinical procedures have had on the patients for whom problems were assessed and plans developed. Each case study discusses rationale for selection, patient profile, plan formulation, initial and revised treatment, and followup, where applicable. The BIMC project is reviewed. Appendixes discusses project background, a vocational rehabilitation program within the Methadone Maintenance Treatment, the Alcohol Treatment Programs, and Drug Addiction Service staff participation in the research project. Vocational Structured Interview and Semantic Differential Forms, comments, and an editorial seminar agenda and its participants are also appended. (LH)
The State of the Art

VOCA TIONAL REHABILITATION
OF THE
DRUG ABUSER

TREATMENT
PLANNING
AND CLINICAL
SUPERVISION
NO. 5 IN A SERIES

YOUTH PROJECTS, INC.

and

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL AND REHABILITATION SERVICE,
Washington, D.C.

1975

U.S. DEPARTMENT OF HEALTH,
EDUCATION & WELFARE
NATIONAL INSTITUTE OF
EDUCATION

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY.
For Information:

Dr. Herbert H. Leibowitz
Research and Demonstration Analyst
Rehabilitation Services Administration
50 Fulton St.
San Francisco, California 94101
Department of Health, Education, and Welfare

Books in this series include:

No. 1 — THEORY AND POLICY
No. 2 — THE PRACTICE OF THE ART
No. 3 — COUNSELING AS THE ART
No. 4 — GAINFULLY EMPLOYED
No. 5 — TREATMENT PLANNING AND CLINICAL SUPERVISION

Graphs by Glenn Myles and Michael Indegand
A special acknowledgment is made to the following members of the Vocational Rehabilitation Department, whose willingness to participate and subsequent work efforts made this project possible: Michael Cetrangolo, Marcie Gerber, Francis Healy, Rita Horn, Linda Kamal, Sheila Mingo, Tina Morrow, Miriam Poser, Holly Robinson, Sue Sackman, Ken Silveri, Rita Washington, and Robert Yankowitz, and to Rhoda Cutler.

A special note of thanks to the following individuals whose assistance contributed to the ease and effectiveness of this project: Tanya Dubrow, Myra Dunlap, Anne Louise Haskins, Wilda Kelly, Grace Kraskin, Jane Sarnoff and Pat Zappel.

Permission to use any of the material included should be obtained directly from the authors, unless specified.
Authors:
Eileen Wolkstein, M.A.:  
Director, Vocational Rehabilitation Department  
Morris J. Bernstein Institute  
Beth Israel Medical Center  

Alex Richman, M.D.:  
Chief, Utilization and Review Activities  
Department of Psychiatry  
Beth Israel Medical Center  
Professor of Psychiatry, Mount Sinai School of Medicine  
of the City University of New York
This report is a response to the State of the Arts Editorial Seminar held at Mills College, March 28-30, 1973. Funds for this project were provided by Grant 15-P-55894 awarded by the Department of Health, Education, and Welfare. Social and Rehabilitation Services, to Youth Projects, Inc.

The project that made this report possible was proposed and developed to introduce new directions and a creative approach to the Vocational Rehabilitation of ex-addicts. It was designed to facilitate qualitative improvement in the vocational services available to the ex-addict.

Dale Williamson
Director — Office of Rehabilitation Services
H.E.W. — O.H.D.
Region 9, San Francisco, Calif.

Dr. Herbert Leibowitz
Research & Training Consultant
Office of Rehab. Services
H.E.W. — O.H.D. — Region 9
San Francisco, Calif.
Although drug abuse is an age-old problem in many parts of the world and certainly not a new one to this country, our current perception of the problem is new. We have moved from a view of drug abuse as almost exclusively a law enforcement problem to one where health has at least equal billing. In fact, the Drug Abuse Office and Treatment Act of 1972, signed by the President on March 21 of that year, contains as a mandate that "...administering agencies construe drug abuse as a health problem."

This new dimension to our government's approach toward the victims of drug abuse brings the role of the Department of Health, Education, and Welfare more sharply into play. Our overall goals are the elimination of drug abuse as a major social concern in our Nation, the rehabilitation and employment of the drug abuser, and the eradication of those conditions which have allowed the crisis to reach such pervasive proportions.

This Conference has made a valuable contribution toward identifying the proper role of rehabilitation in securing the return to productivity for those who have been victims of drug abuse.

[Signature]
Secretary
Our experience treating drug addicts has taught us that the elimination of illicit drug use by itself is not enough. A program can release a model patient, after months or even years of treatment. But if he goes back to the same environment, with the same limited capacities he had before, he is far too likely to go back to drugs as well.

Two ingredients, other than drug abuse treatment, are essential for an addict to give up his habit: he must have the will to give it up, and he must have the means to do so.

The will comes largely from within the individual; the means often come from outside. For some addicts, what is needed most is counseling and personal support. For others it may be health care and a balanced diet. But most of those who are ground down in the desperate hell of addiction also need new tools and opportunities to use them.

The vast majority of heroin addicts in the United States have dropped out of school and have little or no work experience.

The need for education, job training and job placement is often apparent. The question is how to provide these services most effectively. A person who invests two or three years in completing his high school equivalency, or taking a vocational education course, or learning some job-related skill, must have an assurance that at the end of that time a new life—a new job—awaits him.

At the present time the Special Action Office is encouraging experimentation with a number of approaches to providing jobs and education to ex-addicts.

— Some treatment programs are experimenting with specialized job placement personnel who serve as intermediaries between treatment programs and potential employers. These personnel are responsible for educating prospective employers about drug addiction, for arranging interviews for ex-addicts seeking jobs, and in some cases for working in a follow-through capacity once an ex-addict is employed.

— Other treatment programs are using a referral system, under which job-ready patients are referred to state and local employment agencies or to job-training or education programs.

— Some treatment facilities provide both education and vocational training as part of their general supportive services.
In conjunction with these various approaches, the Special Action Office is moving on many fronts to overcome the discrimination which presently exists in the employment of ex-addicts:

— We have worked with the Civil Service Commission to develop standard guidelines for implementing Section 413 of the Drug Abuse Prevention Act. These include non-discrimination against ex-addicts in consideration for employment in non-sensitive government positions; opportunities for treatment without loss of employment; and a more "positive policy" of providing government employment opportunities to ex-addicts.

— Where agencies and departments of government are found to be lax in implementing these new guidelines, the Special Action Office has tried to work with the organizations to help them develop reasonable and constructive programs.

— The Special Action Office has also established a Task Force on Employment and Industry. Staffed by SAO personnel, the Task Force has begun working with industry and labor to create greater understanding of drug addiction and the ways in which employment of ex-addicts can be implemented. It is expected that guidelines for industry and labor, as well as for state and local governments can be developed.

In some cases, however, simply making the skills and opportunities available to ex-addicts is not enough. For those ex-addicts who have no work experience, who have never kept to a regular schedule or exercised personal or cooperative responsibilities, something more is required if they are to become productive members of society. For such people, we are experimenting with sheltered work. Special subsidized workshops are established where ex-addicts may learn to apply their new vocational skills in a work environment. It is felt that by working with other individuals who likewise have few job skills, the tensions and pressures of employment will be reduced. Only after the ex-addict has achieved a reasonable level of competence and stability will he be ready to compete in the open job market.

In promoting jobs for ex-addicts, we cannot ask that they will be given preference over other persons seeking work. But we can ask that they be given an equal opportunity, commensurate with their training and skills, to become productive members of our society. We must also do more to equip the ex-addicts with the skills needed to use these opportunities:

Robert L. DuPont, M.D.
Director
Vocational Rehabilitation of the Ex-Addict
A Research Demonstration of Selected Techniques of Patient Assessment, Treatment Planning and Supervision.

Introduction
A discussion of the need for qualitative clinical approaches in the vocational rehabilitation of the ex-addict. Considerations include:
- defining goals in vocational rehabilitation
- defining goals in vocational rehabilitation
- clinical process
- the future of vocational rehabilitation

Project Results
A description of the project results under the heading of Value to patient.

Clinical Procedures
A description of the research project under the headings of:
Vocational Rehabilitation Staff
Tools: Vocational Structural Interview Form (VSIF) for diagnostic assessment
Semantic Differential Form (SD) for attitude assessment

Systematic Treatment, Planning
A discussion of the rationale for the research project as related to the need for systematic planning in vocational rehabilitation.

Clinical Supervision
A discussion of the dynamics of supervision during the research project, including a general introduction and specific material under the headings of:
Staff reactions to project
Staff reaction to the VSIF and SD
A closer look at staff reactions
Summary of key issues in counselling and the supervisory process
Clinical Profiles

Three clinical profiles of research project patients. The Clinical Profiles section includes:

Introduction — a general discussion of the case studies

First Clinical Profile — a patient who has been in treatment for three months, unemployed, wants to work

Second Clinical Profile — a patient who has been in treatment one year, unemployed, wants to work

Third Clinical Profile — a patient who has been in treatment more than one year, working, wants a job change.

Each Clinical Profile includes a description of rationale for selection, a short patient profile, an initial treatment plan, and discussion of the plan. In addition, the First Clinical Profile includes a revised treatment plan, and the Third Clinical Profile includes a three-month follow-up.

APPENDICES:

Appendix A: Background

A discussion of the background including major areas of impetus for the project:

Traditional attitudes

Methadone maintenance

Conflict and coordination within treatment programs

Appendix B: A Closer Look at Vocational rehabilitation within a Methadone Maintenance Program

A discussion and description of a vocational rehabilitation program within the Methadone Maintenance Treatment Program at Beth Israel Medical Center, divided into the following headings:

Introduction

Methadone maintenance treatment: A definition
The function of vocational rehabilitation counselling
Training professional and non-professional staff of other disciplines in techniques of vocational rehabilitation counselling
Delivery of vocational rehabilitation services
Identification and evaluation techniques
Community attitudes

Appendix C: Alcohol Treatment Program

A description of the Alcohol Treatment Program vocational rehabilitation services, which were modeled after the Methadone Maintenance Treatment Program.
Appendix D: Drug Addiction Service Staff Participation in Research Project

A description and discussion of DAS staff participation in the research project, with special emphasis on the similarities and differences between DAS procedures and the procedures of the research in general.

Appendix E: Vocational Structured Interview Forms for
- Methadone Maintenance Treatment Program
- Alcohol Treatment Program
- Drug Addiction Service

Appendix F: Semantic Differential Form

References

COMMENTS
These volumes reflect a concern on the part of rehabilitation services personnel... both counselors and administrators... to better understand their role in the vocational rehabilitation of drug abusers.

We have attempted to derive from current theory and practice in the field of vocational rehabilitation a base for defining a state of the art statement.

These volumes reflect only a beginning in the process of truly understanding the dimensions of this problem. We hope that they will introduce you to the constellations of factors that enter into the task of viable vocational rehabilitation programming for the drug abuser.

We hope that some of the words will engage you in furthering this process... of bringing effective social and vocational services to the addicted person.

Herbert H. Leibowitz
The Buck Stops Here

It's going to come either from NIMH on the basis of agreements worked out between State Rehab directors and NIMH treatment center directors, or it's going to come out of the state plan where it's built in...

The State Directors... these are the people who are going to change this thing...

It almost sounds as if we're calling for the kind of revitalization of a profession that has, somehow or other, become pretty encrusted... Is there a possibility of revitalizing this profession through some kind of middle management retraining?

In my own state, I'm way down the totem pole. I'm the one who is sent to all of these various drug and public offender conferences.

I think the counselors, naturally, know a lot more about what's going on than the Voc Rehab Leadership...
Defining goals in vocational rehabilitation

In our society, where work is both role and function, rehabilitation must include meaningful work. While most of the helping professions are concerned with having their patients "go to work", vocational rehabilitation is the discipline primarily concerned with enhancing the meaning of work to the individual.

The development of a treatment plan is not generally stressed in graduate or training programs. Without emphasis on developing and implementing comprehensive treatment plans, vocational rehabilitation can be diffuse and ineffective, unsatisfying, and may often foster inherently hostile attitudes toward patient care and professional roles. However, with the "focus" provided by a treatment plan, it becomes possible to consider patient care in perspective, to provide more concise material susceptible to supervision, and to allow for assessment of the course of treatment.

A treatment plan is "a written report which states the immediate and long-term goals of treatment and defines what the therapist and patient are going to do relative to each other."

This volume describes a format for in-service training and group supervision which focuses on the treatment plan as an
integral part of staff function. Personal data are needed for development of a treatment plan. Procedures for history-taking and attitude assessment, which are not stereotyped, promote interaction and provide concise records of patients' backgrounds, and current status as they relate to potential development.

These clinical tools are essential to evaluating the patient's abilities, problems, and current goals in order to develop a vocational plan. In-service training is directed toward increasing the counselor's awareness of and opportunity to express creativity in developing a comprehensive treatment plan. These clinical approaches enhance the quality of patient care.

The former addict as a vocational rehabilitation (VR) client

In a drug abuse treatment population, many patients have a limited prior working experience, little evidence of positive attitudes toward work, and a general orientation that does not include work as a clearly defined focus in life. Patients vary from those with a specific goal to those who are unstructured and unaware of any sense of direction. The counselor, in trying to strike a balance, can too often lose sight of a clear direction and, in the process of trying to engage the patient and attempting to make constructive changes, can lose clarity of purpose and move away from clearly defined goals.

Traditionally VR clients come from backgrounds that are work oriented and tend to be separated from the work force primarily because of their disability. This creates less of a distance from society in terms of a total life style and is not viewed by the community with such suspicion and hostility as is directed toward the drug abuser. Because of the perceived differences, the VR counselor may become less concrete, systematic and goal oriented and succumb to the pressure to accept the patient's interpretation of reality. It is not only ex-addict clients who are often unreliable in keeping appointments, timid about going to interviews, reluctant to accept the routine of menial jobs, and lacking in ambition. Similar to other VR clients, there is often evidence of a fear of returning to work, feelings of inadequacy and helplessness.

Approximately 15 percent of patients are able to meet their vocational goals with a minimum of assistance, and for these individuals VR services are not indicated. For an additional 15 percent, vocational services are inappropriate because of repeated abuse and chronic behavioral disturbance. Attention is therefore directed to the remaining 70 percent. There are two basic patient types within this group, those who are employed but are dissatisfied with their employment and the quality of their lives, and those with sporadic and unsuccessful work his-
tories, negative vocational experience and a panoply of personal-social problems.

The counselor's efforts are directed toward exploring the reality of the presenting requests and the patient's potential for meeting expressed goals. Within the boundaries of the counselling contract, the subsequent counselling is directed toward helping the individual explore his/her reasons for destructive behavior and find alternate modes of behavior. The objectives of counselling are to help the patient establish an identity as an employee and to secure and maintain suitable employment.

Requests for job upgrading should be approached with an emphasis on the patient's total life situation. Frequently, patients attempt to change all aspects of their life simultaneously, often after a significant positive experience. Counselling is directed at exploring the reasons for change and the best possible means of achieving expressed goals. Vocational or academic training programs may be provided. An alternate means of achieving job upgrading may be through encouraging patients to work toward promotion into a more responsible position.

**Clinical process**

The goal of the vocational rehabilitation counselor (VRC) is not solely job placement. Far more important, the counselor must help the addict develop his/her personal satisfaction, social role and earning ability. The meaning of work must be enhanced for the addict. The VRC, in order to achieve these goals, acts as a lever, focusing on the dimensions of intrapsychic development, social rehabilitation and work behavior.

Frequently great pressure is put on the VRC to gloss over this clinical planning process. When a patient requests some form of vocational assistance, the tendency may be to respond only to that need. The pressure is magnified when the patient is in a state of crisis and "the" job seems to be the salvation. Unfortunately, many former drug addicts are chronically in a crisis situation.

For example: A patient says he has to get a job. An impatient judge and a pregnant wife, apply additional pressure. Everybody else has failed. The VRC must help. It may be difficult, at that point, for the VRC to resist the crisis and the pressure. On the other hand, to attempt to get a job for the patient may not only be totally unrealistic but may lead to the creation of increased immediate problems. To try to assess the patient's needs objectively and systematically may seem far-fetched. However, formulating a picture of the patient and assessing his needs, although difficult, is requisite to treatment planning necessary for quality VR. The outcome of this assessment may well be very short-term goals. Never-
theless, these goals will exist within the context of reality and help to focus the counselor and patient toward future vocational planning.

A need for definition

Concurrently, vocational rehabilitation has become more accepted in addiction treatment. Treatment programs are requesting a means for meeting patients' vocational needs.

The community, including business and industry, is becoming involved in the VR of addicts in treatment. Various levels of government and private foundations have supported the expansion of vocational services and encourage the leadership and professional role of VR.

With the increased focus on the employment of the ex-addict, greater numbers of staff are directing their efforts toward developing expertise in the area of job development. Under pressure for guidance from these individuals, it is important, perhaps even urgent, that VR declare its goals and make the clinical procedures visible.

Towards the future of vocational rehabilitation

Perhaps it will be a relief to know that in certain programs VR has already developed an impressive record in addiction treatment. It is hoped that by considering the skills of VR methodically and systematically, VR can be helped to meet these expanding needs, the concepts of VR can be taught to others, and the benefits can be brought to greater numbers of addicts.

The procedures described in this volume are part of that process of systemization and self-examination. Although this work concerns VR of the drug abuser, and was stimulated by the needs of drug abuse programs, it is felt that the efforts of systemization are applicable for other psycho-social disability groups. The principles are the same; the tools are adaptable.

In some situations the role of the VRC is poorly understood, not visible or vague, counselling is without goals and lacks the tempo of progress. The VRC often feels isolated, overwhelmed, frustrated and disappointed. Referrals are inappropriate, employers are resistant and patients are demanding. Relationships based on trust and acquired through prolonged, diffuse counselling sessions are often fragile and tenuous.

When these problems surface in the context of program planning, in-service training and supervision, the blame for clinical failure is placed on the patient rather than on the interaction. A myriad of feelings often prevents a focus on the patient.

The key elements in this procedure include the diagnostic tools of the Vocational Structured Interview Form, which is an
interview guide (See Appendix E) and an attitude assessment based on the Semantic Differential (See Appendix P). These are used to develop a written treatment plan. The tools and plan are used as the basis for clinical supervision, in-service training or consultation.

Clinical Procedures

The process to be described has been developed to enhance VR services by emphasizing individual patient assessment, treatment planning, and the supervisory process.

In our setting we have nine professionally trained VRCs who are full-time employees of Beth Israel Medical Center working in the Methadone Maintenance Treatment and Alcohol Treatment programs. Each counselor has a Master’s degree in VR and a minimum of one year’s professional experience. Each is involved in two hours of weekly group supervision.

Assessment Tools: Vocational Structured Interview Form

To facilitate treatment planning in the VR of drug abusers, we have developed a structured interview procedure which is used for initial diagnostic assessment. It was hypothesized that such an interview outline would encourage structure in meetings with patients as well as serve as a device which could be used in treatment planning.

The form selected had been initiated by the department for a research project conducted in 1971. It had been developed to record patient information in a systematic fashion, but had not been used in clinical supervisory sessions. The form was converted for such use with minimal revisions. The wording is appropriate for our patients, the sequence is clinically sound, and there is sufficient space available to record findings.

A brief discussion of the way in which the form was developed may help give an understanding of the content.

The VSIF is intended to focus the diagnostic interview and to facilitate the recording of clinical information, pertinent to the provision of VR services. It was developed to structure the interview situation and provide systematic information on a wide variety of relevant vocational issues in a patient’s history.

The VSIF was developed by the VR staff who proceeded by selecting topics appropriate for the initial VR interview. The purpose of the initial interview is the determination of the vocational and personal/social dimensions necessary for assessment and planning. Factors of expediency and comprehensiveness were considered. Although the time required to complete the form ranged from an hour to an hour and a half, length became a secondary factor as appreciation of its clinical value increased.
Initially there were negative staff reactions to the time necessary for completion, but as they worked with the VSIF, time and length became less significant. The comprehensiveness of the material gained in one interview reduced the necessity to focus on basic historical information in subsequent meetings. The process of completing the VSIF was found to stimulate the patient into thinking about many aspects of vocational development.

Attitude Assessment

The second tool we have developed for our clinical procedures is based on the semantic differential. The staff selected paired words which relate to and are significant in VR. Some of the words were general and might be used in other fields; some pairs of words — skilled-unskilled, experienced-inexperienced — are directly related to the concerns of the VRC.

This attitude scale provides a more specific means and vocabulary for describing a patient. It is used to elicit staff attitudes towards specific patients.

Used in conjunction with the VSIF just described, the semantic differential form provides additional information for comprehensive patient assessment and development of a treatment plan.

In order to describe a patient by one of the words of a pair, it is necessary to consider the ingredients of each word. For example, a patient may be described as motivated (rather than unmotivated) to go to work. Because "motivation" may generate differing reaction, the counselor has to consider "motivation" in more specific and descriptive ways. In the process of being more descriptive, it becomes necessary for the counselor to explore feelings, attitudes and assumptions in order to assign the appropriate dimensions of a concept to a patient.

Discussions surrounding this type of attitude assessment lead to a clearer understanding about distinctions in degree in assessing accomplishments in different lifestyle environments.

The semantic differential form helps counselors to become more sensitive to and understanding of contradictions in a patient’s presentation of self. It is apparent that the counselor may need to legitimize a contradiction rather than explore the implications. Once the counselor is clearly aware of the contradictions, he/she can better help the patient to understand them.

Systematic treatment planning

All forms of therapy are interventions; they differ only in means of developing and carrying out the plan. In theory, treatment intervention requires systematized planning; in re-
ality, little attention is given to systematized planning of treatment. The consequences of failure to formulate a treatment plan are sloppiness in counselling, little objectivity, and, seemingly, an over-abundance of emotion, contradiction, competition and lack of scientific inquiry.

An integral part of treatment planning is the assessment of the needs of the patient. The assessment process includes an accurate formulation of a patient profile, including achievements and limitations. The patient has to be seen as objectively and realistically as possible. The many barriers to objectivity, whether or not they are consciously constructed, are deterrents to effective planning, and to the rehabilitation of the patient. Understanding and overcoming these barriers contribute to the counselor's overall assessment and treatment of the patient.

The availability of a written plan and specific goal orientation give counselors the chance to periodically reassess the patient's growth and needs, as well as to make the plan visible to other members of the team. The implementation of the plan becomes a means of remaining constantly in touch with a carefully thought-out approach and facilitates a closer and more realistic clinical procedure. It becomes possible to explore the reasons for individual responses and, ultimately, to arrive at a comprehensive perspective on the patient.

Clinical Supervision

The ability of the VRC to treat addicts demands both technical skill and personal integration. The job is challenging, often frustrating, and frequently laden with pressure and disappointment. And yet it can be highly gratifying.

In order to maintain a balance of the parts, and indeed to increase the opportunities for gratification, the counselor is provided with the opportunity for supervision. Supervision is directed at improving technical skills and resolving personal conflicts and obstacles to learning. For the counselor to take full advantage of supervision, a willingness to be open to growth and change is required. Although the prospect of such personal confrontation may be alarming at first, the counselor, in realizing the possible benefits, becomes receptive to addressing needs of the clients.

Supervision seeks to reduce the possibility that personal obstacles may be transferred to the client and restrict opportunities, punish behavior or exaggerate permissiveness. The more the counselor is ready to learn to develop technical skills, the better prepared he/she is to accept the client's struggle to learn and grow.

With these goals in mind, supervision has become an integral part of the VRC staff functioning at BIMC. Initially, with
a small staff, supervision was in a one-to-one situation. As the size of the staff increased, group supervision became necessary. With group supervision came the realization that learning with peers facilitates the speed and, perhaps, the depth of learning. VRCs, who often feel isolated from each other, are able to share their positive experiences as well as their problems. With a structure in which to operate, the “mystery” of VR counselling and supervision can be dispelled and patient and staff needs addressed.

The patient, as described in the VSIF, is presented in group supervision. The use of the VSIF allows the group to gain comprehensive information about the patient in a concentrated manner. It allows them to be able to formulate an objective picture of the patient, as opposed to other supervisory situations in which the presenting counselor would be called on to give a patient profile based on personal experience. Certainly, before the VSIF was used, there were many complaints of lack of awareness about the patient’s life and needs. With this structured form, it is possible for a counselor to consider a wide variety of areas of the patient’s life.

Questions left unasked or unanswered are helpful in the supervisory situation. The staff is able to examine the degree to which the “blanks” reflect the counselor’s attitude toward the patient. When a counselor gives an incomplete profile of a patient through limiting the use of the VSIF in the interview, the group is able to deal with the lack directly. They can express feelings of being deprived of information necessary to their own patient assessment. It is possible for a patient not to receive assistance because important information is deemed irrelevant by the counselor. This problem is obviated by the form’s comprehensiveness.

The style in which the VSIF is presented in the supervisory session conveys the attitude or approach to the patient held by the counselor. One staff member might review the VSIF slowly, another very quickly. It is noted that a slow reading might be reflective of hesitance to begin work on problem areas. A quick reading, on the other hand, might be a glossing over of details. The VSIF, when used in supervision, becomes a projective device. It gives the group something concrete to respond to. There is no longer a need to question omitted details; rather, the exploration focuses on quality in the approach to the patient and his/her needs.

A review of the semantic differential form and the VSIF, in the supervisory session, shows that the counselor needs clarification in defining and assessing the patient. The combination of VSIF and the semantic differential are essential in the clari-
The consequence of using both instruments is the ability to deal more appropriately with the patient.

In supervision, the structuring of clinical procedures, once implemented, dissipates the counselor's resistance to learning. Initial pressure to get a task done is soon superseded by an increased concern with assessment and planning. The structuring is beneficial to the organization of responsibilities and the realization of limitations and potentialities of carrying out a professional role. The benefits of the process are not achieved, however, without group and personal struggles. The need to continually consider the group process and reflect on problems of integration, clarity and acceptance is of prime importance to group growth.

The supervisory sessions include time for group members to discuss their learning problems and reflect on changes accomplished. The counselors begin to identify instances of increased sensitivity to verbal and non-verbal interaction with patients and are better able to explore patient needs. When experiences within the counseling sessions are connected to those in the group supervisory sessions, the need for direct, open and honest communication and a conscious response to interaction is clarified.

Direct efforts are made to enhance communications within the group and to get to the underlying dynamics of behavior. Once commitment is made, there is an increased ease in presenting patients and developing specific, creative treatment plans.

Key issues in VR counselling

Following is a summary of the factors to be dealt with in the course of the counseling process. They are considered relevant to potential clinical experiences since they represent sources of influence on the client-counselor relationship.

1. Consider addiction as a disability.
2. Focus on the details of VR and the VR needs of clients as individuals.
3. Concretely define the counselling process and establish a contract. Few ex-addicts are sophisticated about one-to-one relationships.
4. Resist making assumptions about patients. The client's need to appear positive or negative may be a denial.
5. Be influenced by the needs of the patient. The patient may not want to appear in need.
6. Listen closely to the client and be in touch with the feelings expressed.
7. Confront, question, explore what the client is asking for. The ex-addict has been subjected to much questioning but little that was positively oriented.

8. Feel a sense of responsibility for the care of the patient but not to the point where it does not allow for the patient taking responsibility for himself/herself. The dependency that often appears may be all the person knows so far. Drugs fulfilled many needs! There is a need for positive substitutes that are self-determined.


10. Counsel with creativity and expand the opportunities for the client.

11. Be willing and able to make definitive statements.

VR cannot exist in an environment that does not allow for growth and change. If a patient and a counselor are discussing the degree of responsibility necessary to function as a productive member of society, the relationship must encourage behavior which allows for this goal to be met. The addict must be helped to deal with his/her problems in an atmosphere that conveys confidence and respect. These elements are especially necessary for a group which has had little respect or acceptance from the community.

The problems of the abuser in going back to work, in any capacity, are so large and diversified that the VRC must be receptive to individual needs and the individual means for enhancing rehabilitation.
CLINICAL PROFILES
CLINICAL PROFILES

Introduction

The Clinical Profiles section demonstrates the impact of the clinical procedures on the patients for whom problems were assessed and plans developed. Three cases are presented in depth to allow for the broadest possible insight into our approach to assessment and planning.

For those who have had experience working with ex-addicts, the content may not be entirely new. Hopefully, however, “old” learning can be reinforced and expanded through the sharing of experience with others.

For those who have not had the occasion to work with the former addict, these cases may provide a stimulus to proceed and directions to consider. Styles and means of interaction may already be developed, but through the experiences of others it is possible to gain in new areas.

For the supervisor, the content of this volume represents an orientation to VR which can be implemented where appropriate. The personal and professional rewards available for the supervisor from an integrated and well-functioning team are a stimulus to further growth and development. There is a never-ending urgency to be expansive and innovative in dealing with the needs of the addict population, as well as with the staff which attempts to meet these needs.

The Clinical Profiles demonstrate that it is possible to define and implement realistic improvements in clinical services. Note should be taken, however, that improvement of old problems is often followed by the emergence of new problems.

First Clinical Profile (See page 37 for completed VSIF)

Rationale For Selection

In our setting, where admissions are on-going, there are patients who have been in treatment for three months, are stabilized on methadone but remain unemployed. This category represents a group of patients in a crucial stage of change who may well benefit from early vocational planning. As reflected by this patient, it is possible to formulate a patient profile and to consider the way in which a counselor responds to a patient who is new in treatment.

Patient Profile

Ms. X is a 43-year-old white woman, the mother of five, separated from her husband and living with a man she describes as a “companion.” The patient was admitted to the program three months ago and has been engaged only minimally in clinical activities. She claims to have become an addict many
years ago but has had no successful treatment experiences. She had many detoxifications. In addition to her drug problems, she has had three operations for colitis and has varicose veins in both legs. Ms. X has had little work experience except for several months as a chambermaid. The patient was referred to VR because she had been drug free for several months but was not showing interest in anything. Her general counselor felt that vocational activities might be helpful to Ms. X.

**Plan Formulation**

During the group supervisory session, after discussing the patient's self-presentation during the initial interview, group participants questioned details that had not been included on the form.

What was occurring during the session was a consideration of the use of the VSIF as a device for a clinical supervisory experience. The initial confrontation with the lack of completeness in the VSIF occupied much of the first session. Since the VSIF is a structuring device, its use brought out a concern for details and a need for clarity in presentation. Much energy was expanded in response to the completed VSIF and the initial patient interview.

Effort was then directed to developing a treatment plan. However, the group members were divergent in their perception of the patient, partly because of the details missing from the VSIF. When the details were provided by the interviewing counselor, the patient profile was expanded. A treatment plan developed by the interviewing counselor was presented.

**Initial Treatment Plan Presented by VRC**

1. Patient should undergo medical evaluation to determine what limitations, if any, are imposed on employment by physical condition.
2. Patient should be helped to accept these limitations and to follow through on medical advice regarding such treatment as may be prescribed.
3. Patient’s general life style should be evaluated to determine what obstacles to rehabilitation exist.
4. Patient should be helped to understand these obstacles and how they may be overcome to as great an extent as possible.
5. Patient should be helped to begin structured activity so as to learn fundamentals of work-oriented behavior.
6. Patient should be encouraged, through counseling relationship, to explore areas of interest and ability so as to widen range of vocational possibilities.
7. Patient should be encouraged to undergo a vocational evaluation so as to be exposed to a variety of work tasks which may not previously have been considered.

8. Patient should be encouraged to gain awareness of sources of satisfaction and of stress as these relate to work activity as well as to life style.

9. Through combination of counselling and evaluation, patient should be helped to understand own feelings about work and to evaluate own strengths and weaknesses.

10. Patient should be encouraged to explore possibilities and to evaluate them as they relate to increasing awareness of self as worker.

11. Throughout process, patient should be helped to bridge whatever gaps exist between vocational areas and general life style, so as to increase the meaningfulness of the vocational exploration and counselling experience.

The following discussion of the treatment plan is meant to serve the purpose of sharing the discussion process (including commentary on the relevance of the steps involved) and a few of the suggested alternatives.

**Discussion of Initial Treatment Plan**

Initially there was an emphasis on medical evaluations and an assessment of strengths and limitations in terms of ultimate vocational capacities. Although this emphasis reflected accuracy in evaluation, it was seen at first as superseding the establishment of a positive relationship. Also reflected was a "doing to" the patient rather than helping the patient do for herself. Despite the appropriateness of the plan, its value was likely to be lost because of a lack of rationale and creativity.

The group took exception to the lack of focus on engaging the patient in a counselling relationship, as well as the seemingly minimal concern about the patient's ability to interact with the environment without the use of a drug. This conveyed a feeling of optimism about the patient who had not yet experienced failure since entering treatment.

The first step in a plan for this patient might better have explored possibilities for establishing a relationship that was supportive and sought to remove the patient from a perceived sense of communal isolation. Relationships outside of treatment are often, at this point in treatment, imperceptible in terms of nature and depth. There is, therefore, a need to develop a relationship with the patient that is focused.

For this patient, Ms. X, the eventual recommendation for the first step is that the patient be accepted by the VRC in an
effort to facilitate participation in other recommended clinic activities. The next step is that the patient's strengths and weaknesses be explored in an effort to help her perceive accurately her place in her surroundings and gain a sense of self. Ultimately the exploration is expected to expose to understanding the patient's life style and the degree to which the life style would be supportive of or contrary to vocational rehabilitation.

With a basic understanding of the patient's limitations and current life style, the counselor and patient can begin to engage in vocational exploration focused on what could be done to change the current situation. It was suggested that a structured activity might help the patient learn the fundamentals of work-oriented behavior. While this suggestion was certainly valid, the means of achieving it were missing — the suggestion was vague and undefined, lacking specificity and creativity.

What might be considered is a vocationally related activity such as a school course or a volunteer job. Both of these would provide a means of socialization and structure with a minimum of stress and physical exhaustion. In addition, either would provide an opportunity for reality testing outside of the counseling relationship.

The initial plan suggested using the counseling relationship to explore areas of interest. Here again there is little acknowledgment of the patient's involvement in her rehabilitation. The patient has a narrow perspective of her own possibilities. If, however, she can be involved in her own planning, she might be in a better position to consider alternatives. Through cooperation in planning, the patient can learn about herself and the world of work. Without cooperating in planning, the patient too often perceives anything as a possibility, and, because too many alternatives are confusion, nothing is possible.

The seventh step of the initial treatment plan fits in well with the revised plan where it did not in the initial plan. In the original plan, the recommendation that the patient undergo vocational evaluation is more than questionable. There is doubt that the patient could move from inactivity to a workshop evaluation solely through the help of counseling. Even if she could, it would be expected that her learning experience would be limited.

The remainder of the initial plan dealt with gaining satisfaction with work evaluation and understanding feelings about work. As a totality, steps seven through eleven tend to be vague and redundant and can perhaps be combined into one step. Without more specificity there is a feeling of gliding along a path of increasing self-awareness with minimum
vocational orientation. This "gliding" leaves the counselor without direction or milestones of growth for evaluation and suggests little for the patient in terms of outcome.

The discussion of the initial plan focused on these issues. While no concrete alternatives were offered at the time, the need for revision was obvious. The following revised plan was offered as an approach for this patient.

**Revised Treatment Plan**

1. Elicit the cooperation of the patient to engage in a counselling relationship that is structured and oriented toward achieving a realistic vocational goal. Emphasize the support possible within the relationship. Share an understanding of the continuity of relationships in other treatment situations, especially the clinic and the patient's relationship with the referring counselor.

2. Explore, with the patient, the current life style as it reflects an environment in which vocational activities can be a realistic component. This exploration would involve a clarification of personal, social, medical and vocational activities as they enhance or limit vocational development. Encourage patient to engage in this assessment as an effort to become more sensitive to her environment and to consider it as a contribution to her life.

3. If indicated, engage patient in specialty evaluations consistent with possible limitations. In this case, a comprehensive medical evaluation should be suggested to clarify for patient and counselor the extent, nature, possible treatment and limitations of her medical problems.

4. Assist patient's engagement in a structural vocational activity which will legitimize the stated vocational development goal. Provide the patient with an opportunity to learn from her own experiences and bring first-hand material to counselling. A part-time volunteer position or one course which may be academic or avocational are suggested. Encourage patient to share these changes with companion since such changes may disrupt relationship. Offer assistance in clarifying conflicts.

5. Help patient absorb developments and growth resulting from counselling experiences, thus providing a structured learning experience. At the same time, consider with the patient the legitimate next step. At this point in counselling, the patient may have gained awareness and sense of her ability to work. If so, it is appropriate to channel this awareness in a specific direction such as...
an evaluation in a sheltered workshop which can provide a more comprehensive and definitive environment.

6. Work with the patient to adjust to new environment and to help in changing self-perception. Consider with patient alternatives recommended through this experience. Support levels of decision-making regarding definitive course.

These points are the basis of an initial treatment plan geared toward helping the patient begin to develop realistic vocational goals. There is no time limit to the individual steps. It is difficult to anticipate the speed with which change can take place, or to anticipate the degree of change. There should be an encouragement to recognize exigencies, but sight should not be lost of good clinical practice.

Once the mutual goal has been achieved, the plan can be updated to reflect the nature of the on-going relations as it relates to implementation of a more definitive course. The updated plan may include helping the patient arrange for schooling or prepare for work. It would be premature to develop such an updated plan before this preliminary exploratory course is completed.

Second Clinical Profile (See page 39 for completed VSIF)

Rationale For Selection

A significant number of individuals, in the MMTP have been in treatment one year, are unemployed, but want to work. They represent a large proportion of the patients referred for vocational rehabilitation counselling. For patients who are unable to resolve their difficulties and establish a new life style within the first year of methadone maintenance, there appear to be clinical issues which may be resolved by comprehensive vocational assessment and planning.

The clinic staff often reviews the cases of patients who have been in treatment for one year to determine plans for future treatment. It is within this context that a patient who presents the patient counselor with few achievements but a desire to lead a productive life may be referred to the VRC. The motivation of the referral is to help the patient to change the current life style, to adapt to a new way of life, and to face the future more optimistically. As is demonstrated in the following discussion, the vocational area is frequently not the only one in which there are disruptions or lack of achievements. The patient, without a grasp of a meaningful life, is often found not to have made a clean transition from a former life style. Indeed, the patient may be peripherally involved in conflicting ways of life.
Patient Profile

Mr. Z is a 36-year-old black male who became addicted to heroin at age 15. He has served more than ten years in prison. Although he has a high school equivalency diploma, he has had only a few short-term jobs. His longest "square" position was two years as a shipping clerk, four years ago. Mr. Z has spent most of his life in street-oriented activities. Since entering treatment he has been a street vendor of perfumes. He is dissatisfied with this work because the income is unstable and he is afraid of being arrested for not having a vendor's license. His wife is physically disabled and confined to a wheelchair and unable to leave their hotel room without assistance. Mr. Z expresses anxiety regarding his present situation and a desire to change to one that is more conventional and socially acceptable.

Plan Formulation

When Mr. Z's case was presented to the supervisory group there were questions about his work status which had to be clarified before any plan could be developed. Could he be considered employed? The two status alternatives that became crystalized were based on his level of sophistication. Although he was sophisticated about the street and his job as an unlicensed vendor, he was naive and inexperienced about functioning in the "square" world. This dichotomy made further clarification of him as an individual necessary in order to plan a course of treatment. To see Mr. Z as inexperienced would negate his life experiences as an addict and his present job as a street salesman; To see him as experienced would be to overevaluate the degree to which his past functioning prepared him to cope in a non-drug environment. The group was divided as to a definition of the patient in these experienced-nonexperienced, work-nonwork terms.

The group discussion focused on the need to address the degree to which one's life style is transferable as a learning experience for another drastically different life style. The group also expressed a need to understand the degree to which the counselor's norms and expectations influenced the evaluation of the patient. Conformity was apparently not Mr. Z's goal — nor need it be the goal of the counselling relationship. There was, however, a need to determine the degree of conformity desirable and realistic for this patient.

Seemingly, other individuals in a similar situation are unable to assess themselves, their feelings about work, and their role in life realistically. The only experiences that were at all clearly understood by the patient were related to a period of addiction. The treatment process had, after a year, not yet
been successful in effecting any significant life-style changes other than termination of drug use.

A basic clinical issue was, therefore, a consideration of the degree to which a patient can develop a personal identity and an awareness which will allow for planning. In order to accomplish this, or even to begin to address the issue, there is a need for the counselor to clarify his/her reactions and assumptions. Without this self-clarification on the part of the counselor, the patient cannot have a full range of vocational possibilities to consider. If the counselor can address the discrepancies and ambiguities as they are received, the patient can have the benefit of reality testing in a supportive situation.

In the case of Mr. Z, the use of the semantic differential was essential to accurately describe feelings and come to terms with the patient's realities and the degree to which they influence his life. Some of the words used to describe Mr. Z, by those who saw him as experienced and sophisticated, were active, strong, industrious, flexible, serious and talkative. Counselors who saw him as inexperienced and naive described him as weak, calm, staid and serious. In addition, there were questions as to his level of hesitancy and cautiousness. Further discussion led to a clarification of Mr. Z's profile as that of a person apparently in great conflict, living between two worlds, neither of which was strong enough to cause more movement than an appointment with a VRC. It was agreed that Mr. Z was ambivalent about change, that it would take a long time before he could clarify his position and legitimate his desire to change. Certainly, the degree to which he felt in crisis would have a bearing on the outcome of his treatment.

The treatment plan went through many revisions as the counselors worked on a theory that would be suitable for working with this patient. The treatment plan shown here is the last revision.

Revised Treatment Plan

1. Work with patient toward developing a trusting relationship through which the patient can be helped to feel more confident and consider the possible changes he wishes to make in his life. The relationship would provide acceptance "off the street" where structure, limits and goals can be established.

2. Consult clinic staff about the patient's physical condition and support patient in following through on recommended medical treatment. This consultation will assess the degree of liver damage present and its potential limitations for the patient.
3. Explore with patient his present life style and help him clarify and evaluate its advantages and disadvantages. The exploration should address the patient's need to increase his self-awareness and evaluate what he has learned on the street. Through such evaluation he may begin to see what he has to give up and what he may gain from changes. He will have an opportunity to make whatever decisions he can, based on more logical input than has been available to him.

4. Explore with patient his present and past work experiences. An exploration of past and present work experiences will help the patient broaden his scope of occupational information. In addition, he may come to learn what skills have been involved in his work, and to understand whether or not these skills can be related to possible vocational desires.

5. Consider, with the patient, alternative work possibilities available as a means of seeing the realities of more structured work. A part-time or temporary job might provide a meaningful experience, a reliable income and a source for further discussion.

6. If the patient is able to accomplish the preceding goal, discuss the meaning of more conventional work-oriented behavior. The discussion should be concrete and related to patient's present work. The discussion would help the patient relate his strengths and weaknesses to a more conventional work situation.

If the patient is able to achieve success in these efforts, the following long-term goals might be considered:

1. Explore the possibility of and the patient's feelings about further evaluation and/or training. The outcome of this exploration will ultimately determine a further course of treatment. The degree to which the patient wishes to change, with the opportunity to consider alternatives, will relate to a subsequent referral.

2. If the patient is agreeable to a further exploration of change, this might include an exploration of his current social relationships and the degree to which a major change might affect them. This exploration might include involvement in a group which would consist of individuals interested in attaining a structured work experience. It might also include a referral for vocational evaluation or direct full-time job placement. Referral or placement would depend on the patient's desire to achieve long-term goals. If more immediate steps are
indicated, referral to a job with on-going counselling contact might be suitable. If the needs are less immediate, exploration in a workshop might be appropriate.

**Third Clinical Profile (See page 41 for completed VSIF)**

**Rationale For Selection**
Job satisfaction and consideration for upgrading are integral to high quality VR. There are patients in treatment more than one year, who are working, but want a job change. These individuals have made an initial satisfactory adjustment to the Methadone Maintenance Treatment Program but want to improve their life situation, especially vocationally. In most instances the interest the patient expresses, in terms of VR, is to have an opportunity to explore alternatives to his/her current work situation. It sometimes develops, however, that the patient is asking for more than a job change and that he/she may be experiencing problems in areas of socialization and leisure time activities. The desired vocational changes are the focus of contract with the VRC.

**Patient Profile**
Mr. X is a 22-year-old, well-dressed, white male who has completed the tenth grade. Mr. X became addicted at 15, but was never incarcerated. He has been on MMTP for four years and has been employed as a night elevator operator, on the same job, for three years. He had training in printing and courses in electricity in high school. Mr. X lives with his mother and four siblings. He is engaged to be married; his fiancee lives out of the city. He expresses interest in returning to school and establishing himself in a better job. Although he is responsive and eager for assistance, he is unanimated in his self-presentation.

**Plan Formulation**
The initial discussion of Mr. X revealed a dependent individual, living with his mother and four sisters, who was being encouraged by his fiancee and her father to improve himself vocationally. He presented no conscious acceptance of his achievements while on MMTP despite the fact that he was no longer continuing his seven-year addiction history. It is important then to help him evaluate his strengths and weaknesses as they influence his present situation and his future goals.

Exploration with VRC will make it possible to consider alternatives for employment or education that might be available for Mr. X. It is important to understand that a counselor’s clarity of treatment goals and approach have a significant ef-
flect on treatment outcome for the patient who conveys ambivalence about making a change.

The patient was seen as having his addiction under control, maintaining employment and considering career alternatives. On the other hand, he was cautious in his approach — two training program attempts were not completed — and needed to be urged by others to make changes. In addition, Mr. X was considering many different changes at the same time: getting married, moving out of state to a rural area, returning to school. His approach to change reflected some elements of a generalized "breaking out", but lacked clarity of design and purpose.

As the counselors described their perceptions of the patient, insight was gained as to the need to avoid assumptions about him. Instead, counselors found that he should be encouraged to explore alternatives and that the counseling relationship should include the sharing of the need to establish priorities in order to help the patient direct himself appropriately.

Insights into this patient are relevant in different ways for other patients in a similar situation. The basic need is to develop a realistic picture that neither punishes the patient for not being someone he isn't, nor overestimates him because of his accomplishments.

Job up-grading is an anxiety provoking concept that is unfamiliar to many addicts and may generate anxiety in professionals as well. It is necessary, therefore, to develop a sensitivity to the inherent dynamics of job up-grading. What is constructive change? What personal awareness is necessary to decide on a change? What role do prestige and status play in job change? Can the capabilities of the patient be over- or underestimated by the counselor and/or the patient? With what consequences? How far can someone the counselor sees as a patient move out of the mold of "patient" without generating inappropriate judgmental elements?

**Initial Plan**

1. To establish a counseling contract and begin exploratory vocational counselling to help patient continue his vocational development. Begin by focusing on his likes and dislikes about jobs, his successes or failures and what he has learned from them as a basis for thinking about a future field of work. Discuss with patient his feelings about changing his life style in relation to himself, family, and future marriage. Discuss hobbies, school, history, earlier vocational interests.

2. Skill assessment. Probable vocational and aptitude testing, followed by discussion.
3. Probable referral or encouragement for patient to pursue areas where remediation may be needed in preparation for high school equivalency diploma.

4. Continued counselling to involve patient in active pursuit of possible area of training.

5. Training with continued counselling to integrate specific training experience with vocational goal. Help patient to continue to explore possibilities in rural areas.

6. Placement.

Discussion of Initial Plan

This plan indicates that the patient was seen as flexible and dependable and the counselor would take an active and directive role. The expectation was that, given the opportunity, the patient would do what was needed to be done.

The first step in the plan made many assumptions about the patient and the possibility that his past could be "lumped together". There was no flow nor progression in establishing a plan for treatment. Although the patient was seen as flexible, he was not given much room for flexibility.

There was no emphasis in the plan as to the patient's individuality, nor was there an anticipation of the anxieties he might be feeling about making a major change. It is important that he not go too far into anything without knowing what he's doing and why. Who is he? What does he need? What may be some of the obstacles he may face?

The recommended point of engagement then became one that was related specifically to this individual and the purpose of the relationship to him. Since he was perceived as having accepted much of what had been suggested to him in the past, it might be more realistic to try to help him make a decision and relate more independently. How much of the present job reflects his ability to function only in a low-level, unskilled, dependent type of job? Perhaps a change would be harmful to his present level of integration.

An additional questionable area is the primary consideration that training is the alternative, assuming he does in fact decide to make a move. There was no consideration that the alternative might be a different job at a new company or a better job with his present employer. Another possibility is that he might best stay where he is and consider other, non-vocational outlets that would satisfy other needs. Many people who work at night do so to stay disengaged from the mainstream.

Profile and Revised Treatment Plan

Since it had been ascertained that he might be experiencing anxiety and fear in relation to his desired vocational change, it
was decided that the treatment plan attempt to explore with the patient possible areas of pressure. Pressures that patient feels might be coming from external sources as well as or in addition to internal ones.

1. Establish relationship by focusing attention on patient's feelings concerning his anticipated change. What and who is pressuring him to change? What demands are coming from within, which from without? What does he really feel he wants to do?

2. Patient may be somewhat ambivalent and frightened about this type of exploration, but he will probably accept it and get involved in an assessment of his vocational needs and interests. It will then be necessary to explore and enhance the range of possibilities. The facilitating process will require support and clarification. Expansion of leisure activities may be indicated.

3. Work with general counselors through conferences and discussions in the agreed plan of treatment. This will alert everyone to patient's work with VR counselling and would support consistency of approach.

4. If some movement is acceptable, consider referral for equivalency diploma.

5. Assist patient in terms of a skill assessment and evaluation to determine range of abilities and interests. This can include reviewing reading material, want ads, visiting schools, or a workshop evaluation.

6. Help patient to make a choice and help integrate it into his general life style.

Three-Month Follow-Up of This Patient

The patient was presented to the group again three months after the development of the treatment plan. The follow-up concentrated on the patient's status, with special emphasis on any changes that occurred. Attention was directed at the original plan in an effort to determine the accuracy of assessment and planning, the implementation and suitable revisions.

Here, we have focused on these elements by presenting the course of events over the past three months, an integration of events, an analysis of different approaches that might have been tried, and, finally, a revised plan.

Course of Events

During the three-month period the patient was seen by the VRC in five counselling sessions. The first session began to establish a relationship in which future goals could be explored and developed. It was apparent at the first session that the
patient did not have job change as an immediate goal, but rather was expressing an interest in change in general.

As the range of possibilities was introduced to him, however, his ambivalence and fear in the face of the alternative became obvious. He expressed a need to be concrete and to have direction. He began to feel pressure to make a definitive step and was not capable of exploring the sources of pressure. In addition, he could not see that if he moved in haste or without confidence in response to the pressure, he could limit his future possibilities. He did make a choice, however, and his requests were legitimate and seemingly realistic.

He was supported and encouraged in his efforts to return to school for his high school equivalency. He is at present enrolled in a program and is attending school four days a week. He is very satisfied with this step and finds a positive alliance with school and its ability to make him feel productive.

The patient is currently expressing an interest in college or trade school. The reality of either of these goals is being explored with him. The patient has also begun to explore apprenticeship programs where training is offered and is referring to vocational information sources for further clarification. He was also encouraged to attend an electronics exhibit—an area of expressed interest—at a local show. The plans in this area are vague and tenuous at this time. While the patient says he wants to explore possibilities, it is the counselor’s impression that he is just looking for something in order to “answer them when they ask me what I’m doing.”

**Interpretation of Events**

Despite the advances he seems to be making, there is concern on the counselor’s part as to the patient’s level of vocational identification and satisfaction. At this point the most that can be done is to point this concern out to the patient when appropriate and encourage more self-awareness and assuredness.

The patient expresses concern that he is doing nothing. Part of this concern can be alleviated by making significant vocational progress. The other part relates to feeling good about himself—and that is more difficult for him to accomplish.

An issue that remains a conflict is how much freedom of choice and independence can be encouraged for the patient without sacrificing quality. There is a constant need to legitimize the sense of progress he is feeling, as well as his need for clarification and precise direction. At the same time, there is a need to explore his range of possibilities as much as is possible. The counselor must understand the obstacle created by the patient’s ambivalence.
It has also been important to maintain continuity with the clinic staff in terms of the patient's total care. The patient has expressed a desire to reduce his methadone dosage. This reduction, occurring at a time when many other major changes are imminent, will necessitate much support of and sensitivity to potential problem areas.

Alternate Approaches

The approach stimulated by the discussion of the patient refers more to establishing clarity of purpose and more concrete situations to which the patient can respond. It is apparent that too much independence and exploration is anxiety-provoking and limited in achieving a successful outcome. It is, therefore, necessary to reduce the more open discussion and exploration and focus instead on specific areas related to vocational and personal changes. Issues related to personal satisfaction may be explored through encouraging structured leisure time activities and opportunities for satisfaction. Concurrently, alternative means of vocational development should be introduced in an effort to engage the patient more completely in the consideration of further growth and development. Focus on the patient's present life style may aid him in achieving more of an identity on which to build.

1. Continue to support and encourage patient in his effort to evaluate and change his present situation. Explore his present life style, including social and vocational aspects, in an effort to enhance his positive identity.

2. Follow up his achievements in his high school course as a means of positive feedback. Use this experience as a means of reality testing and analysis for further growth and development.

3. Consider possible referral for vocational testing and to a workshop for a short skill evaluation if this is indicated. Help patient relate to positive aspects of performance that he demonstrates. Help identify them as improvements that can fit into his present life.

4. Support efforts to continue education or change jobs as evaluation: behavior and interest indicate.
PROJECT RESULTS

Value to patient

The ultimate value of the procedure is evident in the improved quality of the VR service provided to the patients.

The range of possible service to the patient was increased because the counselors benefited from the structure and planning elements as well as encouragement and technical assistance of peers and supervisor. Through the supervisory process, group members had an opportunity to experience each new patient clinically and objectively, and thus were in a better position to explore the treating counselor's clinical procedures. The frequency and intensity of clinical presentations expanded the scope of patient contact, thereby increasing the opportunity to learn about a variety of problems and approaches.

The structuring of the interview and the systematic development of a plan established a framework for the patient-therapist interaction. This structuring is crucial in work with former addicts who frequently have difficulty in communication, often lack clarity of purpose, and express eagerness for rapid gratification. As the counselors stressed the concept of planning in the counselling sessions, the ex-addict became aware of personalized goals and responsibility, and the effort required to achieve the goals. In moving toward goal definition, the patient's trust of the VRC can be based on accomplishments.

This value of the systematization of individual patient needs can be better understood through the following points:

1. The focusing provided by the VSIF reduced the time needed for the initial assessment process. One counselor reported finding out more about a patient in one interview using the VSIF than in months of counselling sessions. The staff in our setting finds the VSIF a significant contribution. It elicits a large amount of relevant information in a concise manner.

2. Treatment planning is facilitated by integrating the material obtained. Counselors can utilize diagnostic tools to establish a realistic profile of the patient. Complexities within the counselling relationship, often missed without the opportunity to have a clear and objective perspective, were an invaluable source for realistic and creative planning. When this process can be shared with peers the communication of clinical skills improves patient care.
3. The enormity of the counselling process becomes manageable by focusing attention and directing effort. The counselors are better able to see the patient in a vocational perspective. The personal/social problems which might have consumed much of the counselor's attention are now shared with the appropriate members of the OPD team. This allows the VRC to maximize VR efforts with the patient.
Appendix A

Background

In 1973, at a conference designed to consider the state of vocational rehabilitation of former drug abusers, professionals shared a wide variety of experiences. One outcome of the conference was a five-volume series entitled *State of the Art of Vocational Rehabilitation of Drug Abusers*; a second was the stimulation of the research described in the present volume. The research is, basically, a pilot demonstration of selected techniques available to enhance the provision of VR service. Specifically, the research is concerned with techniques of patient assessment and treatment planning and the supervisory process.

Although the conference served as immediate stimulus for the research, it would not have been completed without the impetus provided in a number of other ways:

1. Personal experience with VR of drug addicts.
2. The advent of methadone maintenance treatment.
3. The increase in government supported jobs for ex-addicts.
4. An increased understanding, personal and field-wide, of the need to be more specific and less subjective in the VR of addicts.
5. An increased acknowledgment, by the profession and the community, of the problem of VR for drug abusers.
6. An increased number of requests for guidance and guidelines in the field of VR of drug abusers.

The following “Considerations” section will discuss and connect some of these points and help to give a “why-to” background to the more “how-to” oriented section discussed earlier.

**Traditional attitudes**

Addiction has traditionally relied on medical treatment and the counselling support of ex-addicts. Addicts are, of course, accustomed to self-medication and treatment. They resist outside efforts of rehabilitation and recidivism is high. The community has not made the problem easier; it has not been willing to accept, or re-accept, the ex-addict. Explicit aid has been even more difficult to obtain.

**Methadone maintenance**

Methadone maintenance treatment makes it possible for the individual to remain in treatment for extended periods of time, and be receptive to rehabilitation. Understanding the meaning
of work for the addict, and treating his her many work-related problems, have begun to be recognized as important treatment objectives. Professionals who work in methadone programs are finding that a return to work is, for the addict in treatment, an integral part of treatment.

Conflict and coordination within treatment programs

Therapeutic communities have not, traditionally, had a vocational orientation. In therapeutic communities the emphasis is most often either on separation from the community, or on a reliance on problem-solving through therapy. In methadone maintenance programs, there is a medical approach, with the fundamental goal being rehabilitation. Vocational rehabilitation is an integral component. In these, as in other rehabilitation programs, the ultimate goal is that the patient not return to a disruptive state. Instead, the patient is encouraged to achieve a more personally and socially acceptable life style.

The goals are, of course, compatible with the goals of VR. Success, to the VRC and to others concerned with more qualitative changes, extends to accomplishing a realistic level of employment in a steady job, with a steady source of income and personal income.

Appendix B

A Closer Look at Vocational Rehabilitation within a Methadone Maintenance Program

Introduction

The 1968 Amendments of the Vocational Rehabilitation Act (P.L. 90-391) expanded the criteria for eligibility to include the disadvantaged person. Under that new definition, individuals with a history of addiction became possible candidates for VR services. VR could reach out, on a national level, to a neglected part of society.

The task of defining a place for VR within addiction treatment has presented a need for continually stating, restating and clarifying the roles, goals, and potentialities of VR for the addict. The major obstacle to the provision of service lies in a conflict between a tenet basic to VR and a basic condition of the addict. The key word is time. The process of VR takes time, but addicts are almost always in a hurry. And often, staff members working with addicts are in a hurry.

In the midst of the urgency of the drug addict, the drug problem, and the treatment of the addict, VRCs are struggling to solve the problem of time — without sacrificing quality for
The following points reflect that struggle on the part of VR at the Beth Israel Medical Center Methadone Maintenance Treatment Program.

1. **Methadone Maintenance Treatment: A Definition**

   A methadone maintenance patient has a history of opiate addiction and is either currently on or has been on a maintenance dosage of methadone in an effort to become free from addiction through the blocking of the "high" and "craving" qualities of heroin.

   Methadone maintenance is a medical approach to opiate addiction. For this reason, methadone patients have characteristically been seen as individuals for whom the use of methadone in maintenance treatment has been the answer. Evidence, however, has shown that methadone is not enough for many patients. For them, once the addiction has been dealt with, the pressures of daily living surface and can be handled only with extreme difficulty.

   One of the most striking pressures is the problem of employability, both as a goal for patients to achieve and a concept for the community to accept. Patients and staff have a difficult time defining and then treating these occupational problems. It is equally difficult for them to deal with the community's response to accepting and employing the former addict.

   In the face of these problems, Vocational Rehabilitation Counselling has become an essential element of support within the methadone maintenance treatment program.

2. **The Function of Vocational Rehabilitation Counselling**

   The VR department faces eight primary responsibilities:
   - to provide counselling and guidance to patients to obtain and maintain suitable employment.
   - to assess patient vocational needs.
   - to provide non-VR staff with training in meeting the vocational needs of the patients.
   - to develop and explore relationships with community agencies for evaluation, education and training.
   - to establish and broaden placement opportunities.
   - to lessen the discrimination which confronts methadone patients.
   - to develop vocational information and resource files.
   - to evaluate and improve VR services.
3. Training professional and non-professional staff of other disciplines in techniques of VR Counselling

The concepts of VR are seemingly alien to people not in the profession. The need felt by the non-VR staff for immediate results has always been an obstacle to the full inclusion of VR services within a basic program. The most often heard rebuttal to offers of counselling and guidance, evaluation and exploration of vocational goals is, "But he needs a job now. If he had a job everything would be okay." It really would be miraculous if all he needed were a job.

The patient's daily contact is with his/her clinic counselor. It is in this relationship that he/she should begin to address his/her concern regarding confrontation with the business and industrial community. The clinic staff needs to become aware of the complexities associated with work — to become sensitive to vocational adjustment as a rehabilitation goal.

It is the responsibility of the VRC to train non-VR staff to be aware of and able to deal with the reality of the value of work. Patients often present deep-seated problems about employment. Helping patients to prepare for entry into the labor market requires attention to the psychological components of job readiness, job satisfaction and work adjustment. The training of the non-VR staff to focus on these areas so that they can help patients to delay gratification and take transitional steps is the responsibility of the VRC — and an on-going struggle.

4. Delivery of VR services

The delivery of VR services takes place, of course, through its counselors. Delivery is divided between direct patient care and the provision of information. The services to be delivered are a response to surveys of patient characteristics and needs, those expressed and those anticipated, as well as individualized experiences.

In the context of direct patient care, it is necessary to work through the non-VR counselors. The VRC attempts to assist in the definition of the vocational problems the patient is experiencing. Suggestions may be offered to the primary counselor for follow-up, or referral may be made if the patient's problems appear complex enough. If the referral is made, the rehabilitation counselor will continue to provide counselling services to the patient until the vocational goal is achieved. Often this includes efforts directed at overcoming feelings of inadequacy and isolation. A major objective of counselling is to help the patient establish a realistic identity as an employee and to engage in vocational planning.
Efforts that are taken to communicate vocational information within each clinic include:

- the sharing of patients' clinical experiences with the staff.
- the provision of basic resource material.
- the encouragement of staff to utilize available resources.
- the holding of formal and informal discussions about patients.
- the announcement of training and employment opportunities.
- the maintenance of an on-going vocational information notebook and file.
- the maintenance of a vocational information bulletin board.

In all of these areas, attention should be given to a delivery system that maintains a personal flavor. This necessitates that the VRC should be seen as a member of the team and function as an integral part of the staff.

The VR department has been designated as the focal point for establishing rapport with the business sector, to develop jobs, to address issues of discrimination and to attack the many barriers to employment of the addict, such as bonding, licensing and certification. The complexities are in direct proportion to the business and industrial community's willingness to hire the ex-addict and the program's ability to supply qualified and reliable people.

5. Identification and evaluation techniques

A pilot survey reports on the difference between working and non-working Methadone Treatment Program patients. The objective of the survey was to improve rehabilitation services through a better understanding of the patients' needs and interests. The survey found that approximately two-thirds of patients in treatment from one to two years were employed. Significant problems, however, in the areas of work adjustment and job satisfaction continued to exist for these patients. The most serious problems concerned job satisfaction, awareness of potential for vocational growth and development and use of leisure time. Conflicts continued in terms of changing a lifestyle and comfortably returning to the community. The non-employed groups of patients were seen as needing a full range of vocational rehabilitation counselling.

6. Community attitudes

Aside from the patient's psychological readiness to start work, the business community, consciously or not, presents a myriad
of barriers to the attainment of meaningful employment and acceptance. These barriers are most often seen in terms of employment discrimination, bonding, licensing, and refusal to hire an ex-addict with a long criminal history and at present maintained on methadone. Whether the discrimination is toward the history of addiction and convictions or the methadone status itself, the destructive effects are the same.

Discrimination is also felt in facilities for leisure time activities. Most centers are unwilling to include an ex-addict. Those that do accept ex-addicts present enormous bridges for the patient to cross. It is our belief that treatment programs have the responsibility to ease this gap as a further rehabilitation goal. Patients, working out, express widespread dissatisfaction, loneliness and isolation in regard to leisure activities.

Efforts have been directed toward establishing contact with employers and employment agencies who would be agreeable to permitting a patient to present himself honestly and providing him with equal opportunities in employment. Legal means have been sought to change legislation and attack possible discriminatory experiences of patients, but returns from these efforts are slow.

Appendix C

Alcohol Treatment Program (ATP)

One member of each of the two groups described in the body of the report works in the Alcohol Treatment Program. The ATP is designed to offer comprehensive services to people residing or employed in the lower Manhattan area. It consists of three main elements: a 50-bed detoxification unit, an out-patient clinic with a patient population of 500, and a 50-bed residential halfway house.

The in-patient unit provides seven days of hospitalization and for many reflects the means of entrance into the program.

The out-patient clinic is the appropriate form of long-term treatment for most patients. It is equipped to provide a broad range of services — medical diagnosis and treatment, psychiatric consultation, social services and vocational rehabilitation counseling, recreation and occupational therapy. These services are integrated with other existing community resources. Within the out-patient clinic the patients may use Antabuse as they choose and/or may attend Alcoholics Anonymous as they choose. The clinic is available seven days a week.

The halfway house provides service through comprehensive residential treatment. The individual patient may enter the
house directly or can come on referral from the out-patient clinic. The services provided include individual and group counselling, recreation, social service and vocational rehabilitation. In this facility Antabuse is prescribed for all residents. The majority of the residents stay in the house for up to six months; however, this is voluntary.

The individual, ATP patient has the benefit of services from the generalized and specialized staff members. As in the description of the MMTP, the role of the VRC in this setting is to act as a resource person and a consultant to the staff, and as a practitioner to patients whom the staff sees or who see themselves as being in need of VR services. In the halfway house the VRC assumes responsibility for general counselling as well as special vocational services.

For further reference to the functioning of the VRC in the ATP, one would look to the discussion of the MMTP, since the MMTP was the model for VR in the ATP. A special element that has been added to this program is a comprehensive pre-vocational program which exists within a day-room setting. This includes simulated work experiences in clerical tasks and in the operation of a commissary. In addition, a teacher, assigned by the Board of Education, provides a five day a week high school equivalency course. These services have provided a means for engaging the more isolated and unskilled patients in activities that pave the way toward more advanced rehabilitation.

Appendix D

Drug Addiction VR Staff Participation in Project

A third group that participated in this research consisted of the VRCs who work on the Drug Addiction Service (DAS), a three-week heroin detoxification unit located in the Morris J. Bernstein Institute of Beth Israel Medical Center. The facility is primarily geared toward brief hospitalization with an emphasis on medical treatment and counselling which focuses on developing suitable plans for after-care. A typical patient stays in the hospital for eleven days, the amount of time necessary to detoxify from heroin and other substances of abuse. The goal, however, remains to try to provide a vital component of drug treatment, detoxification and the opportunity to explore alternatives. Many patients return to this facility time and time again, repeatedly failing in their rehabilitation and requiring further care.
The staffing in DAS is essentially generic in nature, with the entire team—sharing in the responsibilities of patient care. The disciplines that are represented are, in addition to medicine, psychiatry, nursing, social service, occupational therapy, recreation therapy and vocational rehabilitation. All staff members have a case load and provide the full range of services, while concurrently introducing their special skills either to their patients or the patients of other staff members who may need this expertise. In this way the VRC, for example, has a case load and also develops activities and services suitable to the needs of all the patients. This may include introducing pre-vocational activities, educational programs, resources for referral, and the evaluation of individual skills and interests.

In preparation for this project, it was essential for the vocational rehabilitation staff to re-clarify the role of VR in DAS. This proved beneficial both as a stimulus and as a consolidating technique. The outgrowth of this was the development of a form similar to the VSIF, but one that reflected their particular needs and concerns for emphasis in planning. The development of the form proved to be a positive and integrating experience.

The majority of the time these counselors spend is in generic functioning, and not as VRCs. They had problems, therefore, in integrating the two and functioning as professional VRCs. However, in examining their skills in the generic capacity, problems also appeared in terms of being in touch with what the patient is saying. They were not approaching counselling as a clinical process. An attempt was made to help the counselors become more aware of what they are doing, and how they can help the patient beyond simple maintenance.

Appendix E (Pages 43-48)
1. VSIF for Methadone Program
2. VSIF for Alcohol Program
3. VSIF for Drug Addiction Service
   (Enlarged copies of forms available from authors)

Appendix F (Page 49)
Semantic Differential
References


VOCATIONAL STRUCTURED INTERVIEW FORM

PATIENT'S NAME

ADDRESS

DATE OF BIRTH

AGE

SEX

DATE

FEMALE

LENGTH OF TIME LIVING

IN NEW YORK CITY

YES

ETHNIC

WHITE

OTHER

BLACK

Puerto Rican

VOCATIONAL STRUCTURED INTERVIEW FORM

PATIENT'S NAME

ADDRESS

DATE OF BIRTH

AGE

SEX

DATE

FEMALE

LENGTH OF TIME LIVING

IN NEW YORK CITY

YES

ETHNIC

WHITE

OTHER

BLACK

Puerto Rican

EDUCATION

1 2 3 4 5 6 7 8 9 10 11 12 HS. GRAD EQUIVALENCY

— Y — N COLLEGE

MAJOR IN, HIGH SCHOOL

MAJOR IN COLLEGE

TRADE SCHOOL OR TRAINING PROGRAM

COMPLETED SUBJECT

— Y — N

TRADE OR PROFESSIONAL LICENSE (SPECIFY)

CURRENT UNION MEMBERSHIP

LIVING SITUATION:

ROOM (HOUSE) — OTHER (SPECIFY)

OWN HOME — HOTEL — APARTMENT

MARITAL STATUS

SM

— W

— NM

SEP

D

NUMBER OF

ALONE

FRIEND

DEPENDENTS — M — F

OWNERSHIP

RENTAL

SOCIAL SECURITY PHYSICAL LIMITATIONS

— Y — N

SOURCE OF INCOME

AMOUNT: $/WK

WELFARE

NUMBER TIMES CONVICTED

MONTHS SERVED

CURRENTLY ON

PAROLE

PROBATION

CASE PENDING

— Y — N

AGE ADDICTED TO HEROIN

OTHER SUBSTANCES USED DAILY BEFORE MMTP

DATE APPLIED

DATE ADMITTENT MMTP TREATMENT

EMPLOYED AT ADMISSION BIMC

Y — N

FREQUENCY OF PICK-UP & TIME

WORK

YS — N

SUPERVISORY

USUAL LINE OF WORK PRESENT STATUS (RE: WORK)

NONE

W. FULL-TIME

W. PART-TIME

PRESENT OCCUPATION

DATE BEGAN

WHEN WAS LAST JOB

LENGTH OF LAST JOB

2

YES

900

2 MONTHS

HOW OBTAINED

JOB DUTIES

HOW OBTAINED

JOB DUTIES

REASON FOR LEAVING

HUSBAND

CHAMBERMAID

WENT BACK TO HUSBAND

PLEASE RATE PRESENT OR LAST JOB

EXCELLENT — POOR

YOUR SATISFACTION WITH JOB

FAIR

YOUR EMPLOYER

GOOD

CO-WORKER RELATIONSHIPS

GOOD

WORKING CONDITIONS

FAIR

PROMOTIONAL OPPORTUNITIES

POOR

YOUR SUCCESS

GOOD

YOUR SALARY

FAIR

HOW WOULD YOUR EMPLOYER RATE

YOUR WORK

POOR

WHAT SKILLS WERE REQUIRED FOR JOB

CLEANING

ARE THE DEMANDS ReasonABLE

Y — N

SALARY: $/HR $/WK UNION POSITION

YET — Y — N

PLEASE RATE PRESENT OR LAST JOB

EXCELLENT — POOR

YOUR SATISFACTION WITH JOB: FAIR

YOUR EMPLOYER: GOOD

CO-WORKER RELATIONSHIPS: GOOD

WORKING CONDITIONS: FAIR

PROMOTIONAL OPPORTUNITIES: POOR

YOUR SUCCESS: GOOD

YOUR SALARY: FAIR

HOW WOULD YOUR EMPLOYER RATE

YOUR WORK: POOR

WHAT SKILLS WERE REQUIRED FOR JOB

CLEANING

ARE THE DEMANDS ReasonABLE

Y — N

SALARY: $/HR $/WK UNION POSITION

YET — Y — N

PLEASE RATE PRESENT OR LAST JOB

EXCELLENT — POOR

YOUR SATISFACTION WITH JOB: FAIR

YOUR EMPLOYER: GOOD

CO-WORKER RELATIONSHIPS: GOOD

WORKING CONDITIONS: FAIR

PROMOTIONAL OPPORTUNITIES: POOR

YOUR SUCCESS: GOOD

YOUR SALARY: FAIR

HOW WOULD YOUR EMPLOYER RATE

YOUR WORK: POOR

WHAT SKILLS WERE REQUIRED FOR JOB

CLEANING

ARE THE DEMANDS ReasonABLE

Y — N

SALARY: $/HR $/WK UNION POSITION

YET — Y — N

PLEASE RATE PRESENT OR LAST JOB

EXCELLENT — POOR

YOUR SATISFACTION WITH JOB: FAIR

YOUR EMPLOYER: GOOD

CO-WORKER RELATIONSHIPS: GOOD

WORKING CONDITIONS: FAIR

PROMOTIONAL OPPORTUNITIES: POOR

YOUR SUCCESS: GOOD

YOUR SALARY: FAIR

HOW WOULD YOUR EMPLOYER RATE

YOUR WORK: POOR

WHAT SKILLS WERE REQUIRED FOR JOB

CLEANING

ARE THE DEMANDS ReasonABLE

Y — N

SALARY: $/HR $/WK UNION POSITION

YET — Y — N
| PREVIOUS MEDICAL TREATMENT OR HOSPITALIZATION | X | YES | NO |
| POSITIONS HELD 5 YEARS PRIOR TO ADMISSION | | |
| POSITION | AT HOFFMAN-LORIAN | DATES | 1971 |
| HOW OBTAINED | HUSBAND | WHY LEFT | WENT BACK TO N.Y. |
| SALARY | $2.25/hr |
| HAVE YOU EVER HAD JOB COUNSELING | Y | N |
| IF YES: WHERE | | |
| WHEN | | |
| WHAT HAPPENED | | |
| SINCE ADMISSION HAVE YOU USED ANY DRUGS OR ALCOHOL | Y | N |
| IF YES: SPECIFY WHAT | | |
| FIRST 3 MONTHS ONLY | Y | N |
| IF YES: WERE YOU WORKING | Y | N |
| IF YES: HOW OFTEN | | |
| HAVE YOU EVER HAD JOB TESTING | Y | N |
| IF YES: WHERE | | |
| WHEN | | |
| WHAT HAPPENED | | |
| ONCE ENTERING MMTP HAVE YOU BEEN ARRESTED | Y | N |
| IF YES, WAS IT DRUG RELATED | Y | N |
| HOW MANY TIMES | | |
| IF NOT DRUG RELATED WHAT WAS CHARGE | | |
| LAST TIME | | |
| WERE YOU | Jailed | PROBATION | OTHER |
| DOES METHADONE AFFECT YOUR ABILITY TO WORK | | |
| — POSITIVELY | — NEGATIVELY | — NOT AT ALL |
| WHO DO YOU ASSOCIATE WITH AT WORK | | |
| DO THEY KNOW MMTP STATUS | | |
| DOES EMPLOYER KNOW MMTP STATUS | Y | N |
| DOES PERSONNEL OFFICE KNOW MMTP STATUS | Y | N |
| WOULD YOU WANT THIS KNOWLEDGE OR LACK OF KNOWLEDGE TO BE DIFFERENT | Y | N |
| IF YES: DESCRIBE | | |
| WHAT WOULD YOU LIKE TO BE DOING IN THREE MONTHS | | |
| ONE YEAR | | |
| FIVE YEARS | | |
| DOES YOUR BEING ON WELFARE DISCOURAGE YOUR GOING TO WORK | Y | N |
| HOW: | | |
| WHAT IS THE BIGGEST PROBLEM TO OVERCOME IN OBTAINING A JOB | MY EDUCATION |
| WHAT HAS MADE GOING TO WORK EASIEST FOR YOU | | |
| WHAT DO YOU DO IN YOUR NON-WORKING HOURS | ATTEND CLINIC WITH WHOM | | |
| LIST THREE VOCATIONAL CHOICES IN ORDER OF PRIORITY | SEWING MACHINE OPERATOR | CLERICAL | CHAMBERMAID |
| INTERVIEWER'S COMMENTS AND OBSERVATIONS | | |
| DO YOU FEEL PATIENT IS SUITABLE FOR | VOC. REHAB. COUNSELING | PLACEMENT |
| PSYCHOTHERAPY | TRAINING |
| EVALUATION | OTHER |
| PROGNOSIS FOR TREATMENT: | FAIR |
| ADDITIONAL COMMENTS: | CHEERFUL, OPTIMISTIC. VERY LIMITED UNDERSTANDING OF DEMANDS OF WORKING. EMPHASIZES LACK OF EDUCATION | |
| SIGNATURE OF VRC | |
# VOCATIONAL STRUCTURED INTERVIEW FORM

**PATIENT'S NAME**

**ADDRESS**

**TELEPHONE #**

**DATE OF BIRTH**

**AGE**

**SEX**

- **MALE**
- **FEMALE**

**LENGTH OF TIME LIVING IN NEW YORK CITY**

**EDUCATION**

**H.S. GRAD. EQUIVALENCY**

- **Y**
- **N**

**SCHOOL**

**TRADE SCHOOL OR TRAINING PROGRAM**

**MAJOR IN HIGH SCHOOL**

**MAJOR IN COLLEGE**

**TRADE SCHOOL OR TRAINING PROGRAM**

**CURRENT UNION MEMBERSHIP**

**LIVING SITUATION:**

- **OWN HOME**
- **HOTEL**
- **OTHER (SPECIFY)**

**MARITAL STATUS**

- **M**
- **W**
- **NM**
- **SEP**

**NUMBER OF DEPENDENTS**

- **M**
- **F**
- **OTHER (SPECIFY)**

**SOCIAL SECURITY NUMBER**

**# OF SIBLINGS**

**# OF CHILDREN**

**SOURCE OF INCOME**

**AMOUNT WK**

**IF ON WELFARE**

**LENGTH OF TIME**

**NUMBER TIMES CONVICTED**

**MONTHS SERVED**

**COURT ORDER**

**DATE APPLIED**

**DATE ADMITTED**

**AGE ADDICTED TO HEROIN**

**OTHER SUBSTANCES USED DAILY BEFORE MMTP**

**DATE MMTP TREATMENT BEGAN**

**AGE**

**FREQUENCY OF PICK-UP**

**DOES YOUR SPOUSE WORK**

- **Y**
- **N**

**USUAL LINE OF WORK**

**PRESENT STATUS**

- **W, FULL-TIME**
- **W, PART-TIME**
- **NOT WORKING**

**PRESENT OCCUPATION**

**DATE BEGAN**

**WHEN WAS LAST JOB**

**LENGTH OF LAST JOB**

**HOW OBTAINED**

**JOB DUTIES**

**REASON FOR LEAVING**

**PLEASE RATE LAST OR PRESENT JOB**

**EXCELLENT**

**POOR**

**YOUR SATISFACTION WITH JOB**

**FAIR**

**YOUR EMPLOYER**

**GOOD**

**CO-WORKER RELATIONSHIPS**

**POOR**

**WORKING CONDITIONS**

**GOOD**

**PROMOTIONAL OPPORTUNITIES**

**NONE**

**YOUR SUCCESS**

**FAIR**

**YOUR SALARY**

**GOOD**

**HOW WOULD YOUR EMPLOYER RATE YOUR WORK**

**GOOD**

**WHAT SKILLS WERE REQUIRED FOR JOB**

**NONE**

**ARE THE DEMANDS REASONABLE**

- **Y**
- **N**

**SALARY**

- **$**
- **PER HOUR**
- **PER WEEK**
- **UNION POSITION**

**POSITIONS HELD SINCE ADMISSION**

**BICM-MMTP**

**EXCEPT PRESENT JOB**

**HOW REASON FOR LEAVING SALARY**

**BONUS**

**39**
PREVIOUS MEDICAL TREATMENT OR HOSPITALIZATION?  YES  NO
EXPLAIN

POSITIONS HELD 5 YEARS PRIOR TO ADMISSION

<table>
<thead>
<tr>
<th>POSITION</th>
<th>DATES</th>
<th>HOW OBTAINED</th>
<th>WHY LEFT</th>
<th>SALARY</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUPER</td>
<td>7/71</td>
<td>FRIEND</td>
<td>DRUG</td>
<td>6578945</td>
</tr>
<tr>
<td>WORKER</td>
<td>9/71</td>
<td></td>
<td>FROWNED</td>
<td>9345789</td>
</tr>
<tr>
<td>TRUCK</td>
<td></td>
<td></td>
<td>TIRED OF IT</td>
<td>9345789</td>
</tr>
<tr>
<td>DRIVER</td>
<td>178-17</td>
<td></td>
<td></td>
<td>9345789</td>
</tr>
</tbody>
</table>

HAVE YOU EVER HAD JOB COUNSELING  YES  NO
JOB TESTING  YES  NO

IF YES, WHERE  WHEN  WHAT HAPPENED

SINCE ADMISSION HAVE YOU USED ANY DRUGS OR ALCOHOL  YES  NO
IF YES, SPECIFY WHAT  FIRST 3 MONTHS ONLY  YES  NO
IF YES, WERE YOU WORKING  YES  NO  HOW OFTEN

ONCE ENTERING MMTP HAVE YOU BEEN ARRESTED  YES  NO
IF YES, WAS IT DRUG RELATED  YES  NO
HOW MANY TIMES  YES  NO  IF NOT DRUG RELATED WHAT WAS CHARGE

DEPARTMENT OF METHADONE AFFECT YOUR ABILITY TO WORK
POSITIVELY
NEGATIVELY
NOT AT ALL

WHO DO YOU ASSOCIATE WITH AT WORK  DO THEY KNOW MMTP STATUS  DOES EMPLOYER KNOW MMTP STATUS  YES  NO

DOES PERSONNEL OFFICE KNOW MMTP STATUS  WOULD YOU WANT THIS KNOWLEDGE OR LACK OF KNOWLEDGE TO BE DIFFERENT  YES  NO
IF YES, DESCRIBE

WHAT WOULD YOU LIKE TO BE DOING IN THREE MONTHS  ONE YEAR  FIVE YEARS

GET OFF STREET
GOOD JOB/MANUAL WORK
"LIVING W  OOD"/DEATH
DEP. METHADONE

DOES YOUR BEING ON WELFARE DISCOURAGE YOUR GOING TO WORK  YES  NO

WHAT IS THE BIGGEST PROBLEM TO OVERCOME IN OBTAINING A JOB?  YES  NO
SERIAL

WHAT HAS MADE GOING TO WORK EASIEST FOR YOU?  YES  NO

WHAT DO YOU DO IN YOUR NON-WORKING HOURS?  YES  NO

LIST THREE VOCATIONAL CHOICES IN ORDER OF PRIORITY
MAINTAIN SAME WORK  CONQUER YOUNG ADDICTS

INTERVIEWER'S COMMENTS AND OBSERVATIONS
DO YOU FEEL PATIENT IS SUITABLE FOR  YES  NO
VOC. REHAB. COUNSELING  PLACEMENT
PSYCHOTHERAPY  TRAINING
EVALUATION  OTHER

PROGNOSIS FOR TREATMENT:  FAIR

ADDITIONAL COMMENTS:  PT. SEEMED SINCERELY CONCERNED ABOUT LIFE STYLE  ANSWERED THOUGHTFULLY  SEEMS OVERWHELMED BY CHANGES  STEADY JOB WOULD ENTAIL.

SIGNATURE OF VRC
<table>
<thead>
<tr>
<th><strong>PATIENT'S NAME</strong></th>
<th><strong>ADDRESS</strong></th>
<th><strong>TELEPHONE #</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>DATE OF BIRTH</strong></th>
<th><strong>AGE</strong></th>
<th><strong>SEX</strong></th>
<th><strong>ETHNIC</strong></th>
<th><strong>OTHER</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>7/29/52</td>
<td>22</td>
<td>MALE</td>
<td>WHITE</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>LENGTH OF TIME LIVING</strong></th>
<th><strong>IN NEW YORK CITY</strong></th>
<th><strong>YRS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>EDUCATION</strong></th>
<th><strong>H.S. GRAD/EQUIVALENCY</strong></th>
<th><strong>Y</strong></th>
<th><strong>N</strong></th>
<th><strong>COLLEGE</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1 2 3 4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>MAJOR IN HIGH SCHOOL ELECTRICITY</strong></th>
<th><strong>MAJOR IN COLLEGE TRADE OR PROFESSIONAL LICENSE (SPECIFY)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>TRADE UNION</strong></th>
<th><strong>CURRENT UNION MEMBERSHIP</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>LIVING SITUATION</strong></th>
<th><strong>OWN HOME</strong></th>
<th><strong>HOTEL</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>MARITAL STATUS</strong></th>
<th><strong>RESIDING WITH</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>SOCIAL SECURITY REGISTRATION</strong></th>
<th><strong>PHYSICAL LIMITATIONS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>SOURCE OF INCOME</strong></th>
<th><strong>AMOUNT/WK</strong></th>
<th><strong>EMPL &amp; TYPE</strong></th>
<th><strong>LENGTH OF TIME</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>NUMBER TIMES CONVICTED</strong></th>
<th><strong>MONTHS SERVED</strong></th>
<th><strong>CURRENTLY ON</strong></th>
<th><strong>FOR HOW MUCH LONGER</strong></th>
<th><strong>CASE PENDING</strong></th>
<th><strong>Y</strong></th>
<th><strong>N</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>DATE APPLIED</strong></th>
<th><strong>DATE ADMITTED</strong></th>
<th><strong>MMTP TREATMENT</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>9/69</td>
<td>9/69</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>EMPLOYED AT ADMISSION</strong></th>
<th><strong>FREQUENCY OF PICK-UP</strong></th>
<th><strong>BIMC</strong></th>
<th><strong>Y</strong></th>
<th><strong>N</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>ELEVATOR CREATOR</strong></th>
<th><strong>DATE BEGAN</strong></th>
<th><strong>WHEN WAS LAST JOB</strong></th>
<th><strong>LENGTH OF LAST JOB</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>HOW OBTAINED</strong></th>
<th><strong>OPERATE ELEVATOR</strong></th>
<th><strong>HOW OBTAINED</strong></th>
<th><strong>JOB DUTIES</strong></th>
<th><strong>REASON FOR LEAVING</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>PLEASE RATE PRESENT OR LAST JOB</strong></th>
<th><strong>POSITIONS HELD SINCE ADMISSION BIMC-MMTP</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>YOUR SATISFACTION WITH JOB</strong></th>
<th><strong>HOW, REASON FOR LEAVING</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>POOR</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>YOUR JOB DUTIES</strong></th>
<th><strong>WHEN OBTAINED</strong></th>
<th><strong>REASON FOR LEAVING</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>YOUR COMPENSATION</strong></th>
<th><strong>SALARY</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HR/1/5/WK</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>ARE THE DEMANDS REASONABLE</strong></th>
<th><strong>SALARY</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>POOR</td>
<td>HR/1/5/WK</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>WHAT SKILLS WERE REQUIRED FOR JOB</strong></th>
<th><strong>HOW WOULD YOUR EMPLOYER RATE</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>HOW WOULD YOUR EMPLOYER RATE YOUR WORK</strong></th>
<th><strong>HOW WOULD YOUR EMPLOYER RATE YOUR SALARY</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>WHAT CO-WORKER RELATIONSHIPS WERE REASONABLE</strong></th>
<th><strong>WORKING CONDITIONS WERE REASONABLE</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>YOUR SUCCESS AT WORK</strong></th>
<th><strong>PROMOTIONAL OPPORTUNITIES WERE REASONABLE</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>YOUR LAST JOB</strong></th>
<th><strong>YOUR SUCCESS AT YOUR LAST JOB</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>ARE THE DEMANDS REASONABLE</strong></th>
<th><strong>SALARY</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>POOR</td>
<td>HR/1/5/WK</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>ARE THE DEMANDS REASONABLE</strong></th>
<th><strong>SALARY</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>POOR</td>
<td>HR/1/5/WK</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>ARE THE DEMANDS REASONABLE</strong></th>
<th><strong>SALARY</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>POOR</td>
<td>HR/1/5/WK</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>ARE THE DEMANDS REASONABLE</strong></th>
<th><strong>SALARY</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>POOR</td>
<td>HR/1/5/WK</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>ARE THE DEMANDS REASONABLE</strong></th>
<th><strong>SALARY</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>POOR</td>
<td>HR/1/5/WK</td>
</tr>
</tbody>
</table>
### Previous Medical Treatment or Hospitalization?
- **YES**
- **NO**

### Positions Held 5 Years Prior to Admission:

<table>
<thead>
<tr>
<th>Position</th>
<th>Dates</th>
<th>How Obtained</th>
<th>Why Left</th>
<th>Salary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Assistant</td>
<td>1968-9</td>
<td>Friend</td>
<td>To be Detoxed</td>
<td>$85/WK</td>
</tr>
<tr>
<td>Assistant Manager</td>
<td>1968</td>
<td>Friend</td>
<td>Lost Funds</td>
<td>$50/WK</td>
</tr>
<tr>
<td>Food Delivery</td>
<td>1969</td>
<td>Friend</td>
<td></td>
<td>$50/WK</td>
</tr>
</tbody>
</table>

### Have You Ever Had Job Counseling?
- **YES**
- **NO**

### Since Admission Have You Ever Used Any Drugs or Alcohol?
- **YES**
- **NO**

### Does Methadone Affect Your Ability to Work?
- **POSITIVELY**
- **NEGATIVELY**
- **NOT AT ALL**

### What Would You Like to Be Doing in Three Months?
- **GOING TO SCHOOL**
- **FINISHING SCHOOL**
- **ESTABLISHED IN REPUTABLE JOB**

### What Is the Biggest Problem to Overcome in Obtaining a Job?
- **QUALIFICATIONS**
- **SAVINGS**

### List Three Vocational Choices in Order of Priority
- **ELECTRICITY**
- **PLUMBING**
- **CARPENTRY**

### Prognosis for Treatment: **VERY GOOD**

### Additional Comments:
- PT presents neat appearance. Answers questions with volunteers in information willingly. Presents himself in flat-ironed fashion.

---

**Signature of VRC**
VOCATIONAL STRUCTURED INTERVIEW FORMS
# Vocational Structured Interview Form

**Patient's Name**  

**Address**  

**Telephone #**

<table>
<thead>
<tr>
<th>Date of Birth</th>
<th>Age</th>
<th>Sex</th>
<th>Ethnic</th>
<th>Length of Time Living in New York City</th>
</tr>
</thead>
<tbody>
<tr>
<td>/ /</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Education | Major in High School | Major in College | Trade School or Training Program:  
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3 4 5 6 7 8 9 10 11 12</td>
<td>H.S. Grad/Equivalency</td>
<td>College: 1 2 3 4</td>
<td></td>
</tr>
</tbody>
</table>

| Trade or Professional License | Current Union, Membership | Living Situation: Room (House):  
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(Specify)</td>
<td></td>
<td>Other (Specify)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Residing With</th>
<th>Social Security</th>
<th>Physical Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>W</td>
<td>Childre</td>
<td>Care</td>
</tr>
<tr>
<td>NM</td>
<td>Alone</td>
<td>Parents</td>
<td>Y</td>
</tr>
<tr>
<td>SEP</td>
<td>Number of</td>
<td>Relatives</td>
<td>Y</td>
</tr>
<tr>
<td>D</td>
<td>Dependents</td>
<td>Other</td>
<td>Y</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Source of Income</th>
<th>Amount/WK</th>
<th>If on Welfare: Type</th>
<th>Length of Time</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Number Times Convicted</th>
<th>Months Served</th>
<th>Currently On</th>
<th>For How Much Longer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Felony</td>
<td>Misdeemeanor</td>
<td>Parole</td>
<td>Probation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age Addicted to Heroin</th>
<th>Other Substances Used Before MMTTP &amp; Time</th>
<th>Date Applied</th>
<th>Date Admitted MMTTP Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily</td>
<td>MMTTP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>U</td>
<td>ALC</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employed at Admission</th>
<th>Frequency of Pick-Up</th>
<th>Does Your Spouse Work</th>
<th>If Yes, What Status (Re: Work)</th>
</tr>
</thead>
<tbody>
<tr>
<td>U</td>
<td>W</td>
<td>Student</td>
<td>Homemaker</td>
</tr>
<tr>
<td>Full-Time</td>
<td>W, Part-Time</td>
<td>Not Working</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Usual Line of Work Present Status</th>
<th>Date Began</th>
<th>When Was Last Job</th>
<th>Length of Last Job</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>How Obtained</th>
<th>Job Duties</th>
<th>How Obtained Job Duties</th>
<th>Reason for Leaving</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Please Rate Present or Last Job</th>
<th>Positions Held Since Admission BIMC-MMTTP (Except Present Job)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your Satisfaction with Job</td>
<td>How, Reason for Dates Obtained Leaving, Salary</td>
</tr>
<tr>
<td>Your Employer</td>
<td>Position</td>
</tr>
<tr>
<td>Co-Worker Relationships</td>
<td>Working Conditions</td>
</tr>
<tr>
<td>Promotional Opportunities</td>
<td>Promotional Opportunities</td>
</tr>
<tr>
<td>Your Success</td>
<td>Your Success</td>
</tr>
<tr>
<td>Your Salary</td>
<td>Your Salary</td>
</tr>
<tr>
<td>How Would Your Employer Rate</td>
<td>How Would Your Employer Rate</td>
</tr>
<tr>
<td>Your Work</td>
<td>Your Work</td>
</tr>
<tr>
<td>What Skills Were Required for Job</td>
<td>What Skills Were Required for Job</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Are the Demands Reasonable</th>
<th>Salary: /HR /WK Union Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>

---

**Note:**  

1. 2. 3. 4. 5.  

---

**Source:** BETH ISRAEL MEDICAL CENTER  
METHADONE MAINTENANCE TREATMENT PROGRAM  
DEPARTMENT OF VOCATIONAL REHABILITATION
PREVIOUS MEDICAL TREATMENT OR HOSPITALIZATION?  YES  NO

EXPLAIN

POSITIONS HELD 5 YEARS PRIOR TO ADMISSION:

<table>
<thead>
<tr>
<th>POSITION</th>
<th>DATES</th>
<th>HOW OBTAINED</th>
<th>WHY LEFT</th>
<th>SALARY</th>
</tr>
</thead>
</table>

HAVE YOU EVER HAD JOB COUNSELING — Y — N  JOB TESTING — Y — N

IF YES: WHERE  WHEN  WHAT HAPPENED

SINCE ADMISSION HAVE YOU USED ANY DRUGS OR ALCOHOL — Y — N

IF YES, SPECIFY WHAT  FIRST 3 MONTHS ONLY — Y — N

IF YES, WERE YOU WORKING — Y — N

IF YES, HOW OFTEN

ONCE ENTERING MMTP HAVE YOU BEEN ARRESTED — Y — N

IF YES, WERE YOU WORKING — Y — N

IF YES, WAS IT DRUG RELATED — Y — N

HOW MANY TIMES

IF NOT DRUG RELATED WHAT WAS CHARGE

LAST TIME

WERE YOU JAILED

PROBATION

OTHER

DOES METHADONE AFFECT YOUR ABILITY TO WORK

— POSITIVELY — NEGATIVELY — NOT AT ALL

WHO DO YOU ASSOCIATE WITH AT WORK  DO THEY know MMTP STATUS  DOES EMPLOYER KNOW

MMTP STATUS — Y — N

DOES PERSONNEL OFFICE KNOW MMTP STATUS

— Y — N

WOuld YOU WANT THIS KNOWLEDGE or LACK OF KNOWLEDGE to BE DIFFERENT — Y — N

IF YES, DESCRIBE

WHAT WOULD you LIKE to BE DOING in THREE MONTHS

ONE YEAR

FIVE YEARS

DOES your BEING ON WELFARE DISCOURAGE your GOING to WORK — Y — N

HOW:

WHAT IS THE BIGGEST PROBLEM to OVERCOME in OBTAINING a JOB?

WHAT HAS MADE GOING to WORK EASIEST for YOU?

WHAT DO you DO in YOUR NON-WORKING HOURS?  WITH WHOM?

LIST THREE VOCATIONAL CHOICES IN ORDER of PRIORITY

INTERVIEWER'S COMMENTS and OBSERVATIONS

DO you FEEL patient IS Suitable FOR

— VOC. REHAB. COUNSELING — PLACEMENT

— PSYCHOTHERAPY — TRAINING

— EVALUATION — OTHER

PROGNOSIS FOR TREATMENT:

ADDITIONAL COMMENTS:

SIGNATURE OF VRC
## Vocational Structured Interview Form

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient's Name</strong></td>
<td>Address</td>
</tr>
<tr>
<td><strong>Date of Birth</strong></td>
<td>Age</td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td>Male</td>
</tr>
<tr>
<td><strong>Length of Time Living</strong></td>
<td>In New York City</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td>Grad. Equivalency</td>
</tr>
<tr>
<td><strong>Major in High School</strong></td>
<td>Completed Subject</td>
</tr>
<tr>
<td><strong>Trade or Professional License</strong></td>
<td>Current Union Membership</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td>Residing With</td>
</tr>
<tr>
<td><strong>Source of Income</strong></td>
<td>Amount/WK</td>
</tr>
<tr>
<td><strong>Number Times Convicted</strong></td>
<td>Months Served</td>
</tr>
<tr>
<td><strong>Age Addicted to Alcohol</strong></td>
<td>Other Substances Used</td>
</tr>
<tr>
<td><strong>Employee at Admission</strong></td>
<td>Frequency of Pick-Up</td>
</tr>
<tr>
<td><strong>Usual Line of Work</strong></td>
<td>Worked for How Much Longer</td>
</tr>
<tr>
<td><strong>Present Occupation</strong></td>
<td>Date Began When Was Last Job</td>
</tr>
<tr>
<td><strong>Employed at Admission</strong></td>
<td>Holds since Admission</td>
</tr>
<tr>
<td><strong>How Obtained</strong></td>
<td>Held since Admission</td>
</tr>
<tr>
<td><strong>Reason for Leaving</strong></td>
<td><strong>Position Held Since Admission</strong> (EXCEPT PRESENT JOB)</td>
</tr>
<tr>
<td><strong>Your Satisfaction with Job</strong></td>
<td><strong>Position</strong></td>
</tr>
<tr>
<td><strong>Your Employer</strong></td>
<td><strong>Dates Obtained</strong></td>
</tr>
<tr>
<td><strong>How Reason for Leaving</strong></td>
<td><strong>Leaving</strong></td>
</tr>
<tr>
<td><strong>Your Salary</strong></td>
<td><strong>Position Held Since</strong></td>
</tr>
<tr>
<td><strong>Salary</strong></td>
<td><strong>Dates Obtained</strong></td>
</tr>
<tr>
<td><strong>What Skills Were Required</strong></td>
<td><strong>Leaving Salary</strong></td>
</tr>
</tbody>
</table>

### Vocational Structured Interview Form Details

- **Patient's Name**: [Name]
- **Address**: [Address]
- **Date of Birth**: [Date]
- **Age**: [Age]
- **Sex**: [Male/Female]
- **Length of Time Living**: In New York City
- **Education**: Grad. Equivalency: [Y/N]
- **Major in High School**: [Subject]
- **Trade or Professional License**: [Current Union Membership]
- **Marital Status**: Residing With: [Spouse/Children/Parents/Relatives]
- **Source of Income**: Amount/WK
- **Number Times Convicted**: [Felony/Misdemeanor]
- **Age Addicted to Alcohol**: [Barb/Alc/Amph/Coc]
- **Employee at Admission**: [Y/N]
- **Usual Line of Work**: Worked for How Much Longer
- **Present Occupation**: Date Began When Was Last Job
- **Employed at Admission**: Holds since Admission
- **How Obtained**: Held since Admission
- **Reason for Leaving**: **Position Held Since** (EXCEPT PRESENT JOB)
- **Your Satisfaction with Job**: **Position**
- **Your Employer**: **Dates Obtained**
- **How Reason for Leaving**: **Leaving Salary**
- **Your Salary**: **Position Held Since**
- **Salary**: [Y/N]
- **What Skills Were Required for Job**: [Y/N]
- **Are the Demands Reasonable?**: [Y/N]
- **Salary**: [Y/N]
- **Union Position**: [Y/N]

**Note**: Please rate present or last job (Excellent - Poor).
**Are you on Antabuse?**

- **Y**
- **N**

If **Y**, since when?

**Previous Medical Treatment or Hospitalization?**

- **Y**
- **N**

Explain:

**Positions Held 5 Years Prior to Admission**

<table>
<thead>
<tr>
<th>Position</th>
<th>Dates</th>
<th>How Obtained</th>
<th>Why Left</th>
<th>Salary</th>
</tr>
</thead>
</table>

**Have you ever had: Job Counseling?**

- **Y**
- **N**

If **Y**, where and when?

**Job Testing?**

- **Y**
- **N**

If **Y**, explain what?

**First 3 Months Only?**

- **Y**
- **N**

If **Y**, explain what?

**Once entering ATP have you been arrested?**

- **Y**
- **N**

If **Y**, was it alcohol related?

- **Y**
- **N**

**How many times?**

If not alcohol related, what was charge?

**Last time**

Were you:

- **Jailed**
- **Probation**
- **Other**

**Does ATP affect your ability to work?**

- **Y**
- **N**

**Does Antabuse affect your ability to work?**

- **Positively**
- **Negatively**
- **Not at all**

**Who do you associate with at work?**

Do they know ATP status?

- **Y**
- **N**

Does employer know ATP status?

- **Y**
- **N**

Would you want this knowledge or lack of knowledge to be different?

- **Y**
- **N**

If **Y**, describe.

**What would you like to be doing in three months?**

- **One Year**
- **Five Years**

Does your being on welfare discourage your going to work?

- **Y**
- **N**

**What is the biggest problem to overcome in obtaining a job?**

**What has made going to work easiest for you?**

**What do you do in your non-working hours?**

With whom?

**List three vocational choices in order of priority**

**Interviewer's comments and observations**

Do you feel patient is suitable for:

- Voc. Rehab. Counseling
- Placement
- Psychotherapy
- Training
- Evaluation
- Other

**Prognosis for treatment:**

**Additional comments:**

Signature of VRC
## Vocational Structured Interview Form

<table>
<thead>
<tr>
<th>Patient's Name</th>
<th>Address</th>
<th>Telephone #</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Personal-Social</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name:</td>
<td>Date of Birth:</td>
<td>Age:</td>
</tr>
<tr>
<td>Place of Residence:</td>
<td>Sex:</td>
<td>Marital Status:</td>
</tr>
<tr>
<td>Apartment Residing With:</td>
<td>Time Living In New York:</td>
<td></td>
</tr>
<tr>
<td>Room (Hotel)</td>
<td>Where Living Before New York:</td>
<td></td>
</tr>
<tr>
<td>Home</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (Specify) How Long There:</td>
<td>Place of Birth:</td>
<td></td>
</tr>
</tbody>
</table>

If Any Children, Who Cares For Them: | Have You A Social Security Card: | |
| Any Other Family Members Drug Abusers: | | |
| Who Substance(s): | Any Physical Limitations: | |

Present Source Of Income: | Does Spouse Work: | |
| | Yes: | No: |

Amount Weekly: | If Yes, Occupation: | Salary: |

Education: | College (If Any): | |
| Last Grade School: | Diploma or Deg: | Yes: No: |
| | School: | Dates: |
| Vocational Training: | Major: | |
| School: | Major Course: | Dates Attended: |
| Did You Finish: | Yes: No: | |

Military: | | |
| Branch: | Dates: | Where Stationed: |
| Type Of Discharge: | Duties When In Service: | |
| Training-Where In Service: | | |
| Additional History: | | |
| Age First Used Drugs: | What Drug(s): | Other Drugs Used Daily: |
| Age First Addicted (Heroin): | | |

Number of Heroin Detoxifications: | | |
Means of Supporting Habit: | | |

Drug Free Periods: (Indicate Whether On MMTP, Residential, 9-5 Program) | | |
| | | |

If On MMTP Currently: | | |
| No. Of Detoxes Other Substances: | What Substance: | |
| Working: | Full Time: | Part Time: |
| Homemaker: | Yes: No: | |
| | | |

Are You Being Detoxed From MMTP: | Yes: No: |

Previous Therapeutic Community or 9-5 Program (Additional Space If More Than 1) | | |
| Dates: | | |
| Program: | | |
| Why Left: | | |

47
**Criminal History:**

<table>
<thead>
<tr>
<th>Number Times Convicted</th>
<th>Months Served</th>
<th>Currently On</th>
</tr>
</thead>
<tbody>
<tr>
<td>Felony</td>
<td>Felony</td>
<td>Probation</td>
</tr>
<tr>
<td>Misdemeanor</td>
<td>Misdemeanor</td>
<td>Parole</td>
</tr>
</tbody>
</table>

**Employment History**

**Previous Jobs Held: (Last 5 Years)**

<table>
<thead>
<tr>
<th>Position</th>
<th>Dates</th>
<th>How Obtained</th>
<th>Why Left</th>
<th>Salary</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Present, Job (or Last)</td>
<td>Hours/Wk</td>
<td>Date-Begun</td>
<td>How Obtained</td>
<td>Salary</td>
</tr>
</tbody>
</table>

**Rate:** Present Job (Excellent — Poor)

<table>
<thead>
<tr>
<th>Working Conditions</th>
<th>Your Satisfaction with Job</th>
<th>Promotion Opportunities</th>
<th>Your Employer</th>
<th>Your Success</th>
<th>Co-Worker Relationships</th>
<th>Your Salary</th>
<th>How Would Your Employer Rate Your Work</th>
</tr>
</thead>
</table>

**Additional Comments:**

- What is the biggest problem you need to overcome to get a job?
- When you've worked, what has made getting a job easiest?
- What do you do in your non-working hours? With whom?
- What would you like things to be like in 3 months?
- What would you like things to be like in 6 months?

**Indicate 3 Vocational Choices in Order of Preference**

**Interviewer's Comments:**

**Recommendations:**

---

Signature of VRC
### SEMANTIC DIFFERENTIAL

#### "THIS CLIENT"

<table>
<thead>
<tr>
<th>Active:</th>
<th>Inactive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hard:</td>
<td>Soft</td>
</tr>
<tr>
<td>Naive:</td>
<td>Sophisticated</td>
</tr>
<tr>
<td>Slow:</td>
<td>Fast</td>
</tr>
<tr>
<td>Strong:</td>
<td>Weak</td>
</tr>
<tr>
<td>Experienced:</td>
<td>Inexperienced</td>
</tr>
<tr>
<td>Calm:</td>
<td>Excitable</td>
</tr>
<tr>
<td>Staid:</td>
<td>Flexible</td>
</tr>
<tr>
<td>Frivolous:</td>
<td>Serious</td>
</tr>
<tr>
<td>Reticent:</td>
<td>Talkative</td>
</tr>
<tr>
<td>Hesitant:</td>
<td>Sure</td>
</tr>
<tr>
<td>Formal:</td>
<td>Casual</td>
</tr>
<tr>
<td>Industrious:</td>
<td>Lazy</td>
</tr>
<tr>
<td>Dull:</td>
<td>Sharp</td>
</tr>
<tr>
<td>Dependable:</td>
<td>Capricious</td>
</tr>
<tr>
<td>Cautious:</td>
<td>Daring</td>
</tr>
<tr>
<td>Skilled:</td>
<td>Unskilled</td>
</tr>
<tr>
<td>Willful:</td>
<td>Compliant</td>
</tr>
</tbody>
</table>
COMMENTS

The Bernstein Institute of Beth Israel Medical Center has played a central role in the treatment of drug addiction for the past 15 years. It is the largest non-governmental hospital for treatment of addictive diseases. It currently provides a treatment approach that includes a heroin detoxification unit, an inpatient medical treatment unit for the addict, and a comprehensive MMTP program. It also has extensive services for treatment of alcoholism. There have been, since 1961, over 100,000 admissions to the heroin detoxification unit alone.

Our focus has been on the patient as an individual who is in need of a full range of opportunities in order to achieve restoration to as satisfying a lifestyle as possible. This includes medical treatment, counselling and social services under medical supervision, and a wide range of vocational rehabilitation counseling activities. Unless the individual has the opportunity to rejoin the community with dignity, our treatment goals have not been met. It is here that vocational rehabilitation counselling is crucial in addressing the quality of life in the realm of meaningful employment.

This volume represents an important step in bringing these services closer to the individual patient in need, and to those responsible for providing services.

Harvey Gollan tce, M.D.
Director
Morris J. Bernstein Institute
Beth Israel Medical Center
In our society, unless an individual patient is provided with the opportunity to work, rehabilitation has been an incomplete process. We can talk about support and restoration but without the substance a meaningful job can provide, the individual remains dependently in need. The services that work to make this quality of life possible are becoming an integral part of treatment in the Beth Israel Medical Center Alcohol Treatment Program. It is our goal to provide a full range of interrelated vocational rehabilitation counseling services in order to meet individual patient needs.

The individualized approach described in this volume is an essential component in establishing a workable model for prescriptive treatment planning. I find the work described so creative and directly relevant to the treatment needs of our patients that I visualize such an approach becoming the foundation of our treatment of the individual dependent on alcohol.

Robert A. Senescu, M.D.
Director, Department of Psychiatry,
Beth Israel Medical Center
Professor of Clinical Psychiatry,
Mount Sinai School of Medicine of the City University of New York
Vocational rehabilitation counselling is an integral part of the Methadone Maintenance Treatment Program at Beth Israel Medical Center. It is recognized that unless individuals in treatment are afforded the opportunity to explore their potential for placement in the labor market, we are neglecting a vital component of rehabilitation.

The material in this volume not only highlights the components of comprehensive vocational rehabilitation counselling but provides a workable model that may well be adapted to many treatment modalities. It has been my privilege to assist in the development of this publication.

Harold L. Trigg, M.D.
Associate Director,
Morris J. Bernstein Institute
Chief, Methadone Maintenance Treatment Program
Chief, Drug Addiction Service
Associate Professor of Clinical Psychiatry
Mount Sinai School of Medicine of the City University of New York
Vocational Rehabilitation counselors have been influenced by the major conceptual models of mental health work. These have included the psychotherapeutic model, which has emphasized the subjective, private nature of the activity, and the advocacy model, which has emphasized rapid solutions for quite complex problems. Neither of these extreme models provides a basis for sound vocational rehabilitation. This volume describes a project in which vocational rehabilitation counselors successfully applied new techniques which appear to be increasingly attractive and productive. Among the techniques were use of a structured interview, written treatment plans, emphasis on objective, attainable goals, and group supervision. Traditionalists might say this makes for a mechanical approach, and activists might say this is an inhibiting, plodding approach, but it appears to have led to more competent work by the counselors.

Henry Pinsker, M.D.
Associate Director, Department of Psychiatry,
Beth Israel Medical Center
Associate Clinical Professor of Psychiatry,
Mount Sinai School of Medicine of the City University of New York
VOCATIONAL REHABILITATION OF THE DRUG ABUSER

Editorial Seminar

March 28-30, 1973
Mills College, Oakland, California

Advisory Council

DAVID SMITH, M.D., Chairman
Medical Director
Haight-Ashbury Free Medical Clinic
1698 Haight St.
San Francisco, California 94117
Dr. G. G. DeANGELIS
Dr. LEONARD GREENE
Dr. JOSEPH ROTHSTEIN
Mr. ARTHUR JOHNSON
Dr. EDWARD SCOTT
Mr. BRUCE BROWN
Dr. ROGER MYERS
Ms. JANET PENCE
Mr. ROBERT CAMPOS
Dr. DAVID BENTEL
Dr. LOUIS NAU
Mr. ROBERT A. BATTEN, JR.
WENDELL, LIPSCOMB, M.D., M.P.H.
SCHEDULE

WEDNESDAY, MARCH 28

7:45-8:30 AM  Registration continued (Rothwell College Center Faculty Room)

Breakfast (all meals will be in the Rothwell College Center Tea Room)

9:00  Introduction, Orientation (Rothwell College Center Faculty Room)

Herbert H. Leibowitz, Research & Demonstration Specialist Social & Rehabilitation Services, DHEW

Philip Schafer, Regional Commissioner, Social and Rehabilitation Services, DHEW

9:30  "Perspectives of Vocational Rehabilitation of the Drug Abuser"

David E. Smith, Medical Director
Haight Ashbury Free Medical Clinic

Fred Kelly, Staff Advisor, Community Planning Office of Deputy Director of Priority Program

Gregory March, Program Analyst
Rehabilitation Services Administration, SRS

Thomas Cahill, Project Coordinator
University of Miami Center for Urban Studies

Sol Silverman, Commissioner
National Commission on Marijuana & Drug Abuse

Maryann Urbán, Program Director
National Commission on Marijuana & Drug Abuse

Impromptu Panel Responding:

Gerry DeAngelis, Treatment, Rehabilitation & Training Consultant, Vitam Center, Inc.

Wendell Lipscomb, Executive Director
Source, Inc.: Studies of Urban Research & Community Education

Robert Campos, Director of the Methadone Withdrawal Project Addiction Research Laboratory, Palo Alto

Irving Lucoff, Director, Addiction Research & Treatment Corporation Evaluation Team, Columbia University

Arlene Lissner, Associate-Director of Program Development and Training, Illinois State Drug Abuse Program

12:30  Lunch (Tea Room)
1:30 PM  "A Theoretical Exploration" (Faculty Room)

Dr. Donald E. Super, Director of Division & Chairman of the Department of Psychology, Columbia University

Panel Responses:

Sanford J. Feinglass, Director
Institute for Social Concerns

Irving F. Lukoff, Director, Addiction Research & Treatment Corporation Evaluation Team, Columbia University

Charlotte Taylor, Director of Training, Division for Research & Training in Rehabilitation, University of Southern California

David Franklin, School of Social Welfare, University of Southern California

3:30-5:00  Group Workshops (Lucie Stern Hall)

6:00  Social Hour (Living Room of Mary Morse Hall)

7:00  Dinner (Tea Room)

8:30  Haight Ashbury Youth Projects, Inc. Presentation of Program (Faculty Room)

David Smith, Medical Director
Haight Ashbury Free Medical Clinic

Stuart Loomis, Director of the Psychological Services Section Haight Ashbury Free Medical Clinic

Leona Jacobs-White, Director, Social Rehabilitation Section “Crackerjack,” Haight Ashbury Free Medical Clinic

THURSDAY, MARCH 29

7:45-8:30 AM  Breakfast (Tea Room)

9:00  "Vocational Rehabilitation of the Drug Abuser—In Practice" Panel Presentation

Regional Overview of Vocational Rehabilitation Practices (Faculty Room)

Michael Gold, Project Director
Jewish Employment Vocational Service, Philadelphia

Jim Cosse, Research Assistant
Department of Psychology, Columbia University

Arlene Lissner, Associate Director of Program Development & Training, Illinois State Drug Abuse Program

Edward Scott, Clinical Director
Oregon State Mental Health Division
William Fletcher, Program Supervisor  
Florida Department of Vocational Rehabilitation  
G. G. DeAngelis, Moderator

11:15-12:15 Group Workshops (Lucie Stern Hall)  
12:30 Lunch (Tea Room)  
1:30 Group Workshops continue  
3:30 "Defining the Rehabilitation Goal" (Faculty Room)  
   Thomas Cahill, Project Coordinator  
   University of Miami Center for Urban Studies  
   Joseph Carano, Acting Director of Training  
   Connecticut Division of Vocational Rehabilitation  
   Henry Kavkewitz, Professor of Psychology & Education  
   Department of Psychology, Columbia University  
   Eileen Wolkstein, Chief, Vocational Rehabilitation  
   Beth Israel Medical Center, New York  
   Howard Berger, Director of Vocational Rehabilitation  
   Operations, New York Office of Vocational Rehabilitation  
   Philip Schafer, Moderator  
   Regional Commissioner, SRS, Region IX  
6:00 Hospitality Hour (Living Room of Mary Morse Hall)  
7:00 Dinner (Tea Room)  
8:30 PM Providing Service  
   Ex-addicts and program directors present their views  
   Richard Montes, Job Developer  
   Boyle Heights Center, Los Angeles  
   Franklin Jackson, Former Aide  
   Vera, Inc., New York  
   Jean Brinkley, Administrative Aide  
   Narcotic Educational League, Oakland  
   Armando Mendoza, Institute for Social Concerns  
   Jim Cosse, Director, Treatment Program  
   Jack Feinglass, Moderator

FRIDAY, MARCH 30
7:45-8:30 AM Breakfast (Tea Room)  
9:00 "The Job at the End of the Rainbow" (Faculty Room)  
   Labor, Management and Vocational Rehabilitation Panel:  
   Robert S. Graham, Medical Director  
   Equitable Life Assurance-of US
William Gregor, AFL-CIO Local Union #2869
United Steelworkers of America, Fontana, Ca.

I. Ira Goldenberg, Associate Professor of Clinical Psychology & Public Practice, Harvard University

David N. Nurco, Research Scientist
Maryland Department of Mental Hygiene

Richard Atkins, Esquire, Moderator

11:00 AM  Group Workshops in Summary (Lucie Stern Hall)
12:30     Lunch (Tea Room)
1:30      "Challenges of the Vocational Rehabilitation of the Drug Abuser"

Conclusions and Implications for the Future (Faculty Room)

Eileen Wolkstein, Chief, Vocational Rehabilitation
Beth Israel Medical Center, New York

Thomas Cahill, Project Coordinator
University of Miami Center for Urban Studies

Louis Nau, Special Assistant to the Commissioner
Rehabilitation Services Administration

Roger Myers, Moderator

Closing Statement:

Wade Coleman, Special Assistant to the Secretary for Drug Abuse Prevention, Washington, D.C.
PARTICIPANTS

RICHARD ATKINS, Esquire
Suite 1616 One East Penn Square
Juniper & Market
Philadelphia, Penn. 19107

FREDERICK BECKNER
Special Assistant for Program Planning & Coordination
Dept. of Health, Education & Welfare
Public Health Service
National Institute of Mental Health
5600 Fishers Lane
Rockville, Md. 20852

HOWARD BERGER
Director, Vocational Rehabilitation Operations
Office of Vocational Rehabilitation
New York State Education Department
99 Washington Ave.
Albany, New York 12210

BART BILLINGS
Rehabilitation Counselor
State Department of Rehabilitation
2240 Professional Drive
Santa Rosa, Ca. 95401

BILL BRICKER
Rehabilitation Counselor
Haight Ashbury Free Medical Clinic — Psychological Services
409 Clayton St.
San Francisco, Ca. 94117

BRUCE BROWN
Research & Demonstration Grants Coordinator
Human Relations Agency
Department of Rehabilitation
714 “P” Street
Sacramento, Ca. 95814

THOMAS CAHILL
Project Coordinator
NIMH-National Training Center
University of Miami
Center for Urban Studies
PO Box 8002
Coral Gables, Flo. 33124

ROBERT CAMPOS
Director of the Methadone Withdrawal Project
Addiction Research Laboratory
800 Welch Road, Room 363
Palo Alto, Ca. 94304
JOSEPH CARANO
Acting Director of Training
Division of Vocational Rehabilitation
Bureau of Community & Institutional Services
State of Connecticut
600 Asylum Avenue
Hartford, Conn. 06105

JOHN CHAMBLEY
Director, Rehabilitation Counseling Program
Department of Education
San Diego State College
5402 College
San Diego, Ca. 92115

EDWARD CHAVEZ
Probation & Parole Officer II
State Department of Corrections
Drug Screening
510 2nd St., N.W.
Albuquerque, New Mexico 87101

MICHAEL CHEMODUROW
Grant Management Specialist
Vocational Rehabilitation Services
1501 McKinney
Boise, Idaho 83704

WADE COLEMAN
Special Assistant to the Secretary for Drug Abuse Prevention
Department of Health, Education, and Welfare
330 Independence Ave., S.W., Room 4059
Washington, D.C. 20201

JIM COSSE
Research Assistant
Department of Psychology
Teachers College
Columbia University
525 West 120th St., Box 164
New York, NY 10027

THOMAS CRUZ
Director of the Narcotic Addicts Rehabilitation Act Program
Southwest Denver Community Mental Health Services, Inc.
3052 West Mississippi Ave.
Denver, Colorado 80219

G. G. DeANGELIS
Treatment, Rehabilitation & Training Consultant
Vitam Center, Inc.
57 West Rocks Road
Norwalk, Conn. 06851

CHARLES ELLIOTT
Assistant Coordinator
Vocational Rehabilitation
1616 Missouri Blvd.
Jefferson City, Mo. 65101

MARY ETHRIDGE
Vocational Rehabilitation Counselor
Oregon State Mental Health Division
309 Southwest 4th Avenue
Portland, Oregon 97204
TOBY FAIRES  
Director, Rehabilitation Services  
Texas Research Institute of Mental Sciences  
1300 Moursand Avenue  
Houston, Texas 77025

STANLEY FEINBERG  
Rehabilitation Counselor  
Office of Vocational Rehabilitation  
The State Education Department  
1000 Franklin Ave.  
Garden City, Long Island, NY 11530

SANFORD FEINGLASS  
Director, Institute for Social Concerns  
PO Box 9945  
Mills College  
Oakland, Ca. 94613

WILLIAM FLETCHER  
Program Supervisor  
Division of Health & Rehabilitation  
Department of Vocational Rehabilitation  
254 Charley John Bldg.  
Tallahassee, Flo. 32304

DAVID FRANKLIN  
Associate Director of Regional Research  
Institute in Social Welfare  
School of Social Welfare  
University of Southern California  
University Park  
Los Angeles, Ca. 90007

WILLIAM GREGOR  
AFL-CIO Local No. 2869  
United Steelworkers of America  
Fontana, Ca.

MICHAEL GOLD  
Project Director  
Jewish Employment Vocational Service  
1913 Walnut Street  
Philadelphia, Penn. 19103

I. IRA GOLDENBERG  
Associate Professor of Clinical Psychology & Public Practice  
Graduate School of Education  
Harvard University  
Cambridge, Mass. 02138

HELEN DUNN GOUIN  
Director, National Drug Education Center  
University of Oklahoma Medical Center  
820 N.E. 15th St.  
Oklahoma City, Oklahoma 73104

ROBERT GRAHAM  
Second Vice President & Medical Director  
Equitable Life Assurance of US  
1285 Avenue of the Americas  
New York, NY 10019

ARTHUR JOHNSON  
Coordinator of Inter-Agency Programs  
Division for Research & Training in Rehabilitation  
University of Southern California  
School of Medicine  
1739 Griffin Ave.  
Los Angeles, Ca. 90031
<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Institution</th>
</tr>
</thead>
<tbody>
<tr>
<td>BILL JOHNSON</td>
<td>Rehabilitation Services Representative, Rehabilitation Services Administration, Social &amp; Rehabilitation Services, Department of Health, Education, &amp; Welfare, 50 Fulton St., San Francisco, CA 94102</td>
</tr>
<tr>
<td>HENRY KAVKEWITZ</td>
<td>Director of Psychological Consultation Center, Department of Psychology, Teachers College, Columbia University, 525 West 120th St., Box 111, New York, NY 10027</td>
</tr>
<tr>
<td>FRED KELLY</td>
<td>Staff Advisor, Community Planning, Office of Deputy Director of Priority Program, Dept. of Health, Education &amp; Welfare, Social &amp; Rehabilitation Services, HEW South Bldg., Room 5122, Washington, D.C. 20201</td>
</tr>
<tr>
<td>BRYAN KEMP</td>
<td>Coordinator of Research Vocational Services, Rancho Los Amigos Hospital, 7601 E. Imperial Highway, Downey, Ca. 90242</td>
</tr>
<tr>
<td>JOSEPH KUNCE</td>
<td>Project Director &amp; Professor of Education, Regional Rehabilitation Research Institute, University of Missouri, 223 South 5th Street, Columbia, Mo. 65201</td>
</tr>
<tr>
<td>HERBERT LEIBOWITZ</td>
<td>Research &amp; Demonstration Specialist, Social &amp; Rehabilitation Services, Dept. of Health, Education, &amp; Welfare, 50 Fulton St., Room 352, San Francisco, Ca. 94102</td>
</tr>
<tr>
<td>ROSE LEOPOLD</td>
<td>Vocational Counselor, Vocational Rehabilitation Division, Dept. of Human Resources, 309 Southwest 4th Avenue, Portland, Oregon 97204</td>
</tr>
<tr>
<td>PAUL LEUNG</td>
<td>Assistant Professor, The Rehabilitation Center, College of Education, University of Arizona, Tucson, Arizona 85721</td>
</tr>
<tr>
<td>WENDELL LIPSCOMB</td>
<td>Executive Director, Source, Inc: Studies of Urban Research and Community Education, Suite B, 1918 Bonita St., Berkeley, Ca. 94704</td>
</tr>
<tr>
<td>ARLENE LISSNER</td>
<td>Assistant Director of Program Development and Training, Illinois State Drug Abuse Program, 1440 South Indiana, Chicago, Ill. 60605</td>
</tr>
<tr>
<td>Name</td>
<td>Title</td>
</tr>
<tr>
<td>-------------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>STUART LOOMIS</td>
<td>Director of the Psychological Services Section</td>
</tr>
<tr>
<td>IRVING LUKOFF</td>
<td>Director, Addiction Research &amp; Treatment Corporation Evaluation Team</td>
</tr>
<tr>
<td>LLOYD MACK</td>
<td>Chief of Planning, Research &amp; Program Development</td>
</tr>
<tr>
<td>GREGORY MARC</td>
<td>Program Analyst&lt;br&gt;Rehabilitation Services Administration</td>
</tr>
<tr>
<td>ROBERT MARKEL</td>
<td>Rehabilitation Counselor&lt;br&gt;Division of Rehabilitation Services</td>
</tr>
<tr>
<td>ROBERT MARX</td>
<td>Program Specialist for Drug Abuse&lt;br&gt;Texas Rehabilitation Commission</td>
</tr>
<tr>
<td>RICHARD MONTES</td>
<td>Job Developer&lt;br&gt;Boyle Heights Center</td>
</tr>
<tr>
<td>WILLIAM MORGAN</td>
<td>Vocational Rehabilitation Program Specialist</td>
</tr>
<tr>
<td>LOIS MUNSON</td>
<td>Counselor&lt;br&gt;Veteran's Administration Hospital</td>
</tr>
<tr>
<td>ROGER MYERS</td>
<td>Professor of Psychology &amp; Education &amp; Associate Director&lt;br&gt;Program Coordinator of Counseling &amp; Personnel</td>
</tr>
<tr>
<td>Name</td>
<td>Position and Affiliation</td>
</tr>
<tr>
<td>--------------------</td>
<td>-----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>LOUIS NAU</td>
<td>Special Assistant to the Commissioner, Rehabilitation Services Administration</td>
</tr>
<tr>
<td></td>
<td>DHEW South Bldg., Room 3110, 330 Independence Avenue, Washington, D.C. 20201</td>
</tr>
<tr>
<td>DAVID NURCO</td>
<td>Research Scientist, Dept. of Mental Hygiene, Maryland Psychiatric Research Center, Drug Abuse Study</td>
</tr>
<tr>
<td></td>
<td>1229 W. Mount Royal Avenue, Baltimore, Md. 21217</td>
</tr>
<tr>
<td>JOSEPH PALEVSKY</td>
<td>Associate Rehabilitation Counselor, Office of Vocational Rehabilitation, State Education Department</td>
</tr>
<tr>
<td></td>
<td>225 Park Ave., South, New York, NY 10003</td>
</tr>
<tr>
<td>JANET PENCE</td>
<td>Rehabilitation Counselor, Dept. of Vocational Rehabilitation, 1299 4th St., San Rafael, Ca. 94901</td>
</tr>
<tr>
<td>DON PERKINS</td>
<td>Chief Resource Manager, Resource Division Unit, Division of Rehabilitation Education &amp; Services Branch</td>
</tr>
<tr>
<td></td>
<td>801 Bankers Trust Bldg., Des Moines, Iowa 50309</td>
</tr>
<tr>
<td>ADELE PILSK</td>
<td>Coordinator, Drug Abuse, Editorial Seminar, 50 Fulton St., Room 342, San Francisco, Ca. 94102</td>
</tr>
<tr>
<td>FATHER JIM REARDON</td>
<td>Group Therapist, State Industrial School, Mandan, North Dakota 58554</td>
</tr>
<tr>
<td>CHARLES REEDER</td>
<td>Research Assistant, Regional Rehabilitation Research Institute, University of Missouri</td>
</tr>
<tr>
<td></td>
<td>223 S. 4th Street, Columbia, Mo. 65201</td>
</tr>
<tr>
<td>BILL REINER</td>
<td>Vocational Services Counselor, Marin Open House, 918 &quot;C&quot; Street, San Rafael, Ca. 94901</td>
</tr>
<tr>
<td>ROSE ROBINSON</td>
<td>Social Science Analyst, Division of Rehabilitation &amp; Employability Research, Research &amp; Demonstration</td>
</tr>
<tr>
<td></td>
<td>Social &amp; Rehabilitation Services, Dept. of Health, Education &amp; Welfare, Room 5327 HEW South Bldg.</td>
</tr>
<tr>
<td></td>
<td>330 &quot;C&quot; Street, Washington, D.C. 20201</td>
</tr>
</tbody>
</table>
JOSEPH ROTHSTEIN  
Director, Office of Addictive Programs  
Office of the Governor  
State Capitol Bldg.  
Helena, Montana 59601

DANIEL SANFORD  
Rehabilitation Counselor  
Office of Vocational Rehabilitation  
University of New York  
State Education Department  
225 Park Ave. South  
New York, NY 10003

PHILIP SCHAER  
Regional Commissioner  
Social & Rehabilitation Services  
Dept. of Health, Education, & Welfare  
50 Fulton St., Room 450  
San Francisco, Ca. 94102

EDWARD SCOTT  
Clinical Director  
Oregon State Mental Health Division  
309 Southwest 4th Avenue  
Portland, Oregon 97204

FLORENCE SEAMAN  
Project Officer  
National Institute for Mental Health  
Room 13-C-05  
5600 Fischer Lane  
Rockville, Md. 20852

SOL SILVERMAN  
Special Assistant to the Director  
for Formula Grants  
Division of Narcotic Addiction & Drug Abuse  
National Institute of Mental Health  
5600 Fishers Lane  
Rockville, Md. 20852

HAROLD SIMMONS  
Social Rehabilitation Services Specialist  
Division of Local Programs  
Dept. of Mental Hygiene  
744 "P" Street  
Sacramento, Ca. 95814

JIM SINGLETON  
Business Manager of Medical Clinic  
Haight Ashbury Free Medical Clinic  
558 Clayton St.  
San Francisco, Ca. 94117

DAVID SMITH  
Chairman of the Advisory Council of the  
Drug Abuse Editorial Seminar  
Medical Director of the Haight-Ashbury  
Free Medical Clinic  
1698 Haight St.  
San Francisco, Ca. 94117

DONALD SUPER  
Director of Division & Chairman of the  
Dept. of Psychology  
Teachers College  
Columbia University  
Box 214, 525 West 120th St.  
New York, NY 10027
CHARLOTTE TAYLOR  
Director of Training  
Division for Research & Training in Rehabilitation  
University of Southern California  
School of Medicine  
1739 Griffin Ave.  
Los Angeles, CA 90031

MARYANN URBAN  
Program Director  
National Commission on Marijuana & Drug Abuse  
801 19th St., N.W.  
Washington, D.C. 20006

HUGH W. WARD  
PACT  
415 Madison Avenue  
New York, N.Y. 10017

EDWARD WASHINGTON  
Director, Model Neighborhood Inner City Drug Abuse Program  
4707.15 Woodward Ave.  
Detroit, Michigan 48201

LEONA JACOBS-WHITE  
Director, Social Rehabilitation Section  
"Crackerjack," Haight Ashbury Free Medical Clinic  
1644 Haight St.  
San Francisco, Ca. 94117

EILEEN WOLKSTEIN  
Chief, Vocational Rehabilitation  
Beth Israel Medical Center  
Beth Israel Hospital  
Morris J. Berstein Institute  
307 Second Ave.  
New York, NY 10003

PEGGY WOODRUFF  
Director of Vocational Services  
Marin Open House  
918 "C" Street  
San Rafael, Ca. 94901

PATRICIA WRIGHT  
Social Science Analyst  
Community Services Administration  
Social & Rehabilitation Services  
Dept. of Health, Education, & Welfare  
Room 2125 HEW South Bldg.  
330 "C" Street, SW  
Washington, D.C. 20201

PAUL WRIGHT  
Coordinator—Addiction, Alcoholism Correction Vocational Rehabilitation  
Box 1016  
Lansing, Michigan 48904

THAYNE WRIGHT  
Program Coordinator, Medical Social Work  
Vocational Rehabilitation Services Division  
Dept. of Social & Health Services  
P.O. Box 1788 MS 24-2  
Olympia, Washington 98504

WILLIAM WRIGHT  
Counselor, Dept. of Vocational Rehabilitation  
Area 5 Special Programs  
117 Richmond, N.E.  
Albuquerque, New Mexico 87106