

Supporting Drug & Alcohol Service Users Back to Work: The Research Evidence

Background

In comparison with mental health, where there is a strong evidence base to guide the development of vocational services, far less research has been done with people who misuse drugs and alcohol. However, in 2004 the international journal *Substance Use & Misuse* devoted two issues, published together as a special issue that year, to this topic. The collected papers comprise a review of all the previous research since 1980 and reports of more recent or current research. As would be expected, the majority of studies have been carried out in the US. The main conclusions are:

1. Until recently it has been assumed that simply treating substance misusers (i.e. enabling them to achieve abstinence) would be sufficient to enable them to get a job. A considerable body of research has demonstrated that this assumption is unfounded. The implication is that specialist vocational services are required as part of treatment¹.
2. As in the field of mental health, sheltered work involving specialist placements on below market wages does not lead to people getting real jobs².
3. Equally, job preparation alone, such as job seekers' workshops, seems only to have any impact for people who have a strong external motivation to get a job, such as a parole or probation condition².
4. More research is needed, but there are two more promising interventions: a stepped care model³ and the comprehensive employment supports (CES) model⁴. These two models are outlined below.

The stepped care model

This is essentially a behavioural, methadone substitution programme in which service users who do not respond to initial lower levels of counselling have to attend increasing numbers of individual and group counselling sessions to obtain methadone. It is a requirement that people are working at least part time by the end of the first year. Those who are not working after a year are systematically moved to higher levels of counselling intervention until they do get a job. If they still don't find work their methadone is tapered in preparation for discharge.

Individual counselling is primarily focused on reduction of substance use, with a concurrent focus on overcoming major employment problems. Employment incentives include increased take-home doses of methadone and access to earlier and expanded medication dispensing hours, plus advice to participate in a job seekers skills training group.

Group counselling includes drug education, coping skills, job seekers skills training, community social support, relapse control and CBT. The job seekers' group provides

opportunities for practising completing applications, writing a CV, networking, interviewing and dealing with problems that can occur at work.

Evaluation showed that the great majority of service users (93%) did find a job within a year. The danger is that some people may leave the programme altogether rather than find a job. In fact the people in the study were those who stayed in treatment for at least one year. This means there is a strong risk of bias in the results, since people who dropped out of treatment were not included in the study.

The customised employment supports model

This model is based on the Individual Placement and Support model that has proved effective with mental health service users. The difference is that for substance misusers non-vocational counselling is provided alongside a focus on getting a real job as soon as possible. The rationale for including non-vocational counselling is that substance misusers face additional barriers to employment as a result of years of living a chaotic life outside mainstream society.

The non-vocational element focuses on increasing service users' self-efficacy (their belief in their capacity to initiate tasks and achieve their goals). The main techniques used are:

- Persisting in making contact with people who don't initially engage, as in assertive outreach
- Meeting with people in the community rather than a clinic, to establish partnership working and therapeutic alliance
- Giving people stepped tasks to achieve to build their confidence in their ability
- Helping with immediate needs e.g. housing that affect people's ability to focus on getting a job.

The vocational element is very similar to IPS, except that a substance misuse history is not usually disclosed to potential employers.

People are not expected to be abstinent before the service is provided. Instead, employment is seen as likely to increase the potential for abstinence. As with IPS in the mental health field, wanting to work is the only eligibility criterion.

People who don't make progress are not discharged but 'deferred', with an invitation to make contact at any point in the future.

A five year randomised controlled trial is being carried out to compare the CES model with standard vocational programmes (job seekers groups, help with CVs etc.)⁵. Results after six months indicate that CES is significantly more effective in enabling people to find a job than standard programmes. In the group receiving CES, 27.3% had entered competitive paid employment after six months, compared with 13.6% of the standard programme group. A further 38.2% had obtained informal paid work (off the books work such as babysitting, gardening for neighbours) compared with 27.3% in the standard programme group.

Conclusions

Positive evaluation results for the two models have to be set in the US context. Welfare benefits had recently been withdrawn in the US from people whose only 'disability' relates to substance misuse. This means the incentive to find and keep a job may be greater than in the UK, leading to more positive results. On the other hand, the areas where the research was carried out were experiencing high levels of unemployment, so that getting a job is likely to be considerably harder than in some areas of the UK. On balance, the two probably cancel each other out, meaning that similar results could be expected.

Of the two models the stepped care model may fit less easily with both UK culture and current service approaches some areas of the UK. The early evaluation results reported are more robust for the CES model and this model does appear to have real potential for development. Given the need for further evaluation, a pilot project with one or two DATs comparing results with those for standard treatment might be the best way forward.

References

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Jenny Secker
Professor of Mental Health
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