Something of Value: Bringing Contingency Management to the New York City Health and Hospitals Corporation Drug Treatment Service

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Smart Practice, Practical Science: Blending Treatment and Research

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Science Meets Practice

- As an outgrowth of a Contingency Management Panel (Kellogg and Stitzer) presented at the NIDA CTN Blending Conference held in New York in March, 2002

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- Secondary support was provided by Maxine Stitzer, PhD (Johns Hopkins), and John Rotrosen, MD (NYU) -- both of the CTN as well

Background to the Collaboration

- The HHC Behavioral Health leadership had undertaken a number of projects to improve the quality of chemical dependency treatment in New York City
- Burns and Coleman were very interested in our CTN Contingency Management approach because they were already beginning a program to use incentives or rewards in their vocational training programs in the New York City methadone and medication-free clinics

The Original Plan

- As organized at that point, each clinic was expected to create a plan for distributing reinforcements in an appropriate and systematic way to their patients
- The idea was that when patients reached various benchmarks, they would receive a reward (i.e., a gift certificate)

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- The greatest concern was that it would result in the distribution of prizes to the “best” or “most successful” patients
  - while having little or no impact on those who were having serious problems attaining or maintaining abstinence and sobriety

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- The reward programs was set up to acknowledge major accomplishments – maintaining abstinence for 1 month; holding a job for 3 or 6 months; or completing a one-year program;
- In a sense, it was a program to reward "virtue"
- The problem is that the reward comes after the completion of the goal and is therefore most likely to be received by the highest functioning or most successful patients

Reward Vs. Reinforcement (2)

- While a form of acknowledgment, the risk was that the gifts and vouchers involved would not be powerful enough to result in the sustained behavior change that achieving those goals required

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- We can go from "You have done a good job" to "You have taken a step in the right direction"
- Again, not only the most motivated patients, but also those who are more troubled and/or more severely addicted have the opportunity to benefit (Petry et al., 2001)

Definitions and Constructs

- Technically, “reward” and “reinforcement”, as used here, are the same thing; the issue is the criteria for reinforcement (Kazdin, 1994; Wolpe, 1982)
- However, clinically, the social constructs of “reward” and “reinforcement” were quite meaningful to the staff and the leadership

Definitions and Constructs (2)

- Giving things to people on the way to accomplishing a goal seemed fundamentally different from giving it to them only when they achieved it
- It was this difference that played a crucial role in reorienting the HHC clinics and making this project a success.

The Collaboration

- Ms. Burns and I traveled to 7 sites (9 clinics) where I presented on Contingency Management
- She spoke about vocational training,
- Group and individual therapy,
- The availability of funding for reinforcements,
- And other system issues
- Staff members were also provided with papers by Drs. Stitzer, Petry, and Higgins

Reinforcement Strategies

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2. It should be very easy to earn reinforcements at the start; the “bar” should be kept low
3. An example of this is that when the trainers at Sea World begin to teach the whales to jump over the hoops, they start with the hoop being under the water; the whales are reinforced for simply swimming over it (Coonradt, 1996)

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6. Reinforcements will be most effective if their distribution is connected to specific and observable behaviors and they receive them immediately after exhibiting the behavior (i.e., attending the group)
7. The greater the delay in receiving the reinforcement, the weaker its effect is likely to be

Reinforcement Strategies (3): Clinical Considerations

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- In the face of setbacks, patients should be encouraged, not criticized
- Reinforcement criteria should be clear to both the patients and the staff; if they meet the criteria, they must receive the reinforcement -- regardless of their drug use status

Reinforcement Strategies (4): Social Aspects

- There are powerful social reinforcement processes at work when the counselor gives the reinforcement to the patient
- Counselors who are not enthusiastic might inadvertently have a damaging impact on its efficacy (Petry & Bohn, 2003)
- A congratulatory approach is seen as the most appropriate one

Reinforcement Strategies (5): Implications for Counseling

- It was emphasized that CM is not a substitute for counseling
- Reinforcements do not directly teach people how to abstain nor do they provide skills -- they simply strengthen behaviors that lead to that outcome
- Counselors have a valuable therapeutic opportunity to explore with their patients what actions they took to avoid using drugs;
- This can be used to develop future coping strategies (Morral, Iguchi, & Belding, 1999)

Implementation Issues

- 5 sites implemented programs (4 methadone; 1 medication-free)
- Programs and counselors developed their own models
- Typically group attendance and goal attainment were reinforced and material and social reinforcements were used
- Reinforcements were distributed in both group and individual settings
- One site developed a powerful computer program that enabled patients to monitor their points

Reinforcements for Group Attendance

- The actual reinforcements used included
- movie passes, transportation vouchers (“metro cards”)
- McDonald’s coupons, calendars
- gift certificates for major department stores and music outlets
- date books, tools, clothes, books
- tee-shirts, microwaves, water bottles
- sunglasses, things for children, toiletries, food, and candy

Reinforcements for Group Attendance

- In one program, higher levels of reinforcement were used for groups that involved greater levels of personal vulnerability, such as dance and the creative therapies
- Programs also instituted or expanded upon existing award ceremonies

Implementation Process

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- "This was a long and hard process and there were lots of fights. Staff saw it as a negative at first…,.
- As the director, I allowed the staff to ventilate.
- The Vocational staff started the whole process because their orientation is far more receptive to this kind of thing." (Program Director)

Patient Experiences

- Patients were very enthusiastic about the program from the start, and it was this emotional reaction that helped to sway the counselors
- Some patients initially met the idea that they would get a prize for attending a group with disbelief;
- They had to actually see the prize before they would believe that it was not a trick.

Patient Experiences (2)

- The counselors perceived that the patients' self-esteem was beginning to rise, and that they were becoming more empowered
- This manifested itself both
- In improvements in their appearance,
- And in the development of goals – typically of a vocational or educational nature

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- “Clients are proud and are having fun. Early in treatment, when their name is called out, they are feeling good that they are being acknowledged. For once in their life, they are being rewarded for something.”
- “We know that clients’ dreams were lost to drug addiction. Now, clients are able to go to Macy’s and J.C. Penney. This is big time for them; they’re able to shop at prestigious stores.” (Counselor reports)

Patient Experiences (4)

- A core issue here was the profound emotional and economic deprivation that these patients had experienced and continued to experience
- The reinforcements and awards were so powerful because some believed that the staff did not care about them,
- And others, in their 30's and 40's, had never received a certificate for anything
- Because of their high levels of economic deprivation, the gift certificates frequently made a significant difference in their lives

Patient Experiences (5)

- The basic process was that the reinforcements got them to the groups and motivated them to stay,
- And then the power of the group began to have its impact
- As has been noted elsewhere (Petry et al., 2001),
- Patients first came for external reasons
- And then chose to stay because of their internal motivations.

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- "As one patient put it, 'I used to think the drug dealer cared for me but this is really caring.'" (Counselor)

Patient Experiences (7)

- The prizes became a vehicle for family healing as patients used their gift certificates to buy presents or needed items for their children or other family members
- In a number of cases, these actions began a process of reconciliation (see also Petry & Bohn, 2003)
- Lastly, patients began to socialize with each other
- They would use their coupons and go to movies together in groups
- There were also reports that they were taking care of each other and giving each other gifts

Internalization

- They developed increased sense of ownership and responsibility for their program and their recovery
- As one counselor put it, they went from "You are forcing me" to "I choose"
- In one striking example, patients who felt that methadone initially made them drowsy, delayed the taking of their medication until after their group so they could be more alert and alive
- Clients also began to privately speak to their counselors about individuals who were dealing drugs or otherwise engaging in anti-therapeutic behavior
- The staff said that they had never seen this kind of reporting before

Counselor Experiences

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- “It gives me a great deal of pleasure to know I’m part of a state-of-the-art methadone treatment program.”
- Their perception of the use of reinforcements also began to change
- “We came to see that we need to reward people where rewards in their lives were few and far between. We use the rewards as a clinical tool – not as bribery, but for recognition. The really profound rewards will come later.”

Counselor Experiences (2)

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- "It is a lot easier to do a group with more people. … You don't have to chase people down. The staff feel more fulfilled."
- Another counselor said: "Now, there's no need for coercion, no more contracts. There's more a sense of the clients volunteering. Before we felt like jailers, now we're looked at differently…"

Counselor Experiences (3)

- When patients publicly, and sometimes tearfully acknowledge the counselor's help in public, the staff felt a sense of gratitude
- "In the last two award ceremonies, clients said, 'I want to thank the staff….' That sounded real good – we feel appreciated."

Counselor Experiences (4)

- Clearly, much of the staff appeared to take the positive reinforcement approach to heart
- They began to affirm and celebrate even small steps in the right direction
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- In what could be seen as an example of "gradualism" (Kellogg, 2003) or shaping, patients were reinforced by some counselors if they went from using two drugs to using one
- "I felt resistant at first…. But, as it caught on, I began to like giving points to clients. I saw that my client wasn't using dope, only coke, and I'd say – give him a point! So, now I'm very involved."

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- "There has been a major acceptance now for vocational counseling and activities, and we now have a "Wall of Fame." [A bulletin board with pictures of employed patients.]

Clinic Changes - Mood and Culture

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- “I think it does strengthen the alliance with the team, not just one counselor. The program has become nurturing.”

Staff, Patient, and Clinic Overall Impressions

- At our one-year follow-up visit, the program was extremely popular among both patients and staff and was uniformly seen as a success
- The patients loved it, and some reported that it had saved their lives. They felt that their drug use had been getting worse and worse, and it was the contingencies that empowered them to choose a different life direction
- The staff and leadership were very excited about and proud of their reinforcement programs.

Factors in Successful Implementation

The factors that seemed vital in making this program a success were

1. The work that HHC and NYS-OASAS had done to improve treatment
2. The funding that was available to pay for the reinforcements
3. There was a mandate from the HHC administration that the clinics had to come up with a plan if they wanted to receive the funding

Factors in Implementation Success (2)

4. The scientific and clinical paradigm and framework that came from CTN-affiliated researchers and clinicians
5. Dynamic leadership on-site and higher up in the system
6. The creativity of the counseling staff
7. The enthusiasm of the patients

Comparisons with Research Protocols

This intervention differed from some of the classic contingency management protocols (i.e., Higgins, Silverman, Petry) in two important ways:

1. This was not an add-on to an existing program; it became the centerpiece for all of the psychosocial treatments
2. The reinforcement system itself was, for the most part, devised and run by the counselors themselves.

   They saw, first hand, the power of this kind of behavioral technology, and

   they directly reaped the benefits of it in the form of greater professional success

Limitations

- We are greatly aware of the limitations of this presentation
- Clearly, it is as much a story as a study
- Nonetheless, something remarkable appears to have happened in these clinics that could be a source of inspiration to other programs that are considering adoption of a contingency management approach

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