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Something of value: The introduction of contingency management interventions into the New York City Health and Hospital Addiction Treatment Service

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Abstract

This paper explores the impact of the adoption of the contingency management approach by the Chemical Dependency Treatment Services of the New York City Health and Hospitals Corporation (HHC). The utilization of this approach grew out of an alliance between NIDA Clinical Trials Network-affiliated clinicians and researchers and a leadership team at the HHC. Interviews and dialogues with administrators, staff, and patients revealed a shared sense that the use of contingency management had: (1) increased patient motivation for treatment and recovery; (2) facilitated therapeutic progress and goal attainment; (3) improved the attitude and morale of many staff members and administrators; and (4) developed a more collegial and affirming relationship not only between patients and staff, but also among staff members.

Keywords: Contingency management; Positive reinforcement; Addiction treatment; Methadone; Vocational rehabilitation

1. Introduction

The process of institutional change can appear complex and intimidating. This paper tells the story of the successful adoption of a new empirically-based treatment, contingency management (CM), by a diverse array of chemical dependency treatment programs within the largest public hospital system in the nation. The project involved the collaboration of scientifically-oriented researchers and clinicians from the Clinical Trials Network (CTN) of the National Institute on Drug Abuse (NIDA) and an innovative leadership team from the New York City Health and Hospitals Corporation (HHC), a public benefit corporation in which the treatment programs reside. When the project moved out into the field, the hard work and creativity of the counselors and other clinical staff who further refined the contingency management programs and implemented them in their clinics and the enthusiasm of the patients were key ingredients in making it a success.

2. The Health and Hospitals Corporation

2.1. Background

The New York City Health and Hospitals Corporation was established as a public benefit corporation in 1970 and is a large municipal health care provider, with 11 acute-care

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hospitals, six diagnostic and treatment centers, four long-term care facilities, over 100 community health clinics, a managed care organization (MetroPlus), and a certified home health care agency. In addition to primary heath care, HHC provides a full array of mental health and chemical dependency services, operating over 1,200 inpatient behavioral health beds that generate 20,520 patient discharges per year, and outpatient services that generate over 472,000 visits a year. The array of chemical dependency treatment programs within HHC facilities includes: eight methadone treatment programs, 19 outpatient chemical dependency treatment programs, eight inpatient detoxification units, two halfway houses, a residential program run in partnership with a community-based provider which offers a medication taper and added support for those patients wishing to discontinue their methadone treatment, four hospital intervention and referral services, and an intensive case management program. At the start of the collaboration, HHC had been engaged in a process of evaluating their treatment structures and developing practice guidelines in order to improve treatment outcomes through increased focus on recovery, self-sufficiency, and employment.

2.2. An agency in transition

In 1998, HHC was awarded funds by the New York State Office of Substance Abuse Services (OASAS) to add a vocational rehabilitation counseling component in five of its methadone clinics. The award stipulated that the clinics needed to revise their programs to reflect an integration of vocational and clinical services and develop a "worker-friendly" culture. The following year, after methadone treatment in New York City was directed to place a strong focus on self-sufficiency, additional funds were provided by the City to further enhance the services offered by HHC's methadone treatment and drug-free outpatient programs by enhancing their vocational services. In 2000, there was a second award of funds from OASAS, which added still more vocational resources.

With this infusion of funds, HHC's methadone clinics underwent a profound structural and philosophical change, reflected in a conscious decision to change clinic names from methadone *maintenance* to methadone *treatment* programs. A workgroup made up of physicians, program administrators, and representatives from various disciplines standardized practice guidelines and revised clinic manuals for all of the methadone programs. Clinics and staff were strongly encouraged to embrace rehabilitation, recovery, and self-sufficiency both philosophically and as primary treatment goals. It was expected that evening and Saturday hours of operation would be added, caseloads would decrease, and more intensive counseling services including group treatment would be offered. Career centers, equipped with computers, vocational tests, videos, workbooks, video cameras, televisions, and VCRs, were also established in each clinic. Program administrators meet regularly and worked closely with corporate staff to share ideas and address obstacles, and a statistical reporting system was instituted to collect and analyze data. Similar changes were also being put into place in the outpatient chemical dependency programs.

The second wave of efforts to foment institutional change and facilitate staff "buy-in" included an HHC-organized, day-long workshop for administrative and line staff of the methadone programs entitled *Multidimensional Solutions in Substance Abuse Treatment: Thinking Outside of the Box*. The training emphasized not only the importance of respecting the patient's values, wishes, and culture, but also the need to be aware that change was a cyclical, individual process. In addition, clinics were encouraged to adopt the transtheoretical model of behavioral change as a guiding principle in developing treatment plan goals and matching interventions. OASAS assisted by making available a 2-day training entitled *Project Invest* that focused on the integration of vocational rehabilitation into the treatment process.

A third phase of interventions began when HHC developed, funded, and launched a *Patient Recognition and Motivation Initiative* in the fall of 2001. This initiative was based on research and experience that supported the use of tokens to encourage and motivate patients to attain treatment goals. Recognition of patient achievements was felt to be a valuable mechanism to acknowledge success and the attainment of treatment goals, to further a positive self image, to provide staff and peer support, and to motivate others by furnishing peer models they could emulate. HHC initially developed a recognition plan template that was expected to serve as a model for the clinics to use in developing their own, individual plans. Programs interested in participating in this initiative had to submit a detailed plan for the establishment and ongoing support of a Motivation and Patient Recognition Initiative. The primary focus of this initiative was to be on vocational goals, with substantial emphasis on employment and employment retention. However, recognizing that this is but one piece of drug treatment, and that barriers to recovery and employment are many, Motivation and Recognition Initiatives were also required to be developed in such a way to recognize advancement in treatment and attainment of other significant milestones as well. It was at this point that the HHC leadership came into contact with researchers actively engaged in implementing contingency management protocols.

3. Contingency management

The use of contingency management or positive reinforcement approaches in the treatment of addictive disorders has received increasing levels of attention in recent years as scientific studies continue to demonstrate its efficacy with diverse substance-using populations (Higgins, Alessi, & Dantona, 2002; Petry, 2000; Petry, Martin, Cooney, & Kranzler, 2000; Petry et al., 2001; Silverman et al., 1996; Stitzer, Iguchi, Kidorf, & Bigelow, 1993). As a reflection of