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The Effectiveness of the Treatment Readiness and Induction Program (TRIP) for Improving During-Treatment Outcomes

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ABSTRACT

Treatment engagement is a primary pathway to change. Because motivation consistently predicts engagement and sustained recovery following treatment, targeted efforts at improving problem recognition (i.e., a significant ingredient in motivation) during early weeks of treatment are critical. The purpose of this study is to compare the effectiveness of Standard Operating Practice (SOP) versus SOP plus an 8-session Treatment Readiness and Induction Program (TRIP; delivered in the first weeks of treatment) on cognitive indicators and treatment engagement among youth in 5 residential substance use treatment settings. Structural Equation Modeling (SEM) documented higher problem recognition, decision making, and treatment engagement (participation, satisfaction, counselor rapport) among youth receiving TRIP (compared to SOP only), even when controlling for background characteristics such as age, race-ethnicity, gender, baseline drug use severity, etc. Findings suggest that TRIP is an effective induction tool that directly impacts targeted constructs (i.e., problem recognition, decision making), and also directly affects indicators of engagement.

1. Introduction

Treatment engagement is a primary means through which therapeutic change occurs. The concept can refer to an "intermediate step between initially accessing care (in a first visit) and completing a full course of treatment" (Garnick, Lee, Acevedo, Horgan, & the Washington Circle Public Sector Workgroup, 2007) or to level of participation during sessions (for example, actively contributing to discussion, developing relationships with counselors and peers). Measures of therapeutic involvement – participation in sessions, satisfaction with treatment, relationships with counselors, and perceived support from peers in treatment – are useful indicators of whether individuals are embracing or resisting the process of personal change (Cunningham, Duffee, Huang, Steinke, & Naccarato, 2009; Hawke, Hennen, & Gallione, 2005; Hiller, Knight, Leukefeld, & Simpson, 2002; Simpson, 2004; Simpson & Knight, 2001; Staton-Tindall et al., 2007). The more engaged an individual is in treatment, the stronger the commitment to change, the greater the personal transformation, and the greater the likelihood of sustained change after treatment discharge (Crits-Christoph et al., 2011; Diamond et al., 2006; Garnick et al., 2012; Simpson, Joe, Rowan-Szal, & Greener, 1995). Indeed, the influence of engagement in improving outcomes remains important, even when accounting for other factors such as legal pressures, DSM diagnoses, and demographics (Joe, Knight, Becan, & Flynn, 2014).

Barriers to successful engagement are numerous and include low motivation for change, cognitive challenges, poor relationships, and comorbidity, among others (Broome, Joe, & Simpson, 2001; Dakof, Tejeda, & Liddle, 2001; Hiller et al., 2002; Kaminer & Frances, 1991; Simpson & Joe, 2004). Motivation is pivotal in the engagement process for adults (Simpson, 2004), adolescents in general (Brown & Ramo, 2006), and adolescents referred to treatment by juvenile justice systems (Orlando, Chan, & Morral, 2003). Compared to adults, teens usually are less motivated to change (Melnick, De Leon, Hawke, Jainchill, & Kressel, 1997) and only 20% of those with symptoms indicative of substance abuse problems view their use as a "problem" (Titus & Dennis, 2006). While juvenile justice involvement may provide external motivation or pressure to remain in treatment for a determined length of time, youth under legal pressure exhibit lower motivation for treatment, which can negatively impact therapeutic engagement (Joe et al., 2014) – in other words, these youth are often "going through the motions" without actively engaging. Youth also face cognitive challenges that can interfere in decision making. Compared to adults, youth typically exhibit less preparedness for coping with difficult situations (Myers & Brown, 1990) and tend to place greater importance on social perceptions than on factual information about future consequences (Steinberg, 2007). As they mature, the ability to suppress or inhibit inappropriate thoughts and actions increases (see Casey, Jones, & Hare, 2008 for a review).

Because motivation or "readiness" (including problem recognition) consistently predicts retention, engagement, and the likelihood of

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sustained recovery following treatment (e.g., Broome et al., 2001; Callaghan et al., 2005; Joe et al., 2014, Melnick et al., 1997), targeted efforts at improving motivation are critical in the early weeks of treatment. Educational literature on academic motivation suggests that experiential activities and peer-to-peer interaction can facilitate motivation for learning (Master & Walton, 2013; Plass et al., 2013), increasing content knowledge, stimulating self-awareness, and fostering self-efficacy (O'Donnell et al., 1990; Young, 2005). Given that recovery from substance abuse involves learning to acknowledge personal problems and develop new strategies for coping with challenges (e.g., risk avoidance techniques, cognitive restructuring, and strengthening productive relationships), it is likely that the experiential and interactive principles that influence academic motivation are also applicable in therapeutic settings. Indeed, effective methods for engaging youth include high arousal activities that capture attention, followed by a transition to lower-arousal activities that promote self-reflection and personal insight (Perry et al., 2011). Interventions designed to boost problem recognition and decision making competencies through structured, interactive activities have the potential to impact treatment engagement as well.

Considering the aforementioned learning principles and approaches to facilitating motivation and engagement, evidence-based induction and readiness tools were adapted for adolescents in substance abuse treatment and bundled as the Treatment Readiness and Induction Program (TRIP). The goal of TRIP (Knight, Dansereau, Becan, Rowan, & Flynn, 2015) is to enhance therapeutic engagement (facilitate participation, strengthen therapeutic relationships) by improving readiness (problem recognition) and capacity (decision making) for personal change. Increasing readiness and capacity for change is accomplished through interactive modules and activities that promote problem recognition and more thoughtful, reasoned decision making. The TRIP intervention was designed as an enhancement to standard substance abuse treatment for adolescents and is based on a compilation of effective strategies and materials for engaging adults in treatment (e.g., Blankenship, Dansereau, & Simpson, 1999; Czuchry & Dansereau, 2000; Dees, Dansereau, & Simpson, 2002; Sia, Dansereau, & Czuchry, 2000). *TCU Mapping Enhanced Counseling* forms the core and serves to focus attention, facilitate communication, and visually illustrate concepts and ideas for better decision making (Dansereau & Simpson, 2009). Mapping is particularly effective for clients with attentional problems or lower cognitive functioning (Czuchry & Dansereau, 2004; Newbern, Dansereau, Czuchry, & Simpson, 2005) and leads to a more engaging counseling approach, especially when included with interactive games and peer mentoring (Czuchry, Sia, & Dansereau, 2006; Czuchry, Sia, Dansereau, & Dees, 1997). The intervention incorporates the use of guide maps or analytically created schemas that provide a structure for thinking through complex problems. Through practice, these schemas can be internalized and used to address everyday problems as they arise. "Helping individuals form more robust and effective schemas can serve to enhance judgment, decision-making, and self-regulation" (Dansereau, Knight, & Flynn, 2013, p. 278).

TRIP was designed to facilitate awareness of personal problems and to help youth make better choices (targeting decision making skills). Indeed, TRIP is effective for promoting decision making among youth in early phases of treatment. Compared to youth in residential settings who received standard operating practice, youth in TRIP reported greater gains in decision making competence (Knight et al., 2015). In addition, TRIP has been found to promote treatment motivation among adolescents, especially for those who have a low tendency to behave rashly when experiencing positive emotions (Becan, Knight, Crawley, Joe, & Flynn, 2015). While TRIP appears to be successful in promoting targeted skills, the degree to which it also promotes active participation and development of productive therapeutic relationships is unknown.

The purpose of this study is to expand on the impact that TRIP has on cognitive outcomes during treatment and examine the intervention's effectiveness in promoting engagement in residential substance use treatment. Because personal change occurs through active participation and development of productive relationships during treatment sessions, and because TRIP uses interactive activities to promote interpersonal communication and improve introspection, the primary hypothesis states that youth receiving TRIP sessions in addition to SOP during the first weeks of treatment will report better during-treatment outcomes than youth receiving SOP only. Two groups of youth entering 5 residential substance use treatment agencies were compared on during-treatment measures of problem recognition, decision making, and therapeutic engagement. The study design uses sequential comparison, whereby each treatment agency served as its own control (i.e., a separate sample pretest–posttest design; Campbell & Stanley, 1963) and controls for historical differences in client population characteristics.

2. Method

2.1. Procedures

Data were collected as part of an ongoing research project funded by the National Institute on Drug Abuse (NIDA; Grant R01DA013093). A sequential comparison design was used to gather data from 2 groups of adolescents enrolled in 5 community-based residential substance abuse treatment agencies from 2011 through 2013. This design was chosen because a randomized control trial could not be satisfactorily maintained in the residential programs (no assurance that control group members would not be exposed to the TRIP intervention material). To avoid contamination across groups, all agencies agreed to provide assessment data for a 6-month period before implementing TRIP with clients. Therefore, in this design, agency participation occurred in two phases (1) assessment only and (2) assessment and curriculum. Youth participated in only 1 phase (SOP or SOP + TRIP) and group assignment was made based their date of admission to the agency. This enabled a comparison between two groups: standard operating practice (SOP) versus SOP plus the TRIP curriculum (TRIP). For both groups, background, motivation, psychosocial functioning, and engagement data were collected at intake and during treatment. After an initial period (range: 5 to 8 months; average: 6 months), agency staff were trained to facilitate the TRIP intervention. Each agency incorporated the 8-session intervention into existing practice and implemented it with newly-admitted youth during their first month of treatment. Youth who enrolled in treatment during the initial 6-month period of data collection received standard operating practice (SOP) and comprised the SOP group. Youth who enrolled following the agency's adoption of the TRIP curriculum comprised the TRIP group. TRIP group data reported here reflect TRIP implementation over a 5-month period (an average of 6 intervention cycles). The TRIP group was an intent-to-treat sample; however, 80% of youth received 4 or more of the 8 TRIP sessions. To further reduce potential for cross-group influence (i.e., youth in the SOP group being exposed to TRIP concepts after staff were trained on TRIP but before TRIP groups began), all youth admitted to treatment within the 30 days prior to the agency's first TRIP group were excluded from the sample. Institutional Review Boards affiliated with the research institution and participating treatment agencies approved all research protocols.

Throughout the project, participating agencies were granted access to the Texas Christian University (TCU) Adolescent Screening and Assessment Package (TCU-ASAP) via an online assessment system developed and managed by the research team. Clinical staff within the participating agencies administered the TCU-ASAP (Knight, Becan, Landrum, Joe, & Flynn, 2014) to newly-enrolled youth at intake (Time 1) and at 30–45 days into treatment (Time 2; during treatment). While the ideal target date for Time 2 data collection was Day 45 (to allow time for initial assessments plus completion of 8 TRIP sessions), youth admitted to the two shorter-term programs were encouraged to complete Time 2 at discharge, which often occurred at Day 30. The average time from treatment admission to when the time 2 instruments were given were 40.1 days (SD = 8.6; agency averages ranged from 32.1 to 49.4 days). Agency staff assigned identification numbers to