



blending initiative
NIDA • SAMHSA

PROMOTING AWARENESS OF MOTIVATIONAL INCENTIVES

2nd Edition (2011)

PRODUCT



Promoting Awareness of Motivational Incentives (PAMI)

Findings and Strategies from a NIDA Clinical Trials Network Study

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Promoting Awareness of Motivational Incentives

Findings and Strategies from a NIDA Clinical Trials Network Study

Background Information: NIDA/SAMHSA Blending Initiative

The National Institute on Drug Abuse (NIDA) and the Substance Abuse and Mental Health Services Administration (SAMHSA) have created a partnership to disseminate information to the addiction treatment field. Through the NIDA/SAMHSA Blending Initiative, special groups called Blending Teams meet to design dissemination strategies and develop research-based products. Members of these Blending Teams come from the NIDA-funded National Drug Abuse Treatment Clinical Trials Network (CTN) and the SAMHSA-funded Addiction Technology Transfer Center (ATTC) Network.

In 1999, NIDA created the National Drug Abuse Treatment Clinical Trials Network (CTN). The CTN conducts studies of behavioral, pharmacological, and integrated behavioral and pharmacological treatment interventions in rigorous, multi-site clinical trials to determine effectiveness across a broad range of community-based treatment settings and diverse patient populations. As the CTN research is completed, NIDA researchers work with representatives from the ATTC network to provide the results and strategies for implementing these findings into clinical settings. This will decrease the time it takes for research to be incorporated into treatment settings and will thereby improve the quality of drug abuse treatment throughout the country.

Focus on Motivational Incentives

In 2000, the National Institute on Drug Abuse (NIDA) funded the large scale study, Motivational Incentives to Enhance Drug Abuse Recovery (MIEDAR), aimed at evaluating the potential benefits associated with the use of low cost incentives in a sample of 800 patients with a co-occurring stimulant use disorder. This study is often referred to as the “MIEDAR Study” (pronounced *my'-dar*).

In 2005, the CTN trial examined a sub-sample of this population (N=415) and randomly assigned patients to one of two groups: treatment as usual or treatment as usual plus Motivational Incentives. The Fishbowl Method for distributing incentives was developed in an effort to contain costs for community treatment providers. Study results indicated that, on average, patients who received treatment as usual plus incentives were retained in treatment longer than those patients in the treatment as usual group and achieved longer durations of continuous abstinence.

Promoting Awareness of Motivational Incentives (2007)

With the results of the MIEDAR study findings strongly supporting the Fishbowl method of distributing low-cost incentives, the Substance Abuse and Mental Health Service Administration's (SAMHSA) Addiction Technology Transfer Centers (ATTCs), in partnership with NIDA and NIDA researchers, Drs. Maxine Stitzer, Nancy Petry, and Scott Kellogg, developed the original Promoting Awareness of Motivational Incentives (PAMI) Blending Product (2007) to promote the awareness and understanding of Motivational Incentives.

PAMI Blending Team (2007)

Members

- Lonnetta Albright, BS, Chair – Great Lakes ATTC
- John Hamilton, LADC – Regional Network of Programs, Inc.
- Scott Kellogg, PhD – Rockefeller University
- Therese Killeen, RN, PhD – Medical University South Carolina
- Amy Shanahan, MS – Northeast ATTC
- Anne-Helene Skinstad, PhD – Prairielands ATTC

Contributors

- Candace Peters, MA, CADC – Prairielands ATTC
- Nancy Petry, PhD – University of Connecticut Health Center
- Maxine Stitzer, PhD, CTN PI – Johns Hopkins University

Update 2011: Promoting Awareness of Motivational Incentives, 2nd Edition

The ATTC Network is pleased to present this updated 2nd Edition (2011) of the **Promoting Awareness of Motivational Incentives (PAMI)** presentation. This Blending Team product, initially produced in 2007, was revised in 2011 in response to feedback from participants, trainers, clinical supervisors, and policy makers around the country. Since 2007, the groundswell of interest from the field has moved along a continuum of awareness of Motivational Incentives to a request for a more advanced and focused look at how the 7 Principles of Motivational Incentives can be applied in the process of adopting effective incentive programs.

PAMI Update Team (2011)

Members

- Patricia Stilen, LCSW, Chair – Mid-America ATTC
- Lonnetta Albright, BS – Great Lakes ATTC
- Holly Hagle, MA – Northeast ATTC
- Candace Peters, MA, CADC – Prairielands ATTC

Contributors

- Heather Gotham, PhD – Mid-America ATTC
- Scott Kellogg, PhD – New York University
- Nancy Petry, PhD – University of Connecticut Health Center
- Deborah Rockford, BA – Mid-America ATTC
- Doris Rogers, BS – Mid-America ATTC
- Maxine Stitzer, PhD, NIDA CTN PI – Johns Hopkins University
- Susan Storti, PhD, RN – Synergy Enterprises, Inc.
- Jan Wrolstad, MDiv – Mid-America ATTC

About the Promoting Awareness of Motivational Incentives (PAMI) Training Materials

The PAMI materials provide information and content for a stand-alone training of approximately 3 hours to 6 hours in length. The training can be conducted in small- to large-sized groups (10 -100 people). Smaller sized groups will allow time for more discussion and interactive exercises. Larger-sized groups will necessitate a more didactic teaching style interspersed with brief question and answer periods.

Trainers are encouraged to adapt these materials to meet the needs of specific target audiences including making use of interactive exercises, discussion questions, and an optional Fishbowl Method demonstration. The Trainer Notes contain information that can be presented with each corresponding PowerPoint slide including literature and publication references. This information is designed as a guidepost and can be adapted to meet the needs of the specific training situation. Information can be added or deleted at the discretion of the trainer(s).

It is essential that the trainer(s) identify the extent of the participants' background and experience with motivational incentive or behavioral approaches, generally, and with implementing evidence-based clinical practices. For example, if the training audience is comprised of practitioners well versed in the principles of Behavioral Psychology, discussion about Classical and Operant Conditioning may not be warranted.

Objectives of the PAMI Awareness Training

1. Describe how motivational incentive programs can enhance treatment outcomes and facilitate patient recovery.
2. Understand the results of NIDA's Clinical Trials Network (CTN) study that used low-cost incentives to increase patient motivation for treatment and recovery.
3. Identify key behavioral terms, definitions and principles underlying successful motivational incentive programs.
4. Describe how the Fishbowl Method can be used to reinforce and strengthen desired patient behavior.

Trainer Notes

For this manual, text that is shown in bold italics is a “***Note to the Trainer.***” Text that is shown in normal font relates to the “Trainer’s Script” for the slide. It is not possible to edit text, graphics, or add animation effects to the original slides numbered 1-75. Two customizable slides (Slides 76-77) can be inserted into the slide presentation. Customizable slides could be used for introductory and closing slides, additional content, or inserting interactive participant exercises such as those slides needed for Optional Trainer Activities. The PAMI Video/DVD assists participants in considering how the 7 Principles of Motivational Incentives relates to the Fishbowl Method used to distribute incentives. Recommended video insertion placements are:

- Video Placement Option 1: Slide 49: The 3 Essential Elements
- Video Placement Option 2: Slide 58: Duration of Intervention – How Long?

Each PowerPoint Slide is pictured next to the corresponding trainer script. The script is designed as a guide and should be tailored to meet the needs of the training audience. Information can be added or deleted at the discretion of the trainer(s).

It is critical that, prior to conducting an actual training, the trainer(s) practice using this guide while showing the slide presentation in Slideshow Mode in order to be prepared to use the slides in the most effective manner.



Note to Trainer



References



Optional Trainer Activity



PAMI Video/DVD

Materials Required to Deliver PAMI Training

Equipment

- Computer with PowerPoint software installed (2003 or higher version)
- LCD projector and screen area to project the PowerPoint slides and PAMI Video/DVD
- Audio speaker or public address system

Curriculum Materials

- PAMI Trainer Guide and PowerPoint Slides
- PAMI Video/DVD – Revised (2011)

Download these curriculum materials from www.bettertxoutcomes.org (Motivational Incentive Web-Portal); www.ATTNetwork.org; or www.nida.nih.gov/blending.

Note: Additional materials needed for Optional Trainer Activities listed separately

Motivational Incentive Companion Products

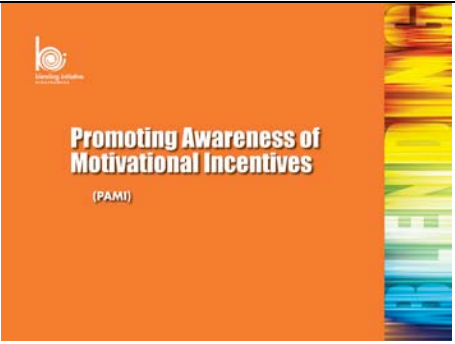
This training package, *Promoting Awareness of Motivational Incentives* (2011), is designed to serve as the foundation for two companion Motivational Incentive Blending Products:



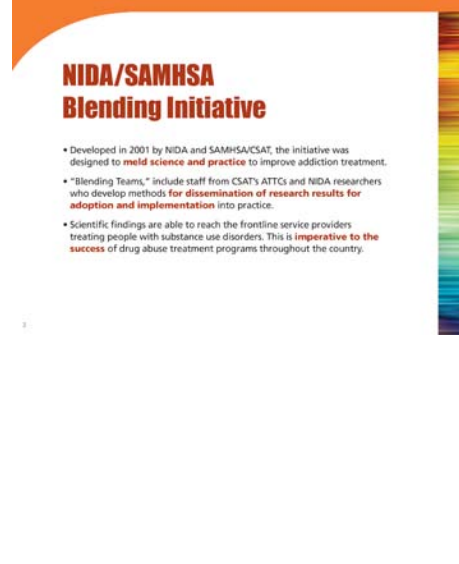

- 1) ***Motivational Incentives: Positive Reinforcers to Enhance Successful Treatment Outcomes (MI-PRESTO)***, a self-paced online course designed to assist clinical supervisors in designing and customizing a Motivational Incentives Program within the context of their community-based treatment organization.
- 2) ***Motivational Incentives Implementation Software (MIIS)*** platform, developed by the National Institute on Drug Abuse, provides the mechanism to accomplish two goals:
 - 1) To assist researchers, clinicians, and counselors in utilizing and applying motivational incentives for treating substance abuse patients; and
 - 2) To maintain information about clinic patients as well as in the implementation and calculation of incentives based on the defined parameters.


MIIS is secure, easy to use, and easy to understand. It consists of a user interface to enter pertinent information and parameters, and to manage patient activities. It also contains a database where patient information is stored. The information recorded by MIIS includes patient identification and demographics, attendance records, abstinence history, incentives (draws and prizes), and drugs of choice.

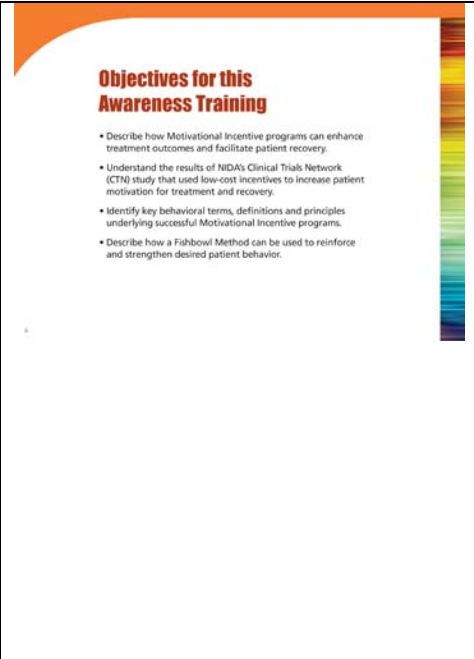
The user can manage patient appointments and print detailed reports about patient activity. Patients are automatically awarded draws as an incentive for attendance and abstinence. The system can be configured to provide draws in varying escalation schedules that are sensitive to patient history of compliance and lapses. Patients may receive prizes in exchange for successful draws (in a Fishbowl-type context), and the system will maintain a record of prizes received by patients. An inventory utility is included to enable counselors to track prizes for the patients. Drug treatment community centers as well as research centers will be able to use this software and enhance their treatment success. MIIS will be available to the public at no cost.

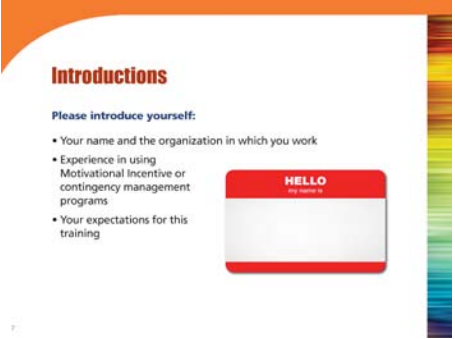

Download these companion products from www.bettertxoutcomes.org (Motivational Incentive Web-Portal); www.ATTNetwork.org; or www.nida.nih.gov/blending.

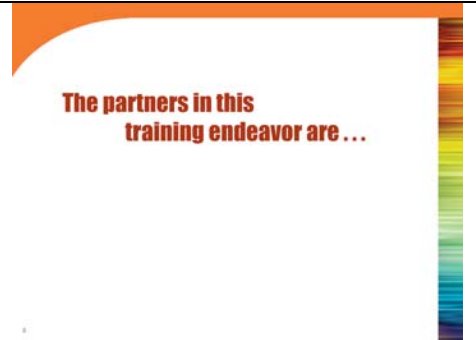
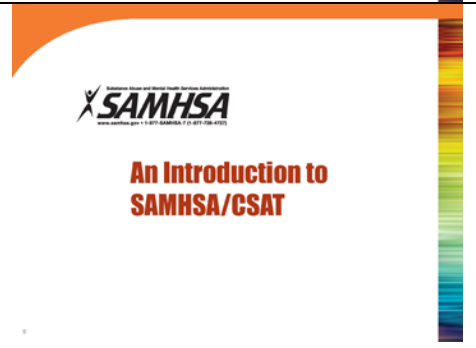

Slide Picture	Trainer Notes	Slide #
	<p>Slide 1: Title Slide -- Presentation Introduction</p> <p>Welcome participants and take care of housekeeping details such as location of restrooms, turning off cell phones, active participation, etc.</p> <p>It is important to note that this training is introductory and is focused on building awareness and encouraging multidisciplinary addiction professionals to learn more about Motivational Incentives.</p> <p>Define (briefly) Motivational Incentives -- is a supplement to therapy that has been shown in research to be an effective strategy in the treatment of substance use disorders. Also known as contingency management, this method has found great success in the treatment of substance use disorders. The term Motivational Incentives is used throughout this presentation.</p> <p>Why “Awareness”?</p> <p>This awareness product introduces background information and methods, including testimonials about how community-based treatment providers have overcome barriers and successfully implemented Motivational Incentive programs.</p> <ul style="list-style-type: none"> • 30 years of research continue to point to positive outcomes if used appropriately. • NIDA recently funded research with low-cost incentives that continues to point to positive outcomes. • Barriers to implementation, such as financial restraints, have prevented the adoption of using Motivational Incentives in treatment. • This “Awareness” project is designed to assist providers and leaders to recognize and understand benefits and consider implementation strategies for using Motivational Incentives. 	<p>Slide # Slide 1</p>


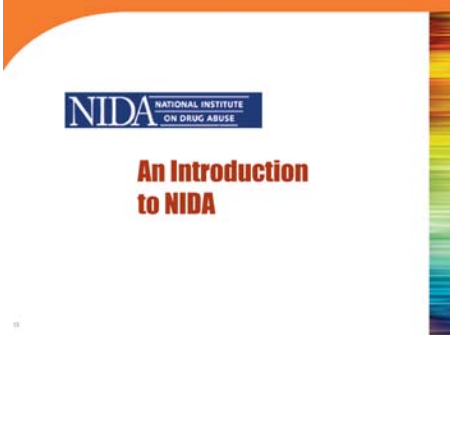
Slide Picture	Trainer Notes	Slide #
	<p>Slide 2: NIDA/SAMHSA Blending Initiative</p> <p><i>Share the definition of “blend” based upon the Merriam-Webster dictionary.</i></p> <p>Blend. (2010). In <i>Merriam-Webster Online Dictionary</i>. Retrieved March 16, 2010, from http://www.merriam-webster.com/dictionary/blend</p>	<p>Slide 2</p> 
	<p>Slide 3: NIDA/SAMHSA Blending Initiative</p> <p>Developed in 2001 by the National Institute on Drug Abuse (NIDA) and the Substance Abuse and Mental Health Services Administration’s (SAMHSA) Center for Substance Abuse Treatment (CSAT), the NIDA/SAMHSA Blending Initiative is designed to meld science and practice together to improve substance use disorder treatment. The primary goal of this initiative is to develop methods for disseminating research findings that will accelerate the adoption and implementation of research-based drug abuse treatment into community-based practice.</p> <p>Blending Products are designed to shorten the time that it takes scientific findings to become available in a usable way for frontline service providers. This is imperative for successful outcomes of clients in substance use disorder treatment programs throughout the country.</p>	<p>Slide 3</p>
	<p>Slide 4: PAMI Blending Team 2007</p> <p>One major point: In 2007, the ATTC Network originally introduced the Promoting Awareness of Motivational Incentives (PAMI) awareness package that included a slide presentation, a video, and an annotated bibliography. The original PAMI Blending Team member and contributor names and affiliations are listed on this slide.</p>	<p>Slide 4</p>

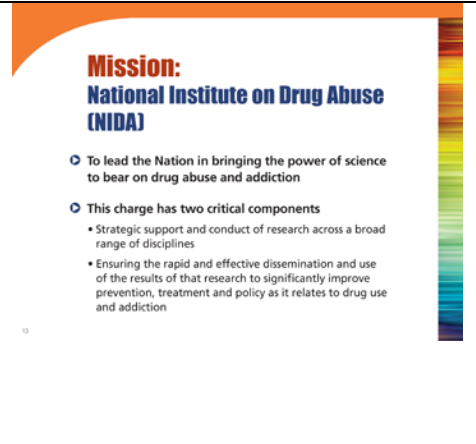
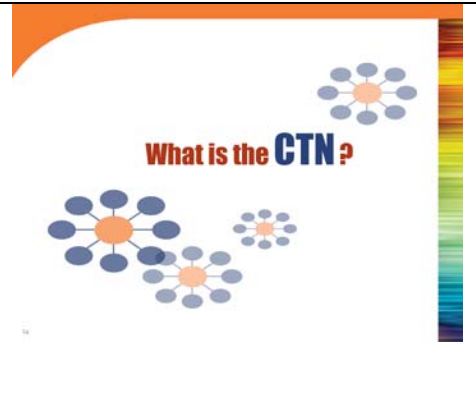

Slide Picture	Trainer Notes	Slide #
	<p>Slide 5: PAMI Update Team Members</p> <p>Two major points:</p> <ol style="list-style-type: none"> 1. The ATTC Network is pleased to present this revised 2011 Edition of the Promoting Awareness of Motivational Incentives (PAMI) presentation. This Blending Team product, initially published in 2007, was revised in 2011 based on: <ol style="list-style-type: none"> a. Input from the field – participants from around the country have moved along the learning continuum and are now requesting a more advanced and focused look at the 7 Principles of Motivational Incentives. b. Lessons learned and the outpouring of interest and feedback from PAMI trainers suggested corrections along the way c. The need to use a more advanced awareness training that will form the foundation for a subsequent Motivational Incentives Blending Product designed to help clinical supervisors actually design and customize a Motivational Incentive Program for their treatment organization 2. The PAMI Update team includes ATTC Regional Center contributors and NIDA-funded researchers. This team will introduce a self-paced online course for supervisors as part of a larger suite of Motivational Incentives web-based products in Summer 2011. <p>Contact your regional ATTC to learn about this new suite of Motivational Incentive products.</p>	<p>Slide # Slide 5</p>

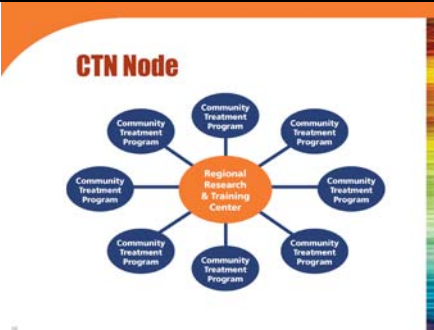

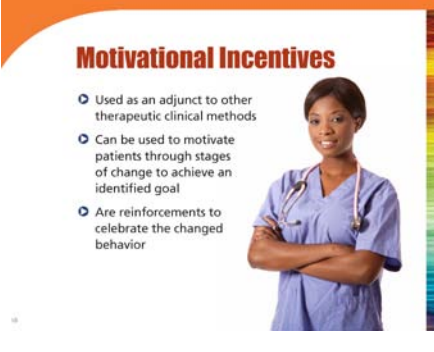
Slide Picture	Trainer Notes	Slide #
 <p>Objectives for this Awareness Training</p> <ul style="list-style-type: none"> • Describe how Motivational Incentive programs can enhance treatment outcomes and facilitate patient recovery. • Understand the results of NIDA's Clinical Trials Network (CTN) study that used low-cost incentives to increase patient motivation for treatment and recovery. • Identify key behavioral terms, definitions and principles underlying successful Motivational Incentive programs. • Describe how a Fishbowl Method can be used to reinforce and strengthen desired patient behavior. 	<p>Slide 6: Objectives for the Training</p> <p>The four primary objectives for this training:</p> <ul style="list-style-type: none"> • Describe how Motivational Incentive programs can enhance treatment outcomes and facilitate patient recovery. • Understand the results of NIDA's Clinical Trials Network (CTN) study that used low-cost incentives to increase patient motivation for treatment and recovery. • Identify key behavioral terms, definitions and principles underlying successful Motivational Incentive programs. • Describe how the Fishbowl Method can be used to reinforce and strengthen desired patient behavior. 	<p>Slide # Slide 6</p>




Slide Picture	Trainer Notes	Slide #
	<p>Slide 7: Introductions</p> <p><i>For smaller groups (20 or less): Ask participants to briefly introduce themselves by providing their names and organizations for which they work, whether or not they have used Motivational Incentive programs, and what they expect to gain from the training. Write their training expectations on a large white tablet, whiteboard or blackboard. At the end of the introductions, go through the list to explain which will be covered and which will not.</i></p> <p><i>For larger groups: Personal introductions will take too much time to complete. Omit this slide and proceed by asking people to identify their role in the treatment system by raising their hand. Explain that participants may raise their hands for more than one category.</i></p> <p>Ask: Who is:</p> <ul style="list-style-type: none"> • A counselor • A clinical supervisor • A nurse • A physician • A social worker • An administrator • An educator • Anyone that I missed? <p>OR: Do you know of organizations that have implemented motivational incentive programs?</p> <p><i>Time permitting, also ask participants in a larger group for a list of their training expectations and when completed, go through the list explaining which will be covered and which will not.</i></p>	<p>Slide 7</p> 

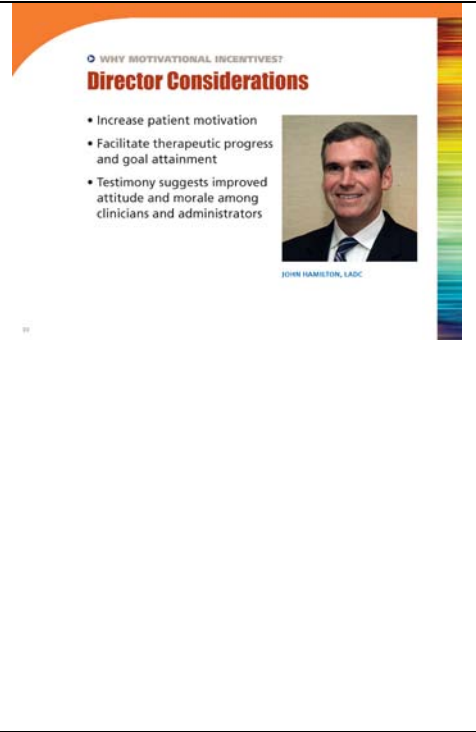


Slide Picture	Trainer Notes	Slide #
 <p>The partners in this training endeavor are ...</p>	<p>Slide 8: The partners in this training endeavor are . . .</p> <p>Now we will introduce the key participants who helped put these materials together.</p>	<p>Slide 8</p>
 <p>SAMHSA Substance Abuse and Mental Health Services Administration</p> <p>An Introduction to SAMHSA/CSAT</p>	<p>Slide 9: An Introduction to SAMHSA/CSAT</p> <p>The Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (DHHS), was created in October 1992 with a congressional mandate to expand the availability of effective substance use disorder treatment and recovery services.</p>	<p>Slide 9</p>
 <p>SAMHSA/CSAT</p> <p>CSAT's Mission:</p> <ul style="list-style-type: none"> ○ To improve the lives of individuals and families affected by alcohol and drug abuse by ensuring access to clinically sound, cost-effective addiction treatment that reduces the health and social costs to our communities and the nation. ○ CSAT's initiatives and programs are based on research findings and the general consensus of experts in the addiction field that, for most individuals, treatment and recovery work best in a community-based, coordinated system of comprehensive services. ○ Because no single treatment approach is effective for all persons, CSAT supports the nation's effort to provide multiple treatment modalities, evaluate treatment effectiveness, and use evaluation results to enhance treatment and recovery approaches. 	<p>Slide 10: SAMHSA/CSAT</p> <p>Read CSAT mission.</p> <p>Trainer Note: <i>Highlight the importance of the research base in all of CSAT's programming and educating the field about the advances of science to continually improve the quality of services provided.</i></p>	<p>Slide 10</p>





Slide Picture	Trainer Notes	Slide #
	<p>Slide 11: The ATTC Network</p> <p>One major vehicle SAMHSA has for ensuring that the workforce is adequately trained is the Addiction Technology Transfer Center (ATTC) Network.</p> <p>Fourteen regional Centers and a National Office comprise the ATTC Network, which is dedicated to identifying and advancing opportunities for improving addiction treatment.</p> <p>The vision of the ATTC Network is to unify science, education and services to transform the lives of individuals and families affected by alcohol and other substance use disorders.</p> <p>Serving the 50 United States, the District of Columbia, Puerto Rico, the U.S. Virgin Islands and the Pacific Islands, the ATTC Network delivers cutting-edge knowledge and skills that develop a powerful workforce.</p>	<p>Slide 11</p>
	<p>Slide 12: An Introduction to the National Institute on Drug Abuse</p> <p>The National Institute on Drug Abuse (NIDA) was established in 1974, and in October 1992 it became part of the National Institutes of Health, Department of Health and Human Services.</p> <p>Recent scientific advances have revolutionized our understanding of drug abuse and addiction. The majority of these advances, which have dramatic implications for how to best prevent and treat substance use disorders, have been supported by the National Institute on Drug Abuse (NIDA).</p>	<p>Slide 12</p>



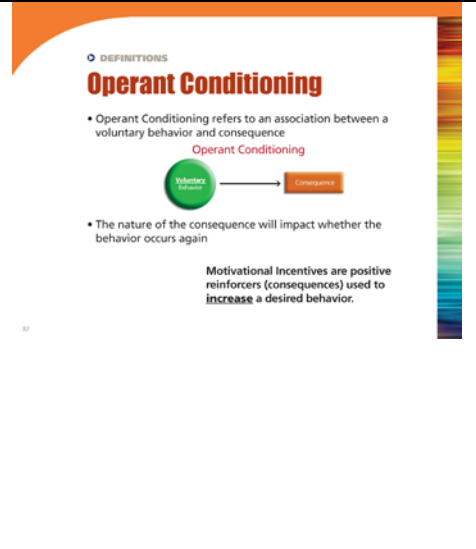

Slide Picture	Trainer Notes	Slide #
	<p>Slide 13: The Mission of National Institute on Drug Abuse (NIDA) -- 2011</p> <p>NIDA is not only seizing upon unprecedented opportunities and technologies to further the understanding of how drugs of abuse affect the brain and behavior, but also working to ensure the rapid and effective transfer of scientific data to policy makers, clinicians, other health care practitioners, and the general public. The scientific knowledge that is generated through NIDA-funded research is a critical element to improving the overall health of the Nation. The goal of NIDA is to ensure that science, not ideology or anecdote, forms the foundation for all of our Nation's drug use reduction efforts.</p>	<p>Slide 13</p>
	<p>Slide 14: What is the CTN?</p> <p>To date, the efficacy of new treatments for substance use disorders has been demonstrated primarily in specialized research settings with somewhat restricted patient populations. This presents a problem when trying to apply these findings about new treatments to community-based treatment programs, which typically serve diverse populations. To address this problem, the National Institute on Drug Abuse (NIDA) established the National Drug Abuse Treatment Clinical Trials Network (CTN).</p>	<p>Slide 14</p>
	<p>Slide 15: NIDA's Clinical Trials Network</p> <p>The mission of the CTN is twofold:</p> <ul style="list-style-type: none"> • Conduct studies of behavioral, pharmacological, and integrated behavioral and pharmacological interventions to determine therapeutic effect in rigorous, multisite clinical trials to determine effectiveness across a broad range of community-based treatment settings and diversified patient populations; and • Transfer the research results to physicians, providers, and their patients to improve the quality of substance use disorder treatment throughout the country using science as the vehicle. 	<p>Slide 15</p>


Slide Picture	Trainer Notes	Slide #
	<p>Slide 16: CTN Node</p> <p>The CTN is comprised of Nodes that are dispersed across the country. Each Node consists of one Regional Research Training Center (RRTC) and 5 to 10 affiliated community treatment programs (CTP). CTN research is conducted in the CTPs. CTPs are chosen to participate in a given research protocol based on match between the study questions and requirements and the populations served by the CTP.</p>	<p>Slide 16</p>
	<p>Slide 17: Motivational Incentives</p> <p>Additional information: A variety of incentives have been used to promote positive behavioral changes in the counseling field for many decades.</p> <p>Over the past 40 years the use of Incentives, such as vouchers, cash, points, and prizes have been studied in the specialty treatment field and have yielded positive results.</p>	<p>Slide 17</p>
	<p>Slide 18: Motivational Incentives</p> <p>Most recently, the NIDA's Clinical Trial Network (CTN) has found positive results in studies that used ways to lower the overall costs of incentives.</p> <p>This presentation will offer an overview of this history along with highlights from the CTN studies that show positive outcomes when using incentives for patients in a treatment facility.</p>	<p>Slide 18</p>

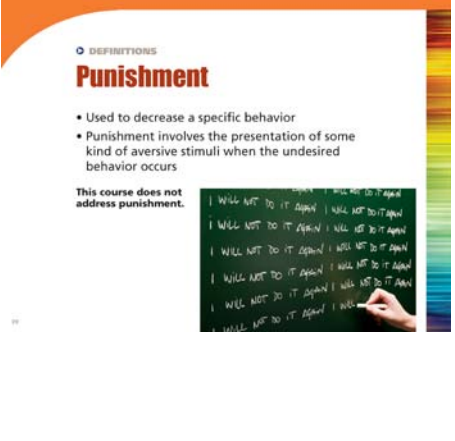

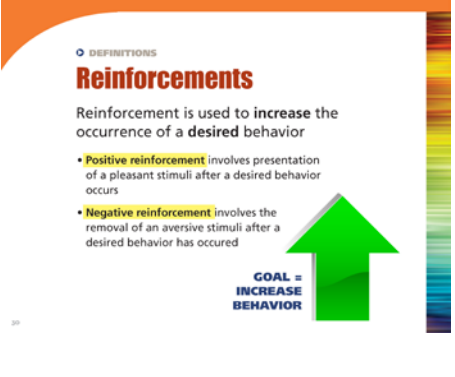

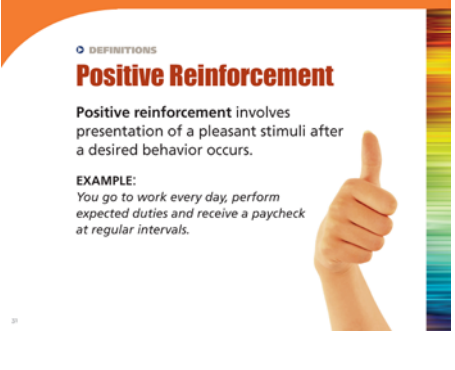

Slide Picture	Trainer Notes	Slide #
<p>Course Content</p> <ul style="list-style-type: none"> Why Use Motivational Incentives? <ul style="list-style-type: none"> Definitions History & Research Founding Principles Low Cost Incentives Perspectives 	<p>Slide 19: Course Content - Why Use Motivational Incentives?</p> <p>There are 6 sections in this presentation. In the first one we will look at “Why Use Motivational Incentives?”</p>	<p>Slide 19</p>
<p>Motivational Incentive Programs</p> <p>A Motivational Incentive program provides tangible reinforcers such as vouchers, goods, or privileges to patients for reaching concrete targeted behaviors.</p> 	<p>Slide 20: Motivational Incentive Programs</p> <p>Provide participants with a basic definition:</p> <p>A Motivational Incentive program provides tangible reinforcers such as vouchers, goods or privileges to patients for reaching concrete targeted behaviors.</p>	<p>Slide 20</p>
<p>Your Experience with Motivational Incentives</p> <ul style="list-style-type: none"> Does your organization currently provide something tangible to patients to celebrate a behavior change? If your organization provides tangible items, do those items “reward” patients for major accomplishments? Do only the more motivated patients receive rewards? 	<p>Slide 21: Your Experience with Motivational Incentives</p> <p>Optional Discussion Questions:</p> <ul style="list-style-type: none"> Does your organization currently provide something tangible to patients to mark or celebrate a behavior change? If so, do those tangible items “reward” patients for major accomplishments? Do only the more motivated and/or higher functioning patients receive those rewards? <p><i>Petry, N. M. (2000). A comprehensive guide to the application of contingency management procedures in clinical settings. Drug & Alcohol Dependence, 58, 9-25.</i></p> 	<p>Slide 21</p>




Slide Picture	Trainer Notes	Slide #
	<p>Slide 22: Director Considerations</p> <p>Trainers can add to this list by offering personal examples.</p> <p>Some things learned when observing programs that have implemented Motivational Incentives.</p> <p>Health and Hospitals Corporation (HHC) in New York instituted a Motivational Incentive program in their clinics and reported that Motivational Incentives:</p> <ol style="list-style-type: none"> (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. <p><i>Kellogg, S. H., Burns, M., Coleman, P., Stitzer, M. L., Wale, J. B., & Kreek, M. J. (2005). Something of value: The introduction of contingency management interventions into the New York City Health and Hospital Addiction Treatment Service. Journal of Substance Abuse Treatment, 28, 57-65.</i></p>	<p>Slide 22</p> 
	<p>Slide 23: Policy Maker Considerations</p> <ul style="list-style-type: none"> • Motivational Incentives are an effective, evidenced-based strategy when used as an adjunct to counseling. • In one major study conducted by the NIDA CTN, patients receiving incentives attended more counseling sessions and had longer periods of abstinence than those patients not receiving incentives. • In 2008, the Department of Health and Human Services Office of the Inspector General issued an opinion per the request of a specific treatment center that federal dollars could be used to support Motivational Incentive program. 	<p>Slide 23</p>



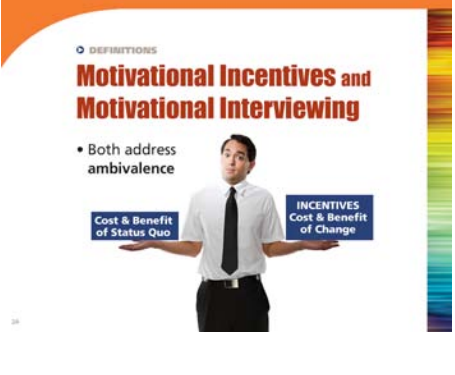
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	<p><i>Kellogg, S. H., Burns, M., Coleman, P., Stitzer, M. L., Wale, J. B., & Kreek, M. J. (2005). Something of value: The introduction of contingency management interventions into the New York City Health and Hospital Addiction Treatment Service. Journal of Substance Abuse Treatment, 28, 57-65.</i></p> <p><i>Office of Inspector General, SAMHSA. (2008, September 24). OIG Advisory Opinion No. 08-14. Retrieved January 12, 2011, from http://oig.hhs.gov/fraud/docs/advisoryopinions/2008/AdvOpn08-14.pdf</i></p> <p><i>Petry, N. M., Peirce, J. M., Stitzer, M. L., Blaine, J., Roll, J. M., Cohen, A., et al. (2005). Effect of prize-based incentives on outcomes in stimulant abusers in outpatient psychosocial treatment programs: A National Drug Abuse Treatment Clinical Trials Network study. Archives of General Psychiatry, 62, 1148-1156.</i></p>	
	<p>Slide 24: Clinical Staff Considerations</p> <p>There have been some things learned when observing programs that have implemented Motivational Incentives.</p> <ol style="list-style-type: none"> 1. “We came to see that we need to reward people where rewards are few and far between. We use rewards as a clinical tool – not as bribery – but for recognition. The really profound rewards will come later.” 2. Motivational Incentives increase the number of patients keeping appointments, and lead to better treatment outcomes. <p><i>Kellogg, S. H., Burns, M., Coleman, P., Stitzer, M. L., Wale, J. B., & Kreek, M. J. (2005). Something of value: The introduction of contingency management interventions into the New York City Health and Hospital Addiction Treatment Service. Journal of Substance Abuse Treatment, 28, 57-65.</i></p>	<p>Slide 24</p> 
	<p>Slide 25: Course Content</p> <p>Next, we will review some terminology related to Motivational Incentives.</p> <p>Understanding the following definitions will provide a basis for participants to conceptualize Motivational Incentives and further understand the principles later discussed in this presentation.</p>	<p>Slide 25</p>





Slide Picture	Trainer Notes	Slide #
	<p>Slide 26: Classical Conditioning</p> <ul style="list-style-type: none"> • Classical Conditioning is an involuntary or automatic response to a stimulus. • Patients are often “triggered” by stimuli in their environment which automatically creates a craving for alcohol or drugs. For example, a person has a recent history of using cocaine. She prepares a meal and spills flour on the counter. The sight of flour triggers a craving for cocaine. • This example illustrates how classical conditioning works. • Motivational Incentives are not based on Classical Conditioning but rather on Operant Conditioning principles. <p><i>Schwartz, B., Wasserman, E. A., & Robins, S. J. (2002). Psychology of learning and behavior (5th ed.). New York: Norton.</i></p>	<p>Slide 26</p> 
	<p>Slide 27: Operant Conditioning</p> <ul style="list-style-type: none"> • Operant Conditioning is based on the principle that behaviors are altered by the consequences that follow them. • Operant Conditioning refers to the association between a behavior and a consequence. • For example, an adolescent cleans his room and the consequence is verbal praise. The adolescent is more likely to clean his room in the future. • In Motivational Incentives, the consequences are the reinforcers. <p><i>Schwartz, B., Wasserman, E. A., & Robins, S. J. (2002). Psychology of learning and behavior (5th ed.). New York: Norton.</i></p>	<p>Slide 27</p> 

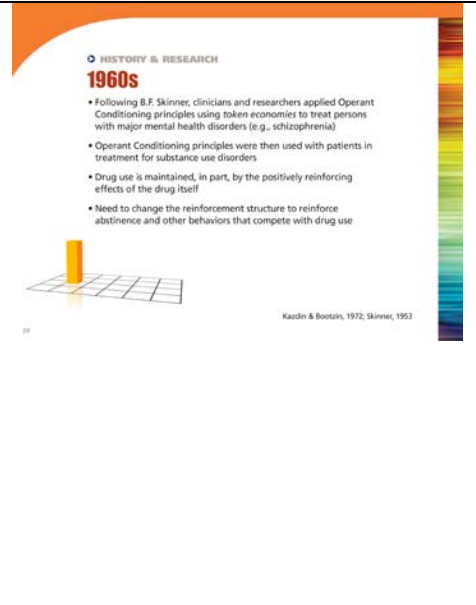

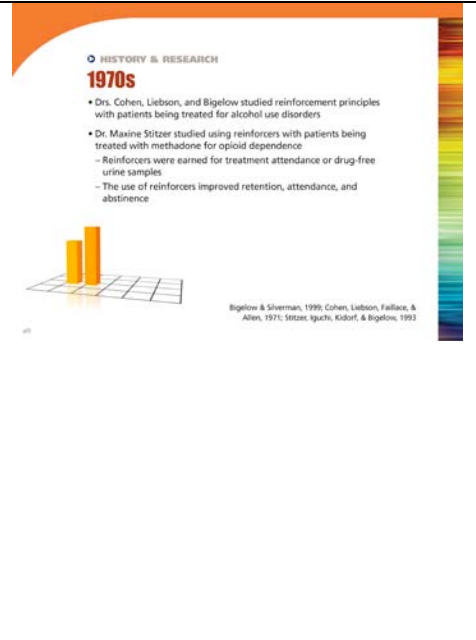

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<p>DEFINITIONS</p> <h2>Incentives (Contingencies)</h2> <p>Two types used to shape and change behavior in the early stages of change:</p> <div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; padding: 5px; background-color: #2c5e8c; color: white;"> <p>Reinforcement Used to increase a specific behavior</p> </div> <div style="border: 1px solid black; padding: 5px; background-color: #2c5e8c; color: white;"> <p>Punishment Used to decrease a specific behavior</p> </div> </div>	<p>Slide 28: Incentives (Contingencies)</p> <p>Incentives or contingencies can be divided into <i>two types</i> – reinforcements and punishments. The goal of <i>reinforcement</i> is to <u>increase the occurrence</u> of a behavior while the goal of <i>punishment</i> is to <u>decrease the occurrence</u> of a behavior.</p> <p>Reinforcements: There are two kinds of reinforcements – positive and negative.</p> <ul style="list-style-type: none"> • <i>Positive</i> reinforcement involves the <u>presentation</u> of a pleasant stimuli after a desired behavior occurs, while • <i>Negative</i> reinforcement involves the <u>removal</u> of an aversive stimuli once a desired behavior has occurred. <p>Punishment involves the <u>presentation</u> of some kind of aversive stimuli when the <u>undesired</u> behavior occurs. An example of this would be receiving a ticket after speeding.</p> <p>The core difference between reinforcement and punishment is not whether it is pleasant or unpleasant; it is whether the goal is <u>to increase or decrease the likelihood of a behavior.</u></p> <ul style="list-style-type: none"> • Reinforcement – increases the likelihood that a behavior will occur • Punishment – decreases the likelihood that a behavior will occur <p><i>Schwartz, B., Wasserman, E. A., & Robins, S. J. (2002). Psychology of learning and behavior (5th ed.). New York: Norton.</i></p>	<p>Slide 28</p> 



Slide Picture	Trainer Notes	Slide #
 <p>DEFINITIONS Punishment</p> <ul style="list-style-type: none"> Used to decrease a specific behavior Punishment involves the presentation of some kind of aversive stimuli when the undesired behavior occurs <p>This course does not address punishment.</p> <p>I WILL NOT DO IT AGAIN I WILL NOT DO IT AGAIN I WILL NOT DO IT AGAIN I WILL NOT DO IT AGAIN I WILL NOT DO IT AGAIN I WILL NOT DO IT AGAIN I WILL NOT DO IT AGAIN I WILL NOT DO IT AGAIN I WILL NOT DO IT AGAIN I WILL NOT DO IT AGAIN</p>	<p>Slide 29: Punishment</p> <ul style="list-style-type: none"> Emphasize that punishment is <u>not</u> what we are advocating or discussing in this course. We are discussing the presentation of positive or negative reinforcement. The goal of punishment is to decrease the likelihood that an undesired behavior will occur. Motivational Incentives are based on positive reinforcement. <p><i>Schwartz, B., Wasserman, E. A., & Robins, S. J. (2002). Psychology of learning and behavior (5th ed.). New York: Norton.</i></p> 	<p>Slide 29</p>
 <p>DEFINITIONS Reinforcements</p> <p>Reinforcement is used to increase the occurrence of a desired behavior</p> <ul style="list-style-type: none"> Positive reinforcement involves presentation of a pleasant stimuli after a desired behavior occurs Negative reinforcement involves the removal of an aversive stimuli after a desired behavior has occurred <p>GOAL = INCREASE BEHAVIOR</p>	<p>Slide 30: Reinforcement</p> <ul style="list-style-type: none"> Emphasize the common goal of both positive and negative reinforcement is to increase the occurrence of a desired behavior. The next few slides examine the differences between positive reinforcement and negative reinforcement. <p><i>Schwartz, B., Wasserman, E. A., & Robins, S. J. (2002). Psychology of learning and behavior (5th ed.). New York: Norton.</i></p> 	<p>Slide 30</p>
 <p>DEFINITIONS Positive Reinforcement</p> <p>Positive reinforcement involves presentation of a pleasant stimuli after a desired behavior occurs.</p> <p>EXAMPLE: You go to work every day, perform expected duties and receive a paycheck at regular intervals.</p>	<p>Slide 31: Positive Reinforcement</p> <p>Offer examples of positive reinforcement</p> <ul style="list-style-type: none"> The child cleans his room (a desired behavior). The parent presents a pleasant stimulus (verbal praise, added privileges, stickers on a behavior chart). The goal is to increase the child's desired behavior – cleaning his room. <p><i>Schwartz, B., Wasserman, E. A., & Robins, S. J. (2002). Psychology of learning and behavior (5th ed.). New York: Norton.</i></p> 	<p>Slide 31</p>

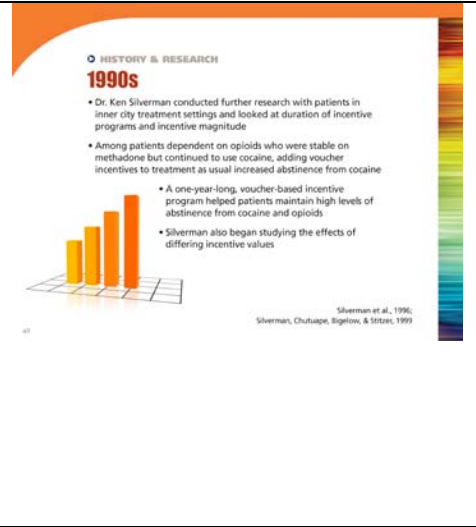

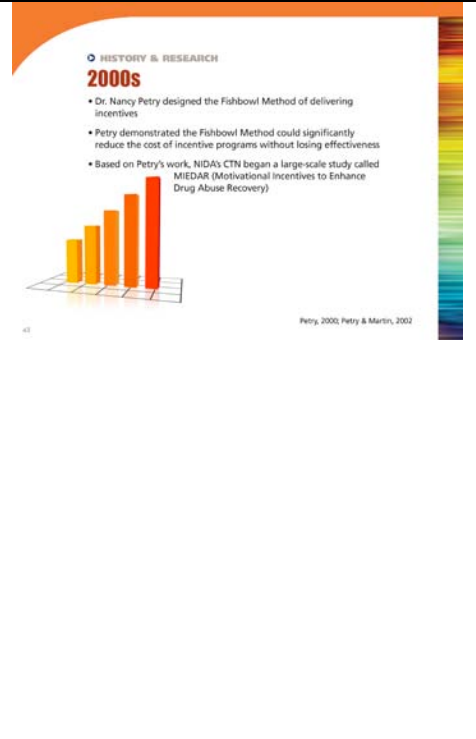

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	<p>Slide 32: Negative Reinforcement</p> <p>Negative reinforcement is commonly confused with punishment. Remember, the goal of negative reinforcement is to increase a desired behavior. The goal of punishment is to decrease the likelihood that a behavior will occur.</p> <p>Offer examples of negative reinforcement:</p> <ol style="list-style-type: none"> 1. An adolescent is expected to straighten and clean his room weekly (a desired behavior = cleaning the room). Let’s say the adolescent has not exhibited the desired behavior (i.e., cleaning) in a couple of weeks. The parent notices the desired behavior has not occurred for some time now and verbally reprimands the adolescent. The adolescent cleans his room to stop the parental reprimands. The parental reprimands are a negative reinforcer. 2. A driver inserts and turns his key in a car’s ignition. A repetitive “ding, ding” sounds to remind the driver to buckle his seat belt. The irritating “ding, ding” sound stops when the driver wears his seat belt. The “ding, ding” is the negative reinforcer targeting the desired behavior – in this circumstance, wearing a seat belt. <p><i>Schwartz, B., Wasserman, E. A., & Robins, S. J. (2002). Psychology of learning and behavior (5th ed.). New York: Norton.</i></p>	<p>Slide 32</p> 
	<p>Slide 33: Motivational Incentives = Contingency Management</p> <ul style="list-style-type: none"> • Motivational Incentives & Contingency Management are the same and the two terms can be used interchangeably. • In this training, we use the term Motivational Incentives. 	<p>Slide 33</p>

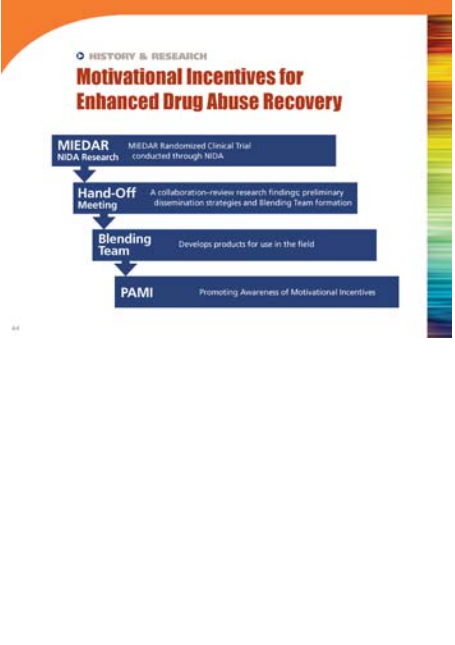
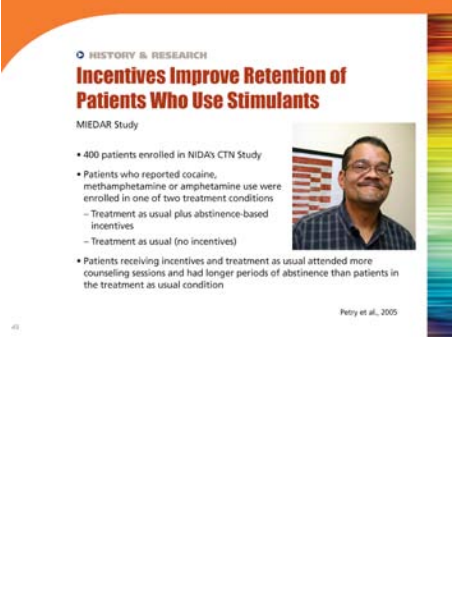

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	<p>Slide 34: Rewards</p> <ul style="list-style-type: none"> • Mark an accomplishment or milestone worthy of celebration and acknowledge the achievement of larger goals. • Typically rely on a patient’s internal motivation for success. • Examples: <ol style="list-style-type: none"> 1. An individual receives a diploma for completing academic studies. 2. A patient receives a “chip” for maintaining abstinence for a longer increment of time – a 30 day/one month chip. 	<p>Slide 34</p>
	<p>Slide 35: Reinforcement/Reinforcers</p> <ul style="list-style-type: none"> • Reinforcement strategies increase the likelihood of the occurrence of a specific, desired behavior by breaking the larger goal down into smaller steps and reinforcing each of the steps. • Reinforcers are given at a high frequency for small, manageable instances of behavior change with the intent to make the reinforcers easy to earn. <p>Example: In a treatment setting, a patient might receive an incentive for attending each group session. These are small steps to encourage a patient to attain a larger goal of completing a course of treatment.</p>	<p>Slide 35</p>
	<p>Slide 36: Motivational Incentives and Motivational Interviewing</p> <p>Motivational Incentives and Motivational Interviewing both address patients’ ambivalence about stopping or reducing alcohol and other drug use.</p> <ul style="list-style-type: none"> • Motivational Interviewing – the goal of motivational interviewing is to work with the patient’s ambivalence to create inner conflict (dissonance) that assists the patient to make a decision to pursue a path toward recovery (Miller & Rollnick, 2004). This intervention is a therapeutic skill 	<p>Slide 36</p>







Slide Picture	Trainer Notes	Slide #
	<p>that needs to be developed and practiced by the clinician over time under clinical supervision.</p> <ul style="list-style-type: none"> • Motivational Incentives – the goal of using incentives is to modify and change a specific behavior. Offering an immediate and tangible reinforcer for engaging in desired behavior often helps patients resolve their ambivalence about continued use of alcohol and other drugs. Motivational Incentives is a tool or adjunct to the therapeutic relationship and other treatment interventions. <p><i>Miller, W. R., & Rollnick, S. (2004) Motivational interviewing: Preparing people to change addictive behavior (2nd ed.). New York: Guilford Press.</i></p>	
	<p>Slide 37: History & Research</p> <p>We will now look at the History and Research behind Motivational Incentives.</p>	<p>Slide 37</p>
	<p>Slide 38: Decades of Evidence</p> <p>As previously discussed, Motivational Incentives have their roots in Operant Conditioning, a term coined by B.F. Skinner. Skinner’s idea was that behavior is learned and can be changed through the use of reinforcement. Skinner’s classic scientific studies on laboratory animals’ observable behavior focused on how learning takes place in animals and humans.</p> <p><i>Kazdin, A. E., & Bootzin, R. R. (1972). The token economy: An evaluative review. Journal of Applied Behavior Analysis, 5, 343-372.</i></p> <p><i>Skinner, B. F. (1953). Science and human behavior. New York: Macmillan.</i></p>	<p>Slide 38</p> 





Slide Picture	Trainer Notes	Slide #
	<p>Slide 39: History & Research – 1960s</p> <p>During the 1950s, following the work of B.F. Skinner, researchers and clinicians had used Operant Conditioning principles to develop token economies to treat major mental health disorders (i.e., schizophrenia). Beginning in the 1960s, Operant Conditioning principles were used when treating persons diagnosed with a substance use disorder. Researchers recognized that drug use was maintained in part by the positively reinforcing effects of the drug itself. As a result of this finding, researchers began to systematically apply Operant Conditioning principles to reinforce abstinence and other behaviors that <u>competed with</u> drug use.</p> <p><i>Kazdin, A. E., & Bootzin, R. R. (1972). The token economy: An evaluative review. Journal of Applied Behavior Analysis, 5, 343-372.</i> <i>Skinner, B. F. (1953). Science and human behavior. New York: Macmillan.</i></p>	<p>Slide 39</p> 
	<p>Slide 40: History & Research – 1970s</p> <p>In the 1970s, a series of studies conducted at Johns Hopkins University by Drs. Cohen, Liebson and Bigelow focused on how reinforcement principles could be applied in treating persons with alcohol use disorders.</p> <p>During the same decade, Dr. Maxine Stitzer studied the use of reinforcers with patients in treatment for opioid dependence. Through her systematic and controlled studies, Dr. Stitzer found the use of reinforcers actually <u>improved</u> patient retention, attendance and abstinence while enrolled in treatment.</p> <p><i>Bigelow, G., & Silverman, K. (1999). Theoretical and empirical foundations of contingency management treatments for drug abuse. In S.T. Higgins & K. Silverman (Eds.), Motivating behavior change among illicit-drug abusers: Research on contingency management interventions (pp. 15-31). Washington, DC: American Psychological Association.</i> <i>Cohen, M., Liebson, I. A., Faillace, L., A., & Allen, R.P. (1971). Moderate drinking by chronic alcoholics. A schedule-dependent phenomenon. Journal of Nervous and Mental Disease, 153, 434-444.</i></p>	<p>Slide 40</p> 

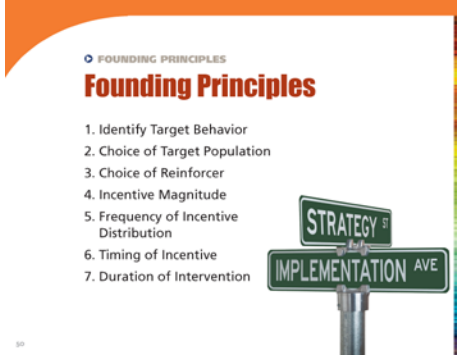

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	<p><i>Stitzer, M., Iguchi, M. Y., Kidorf, M., & Bigelow, G.E. (1993). Contingency management in methadone treatment: The case for positive incentives. In L.S. Onken, J.D. Blaine, & J.J. Boren (Eds.), Behavioral treatments for drug abuse and dependence: NIDA monograph 137 (pp. 19-35). Rockville, MD: National Institute on Drug Abuse.</i></p>	
	<p>Slide 41: History & Research – 1980s</p> <p>By the late 1980s, Dr. Stephen Higgins and colleagues initiated studies to determine how reinforcement principles could be applied with patients engaged in treatment for stimulant dependence. Dr. Higgins used a voucher method of reinforcing patient abstinence. Patients earned a voucher each time they submitted a drug-free urine screen. In one study, 75% of the patients who received the voucher incentive plus treatment as usual were retained in the 6-month study. Of those patients who received only treatment as usual, only 40% were retained in the study.</p> <p>Higgins found significant differences in cocaine abstinence rates when vouchers were used to reinforce drug-free urine screens. Fifty-five percent (55%) of patients who received incentives plus treatment as usual achieved at least 10 weeks of continuous cocaine abstinence vs. 15% of those who received only treatment as usual.</p> <p><i>Higgins, S. T., Budney, A. J., Bickel, W. K., Foerg, F. E., Donham, R., & Badger, G. J. (1994). Incentives improve outcome in outpatient behavioral treatment of cocaine dependence. Archives of General Psychiatry, 51, 568-576.</i></p>	<p>Slide 41</p> 

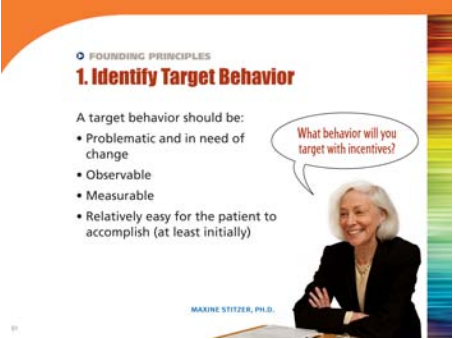
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	<p>Slide 42: History & Research – 1990s</p> <p>By the 1990s, Dr. Ken Silverman began research on how duration of incentive programs and incentive magnitude impacted opioid dependent patients’ abstinence from secondary drug use. Research findings demonstrated that use of incentive programs helped opioid dependent patients maintain high levels of abstinence from cocaine <u>and</u> opioids.</p> <p><i>Silverman, K., Chutuape, M. A., Bigelow, G. E., & Stitzer, M. L. (1999). Voucher-based reinforcement of cocaine abstinence in treatment-resistant methadone patients: Effects of reinforcement magnitude. Psychopharmacology, 146, 128-138.</i></p> <p><i>Silverman, K., Higgins, S. T., Brooner, R. K., Montoya, I. D., Cone, E. J., Schuster, C. R., et al. (1996). Sustained cocaine abstinence in methadone maintenance patients through voucher-based reinforcement therapy. Archives of General Psychiatry, 53, 409-15.</i></p>	<p>Slide 42</p> 
	<p>Slide 43: History & Research – 2000s</p> <p>Dr. Nancy Petry’s work in the 2000s explored methods of delivering incentives that would reduce the cost to the treatment organization without sacrificing the demonstrated effectiveness of incentive programs. Dr. Petry designed the “Fishbowl Method” of delivering incentives and determined that this method reduced the cost to the treatment organization yet retained its effectiveness in maintaining high abstinence rates.</p> <p>Based on Petry’s work, NIDA’s CTN began a large scale study known as “MIEDAR”(pronounced <i>my’-dar</i>) which stands for Motivational Incentives to Enhance Drug Abuse Recovery. The studies were aimed at reducing cocaine use among patients who were opioid dependent and receiving methadone.</p> <p><i>Petry, N. M. (2000). A comprehensive guide to the application of contingency management procedures in clinical settings. Drug & Alcohol Dependence, 58, 9-25.</i></p> <p><i>Petry, N. M., & Martin, B. (2002). Low-cost contingency management for treating cocaine-and opioid-abusing methadone patients. Journal of Consulting and Clinical Psychology, 70, 398-405.</i></p>	<p>Slide 43</p> 


Slide Picture	Trainer Notes	Slide #
	<p>Slide 44: History & Research – MIEDAR</p> <ul style="list-style-type: none"> • This slide outlines the steps involved in developing a NIDA-SAMHSA Blending Team product and diagrams how research results from the MIEDAR study – go through the ‘Blending process’ leading to dissemination, which is reflected in the finished PAMI product. • In 2005, the Substance Abuse and Mental Health Service Administration’s (SAMHSA) Addiction Technology Transfer Centers (ATTCs), along with NIDA Researchers, Drs. Stitzer, Petry, and Kellogg, developed this Blending Product to promote the awareness and understanding of Motivational Incentives. • The product resulting from this principle-based dissemination effort, known as PAMI (Promoting Awareness of Motivational Incentives), is the training you’re attending today. • Petry’s Fishbowl Method of delivering low-cost incentives is featured in this training. 	<p>Slide 44</p>
	<p>Slide 45: History & Research – Incentives Improve Patient Retention</p> <ul style="list-style-type: none"> • Petry, Peirce, Stitzer and colleagues’ published article from the CTN study reports on 400 patients who reported cocaine, methamphetamine or amphetamine use and were randomly assigned to treatment as usual or treatment as usual plus abstinence-based incentives. • The study found that incentives improved retention in treatment. • In addition, 49% of the patients receiving treatment as usual plus abstinence-based incentives were retained at 12 weeks compared with 35% of the patients receiving only treatment as usual. • Essential Point: <i>Patients receiving treatment as usual plus incentives attended more counseling sessions and had longer periods of abstinence than patients receiving only treatment as usual.</i> 	<p>Slide 45</p> 

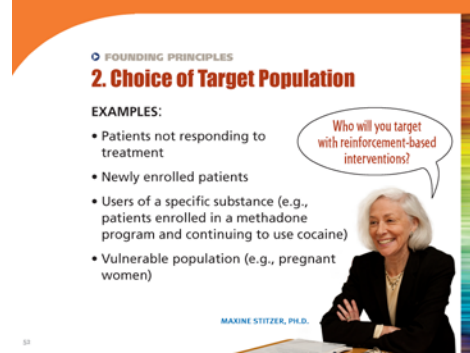

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	<p><i>Petry, N. M., Peirce, J. M., Stitzer, M. L., Blaine, J., Roll, J. M., Cohen, A., et al. (2005). Effect of prize-based incentives on outcomes in stimulant abusers in outpatient psychosocial treatment programs: A National Drug Abuse Treatment Clinical Trials Network study. Archives of General Psychiatry, 62, 1148-1156.</i></p>	
	<p>Slide 46: History & Research – Incentives Improve Patient Outcomes</p> <p>The MIEDAR Study found that patients who met criteria for methamphetamine use disorders and received incentives improved in the following way:</p> <ul style="list-style-type: none"> • Essential Point: <i>Patients receiving incentives plus treatment as usual submitted more stimulant- and alcohol-negative samples than patients who only received treatment as usual.</i> <p><i>Roll, J. M., Petry, N. M., Stitzer, M. L., Brecht, M. L., Peirce, J. M., McCann, M. J., et al. (2006). Contingency management for the treatment of methamphetamine use disorders. American Journal of Psychiatry, 163, 1993-1999.</i></p>	<p>Slide 46</p>  
	<p>Slide 47: History & Research – Lower Cost Incentives Improve Stimulant Abstinence for Patients in Methadone Maintenance Treatment</p> <ul style="list-style-type: none"> • Patients in methadone maintenance treatment reduced their alcohol and stimulant use when given lower-cost incentives • Patients receiving incentives submitted more stimulant- and alcohol-negative samples than patients who only received treatment as usual • Patients in the incentive group received an average of \$120 in incentives/per participant over 12 weeks <p><i>Peirce, J. M., Petry, N. M., Stitzer, M. L., Blaine, J., Kellogg, S., Satterfield, F., et al. (2006). Effects of lower-cost incentives on stimulant abstinence in methadone maintenance treatment: A national drug abuse treatment clinical trials network study. Archives of General Psychiatry, 63, 201-208.</i></p>	<p>Slide 47</p> 

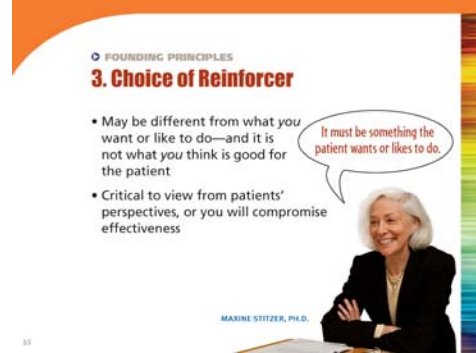

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	<p>Slide 48: The 7 Founding Principles</p> <ul style="list-style-type: none"> • Now we'll provide an overview of the foundational principles which need to be considered in establishing a Motivational Incentive program. • One of the objectives of this training is to familiarize clinicians and administrators with the 7 core principles which must be addressed in designing and implementing a Motivational Incentive program. <p>“ . . . if treatment centers are willing to design interventions that incorporate the 7 principles described in the following slides, then they are on a path toward creating an effective program.”</p> <p><i>Kellogg, S. H., Stitzer, M. L., Petry, N. M., & Kreek, M. J. (2007). Contingency Management: Foundations and Principles. PAMI Blending Product unpublished chapter.</i></p>	<p>Slide 48</p> 
	<p>Slide 49: The 3 Essential Elements</p> <p>The 7 core principles are based on 3 essential elements:</p> <ol style="list-style-type: none"> 1. Target behaviors must be readily detected 2. Tangible reinforcers are provided whenever the target behavior is demonstrated 3. When the target behavior does not occur, reinforcers are withheld 	<p>Slide 49</p> <p>Video Placement Option 1</p> 

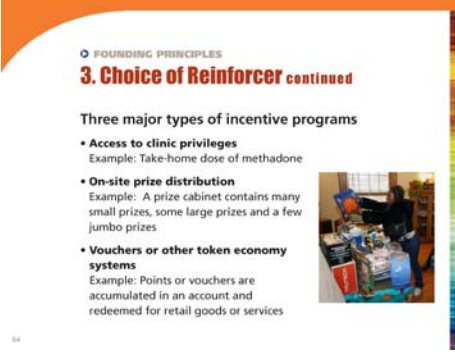

Slide Picture	Trainer Notes	Slide #
 <p>FOUNDED PRINCIPLES</p> <h3>Founding Principles</h3> <ol style="list-style-type: none"> 1. Identify Target Behavior 2. Choice of Target Population 3. Choice of Reinforcer 4. Incentive Magnitude 5. Frequency of Incentive Distribution 6. Timing of Incentive 7. Duration of Intervention <p>STRATEGY ST IMPLEMENTATION AVE</p>	<h3>Slide 50: The Founding Principles</h3> <ul style="list-style-type: none"> • There are 7 founding principles that all behavior modification or Motivational Incentive programs must address. • To ensure positive patient outcomes, it is recommended that the clinician, the clinical supervisor, and/or the organization carefully plan and initially implement a small, simple Motivational Incentive program. • With careful planning and focus on these 7 principles, the program can succeed the first time. • Let's begin looking at the first principle – Identify the Target Behavior. <p><i>Budney, A. J., Higgins, S. T., Mercer, D. E., & Carpenter, G. (1998). A community reinforcement plus vouchers approach: Treating cocaine addiction. (NIH Publication No. 98-4309). Washington, DC: US Government Printing Office.</i></p> <p><i>Kazdin, A. E. (1994). Behavior modification in applied settings (5th ed.). Pacific Grove, CA: Brooks/Cole.</i></p> <p><i>Kellogg, S. H., Stitzer, M. L., Petry, N. M., & Kreek, M. J. (2007). Contingency Management: Foundations and Principles. PAMI Blending Product unpublished chapter.</i></p> <p><i>Petry, N. M. (2000). A comprehensive guide to the application of contingency management procedures in clinical settings. Drug & Alcohol Dependence, 58, 9-25.</i></p> <p><i>Petry, N. M., & Stitzer, M. L. (2002). Contingency management: Using motivational incentives to improve drug abuse treatment. West Haven, CT: Yale University Psychotherapy Development Center.</i></p> 	<p>Slide 50</p>



Slide Picture	Trainer Notes	Slide #
 <p>FOUNDING PRINCIPLES</p> <h3>1. Identify Target Behavior</h3> <p>A target behavior should be:</p> <ul style="list-style-type: none"> • Problematic and in need of change • Observable • Measurable • Relatively easy for the patient to accomplish (at least initially) <p>What behavior will you target with incentives?</p> <p>MAXINE STITZER, PH.D.</p>	<p>Slide 51: Identify Target Behavior</p> <ul style="list-style-type: none"> • Maxine Stitzer, Ph.D., a lead investigator in the MIEDAR Study, is pictured on this slide presenting a key question, “What behavior will you target?” • The first step in designing a Motivational Incentive program is to decide upon the specific behavior you want to change. • The target behavior should be: <ul style="list-style-type: none"> ○ Problematic and in need of change ○ Observable and measurable ○ Relatively easy for the patient to accomplish (at least initially) • The target behavior is the centerpiece of the behavioral contract or treatment plan. • The target behavior should occur frequently for Motivational Incentives procedures to be effective. For example, if a client uses cocaine only once or twice a year, reinforcing cocaine abstinence may be unlikely to change behavior substantially. • Frequent monitoring is a must so behaviors can be reinforced often. Patients need to receive reinforcers early in treatment to learn the association between behavior and reinforcement. • While the MIEDAR study clearly demonstrates the effectiveness of Motivational Incentives targeted to drug abstinence, growing evidence suggests that procedures may be adapted to address other target behaviors such as attending a medical appointment, filling out a job application, etc. 	<p>Slide 51</p>

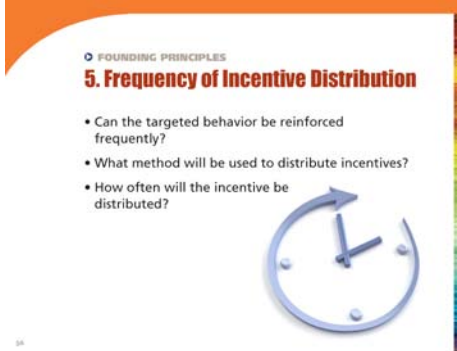
Slide Picture	Trainer Notes	Slide #
	<ul style="list-style-type: none"> • Motivational Incentive programs can be designed to target behaviors for an individual patient, a specific program population, or a patient population issue such as attendance at group therapy. • Example of a program designed to target the behaviors of individual patients: Target patients who are having a specific problem with drug use or are failing to take the necessary steps in his/her treatment or recovery plan. • Example of a program designed to target the behaviors of a specific population: Target new patients in a methadone program who have difficulty abstaining from cocaine use. • Or if the problem is a patient population issue, such as lack of on-time attendance at group therapy, a Motivational Incentive program could be designed to target this issue among all patients. <p><i>Petry, N. M. (2000). A comprehensive guide to the application of contingency management procedures in clinical settings. Drug & Alcohol Dependence, 58, 9-25.</i></p> <p><i>Petry, N. M. (2001). A Clinician's Guide for Implementing Contingency Management Programs: A guideline developed for the Behavioral Health Recovery Management project. Retrieved January 12, 2011, from http://www.bhrm.org/guidelines/petry.pdf</i></p>	


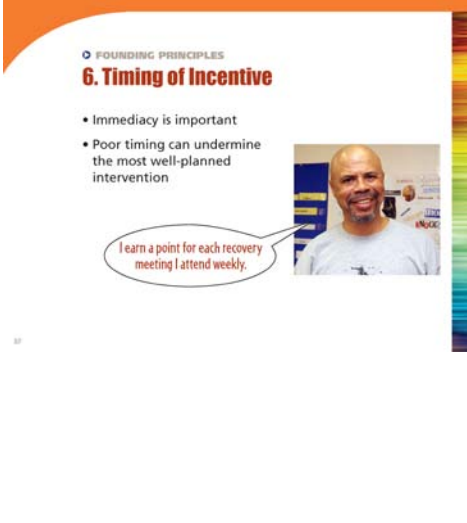
Slide Picture	Trainer Notes	Slide #
	<p>Slide 52: Choice of Target Population</p> <ul style="list-style-type: none"> • While it might be ideal to provide reinforcements for all the patients, this may not be feasible or even necessary. • Choices will need to be made as to which group or subpopulation to target with reinforcement-based interventions. <p>Examples:</p> <ul style="list-style-type: none"> • Target only those individuals who are not responding to treatment, regardless of drug of choice. • Target new patients in an effort to increase retention in treatment. • Target users of a specific substance. • Target those behaviors of particularly vulnerable populations, such as women who are pregnant. <p><i>Elk, R. (1999). Pregnant women and tuberculosis-exposed drug abusers: Reducing drug use and increasing treatment compliance. In S. T. Higgins & K. Silverman (Eds.). Motivating behavior change among illicit-drug abusers: Research on contingency management interventions (pp. 123-144). Washington, DC: American Psychological Association.</i></p> <p><i>Shaner, A., Tucker, D. E., Roberts, L. J., & Eckman, T. A. (1999). Disability income, cocaine use, and contingency management among patients with cocaine dependence and schizophrenia. In S. T. Higgins & K. Silverman (Eds.). Motivating behavior change among illicit-drug abusers: Research on contingency management interventions (pp. 95-122). Washington, DC: American Psychological Association.</i></p>	<p>Slide 52</p> 





Slide Picture	Trainer Notes	Slide #
 <p>FOUNDED PRINCIPLES</p> <h3>3. Choice of Reinforcer</h3> <ul style="list-style-type: none"> • May be different from what you want or like to do—and it is not what you think is good for the patient • Critical to view from patients' perspectives, or you will compromise effectiveness <p>It must be something the patient wants or likes to do.</p> <p>MAXINE STITZER, PH.D.</p>	<p>Slide 53: Choice of Reinforcer</p> <ul style="list-style-type: none"> • The choice of reinforcer is a crucial element to consider in designing a Motivational Incentive program. • Incentives that are perceived as desirable are likely to have a much greater influence on behavior than those that are perceived as being of less value. • The <i>quality or desirability of a reinforcer</i> (or incentive) is important to consider. Incentives need to be attractive to the patients. Incentives may or may not be particularly attractive to the staff. • A variety of reinforcers can be used in Motivational Incentive programs and can be selected based on availability. <p>VARIETY of Reinforcers and how they work:</p> <ul style="list-style-type: none"> • Vouchers – patients can earn vouchers that are later redeemed for a variety of retail goods. • Intermittent schedule (or low-cost methods) – patients accumulate points and have opportunities to exchange them for tangible goods or privileges. • Refunds or rebates – patients pay a fee upon entering treatment. They receive a refund if they complete treatment and remain abstinent. • Small incentives such as restaurant gift certificates, take-home doses (methadone), privileges, goods and services, tokens and/or point systems, distribution of tangible goods. <p><i>Kazdin, A. E. (1994). Behavior modification in applied settings (5th ed.). Pacific Grove, CA: Brooks/Cole.</i></p> <p><i>Kellogg, S. H., Stitzer, M. L., Petry, N. M., & Kreek, M. J. (2007). Contingency Management: Foundations and Principles. PAMI Blending Product unpublished chapter.</i></p>	<p>Slide 53</p> 



Slide Picture	Trainer Notes	Slide #
	<p>Slide 54: Choice of Reinforcer, continued</p> <p>Three basic types of incentive programs have been researched:</p> <ol style="list-style-type: none"> 1. Access to clinic privileges <ul style="list-style-type: none"> • Use of privileges that already exist within a program setting. 2. On-site prize distribution <ul style="list-style-type: none"> • Tangible goods are distributed when a targeted behavior is exhibited. • In the MIEDAR study, Dr. Nancy Petry designed the Fishbowl Method to distribute tangible incentives to patients achieving targeted behaviors. This method is featured in this training and will be explained (and/or demonstrated) shortly. 3. Vouchers or other token economy systems <ul style="list-style-type: none"> • Patients receive points or vouchers for meeting specific treatment plan goals. • Points can then be redeemed for goods or privileges. <p>Discussion Questions:</p> <ul style="list-style-type: none"> • What are some examples of incentives – tangible or intangible – that may be desired by the patient population you serve? • Explain how these incentives would have a positive motivating effect. <p><i>Petry, N. M., Martin, B., Cooney, J. L., & Kranzler, H. R. (2000). Give them prizes and they will come: Contingency management for treatment of alcohol dependence. Journal of Consulting and Clinical Psychology, 68, 250-257.</i></p> <p><i>Stitzer, M. L., Iguchi, M. Y., & Felch, L. J. (1992). Contingent take-home incentive: Effects on drug use of methadone maintenance patients. Journal of Consulting and Clinical Psychology, 60, 927-934.</i></p>	<p>Slide 54</p> 


Slide Picture	Trainer Notes	Slide #
	<p>Slide 55: Incentive Magnitude</p> <p>Closely connected to Principle #3 (Choice of Reinforcer) is the 4th Principle: Incentive Magnitude – or how much reinforcement should be provided.</p> <ul style="list-style-type: none"> • The magnitude of the reinforcement will determine the degree to which the intervention is effective. • Choose a reinforcer that can compete with reinforcement derived from the behavior targeted for change (i.e., reinforcing effects of the drug). • Reinforcing short-term goals and steps toward longer-term goals is recommended especially in the early stage of treatment. • Petry’s Fishbowl Method is popular because it lowers the costs of implementing an effective Motivational Incentive program. • The key to designing an effective Motivational Incentive program is to identify patient-desired reinforcers that are not associated with high programmatic costs. <p>Example: Consider this. What if you were offered a dime as an incentive for every 50 miles driven within the posted speed limit? Would that change your behavior? Maybe a dime is not enough. \$1.00? \$5.00? Perhaps \$10.00 for every 50 miles driver within the posted speed limit? The point is that the reinforcement would have to be large enough to compete with the reasons you have for speeding.</p> <p><i>Higgins, S. T., Heil, S. H., & Lussier, J. P. (2004). Clinical implications of reinforcement as a determinant of substance use disorders. Annual Review of Psychology, 55, 431-461.</i></p> <p><i>Peirce, J. M., Petry, N. M., Stitzer, M. L., Blaine, J., Kellog, S., Satterfield, F., et al. (2006). Effects of lower-cost incentives on stimulant abstinence in methadone maintenance treatment: A national drug abuse treatment clinical trials network study. Archives of General Psychiatry, 63, 201-208.</i></p> <p><i>Petry, N. M., & Bohn, M. J. (2003). Fishbowls and candy bars: Using low-cost incentives to increase treatment retention. Science & Practice Perspectives: A Publication of the National Institute on Drug Abuse, National Institutes of Health, 2, 55-61.</i></p>	<p>Slide 55</p> 




Slide Picture	Trainer Notes	Slide #
	<p><i>Petry, N. M., Peirce, J. M., Stitzer, M. L., Blaine, J., Roll, J. M., Cohen, A., et al. (2005). Effect of prize-based incentives on outcomes in stimulant abusers in outpatient psychosocial treatment programs: A National Drug Abuse Treatment Clinical Trials Network study. Archives of General Psychiatry, 62, 1148-1156.</i></p> <p><i>Silverman, K., Chutuape, M. A., Bigelow, G. E., & Stitzer, M. L. (1999). Voucher-based reinforcement of cocaine abstinence in treatment-resistant methadone patients: Effects of reinforcement magnitude. Psychopharmacology, 146, 128-138.</i></p>	
	<p>Slide 56: Frequency of Incentive Distribution</p> <p>In operant conditioning, schedules of reinforcement determine when and how often a desired behavior is reinforced.</p> <p>The 7 principles work in concert with one another. A scenario of how two principles (i.e., 1st and 5th principle) are interrelated:</p> <ul style="list-style-type: none"> • 1st Principle – Identify a Target Behavior • 5th Principle - Frequency of Incentive Distribution <p>Scenario:</p> <ul style="list-style-type: none"> • A clinician considers Principle #1 – Identify a Target Behavior and decides the targeted behavior will be “abstinence.” Proceeding down the Checklist of the 7 Principles, the clinician deliberates on Principle #5 – Frequency of Incentive Distribution. The next question becomes, “<i>Is it possible for our organization to reinforce abstinence frequently?</i>” If the response is, “<i>No, our organization only has the capacity to do on-site testing monthly,</i>” then they will want to reconsider the selected targeted behavior. • Principle #5 – Frequency of Incentive Distribution instructs reinforcing patients frequently in order to establish an association between the desired behavior and the reinforcer. When the behavior change is well established, the frequency of reinforcement can be reduced or reinforced only part of the time. 	<p>Slide 56</p>


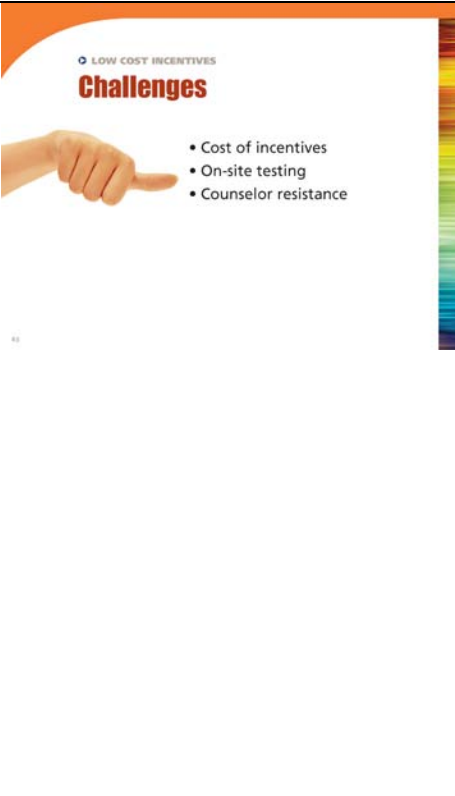
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	<p>Example: Let's go back to our example of what it would take for you to drive the speed limit. Again, what if you were offered a dime as an incentive for every 50 miles driven within the posted speed limit? Would that change your behavior? Maybe every fifty miles would not provide a frequent enough reinforcement. How about every 25 miles? Every 10 miles? Perhaps you would need to be paid a dime every mile in order to have incentive enough to drive within the posted speed limit! The point here is that the reinforcement would have to be given often enough to compete with the reasons you have for speeding.</p> <p><i>Kazdin, A. E. (1994). Behavior modification in applied settings (5th ed.). Pacific Grove, CA: Brooks/Cole.</i></p> <p><i>Kirby, K. C., Amass, L., & McLellan, A. T. (1999). Disseminating contingency management research to drug abuse practitioners. In S.T. Higgins & K. Silverman (Eds.), Motivating behavior change among illicit-drug abusers: Research on contingency management interventions (pp. 327-344). Washington, DC: American Psychological Association.</i></p> <p><i>Petry, N. M. (2000). A comprehensive guide to the application of contingency management procedures in clinical settings. Drug & Alcohol Dependence, 58, 9-25.</i></p>	
	<p>Slide 57: Timing of Incentive</p> <ul style="list-style-type: none"> • The core concept here is that the reinforcement needs to follow the exhibition of the target behavior as closely as possible. Poor timing can undermine the most well-planned intervention; immediacy is important. • Distributing the reinforcement before the desired, targeted behavior occurs will not be reinforcing. • Reinforcing a targeted behavior a week after it occurs will not be reinforcing. • The sooner an incentive is distributed, the more likely the desired behavior will be reinforced. The goal is to identify the behavior and reinforce it immediately. 	<p>Slide 57</p>


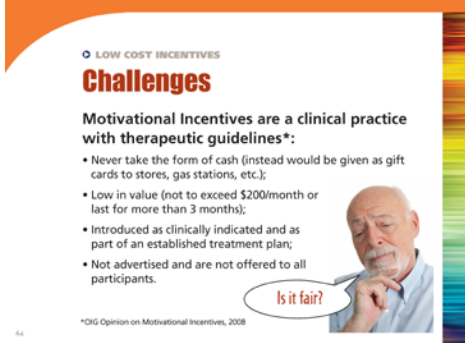
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	<p>Kirby, K. C., Amass, L., & McLellan, A. T. (1999). Disseminating contingency management research to drug abuse practitioners. In S.T. Higgins & K. Silverman (Eds.), <i>Motivating behavior change among illicit-drug abusers: Research on contingency management interventions</i> (pp. 327-344). Washington, DC: American Psychological Association.</p>	
	<p>Slide 58: Duration of Intervention - How Long?</p> <ul style="list-style-type: none"> • Ultimately, patients will need to internalize the recovery process and find or develop naturally-occurring reinforcers that will support their recovery-based and non-addict identities. • The issue of incentive duration is connected to the issue of relapse. While the data are mixed, patients, after the removal of incentives, have at times returned to pre-intervention levels of drug use or to levels of drug use that were indistinguishable from those of the control group. • Paradoxically, relapse under these circumstances may be a sign of a successful intervention . . . that the intervention has been working. • Some researchers make the point that in a clinical setting it would be much better to adapt treatment duration to patient behavior. They suggest that this could be done by gradually increasing the requirements necessary to receive an incentive while lowering the level of magnitude of the incentive given. Eventually the intervention could be faded out. <p>Higgins, S. T., Wong, C. J., Badger, G. J., Haug Ogden, D. E., & Dantona, R. L. (2000). Contingent reinforcement increases cocaine abstinence during outpatient treatment and 1 year of follow-up. <i>Journal of Consulting and Clinical Psychology, 68</i>, 64-72.</p> <p>Kellogg, S. H. (1993). Identity and recovery. <i>Psychotherapy: Research, Theory, Practice, Training, 30</i>, 235-244.</p> <p>Kirby, K. C., Amass, L., & McLellan, A. T. (1999). Disseminating contingency management research to drug abuse practitioners. In S.T. Higgins & K. Silverman (Eds.), <i>Motivating behavior change among illicit-drug abusers: Research on contingency management interventions</i> (pp. 327-344). Washington, DC: American Psychological Association.</p> <p>Lewis, M. W., & Petry, N. M. (2005). Contingency management treatments that reinforce completion of goal-related activities: Participation in family activities and its association with outcomes. <i>Drug and Alcohol Dependence, 79</i>, 267-271.</p>	<p>Slide 58</p> <p>Video Placement Option 2</p>  



Slide Picture	Trainer Notes	Slide #
	<p><i>Silverman, K., Robles, E., Mudric, T., Bigelow, G. E., & Stitzer, M. L. (2004). A randomized trial of long-term reinforcement of cocaine abstinence in methadone-maintained patients who inject drugs. Journal of Consulting and Clinical Psychology, 72, 839-854.</i></p>	
	<p>Slide 59: Low Cost Incentives</p> <ul style="list-style-type: none"> • Although voucher incentive programs are effective interventions, community-based programs have yet to implement these procedures broadly. • One of the primary criticisms is cost. Voucher incentive treatments, the intervention with the most empirical support, are expensive to employ and manage with average earnings of approximately \$600 per patient. These associated costs can be prohibitive in many community treatment settings. • Several strategies have been utilized to apply less costly incentives, rather than vouchers. • A method used to reduce the costs of these Motivational Incentive programs is to use a system developed by Dr. Nancy Petry. • Petry’s Fishbowl Method features an intermittent schedule of reinforcement that contains the cost of a program without sacrificing program effectiveness. • The next 3 slides will describe how the MIEDAR study utilized Dr. Petry’s low-cost incentives method as an effective intervention that is well suited for treatment settings. <p><i>Bickel, W. K., & Marsch, L. A. (2001). Toward a behavioral economic understanding of drug dependence: Delay discounting processes. Addiction, 96, 73-86.</i></p> <p><i>Higgins, S. T., Budney, A. J., Bickel, W. K., Foerg, F. E., Donham, R., & Badger, G. J. (1994). Incentives improve outcome in outpatient behavioral treatment of cocaine dependence. Archives of General Psychiatry. 51, 568-576.</i></p> <p><i>Higgins, S. T., Budney, A. J., Bickel, W. K., Hughes, J. R., Foerg, F., & Badger, G. (1993). Achieving cocaine abstinence with a behavioral approach. American Journal of Psychiatry, 150, 763-769.</i></p>	<p>Slide 59</p> 


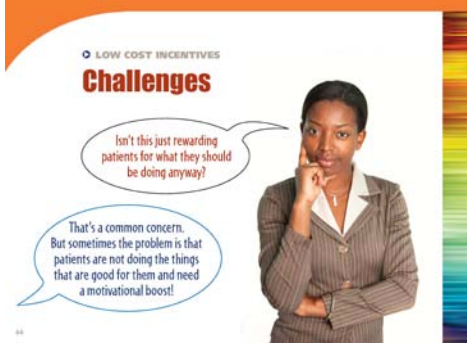


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	<p>Higgins, S. T., Delaney, D. D., Budney, A. J., Bickel, W. K., Hughes, J. R., Foerg, F., et al. (1991). A behavioral approach to achieving initial cocaine abstinence. <i>American Journal of Psychiatry</i>, 148, 1218-1224.</p> <p>Petry, N. M. (2000). A comprehensive guide to the application of contingency management procedures in clinical settings. <i>Drug and Alcohol Dependence</i>, 58, 9-25.</p> <p>Silverman, K., Wong, C. J., Higgins, S. T., Brooner, R. K., Montoya, I. D., Contoreggi, C., et al. (1996). Increasing opiate abstinence through voucher-based reinforcement therapy. <i>Drug and Alcohol Dependence</i>, 41, 157-165.</p>	
	<p>Slide 60: Managing the Cost</p> <ul style="list-style-type: none"> • Dr. Nancy Petry has led the way in searching for cost-effective strategies that are less expensive than the standard voucher system. • In 2000, Dr. Petry first studied the intermittent schedule of reinforcement approach with patients being treated for alcohol dependence. The approach was to provide only a proportion of the target behaviors with a reinforcer. Patients earned the chance to draw from a bowl and win prizes of varying magnitudes for submitting negative breath-alcohol samples and completing steps toward their treatment goals. • Examples of Low Cost Incentives: <ul style="list-style-type: none"> ○ Non-monetary - “good job” ○ Special parking privileges ○ Take-home methadone ○ Clinic privileges • In the MIEDAR study, patients in the incentive group earned at least one draw from the Fishbowl for each sample submitted that tested negative for the patient’s primary drug of choice. • The number of draws allowed at each sample collection escalated with consecutive weeks of negative testing thereby allowing for immediate reinforcement. 	<p>Slide 60</p>

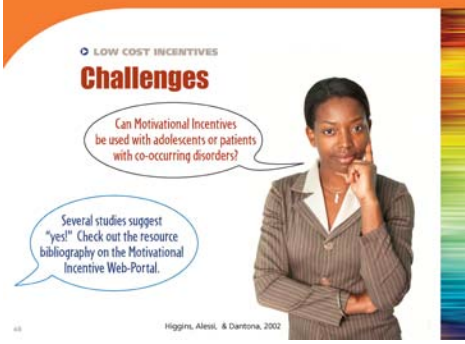


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	<ul style="list-style-type: none"> This escalating schedule is designed to sustain long periods of abstinence, and as such, the highest rates of reinforcement are scheduled later in the intervention. <p><i>Petry, N. M., Peirce, J. M., Stitzer, M. L., Blaine, J., Roll, J. M., Cohen, A., et al. (2005). Effect of prize-based incentives on outcomes in stimulant abusers in outpatient psychosocial treatment programs: A National Drug Abuse Treatment Clinical Trials Network study. Archives of General Psychiatry, 62, 1148-1156.</i></p>	
	<p>Slide 61: Fishbowl Ticket Ratios</p> <ul style="list-style-type: none"> In the MIEDAR study, the Fishbowl contained a total of 500 tickets. To keep the cost lower, 50% of the tickets said “Good Job” and did not result in an incentive prize; 41.8% of the tickets resulted in a “Small” incentive prize; 8% resulted in a “Large” incentive; and only a very small percentage (0.2%) resulted in a “Jumbo” incentive. Tickets printed with “Small,” “Large” or “Jumbo” were turned in for incentives. Using this approach the average cost per patient was under \$200 as compared to the historical cost of \$600/client using the voucher system. “Small” incentive prizes cost \$1, “Large” incentive prizes cost about \$20, and “Jumbo” prizes cost \$80-\$100. <ul style="list-style-type: none"> 50.0% – chance of drawing a “Good Job” 41.8% – chance of drawing a “Small” 8.0% – chance of drawing a “Large” 0.2% – chance of drawing a “Jumbo” <p>Tangible item ideas: Health and beauty aids; bottles of water or juice; restaurant coupons; electronics (radio, small TV, VCR, etc); toys; gift certificates</p> <p><i>Petry, N. M., Peirce, J. M., Stitzer, M. L., Blaine, J., Roll, J. M., Cohen, A., et al. (2005). Effect of prize-based incentives on outcomes in stimulant abusers in outpatient psychosocial treatment programs: A National Drug Abuse Treatment Clinical Trials Network study. Archives of General Psychiatry, 62, 1148-1156.</i></p>	<p>Slide 61</p> 





Slide Picture	Trainer Notes	Slide #
	<p>Slide 62: Fishbowl Method</p> <p>Patients select an increasing number of draws each time they display a targeted behavior.</p> <ul style="list-style-type: none"> • Patients receive one draw for the first drug-free urine sample, two draws for the second drug-free urine sample, and so on. • Patients lose the opportunity to draw a prize with a positive urine screen, but are encouraged and supported. • When patients test drug-free again, they start with one draw. 	<p>Slide 62</p>
	<p>Slide 63: Challenges</p> <p>Challenges & Responses:</p> <ul style="list-style-type: none"> • Using a program such as the Fishbowl Method has been popular with patients because they earn chances to win tangible prizes in exchange for exhibiting desirable behaviors (i.e., attending treatment activities and testing drug-free). • Costs of Motivational Incentive programs can be further adjusted by: <ol style="list-style-type: none"> 1) Identifying an eligible clinic population where a specific desired behavior is targeted (i.e., abstinence or program attendance) 2) Targeting the use of a specific substance (i.e., cocaine abstinence) among patients on methadone maintenance 3) Working with particularly vulnerable populations such pregnant women. • Clinician antidotes suggest using a Motivational Incentive program can be fun and builds team spirit in the treatment setting. Clinicians have also commented on how the culture of treatment shifts when they spend more time recognizing and celebrating patient achievements. 	<p>Slide 63</p>







Slide Picture	Trainer Notes	Slide #
	<ul style="list-style-type: none"> • Program administrators have found using a Fishbowl Method keeps costs to a minimum by reinforcing only a proportion of patients' target behaviors with a tangible, on-site prize. • Abstinence-based Motivational Incentive programs may seek to establish abstinence as a target behavior only when on-site sample test kits are used regularly, are relatively low in cost and provide immediate results. • Targeting other behaviors like that of attendance is an option if the cost of sample testing is prohibitive or requires the patient to wait for a test result prior to having his/her abstinence reinforced. <p><i>Petry, N. M. (2000). A comprehensive guide to the application of contingency management procedures in clinical settings. Drug & Alcohol Dependence, 58, 9-25.</i></p>	
 <p>LOW COST INCENTIVES Challenges</p> <p>Motivational Incentives are a clinical practice with therapeutic guidelines*:</p> <ul style="list-style-type: none"> • Never take the form of cash (instead would be given as gift cards to stores, gas stations, etc.); • Low in value (not to exceed \$200/month or last for more than 3 months); • Introduced as clinically indicated and as part of an established treatment plan; • Not advertised and are not offered to all participants. <p><i>Is it fair?</i></p> <p><small>*OIG Opinion on Motivational Incentives, 2008</small></p>	<p>Slide 64: Challenges – Is it Fair?</p> <p>In regard to the “fairness” challenge:</p> <ul style="list-style-type: none"> • Several states have responded to Medicaid regulation concerns regarding the use of Motivational Incentives. The issue commonly raised is whether or not the use of incentives would be considered an inducement. The answer is no. • Motivational Incentives are a clinical practice with therapeutic guidelines* and safeguards which include: <ul style="list-style-type: none"> ▪ The incentives never take the form of cash (instead would be given as gift cards to stores, gas stations, etc.); ▪ The incentives are low in value (not to exceed \$200/month or last for more than 3 months); ▪ The incentives are only introduced as clinically indicated and as part of an established treatment plan; ▪ The treatment plans are certified to be "medically necessary" and appropriate; ▪ The incentives are not advertised and are not offered to all participants. 	<p>Slide 64</p>



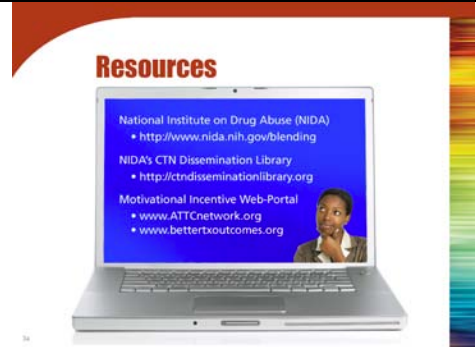

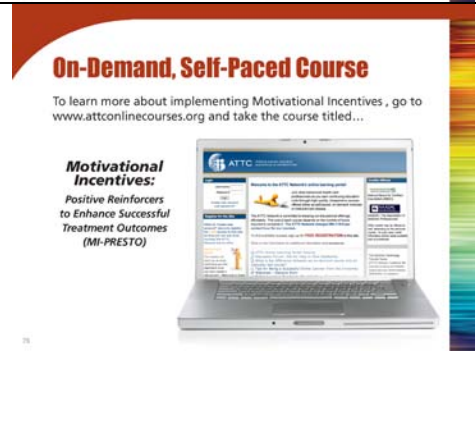

Slide Picture	Trainer Notes	Slide #
	<p>*Excerpts from the OIG <u>Opinion on Motivational Incentives, 2008</u></p> <p><i>Office of Inspector General, SAMHSA. (2008, September 24). OIG Advisory Opinion No. 08-14. Retrieved January 12, 2011, from http://oig.hhs.gov/fraud/docs/advisoryopinions/2008/AdvOpn08-14.pdf</i></p>	
	<p>Slide 65: Challenges – Does it Lead to Increased Gambling Behavior Among Patients in Substance Use Disorder Treatment?</p> <ul style="list-style-type: none"> • Researchers acknowledge the concern with using a Fishbowl because patients are given “chances” to win prizes somewhat like that of a lottery. However, the Fishbowl is unlike a lottery in that patients do not stand to lose anything of value when they draw from the Fishbowl. This chance of losing is what makes Motivational Incentives different from a lottery. • Clinical judgment always plays a role in determining client inclusion or exclusion from a Motivational Incentive program. If a patient is in recovery from a Pathological Gambling Disorder and making efforts to not gamble, the clinician may want to monitor the patient’s gambling urges and behaviors more closely and/or opt to exclude the patient from a Motivational Incentives program. <p>Trainer Note regarding MIEDAR Study specifically addressing gambling behavior: In the MIEDAR study, patients were excluded from the study if they screened positive for a gambling problem, but not if they reported some gambling behavior. Roughly half (N=400) of the 803 patients in the study received treatment as usual plus prize-based Motivational Incentives. The data revealed NO increase in frequency of gambling behavior as a result of the prize-based Motivational Incentives.</p>	<p>Slide 65</p>

Slide Picture	Trainer Notes	Slide #
	<p>Petry, N. M., Kolodner, K. B., Li, R., Peirce, J. M., Roll, J. M., Stitzer, M. L., et al. (2006). Prize-based contingency management does not increase gambling. <i>Drug and Alcohol Dependence</i>, 83, 269-273.</p>	
	<p>Slide 66: Challenges – Isn't this just rewarding patients for doing what they're supposed to do anyway?</p> <p>Abstinence brings its own reinforcement (i.e., healthier lifestyle, employment, educational opportunities, positive relationships); however, the pull of dependence and its immediate reinforcement continues. In the process of becoming abstinent, it typically takes a long time before any rewards are experienced.</p> <p>Motivational Incentives are designed to reinforce and strengthen a desired behavior. They are not used as a substitute for counseling, but as an adjunct to counseling. Motivational Incentive programs make it possible to reach and motivate those patients who are least responsive to treatment and most in need of help.</p> <p>Petry, N. M., & Bohn, M. J. (2003). <i>Fishbowls and candy bars: Using low-cost incentives to increase treatment retention. Science & Practice Perspectives: A Publication of the National Institute on Drug Abuse, National Institutes of Health</i>, 2, 55-61. Available: http://www.nida.nih.gov/PDF/Perspectives/vol2no1/06Perspectives-Fishbowls.pdf</p>	<p>Slide 66</p> 
	<p>Slide 67: Challenges – Setting up a Prize Cabinet and Delivering Prizes</p> <p>A prize cabinet is an essential component of setting up a Motivational Incentive program using the Fishbowl Method.</p> <ul style="list-style-type: none"> • Items in the prize cabinet should be things your patients want. • Prize categories should include “Small” incentive prizes (i.e., \$.70 to \$1.00); “Large” incentive prizes (i.e., about \$20); and “Jumbo” prizes (i.e., \$80-\$100). 	<p>Slide 67</p>


Slide Picture	Trainer Notes	Slide #
	<ul style="list-style-type: none"> • Ways to reduce the cost of setting up a prize cabinet are: <ul style="list-style-type: none"> ▪ Consider having monetary and non-monetary prizes available. Non-monetary prizes might include special parking spots for a week, or a rapid dosing line in the methadone clinic ▪ Ask staff and donors to donate gently-used items to add to the prize cabinet ▪ Donated items can vary (e.g., toiletries, food, clothing, iTunes cards) <p>To know more about implementing a Motivational Incentive program, visit the Motivational Incentive Web-Portal hosted on www.attcnetwork.org or www.bettertxoutcomes.org.</p>	
	<p>Slide 68: Challenges – Adolescent/Co-Occurring</p> <p><i>YES, historically incentives have been used to target a variety of behaviors in adolescents and patients with co-occurring disorders.</i></p> <p>Across a number of studies, incentives have been used to target drug and tobacco use among special populations of substance users including pregnant and postpartum women, adolescents, and individuals with a serious co-occurring mental illness.</p> <p><i>Remind participants to visit the Motivational Incentive Web-Portal for additional resources including the resource bibliography (www.attcnetwork.org or www.bettertxoutcomes.org).</i></p> <p><i>Higgins, S. T., Alessi, S. M., & Dantona, R. L. (2002). Voucher-based incentives: A substance abuse treatment innovation. Addictive Behaviors, 27, 887-910.</i></p>	<p>Slide 68</p>  


Slide Picture	Trainer Notes	Slide #
	<p>Slide 69: Course Content</p> <p>In this final section we will read some comments from the field and then we would like to hear your thoughts and comments.</p>	<p>Slide 69</p>
	<p>Slide 70: What do patients say?</p> <p>“I felt that I was going down the drain with drug use, that I was going to die soon. This got me connected, got me involved in groups and back into things. Now I’m clean and sober.”</p> <p><i>Time permitting, solicit participant discussion/feedback.</i></p> <p><i>Kellogg, S. H., Burns, M., Coleman, P., Stitzer, M. L., Wale, J. B., & Kreek, M. J. (2005). Something of value: The introduction of contingency management interventions into the New York City Health and Hospital Addiction Treatment Service. Journal of Substance Abuse Treatment, 28, 57-65.</i></p>	<p>Slide 70</p>  


Slide Picture	Trainer Notes	Slide #
<p>PERSPECTIVES What do treatment providers say?</p> <p>We came to see that we need to reward people where rewards are few and far between.</p> <p>We use rewards as a clinical tool—not as bribery—but for recognition.</p> <p>The really profound rewards will come later.</p>  <p><small>Kellogg et al., 2005</small></p>	<p>Slide 71: What does treatment staff say?</p> <p>“We came to see that we need to reward people where rewards are few and far between.”</p> <p>“We use rewards as a clinical tool—not as bribery—but for recognition.”</p> <p>“The really profound rewards will come later.”</p> <p><i>Time permitting, solicit participant discussion/feedback.</i></p> <p><i>Kellogg, S. H., Burns, M., Coleman, P., Stitzer, M. L., Wale, J. B., & Kreek, M. J. (2005). Something of value: The introduction of contingency management interventions into the New York City Health and Hospital Addiction Treatment Service. Journal of Substance Abuse Treatment, 28, 57-65.</i></p>	<p>Slide 71</p>  
<p>PERSPECTIVES What do administrators say?</p> <p>The staff have heard patients say that they had come to realize that there are rewards just in being with each other in group. There are so many traumatized and sexually abused patients who are only told negative things. So, when they heard something good—that helps to build their self-esteem and ego.</p>  <p><small>Kellogg et al., 2005</small></p>	<p>Slide 72: What do administrators say?</p> <p>“The staff have heard patients say that they had come to realize that there are rewards just in being with each other in group. There are so many traumatized and sexually abused patients who are only told negative things. So, when they heard something good—that helps to build their self-esteem and ego.”</p> <p><i>Time permitting, solicit participant discussion/feedback.</i></p> <p><i>Kellogg, S. H., Burns, M., Coleman, P., Stitzer, M. L., Wale, J. B., & Kreek, M. J. (2005). Something of value: The introduction of contingency management interventions into the New York City Health and Hospital Addiction Treatment Service. Journal of Substance Abuse Treatment, 28, 57-65.</i></p>	<p>Slide 72</p>  


Slide Picture	Trainer Notes	Slide #
 <p>PERSPECTIVES What do you say?</p> <ul style="list-style-type: none"> • What are your thoughts about Motivational Incentives? • What are your concerns? • What are some things you would need to do to consider implementing Motivational Incentives? 	<p>Slide 73: What do you say?</p> <p>Ask for responses to the following questions:</p> <ul style="list-style-type: none"> • What are your thoughts about using Motivational Incentives? • What are your concerns? • What are some things you would need to do to consider implementing a Motivational Incentive program? <p><i>Time permitting; continue to solicit participant discussion/feedback.</i></p>	<p>Slide 73</p> 
 <p>Resources</p> <ul style="list-style-type: none"> National Institute on Drug Abuse (NIDA) <ul style="list-style-type: none"> • http://www.nida.nih.gov/blending NIDA's CTN Dissemination Library <ul style="list-style-type: none"> • http://ctndisseminationlibrary.org Motivational Incentive Web-Portal <ul style="list-style-type: none"> • www.ATTNetwork.org • www.betterxoutcomes.org 	<p>Slide 74: Resources</p> <p><i>If you have a live internet connection, link to website address and show the group the various resources.</i></p> <p><i>Facilitate a discussion on how participants could use these resources to implement a Motivational Incentive program in their organization.</i></p>	<p>Slide 74</p> 
 <p>On-Demand, Self-Paced Course</p> <p>To learn more about implementing Motivational Incentives, go to www.attconlinecourses.org and take the course titled...</p> <p>Motivational Incentives: <i>Positive Reinforcers to Enhance Successful Treatment Outcomes (MI-PRESTO)</i></p>	<p>Slide 75: On-Demand, Self-Paced Course</p> <p><i>Prior to this PAMI presentation, secure a username and password for the ATTC Online Learning Portal.</i></p> <p><i>Then, if you have a live internet connection, go to the on-demand, self-paced course at www.attconlinecourses.org.</i></p> <p><i>Demonstrate how a participant could access the training on implementing a Motivational Incentive program: Motivational Incentives: Positive Reinforcers to Enhance Successful Treatment Outcomes (MI-PRESTO).</i></p>	<p>Slide 75</p> 

Optional Trainer Activities

ACTIVITY #1 – Training Expectations	Suggested Placement
<p>Large Group Activity</p> <p>Purpose: Clarify expectations of this awareness training</p> <p>Materials needed: White board or large tablet paper, markers</p> <p>Use during introductions for groups of 20 or less. On the Slide #7 Trainer Notes, the instructions for introductions for groups of 20 or less state that participants provide the following:</p> <ul style="list-style-type: none"> • names and organizations • experience using motivational incentive or behavior modification programs • expectations for this training <p>One of the trainers captures on a white board or large tablet paper: all of the training expectations participants bring up in the introduction of the course. Tick marks can be used as expectations are repeated. After all participants have introduced themselves and spoken aloud the reasons they are attending the training, the trainers should go through the list and indicate which expectations will be covered.</p> <p>For participants who want to know more about how to design and implement a Motivational Incentive program, refer to the online course, <i>Motivational Incentives: Positive Reinforcers to Enhance Successful Treatment Outcomes (MI:PRESTO)</i>. This course is available on-demand through www.attconlinecourses.org or www.bettertxoutcomes.org and instructs clinical supervisors in how to design and customize a Motivational Incentive program within the context of their community-based treatment organization.</p> <p>There are several purposes for this exercise: Adult learners want time to be well-spent and have particular expectations when attending training. This opening activity will reinforce that there are clear training goals by clarifying what will and will not be covered.</p>	<p>Slide #7</p>  <p><i>Estimated Cost: None</i></p>

ACTIVITY #2 – Incentives in Our Lives	Suggested Placement
<p>Large Group Activity</p> <p>Purpose: Stimulate participant thinking about how daily decisions and actions are motivated by rewards and reinforcements</p> <p>Insert this activity into one of several places in the training:</p> <ul style="list-style-type: none"> • Option 1— following Slide #18 • Option 2— following Slide #25 • Option 3— following Slide #36 <p>Ask participants to brainstorm examples of how our lives are affected by rewards, reinforcements, prizes and incentives. Elicit participant responses and capture them in brief phrases on a white board or large tablet paper. The goal of this activity is to serve as no-wrong-response brainstorm session without distinguishing whether their ideas are rewards, reinforcements, prizes or incentives. This activity raises awareness of how rewards and reinforcements influence one’s daily life. Participants should begin to conceptualize how incentives could reinforce positive behavior change in a patient’s recovery process.</p> <p>After a few ideas have been voiced, begin to toss out a piece of candy or other small item to those who offer ideas. The trainer(s) may wish to offer additional examples. To conclude, trainer(s) should briefly facilitate a discussion.</p> <ul style="list-style-type: none"> • Ask for observations regarding level of participation or personal willingness to participate once candy and/or other small items were provided as incentives. • If participants indicate that candy and/or the small item did not motivate them, explain that their observation is a good example of a point addressed in the 7 Principles of Motivational Incentives (i.e., Principle 3: Choice of Reinforcer, Slide # 53). • End by emphasizing that all behavior is influenced by rewards and reinforcements. 	<p>Slide #18 or Slide #25 or Slide #36</p>  <p><i>Estimated Cost: \$5-\$15</i></p>

ACTIVITY #3 – Barriers to Implementation Activity	Suggested Placement
<p>Dyad or Triad Activity</p> <p>Purpose: Encourage discussion of the barriers to implementing Motivational Incentives and begin to look at ways to overcome these barriers</p> <p>This activity should be conducted in dyads (groups of 2) or triads (groups of 3), followed by brief group report-outs. Placement options follow:</p> <ul style="list-style-type: none"> • Option 1—Slide #63 • Option 2—Slide #68 <p>Trainer(s) ask participants to form dyads or triads. Instruct participants to identify potential barriers to incorporating a Motivational Incentive program in their particular clinical settings. Next, ask groups to explore how they might address those barriers.</p> <p>Trainer(s) should affirm group suggestions for overcoming barriers and offer additional examples if desired.</p>	<p>Slide #63 or Slide #68</p>  <p><i>Estimated Cost: None</i></p>

ACTIVITY #4 – PAMI “Bingo” Activity	Suggested Placement
<p>Individual Activity</p> <p>Purpose: To demonstrate one method of distributing low-cost incentives and illustrate how using incentives can add fun and a spirit of positive affirmation to any setting</p> <p>Introduce the PAMI <i>Bingo Activity</i> on page 59 at the beginning of the training and use throughout the training.</p> <p>Provide each participant with a copy of the PAMI <i>Bingo Activity</i>, adapted with permission from the New York City Health and Hospitals Corporation’s Recovery Activity Handout. This activity illustrates an alternative low-cost method of delivering incentives.</p> <p>Each participant keeps track of his or her own behavior during the training. When participants have achieved and checked-off three behaviors in a vertical, horizontal, or diagonal line, they call out “Bingo.”</p> <p>The trainers should provide small incentives each time someone achieves behavioral BINGO. Incentives might include: candy bars, packs of gum, breath lozenges, Post-It Notes, pens, small table toys, etc.</p> <p>The trainer may end this activity as desired: when there are no more prizes, when enough “Bingos” have been awarded to deem the activity understood, or when, in the interest of time, the training must move on with no more “Bingo” interruptions.</p>	<p>Throughout</p>  <p><i>Estimated Cost: \$25-\$75</i></p>

PAMI BINGO ACTIVITY

<p>Seated when trainer introductions begin</p>	<p>Participate in discussion following PAMI video</p>	<p>Ask a question during training</p>
<p>Share idea during a brainstorming session</p>	<p><i>FREE SPACE</i></p>	<p>Return from break on time</p>
<p>Offer a comment during training</p>	<p>During break engage colleague(s) in conversation about how Motivational Incentives are currently used in work setting</p>	<p>Commit to share material with a colleague or supervisor</p>

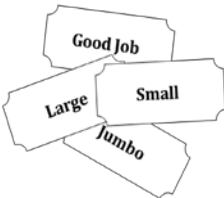

Instructions

1. Initial spaces when targeted behavior is demonstrated
2. Any 3 vertical, horizontal, or diagonal connecting boxes = Bingo!
3. Ask peer to witness and sign below
4. Call out "Bingo!"

Participant Name: _____

Witness Name: _____

Source: New York City Health and Hospitals Corporation. (Adapted with permission)

ACTIVITY #5 – Fishbowl Training Simulation Activity	Suggested Placement
<p>Large Group Activity</p> <p>Purpose: Simulate the Fishbowl method throughout the 3-hour or 6-hour training event providing participants with opportunities to experience the process of distributing and receiving incentives using this low-cost method.</p> <p>Review Slides #60-63 Trainer Notes for information on using the Fishbowl Method in a clinical setting.</p> <p>Fishbowl Tickets: Print and cut apart the Fishbowl tickets provided at the end of this exercise. These tickets have been adapted for training purposes only and include 101 tickets. (A 500-ticket Fishbowl template developed for use in clinical settings can be found on the Motivational Incentive Web-Portal www.betterxoutcomes.org or www.attcnetwork.org.)</p>  <p>Rationale for Adapting the Number of Tickets Used in Training In a treatment setting, patients have many opportunities to draw from the Fishbowl as they exhibit the target behavior, whereas training participants have only the relatively short period of an actual training event. Thus the likelihood of drawing “Small,” “Large” or “Jumbo” tickets from the Fishbowl has been increased for the training setting in order for more prizes to be drawn. However, the <u>percentages</u> of each type of Fishbowl ticket shown to be effective in the MIEDAR studies are maintained in the Fishbowl ticket template provided and in the Fishbowl at the beginning of the training. (See Slide #61.)</p> <p>Note that when the percentages create a fraction of a ticket, the number is rounded up as follows: 41.8% (Small) becomes 42 tickets and .2% (Jumbo) becomes 1 ticket. The ticket template provided includes 50 “Good Job” tickets (50%), 42 “Small” tickets (41.8%), 8 “Large” tickets (8.0%) and 1 “Jumbo” ticket (0.2%).</p> <p>Setting Up a Prize Table Provide enough tangible items on the Prize Table to accommodate the potential draws from the Fishbowl during the training. Keep in mind the total number of draws represented by the scenarios incorporated in the presentation <u>and</u> the ratio of “Small”, “Large” and “Jumbo” Fishbowl tickets.</p> <ul style="list-style-type: none"> A minimum of 42 “Small” items, 8 “Large” items and 1 “Jumbo” item are needed to match the number of each category of Fishbowl tickets. However, ideally, the trainer provides more items for the Prize Table than will be utilized, so that participants have a variety of items to choose from throughout the training. 	<p>Throughout</p>  <p>Estimated Cost: \$200-\$300</p> <p>Supplies:</p> <ul style="list-style-type: none"> • Roll of double raffle tickets • Fishbowl tickets from template • Large bowl for Fishbowl tickets • Small bowl for raffle tickets • Signs for prize table: Small, Large, Jumbo • Small and large prizes and one jumbo prize

ACTIVITY #5 – Fishbowl Training Simulation Activity - continued

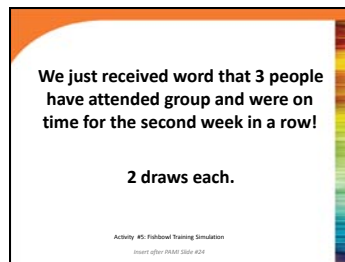
Fishbowl Scenario Slides

Fishbowl Scenario Slides are inserted within the PAMI Trainer Slide Presentation. Each inserted slide prompts the trainer to pause and draw raffle tickets for 2-6 training participants. Scenarios provide an opportunity for the trainer(s) to state key learning point(s) throughout the training.

Option 1:

Download PAMI Trainer Activity 5-Fishbowl Scenario Slides located on the Motivational Incentive Web-Portal www.betterxoutcomes.org or www.attcnetwork.org.

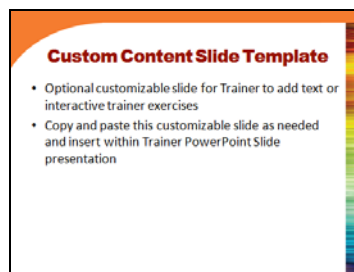
Example Fishbowl Scenario Slide



Trainer(s) may increase or reduce the number of Fishbowl Scenario Slides used in order to accommodate a 3-hour or longer training event. These slides should not be copied in participant handouts. If all slides are used, they represent 99 draws from the Fishbowl, which would be accommodated by the 101 Fishbowl tickets provided in the template.

Option 2:

To create customized demonstration slides, copy and paste multiple copies of PAMI PowerPoint Customizable Slide #77:



ACTIVITY #5 – Fishbowl Training Simulation Activity - continued

Using Raffle Tickets:



As each Fishbowl scenario slide is viewed, the container holding the duplicate copies of participants' raffle tickets is used to draw the designated number of participants to come to the front of the room and draw from the Fishbowl. For example, the first slide indicates 3 people, so 3 raffle tickets are chosen from the container.

The trainer(s) facilitate the raffle ticket draw by asking for a volunteer to draw numbered tickets from the container. If a participant temporarily steps out of the room when their ticket is selected, another participant's raffle ticket is drawn.

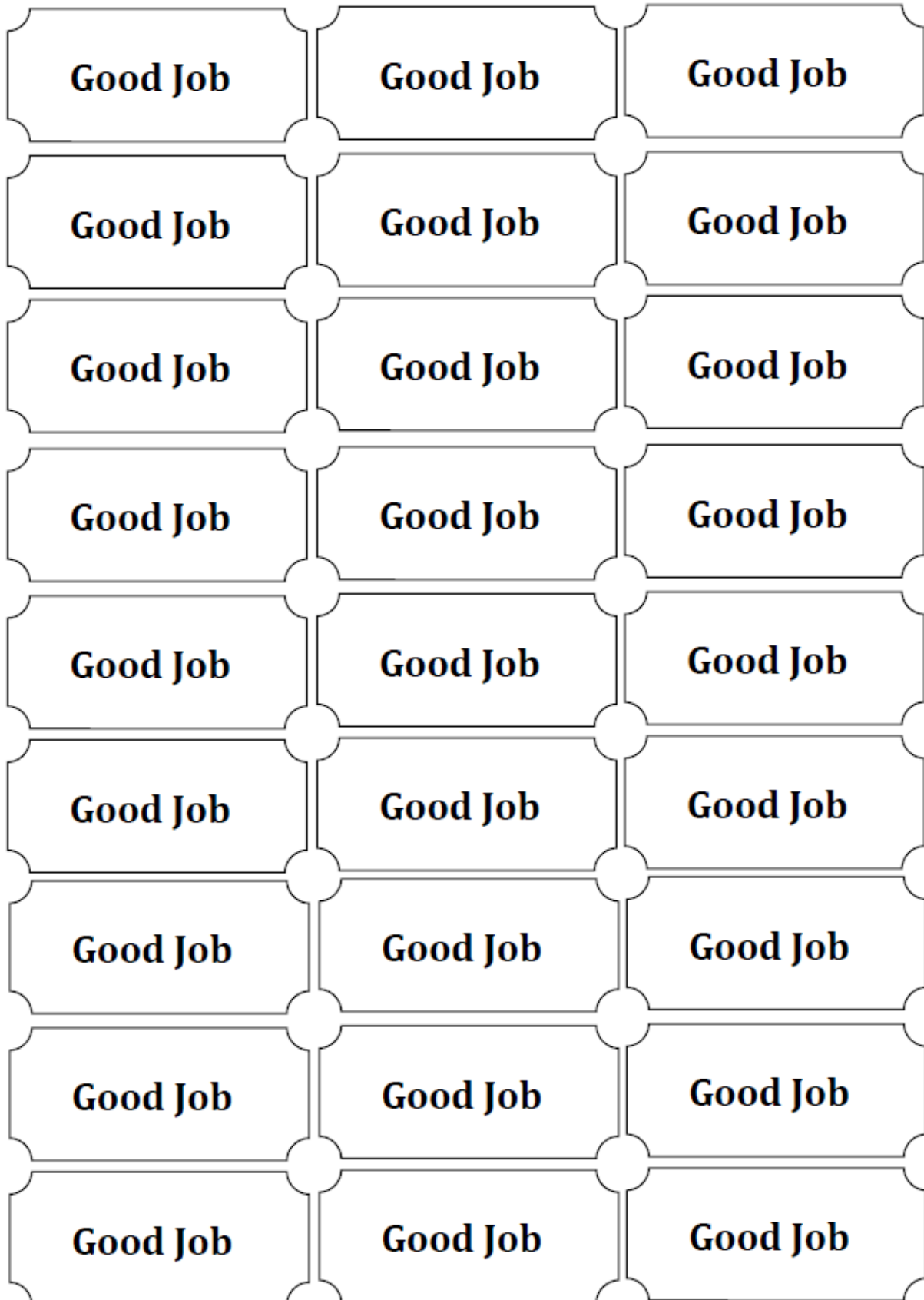
When participants have been identified for the Fishbowl drawing, the duplicate raffle tickets are NOT returned to the container, but are laid to the side or placed in a separate container so that each participant has only one opportunity to have his/her raffle ticket drawn. This way, more participants have an opportunity to draw from the Fishbowl.

At the end of the training, all raffle tickets are returned to the container for a final draw.

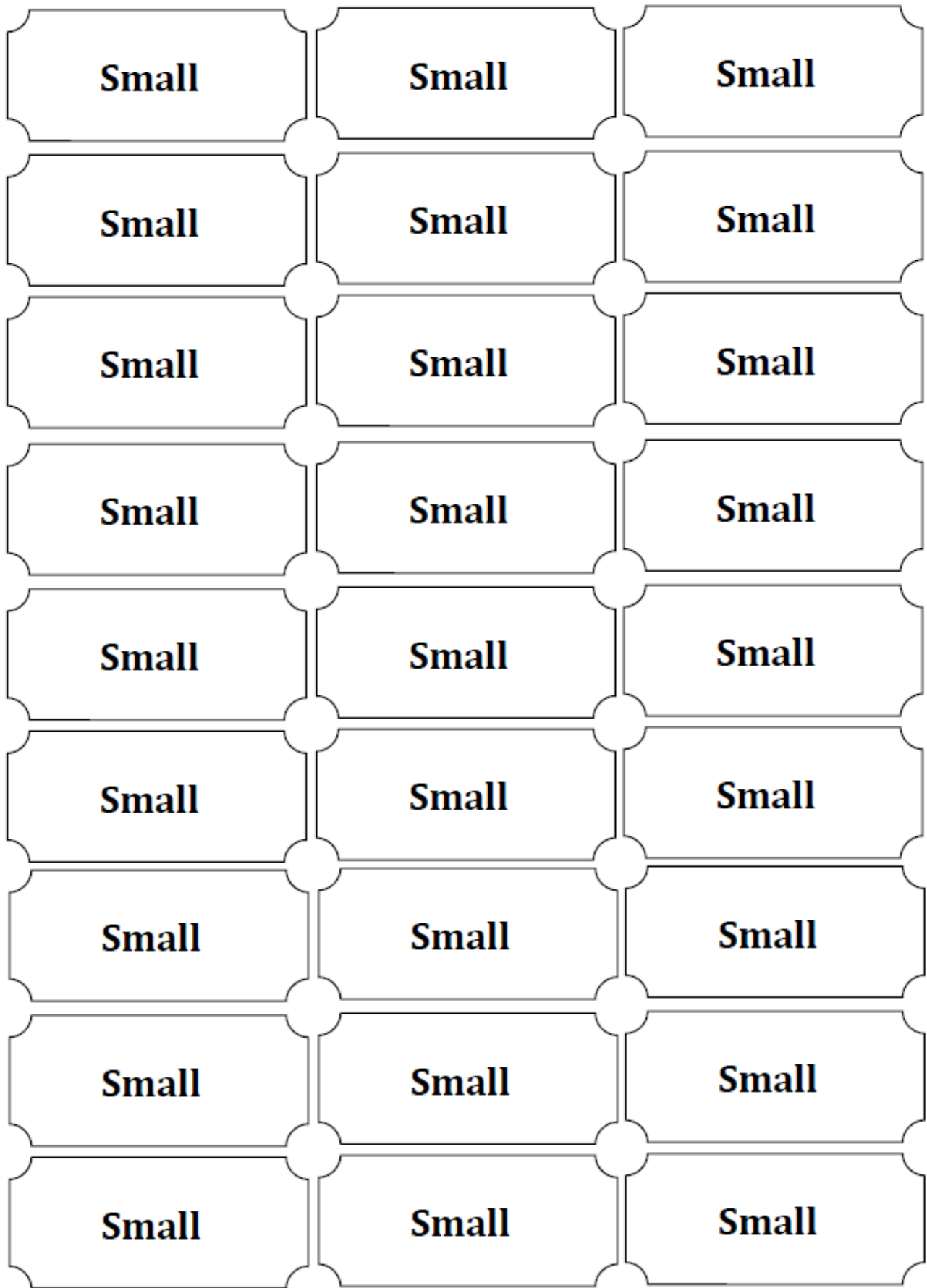
Fishbowl Draw and Incentive Distribution:

- Participants whose numbered raffle tickets have been drawn come to the prize table at the front of the room. If there is a second trainer, that person facilitates the Fishbowl draw and incentive distribution.
- Each participant identified to take part in the Fishbowl, draws the number of Fishbowl tickets designated on the slide. For example, the first scenario slide indicates that each person draws 2 Fishbowl tickets.
- Trainer(s) may ask participants to read their Fishbowl tickets to the group or may read tickets aloud.
- When a participant draws a "Small," "Large" and/or "Jumbo" ticket, he/she selects items from the Prize Table based on the type of ticket(s) drawn and is seated again.
- When participants draw a "Good Job" ticket, trainers lead the group in applauding the person.
- For demonstration purposes, Fishbowl tickets drawn by participants are set aside and not placed back into the Fishbowl.

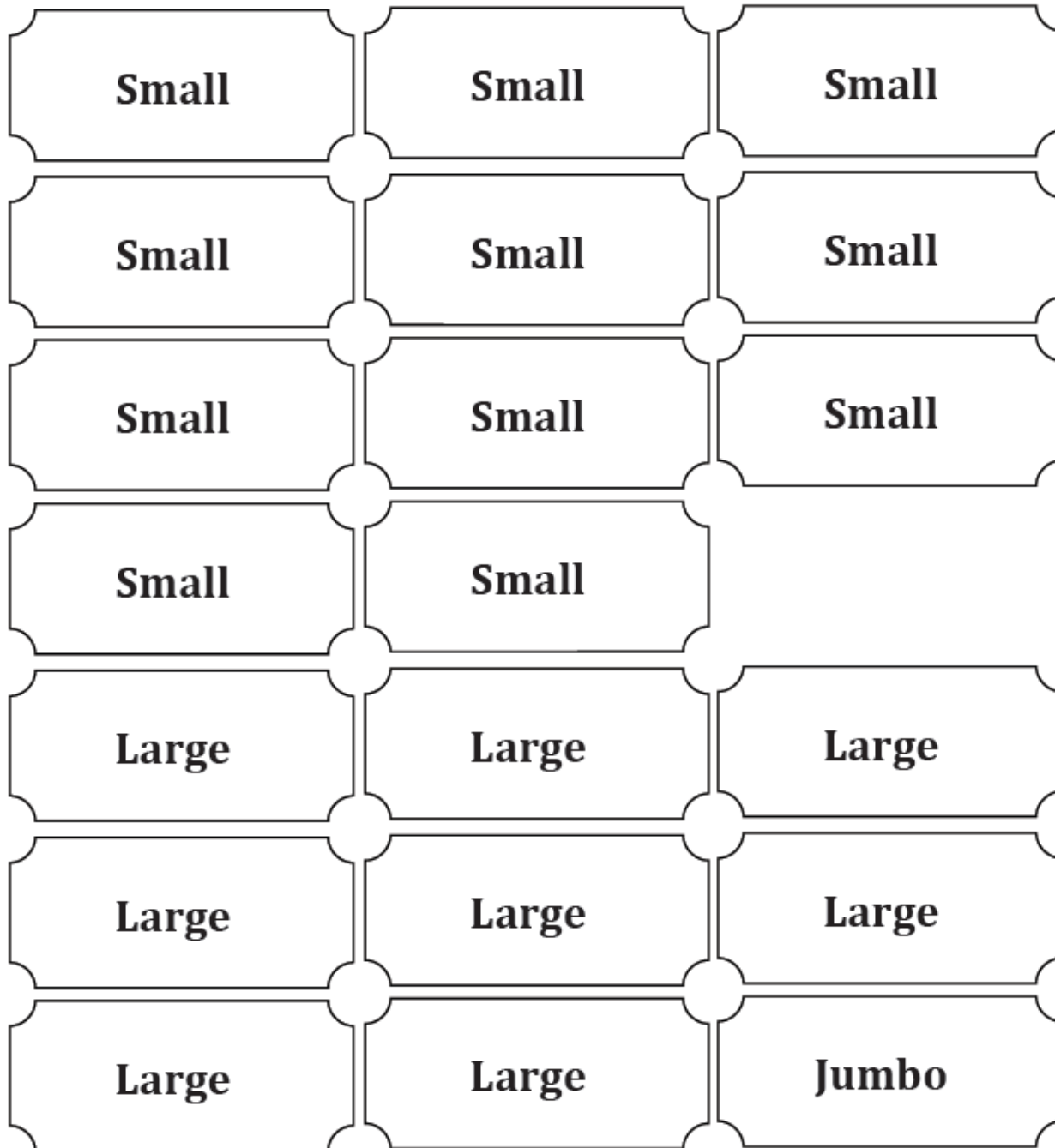
Activity 5: Fishbowl Training Simulation Activity — 101 Fishbowl Tickets



Good Job	Good Job	Good Job
Good Job	Good Job	Good Job
Good Job	Good Job	Good Job
Good Job	Good Job	Good Job
Good Job	Good Job	Good Job
Good Job	Good Job	Good Job
Good Job	Good Job	Good Job
Good Job	Good Job	Small
Small	Small	Small



Activity 5: Fishbowl Training Simulation Activity — 101 Fishbowl Tickets



This 4-page ticket set (a total of 101 tickets) is designed to simulate Petry's Fishbowl method of distributing incentives in the context of a PAMI training.

This template includes: 50 "Good Job" tickets; 42 "Small" tickets; 8 "Large" tickets; 1 "Jumbo" ticket. The correct ratio is maintained: 50% — "Good Job"/41.8% — Small"/8% — "Large"/.2% — "Jumbo" (Because the percentages result in a fraction of a ticket in those numbers are rounded up as in the case of the 41.8% "Small" becomes 42 tickets and the .2% Jumbo becomes 1 ticket.)

Instructions: Print all 4 pages of Fishbowl tickets on 8"x 11 1/2" cardstock to achieve correct ratio. Cut tickets apart.

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