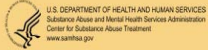


The Reinforcing Therapist Performance (RTP) Experiment: An Overview

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Assertive Adolescent and Family Treatment (AAFT)



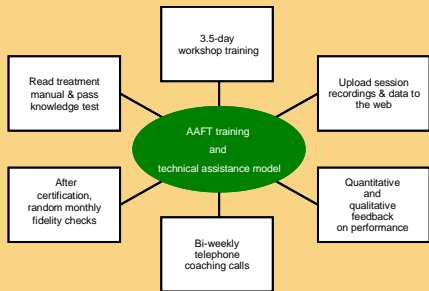
Although significant progress has been made with regard to the advancement of the substance abuse treatment fields' knowledge about attitudes toward and the extent to which evidence-based treatments (EBTs) have been adopted in practice, the field is still in the early stages of development and knowledge regarding EBT implementation (Garner, in press).

While multiple factors influence the quality and degree of EBT implementation in practice settings, attention has increasingly focused on the role of the therapist as a key mediator of treatment delivery. Indeed, in multiple studies that examined this issue, the size of the "therapist" effect has been as large as or larger than the mean effects between conditions (Crits-Christoph et al., 1991, 2006; Kim et al., 2006; Luborsky et al., 1997; Najavits & Weiss, 1994).

A systematic review of the effectiveness of workshop training for psychosocial addiction treatments concluded workshop trainings generally improved therapist knowledge, attitude, and confidence in working with clients, as well as some skills immediately after training, but in order for therapists to incorporate these skills in their repertoire for the long-term, extended contact such as feedback, supervision, and consultation, are also necessary (Walters et al., 2005).

Consistent with these findings the Center for Substance Abuse Treatment (CSAT) is currently providing 34 grantees with approximately \$300,000 per year (for three years), as well as a comprehensive training and technical assistance model (see below) to facilitate the implementation of the Adolescent Community Reinforcement Approach (A-CRA; Dennis et al., 2004; Godley et al., 2001). This Assertive Adolescent and Family Treatment (AAFT) initiative provides the foundation for the Reinforcing Therapist Performance (RTP) experiment funded by the National Institute on Alcohol Abuse and Alcoholism (NIAAA; PI Garner).

AAFT Training and Technical Assistance Model



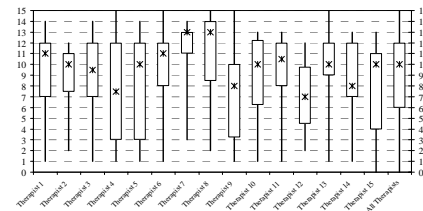
Reinforcing Therapist Performance (RTP)



Background

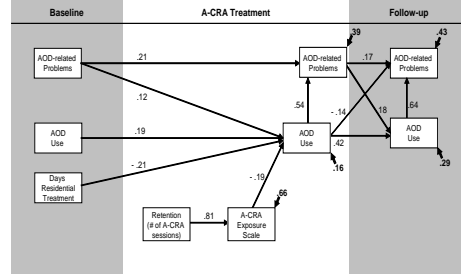
Research has shown that even within carefully controlled clinical trials that employ state-of-the-art training strategies being used in AAFT, it can be difficult to achieve the same level of implementation and treatment fidelity across all therapists (Garner et al., in press; Najavits et al., 2000; Shaw et al., 1999). Combining data from four A-CRA randomized trials, Garner and colleagues (in press) created a data set based on 15 therapists who provided A-CRA to 399 adolescents. As shown below, there was significant variation with regard to the number of A-CRA procedures therapists delivered to their clients on average, $F(14,384) = 3.77, p < .001$.

Box plot of number of A-CRA procedures delivered by therapists



As illustrated below, Garner et al. (in press) also found implementation of A-CRA procedures was a significant mediator of the relationship between adolescent substance abuse treatment retention and outcome.

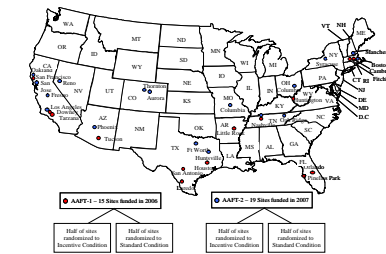
Model showing AES as a significant mediator of retention and outcome



Study Rationale and Aims

Given therapist behavior has increasingly been recognized as a central mediator of implementation, researchers have increasingly focused on improving our understanding of therapist behavior. One approach recently recommended to improve the quality of healthcare is to reward provider and therapist performance (i.e., pay-for-performance; see IOM, 2007; Kimberly & McLellan, 2006; Shepard et al., 2006; Weisner et al., 2004). Thus, the specific aims of the proposed study are to evaluate the effectiveness and cost-effectiveness of providing monetary incentives to therapists as a method to improve treatment implementation and subsequent treatment outcomes for clients.

Randomization of Sites

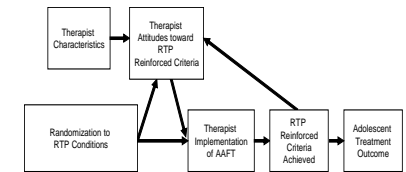


Implementation Targets Being Reinforced cont.

2. Monthly Competence – Study participants who work at agencies assigned to the Incentive Condition will receive \$50 for each month that a randomly selected digital session recording (DSR) has at least one A-CRA procedure (excluding Homework, Overall, and General Clinical Skills) rated at or above the minimum level of competence required for A-CRA certification.

Conceptual Framework

The conceptual framework for the current study was adapted from one specifically developed to evaluate pay-for-performance programs (see Meterko et al., 2006; Young et al., 2005). While based upon an extensive review of the literature and discussions with experts in the field, RTP is the first study to empirically test this conceptual framework.



RTP recruitment as of 1/15/2009

AAFT-1

14/14 (100%) eligible sites agreed to participate.

38/43 (88%) eligible therapists agreed to participate.

AAFT-2

15/16 (94%) eligible sites agreed to participate.

Study packets mailed to therapists on 1/15/2009.

References

Available upon request.

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Implementation Targets Being Reinforced

1. Target A-CRA – Therapists who work at agencies assigned to the Incentive Condition will receive \$200 for each adolescent who within the first 14 weeks of AAFT receives Target A-CRA in no fewer than seven A-CRA sessions. Target A-CRA is defined as the delivery of 10 or more of the following 12 A-CRA procedures: 1) Functional Analysis of Substance Using Behavior, 2) Functional Analysis of ProSocial Behavior, 3) Happiness Scale, 4) Treatment Plan/Goals of Counseling, 5) Communication Skills, 6) Problem Solving Skills, 7) Adolescent-Caregiver Relationship Skills, 8) Caregiver Overview, Rapport Building, and Motivation, 9) Homework Reviewed, 10) Drink/Drug Refusal Skills, 11) Relapse Prevention, and 12) Increasing ProSocial Recreation. Additionally, because identifying, discussing, and reviewing the adolescent's reinforcers is considered a central mechanism of change within the A-CRA philosophy, therapists must demonstrate one of these three components in at least 50% or more of the sessions conducted during this time period.