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Addiction Medicine

ASAM Practice Pearls Transcript

Contingency Management: *The Nuts and Bolts of Implementation*

Dr. Stephen Taylor: Hello friends and colleagues, and welcome back to ASAM Practice Pearls, where we turn clinical expertise into everyday addiction care, one conversation at a time. I'm your host, Dr. Stephen Taylor. Today we're going to talk about a topic that isn't always widely understood: contingency management. Many of us hear people say that contingency management is just paying patients, and that perception can be a barrier to considering an evidence-based treatment option. Well, I want to share two quotes with you in that regard.

The first quote is from Steve Martin, and he says, "I love money. I love everything about it. I bought some pretty good stuff. Got me a \$300 pair of socks, got a fur sink, an electric dog polisher, a gasoline-powered turtleneck sweater, and of course, I bought some dumb stuff too."

The second quote is from Benjamin Franklin, and he says, "An investment in knowledge pays the best interest."

What I think is important about these two quotes is whether you think of contingency management as being something that's more akin to the first quote or more akin to what's described in the second quote, it really is important to think about the fact that many people think of contingency management as paying people to do something that they really ought to do anyway, which is to pursue their recovery.

And that problematic notion about contingency management is something that I think we're going to address today as we discuss contingency management in today's episode, and there could be no better guest for me to have on our podcast today to have that discussion with than my colleague, my friend, our immediate past president of the American Society of Addiction Medicine, Dr. Brian Hurley. Dr. Hurley, please say hello to our audience.

Dr. Brian Hurley: Oh, thank you so much, Stephen. Thank you for having me on the podcast again. It's really good to be back.

Dr. Stephen Taylor: Awesome. It's great to have you back. And of course, the last time I had you with me here talking with our friends and our colleagues, we were talking about treatment of patients with stimulant use disorder. And of course, you did mention that, in fact, contingency management is the treatment of choice for patients with stimulant use disorder.

Today, we're going to take that deep dive into contingency management. And I'll start us off with a basic question of what does the research and evidence tell us about contingency management?

Dr. Brian Hurley: The research is pretty clear. Contingency management works. Now, what contingency management fundamentally is, is where somebody gets something of value to them. You can imagine that could be everything from cash, gift cards, privileges, but something of value, when they exhibit an objective behavior - so that objective behavior, you know, for anyone with children knows cleaning your room - but with respect to substance use disorders, it would be urine toxicology, verified abstinence from a substance of interest. It could also be medication adherence. It could also be attendance. There's a number of objective behaviors. And so, contingency management actually has a number of applications because, essentially, what you're doing is applying a reward, an incentive, as it were, when people demonstrate the objective behavior that we're looking for.

Dr. Stephen Taylor: Absolutely. So, when is it most effective? Are there populations or specific substance use disorders where contingency management is recommended? And I've obviously mentioned one already, but are there others?

Dr. Brian Hurley: You mentioned the prior podcast on the treatment of stimulant use disorder and the ASAM and AAP guidelines are pretty clear. Contingency management is the treatment of choice for stimulant use disorder. So, that means if you have a patient with cocaine use disorder or an amphetamine use disorder or is using another psychostimulant and has a use order related to that, that contingency management should be the first thought. And one of the reasons that we so strongly emphasize contingency management for stimulant use disorder is because, well, one, it works, and two, we don't have a ton of other medication treatments.

And there are other counseling treatments, but they don't have the same effect size of contingency management. So, contingency management in comparison to other

interventions essentially elevates itself because it's so effective. But contingency management's effectiveness is not limited to stimulant use disorder.

In fact, virtually every substance use disorder condition, addiction involving cannabis, tobacco, alcohol, or opioids, can respond to contingency management. That is, outcomes get better. That said, other substance use disorders also respond to other treatments, right? So, for opioid use disorder, medications for opioid disorder have a particular role, and our guideline on opioid use disorder treatment reflects that. But contingency management can also be a helpful emphasis to that. And in our, federally licensed opiate treatment programs, there's a long history of using take home doses kind of as a contingency management, right?

Like as a way of providing people with more flexibility, which is of value to them. When they exhibit participation in the components of the opiate treatment program that the opiate treatment program wants somebody to participate in. So, we already kind of have some built in contingency management in some of the ways we do other treatment.

It doesn't necessarily exactly have to be a cash or gift card incentive in response to toxicology testing. There are other ways of operationalizing it. I'm glad we're talking about contingency management today, but I wanted to emphasize, its application is not restricted to stimulant use disorder.

Dr. Stephen Taylor: Not only is that true, but I think your point really helps us to remember that many of us are already applying contingency management techniques in the treatment that we've been providing for our patients, and in many cases have been doing so for many years. We just haven't been calling it contingency management.

And I think that's an important point to emphasize, that a lot of us are already doing it and doing it with great effect.

Dr. Brian Hurley: Yes. That said, there are clear manuals for certain targets. So, for example, urine verified abstinence from stimulants will generate more abstinence from stimulants than contingency management focused on other behavioral targets, right? So, you get what you incentivize, generally speaking.

It is important when you have a model set up to stay in fidelity to that model. So, yes, it's true. We use contingency management in all sorts of ways, subtle ways and explicit ways, depending on our treatment setting and depending on exactly what it is we're

looking for. I think it's also important to note when you're doing contingency management, hypothetically, to support ongoing remission from stimulant use disorder, making sure that your infidelity to urine verified absence from stimulants is what would be necessary to generate that outcome.

Dr. Stephen Taylor: That's so true. So, here's another thought. Because of the thought about applying this in treatment settings in which so many of us are already working, how do you provide contingency management alongside other treatment options? Or is contingency management something that you can only do when you're doing contingency management? Let's talk about the practicality of using this treatment modality.

Dr. Brian Hurley: Contingency management is actually really straightforward. You measure an objective behavior and you provide an incentive. So, I'll use California's contingency management program as an example of this. California has set up a manualized program. It's 12 weeks of twice a week urines. When the urine is negative for stimulants, there's an incentive.

And the way California is set up, it's what's called a fixed incentive. That is, the amount is already known that there's a table that people follow and the amount escalates over time. Starts at \$10 a urine, and \$20 for the first week, and then goes up in value from there, for 12 weeks, and then there's an additional 12 weeks. So, it's altogether a 24-week program where people get weekly urines after that.

So, in the California program, what you need is a method of giving somebody a gift card or essentially the monetary value of interest, right? The mechanism that somebody gets the reward. and you have to have point of care cups that can be read immediately, and that's an important component of contingency management, right? Somebody demonstrates the behavior, they get the immediate reward. Sending to a lab and waiting for a couple days really then would diminish the effectiveness of contingency management because it separates the behavior from the measurement.

The idea is you're doing a measurement and seeing right there whether somebody qualifies for the incentive or not. When somebody has, say, shown up at a treatment program, provided their urine, got their incentive, you can do all sorts of things. You could do assessments, you could do motivational interviewing, you could do cognitive behavioral therapy. You can run somebody through a manualized intensive outpatient program like the Matrix Model IOP, which is an evidence-based intensive outpatient

manual focused on stimulant use disorder. There's all sorts of other things that you can do when somebody's shown up to a treatment program.

So, interestingly, although contingency management certainly can be effective as a standalone treatment, somebody shows up, gets a urine, gets their incentive, and leaves. At a very practical level, what we actually see is when people show up, for you know, the incentive, they do all the other stuff that's there, right? They get the counseling, they get the support, they get the care coordination. They receive the other service components at the treatment program, and that's part of how you can then combine contingency management with, well, anything you're doing; medication management visits, motivational interviewing visits. It can be delivered alongside virtually any other treatment.

Dr. Stephen Taylor: That is great. Because weaving it into a full-scale comprehensive treatment program is something that I would imagine many of our listeners would want to do, and so I think that's a great suggestion.

Dr. Brian Hurley: That's right. And I do just want to sort of emphasize one more thing. I think it's important when we think about the components of care. We have a history in addiction treatment of setting up high threshold, right? Unless you do all of these things and check all of these boxes, then you clearly are not ready for treatment. Come back when you're ready. And one of the things I think the overdose crisis has taught us is if we wait for just everyone to be ready for treatment, too many people die. That is not actually going to be a scalable approach to reach all the people that need treatment.

So, I think I'm saying two things at the same time. One, I'm actually all for delivering contingency management as a standalone treatment in the sense that if that's all the person wants, that's okay. I'm not going to gatekeep contingency management behind somebody having completed a whole bunch of other types of programming. In the field, we need to make sure that all of those other types of programming are available. That they're on the menu for people to receive alongside contingency management, because we do know that people then also respond to the full bio-psychosocial components of care.

Dr. Stephen Taylor: Interesting. So, once again, we're back to that basic principle that's in the ASAM Criteria and throughout everything we do, which is that treatment needs to be individualized according to the needs of the person seeking treatment. That makes perfect sense. Do contingency management alone, if that's the way this particular

individual might need it, or combine it with other evidence-based treatments, if that's what the person needs and wants. That makes a lot of sense to me.

What are the barriers? You talk about California and California's a great example for so many things, including its approach to contingency management. But what if I'm not in California? What if I'm in Minnesota? What if I'm in New York? What if I'm in Oregon? What are the challenges of different states and what are the states that maybe will cover and may not yet cover contingency management through Medicaid?

Dr. Brian Hurley: I do want to talk about covering contingency management through Medicaid. I'm going to make a broader comment first. The largest health system in our country is actually the Veteran Administration. It's a federally run health system for people who are eligible for VA services, and the VA has a contingency management program that's broadly accessible.

They've worked very hard to make contingent management available wherever there's a VA. So, there are states that have contingency management programs. The issue with the VA, of course, is that there's a narrowing of the eligibility, right? Not everyone can get VA services. But I just wanted to make the point: our nation's largest health system, the VA health system, does offer contingency management. So, that's point one.

Point two is contingency management has been validated for 30 years, right? This is not a new treatment. This is not a new technology. It's been validated for a long time. And so, there's a long history of treatment providers getting grants to pay for a contingency management program. But the problem with grant-based programming is that grants end. And unless you connect the service to something that's sustainable, well, it's hard to sustain, right? The grant goes away, the program goes away. So, the key to getting contingency management sustained is exactly what you just mentioned, which is how do we connect this to sustainable payment? And Medicaid is a great way of doing that, because the Medicaid program reaches a huge proportion of Americans.

There are actually five states that CMS has approved to offer contingency management as part of the Medicaid benefit. So, I'm in California, I've already mentioned California, but Delaware, Hawaii, Montana, and Washington as of 2025, have approved waivers. And there were two states that had waivers in process, I think pending approval. Those are Michigan and Rhode Island.

So that means that we're seeing kind of a slow, but gradual increase in the number of states whose Medicaid programs cover contingency management. Now, in order to offer it, the person has to be eligible for Medicaid. There are other eligibility considerations.

And I think the future vision is that this becomes part of the standard health benefit in commercial insurance. It'd be great to cover this in Medicare if we were able to configure the Medicare benefit to cover substance use treatment this way. I mean, I think that there's a whole number of opportunities for payers to build this into their benefit.

And the Medicaid demonstration projects, I think are a great then model to looking at how do we sustain funding for contingency management. One of the common things I hear is, okay, great, I'm seeing these patients, but the benefit doesn't cover contingency management. That is a common frustration.

But what I wouldn't then do is get nihilistic and say, "well, it won't ever," right? Like we are seeing movement of insurance reimbursed contingency management here in the United States.

Dr. Stephen Taylor: And that's great and encouraging to know that. So, that's an external barrier that we are seeing slowly but surely breaking down. But there are the internal barriers. You know, if I'm a program director and I have, people on my staff, some of whom may be in recovery themselves or what have you, I've still got to deal with the attitudes towards contingency management.

And I started off this episode making some fun of some of the attitudes that people may have about contingency management. But for a lot of our listeners, that's a real thing. How can clinicians get their staff to buy into contingency management programs? And as a real concern, what are some ethical considerations when implementing contingency management into treatment?

Dr. Brian Hurley: Well, the integration of evidence-based practices into our field. I mean, isn't that the burden of ASAM and the importance of being an addiction physician is to really advance the quality of care in our field. I mean, I think we can speak about a whole number of evidence-based practices that maybe are not widely understood, but we're here talking about contingency management.

I think it's helpful when you're doing any level of organizational readiness advancement, to really actually start with the people. Who's on the team, right? Who's on the

implementation team, who's your champion? Because having somebody external, right? Like the ASAM president come and give a talk. Yeah, that can help and, you know, help increase awareness, but it doesn't solve the, "Okay which cups are we buying? Where are they being stored? How does this work? Are we doing a fixed incentive or are we doing what's called the fishbowl method where you draw and you know, you get the chance at incentive?"

There's a whole bunch of questions that need to be answered, and those are implementation questions. And it really then makes building the organization's embracing of this as a treatment, truly organization wide. Oftentimes we just focus on, say, the physician members of the team, other medical members of the team, the clinical director, sort of the leadership.

But if you're not talking to the frontline counselors, heck, if you're not talking to the people answering the phone, if you're not talking to the security staff that are out front, those people are oftentimes the very first people a patient might see when they're coming into treatment and if they start asking questions, it's important for everyone to be on the same page. So there actually is a fair amount of increasing organizational readiness.

Now, fortunately, with contingency management, it's a relatively straightforward program. There's not a ton of expense, not a ton of technology. Like, you don't have to buy a big fancy machine and it doesn't require a ton of advanced training. On the other hand, you really do have to make sure people understand the evidence, right? The evidence is so compelling that I think when people see this in action, they really come around, but it requires them to see it in action in order to have that shift.

Dr. Stephen Taylor: That does make sense. Okay, so, if I understand you correctly, the way you can get buy-in and create organizational readiness is by getting the members of your organization involved in making the decisions on how you actually implement contingency management. What are the different techniques that are going to be used? What approach might be used? Did I get that right?

Dr. Brian Hurley: You did, and this is the plan-do-study-act cycle of quality improvement, where you do a small demonstration, usually led by a few people with a few patients. See how it goes. You know, what goes well, what doesn't go well. Learn that, educate others. And that's how you scale something, is usually start in a demonstration project and then scale it across your organization.

Dr. Stephen Taylor: That's awesome. And you know, in our current times, of course, we can't really have this conversation without talking about some of the newer technologies.

So, what are your thoughts about digital therapeutic options and whether that might be something that we could utilize to assist with contingency management?

Dr. Brian Hurley: So, contingency management's effective whether or not it's delivered in person or delivered virtually, right? So, what we see with essentially digital delivery of contingency management is that it can work just as well. The key though is that digital therapeutics tend to work best when people are engaged, and that engagement is typically to a treatment program, right?

So, many of the digital therapeutics, they work complimentary to a treatment program somebody's already participating in, which kind of references what we mentioned earlier, right? People benefit from the full range of biopsychosocial, comprehensive treatment. Digital therapeutics are, again, evidence-based, they can generate behavior change and they tend to work best when they're working in concert with a recovery program that the person's participating in. It's a great way of extending the reach of contingency management when people can access the device and participate in contingency management.

I tend to think about them as tools that work really well when somebody is sort of participating in other components of care. I wouldn't necessarily say somebody couldn't start treatment with the digital therapeutic. The key then at that point is, okay, how are we helping support that person engaging in additional care when they're ready to do so?

Dr. Stephen Taylor: Absolutely. So always got to think about how we are utilizing this in the clinical care of the patient. That makes perfect sense to me. Brian, I just got to give you the opportunities by way of either summation or any additional thoughts that you might have that you want to share with our listeners.

What else do you want folks to know about contingency management, or what other concerns have you heard that you want to have this opportunity to address?

Dr. Brian Hurley: I don't know that contingency management is super widely understood. I think that for people that have never heard of it before, they don't understand why would you, let's say, give somebody an incentive? Recovery should be

incentive enough, and you sort of then have to remind people, well, actually this is part of teaching somebody recovery. And contingency management actually is not a, "You have to give an incentive for the rest of the person's life." Like I mentioned, California, just to pick one example, is a 24-week program. And we see that programs that are four or more months tend to be sustainable, and that kind of is intuitive. When somebody has demonstrated a behavior for four months, at that point, they've internalized kind of enough of what it is to not use stimulants or not do whatever other behavior you're looking for them to avoid, enough for them to sustain it, right? So, contingency management isn't this thing you have to do forever. That is not always widely understood.

Another like practical element, I would just add: contingency management works really well when it's being delivered by somebody who is then not also the person's counselor or physician or psychotherapist. And it seems sort of counterintuitive, but when you're working with somebody—when I am somebody's psychiatrist, or I'm somebody's addiction physician, or somebody's psychotherapist, right? And I'm helping evoke from them their ideas and values, helping to support and validate progress that they make. I might feel pulled to provide a recovery incentive if they made progress, even if they didn't exhibit the actual objective behavior. And so, when I talk to people that do contingency management is there's, for lack of a better term, the counselor that runs CM and then the person's treating counselor or psychotherapist or physician because they are actually different roles.

A contingency management practitioner is stone cold objective. Did you pee positive or negative? You get the incentive if you pee negative. I'm going to withhold it from you if you pee positive kind of regardless. There is a real important rigidity to the way contingency management needs to be operationalized.

So, I think that's an important fidelity note. That it's important for contingency management to work, that it is based on the objective behavior, not on the person's reported efforts, not on the subjective stuff. When I'm working with a patient, the subjective stuff's really important. I care about that. I listen to that. I want to validate that, but that probably means I shouldn't be actually the one delivering the incentive.

Dr. Stephen Taylor: That is such a useful insight and not one that's intuitively obvious, I'm glad you shared that. Thanks for that. Working with the patients that I work with, yeah, I want to incentivize them. I want to reinforce their progress and encourage them

almost like a cheerleader for some of my patients. And you can't really do that and also be that stone cold, rigid CM deliverer. So, thanks for that. That's a useful insight.

I'm going to just mention for people that there are opportunities to learn more about contingency management. For example, folks should check out the session from ASAM's 56th Annual Conference on contingency management, Overcoming Implementation Barriers to Bring Science to Practice. See the show notes for more information.

I want to thank our expert, Dr. Brian Hurley, for sharing his insights and his tips on implementing contingency management into addiction treatment. I really feel like people don't appreciate and don't recognize what a valuable set of insights this gentleman has brought to our audience today. Brian, I appreciate you and I thank you for that.

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