



UW PACC

Psychiatry and Addictions Case Conference

UW Medicine | Psychiatry and Behavioral Sciences

CONTINGENCY MANAGEMENT: FROM THE EVIDENCE BASE TO THE REAL WORLD

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SPEAKER DISCLOSURES

- ✓ Board Member for Washington Society of Addiction Medicine
- ✓ AI was used in the outline development, literature search and spell and grammar refining of this presentation. Accuracy was verified by author

PLANNER DISCLOSURES

The following series planners have no relevant conflicts of interest to disclose; other disclosures have been mitigated.

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OBJECTIVES

By the end of the session:

1. Learners would be able to describe contingency management if asked
2. Learners would be able to describe an obstacle of implementation if asked
3. Learners will have had an opportunity to ask questions of the community

CONTINGENCY MANAGEMENT GREW OUT OF WHICH THEORY?

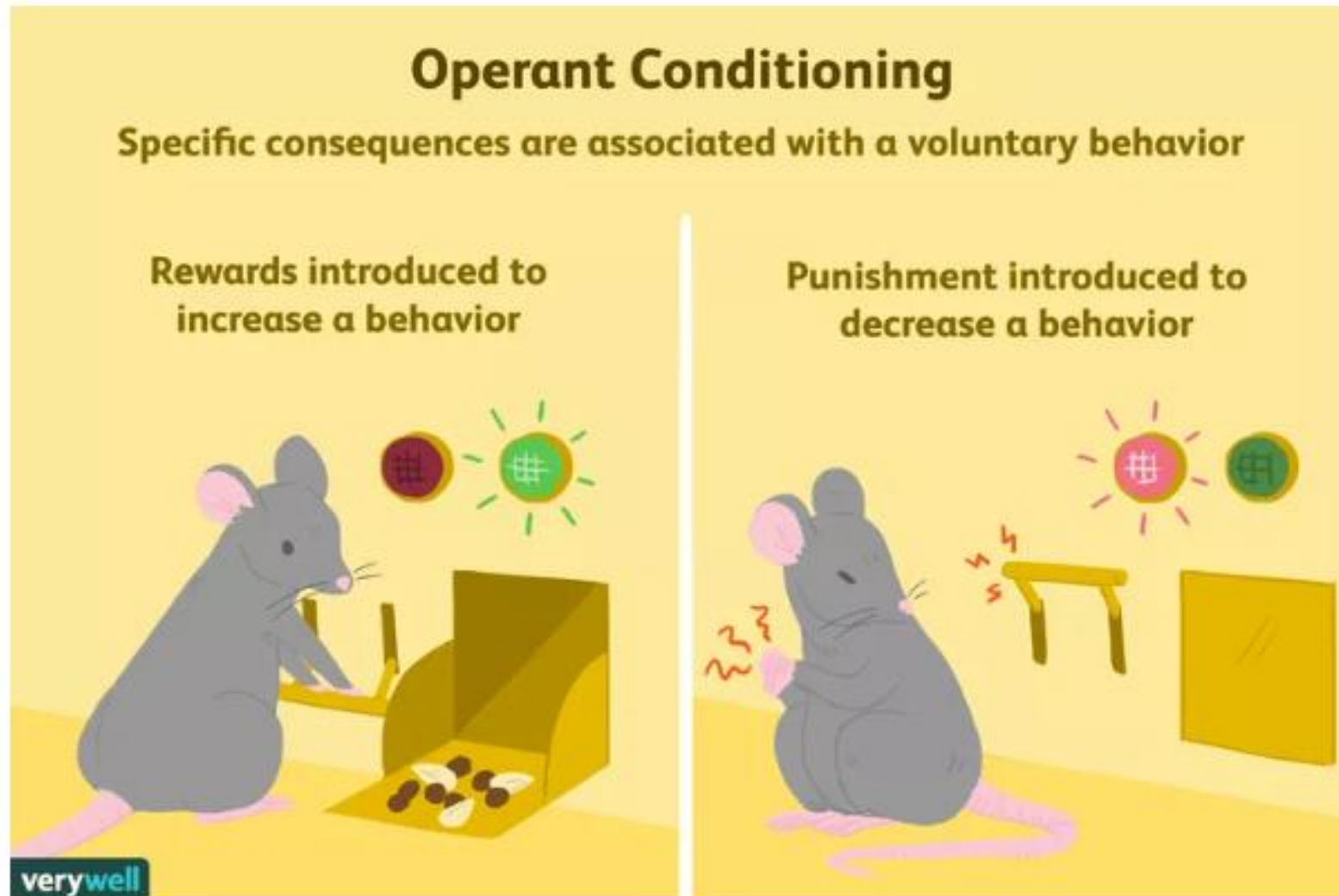
1. *Learning Theory*
2. *Classical Conditioning*
3. *Operant Conditioning*
4. *Psychodynamic theory*
5. *Biosocial theory*

PHARMACO-BEHAVIORAL THEORY OF SUBSTANCE USE

The Four Quadrants of Operant Conditioning		
	POSITIVE (Add Something)	NEGATIVE (Remove Something)
REINFORCEMENT Increases Behavior	Positive Reinforcement Add something desirable Behavior INCREASES Examples: • Praise for good work • Paycheck for working • Treat for dog sitting • Bonus for meeting quota	Negative Reinforcement Remove something aversive Behavior INCREASES Examples: • Take aspirin, pain stops • Buckle seatbelt, beeping stops • Clean room, nagging stops • Study, anxiety reduces
PUNISHMENT Decreases Behavior	Positive Punishment Add something aversive Behavior DECREASES Examples: • Speeding gets ticket • Talk in class, get scolded • Touch stove, feel pain • Late work loses points	Negative Punishment Remove something desirable Behavior DECREASES Examples: • Misbehave, lose recess • Break curfew, lose car keys • Poor grades, no video games • Hit sibling, toy taken away

Key: Positive/Negative = Add/Remove (not good/bad) | Reinforcement/Punishment = Increase/Decrease

OPERANT CONDITIONING



Credit: Verywell / Joshua Seong

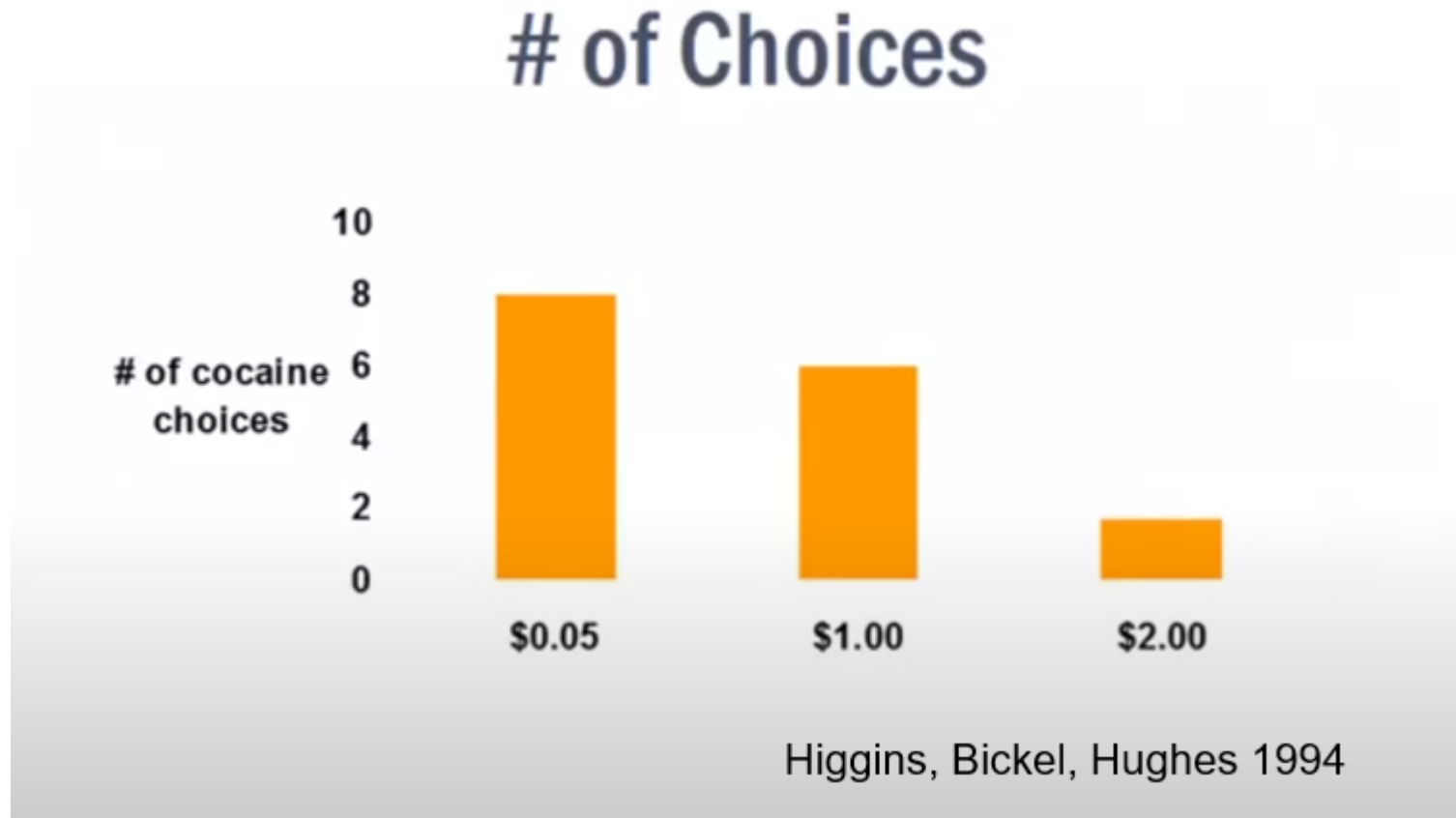
CORE CM DESIGN PRINCIPLES

- Target Behavior:
 - Abstinence: POC negative UDS
 - Adherence: to injectable buprenorphine
 - Attendance: clinic visits, group meetings
 - Ideally objectively measured
- Reinforcement schedule:
 - Typically once or twice a week for 12 weeks (depends on target behavior)

CORE CM DESIGN PRINCIPLES

- Rewards ideally are:
 - Tangible
 - Desirable
 - Delivered immediately after the target behavior
 - Fixed magnitude (Ex: Escalating voucher)
 - Variable magnitude (Ex: Fish bowl)
 - Withheld or “reset” the size of the reinforcement is the behavior does not occur
 - Voucher or prize

DRUG USERS WILL CHOOSE SMALL REWARDS OVER DRUGS



EVIDENCE BASE

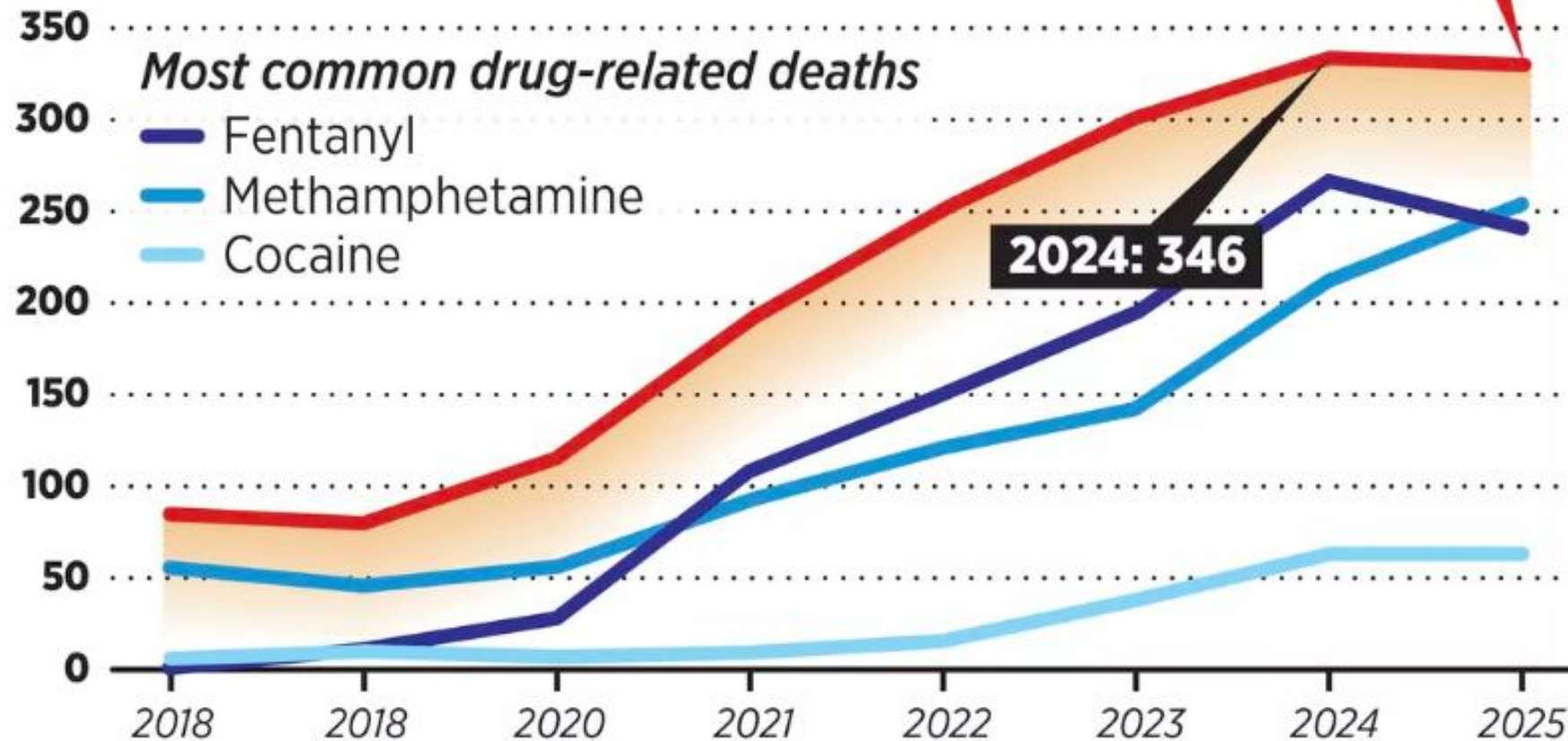
- The evidence base for contingency management is extensive for numerous substance use disorders/behaviors although stimulant use disorder is relevant currently
 - Growing mortality rate/community destruction associated with stimulant use disorders
 - Most effective treatment for stimulant use disorder and current standard of care in the ASAM/AAAP clinical practice Guidelines

Drug-related deaths in Spokane County

ACCIDENTAL DRUG-RELATED DEATHS

Provisional data for 2025
with 20 cases still pending

— *Total drug-related deaths*



Source: Spokane County Medical Examiner's Office

THE SPOKESMAN-REVIEW

JW PACC

EVIDENCE BASE

EXAMPLE: VA ABSTINENCE-BASED CM PROTOCOL FOR STIMULANT USE DISORDER

- Twice weekly point of care urine drug screens over a 12 week program
- Negative urine drug screens earn opportunity to draw from a fishbowl containing 500 prize slips
 - 250 state “Good job!” (no prize value)
 - 209 state “Small” (\$1)
 - 40 state “Large” (\$20)
 - 1 states “Jumbo” (\$100)

First stimulant negative gets one draw, each consecutive negative sample gets one more draw until at a max of 8 draws.

A missed or positive sample resets draws to one with escalation resuming for sustained abstinence.

EXAMPLE: SPOKANE TEACHING HEALTH CLINIC CM PROGRAM

- Target behavior: stimulant use (meth or cocaine)
- Escalating dollar amounts of gift cards are paired with twice weekly negative urine drug screens for stimulants
- Exclusion: Rx for stimulants
- Duration: 12 weeks
- No billing
- Max \$528
- Funded by Providence, donations and HSSA grant Supporting Behavioral Health Access in Spokane County

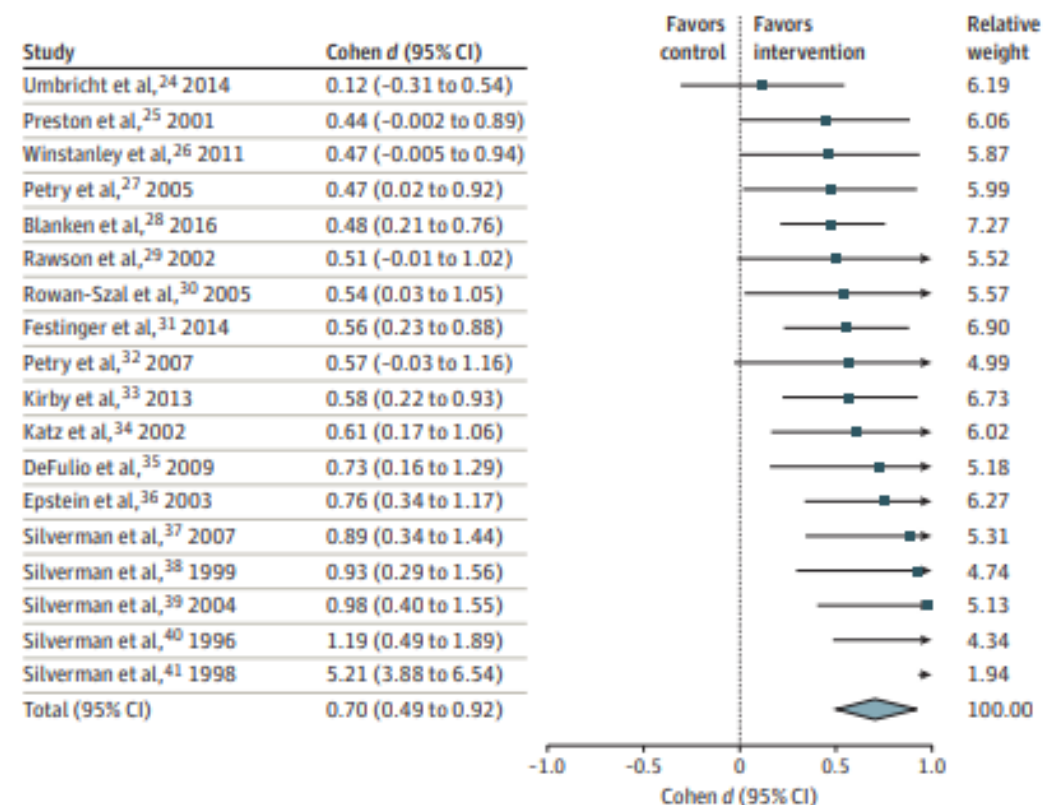
Wk	Visit #	Urine Test result	Voucher earned	Bonus earned	Total for the day
1	1	Negative	\$10	0	\$10
1	2	Negative	\$10	\$2	\$12
2	3	Negative	\$10	\$2	\$12
2	4	Negative	\$12	\$2	\$14
3	5	Negative	\$12	\$2	\$14
3	6	Negative	\$14	\$2	\$16
4	7	Negative	\$14	\$2	\$16 Etc...

Possible total for 12 weeks: \$528

SHORT TERM OUTCOMES

- 74 RCTs, n=10,444 evaluating CM at end of treatment among patients receiving MOUD.
- Effect size of $d=0.7$ which translates to 75.8% of CM treated patients having a better outcome than the average control patient.
- Outcomes included stimulant abstinence, cigarette abstinence, illicit opioid abstinence, medication adherence, polysubstance abstinence, therapy attendance, pooled abstinence, pooled treatment adherence.

Figure 2. Forest Plot of Treatment Effect Sizes of Contingency Management vs Controls: Abstinence From Psychomotor Stimulant Use



LARGE META ANALYSIS SHOW SHORT AND LONG TERM EFFICACY FOR CM

- 23 studies n=3,320 Participants who received CM were 1.22 times more likely to be abstinent based on UDS after 24 weeks than non specific therapy such as IOP or CBT (Ginley et al, 2022)
- Similar to all other SUD treatments, long term effectiveness after treatment ends is modest, but real. Actually, better than IOP's and CBT.

Ginley et al.

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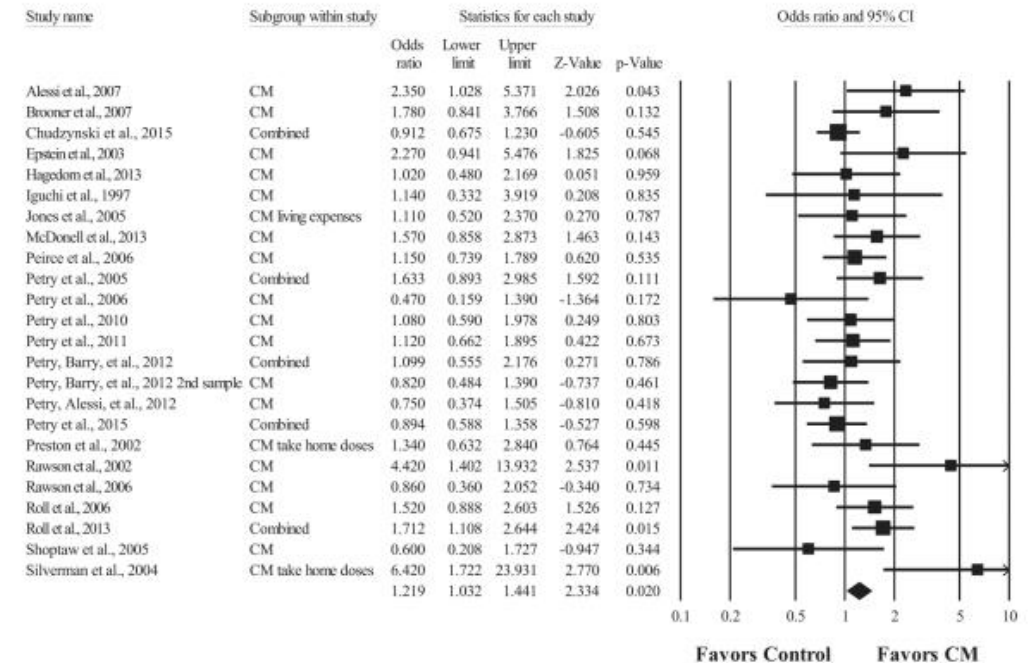


Figure 2. Forest Plot of Effect Sizes for Contingency Management Treatment Versus Comparison Conditions at Long-Term Follow-Up

Note. Values are truncated after the third decimal point. The last row in the forest plot represents the overall odds ratio effect size of all studies. “Combined” indicates a study with multiple contingency management (CM) conditions that were summarized into one odds ratio effect size.

VA MORTALITY STUDY

- N=138,280
- CM for veterans with stimulant use disorder
- 41% lower risk of death within one year compared to veterans with stimulant use disorder that didn't receive CM.

EMERGING EVIDENCE FOR CM DECREASING HEALTHCARE UTILIZATION

- Evidence is limited and indirect, but favorable, primarily by downstream effects of abstinence
 - Lower emergency department visits
 - Inpatient admissions

Microsimulation model showed that a 24 week CM program of 10,000 patients saved 153 deaths over a year and incremental cost effectiveness ratio of \$12,312/QALY gained

At \$50,000 willingness to pay, the 24 week program would be cost effective even if the maximum incentive were \$2,491

IMPLEMENTATION

TRANSLATION TO PRACTICE HAS BEEN SLOW

- Most robustly evidence based interventions for SUDs, yet fewer than 10% of addiction treatment programs use it
- Largest research to practice gaps in behavioral health.

OBSTACLES

- Cost: outside the VA, most programs are short term grant funded
- Staffing support to run the program, track patients, provide the UDS...
- Federal Anti-kickback Statute. CM could be seen as paying patients to have medical services. OIG published that CM is not in violation of this statute and can be considered on a case-by-case basis, BUT compliant implementation remains poorly defined leaving residual uncertainty.
- If paying people, do they become our employees therefore have to pay taxes??
- Staff and community attitudes: Should we pay people to do something that others are doing for free?
- Delivering CM with fidelity is logistically demanding

DESPITE THE OBSTACLES

- California, Washington and Montana have rolled out state funded pilots by expanding Medicaid/SAMHSA funding with the technical support of PRISM at WSU

WSU PRISM COLLABORATIVE

CONTINGENCY MANAGEMENT TRAINING

ABOUT

Since 2020, Washington State University's PRISM Collaborative has been providing Training and Technical Assistance (TTA) focused on evidence-based contingency management (CM) implementation. Our experience includes supporting all phases of state-wide implementation of CM, as well as working with individual agencies and care teams to successfully implement evidence-based CM.

COLLABORATION GUIDES OUR WORK

Our TTA model emphasizes collaboration partnering with providers and organizations to co-develop solutions, strengthen capacity, and support successful CM implementation in real-world practice. Our team includes leading CM researchers, experienced CM interventionists, addiction providers and trainers, and adult learning experts.

Our partners include; Primary Care, Opioid Treatment Programs, Specialty Addiction Treatment Centers, Federally Qualified Health Centers, Permanent Supportive Housing, and more. We've worked across rural and urban communities, and we've partnered closely with American Indian and Alaska Native Tribes.



WA HCA SUPPORTED CONTINGENCY MANAGEMENT PILOTS

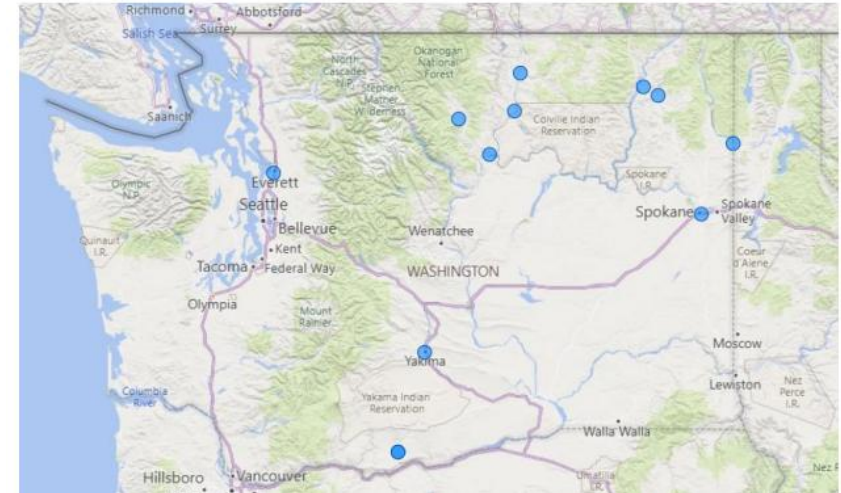
- <https://www.hca.wa.gov/assets/program/cm-map-of-provider-locations.pdf>



Contingency management locations Substance use disorder treatment program

Contingency Management (CM) is an evidence-based behavioral intervention for stimulant use disorder, opioid use disorder, and alcohol use disorder. CM consists of a series of motivational incentives for meeting treatment goals. The motivational incentives may consist of cash equivalents (e.g., gift cards of low retail value) with restrictions placed on the incentives.

Under Washington state's Section 1115 Medicaid demonstration waiver (Medicaid Transformation Project 2.0), CM benefits will be made available to eligible Apple Health beneficiaries with a substance use disorder. The map below shows the locations of providers at certified CM treatment sites; detailed information about each site can be found on page two.

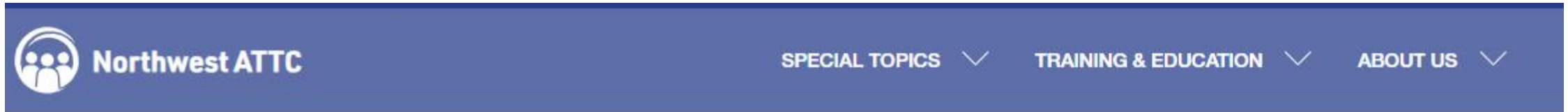


HCA PROVIDING CM GRANTS

- <https://www.hca.wa.gov/assets/program/fact-sheet-contingency-management.pdf>
- HCA anticipates taking applications for new sites, providing training and technical assistance for next summer
- **MTP 2.0**, runs from July 1, 2023, through June 30, 2028.

IMPLEMENTATION RESOURCES

- Free training from the Northwest ATTC: <https://attcnetwork.org/northwest-cm/>



[HOME](#) > [NORTHWEST ATTC](#) > CONTINGENCY MANAGEMENT FOR HEALTHCARE SETTINGS

Contingency Management for Healthcare Settings

This comprehensive online course, originally developed by the Northwest ATTC in 2019 and re-released in an expanded version in 2023, features separate modules for each of four common personnel roles in healthcare organizations: **decision-makers, clinical supervisors, direct care staff, and administrative support staff.**

Healthcare organizations may utilize these training modules as means of an initial didactic introduction to CM principles and practices for their staff; however, **the primary intent of this online course is as a bridge to more intensive**



Contingency Management

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