FGI RCOE Webinar Transcript - Contingency Management: An Evidence-Based Approach to Recovery March 10, 2022

[00:00:00] **Michelle Day:** [00:01:00] Good afternoon, everyone. And welcome to The Fletcher Group Rural Center of Excellence's webinar series. Today's session is scheduled to run from 2:00 PM to 3:00 PM Eastern Standard Time. My name is Michelle Day. I am your moderator for the session, along with Jennifer White and Erica Walker. A couple of brief housekeeping items, and then we'll begin.

You entered today's session on mute, and your video was off and will remain so for the entirety of the webinar. Your chat feature is located at the bottom right of your screen. Use the drop down feature to communicate with either the panelists only, or panelists and attendees. Please direct all questions regarding the webinar content to the Q & A section.

Be advised that this meeting is being recorded and will be available to you on our website once it has been transcribed. You can access our website at [00:02:00] www.FletcherGroup.org. Also at the conclusion of today's session, there will be a short survey regarding the webinar content. Your participation in that survey is greatly appreciated, and will only take a few moments to complete. Today's speakers are Doctors Sara Parent, and Michael McDonell from Washington State University.

Dr. Sara Parent received her Bachelor's of Science and Biology from Rensselaer Polytechnic Institute in 1998 and a Doctor of Naturopathic Medicine from Bastyr University in 2003. She is a Clinical Assistant Professor with the PRISM Collaborative in the Community and Behavioral Health Department of Washington State University's Elson S. Floyd College of Medicine.

She oversees and NIAAA-funded, Phase III Contingency Management study evaluating the effectiveness of this behavioral intervention for people with alcohol use disorder and serious mental illnesses. Additionally, Dr. Parent has contributed to the development and [00:03:00] dissemination of Contingency Management, training materials, fidelity measures, and instructional workshops, including for the Montana Primary Care Association and the Washington State Healthcare Authority, as part of the broad effort to make evidence-based regulatory compliant, Contingency Management available for the treatment of stimulant use disorder.

Dr. Michael McDonell is a Professor in the Elson S. Floyd College of Medicine at Washington State University and the Director of Behavioral Health Innovations. He is a clinical psychologist with over 20 years of experience developing testing, and implementing strengths-based interventions for people with addiction and mental illness in communities.

He has led multiple National Institutes of Health funded studies demonstrating that Contingency Management can be used to reduce alcohol and drug use in individuals living with co-occurring serious mental illness. He also leads efforts to test incentive interventions in collaboration with American Indian and Alaska [00:04:00] Native communities.

Dr. Parent, Dr. MacDonald, the floor is yours.

Wonderful. Thank you. We're really excited to be here with you all. And, um, we're going to hook go ahead and get started. So thank you for joining us, uh, this morning or this afternoon, depending on where you're at. So our goals for today, our objectives are to describe positive reinforcement and how it's used to reinforce drug and alcohol abstinence in Contingency Management.

Uh, and when you think about what Contingency Management is, we'll talk about exactly what it is later, but for those of you who don't know what it is, it's really using incentives, tangible incentives to encourage, um, substance use abstinence or substance apps, abstinence from drugs or alcohol. So then we're gonna work with you to, to, to help help you describe the what positive reinforcement, how it's used in this intervention. We're going to also, uh, the objective, another objective is to identify three components of Contingency Management that make it different from other incentive-based interventions. So it's a very [00:05:00] specific approach that's designed for substance use treatment. So we're going to talk to you about why that's important and then we're going to, uh, work with you through both this webinar,

and then not only is there a survey at the end, cause I know we take a lot of webinars and we all have a survey, but the survey gets you paid. So we believe in incentives. So we're going to actually, we're really want to get your opinions as folks who work in recovery housing, maybe work in rural recovery housing, or, or really know a little bit about how you know about housing or really are experts on housing.

Uh, we really want to figure out how we could do this intervention. Could it be done in housing? What it would be, the barriers, what would be the challenges? What would be the strengths? So the last objective we're really hoping you can help us with by completing this survey at the end, we'll re we'll reimburse you for completing that survey with a $5 gift card.

And that's really going to be a survey that asks you a little bit about, uh, Contingency Management. If the training was helpful to you, but really then also asks you to help us figure out how this would work in a recovery, how rural recovery or recovery housing setting. [00:06:00] Next slide, please.

So our team includes, so thank you for the wonderful introduction. Myself. I'm a clinical psychologist. We're here in, um, in beautiful Spokane, Washington on the Eastern side of the state. Uh, I saw somebody calling in from, from Moscow. So we're not so far away from you in Idaho. Um, and, uh, and so Sara and I, and then are calling in from, from here in Spokane, Washington.

Um, and we also are joined by one of our outstanding Research Coordinators. Uh, Rachael Beck, she's on the she's on the line as well, and at here at the webinar and she's in charge of our survey. So she's going to be the person you're going to reach out to if you have any concerns about the survey or any problems like in the link or, um, you do fill out that survey and what are the, what didn't get your gift card.

Um, then, then you can reach out to Rachael. So she's, she's here joining us as well. So we are in Spokane and Spokane is, gets its name from the Spokane tribe of Indians. And so I want to just make sure to take a pause and, and, um, and say, say, thank you to the [00:07:00] Spokane tribe of Indians for letting us live on their land.

Um, and, and recognizing that they are the owners of this land that we're on. And also recognizing that you are calling in from all kinds of different parts across what we now call the United States. And so, uh, really here, we're here in a good way. Um, try to want to be here in a good way to really support, um, and learn together and, and respect our, our Native communities across the country.

And, um, be part of a solution to helping, uh, in any Native community who's dealing with housing issues or, or in supporting people in recovery in Native

communities. So I want to just do a quick land acknowledgement or acknowledgement wherever we're all calling in from. And then secondarily, I wanted to do disclosure.

So already was mentioned a little bit that, um, Sara and I are being trained, uh, paid to do trainings, um, in Washington state. And then also in Montana. We're also working with a few, uh, we're also being paid to do some trainings with tribal communities, um, in our culturally adapted version of Contingency Management.[00:08:00]

Um, so I just wanted to make sure to make those disclosures. So the next slide, please. All right. If you have questions, please put those in the Q & A, we have a pretty big group, I think today, which we're really excited about calling. I'm seeing where everybody's calling in from all over the place. Um, so please, uh, chat those in the Q & A, and we'll do our best to respond to those at the end of the presentation.

All right. So the goal of this, this, this, um, of this talk is really to give you a, you know, some of you might've heard about Contingency Management. It's a, it's an intervention that's been around for 30 years for substance use treatment. As an intervention for substance use. Um, and, but it really hasn't been that widely disseminated implement, implemented outside of the Veteran's Administration, or it has been in some ways like in drug courts, there's use of Contingency Management.

Um, and, and so we're really partnering with The Fletcher Group. Our groups called the PRISM Collaborative. Um, Sara and I are part of that group. And we're [00:09:00] partnering with, um, Fletcher to, to try to figure out how we could develop a Contingency Management approach that anyone who's working in recovery housing might be able to use.

And so we need the help from you all as staff and residents and folks who are stakeholders are not stakeholders, but people who are part of stakeholders, people are part of this, of this space in terms of uh knowing about housing, understanding housing, and how it relates to substance use care. Um, we really want to make sure to get your, your opinions and your feedback, and that's what that survey is about.

So we're going to be doing a survey. You all will get a link to that survey at the end of the, at the, at the end of the, um, at the end of this webinar. In addition to that, you'll get an email invitation as well for the survey. Uh, and then some of you all will be invited, who filled out that survey, been invited to meet, to see if you want to do a qualitative interview with us, actually sit down with our team and just talk a little bit one-on-one about whether or not, um, how this would work and how, how it might work, and how it might not work, in recovery housing.

So a smaller group will be invited to, to do those qualitative interviews. [00:10:00] Next slide please. Okay. So operant conditioning is what Contingency Management's all about. So if you remember back to your, um, to your, to your first, uh, to your first psych 1 0 1 class, if you took a psychology class in college, um, or maybe for some of you who have gone on in psychology, you, you know, a lot about this, for those of you who work in child care or not in childcare.

Well, if you work in childcare or you have kids, um, or if you've worked in as a child, a child therapist, or, um, worked with families, you know, a lot of, probably about operant conditioning. And so in operant conditioning, we, what we, what we know about operant conditioning is that a person engages in the behavior and then there's a consequence.

And then that behavior changes that either goes up or goes down. And so we have different kinds of what we, what we've learned over and over and in studies. Um, so the first person to talk about operant conditioning was BF [00:11:00] Skinner. Some of you have heard of BF Skinner. And since then, that was like in the fifties and sixties, since then, we've really expanded the field.

But the same four rules of, of operant conditioning are, are still there at the four ways that people can learn to change their behavior. So one, anything, anytime that behavior goes up, so anytime you engage in a behavior and that behavior goes up, it's called reinforcement. Anytime you engage in a behavior, that behavior goes down, it's called punishment.

And, and so we use those terms a little bit different, especially punishment, a little bit different, um, than people typically do in our day-to-day kind of conversation. When we say something's positive, that doesn't mean it's good. It

usually is good. It's usually a good thing. Um, but that means we're adding something.

When, when we use the term negative means we're taking it away. So in positive reinforcement, which is where I really want you to focus because that's what Contingency Management is all about. Positive reinforcement. We add a pleasant stimulus or a pleasant stimulus is added. Something a person likes desires, wants finds, reinforce rewarding is added in that we see an increase in behavior, [00:12:00] or if that behavior is already established, then we see it.

Then we see that behavior is maintained. It stays, the person stays engaging in that behavior. So in Contingency Management, that's what we do. So an example of that just in the real world though, would be right. That if I have a kid who's who's, um, if I have a kid who's struggling to get their homework done and, and they really love pizza, right?

They love pizza. They think pizza is great. They look to go out to their favorite pizza place. I, I'll make me make a deal with my, my kids to say, Hey, look, if you can get your homework done the next two days in a row before this certain time, then we'll going to go out to pizza. So he's like, okay, great. So he gets his homework done.

He's more likely to finish that homework. He gets the reward and then in the future, he's more likely. Now I may go into debt because of my large pizza budget. I do that, but that's the ideas that we offer a reward to, to increase that behavior. So something pleasant's added. Negative reinforcement is where we take away something aversive like anxiety, for instance, all of us, right.

Or anxious about certain things, nervous about certain [00:13:00] things. So we might have it. That's the reverse of stimulus that might be taken away. Um, when, when we. When we, when we're distracted by something. So when we're distracted by our favorite TV show, that might take away that anxiety, we aren't, we will stop thinking about our problems.

We'll stop. We'll really feel a decrease in our body and all those anxiety feelings. And then we're. So then we're more likely to watch TV more. So if we have a great show, we really love, we, we think, well, I'll check that show out. Decreases our anxiety. We're more likely to watch that show in the future.

So those are an examples of, of reinforcement. Both. That means the behavior goes up a behavior that we're trying that what goes up, but it's caused by either taking, adding something great to get the person to, to change their behavior or taking away something that's adversive to someone. So next, next slide, please.

So, and then I didn't talk much about punishment because most of us are, uh, you know, we, we, we really know, the reason I talked about is because of these things. [00:14:00] So I didn't talk about it that much because both changed behavior, punishment, changes behavior too, right? Putting a person in jail that can change behavior, putting a kid in time out, we know that changes behavior.

So we know punishment changes, people people's behavior. But we also know most people would rather be reinforced, right. Rewarded than punished. And then punishment. The biggest, one of the essential problems with punishment is it doesn't teach you to do anything different. I mean, it doesn't teach you what to do.

So when I say no, To my, my 18 month old puppy, my giant puppy. He, he knows to stop doing that, but he doesn't know any w, what I want him to do instead, because I probably want him to do something else instead. Right. So say, stop using drugs. Well, that's great, but we want you to, we want you to do something else instead, right?

Like we want people to get into recovery, want them to live the lives they want. Right. So we want to reward. Um, we want to reward, we want to reward behavior instead of punishing it, because it tells people it helps people learn more quickly what's expected or, um, helps them reach their goals quicker.[00:15:00]

Most punishers like the criminal legal system don't have immediacy, right? You, you are arrested for something and then you end up having to go to trial, et cetera, et cetera. So that those punishers are not very good. Cause they're pretty delayed. Punishment also has all those unnecessary side effects.

Right. Um, so that changes people's behavior often. It also has shame, guilt, a lot of other, um, you know, sadness, depression, as side effects of punishment when it's used too much. And then, um, positive reinforcement really is the best

way to teach people how, to help people reach their goals because it gives them, um, uh, it gives them self-efficacy, it gives them self esteem.

It gives them the pat on the back and it gives them, you know, really helps people get on the path in the right direction. Next slide, please. Okay. So operant conditioning really that positive reinforcement idea is the basis for Contingency Management. Um, in, in the reason that it, [00:16:00] and the reason we think that's so important is because what we know about drugs and alcohol is that they are also positive reinforcement tools, but not for, for, for healthy behavior for less healthy behavior. So for some people, for, for people, for some people. So right drugs can really throw off that reward pathway in our brain. Maybe we all have this, not this reward pathway in our brain. And that's why positive reinforcement works.

However drugs can access that reward pathway. Very, they're very effective at doing that. And so drugs, right, are positive reinforcers. They are that positive doesn't mean they're good, but they in, they people use drugs more and more because they feel good. You get an immediate, really great feeling when you use a drug, or when you have a drink, you might get this immediate feeling and that's happening in your brain.

And that's very reinforcing to a person. And so they're more likely to use it. So there's a pleasant stimulus of drug use, right? We're not talking about all those negative effects down the road, [00:17:00] but there's a positive um, effect or effect on that person and that makes them more likely to use drugs feel good.

They also are a powerful, negative reinforcer, right? When I'm really anxious, I go to a party I'm nervous about going to this party, cause I know there's this, this, um, this person I, I I've met that I think would be, uh, uh, I'd love to date and meet. And, but I'm very nervous to talk to that person. And so I walked by this table and there's all these red cups on this table.

I pick up one of those red cups, nice to take a drink. And I, and then I pick up another one to take a drink. All of a sudden all that anxiety is gone. So I'm much more likely to go up and talk to that, to that person. And so the thing that's happening there is that that's drugs can be also a negative reinforcer.

When you've had a really tough day, you can take a drink and you forget about your problems. You might not experience that anxiety to the same level. Problems are still there. Their problems are not solved, but that's also another way that drugs can hijack that reward pathway in our brain. And then of course drugs [00:18:00] can have a result of a loss of all those other reinforcers.

So the more and more I, I quote, unquote go "into that spiral of addiction," if it happens to me, I start to lose because of the side effects of the drug use. I start to lose those other natural rewards in my life, my family, my spouse, maybe I, I, my, my, my, um, partner leaves me, might lose custody of my children.

And then a for all, for you all in the important work you do, I might lose my housing. So those other things that keep us on a healthy pathway in life, and really, um, living a healthy life, those, those things, those things start to fall away. And so for some people, drugs and alcohol become their only reinforces the only thing that keeps them going.

Um, and so that's why we're really, we really emphasize this idea of operant conditioning and Contingency Management, because we want to realign that reward pathway with Contingency Management so that we offer people abst, and a reward in X instead of drugs. So we offered them a tangible reward instead of a drug or alcohol.

Next slide please. Thank you. [00:19:00] All right, so we're doing our first poll here. So poll's going to pop up when I ask you to fill it out. Have you ever used positive reinforcement to change behavior, yours or someone else's.

Oh, there it is. I'm going to say yes. Oh, it says I can't vote, man. So go ahead. Just real quick. Let's see what the results are. All right. 97% of you said yes. Great. Wonderful. Um, and a couple of you said, no. Well, I hate to tell you for those of, you said no, but you have, you just might not know it. Um, you probably might identity have done this on purpose, but you probably have, whether it's a, uh, sicker track with your kids or a pat on the back to a colleague [00:20:00] who's done a great, great work.

If that person's behavior is changed afterwards, you've done positive reinforcement. So thank you all. All right. Next slide.

Okay. So on this, so if you buy this idea that yeah, drugs are rewarding to people, um, that we could, um, that they are positive reinforcers and negative reinforces that they, the people that reinforce the pathway gets hijacked well, and I'm telling you, cause that's what I'm telling you. We're going to actually use tangible rewards, like a gift card or a prize.

And we're going to offer that for, for abstinence. Um, so if a person gives a urine drug test for stimulant drugs that say, and it's negative, we're going to offer them a tangible reward. Well, you might say, okay, well, wow, Mike, that's, that's great. That sounds like fun. But man, you're gonna have to pay people a lot of money to put use of drugs.

And so what we know from research, and this is an example of a study that was done [00:21:00] a long time ago, back in 1994. Uh, but, but it's been replicated with almost every other drug and alcohol, you know, nicotine, um, alcohol, uh, methamphetamine, has been shown, we've shown the same results. So in this study, what they had was 10 people who identified as being people who use drugs, who use cocaine.

People who identify as using cocaine, came into, uh, into a hospital setting where they're safe and they were offered either 5 cents or a line of cocaine. And believe it or not, um, eight out of 10 people who identified as being using cocaine, pick that line of cocaine. They legally got this cocaine. Um, and, and the researchers did.

And so most people eight out of 10, right? They picked five, the, the, the line of cocaine over the 5 cents. And then when you moved to $1 about six out of, out of, out of 10 pick the cocaine, but when you got to just $2 in 1994, so like $4. So 80% of people, eight out of 10 [00:22:00] people would pick the $2 over the line of cocaine.

So the take home message here is for a very small amount of money or a very small reward. People, most people who are using drugs will pick, or alcohol, will pick the other, an alternative reward. If we just give them a choice. If we just give them a right here in the moment, chance to earn another reward besides using drugs, they will pick that reward for abstinence.

So that's the take home messages. For a small amount of money and Contingency Management ends up being about five to $600 total of incentives over 12 weeks, over 12 weeks, total. Um, for about that relatively small amount of money, um, people will choose abstinence, or a large amount of people, will choose abstinence in that reward of that tangible reward over the truck.

So next slide please.

All right. And Sara, I think I might be, am I handed it over to you?

[00:22:59] **Dr. Sara Parent:** [00:23:00] Yes. Thanks, Mike. Um, so yeah, Mike did a great job, um, orienting you all to how operant conditioning plays a part in developing substance use disorder. And also, um, how we could possibly use things like positive reinforcement to realign that reward pathway.

And then he showed you that choice experiment that shows that people will choose actually other reinforcers, um, when given the opportunity and not always choose the substance, such as cocaine as that reinforcer. So that sets the stage for understanding, um, where Contingency Management came from and why we're using it.

Now, Mike and I, and some of our colleagues, we train people on Contingency Management and we do these four hour workshops. So for today, we are going to give you about, we're like a 40 minute primer on how Contingency Management works. So I'm going to go through kind of some of these principles pretty quickly.

And, you know, just to give you an idea of how Contingency Management works and why it works. So, um, we've, [00:24:00] we've already kind of delivered that message, that Contingency Management is based on positive reinforcement. And so it offers a non-drug reinforcer in exchange for evidence of drug abstinence. So I'm going to show you how that works.

Um, next slide please. So, and then doing Contingency Management, besides just the mechanism of how it works, there's really a lot of benefits to doing it. It increases morale of clients and staff. We've gotten such neat feedback from the nurses and other providers who learned to do Contingency Management, get out there and do it.

And it's really fun because you really get to be a good guy and, um, your patients and clients world, and you will, um, really help them. Uh, it helps build that relationship between the client and staff, which can actually kind of spill out into the other work that you do which is great. Um, Contingency Management though, can be done by anyone.

You don't need to be a nurse. You don't need to be a psychologist. You don't need to be, uh, you know, uh, uh, uh, um, licensed addiction counselor. You [00:25:00] can. Anybody who has a positive attitude and can be taught how to read a urine drug screen test, um, can do Contingency Management. So we do emphasize that you should use an evidence-based protocols such as the one we're going to be introducing to you, but once you learn how to do it, anybody can do it.

There's no specialized license at this time. Um, and it can be adapted to clinical settings, and we're hoping that it can be adapted to these housing models. And so that's, what's really going to be a fun part of this project. And it really makes, um, treatment something that people want to do. So people show up for Contingency Management because they're literally being rewarded to, um, next slide.

And so the basics really the basic flow of Contingency Management for substance use disorders is that you have a negative urine drug test for whatever substance you're focused on. And so right now the focus is for stimulant, um, drug use. It's, it's one of the, you know, it's obviously sort of crisis level in a lot of [00:26:00] communities.

And right now there are no other evidence-based treatments available for stimulant use such as meth use. And so, um, these programs will be focused on, um, helping folks with their stimulant use. And so we use a urine drug test to, um, no, note whether that use has occurred. And if it's negative, then you provide a tangible reward.

And then as Mike explained with positive reinforcement, you're likely to see more of that behavior. So increased abstinence. So you can actually sort of look at this slide almost in a circular way. So negative drug test, you get, you give tangible rewards, you'll see more abstinence, which leads to more negative drug tests.

And so during that treatment period for Contingency Management, say a 12 week period, you'll see this, um, continue on. So next side, please. Um, so there are some key elements that Contingency Management, this is what makes something, you know, we understand the idea of incentives and positive [00:27:00] reinforcement, but what makes something Contingency Management is adhering to these principles.

So these are the general, um, sort of necessary ingredients for Contingency Management. And then I'm going to show you how to apply them to a stimulant use disorder program. So, um, in general, in Contingency Management, you need to choose a behavior that you're focused on, right? So you're not trying to just reinforce all of the elements of a good life that would be kind of confusing and subjective.

So you need to pick something. So, um, you know, for instance, as a substance abstinence, and you need an objective way to measure that. So that's why we talked about urine drug tests. You need to choose a behavior that is measurable, right? So again, just like kind of, you know, being a nicer person or something is not something that you can objectively measure, right?

So you need something specific and then you need to choose achievable and feasible goals. So you'll see in a bit that we talk about urine drug screens and those create [00:28:00] something that you can achieve through just a few days of effort. And you can, it's feasible to, um, watch the, to demonstrate that behavior objectively and consistently over time.

Right? So if you chose something like, um, I want to run a marathon. Well, that happens maybe once in that year. And it takes a long time to build up to that. So in Contingency Management, we want a target behavior that you can observe regularly, consistently measure. Um, you know, at least once or maybe multiple times per week.

And so then of course we reward that behavior, right? That's what the Contingency Management is. We want to reinforce it, use rewards. So what are the elements of that reward, um, that are necessary for Contingency Management while the rewards need to be contingent, right? These incentives. And what that means is that you only give them when you observe the behavior, right?

So you don't just give them, cause you're feeling nice that day. But you give them because the person earned them by demonstrating the behavior that you're focused on. They need to be [00:29:00] tangible and desirable. Meaning that it's something that somebody, no uncertain terms understands. They were worded that day.

They brought something home in their hands. So, you know, while there's intangible rewards like a good relationship with your provider or a smile on their face, when, when, when you show up and show that you're doing well, we really remember we're rewiring this reward pathway that's been hijacked. Really powerful substances, like, you know, like stimulant, um, drugs.

And so you, we need something equally powerful, like a gift card to, um, to be able to compete with that. And then we'll also explain how these rewards should escalate or get bigger over time. And that will make that reinforcement more powerful. So next slide please. So some, again, some details about how you would use that, that model for Contingency Management in stimulant use disorder treatment, or a stimulant use focused CM program.

So, um, our target behavior is going to be a negative urine drug test. Oh, I [00:30:00] shouldn't say stimulant negative urine drug test. Right? So we don't want to rely on self-report. We want to be able to see that negative drug test. We've, um, found something achievable. So these, these point of care, urine drug tests that we recommend people use.

So those are just a cup that gives you instant results. You really only need about two to four days of abstinence to test negative. So this is an achievable goal. So you should, a person should be able to earn that first reward with, uh, you know, just a couple of days of behavior change. Um, it's feasible.

So point of care tests are cheap and they provide these immediate results. Um, in offering conditioning, that immediacy is really important. So you want to be able to see the behavior and immediately be able to reward it. And you can use them twice a week because they're cost-effective. Um, next slide, please.

And then in the rewards, the rewards that we use in a Contingency Management program focused on stimulant use, um, is that, of course the reward needs to be contingent to only give it when, when you, um, when your client or patient or,

um, [00:31:00] T, is able to, uh, give you a urine, a stimulant negative urine drug test, right?

So only when you see that drug test results, when you give the reward. You need to be able to reward immediately. So that's why we want some way to demonstrate the behavior immediately. And we want some mechanism to give out that reward right away. We don't want to have to be something that they earn, you know, several weeks down the line.

Um, and then we want something tangible to be a nice, powerful reinforcers. So that's like prizes or gift cards. And then of course it has to be something that's desirable, something that people want, right. So you're not going to be motivated to change your behavior if what's being offered, isn't really, you know, ed, uh, um, interesting to you, something you need, something you want.

So that's why we find that gift cards are the most universally reinforcing because people can kind of, uh, use them to buy what they want or need and customize it. Um, and we think that you should start, again mike mentioned in that choice experiment, it doesn't have to be a [00:32:00] large amount of money. But these days, $1 might not be enough to get somebody started.

So we want people to start with at least $5 with their first reward and then escalate from there. And, uh, your program could have a total of 300 to $500 available to people in a twice, 12 week period, seems to be sort of a minimum, what we think of as effective dose for Contingency Management. Now we know that HRSA, um, has, uh, programs that right now, um, people can earn a maximum of $75 of incentives through these HRSA funded grants.

We acknowledge that that is the case, um, in some programs, but other programs have been able to kind of patch together some funding and be able to, um, give out, uh, an incentive, um, uh, schedule that is closer to what has been done in the research and has been shown to, um, to be more reinforcing. So next slide please.

And then, uh, Mike mentioned, I think at the beginning that we're going to tell you about some elements that really make Contingency Management different [00:33:00] than general, um, incentive systems. A lot of people out there are doing some form of positive reinforcement and offering rewards. Um, but

Contingency Management, I like to call this the special sauce of Contingency Management, because this is that's what makes it a little bit more detailed to learn.

It takes a little bit longer to learn this part of Contingency Management, but it makes the in, um, reinforcement that much more powerful. So, um, we recommend that you use a program and Contingency Management or a system called Escalation, Reset, and Recovery. And again, I usually, you know, I, when I do teach this, I spend a little more time on it, but I'm going to give you the basics.

So what we mean by escalation is that the rewards get bigger over time. So the longer somebody is abstinent from stimulants, the bigger the reward will be. And then if they do, you know, we know that recovery is not a linear process, right? So nobody's going to just stop using stimulants and never, maybe not nobody, but a lot of folks won't never use it again.

Right. So there might be some ups and downs [00:34:00] in that process. And so if somebody does have a positive urine test along the way, and, or, you know, just doesn't show up for a visit, then they don't earn rewards that day. Remember it's contingent. And then they are going to have to reset back down to their initial reward levels.

So remember the rewards have grown over time. We're going to have them reset. And the reason we do that, we explain it ahead of time, is to help people feel more and more sort of attached to that progress they were made, they had made with their, you know, maybe weeks of abstinence. Right. So that they know if they return to use that.

There's that. You know, more to lose or there's more to gain by not returning to use because they know that their rewards can stay bigger. And I often use a video game analogy here, but basically people don't want to lose their progress. Right. So they they've made a lot of progress and knowing that they could have to return back to that initial reward level is part of what encourages people to stay on, on that abstinent path, on that recovery path.

However, um, [00:35:00] When people reset back down, we don't want to make them climb back up one, you know, one rung at a time of all the time that they

spent, um, earning more and more bonus rewards. And so we use something called recovery, which means that as soon as you show two urine tests in a row that are negative, then we're going to let you recover all of those bonus, um, prizes or bonus level that you had reached, um, previously.

And because basically in Contingency Management, we know that there's slip ups. And we don't want to slip up to turn into giving up or being like, well, I don't want to start over again, forget this. Right? So you really encourage people like, oh, it takes us one more year and test you're going to be right back up to that.

You know, say you were earning $15 rewards at that time and you had to go back down to five. You're going to be right back up to that 15 again. So that's kind of my brief way to explain, uh, this part of Contingency Management. And next slide, please. I think I might be handing back to Mike, um, or I'll tell you [00:36:00] briefly about, um, the different models of Contingency Management,

um, before I hand back to Mike and there, the research has used a few different ways to deliver these rewards. There's a voucher system, that's prearranged. And there's a prize draw system where you draw kind of chips out of a bucket or a fishbowl. It was a fish bowl. So they used to call it the fishbowl method.

Um, the voucher system is a little bit more straightforward. It doesn't have that variable thing of not knowing whether you're going to get, you know, really small prize or maybe no prize at all. Or if you're getting a big prize. And so we do teach people to use the voucher model. And, um, but in order to make sure we get to the rest of our material, I'm going to go ahead and move on to our next poll, which is just a little bit of a moment to check in and see, you know, you guys have been doing a great job sharing where you're coming from in the chats.

And, um, we'd love to use this poll to see where are you in your knowledge of Contingency Management? Um, do you, do you already do do it, do you do some form of it? [00:37:00] Um, or are you kind of a skeptic? Are you thinking like you're not even sure if you would want to, um, use Contingency Management or. So we'll give you a minute to, to answer this poll as a way for us to kind of see what our audience is. It's so fun to be able to be presenting this to, it looks like 84 of you right now.

And, um, and I also see a lot of questions are coming in, so I hope that we do leave enough time at the end to address those. Um, so yeah, we can go ahead and look at the results. So yeah, if a few people are skeptical, but most of you have, um, you know, either about, according to you of just hearing about Contingency Management now, and then the rest of you have at least a little bit of experience with Contingency Management.

So hopefully that we're filling in some of the details for you. And with this, um, I'm going to go ahead and hand it back to Mike.

[00:37:55] **Dr. Mike McDonnell:** Thank you, Sara. We're ready for the next slide.[00:38:00]

Sara gets to talk about all the fun stuff. I've talked about, like theory behind Contingency Management. Now you're talking about the research evidence, so, which is fun for me, I'm a researcher, so, okay. So there's, this is an old study or a, what we call a meta analysis. This is the figure on the left side of your screen.

It's like we're at, we take a bunch of studies that have been done on something, and then we put them all together and we look, and so this was a, and we looked to see together if we combine that information, that what could we learn? And so this is, uh, uh, uh, this is, uh, uh, example of, of, of, uh, comparing Contingency Management studies that were done up until I think, uh, 2008.

So there's been a bunch after that, and for any drug, and comparing it to all other psychosocial intervening, Um, and the effect on abstinence. So that'll come here is abstinence and, and the, basically the thing you need to recognize that this is called an effect size. The thing you need to realize about an effect size is the bigger, the number is the more likely [00:39:00] it's gonna work for your, for you, as a person, getting that treatment, the more likely it's gonna work for your client

if they're receiving the treatment. And so it's the, it's the bigger that number is, or the bigger that bar is, the more powerful that, that intervention is on abstinence. The outcome here is that abstinence. And so at that point they were 14. And then we have very high rule. Like you have to do like a perfect study to get involved in and to getting considered for a meta analysis.

So there's been many more studies than 14 on Contingency Management. 14 were included here. It has a very big effect size and the effect size, so it's much more likely to impact your patient's abstinence, your client's abstinence, or your absence. If your client received the Contingency Management, then something like cognitive behavioral therapy or relapse prevention. When you combine it with cognitive behavioral therapy, it's even more effective.

So that's an overview of sort of what we know about Contingency Management, as an example, putting a bunch of studies together, but what we do since then we've had meta-analyses [00:40:00] that have come out. One just came out. Um, a big, a big paper came out that looked at Contingency Management in the 60s, 6-0 studies, randomized controlled trials that have shown that Contingency Management works to treat stimulant use in people who are receiving MOUD, Medications for Opioid Use Disorder.

So people are, who are receiving buprenorphine or methadone, there's been 60 randomized trials that show Contingency Management works for stimulant use in just that population. So there's been over a hundred studies that have shown that Contingency Management is the best and most effective intervention in terms of getting people to stop using stimulants.

Or similar drugs, are supporting people in their goal to stop or reduce their stimulant use. The effects can last up to 12 months, post intervention. The effect ,there it's effective, also Sara and Rachael and I, all of our work is mostly focused on treating alcohol use disorders with Contingency Management.

So we know that it also works for alcohol, um, and for other drug use disorders and [00:41:00] also is a great tool for, for tobacco. It's the only evidence-based or research-based or whatever term, um, um, evidence based intervention for methamphetamine use disorder. So only it's the only intervention that's shown, um, to sh, to have consistent reductions across studies in methamphetamine use disorder.

And so that's why there's so much excitement about Contingency Management and so much interest in it right now, because unfortunately we are all dealing with and trying to get through together as a community, um, the problems that we're having right now with methamphetamine across our country. So next slide please.

So here's an example study again. This is that, um, Dr. Higgins is one of the originators of Contingency Management. It's a little bit of an old study, but I think it demonstrates, um, how, how, how well Contingency Management can work. So these are folks who enrolled in this study who were, um, had cocaine at what we would call cocaine use disorder right now.

So they're using cocaine. And they were coming to a clinic and they were [00:42:00] either given, um, they all received community reinforcement, which is a evidence-based psychotherapy for addiction, right? So that's the standard group. And then the incentive group also got vouchers, got rewards, got Contingency Management.

And so what you can see here is that 75% of the folks who received the cognitive behavior, the community reinforcement, that the psychotherapy and Contingency Management and the incentives, 75% of those people finished the whole intervention. They didn't drop out so that our retention rate of 75%. Only about 40% of folks actually finished in the, in the, in the, in that standard.

Well, I would call it it's better than standard care. It wasn't a really high quality psychotherapy that they were offered. And then when we look at abstinence, eight weeks of cocaine, abstinence, right. For those of you who do treatment work. Um, a few you're in re you're new to, if you, if you're, when you were new to recovery or where, you know, people are new to recovery, eight weeks of abstinence a big deal.

[00:43:00] Um, and, and it's really important, a really important treatment target and, um, and a real important goal for a lot of people, we could see that over 50%, almost 75% of people who received the incentive, um, were able to achieve eight weeks of abstinence across this intervention, as opposed to the, to the group that just got, um, that got the psychotherapy.

So that's an example of a study. We've done many studies since then, uh, that really show that Contingency Management can improve retention and also, um, re, really give people a better shot at abstinence. Next slide please. Okay, Sara, I'm handed it back to you to talk about the Veteran's Administration.

[00:43:42] **Dr. Sara Parent:** Thanks, Mike. Yeah. I was about to try to answer some of the Q & A in the chat, if you want to try to do that, but also we can,

um, hopefully have some time at the end for those. Um, so yeah, the there, the good news is that Contingency Management has a research for 30 years, but, um, you know, [00:44:00] it's new to the,

what, what I like to call the real world. And so the VA program is a really great real world um, demonstration that Contingency Management can work outside of these, you know, research settings. Um, they have, uh, been doing it at 94 um, VA's across the country. And to me just real quick, the stats are seeing are amazing.

So more than 50% of the visits are attended. And then when they attend those visits more than 90% of them, uh, the folks that are able to submit a urine drug test that's negative for stimulants. And this is just some really great results. Um, the program was able to get started because they, uh, VA's kind of a closed loop system so they can provide rewards and they didn't have to worry about funding them because they can provide a rewards through their own, uh, Cantina, uh, uh, system.

So already some, uh, Pre-funded rewards that don't have to worry about Medicaid anti-kickback laws that we'll talk about in a bit. Um, but just a really great example of how [00:45:00] it is feasible to do this in a variety of settings. So next slide please. Um, what's more fun than talking about research. I know Mike gets all the, uh, all the less fun stuff, but it's talking about what clients say about Contingency Management, because it really does, when people are wondering, does this really work or do people like it, or, you know, sounds great on paper, but we've those of us who have done Contingency Management, you know, in my case, in a research center, you really see some people respond in an amazing way to it.

Um, I'll let you read these on your own. Um, but just know that there's a variety of ways that people feel like it's been a really positive experience for them. And it goes beyond the actual reward, right? It's not about, you know, making a few extra dollars through their abstinence, but it's about feeling rewarded, feeling respected, feeling how that positive approach, where you don't get scolded or punished

if you have a slip up and you have a positive drug test now, and again, but instead you'll get rewarded for getting back on, on track and, uh, [00:46:00] and

getting back to abstinence. And that feels good. And a lot of people are used to, um, urine drug test feeling kind of punishing, or they're stressed out about them.

And now they're celebrated. And, um, so people really liked that and they liked the relationship they have with their CME providers. That is a result. Um, next slide, please. So, um, the and CM has been shown to be cost effective. Of course, that's the first question on a lot of people's mind is, well, we have to fund these rewards.

So that costs money. Is that, is it worth it? Right? So there are a lot of studies that show that CM is cost effective. This really helps funders out there, you know, statewide systems that are considering funding Contingency Management programs, because actually the costs compared to the other healthcare costs are quite low.

So if you're only spending about 300 to $500 worth of incentives on each CM client that, um, you know, that is offset by preventing even just one day of residential treatment or a trip to the ER. Um, we mentioned before that [00:47:00] Contingency Management can be conducted by anyone. So there really aren't, there isn't a high overhead in terms of staffing costs.

The visits are also very short because all you have to do is read a urine drug test and deliver rewards. So you could possibly do Contingency Management in that 10 to 15 minute, um, visit. We also recommend that can be embedded in other services that people, um, get, but it doesn't. So it doesn't take a huge amount of staff time, specialized training.

And so it makes it cost effective. Um, next slide please. Uh, but there are some challenges to using Contingency Management. I saw even in the chats that some people are identifying some of those challenges right now. So, um, we used to have resistance to the idea of incentivizing, uh, abstinence. People used to say, why would you pay somebody to do something that they should be doing

anyway? I think the idea of positive reinforcement, we're hearing less and less of that resistance. So a lot of people are really into it now. And, and, um, so, you know, but again, explaining [00:48:00] to folks what's going on with people's reward pathways and how this realigns that, and that there is a mechanism to this.

It's not a bribe. It is a therapeutic intervention. I think tends to help get people on board there. But, um, you know, my brief introduction to this idea of escalation bonuses and reset recovery, that can be really complicated to track. So when we do teach this, we give people a tracking tool, like an Excel tracker that really helps you understand like, well, what, what dollar value of reward voucher am I giving out today?

Um, so tools can help you with that. And then we briefly touched on this already, but the biggest reason why Contingency Management has been researched for decades, but hasn't been done in these real-world settings until quite recently is that, um, the, the federal government has ruled anti-kickback rules that say you can't incentivize healthcare.

You can't pay somebody to come on in and do something that's gonna make me money or make my agency money. Um, that's been abused in other settings before. And so, um, [00:49:00] in order to make sure that Contingency Management does not appear to be basically a kickback system where, where it is being, um, fraudulently used, there's a lot of.

Of very specific sort of protocol, um, uh, requirements in order to make sure that your program is evidence-based, that it is, uh, based on a protocol that is not just kind of willy-nilly giving out gift cards whenever you feel like somebody is doing well, but you have a very prescribed system of doing that.

Those are ways to make sure that you're not going to get in trouble for basically Medicaid fraud. And so those are things that you're going to want to make sure if they're setting up a CM program, that you talk to a CM mentor that can help you make sure your program will be compliant in that way. And then the biggest question on everybody's minds is where do those, where does that incentive money come from?

And so we'll go onto the next slide and talk about that briefly. Um, so states are starting to adopt this. So we, we have, uh, you know, [00:50:00] we started by training one little, uh, buprenorphine, uh, outpatient clinic who got their own grant to do Contingency Management, just at their setting. And now we, then we got hired by the states of Montana and Washington, we're consulting on the California project.

And you're going to see a lot of change here. So states are able to use some, um, grant money from, uh, different federal sources and some state specific sources in order to, um, fund Contingency Management programs. And right now California was the first state to get a Medicaid waiver. So Medicaid will actually

fund these incentives and they will be able to, um, you know, provide incentives up to $599 a year. So this is a huge changes and it's literally like we're getting emails an email this morning that helps update, um, how this is going forward in a lot of states. So just keep an eye on your state and you'll end up, um, finding out if there'll be some options for state funding.

Otherwise, um, we do recommend that people look, some people have gotten real scrappy, gotten [00:51:00] donations, that sort of thing to do their CM programs, but otherwise you'll be looking for some grants to help support your work. Um, until the, until you know, Medicaid sort of start, what's going to happen in California will probably start to, um, impact how it will be done in other states in the next few years.

Um, and then next slide, please. Um, so one, another little poll here to check on what you are worried most about and, and, um, in doing Contingency Management in your setting. We'll just take a quick second. I want to pass it back to Mike, because he's going to really bring this back to why are we even considering Contingency Management in rural recovery housing, and, um, how can you all help, uh, help give feedback on how that might be feasible?[00:52:00]

[00:52:06] **Dr. Mike McDonnell:** Great. So it sounds like across the board and then maybe some others, but the, that, the concerns that are raised in the poll are the challenges and the poll, um, fit with some of the questions that we've been getting to. So we're just going to finish up and go to the next slide. Really quick, cause we want to make sure to answer some questions.

We're running a little bit or a little bit behind schedule, but that's the. So why, why would we be interested in doing this in rural recovery housing? I'll add a quick point, which is we're here, we've approached, we know we've gotten together The Fletcher Group, and we have a couple of other housing based Contingency Management, um, like studies going on separately from this.

Cause this is really kind of a little, we're gonna ask you to fill out a survey at the end, but really this is a implementation project. We want to figure out how could we do this in housing? And I've worked a lot in rural communities and done Contingency Management in rural communities and one big barrier

is transportation. How do you get around? So how do you get around? Well, and, and [00:53:00] people will often, it's a challenge to come in twice a week to, to these short visits. So why not do it at somebody's house? That was sort of the practical idea in our mind, in our minds. And we've had discussions. So that's one piece of, of one reason that I'm personally interested in this as a potential idea, but 50% of residents in recovery housing exit early, and a lot of that is due to their substance use.

Um, and we don't want, we want people to stay in housing, um, because anyone who stays in housing is going to do better, um, and, and live a healthier, safer life. If they stay in housing. CM is an evidence-based intervention, but you can already think about the challenges. It's been mostly used in ambulatory care settings.

In a clinic-based setting. Um, and so you could think about the ch, challenges and you all are the experts in challenges, um, in a, in a housing setting. And it's, uh, and CM is effective. It has been studied though, when we are doing some studies here, um, of Contingency Management as a housing based program.

So it has been shown to work in housing. But in very specific ways, in a very specific [00:54:00] settings. And it, in my understanding is it hasn't been widely implemented in a housing based setting in the past. So next slide.

Okay. So develop. So these are the kinds of questions. Oh, that we're going to ask you in this survey, we're hoping to get your feedback on. We're hoping to, uh, you know, this is a great group of people with all kinds of different expertise and lived experience. So, um, and experience and expertise from lived experience and other places.

So, so who carries out CM in, in this, in a setting like this? Are residents and staff interested in CM? Do you think it's something people would even want? How would CM be paid for in recovery housing? We're actually going to turn

that question back on you like a good psychologist, I'll turn it right back on you and ask you about this, um, to see how you might have some creative ideas.

We haven't thought about. How can the unique setting of rural recovery housing influence this influenced this approach? So, so we're, those are the kinds of questions we're hoping to get feedback from you on, on the survey that we've been talking about. Next slide, please.

So we're partnering with The Fletcher [00:55:00] Group, uh, to do this survey five. The first we would love it if there's more than a hundred folks. So if you have colleagues, you want to share this out with, you know, please reach out to, to our team. Um, we're also gonna figure out a way to post this on the, on the F on a, on a webpage that people can access it.

Um, the link to the survey. We'd like, we're going to pay the first 100 folks who fill out the survey, so get on it right away, um, uh, $5 for your time. So not a huge incentive, but, um, we, we really appreciate it. And then we'll also invite some of you, a smaller group of folks who fill out that survey to meet with us for an hour long interview where we'll reimburse folks $20 to really get into the nitty-gritty.

So if you're interested in that to be an option, I think of the survey to say, Hey, yeah, I'd be interested in talking with, with the, with the team at WSU and Fletcher to learn, to share a little bit more how I think this could work, or maybe how it couldn't work. Um, cause we need to learn about both sides of that.

So we'll hear there's a link here. I think it's getting chatted out. Um, so next, next question. Or next question, next thing is the questions. Great. So we're going to, um, [00:56:00] there's so many good questions here. I've got to, I think we're going to do sort of a quick moderated discussion. We have about five minutes.

[00:56:10] **Jennifer White:** Great.

Thank you so much, Dr. McDonell and Dr. Parent. Um, we'll just start with, um, Robert Child's first question says, can you discuss the CM programs are doing overdose prevention and over amping prevention training for people who are unable to stay in the program, especially for folks who are returning to use.

[00:56:31] **Dr. Mike McDonnell:** That's a really good question. I think that is a great area of research that we could be in programmatic work that we could be doing, especially as we embed Contingency Management into different treatment settings. So Contingency Management is, most of the evidence focuses on abstinence and that's mostly because of the urine testing capabilities.

So there's point of care, urine test. They just tell you yes, no. As a person been using recently or not. And that's, that's mostly been out of a point of convenience. Um, we have done lots of research cause [00:57:00] I'm reading ahead because Robert's asked a number of really good questions. Um, but we found really good evidence for rewarding people's attendance to care.

So there's also really good evidence to reward people's attendance of, to an outpatient visit, um, follow through to a follow-up visit. There's evidence of that as well for Contingency Management. Anything that you have to do on a regular basis, like, you know, go into group therapy, or um losing weight. I mean, there's a lot of other recovery targets you can think about if it's a daily kind of thing that challenge for a person then Contingency Management works

great. Um, and so there's definitely, there's definitely, uh, so, but the answer is, I don't, I'm not aware of any studies or programs that specifically do that on purpose. I know there's a group in San Francisco that's doing Contingency Management work out of an HIV clinic there. And so I know that there, um, I don't know that program in and out, but I know they're definitely focused on many of the things you talk about.

Contingency Management was created in the context of a harm reduction intervention, methadone maintenance, and then buprenorphine. Um, and so, and so [00:58:00] really we, we, this was added on to deal with cohesive of stimulant. So it's a really good question. Those are things we need, we would like to partner with, with folks to do better.

Um, and we've actually had discussions at our research team about, you know, let's make sure we have more Naloxone on site. Let's, should we be giving out Naloxone to patients, but engagement is higher in Contingency Management than standard outpatient addiction treatment. I will say that.

[00:58:23] **Dr. Sara Parent:** And I would just add to this, that Contingency Management is not designed to be a standalone.

This is the only thing you do with folks. It is actually just one tool in your toolbox and you're absolutely, um, encouraged to use other tools at the same time. So using an analogy of, you know, if you, uh, you provide buprenorphine treatment, then you still need Naloxone for overdoses, right? That's a different treatment.

That's a different, so Contingency Management, you know, in this analogy Is the buprenorphine part. It's the, it's the intervention to help encourage people to, um, you know, not use stimulants. But you're still going to need, um, [00:59:00] other, you know, other interventions to help with things like overdose. Right. So that it it's, it's not an either or, it's both.

I hope that helps, helps answer that question. Um, and I know we only have two minutes left. I wanted to, I keep trying, I keep half answering some of the questions in the chat so I could address, uh, some, how do we get, um, around the $75?

[00:59:23] **Dr. Mike McDonnell:** That's the key question. I, yeah. Can I take the first....

Dr. Sara Parent: Why don't you do that one Mike.

They are two different things.

So SAMHSA and then HRSA have said you can, if you have a grant from us, you can only spend $75 on incentives. That's the cap per person per grant year, I think, or maybe a whole grant. That's completely different than the kickback rules. You can totally use that $75 to commit Medicaid fraud. So you can take money from the federal government.

And if you reward people for attending a billable encounter, that you would have an economic benefit fraud. You are committing Medicaid fraud. So the $75 cap [01:00:00] on SAMHSA is different, a different issue than the Office of Inspector General saying you use, can use prohibitions against using incentives in healthcare.

So those are two different things. I think people get those often confused. They're related because they're both relevant, but they're different. One is a funding issue, and one is what you can use incentives for and what you can't. And that's part of the reason why we're not encouraging people to reward attendance to, to billable encounters.

If it's a non-billable encounter, if it's a recovery goal, um, we think, we think that's totally fine. Um, you know, but, but if it's related directly to a billable encounter and it could look like an agency's making more money because of that reward, then that's where we are cautioning people to be really careful.

[01:00:43] **Jennifer White:** I think we are at our time.

So thank you all very much. Um, I have posted several links and contact phone numbers. Um, this presentation will be available on The Fletcher Group website, um, at next week with more information on how to get [01:01:00] involved. Please stay tuned. Um, after we close here to fill out that survey, so you can get more information and work on those incentives for yourself.

Thank you all. Thank you, Dr. McDonell, and thank you Dr. Parent.