DRUG POLICY ALLIANCE.

CONTINGENCY MANAGEMENT

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Contingency management (CM) is a highly effective model of substance use disorder (SUD) treatment that involves providing incentives for behavioral outcomes aligned with treatment goals. Hundreds of peer-reviewed research articles spanning over thirty years have consistently demonstrated the positive impacts of CM, including reductions in drug use, increased treatment retention, compatibility with other forms of treatment, and effectiveness across diverse populations. CM should be widely implemented in SUD treatment settings across the U.S.

THE NEED FOR EVIDENCE-BASED SUBSTANCE USE DISORDER TREATMENT

In 2022, over 48 million United States residents were estimated to have a substance use disorder (SUD), but only about 7.3 million accessed treatment (less than 15 percent of those in need).[1] Only a small fraction of those who access treatment receive interventions backed by scientific research.[2] This helps explain why less than half of people who access treatment actually complete it, as implementing evidence-based care is known to increase treatment engagement.[3]

CONTINGENCY MANAGEMENT: A HIGHLY EFFECTIVE SUBSTANCE USE DISORDER TREATMENT

Contingency management (CM) is a behavioral intervention that uses tangible (usually monetary) rewards to reinforce positive behavior change. In the context of SUDs, CM involves providing an incentive, such as a voucher, prize drawing, or cash, for behavior aligned with treatment goals, such as attending treatment or submitting a negative urine drug test. Rewards increase with consistent demonstration of the target behavior.

CM is one of the most effective behavioral therapies available for SUD treatment.[4] Both the Substance Abuse and Mental Health Services Administration (SAMHSA)[5] and National Institute on Drug Abuse (NIDA)[6] recognize CM as an established evidence-based intervention, and the Department of Veterans Affairs has incorporated it into their health services throughout the United States.[7]

CONTINGENCY MANAGEMENT SIGNIFICANTLY IMPROVES TREATMENT OUTCOMES

CM implementation vastly improves a wide variety of treatment outcomes, including:

- Significant reductions in drug use while in treatment;[8]
- Improved treatment attendance and participation, key indicators of long-term success;[9]
- Reductions in risky drug use;[10]
- Reductions in risky sexual behavior;[11]
- Reductions in drug cravings;[12]
- Increased medication adherence;[13] and
- Increased physical activity.[14]

CONTINGENCY MANAGEMENT WORKS FOR A VARIETY OF SUBSTANCE USE DISORDERS

Research suggests that CM is effective in treating stimulant (e.g., cocaine and methamphetamine),[15] opioid,[16] marijuana,[17] nicotine,[18] and polydrug use disorders.[19] It also shows promising results in the treatment of alcohol use disorders.[20] CM can be used to prioritize reducing use for a specific drug or class of drugs while not requiring abstinence from other drugs, helping to tailor treatment to individual needs. The Department of Veterans Affairs encourages this method for reducing stimulant use among people who access its SUD services.[21]

CONTINGENCY MANAGEMENT IS THE MOST EFFECTIVE TREATMENT FOR STIMULANT USE DISORDERS

Currently, there are no FDA-approved medications for the treatment of stimulant use disorders, which includes addiction to cocaine and methamphetamine. This makes implementing effective behavioral interventions all the more important for the 2.6 million people living with a stimulant use disorder.[22]

CM is the most successful treatment available for the treatment of stimulant use disorders.[23] A recent meta-analysis found that CM alone and CM in conjunction with other treatments were the only interventions that consistently produced better results for methamphetamine and cocaine use disorder treatment.[24] One study found CM doubled the likelihood of urine samples that tested negative for stimulant drugs like cocaine or methamphetamine compared to those who did not receive CM.[25] CM should be widely available for people with stimulant use needs.

CONTINGENCY MANAGEMENT CAN BE IMPLEMENTED IN ANY SETTING

Studies have found that CM can be applied in a range of treatment settings and in conjunction with other treatment methods.[26] It can be built into varying intensities of substance use disorder treatment, from outpatient to residential. It works with other psychosocial interventions like cognitive-behavioral therapy, often improving the effectiveness beyond what the other intervention would have achieved alone.[27] CM also works as an adjunct to medications for addiction treatment (MAT), including methadone and buprenorphine.[28]

CONTINGENCY MANAGEMENT WORKS FOR DIVERSE POPULATIONS

Research shows that CM is effective for many patient demographics including racial and ethnic minority groups, varying socio-economic groups, and clients with existing health conditions and diverse presenting problems.[29] It has been found to work for people who live with both a SUD and serious mental health needs.[30] CM also improves outcomes for people with criminal legal system involvement and/or who are unemployed or homeless.[31] While all SUD treatment should be tailored to the unique needs of individuals, CM may be a valuable tool regardless of background.

CONTINGENCY MANAGEMENT IS COST-EFFECTIVE

The benefits of CM likely offset the costs of implementation. Reduced risky use and associated behaviors will result in societal benefits, and research shows that investing additional amounts in CM up front can result in great benefits down the line.[32] The Washington State Institute for Public Policy recently estimated that CM is likely to cost only about $600 per participant but produce benefits of over $23,000 per participant, including over $15,000 in reduced mortality, over $4,000 in health care costs, and nearly $4,000 in labor market earnings.[33]

DESPITE THE EVIDENCE, BARRIERS PREVENT WIDESPREAD ADOPTION OF CONTINGENCY MANAGEMENT

CM remains the least implemented evidence-based SUD treatment.[34] Barriers to CM access range from philosophical to practical, including wrongly assumed incompatibility with other models (e.g., 12-Step), lack of provider knowledge and training, and concerns over implementation costs.[35] Notably, insurance rarely covers the costs of CM.[36] The expansion of technology, including web-based CM and remote drug testing tools, may help to alleviate these barriers,[37] but policies and investment of resources supporting CM adoption are sorely needed.

RECOMMENDATIONS TO INCREASE CONTINGENCY MANAGEMENT UTILIZATION

These recommendations would support implementation of this highly effective treatment intervention:

- Federal and state laws should exempt CM for SUD treatment from fraud and anti-kickback statutes, allowing for Medicare and Medicaid reimbursement.
- Public and private health insurance should adequately reimburse providers for providing CM.
- Federal and state health agencies should adopt organization-wide support and implementation procedures for CM in services they provide and contract for third parties to provide, like the Department of Veterans Affairs has done.
- Federal and state governments should remove barriers to telehealth and support use of technologies to facilitate remote CM utilization.
- Addiction and other health professional organizations should prioritize dissemination to ensure their members are trained and supported to provide CM.
- Research should continue to investigate the societal benefits of CM, including reductions in health care, law enforcement, and other social costs.

A CAUTIONARY NOTE

While DPA supports expanded access to CM, we also caution against implementing CM in ways that reinforce abstinence-only treatment for all people with SUDs. Most research to date has focused on CM involving rewards for negative urinalyses, but this is due to our treatment system's focus on abstinence as the primary indicator of treatment success. For many people with SUDs, especially those who are most marginalized, abstinence is not desirable or realistic. Therefore, CM programs and payment models should not be limited to rewards for negative urinalyses. Programs should allow flexibility to adapt to the needs of their clients and to use CM to motivate behaviors including, but not limited to, attending appointments, harm reduction outcomes, medications compliance, or connecting with other needed services like housing supports (which research demonstrates is effective).

CM, as with all other treatment, cannot fully address systemic problems like housing and economic insecurity that can impact treatment engagement and success. Many people with SUDs face challenges such as racism, poverty, criminalization, and lack access to other supports in the community. These and other factors must be accounted for when evaluating client outcomes in CM treatment. CM should not be interpreted to reinforce individualized solutions for systemic problems.

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