Contingency Management

ICWB Shared Learning Call

January 26TH, 2026

Leslie Dabovich, MD

Adapted from Dr Klie's slides in 2025

Objectives

Disclaimer - these objectives are what happens after I have to help kids with homework

Who

- Indicated populations

What

- Contingency Management vs Incentive Programs
- Reward pathway and operant conditioning

When

- Background and an old example

Where

- Clinic/practice implementation
- High vs low tech

Why

- Colorado Stats

How

- Barriers, example, and ideas

Who

- Indications

ALL the USE DISORDERS

* can adjust to make culturally responsive

Stimulant - “the most effective treatment”

Opioid - “CM can increase abstinence but is not recomended as 1st line”

EtoH - research supports the use of urine EtG tests for assessing abstinence in a CM model

Cannabis - “effective for treatment when use as an adjunctive to other psychosocial treatments (CBP, MET)”. limited by urine testing

Nicotine - “CM supported by a large body of literature quoting quit rates that are double those of individuals who receive typical interventions”. Used alone and in combination w/ nicotine replacement. Limited by detection methods

Polysubstance - CM that addresses one substance (i.e stimulants) has secondary reductions in co occurring use of other drugs, etoh, and cigarettes

UTD - Oct 2024 - SUD - CM, MCDonell et all

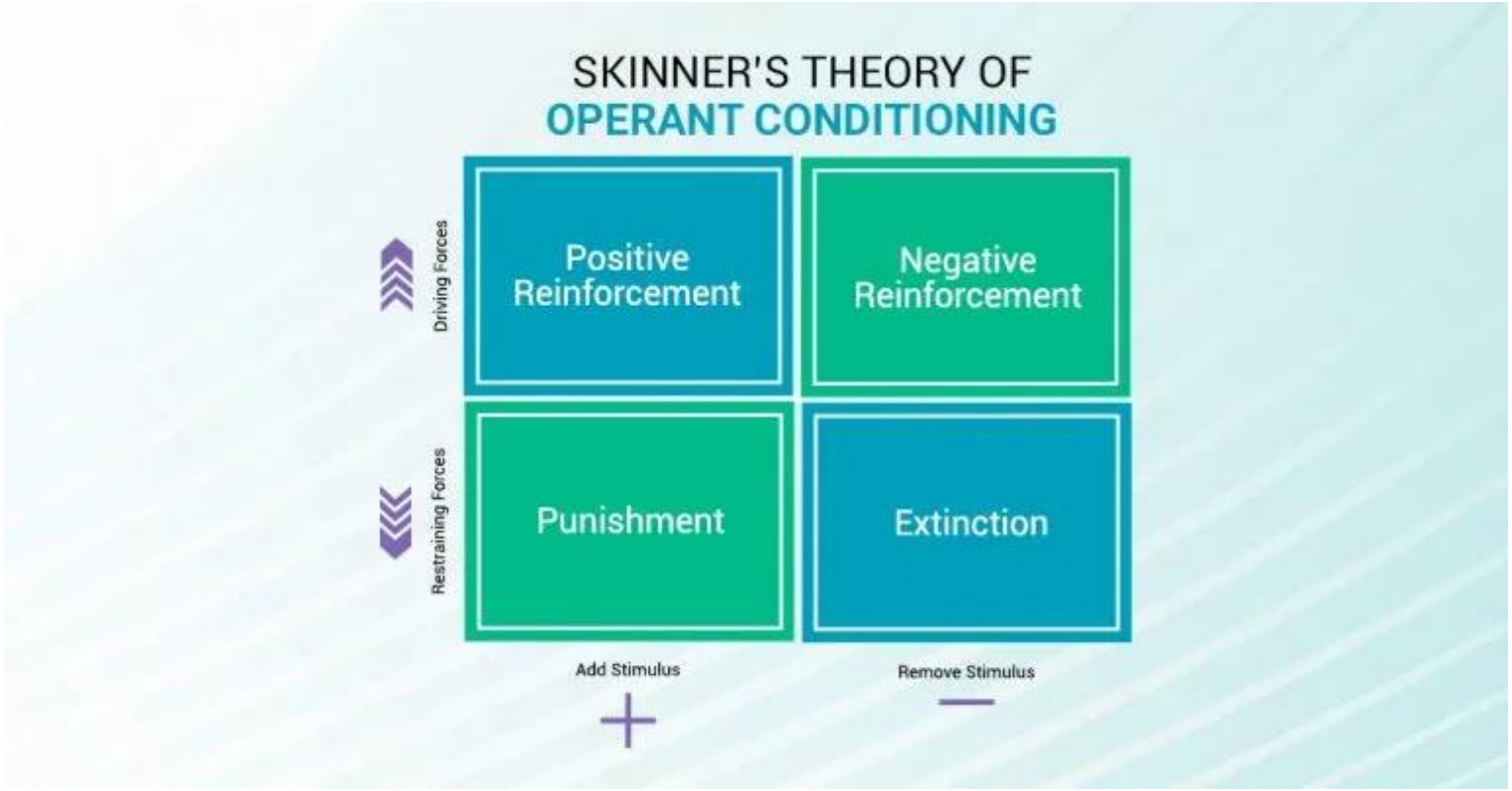
What

- CM vs Incentive Program

- Cross over but incentive programs tend to be less formalized
- CM or Incentive Programs should not be stand alone, but should be integrated and complementary to other treatment interventions (therapy, group, provider appointments, medication adherence (easiest with injection medicines), etc)
- CM is an outpatient behavior intervention where a tangible reinforcer (incentive/reward) is provided when a patient engages in a specific health promoting behavior
  - Based on operant conditioning

Operant Conditioning

- ***A method of learning that taps into the reward pathway and alters voluntary behavior via consequences***



Reward Pathway

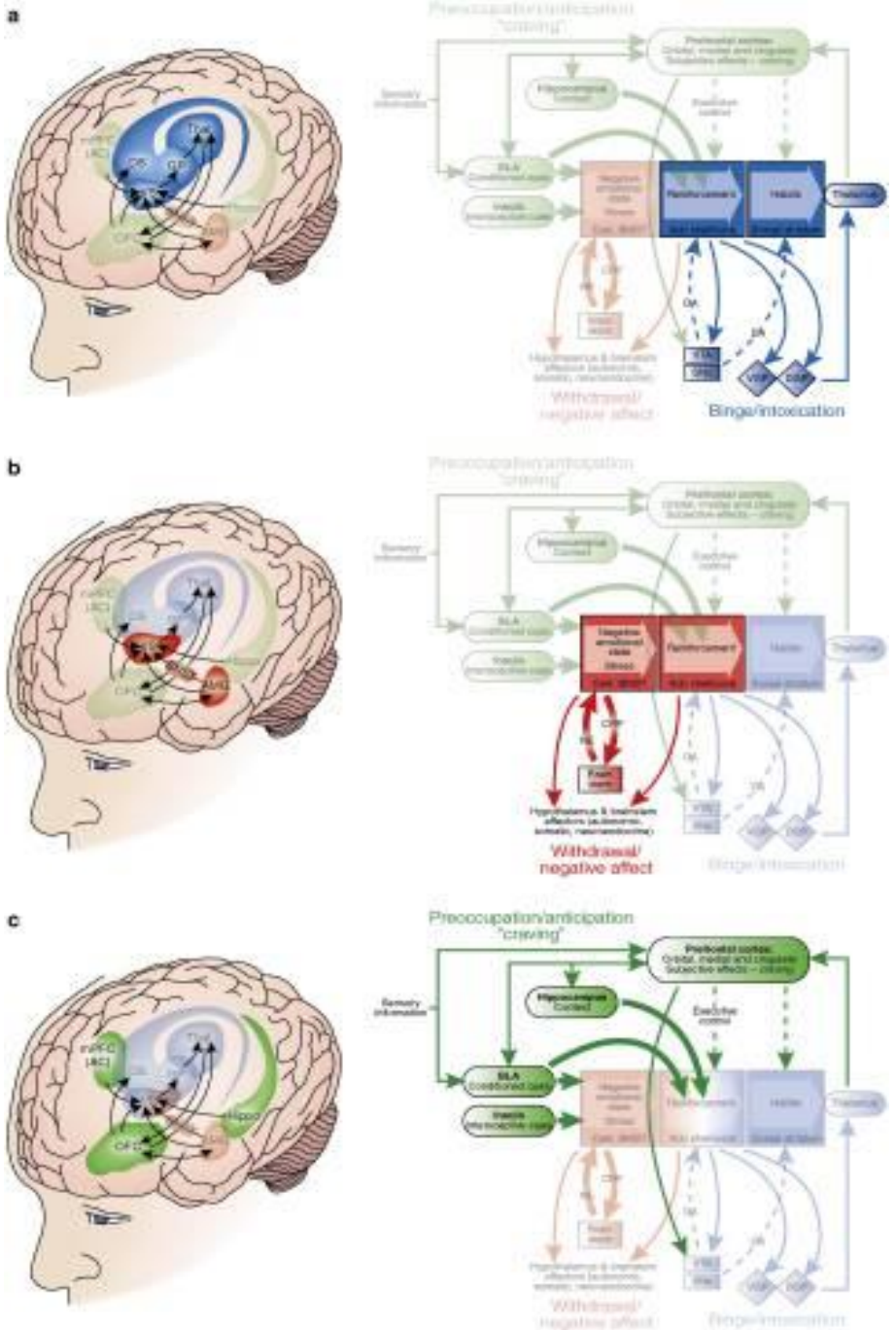
Present in all brains

Evolutionarily protective

Dopamine based (+ more)

Triggered by all substances of abuse - and likely other additions/disorders (i.e. gambling and impulse control d/o)

Dysregulated in addiction and use disorders



Neuropsychopharmacology. 2009 Aug 26;35(1):217–238. doi: 10.1038/npp.2009.110

Contingency Management Principles

- Objective assessment
- Single behavior
- Reinforcement contingent on behavior
- Immediate
  - prefrontal cortex is overridden by the amygdala in drug users if there is a long delay
- Frequent opportunities
  - partial, variable, and immediate rewards are more powerful than consistent
- Desirable dose/magnitude
  - $650-$1800/treatment?
- Duration
  - 12 wks min
  - Longer programs have higher rates of sustained remission

Contingency Management

- CM effective in 61% of treatment episodes versus 39% for other interventions
- CM “shaping:” Reinforce progressively closer estimates of abstinence/goal behavior
- “High magnitude” CM: >$500 vs lower rewards

McPherson SM et al. *Substance Abuse and Rehabilitation* 2018
Roll JM, et al. *Addictive Behaviors* 2013

When

- ***Not new***
  - *Behavioral contracts with rewards as part of therapy discussed in literature as early as the 1960s-1970s*
  - *1990s era "Fishbowl" systems*

- ***Baby and Me Tobacco Free***
  - *est 2001, > 30,000 families enrolled as of 2020*
  - *In Colorado since 2014*
  - *60-68% smoking cessation rates via prenatal counseling and postpartum diaper incentives*
    - *reduced preterm birth by 24-28% and NICU admissions by 25-55% in CO*
  - *Now include MJ use!*

- ***Other examples?***

Where

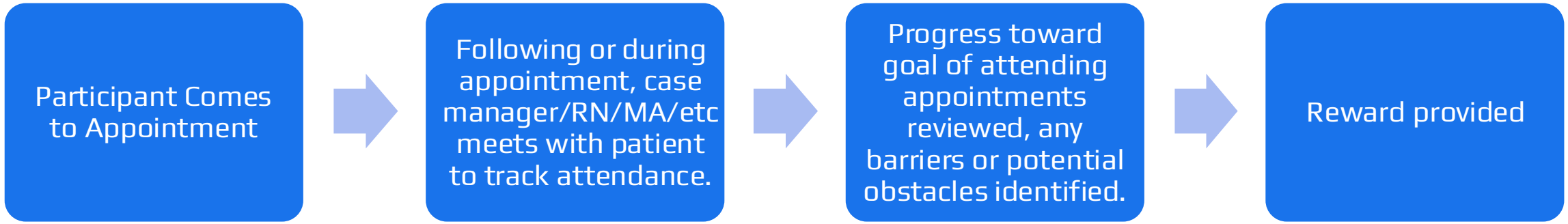
- **Implementation of CM**

- Can be small scale, low-tech
- Can be high tech and automated with tech platform
- Can be based on clinic/program’s goals
- Can be based on patient/client’s goals
- Does not have to be urine toxicology based!

Implementation

- Contingency Management Participant Agreement
  - Clearly state the goal(s)/”target behavior”
  - Clearly state the reward, reward scale, frequency, etc
  - Make clear if participation is attached to any other care patient might receive with you (prenatal care, medication, therapy, etc)

Low-tech Example: Appointment Attendance



High-tech Example: Technology Platform

Automate for Improved Efficiency

Rewards Engine enables providers, states, and payers to implement effective behavior reinforcement seamlessly by automating all program components.

Protocol Management

Streamline your processes with intuitive protocol management that ensures consistency and compliance across all program components.

Behavior Documentation

Monitor and reward positive behavior with an escalating rewards system that encourages sustained engagement and improvement.

Rewards Distribution

Various delivery methods for rewards, including reloadable debit cards and digital gift cards, ensure accessibility and enhance patient engagement.

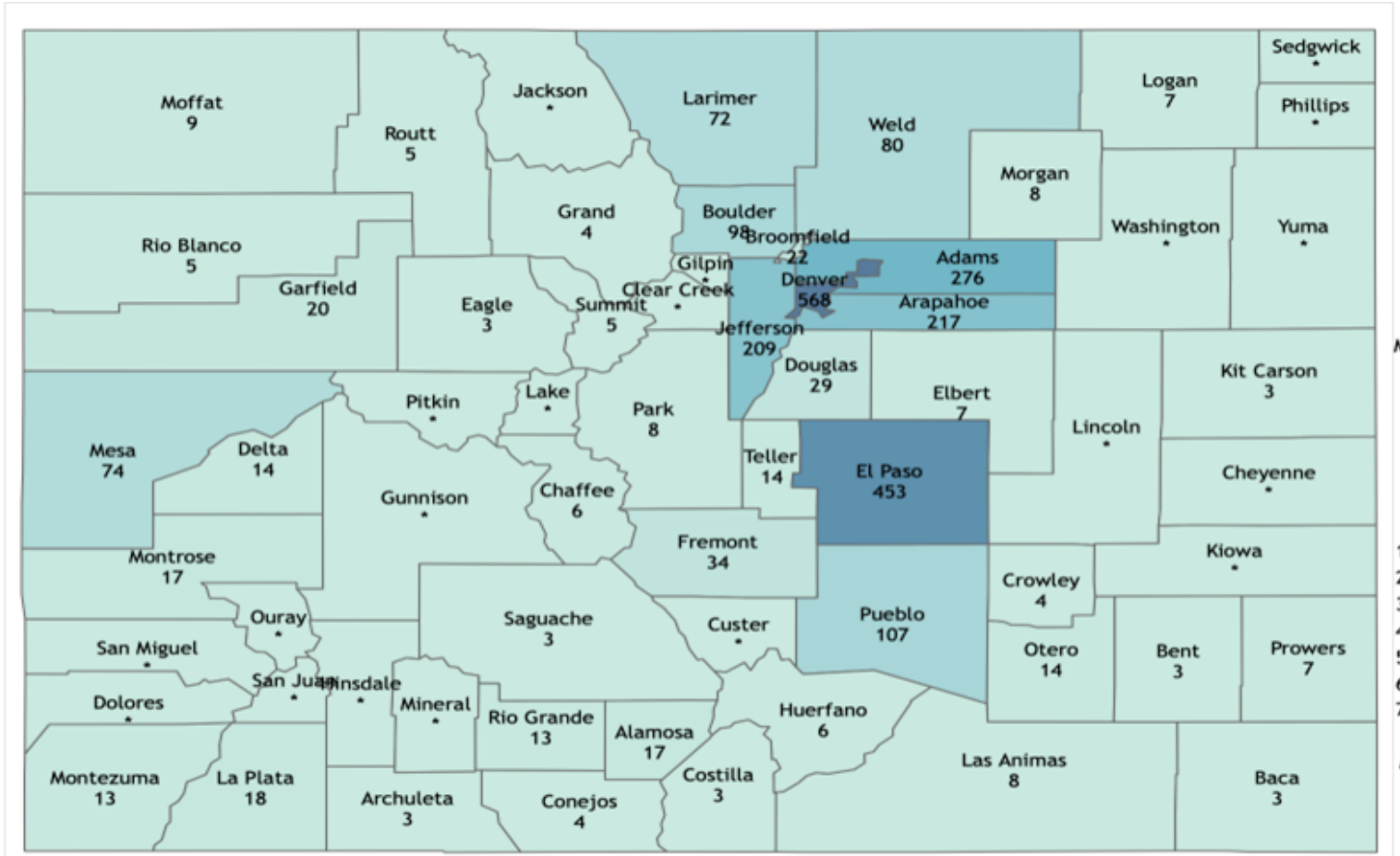
Audit Trail

Maintain transparency and accountability with a comprehensive audit trail, tracking all actions for compliance and review.

Outcomes Reporting

Generate real-time analytics to track participation and measure outcomes for internal and external reporting.

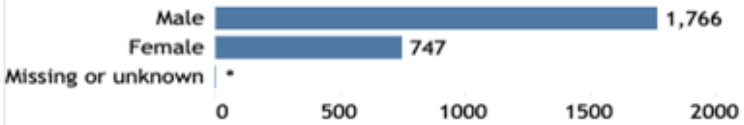
WHY



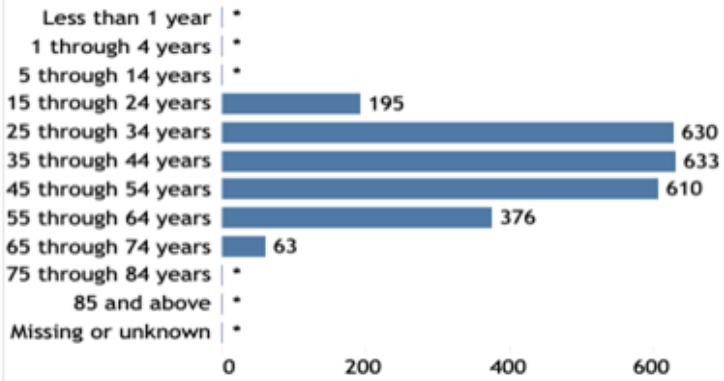
Total number of drug overdose deaths among Colorado residents:

2,513

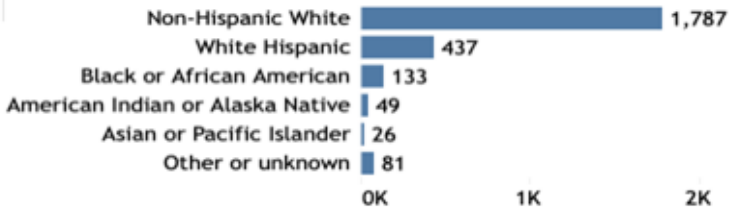
Sex



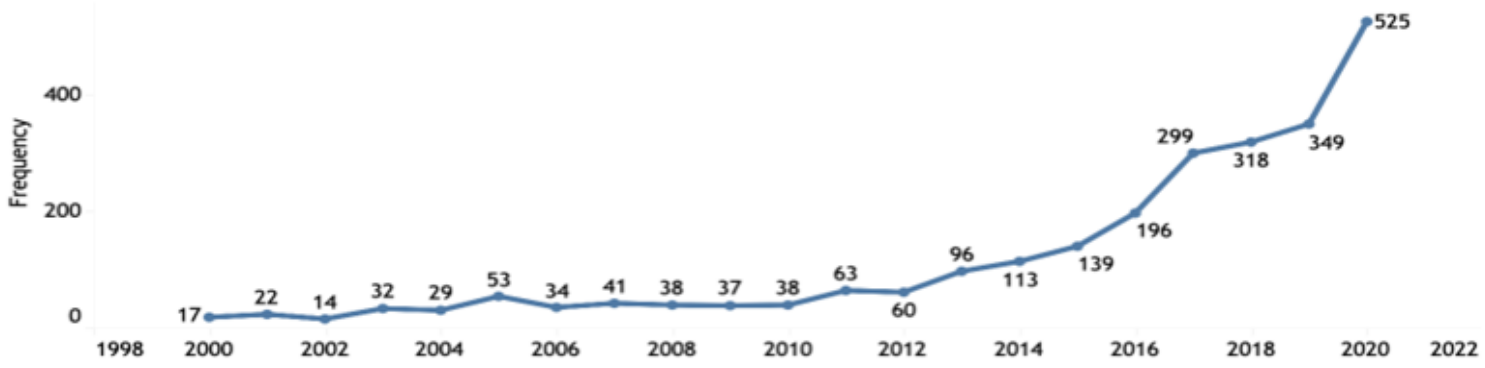
Age groups



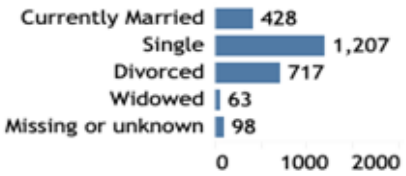
Race and ethnicity



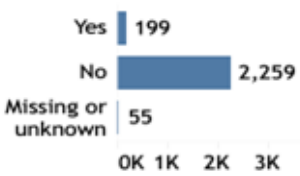
Total number of drug overdose deaths due to methamphetamine per year



Marital status



Veteran status



HOW -
Updates on Rules! SAMHSA and SOR

- Either prize-based or voucher-based protocols
- **Abstinence, SUD treatment attendance, and med adherence**
  - Abstinence requires rapid, CLIA-waived, in-person POC testing
- Incentive is contingent upon achievement of a specified behavior
  - Consistent with the patient's treatment plan
  - Verified with objective evidence
- **Minimum required duration of treatment is 12 weeks**

Rules, cont.

- Incentive magnitudes must align with what has been found effective in the research literature. >$400/yr?
- Caps on the cumulative annual value of incentives per patient must be high enough to accommodate incentives of a sufficient magnitude
- **Incentives must be provided immediately following verification that the incentivized behavior is achieved**

How

- Barriers

- Bias
  - improved w provider and staff education
- Corporate Regulation
  - specific restrictions exist (like against gift card use for example)
- Costly
- Access to POC/objective testing
- Staff bandwidth

ICWB Ideas!

- How is your program using or considering using funds for incentives?
- Have you considered integrating a more formalized CM program, and why or why not?

Contingency Closet @ SCFM

- $7k initial investment, $2k restocking after ICWB grant conclusion
- Attendance based*: Higher risk pregnancy = higher value reward potential
  - Range from $7 teethers & $20 pumping bras to $100 car seats/ergo baby & $250 mammoroos
- Not really immediate :-(
- Single personal management w/ whole clinic “buy in” (but education repeated annually)

Thank You!

Leslie Dabovich - dabovichmd@gmail.com

w/ credit to Kaylin Klie Kaylin.klie@cuanschutz.edu