Contingency Management and Stimulant Use: Training 201

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Outline

1. Contingency Management (CM) as a public health intervention
2. Maximizing the conversations in a CM session: lessons learned
3. Interview with Josh McQueen
4. Q & A; discussion

Recently Published CM Papers

177 (2025) 209763

Contents lists available at ScienceDirect

Journal of Substance Use and Addiction Treatment

journal homepage: www.journals.elsevier.com/journal-of-substance-use-and-addiction-treatment

Interest in contingency management and reducing stimulant use among syringe service program participants

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ARTICLE INFO

Keywords:
Contingency management
Stimulant use disorder
Substance use treatment
Syringe service program
Harm reduction

ABSTRACT

Introduction: Expanding access to effective treatment for stimulant use disorder (StimUD) is increasingly urgent as US fatal drug poisonings involving stimulants have rapidly increased. Limited information is available regarding interest in StimUD treatment among syringe service program (SSP) participants including interest in contingency management (CM).

Methods: We surveyed SSP participants in Burlington, Vermont regarding their interests in reducing and stopping stimulant use, participating in CM, and examined associations between sociodemographics, drug use, and health/treatment variables with interest in reducing and stopping stimulant use using multivariable logistic regression.

Results: Among 139 participants, 64.6 % reported interest in reducing and 59.7 % in stopping stimulant use. Overall, 82.8 % of participants reported interest in CM to reduce or stop stimulant use. Interest in reducing use was greater (odds ratio[95 % CI]) among participants currently receiving substance use disorder (SUD) treatment (3.84[1.61–9.14], $p < .01$), without Hepatitis C viral (HCV) infection (2.61[1.14–5.98], $p = .02$), and being somewhat (19.29[2.25–165.65], $p = .01$) or very (19.65[2.34–164.84], $p = .01$) concerned about anxiety. Interest in stopping use was greater among participants currently receiving SUD treatment (4.98[1.97–12.62], $p < .01$), without HCV infection (2.87[1.22–6.74], $p = .02$), participants whose primary drug was opioids compared to both stimulants and opioids (28.13[2.95–267.93], $p < .01$), and participants whose primary drug was stimulants compared to both stimulants and opioids (12.81[1.45–113.43], $p = .02$).

Conclusions: Results demonstrate interest in stimulant use treatment among this sample of SSP participants, with strong interest in CM. As community-based programs with high social acceptability for their non-judgmental services, SSPs are a novel setting to examine providing evidence-based CM for StimUD.

Introduction

Expanding access to effective treatment for stimulant use disorder (StimUD) has become increasingly urgent as fatal drug poisonings involving stimulants, such as cocaine and methamphetamine, have rapidly increased in the United States (US; Friedman & Shover, 2023; Mattson, 2021; Ahmad et al., 2025). In the US, stimulant involvement in fatal poisonings has increased from 12,122 deaths in 2015 to 64,778 deaths in 2023 (Ahmad et al., 2025). In Vermont, fatal drug poisonings increased over 500 % between 2010 and 2023 with cocaine being the second most prevalent drug detected in 72 % of fatal poisonings (Vermont Department of Health, 2025). Notably, in Vermont, the proportional involvement of cocaine in drug poisonings has risen over sixfold compared its presence in only 11 % of deaths in 2015 (Vermont Department of Health, 2024).

The most efficacious treatment for StimUD is contingency management (CM), a positive reinforcement-based treatment in which individuals earn financial incentives (e.g., gift cards) for completion of

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https://doi.org/10.1016/j.josat.2025.209763
Received 15 April 2025; Received in revised form 9 July 2025; Accepted 28 July 2025
Available online 31 July 2025
2949-8759/

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JAMA Psychiatry | Review

Data-Driven Contingency Management Incentive Magnitudes
A Review

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IMPORTANCE Interest in contingency management (CM) as a treatment for opioid and stimulant use disorders has increased because of the ongoing dual opioid/stimulant crisis, rising stimulant drug deaths, and demand for effective treatments for stimulant use disorder. The success of the US Department of Veterans Affairs nationwide rollout and the launch of California's Recovery Incentives Program provide evidence that this treatment can be translated into effective clinical practice.

OBJECTIVE To provide data-driven inflation-adjusted incentive estimates for modern CM protocols that can be customized for intervention duration. It is essential for CM protocols implemented in clinical care to use efficacious, research-supported parameters, including incentive magnitude.

EVIDENCE REVIEW This review included 112 published CM protocols that involved reinforcement of stimulant- and/or opioid-negative urine drug tests, categorized each protocol in terms of impact (small/medium/large effect size) relative to a non-CM comparator condition, and computed weekly inflation-adjusted incentive magnitudes for voucher- and prize-based CM protocols.

FINDINGS Drawn from protocols with medium to large impacts on patient outcomes, weekly median magnitude estimates are $128/week for voucher protocols and $55/week for prize protocols. For the most common duration of 12 weeks, these estimates translate to $1536 for voucher and $660 for prize protocols.

CONCLUSIONS AND RELEVANCE These incentive magnitude estimates can be used to inform clinical, policy, and advocacy related to CM implementation. Practical suggestions (eg, starting values, escalation) for building protocols that meet these incentive magnitudes are provided and implications are discussed.

JAMA Psychiatry. doi:10.1001/jamapsychiatry.2025.1341
Published online July 2, 2025.

Supplemental content
CME at jamacmelookup.com

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Contingency management (CM) interventions have more than 40 years of research support as a treatment for stimulant and other substance use disorders, patient population characteristics, and clinical settings.[1-14] Despite robust research evidence, clinical implementation of CM for stimulant use disorders has been limited in the United States. The Department of Veterans Affairs (VA) initiated the first large-scale clinical rollout of CM in the US in 2011.[15] This effort was successful in reaching patients with stimulant use disorders[16,17] and continues today.[18] More recent efforts involve the California Recovery Incentives Program,[19] which in just under 2 years has trained 100 sites in 19 counties and has reached more than 5000 patients, as well as other statewide pilots[20] and regional efforts.[21]

CM magnitude is directly related to its efficacy,[2,12,22-27] but little guidance on CM magnitudes is available. As CM continues to expand, it is important that stakeholders support CM programs of sufficient magnitude to reduce substance use. Many of the seminal studies of CM were conducted decades ago. Inflation over this period affects the buying power of the US dollar, and it may be important to consider inflation when determining effective CM magnitudes in the present day.

CM research protocols vary in duration, magnitude, behavioral targets, models, and settings; thus, no single recommended magnitude exists. Although resources are available for CM protocol design, including suggestions for magnitude,[28,29] a thorough examination of evidence-based incentive magnitudes in CM protocols is needed. In this article, we provide a comprehensive review of the incentive magnitudes associated with medium and large reductions in substance use, and we provide inflation-adjusted updates. We hope that this information will help individuals designing CM programs select and budget for CM magnitudes that will yield improved patient outcomes. We elected to separate voucher- and prize-based protocols for analysis because of differences in the methods between the 2 approaches.

A Call to Action: Evidence-Based Contingency Management

Carla J. Rash, Ph.D., Michael McDonell, Ph.D., Tyler Erath, Ph.D., Sara Parent, N.D., Richard Rawson, Ph.D., Sarah Wattenberg, L.C.S.W.-C.

As clinicians and addiction researchers, if a family member or friend were to say "my child/sibling/parent has a stimulant use disorder. I want the best treatment for them," we would quickly reply that contingency management (CM) is the most robust and evidence-backed treatment option. Sadly, we would have to follow up that statement with an acknowledgement that few persons seeking substance use disorder treatment in the U.S. will have access to an evidence-based version of this intervention. Instead, contingency management is either unavailable, or perhaps worse, offered in a manner that deviates from known parameters associated with efficacy. Now, imagine facing this same exchange on repeat with dozens of patients and family members of patients. It is demoralizing as researchers in this field, and maddening as clinicians, to know this effective treatment exists but patients cannot access it.

Our scientific community has provided a plethora of evidence to support CM's efficacy over the past 40 years; however, CM's reach into clinical practice is stymied by regulatory and policy barriers and is characterized by poor adherence to evidence-based versions of CM. A recent report from the U.S. Department of Health and Human Services in CM (1) provides recommendations for implementation integrity and needed policy changes (e.g., consideration of a safe harbor for evidence-based CM incentives); however, action is now required to enact these recommendations. We offer the attached expert consensus statement calling for:

1) Increased access to evidence-based CM interventions to treat stimulant use disorder;
2) Federal agencies to provide the necessary regulatory reforms and funding necessary to accomplish this goal; and
3) The development of specific, approved protocols that include best practices in CM along with the critical training and ongoing coaching infrastructure necessary for implementation.

Now is the time for action—for those with lived experience and their family members, for advocacy organizations, for providers, and for states and treatment organizations to demand access to this treatment. Grassroots demand for treatments delivered with fidelity will draw attention and add additional pressure for change. It may also be valuable for these groups to directly address some of the persistent misunderstandings regarding CM through education and advocacy, including concerns about the durability of CM effects beyond the incentive period (see references 2 and 3 for scientific evidence of durability in comparison to other evidence-based approaches) and objections related to the idea of giving incentives to persons with substance use disorders. The latter point raises the issue of stigma toward these patients, even among healthcare providers (4), and suggests an area of need in our field.

Now is the time for federal agencies to ease the path forward to making CM accessible and effective while still minimizing potential for fraud and abuse. Clark and Davis (5) review multiple regulatory issues that have relevance to CM interventions. Clear federal guidance is needed, as well as a path that does not require case-by-case, expensive, and time-intensive advisory opinions. We also note that state-level reforms may be needed even after federal standards are established. Andraka-Cristou et al. (6) provide a comprehensive state-by-state review of laws relevant to CM. While no state laws were identified that prohibited CM, the variance across states poses challenges for navigating the national landscape for implementation efforts and requires time-intensive state-by-state considerations. For example, some state laws include restrictions on incentive magnitude, type of incentive permitted, or require specific behavioral targets. Similar regulatory reforms at the state level will be necessary to promote best practices.

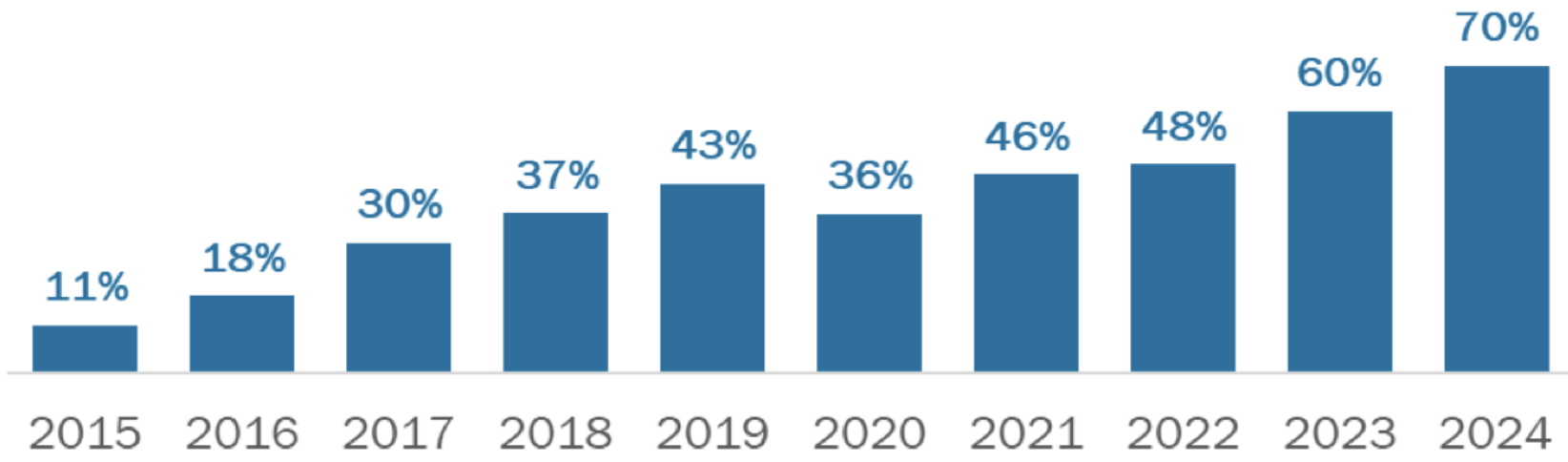
> Over 30 randomized controlled trials demonstrate that CM is an effective intervention to reduce stimulant use among individuals receiving medication for opioid use disorder, and CM can be successfully adapted and tailored for specific populations

Now is the time for our CM scientists and experts to provide strong guardrails to ensure that CM protocols are enacted with fidelity in order to benefit patients in need. Recommendations for best practices and clear guidance on unacceptable practices are needed. In addition, training and ongoing coaching have been critical to the success of large

Fatal Opioid Overdoses Among Vermonters

Annual 2024 Data Brief
May 2025

Cocaine was involved in 7 out of 10 accidental or undetermined opioid-related fatal overdoses in 2024.



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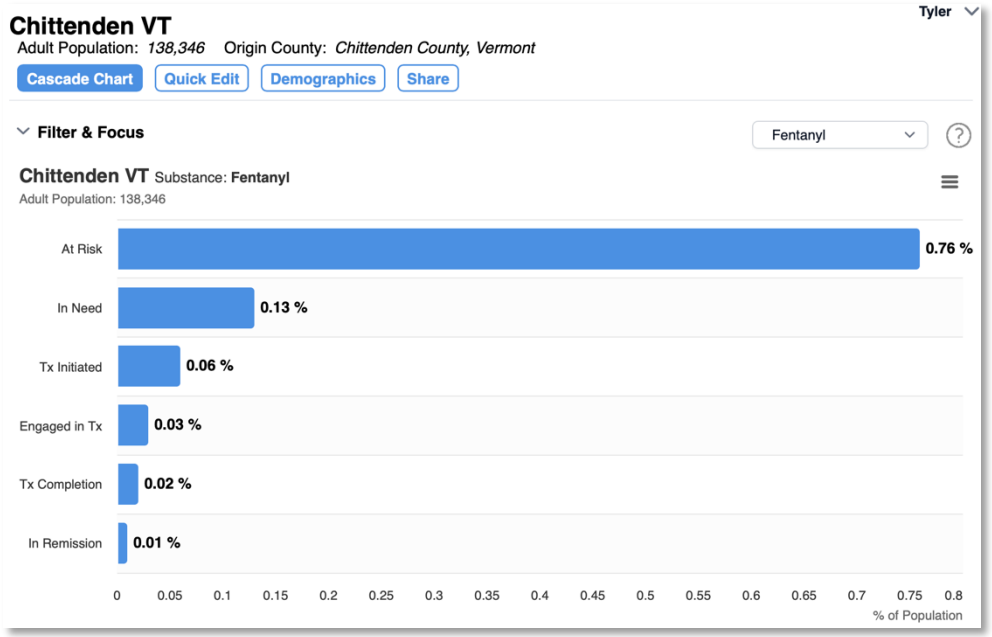
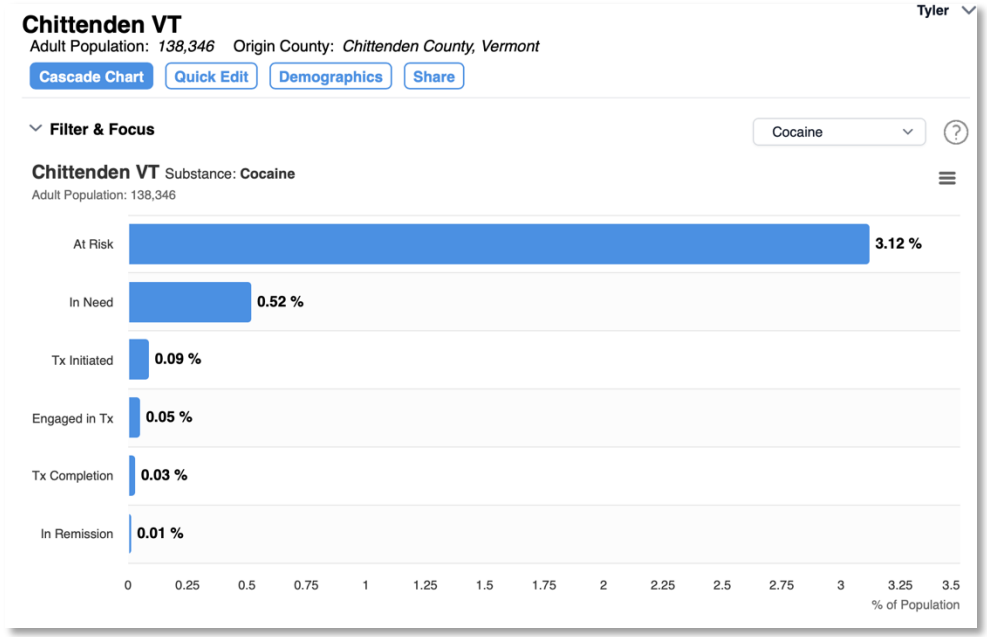
Cocaine involvement in opioid-related fatal overdoses

Cascade of Care Data





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CM as a Public Health Intervention

- Developing high-quality, scalable programs
- Increasing awareness of treatment availability
- Maximizing reach (e.g., those not currently in treatment)
- Development and integration into everyday service delivery
- Treatment fidelity
- Sustainment and maintenance

Interview with Josh McQueen

Bio: Josh McQueen, LCSW, LADC, CCS is the Associate Director of Spurwink Adult Behavioral Health and oversees Spurwink's Contingency Management, Opioid Health Home, and Rapid Access programs. Josh developed Spurwink's Contingency Management pilot program serving individuals struggling with stimulant use disorder, complex behavioral needs and housing insecurity. He has worked in Portland's Bayside neighborhood since 2019.

Questions?

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