CM WORKBOOK

FOR RURAL RECOVERY HOUSING

EST 2023 - 2024

DISCLAIMER

FOR DOCUMENTS

This document is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $3.3 million. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government.

FOR RESEARCH

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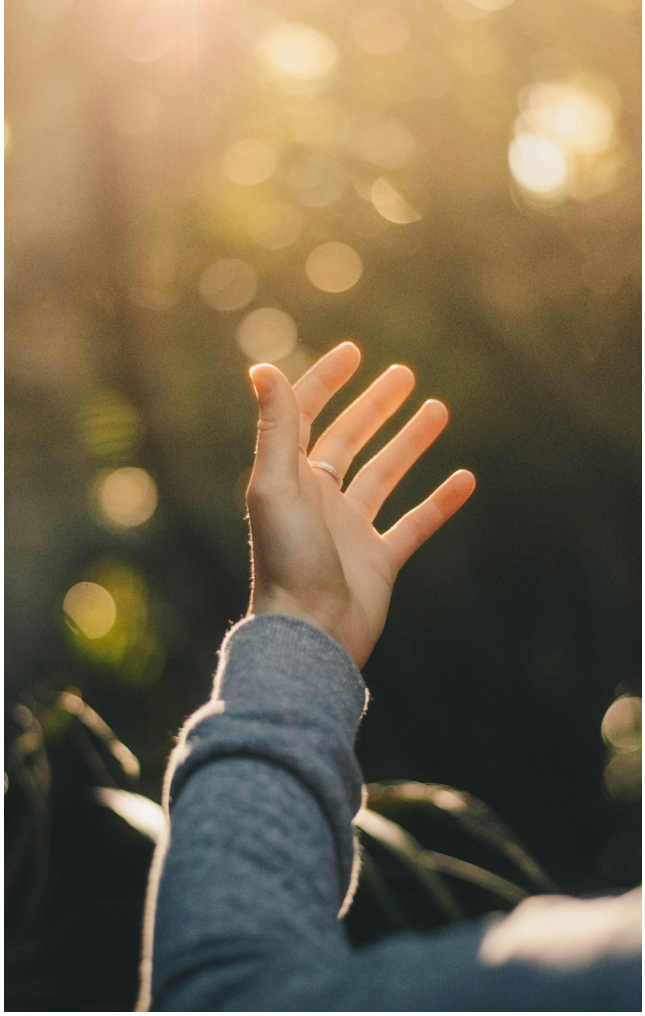
INTRODUCTION

This toolkit considers the unique setting of rural recovery housing and was informed and inspired by surveys and interviews with recovery housing (RH) staff and residents.

This project was a collaboration between the Fletcher Group and Washington State University to develop a contingency management (CM) intervention toolkit specifically tailored for implementation in the RH setting. Given the critical value of this setting and its unique attributes, we wanted to increase awareness of the CM intervention as a tool that can be used to address early exit due to return to use and increase engagement in recovery-oriented activities.

Given variations in the degree of knowledge about the contingency management intervention, staff experience, and to account for setting and cultural variations, we conducted individual interviews to assess barriers and facilitators for contingency management implementation in rural recovery housing. We used the knowledge gained from surveys and interviews to co-develop a contingency management model for rural recovery housing. This toolkit is a product of this.

This toolkit is meant to help you learn more about what a positive reinforcement approach to recovery can look like, determine if contingency management or a positive reinforcement pathway might be a good fit for your house, and begin to prepare for training and technical assistance when you are ready to start your own positive reinforcement program.



POSITIVE APPROACH TO ADDRESSING SUBSTANCE USE

POSITIVE REINFORCEMENT

Psychologists have studied positive reinforcement for nearly 70 years and understand the important ways in which it influences our behavior. Positive reinforcement occurs when a behavior (you run for an hour) is followed by a reward (you stop by your favorite coffee shop for a cup of coffee) and because of the reward, that behavior increases (you go for runs more often in the future). We know that positive reinforcement is the best way to change behavior because it doesn't have the negative side effects (e.g., shame, discomfort) that come with punishment.

POSITIVE REINFORCEMENT IN SUBSTANCE USE DISORDER (SUD) TREATMENT

Our brains have powerful pathways of learning behaviors through our natural reward systems. Substances can interrupt these systems by hijacking the brain's reward pathway, reinforcing their use by making us feel good and removing negative feelings, and resulting in the loss of other rewarding aspects of our life. The good news is that research has shown that positive reinforcement, which is the most effective way to learn new behavior, can bring this pathway back into balance.

CONTINGENCY MANAGEMENT AND POSITIVE-REINFORCEMENT PATHWAYS

Contingency management

The evidence-based approach contingency management (CM) uses positive reinforcement by offering non-drug rewards, like gift cards or prizes, to help people with addiction to develop skills and retrain their pathways to be substance free. This behavior change is measured objectively, usually with urine tests, and frequently enough that return to use can be detected. These urine tests provide people frequent opportunities to demonstrate that they are substance-free and earn rewards. If a person returns to use, they do not receive rewards, but are given encouragement by being reminded that their next opportunity to earn rewards is coming soon. CM is one of the most powerful ways to help people change their substance use and is associated with helping people reduce their substance use for up to one year after treatment. This approach can be added to existing recovery programs or used on its own.

Research evidence

Over 100 studies over 20+ years with people with a substance use disorder demonstrate that CM is the most effective approach for stimulant and other drug use disorders, including methamphetamine, amphetamine, and cocaine use disorders. It also works well for treating cigarette smoking, alcohol use disorders, and prescription drug misuse. Given the lack of other treatment options for stimulant drugs, such as methamphetamine and cocaine (there is no FDA approved medication for stimulant use disorders), CM is an important clinical tool in the treatment of stimulant use disorders. Federal and professional agencies, like the Surgeon General, the Substance Use and Mental Health Services Administration (SAMHSA), National Institute of Health (NIH) and the National Certification Commission of Addiction Professionals (NCCAP) and more, support the use of CM. There is more evidence to support the effectiveness of CM for stimulant use disorders than any other treatment and this evidence has been gathered over 20 years.

Clinician and client evidence

In conducted surveys, clients report appreciating the positive environment in CM and providers viewed CM positively because their clients' treatment attendance increased. Clients said that incentives enhanced their motivation to remain substance-free and provided accountability to do so. People tell us that they like receiving prizes or gift cards, but more often they emphasize that they really liked their CM clinicians and how CM helped them change their lives. Specifically, they tell us that they like how positive their CM providers are, that CM holds them accountable in a positive way and that CM clinicians are respectful to them. One of our CM studies was called the HONOR project, in part because as CM clinicians we are honoring people when they progress in their recovery goals (working to be substance free). Clinicians also like CM, with 77% of clinicians saying they would use it if given the opportunity to do so.

Common factors for success

Having the right training, funding, work force and leadership are key readiness factors. Contingency management can feel like an intensive process and involves regular drug screening, twice weekly visits, monetary and other tangible rewards, and often a culture change towards positive accountability without punishment. However, it is possible to incorporate components of CM and plant seeds for growth and opportunity.

Positive-reinforcement pathway

Not every recovery house or recovery program is ready to adopt contingency management, but that doesn't mean that houses can't start using positive reinforcement today! This workbook includes introductory guides to both contingency management and a Positive-reinforcement pathway. The Positive-reinforcement pathway is a more general approach that allows you to integrate the principles of contingency management into a program that is adapted to your house's current needs and capacity. While positive reinforcement is an evidence-based way to help people make new habits, this pathway does not have the same body of research support as CM.

KNOWLEDGE CHECK

Q: Contingency Management can be defined as:

a. A one-time incentive for a one-time behavior, like getting a gift card in exchange for Hepatitis C screening

b. An evidence-based behavioral therapy that uses positive reinforcement to encourage change

c. A system that can be set up at substance use disorder treatment facilities, which involves positive reinforcement and punishment, depending on the person's behavior

d. Providing people with services, resources, or help

Correct answer: **b**

POSITIVE REINFORCEMENT, RECOVERY HOUSING, AND THE SOCIAL MODEL OF RECOVERY

CM was originally developed for outpatient treatment settings like specialized addiction treatment clinics or primary care clinics where addiction treatments are already being provided. As a result, there might be some differences between your house and the clinics CM is often used in. Research does show that it can be effective in a housing setting (Petry housing study), but there are some things to consider if you want to implement CM in your house. In the next section, we share some details about necessary parts of evidence-based CM. If your house is not able to meet some of those requirements (e.g. limited staff time will affect the frequency of rewards, not enough funds, required consequences for a positive drug test such as moving out) a different approach might be a better fit. This workbook will provide tools to help you with these considerations. If CM might not be the best fit, this workbook contains examples of how a Positive-reinforcement pathway can still bring CM principles into your house. Additionally, if you have a relationship with a local treatment provider you may have the option of referring to a provider that is already offering CM or advocating the adoption of CM by local treatment providers.

WHAT POSITIVE REINFORCEMENT FOR SUBSTANCE USE DISORDERS IS AND ISN'T

Positive Reinforcement is NOT...	Positive Reinforcement is...
A candy bowl on your desk.	Purposeful; done with skill based on set of key principles.
A one-time incentive for a one-time behavior.	An ongoing approach to reward people for meeting their recovery goals.
Providing people with basic needs, services, resources, help, or charity.	An intervention that leverages positive reinforcement in a particular way.
"Rewarding people to do what they are already supposed to be doing"	An intervention that: • Builds confidence • Enhances morale for participants and staff • Improves therapeutic relationships • Creates opportunities to celebrate • Can help people reduce stimulant use or meet other recovery goals • Acknowledges people who are achieving something unique and challenging

COMMON QUESTIONS AND CRITIQUES ABOUT POSITIVE REINFORCEMENT TREATMENT FOR SUBSTANCE USE DISORDERS

Here are some common questions and critiques people have for us about CM and positive reinforcement when they are first introduced to the concept.

People get rewards for doing what they are supposed to in the first place?

All goals are relative to a person's experience, ability, preference, resource, and level of support. Indeed, some people can do it on their own or with the help of mutual aid groups, their faith, family, or other treatments. But some people need a little nudge to get started on the pathway to recovery. Regardless of how people do it, changing substance use is hard work. Positive reinforcement is a tool to help celebrate change and build momentum to engage in the difficult work of behavior change. And it works!

Wait, what happens if someone returns to use, do they still get rewards?

CM doesn't use punishment, it emphasizes accountability. A person who submits a urine sample that is positive for drugs would not earn a reward. However, they would be eligible to earn a reward the next time they submit a drug-negative urine sample. In CM the individual is encouraged to keep trying and is offered many opportunities to succeed.

You pay people to stop using substances?

Many people ask this question when we first introduce the idea of CM. While many people stop using substances on their own, drugs and alcohol can highjack the natural reward pathway in our brain. CM helps bring the reward pathway back into balance by offering people non-substance rewards in exchange for working to stay drug-free. This is especially important when people are just starting treatment or are new to recovery. CM provides small incentives to help encourage people to stay substance-free instead of using substances. It may be surprising to learn that a reward as small as $2 is likely to increase motivation to resist urges to use substances. People don't stop using drugs long term because you pay them. People who are supported to do the hard work of changing drug use behavior do so because they want better lives.

There are enough rewards in being in recovery and being healthy; incentives are not necessary.

Incentives are commonly used in society to promote social behaviors and change (bonuses, discounts, promotions, scholarships). Not everyone has an opportunity to be rewarded and some people turn to drugs or alcohol to experience the same feeling a reward can provide. This means drugs and alcohol can really put our brain's reward pathway out of balance. In fact, they can make it difficult for people to respond to naturally occurring rewards (healthy relationships, meaningful work). Many people can't see a path from where they are to obtain their goals (e.g., getting custody of their children, getting a job). CM provides a powerful immediate positive reinforcement for people who are new to recovery. This helps them walk the first steps in recovery and begin to re-balance their reward pathway so they can see a path to their long-term goals.

Rewards don't address the underlying reasons for unhealthy behaviors.

CM directly addresses the primary reason people use drugs by bringing the reward pathway into balance. While many people begin to use drugs due to trauma or because of depression, helping people to cut down or stop using is the most effective first step in recovery. In fact, many of the most effective treatments in mental health don't address the causes of a person's problem, instead they treat the symptoms. CM can be combined with other treatments or resources that can help people learn new skills to prevent substance use and explore and understand the biopsychosocial aspects of substance use.

People might be offended if you try to bribe them to stay drug-free or engage in recovery activities.

"Bribery" is a legal term and refers to illegal and unethical exchanges of goods and services to influence another person. We don't say that employers bribe employees with a paycheck. We understand that pay is an agreed upon term to help reinforce employees for expected work. Examples of using positive reinforcement to influence behavior are everywhere:

- I increase my behavior of fixing a meal when my family raves about how yummy it is.
- You might be more likely to wear an article of clothing that others compliment.
- Employees are more likely to volunteer to clean the meeting room if lunch is offered after cleaning up.

Can CM or a Positive-reinforcement pathway be added onto existing treatment?

Definitely! CM was created to support traditional intensive outpatient addiction treatment and to treat co-occurring stimulant drug use in people receiving methadone. Because CM visits typically occur twice a week, CM or a Positive-reinforcement pathway are ideal to add to treatment and pathways that require multiple visits per week.

Positive reinforcement isn't going to prepare recovery community members for the real world, recovery community members need to learn to be self-motivated and positive reinforcement makes the motivation external.

Positive reinforcement is a way to celebrate change and helps people get that reward pathway in balance so that naturally occurring external (family, relationships) and internal (pride, self-confidence) rewards are motivating. People who participate in positive reinforcement programs like CM do have motivation to change, those programs support and encourage that motivation to do the hard work of recovery. Other interventions can be combined with CM or a Positive-reinforcement pathway that teach new skills in managing urges and building recovery capital. CM and Positive-reinforcement pathways are bridges that help people get in touch with the internal reasons to pursue recovery, which they can bring with them outside of recovery housing.

Recovery community members might sell or exchange rewards they receive for cash, and then use the money to engage in substance use, or they might use gift cards to buy alcohol or cigarettes.

It's possible that some people use rewards in ways we wouldn't want them to. However, our experience is that most people use rewards for items consistent with their values. Furthermore, by promoting autonomy in recovery community members, we can improve our rapport and encourage further positive change. And remember anyone who uses drugs won't receive a reward when their urine test is positive for use. If you are worried about gift cards being used to buy nicotine or alcohol, you can work with your vendor to limit what can be purchased with the cards.

Can CM or a Positive-reinforcement pathway be delivered without other treatments?

While it is ideal that positive reinforcement is added to ongoing treatment or pathways, we have also found that CM is associated with large reductions in drug use in people who are not involved in other addiction treatments. In fact, many people report that while they aren't interested in treatment they are interested in CM. Therefore, CM and Positive-reinforcement pathways are important tools for engaging people in care. Once engaged in CM or a Positive-reinforcement pathway, it could be that people might be interested in other addiction treatments or pathways.

KNOWLEDGE CHECK

Q1: Alex's home has started a system where every week residents can earn phone cards if they keep their rooms clean without being reminded. Because of this system, Alex's housemates have kept their rooms clean for the past several months.

What kind of reinforcement is this?

Correct answer: **Positive reinforcement.**

The target behavior (keeping your room clean) had a desirable consequence (phone cards) and that behavior increased (Alex's housemates kept their rooms cleaner).

Q2: Why might Contingency Management be a good option for people who use drugs?

a. It's an "evidence-based intervention," meaning that research has shown it works to help people reduce drug use
b. It can be easily added on top of other services provided
c. It offers an alternative to activate brain pathways that are typically activated by substance use
d. All of the above

Correct answer: **d**

RURAL RECOVERY HOUSING SURVEY TAKE-AWAYS

In a survey of recovery housing directors, staff, and residents, members of the recovery house ecosystem felt positively towards contingency management and were optimistic about addressing barriers and challenges in starting a CM program in recovery housing and in a rural community.

People who completed the survey agreed with positive statements about CM (82%), such as **"Incentives can be pouseful in building healthy behaviors (e.g. physical exercise, healthy eating)", "I would be in favor of incentives to build healthy behaviors for residents"**, and **"Overall, I would be in favor of resident incentive programs."**

Most people who completed the survey also agreed with the statement **"Recovery housing is a good place to implement CM"** (85%) and pointed to the ways that CM can build on the existing supportive environment within recovery housing to build positive relationships between self and others and to develop the skills of motivation and confidence as they grow in recovery.

People who completed the survey also agreed with the statement **"Incentives would work in rural communities"** (81%) and in general, did not feel that a rural community would be substantially different than other communities in terms of incentives working or not working. One area of difference that several responses noted was that rural communities tend to be under-resourced, specifically with finances, transportation, and substance use disorder treatment and care options. They saw CM as a way to address these barriers to care.

When asked if there were too many challenges to implement CM in recovery housing, respondents generally agreed that while there would be challenges, they could be overcome. **Most people who identified challenges believed that:**

- Funding and staffing would be the main challenges, as well as
- Concerns about stigma, staff, and resident's willingness to implement a CM program and
- Interpersonal issues like favoritism

Respondents also felt that while there would be barriers to implementing CM in rural communities, those barriers could be overcome.

In addition to the shared challenges of funding, staffing, and stigma within the house, respondents also recognized stigma from the community itself. This stigma may be very important to address in rural communities, as the community the recovery house is part of can be an important resource in addressing other barriers.

EXPERT RECOMMENDATIONS

The table below was constructed from a round-table discussion between CM and rural recovery housing experts on the barriers and facilitators to a robust positive reinforcement program in recovery housing. The group developed recommendations to address potential barriers at the house, community, organizational, and recovery ecosystem levels.

Barrier	Description	Solution
Engage local, program and system leadership for collaboration and alignment		
Stigma and trust	Recovery housing faces social stigma and have to work hard to build trust for community collaboration CM can be viewed negatively by some people who do not believe in "rewards" for people in recovery	Education and messaging in the community on the value of CM to address stigma Consider use of rewards that support health related social needs Remind people that CM is for recovery goals that are harder to reach
Values, belief, and attitudes	Some people in the recovery house ecosystem may have a specific treatment philosophy and may be resistant to a new program	Work to offer a menu of options recovery community members can choose from
Funding and payment	Recovery housing faces social stigma and have to work hard to build trust for community collaboration CM can be viewed negatively by some people who do not believe in "rewards" for people in recovery	Utilize grant funding for a demonstration to track compliance and obtain Medicaid waiver Use private funding Provide incentives for recovery related activities
Agree on a model and build a project charter		
Person centered and evidence based	These concepts may be newer to core decision makers in the recovery house ecosystem	Training on positive reinforcement and its alignment to person centered care
Time and financial constraints	Recovery houses operate under limited budgets and staff/residents have limited time	Consider flexibility of the programming while maintaining foundational behavioral principles Keep evaluation instruments brief

Barrier	Description	Solution
Secure funding to support training, implementation, payment, and sustainability		
Payment for training and implementation	There is an absence of funding for training and implementation support	Seek federally funded technical assistance from a Rural Center of Excellence
Payment for services	CM is an intervention delivered by trained personnel and sometimes credentials are required for reimbursement	Train RRH staff to deliver CM under the supervision of clinicians Work with grants and Medicaid waiver to support reimbursement
Payment for rewards	There are limited fund sources to pay for rewards There are limits on rewards amount	Engage state agencies to explore use of grant and other state funds Use private funding
Ensure system support for data, measurement, and oversight		
Technology access	Recovery houses may have limited access to devices and reliable internet. These resources are often needed to support tracking and oversight	Provide needed devices Prepare digital evaluation alternatives

IS CM OR A POSITIVE-REINFORCEMENT PATHWAY A FIT FOR OUR HOUSE?

There are two paths outlined in the toolkit, one path that involves use of the positive-reinforcement pathway. If you want to start small and begin to experience the value of using positive reinforcement, we guide you into using this approach. We recommend you start here if you are not ready to adhere to all the requirements, have limited staffing, or have limited funding. However, if you or partners, community, or state find that you are ready to proceed with a formal program, we offer the structure and considerations for this model. Remember, there is technical assistance available if you are rural recovery home and want to work with your Fletcher Group outreach and engagement specialist to support you.

To consider whether CM or a Positive-reinforcement pathway might be a good fit at your house, think about the three bold questions below. Other questions are included to help frame these big-picture questions.

- ☐ **Is your home open to positive reinforcement?**
  - Have you started a positive-reinforcement pathway in your house already?
  - Do you feel like house staff and residents appreciate the program?
  - Are rewards and targets consistent among residents over time?
- ☐ **Does your house have the capacity to do regular urine drug testing, up to 2x/week?**
  - Do you already do urine drug testing?
  - Do your staff have the capacity to add this to their tasks?
- ☐ **Are staff and residents open to reinforcing negative drug tests without undesirable consequences for a positive drug test (e.g. strikes, being asked to leave, punishments, etc.)?**
  - Are staff or residents aware of CM as a concept?
  - How open are staff or residents to removing negative consequences for a positive drug tests?
  - How open are staff or residents to the concept of CM?

If you checked less than two boxes OR want to start with a Positive-reinforcement pathway:

If your house may be new to the idea of positive reinforcement or has a Positive-reinforcement pathway that you are looking to improve, you are encouraged to read the Positive-reinforcement pathway section. This section will help you consider how your house can use the powerful psychology of positive reinforcement to support residents and recovery community members in meeting their recovery goals, staying engaged in the community, and healing their brain's reward pathway. If you want to learn more about how you can prepare your house to start a CM program, you are encouraged to read the Evidenced-based contingency management section and reach out to Fletcher's technical assistance to learn about resources your house can access for a CM program.

If you checked at least two boxes:

If your house is either familiar with the idea of positive reinforcement for recovery-oriented behaviors or has already implemented a successful positive-reinforcement pathway, has the capacity to drug test CM clients twice a week, and is ready to reward residents for negative drug tests, you are encouraged to read the Evidence-based contingency management section to learn what a CM program involves and what steps your house can take to start a CM program.

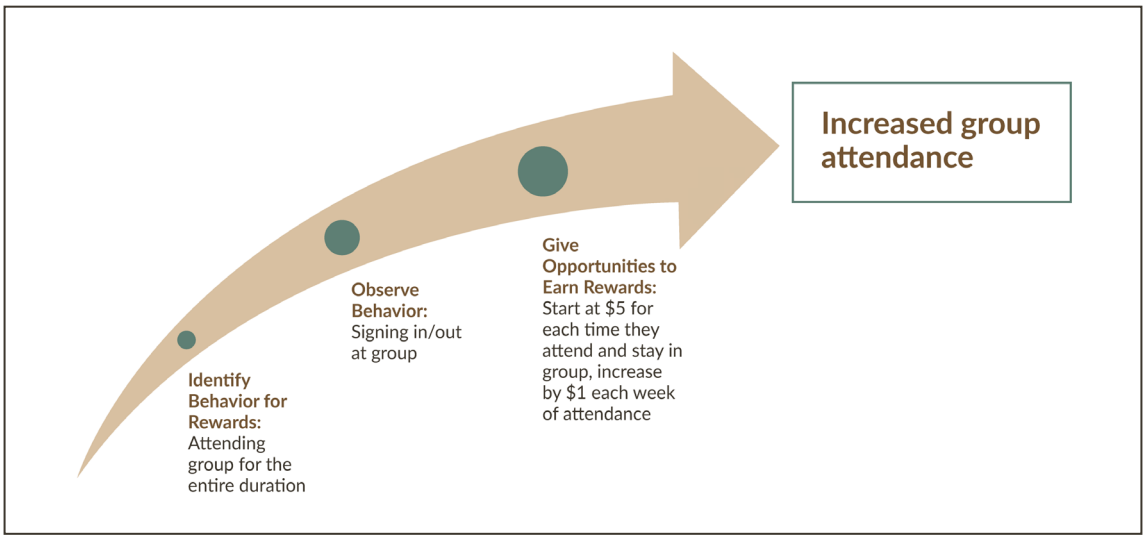
POSITIVE REINFORCEMENT PATHWAY

POSITIVE-REINFORCEMENT PATHWAY OVERVIEW

The Positive-reinforcement pathway is a tool for a recovery toolkit that is based on CM and the psychological principles of positive reinforcement and conditioning. Positive reinforcement uses a desirable outcome (e.g. tokens, favorite food, being told "good job") to condition a person to repeat a behavior more often (e.g. attend group, volunteer to cook, keep their room clean). In other words, a behavior recognized in a positive way is more likely to be repeated. This reward system is a powerful tool our brains use to teach us new skills, but it can be disrupted by substances like drugs and alcohol. People who are in early recovery are doing the hard work of healing their brain's reward system, and a Positive-reinforcement pathway may support this healing.

The Positive-reinforcement pathway uses highly motivating rewards, like gift cards or prizes, to help people meet their recovery goals. Progress in treatment goals is measured objectively, consistently, and frequently enough that the recovery community member and their recovery worker can ensure they are making progress. Desirable, tangible rewards are given immediately when people demonstrate goal mastery and escalate the longer they progress. If a person does not meet their goal, they do not receive rewards, but will earn rewards the next time they show that they have met their goal.

Below is an example of a Positive-reinforcement pathway for a recovery community member who set a goal of staying in group for the duration of each meeting and not leaving in the middle of the meeting:



KEY ASPECTS OF POSITIVE-REINFORCEMENT PATHWAYS

There are key elements that are important to consider when implementing a positive-reinforcement pathway. These include the 1) target behavior, 2) the measuring of the behavior and 3) the reward (reinforcer), and 4) an escalating schedule of rewards.

Key Elements	Aspects	Examples
Target behavior	Objective, observable, measurable, clear, specific, and achievable	• Attending group for the entire duration • Volunteering with a local charity • Completing homework
Measuring behavior	Frequent and feasible	• Signing in/out at group twice a week • Volunteer time sheets turned in to staff weekly • Turning in completed homework twice a week
Reward	Contingent, tangible, desirable, immediate, and closely tracked	• $5 gift card • Prize-draw chips for small, medium, large, or jumbo reward • Extra phone minutes
Escalation	Consistent, contingent and rewarding	• $1 bonus each continuous week • Bonus prize draw chance every 2 check-ins • 2 bonus minutes each continuous week

Recovery behavior

The behavior you are reinforcing should be Objective, Observable, Measurable, Clear, and Achievable.

Objective, Observable, and Measurable by staff

The target recovery behavior needs to be something objective that can be measured. A recovery goal such as "be a better community member" could be subjective and would be difficult to measure on a regular basis, but working towards that goal with an objective behavior like volunteering once a week that can be measured regularly with something like a sign-in sheet would be an appropriate behavior. Here are a list of some behaviors that members of your recovery house might be interested in reinforcing:

- Attending 12 step groups
- Attending substance use disorder treatment
- Going on a family outing
- Job applications
- Educational opportunities
- Volunteering
- Attending mental health treatment
- Physical fitness activities (e.g., gym, exercise)
- Health related activities such as dentist or doctor appointments
- Eating healthy food on agreed upon list
- Working on outstanding legal issues like tickets
- Meeting with recovery coaches
- Creative projects (e.g., building)
- Helping others (e.g., raking leaves, cutting grass)
- Self-care activities

Clear and Unambiguous for the recovery community member and staff

It should be communicated at the beginning of the positive-reinforcement pathway how the target behavior will be measured, so there is no opportunity for disagreement or confusion.

Achievable for the person

The goal should be something that is attainable for people who are new to recovery. Sticking with a goal for several weeks before receiving reinforcement can be very challenging and doesn't allow the reward to reinforce the behavior. Instead, measuring the goal 1-2 times a week gives the person more chances to practice their recovery goal, receive reinforcement, and build confidence in their ability to meet their goal.

The target should also be specific. Trying to meet multiple goals at once to receive rewards is less easily achievable, and research shows that rewarding multiple goals has lower success rates than one goal at a time. Once a person has completed their Positive-reinforcement pathway for one goal, they can pick a new goal to reinforce.

Monitoring of the behavior should be Frequent and Feasible.

Frequent

Positive reinforcement works best when rewards are delivered regularly (at least once a week). Monitoring should also occur often enough that not meeting goals can be detected.

Feasible

Positive reinforcement must be administered consistently over time. We recommend 12 weeks to support someone in consistently meeting their goals. You can vary the duration of the program, but we recommend 8-16 weeks.

KNOWLEDGE CHECK

Q: Which of the following is important to consider when choosing a behavior to reward with contingency management?

a. Choosing smaller increments of change (example: meeting with a recovery coach every few days), to ensure the behavior is achievable
b. A good behavior goal is 1 month of meeting goals before a recovery community member can receive their first recovery incentive
c. It doesn't matter when a recovery community member earns a recovery incentive, as long as they get one someday, they will be encouraged to meet their goals

Correct answer: **a**

Rewards

Rewards should be Contingent, Concrete, Desirable, Immediate, and Closely Tracked.

Contingent - Rewards are only provided when the agreed upon behavior occurs. For example, if you are reinforcing signing in/out at group to increase attendance to the entirety of group, a person would only receive gift cards when they sign out at the end of group.

Concrete - Rewards should be concrete, such as prizes, gift cards, or specific privileges. While other approaches like community reinforcement approach do emphasize more abstract social rewards, like praise, in a positive-reinforcement pathway rewards should be tangible things.

Desirable - Rewards should be desirable and something that recovery community members want, while still promoting recovery and health. Thought should be given to what types of reward you choose. If your rewards are not appealing enough, your positive-reinforcement pathway may be less effective. There is a balance between tailoring them to the individual or group (e.g., young adults) versus ease of implementation (i.e., using the same rewards with everyone). **This is why we strongly recommend using gift cards**. Throughout our work in rural and urban communities, gift cards to grocery stores are highly desirable, as are gift cards to online retailers. Rewards must also be large enough in magnitude that they are desirable to individuals. For instance, $1, or gift cards to stores that aren't accessible might not be rewarding enough to change behavior. If your community identifies other rewards they would like to receive, like specific privileges or activities, those may be a good cost-saving option that is still desirable.

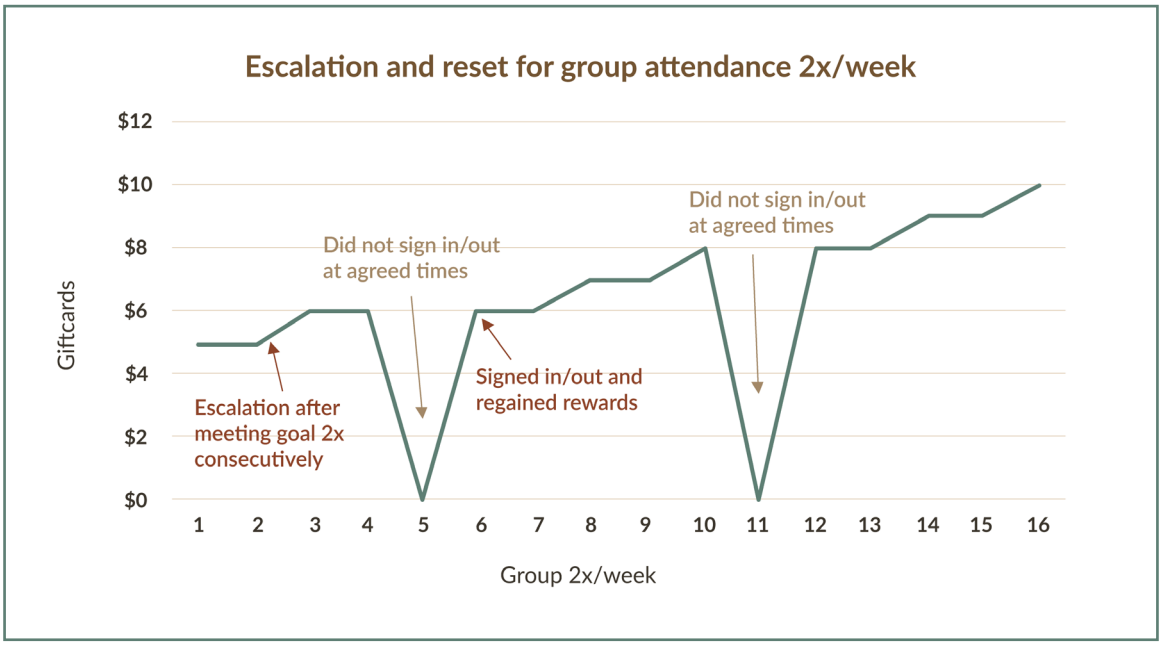
Immediate - Delivered as soon as possible after the behavior has been achieved and verified

Escalating - Rewards increase over time when the behavior is consistently achieved. This is explained in more detail below.

Closely Tracked - It is critical to monitor the rewards your program uses to assure consistency and positive outcomes.

Escalation of Rewards

In positive-reinforcement pathways, rewards escalate in magnitude (they get bigger) the longer a person meets their goal. We want people to be invested in meeting their goals and we want them to learn that the longer they meet their goals the more they have to gain. To help this learning, positive-reinforcement pathways use an escalating schedule of reward. This means that in addition to earning their base rewards (e.g. $10) the recovery community member would earn escalation bonuses (e.g. $2) for every week they continuously meet their goal. If a person does not meet their goal, they do not receive rewards for that visit, but they have the chance to demonstrate their goal and earn rewards again. The escalation makes the rewards even more desirable and further encourages recovery community members to stay engaged.



Types of Rewards: Voucher and Prize Draw

There are two main types of monetary reward systems in positive-reinforcement pathways: voucher and prize-draw rewards. These two approaches are equally effective.

Voucher Rewards

In Voucher-Based Reinforcement Therapy, or Voucher Rewards, a person earns a pre-established voucher amount each time they meet their goal. Vouchers with a monetary value can be exchanged for goods or services consistent with lifestyle changes and goals and are not as potentially triggering as cash. The value of vouchers is established at the beginning of the program, so each person knows exactly what value of reward they will get each time they meet their goal. Here are some examples of voucher rewards:

» Gift cards to desirable retailers. Ask recovery community members where they would like gift cards from. Local retailers, grocery stores, gym memberships, and online stores are popular choices.

» E-gift cards. E-gift card apps like Tango allow people more freedom of choice in redeeming their gift cards for goods and services, and e-gift cards can often be used online and in person.

» Voucher Donations. Local stores may be willing to donate vouchers or gift cards for your CM program.

» House "store". If you have the storage space, you may want to purchase requested items and let people use vouchers earned to shop your house store. Put out a suggestion box for people to request items.

» Privileges. If there are specific privileges, like phone time, trips, family visits, or house events that are desirable, recovery community members may be interested in earning vouchers to trade in for privileges.

> Here is an example of a voucher program in action:
>
> *A person in a positive-reinforcement pathway has a goal of attending group twice a week for eight weeks. They earn $10 each time they attend group, and that value escalates by $2 every week that they attend group twice a week. That means they can earn up to $294 for meeting their goal, and they can use those rewards for things like clothes that fit their new substance-free lifestyle, birthday presents for their children, taking a friend out to eat at a restaurant, or other things that they find rewarding.*
>
> *The main difference between voucher rewards and prize rewards (described below) is that the recovery community member and staff always know the amount of a reward a person will earn for each goal attained or negative urine screen. Therefore, voucher rewards are easier to track, relative to prize rewards.*

Prize-Draw Rewards

In prize-draw rewards people are offered a certain number of prize draws (e.g. 5 draws) of tokens with variable values for each goal attained or negative urine screen they submit. For example, tokens might say 'good job,' 'small prize,' 'large prize,' or 'jumbo prize.' A breakdown of a reward ratio using 500 chips might be 125 "Good Job" chips (no reward), 315 "Small" chips ($1 reward), 59 "Large" chips ($20-30 reward), and one "Jumbo" chip ($80-100 reward).

In prize-draw rewards the staff and recovery community member don't know exactly how many prizes someone will earn when they meet the target behavior. Just like in voucher rewards, prize prize-draw rewards uses escalation. However, it is the number of prize draws that increases. The prize draw algorithm used can be complicated and challenging to track.

KNOWLEDGE CHECK

Q1: In positive reinforcement pathways, we know the most effective rewwards are:

a. Abstract rewards, for example praise
b. Whatever the clinician thinks is the best reward for a given behavior
c. Desirable, immediate, and escalating
d. "Surprised rewards," or rewards given when the person is least expecting it

Correct answer: **c**

Q2: A reward delivered immediately after a behavior occurs would:

a. Increase the probability that the behavior will occur again
b. Decrease the probability that the behavior will occur again
c. Not change the probability that the behavior will occur again
d. Either increase or decrease the probability that a behavior will occur again, depending on whether the behavior is a positive or negative one

Correct answer: **a**

Putting the pieces together

Now that you are familiar with the important aspects of a positive-reinforcement pathway, here are some examples of each aspect in action. Remember, the main takeaway is that the more you recognize a behavior you want to see, the more you will see that behavior. And because our focus is to encourage goal setting, it is important to sit down with people and talk to them about what they feel is important to work on. Buy-in is a key factor to change.

Choose a Goal to Reinforce

You want to reinforce something recovery house staff and residents can clearly recognize as positive. Something like, "be less negative" is not able to be measured objectively, but "write in my gratitude journal every day" can be. If someone is struggling to attend meetings, rewarding signing it at meetings or groups might be a good target. The behavior should also be achievable for the person in the program. Rewarding going to the gym if the person doesn't have reliable transportation to the gym is not going to be very effective. Remember to make sure that the behavior is objectively measurable and not subjective, that both staff and the person in the program have clarity about what is being rewarded and agree on rewarding that behavior, that it is achievable for the person in the program, and feasible to measure frequently.

Monitoring and Reward Schedule

Immediacy of reward is important for our brains to learn that a behavior is rewarding, and frequency gives more opportunities for someone to be rewarded for their behavior goal. We would still recommend measuring behaviors and giving rewards 1-2 times a week if possible. When speaking to a person who is interested in a positive reinforcement pathway, you might also want to ask about what kind of rewards would make this a powerful experience. Physical gift-cards, e-gift cards, and physical prizes are all common rewards, but residents might be interested in earning privileges like more family visits or fun community events like house cooking classes.

Duration of Intervention

We would recommend a minimum of 8 weeks of rewards for a behavior. If at the end of the reward period the person decides that they are benefitting from the positive reinforcement pathway, you could work together to pick a new target behavior to reward.

KNOWLEDGE CHECK

Q: A regular attendee of a meeting Dana is facilitating often leaves the meeting halfway through and stays outside until the meeting is over. Dana has started giving this person a candy bar if they stay until the end of the meeting. Dana hasn't promised this person that they would earn a reward for staying because they might feel that they are entitled to a reward, and it is unclear whether this person likes candy bars.

Is this a positive-reinforcement pathway?

Correct answer: **No.**

(Dana and the meeting attendee did not agree to a clearly defined objective target behavior with a regular schedule for observation and reward. In positive reinforcement pathways, people earn escalating, desirable rewards when they meet the target behavior).

PREPARATION FOR A POSITIVE-REINFORCEMENT PATHWAY

Below are some questions to check in with whether a positive reinforcement pathway might be a good fit for your house. These questions will help you think about the organizational and practical elements of identifying whether this pathway is a fit for your home and starting a program in your home. The organizational readiness questions are meant to help you get "a lay of the land". We also share expert recommendations to consider how you might address barriers. Lastly, the positive-reinforcement pathway preparation checklist will help you translate the fit considerations and recommendations into practical elements needed to start a positive-reinforcement pathway program.

Organizational readiness for a positive-reinforcement pathway

Culture and Population

Your house's culture is foundational for social connections, communal relationships, and growth of your community. Thinking about beliefs, values, and practices that are important to your house will help you run a positive reinforcement pathway that is the best fit for your house and community.

» Does your house have any distinct cultural elements, or serve specific cultural groups?

» Describe your resident/recovery community member population (age, tribal affiliation, cultural identification, sex, gender, sexual orientation, experience in the legal system, history of homelessness, etc.).

» Brainstorm how a positive reinforcement pathway could be congruent with these cultural and demographic elements.

> ***Food for thought:*** *One way to incorporate culture into positive reinforcement is to use it to inform what rewards are available as reinforcers. For instance, in our work with American Indian/Alaska Native communities, we learned that some people appreciate materials for ceremony (e.g. sweet grass) or supplies to make regalia or culturally significant art (e.g. beading kits). Are there specific items that could be used as rewards that might be culturally significant to the members of your house?*

Recruitment, Referral and Screening

The network of service providers and recovery centers is an important resource to the recovery community and to positive reinforcement. These questions are meant to help you think about how you will reach people who could benefit from your program (i.e. communication, outreach, creating a referral network, helping people find and enroll in your program).

» What strategies will your house use to identify residents/recovery community members/community members who might need or want a positive reinforcement pathway?

» Are there other supports (e.g., family, elders, community, spiritual leaders, etc.) that could act as "positive reinforcement champions" who may help encourage people to enroll or stay engaged with your positive reinforcement program?

> ***Food for thought:*** *It is a misconception that once a positive reinforcement program is established, people will knock down the doors to be a part of it. In fact, sometimes in can be challenging to spread the word about the program and encourage people to enroll. For your program to be successful, you may want to determine how you can use existing outreach avenues or create new ones specific to your program.*

Population

Every house is a different community. These questions are meant to help you think about how a positive reinforcement pathway might fit into your community.

» List which 3 recovery goals are most common among your residents/recovery community members (e.g. meeting attendance, volunteering, homework completion, applying to jobs).

» How long does someone typically stay in the house? How long does someone typically engage in other services?

» What are the 3 biggest barriers to seeking, engaging, and remaining in care for your recovery community members?

Staffing and Services

Positive reinforcement pathways require staff time 1-2 times a week for each person receiving positive reinforcement. Adding this approach to existing 1-on-1 staff and recovery community member time, like regular check-ins, is a common approach to staffing concerns.

» What services does your house/program provide (e.g., motivational interviewing, cognitive behavioral therapy, relapse prevention, 12-step facilitation, Wellbriety, mindfulness, MOUD, curriculums etc.)? Which of these services may be able to incorporate a positive reinforcement visit before/after or during the visit, or will you opt to schedule positive reinforcement visits as separate or stand alone?

> ***Food for thought:*** *Attending visits 1-2 times a week can feel like a lot of time commitment (and travel time if not offered where people live). Combining positive reinforcement visits with other appointments and activities can make it easier for people to make it to all of their visits.*

» Are there other supports (e.g., family, elders, community, spiritual leaders, etc.) that could act as "positive reinforcement champions" who may help encourage people to enroll or stay engaged with your positive reinforcement program?

> ***Food for thought:*** *Positive reinforcement pathways are a flexible intervention in that "anyone" can do it, as long as they are trained on the protocol and express a positive and encouraging attitude. That said, professional helpers can bring a variety of skills, such as motivational interviewing, to enhance the delivery of positive reinforcement.*

Motivation and Readiness

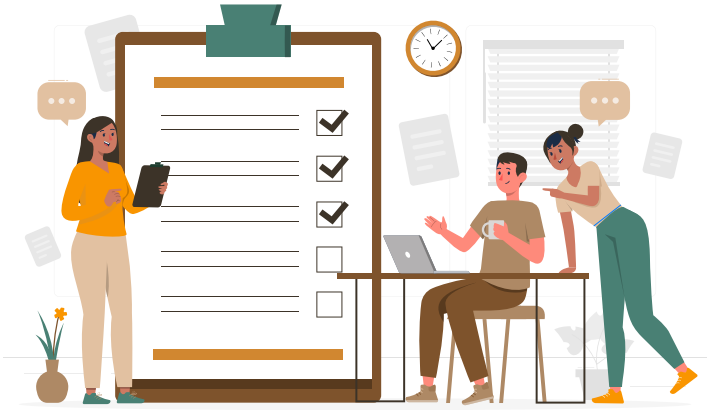
» What do you think residents or other recovery community members think about receiving rewards for meeting their recovery goals? What goals do they think are appropriate for a positive reinforcement pathway?

» Have you spoken to staff about a positive reinforcement approach? How motivated are staff to start providing a positive reinforcement pathway?

» What financial support and buy-in do you have from community partners for the use of a positive reinforcement pathway?

> ***Food for thought:*** *Many people are confused or skeptical about positive reinforcement. Sometimes it's because they don't fully understand what positive reinforcement is, including its scientific foundation and that it truly is an effective way to help people build new habits. Getting buy in from community is an important way to help your program be effective and worth the extra effort it will take.*

Positive-reinforcement pathway preparation checklist



Here is a 10-item checklist to think about the practical details of what a positive reinforcement program could look like at your house. These questions will help you and a training team figure out how to get your house ready to start doing a positive reinforcement pathway.

1. **Decide who is eligible to enroll.**
   - ☐ Residents?
   - ☐ Other recovery community members?

2. **Decide when the sessions will take place.**
   - ☐ Stand alone?
   - ☐ Tagged on to other service? (describe)

3. **Decide who will carry out a positive reinforcement pathway.**
   - ☐ Who is already seeing recovery community members once or more a week?
   - ☐ Who is excited about bringing positive reinforcement to the home?
   - ☐ Who can be trained to ensure a consistent program?

4. **Determine how you will decide on behaviors to reward and what behaviors you will reward.**
   - ☐ How do residents and staff usually make decisions about goals together?

   - ☐ What are common resident recovery goals?

5. **Discuss how targets might impact house practices and decide on an approach.**
   - ☐ If there are currently consequences for not meeting a target (e.g. not attending meetings), will your house be able to modify current practices to meet the positive reinforcement focus?

6. **Pick rewards.**
   - ☐ What do residents think will be most rewarding?

   - ☐ What is going to be the most feasible option? Which rewards would you use?
     - Physical gift cards:
       - Which cards would you stock? (e.g., $10 Walmart, $5 local gas station)

       - Who would be allowed to distribute the gift cards?

     - Electronic gift cards:
       - Do you have a way to print gift cards for those who have technology challenges?

       - Who would be allowed to distribute the e-gift cards?

     - Other (e.g., a "reward shelf" of items that people could choose from, special privileges):
       - Please describe.

       - Who will be in charge of purchasing the items/tracking rewards?

7. **Determine visit frequency.**
   - ☐ Will you schedule visits twice weekly? Once weekly? (Please consider your answer to #2 regarding if your positive reinforcement pathway will incorporate into other services and what the visit frequency is of those services. Note, you could have one visit happen with another service that happens weekly, and then have the second visit stand alone.)

8. **Plan out visit availability.**
   - ☐ Could recovery community members drop in on a designated day (e.g., Mon/Thurs) or would they need to schedule an appointment?

9. **Set an end point.**
   - ☐ How do you know when a recovery community member/patient has completed your positive reinforcement pathway program?
     - When they have completed 12 weeks.
     - When they have completed 24 visits.
     - When they are finished with their other SUD treatment services.
     - Other:
   - ☐ Decide on restart rules.
     - Will people be able to restart the positive reinforcement program?
     - How will you track who has already been in the program?
     - Can people restart with a new goal?

10. **Figure out funding.**
    - ☐ Where do you receive funds from? Please note that positive reinforcement using federal funding may be subject to specific regulatory requirements which may impact your protocol.
    - ☐ Does your house receive community donations that you could use as rewards that your recovery community members could earn? Are there businesses that would be willing to donate rewards?

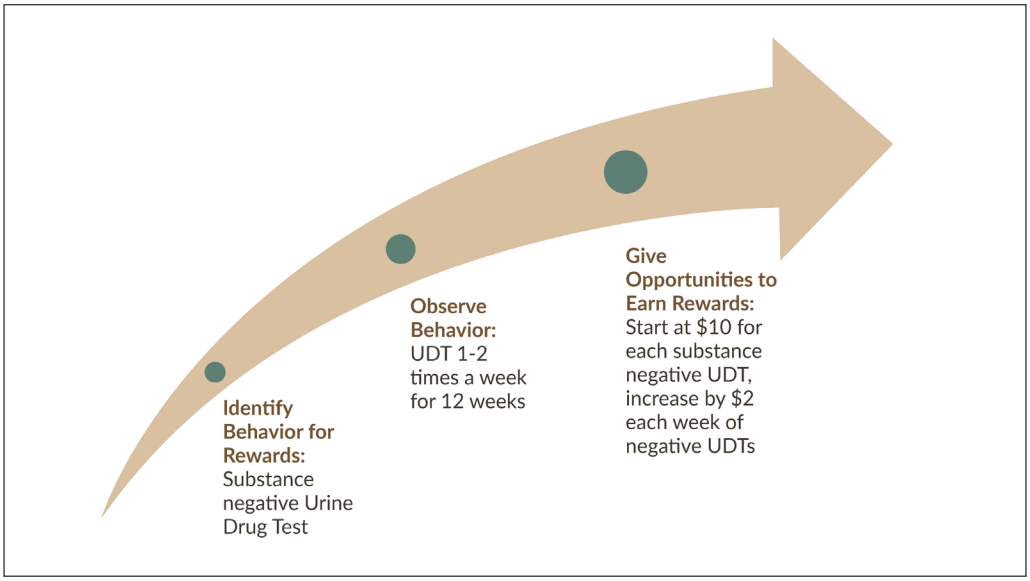
If your house has implemented a positive reinforcement pathway, or you would like to learn more about what a contingency management (CM) program looks like, the next section covers evidence-based contingency management. There are many similarities between CM and positive reinforcement pathways, but there are key differences that this section discusses.

EVIDENCE-BASED CONTINGENCY MANAGEMENT

EVIDENCE-BASED CONTINGENCY MANAGEMENT OVERVIEW

The evidence-based approach contingency management uses positive reinforcement to help people choose to not use substances by offering non-drug rewards, like gift cards or prizes. Progress in treatment goals and maintaining recovery is measured objectively, consistently, and frequently enough that return to use can be detected. Desirable, tangible rewards are given immediately when people give a negative Urine Drug Test (UDT), and escalate the longer they test negative for the substance. If a person returns to use, they do not receive rewards, but will earn rewards the next time they have a negative UDT. Contingency management has been successfully implemented by the Department of Veterans Affairs, which saw >50% of sessions attended and 92% of UDTs were negative for illicit drugs over the past ten years.

Below is an overview of a CM model for changing stimulant use. This model is evidence-based. That means it is based on models used in CM studies that are associated with clinically significant reductions in alcohol and illicit drug use. It is a method that can be implement in rural recovery house programs and may be particularly relevant when there are limited treatment resources available in the rural community.



KEY ASPECTS OF CONTINGENCY MANAGEMENT

There are key elements of CM that are important to consider when implementing a CM program. These include the 1) target behavior, 2) the monitoring of the behavior and 3) the reward (reinforcer), and 4) an escalating schedule of rewards.

Key Elements	Aspects	Examples
Target behavior	Objective, observable, measurable, clear, specific, and achievable	• Negative UDT for stimulants • Negative breathalyzer • Negative saliva test for cannabis
Measuring behavior	Frequent and feasible	• UDT 2x/ a week • Daily breathalyzer • Saliva test every 3 days
Reward	Contingent, tangible, desirable, immediate, and closely tracked	• $5 gift card • Prize-draw chips for small, medium, large, or jumbo reward • Voucher for local retailer
Escalation	Consistent, contingent and rewarding	• $1 bonus each continuous week of negative UDTs • Bonus prize draw chance every 2 negative tests • Extra voucher each negative test

Recovery behavior

The behavior you are reinforcing should be Objective, Observable, Measurable, Clear, and Achievable.

Objective, Observable, and Measurable by staff

The most commonly available objective measurement for staying substance-free is a urine drug test (UDT).

Self-report of alcohol or illicit drug abstinence is not an appropriate marker for monitoring behavior because it is not objective, observable, or measurable by both the staff and recovery community member.

Clear and Unambiguous for the recovery community member and staff

It should be communicated at the beginning of the CM program how the target behavior will be measured, so there is no opportunity for disagreement or confusion.

Achievable for the person

The goal should be something that is attainable for people who are new to recovery. If you are measuring a behavior every 2 to 3 days, most people can stay substance-freelong enough to earn their first CM reward.

The target should also be specific. Many UDTs screen for multiple drugs, but evidence-based CM only rewards negative tests for one type of drug at a time.

Monitoring of the behavior should be Frequent and Feasible.

Frequent

CM works best when rewards are delivered regularly (at least once a week). Less than that is too infrequent to combat the immediate reinforcing effects of drug use. Monitoring should also occur often enough that any return to use can be detected.

Feasible

CM must be administered consistently over time. The standard period for CM is 12 weeks and that is the duration we recommend. You can vary the duration of the program, but we recommend 8-16 weeks.

KNOWLEDGE CHECK

Q: Which of the following is important to consider when choosing a behavior to reward with contingency management?

a. Choosing smaller increments of change (example: meeting with a recovery coach every few days), to ensure the behavior is achievable
b. A good behavior goal is 1 month of meeting goals before a recovery community member can receive their first recovery incentive
c. It doesn't matter when a recovery community member earns a recovery incentive, as long as they get one someday, they will be encouraged to meet their goals

Correct answer: **a**

Rewards

Rewards should be Contingent, Tangible, Desirable, Immediate, and Closely Tracked.

Contingent - Rewards are only provided when the agreed upon behavior occurs. For stimulant abstinence, this means a UDT that is negative for stimulant drugs (cocaine, amphetamine, and methamphetamine).

Tangible - Rewards should be tangible, such as prizes or gift cards. While other approaches like community reinforcement approach do emphasize social rewards, in CM, rewards should be tangible things.

Desirable - Rewards should be desirable and something that recovery community members want, while still promoting recovery and health. Rewards must also be large enough in magnitude that they are desirable to individuals. For instance, $1, or gift cards to stores that aren't accessible might not be rewarding enough to change behavior. Throughout our work in rural and urban communities, gift cards to grocery stores are highly desirable, as are gift cards to online retailers.

Immediate - Delivered as soon as possible after the behavior has been achieved and verified.

Escalating - Rewards increase over time when the behavior is consistently achieved.

Closely Tracked - It is critical to monitor the CM rewards your program uses to assure consistency and positive outcomes.

Some clinicians are worried that gift cards could be exchanged for drugs, or they could be used to buy alcohol. While that might happen, it's important to remember that if a person uses their gift card to get drugs, they will test positive for that drug at their next CM visit and they won't receive prizes at that visit. Therefore, they will learn that this strategy really doesn't work for them if they want to earn gift cards. Importantly, many gift cards can be limited to prohibit the purchase of alcohol and tobacco. This takes a little extra work and is not always possible, but it's one way to decrease the odds that gift cards are used to purchase tobacco or alcohol.

CM Decision Point: Type of Rewards - Voucher or Prize Draw

There are two main types of reward systems in CM: voucher and prize-draw rewards. These two approaches are equally effective and cost the same.

Voucher Rewards

In Voucher-Based Reinforcement Therapy, or Voucher Rewards, a person earns a pre-established voucher amount each time they meet their goal. Vouchers with a monetary value can be exchanged for goods or services consistent with lifestyle changes and goals and are not as potentially triggering as cash. The value of vouchers is established at the beginning of the program, so each person knows exactly what value of reward they will get each time they meet their goal. Here are some examples of voucher rewards:

- *Gift cards to desirable retailers.* Ask recovery community members where they would like gift cards from. Local retailers, grocery stores, gym memberships, and online stores are popular choices.
- *E-gift cards.* E-gift card apps like Tango allow people more freedom of choice in redeeming their gift cards for goods and services, and e-gift cards can often be used online and in person.
- *Voucher Donations.* Local stores may be willing to donate vouchers or gift cards for your CM program.
- *House "store".* If you have the storage space, you may want to purchase requested items and let people use vouchers earned to shop your house store. Put out a suggestion box for people to request items.

The starting value is low, typically about $5-10, with escalating by a set amount for each week of continuous goal attainment and/or abstinence, for example $2 for each week of abstinence. You can read more about escalation below. The vouchers earned can be accumulated and should be carefully tracked. People can redeem the vouchers immediately or save them for logistical reasons (e.g., you only have gift cards in $5 amounts), though we encourage you to provide vouchers to people as often as possible.

The main difference between voucher rewards and prize rewards (described below) is that the recovery community member and staff always know the amount of a reward a person will earn for each goal attained or negative urine screen. Therefore, voucher CM is easier to track, relative to prize CM.

Prize-Draw Rewards

In prize-draw rewards people are offered a certain number of prize draws (e.g. 5 draws) of tokens with variable values for each goal attained or negative urine screen they submit. For example, tokens might say 'good job,' 'small prize,' 'large prize,' or 'jumbo prize.' A breakdown of a reward ratio using 500 chips might be 125 "Good Job" chips (no reward), 315 "Small" chips ($1 reward), 59 "Large" chips ($20-30 reward), and one "Jumbo" chip ($80-100 reward).

In prize CM the staff and recovery community member don't know exactly how many prizes someone will earn when they meet the target behavior. Just like in voucher rewards for CM, prize draw rewards for CM uses the escalation, reset and recovery. However, it is the number of prize draws that increases, resets and recovers. The prize draw algorithm used in this type of CM can be complicated and challenging to track.

Escalation, Reset, and Recovery

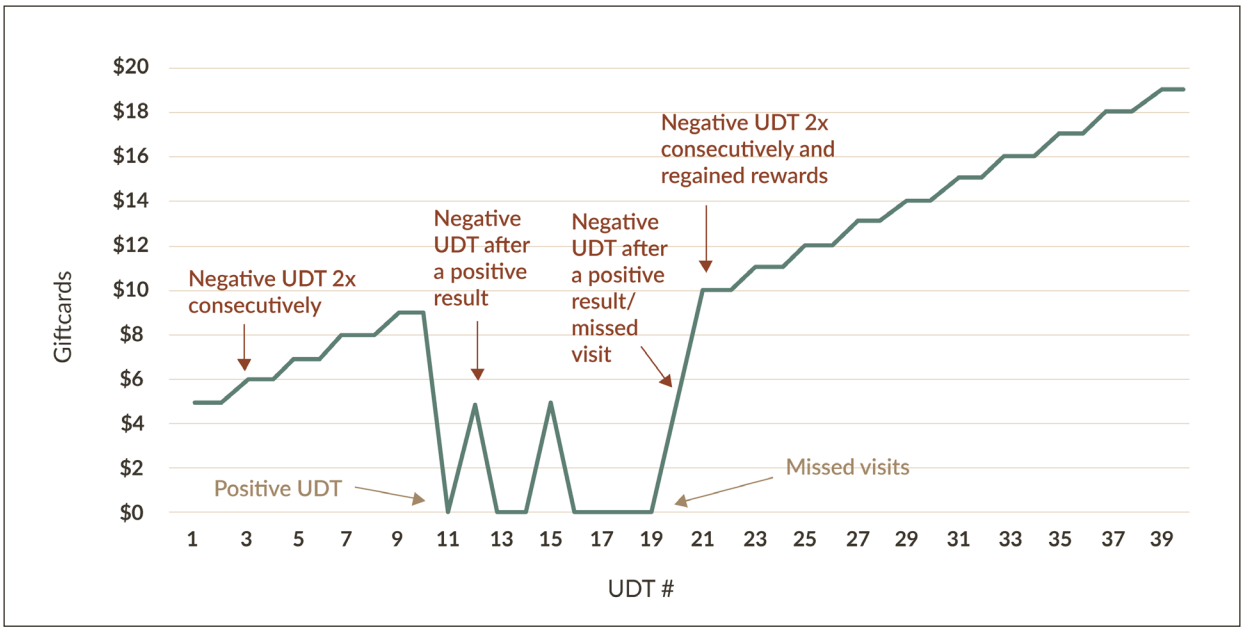
There are three important aspects of CM that help people stay motivated to stay substance-free. Understanding and correctly calculating the escalation, reset and recovery are the most challenging aspects of CM to explain and may be the most challenging aspects of CM to implement.

However, these three things are essential to an effective CM intervention and what makes CM different from other types of reward-based interventions. They are based on lots of amazing science, where researchers figured out exactly how to design a positive reinforcement intervention that maximized their time drug-free.

Escalation Bonus: In CM, rewards escalate in magnitude (they get bigger) the longer a person gives drug-negative UDTs. In CM we want people to be invested in staying drug-free and we want them to learn that the longer they are drug-free the more they have to gain. To help this learning, CM uses an escalating schedule of reward. This means that in addition to earning their base rewards (e.g. $10) the recovery community member would earn escalation bonuses (e.g. $2) for every week they have continuously given negative UDTs. In CM, the amount of reward increases the longer a person is drug-free.

Reset: As we mentioned we don't use punishments in CM. But we do emphasize accountability. When a person has a positive UDT, they do not receive a reward that day. The other consequence is that the CM provider will temporarily "reset" the reward level. This means that people who earned the escalation bonus for one or more weeks of negative UDTs will temporarily lose their bonus. For example, when they submit their first negative UDT after a positive test they will reset to the original week 1 level of rewards (e.g. $10). This can be a big consequence for someone who has worked their way up to a large escalation bonus. When they are aware that they can lose their bonus, this helps people be even more invested in staying drug-free.

Bonus Recoup: In CM, 'recoup' refers to the return to previously achieved bonus when a person returns to staying drug-free. This is usually defined by 2 consecutive drug-negative UDTs. The idea of the recovery is that we don't want a non-abstinent test to turn into a return to use. Therefore, if a person has achieved an escalation bonus, (e.g. $10 per sample) and then they submit a sample that indicates use and the reset occurs, we want to give them motivation to return to maintaining a recovery path as soon as possible. So, if the person submits two consecutive negative UDTs in a row (one week of abstinence) after a reset, then they 'recover' their previously earned $10 escalation bonus PLUS an additional bonus voucher, for a total of $12 in bonus voucher rewards! The 'recovery' helps people get back on track and gives them a reason to return to staying drug-free after use.



KNOWLEDGE CHECK

Q1: In CM, we know the most effective rewwards are:

a. Abstract rewards, for example praise
b. Whatever the clinician thinks is the best reward for a given behavior
c. Desirable, immediate, and escalating
d. "Surprised rewards," or rewards given when the person is least expecting it

Correct answer: **c**

Q2: A reward delivered immediately after a behavior occurs would:

a. Increase the probability that the behavior will occur again
b. Decrease the probability that the behavior will occur again
c. Not change the probability that the behavior will occur again
d. Either increase or decrease the probability that a behavior will occur again, depending on whether the behavior is a positive or negative one

Correct answer: **a**

Example CM for Stimulants Program

Here is an example of an evidence-based CM for stimulant use program in action. This model is evidence-based. That means it is based on models used in CM studies that are associated with clinically significant reductions in drug use.

Reinforce Behavior: Stimulant abstinence as objectively measured by point-of-care UDTs. The point-of-care UDTs measure cocaine, methamphetamine, and amphetamine. It can take some time for recovery community members and staff to get used to this new way of using UDTs. In CM UDTs are still used to keep people accountable, but the focus is on a positive accountability that facilitates trust, self-efficacy, and pride. In fact, many CM clients report that they really value urine testing because it helps them remember that they are accountable to themselves and their CM provider when they have urges to use.

Monitoring and Reward Schedule: Twice weekly, either 1) Mondays and Thursdays or 2) Tuesday and Friday, if possible. If this is not possible, then twice weekly on non-consecutive days. It may be more convenient for you and your recovery community members to have less frequent monitoring. Less frequent monitoring means you may miss some stimulant use and people have less opportunities to earn rewards for not using stimulants. CM for stimulant use disorders should never be less than once a week if you expect it to be effective. If you are testing less than twice a week, however, some people may receive rewards even though they may have used. This is why we prefer the twice-weekly schedule, which also offers more opportunities to reward people for staying drug free.

Duration of Intervention: 12-weeks of voucher CM starting at $10 for each stimulant-negative UDT, escalating by $2 for each week of consecutive abstinence. You could also do up to16 weeks, but 12-weeks has the most evidence. Briefer CM interventions are less likely to have an impact on staying drug-free long term, though they might be effective at helping people stop using early on in treatment, longer interventions are consistent with better outcomes.

KNOWLEDGE CHECK

Q: Casey attended a webinar about Contingency Management (CM) and is excited about implementing a CM program at their house, but isn't sure if it will work. Residents at the house are supposed to be drug-free when they move in, and if someone tests positive on multiple drug tests they may have to go back to treatment. Additionally, Casey isn't sure if the staff are going to have the time to do UDTs twice a week, or if they have the funds to do a pathway like this.

Will the house be able to do CM?

Correct answer: These are all valid concerns.

Some houses might not see the benefit of doing CM for people who are already drug-free, but it is important to remember that 50% of recovery house residents leave within the first 30 days (citation). CM has great potential in supporting residents in all stages of recovery, especially early recovery. It is also worthwhile to think about the negative consequences that could result from increased UDTs.

Is the house willing to adjust rules around positive UDTs to accommodate a CM program? Would it be a better fit to keep the house's rules as they are and adopt a positive reinforcement pathway instead? This could look like rewarding residents for negative UDTs but maintaining house rules around positive UDTs.

How is the house going to run and fund CM? Do they have the staffing and funds to do UDTs at least once a week? Will they be able to afford a minimum of $350 over 12 weeks? If they do not have enough funding for an evidence-based CM program, they can still implement a positive reinforcement pathway with a lower total payout, less frequent tests, or a shorter period of rewards.

If the house chooses a positive-reinforcement pathway instead of evidence-based CM, they may still see good results, but there is not the same body of research supporting that approach. The next section will help you begin to think about whether CM is a good fit for your house.

PREPARATION FOR A CONTINGENCY MANAGEMENT PROGRAM

Below are some questions to check in with whether a CM program might be a good fit for your house, and what your house might need to prepare for a CM program. These questions will help you think about the organizational and practical elements of identifying whether CM is a fit for your home and starting a program in your home. The organizational readiness questions are meant to help you get "a lay of the land". We also share expert recommendations to consider how you might address barriers. Lastly, the CM preparation checklist questions will help you translate the fit considerations into practical elements needed to start a CM program.

Organizational readiness for a Contingency Management Program

Culture and Population

Your house's culture is foundational for social connections, communal relationships, and growth of your community. Thinking about beliefs, values, and practices that are important to your house will help you run a CM program that is the best fit for your house and community.

» Does your house have any distinct cultural elements, or serve specific cultural groups?

» Describe your resident/recovery community member population (age, tribal affiliation, cultural identification, sex, gender, sexual orientation, experience in the legal system, history of homelessness, etc.).

» Brainstorm how CM could be congruent with these cultural and demographic elements.

> ***Food for thought:*** *One way to incorporate culture into CM is to use it to inform what rewards are available as reinforcers. For instance, in our work with American Indian/Alaska Native communities, we learned that some people appreciate materials for ceremony (e.g. sweet grass) or supplies to make regalia or culturally significant art (e.g. beading kits). Are there specific items that could be used as CM rewards that might be culturally significant to the members of your house?*

Recruitment, Referral and Screening

The network of service providers and recovery centers is an important resource to the recovery community and to CM. These questions are meant to help you think about how you will reach people who could benefit from your CM program (i.e. communication, outreach, creating a referral network, helping people find and enroll in your program).

» What strategies will your house use to identify residents/recovery community members/community members who might need or want contingency management?

» Are there other supports (e.g., family, elders, community, spiritual leaders, etc.) that could act as "CM champions" who may help encourage people to enroll or stay engaged with your CM program?

> ***Food for thought:*** *It is a misconception that once a CM program is established, people will knock down the doors to be a part of it. In fact, sometimes in can be challenging to spread the word about the program and encourage people to enroll. For your CM program to be successful, you may want to determine how you can use existing outreach avenues or create new ones specific to your CM program.*

Population

Every house is a different community. These questions are meant to help you think about how CM might fit into your community.

» List which 3 substances are most used among your residents/recovery community members (e.g., stimulants; tobacco/vaping; alcohol; cannabis; prescription opioids; heroin).

» How long does someone typically stay in the house? How long does someone typically engage in other services?

» What are the 3 biggest barriers to seeking, engaging, and remaining in care for your recovery community members?

Staffing and Services

CM programs require staff time 1-2 times a week for each person receiving positive reinforcement. Adding this approach to existing 1-on-1 staff and recovery community member time, like regular check-ins, is a common approach to staffing concerns.

» What services does your house/program provide (e.g., motivational interviewing, cognitive behavioral therapy, relapse prevention, 12-step facilitation, Wellbriety, mindfulness, MOUD, curriculums etc.)? Which of these services may be able to incorporate a CM visit before/after or during the visit, or will you opt to schedule CM visits as separate or stand alone?

> ***Food for thought:*** *Attending CM visits 1-2 times a week can feel like a lot of time commitment (and travel time if not offered where people live). Combining CM visits with other appointments and activities can make it easier for people to make it to all of their CM visits.*

» Which staff might be a good fit to be involved in a contingency management?

> ***Food for thought:*** *CM is a flexible intervention in that "anyone" can do it, as long as they are trained on the protocol and express a positive and encouraging attitude. That said, professional helpers can bring a variety of skills, such as motivational interviewing, to enhance the delivery of CM. Please note that some CM programs might require a referral from a licensed provider.*

Urine Testing

Evidence-based CM requires drug tests. If you are unable to do drug tests that will not negatively impact the person receiving CM due to a positive result (e.g. probation violation, being asked to leave the house) and are able to be completed frequently (i.e. UDTs 2x/week), a positive reinforcement pathway may be a better option.

» Does your house/program have onsite urine drug screening, point of care urine drug tests, or a lab? What do you test for? If you use lab testing, how quickly do you receive results?

> ***Food for thought:*** *An important part of what allows CM to work is to provide reinforcement immediately after the behavior is demonstrated. That is why it is best to use point of care urine testing (e.g. a insta-read cup or dipstick) so that you can get the results right away. Lab testing is usually not the best option for CM unless you can receive results withing 24 hours. Sometimes this involves a conversation with your lab personnel to explain why immediate results are important for CM.*

Other Contingencies

» What happens following the identification of return to use? (Will the house member still have access to your CM program?)

> ***Food for thought:*** *CM works best when residents can continue the CM program even when some UDTs show recent drug use. If a person receives a punisher, like immediately being removed from the house if there is a positive UDT, then they may not want to take the risk of enrolling in the CM program. If frequent urine testing is a deterrent for your program, you may consider a positive reinforcement pathway to reinforce a different behavior, such as attendance to treatment or recovery-oriented activities.*

Motivation and Readiness

» What do you think residents or other recovery community members think about receiving rewards for staying drug-free? What about rewards for other behaviors (e.g., attending 12-step meetings)?

» Have you spoken to staff about a contingency management program? How motivated are staff to start providing contingency management?

» What financial support and buy-in do you have from community partners for the use of contingency management?

> ***Food for thought:*** *Many people are confused or skeptical about CM. Sometimes it's because they don't fully understand what CM is, including its scientific foundation and that it truly is an effective way to help people attain or stay drug-free. Getting buy in from community is an important way to help your CM program be effective and worth the extra effort it will take.*

Contingency management preparation checklist

Here are 11 questions to think about the practical details of what a CM program could look like at your house. These questions will help you and a training team figure out how to get your house ready to start doing CM!

1. **Decide who is eligible to enroll.**
   - ☐ Would you only enroll residents, or do you have other members of your community that may benefit from CM? Will outreach materials be provided (i.e., flyers that describe your CM program)?

2. **Decide when the visits will take place.**
   - ☐ Would the CM sessions be stand-alone or part of other services (e.g., tagged on to counseling session, group, or MOUD visit)?

3. **Determine which staff would be the best fit to carry out a CM protocol.**
   - ☐ Who is already seeing recovery community members once or more a week?
   - ☐ Who can be trained to ensure a consistent, evidence-based program?
   - ☐ Who is supervising?

4. **Decide on a target behavior to reward.**
   - ☐ Specific negative urine drug test only (e.g., stimulant/opioid/alcohol negative). Please list which drugs.
   - ☐ Negative for all substances urine drug test.
   - ☐ Other: please describe.

5. **Decide which rewards to use.**
   - ☐ Physical gift cards:
     - Which cards would you stock? (e.g., $10 Walmart; $5 local gas station)
     - Who would be allowed to distribute the gift cards?
   - ☐ Electronic gift cards:
     - Do you have a way to print gift cards for those who have technology challenges?
     - Who would be allowed to distribute the e-gift cards?
   - ☐ Other (e.g., a "reward shelf" of items that people could choose from):
     - Please describe.
     - Who will be in charge of purchasing the items?

6. **Plan for UDTs.**
   - ☐ Do you (or will you) use Point of Care, CLIA-waved urine drug tests or lab testing?
     - If point of care—list brand name and type (e.g., UScreen, 5-panel)
     - If lab testing, what is the turn-around time for receiving results?
     - If neither, how will you measure your chosen target?

7. **Discuss how targets might impact house practices and decide on an approach.**
   - ☐ How will targets impact house practices? If there are currently consequences for not meeting a target (e.g. positive drug tests, not attending meetings), will your house be able to modify current practices to meet the positive reinforcement focus.

8. **Decide when visits will happen.**
   - ☐ Will you schedule CM visits twice weekly? Once weekly? (Please consider your answer to #2 regarding if CM will incorporate into other services and what the visit frequency is of those services. Note, you could have one CM visit happen with another service that happens weekly, and then have the second CM visit stand alone.)
   - ☐ Could CM recovery community members drop in on a designated day (e.g., Mon/Thurs) or would they need to schedule an appointment?

9. **Set an end point.**
   - ☐ How do you know when a recovery community member/patient has completed your CM program?
     - When they have completed 12 weeks
     - When they have completed 24 visits
     - When they are finished with their other SUD treatment services
     - Other:

- ☐ Will people be able to restart the CM program? How will you track who has already been in the program?
  - ○ Only if they have not exceeded their reward cap that year
  - ○ Only if they did not complete the CM program the first time
  - ○ Other:

10. Figure out how you will you fund your program.

- ☐ Do you receive payments from Medicaid or HRSA (Please note that CM conducted in Medicaid environments or using federal funding may be subject to specific regulatory requirements which may impact your CM protocol)?

- ☐ Does your house receive community donations that you could use as rewards that your recovery community members could earn? Are there businesses that would be willing to donate rewards?

11. Is your house the best fit for CM, or would you refer to a different site or treatment provider?

Thank you for taking the time to learn about steps you can take to bring more positive reinforcement into the recovery community. We hope that this powerful tool can continue to support our community.

To learn more about how you can make a positive reinforcement approach a part of your house culture, please reach out to the Fletcher Group for more information.