# Participant Recommendations for Management (CM)

*Needs Assessment for Expansion of CM in San Francisco*

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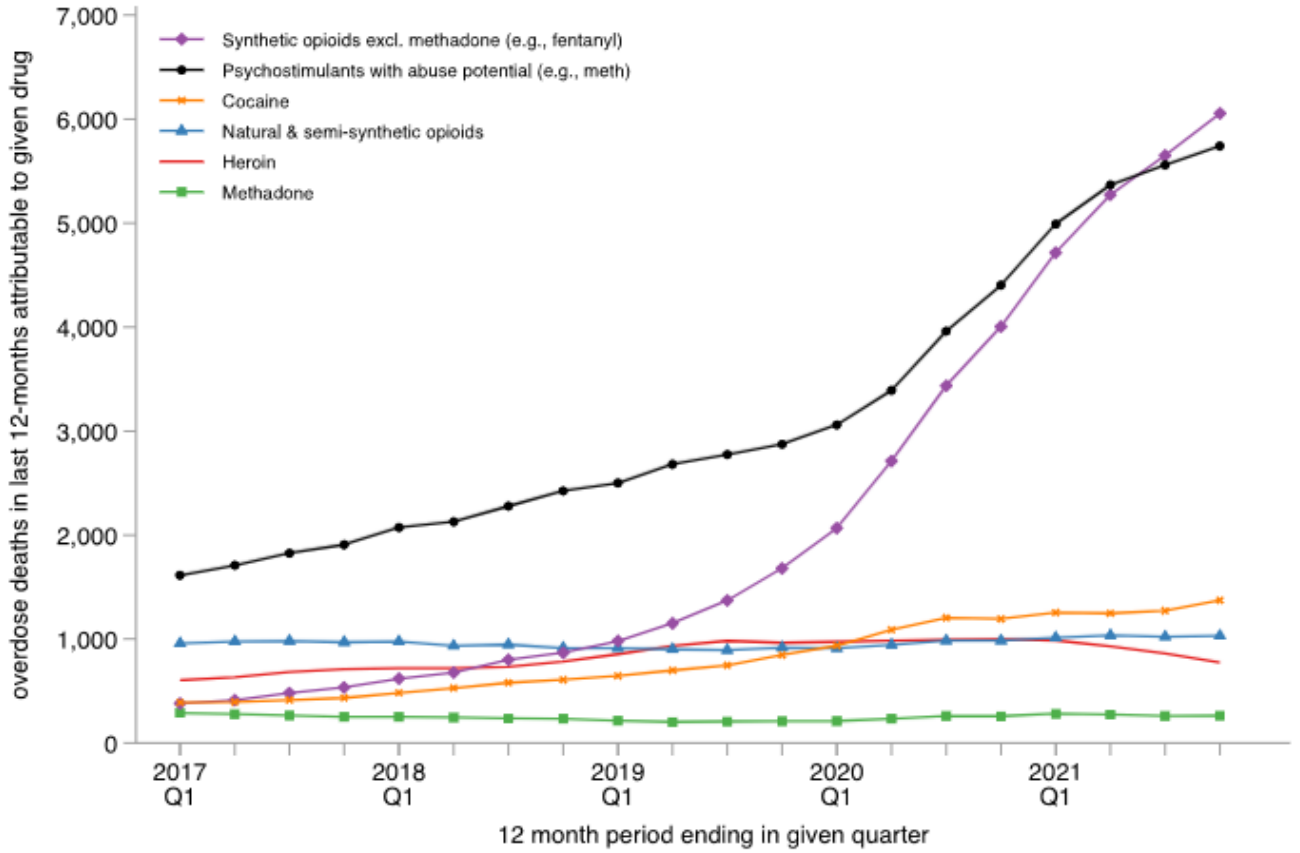
# California + San Francisco Drug Use Landscape

- Overdose death is a top ten cause of death in California - **fentanyl and methamphtamine are the most commonly involved drugs**
- In San Francisco over half of overdose deaths involved methamphetamine
- Access to harm reduction supplies for stimulant use has increased - such as pipe distribution but **harm reduction based treatment options are limited**

**Figure 9.**
**Number of fatal overdose deaths involving each drug or drug class, 2017 to 2021**



# History of CM in San Francisco

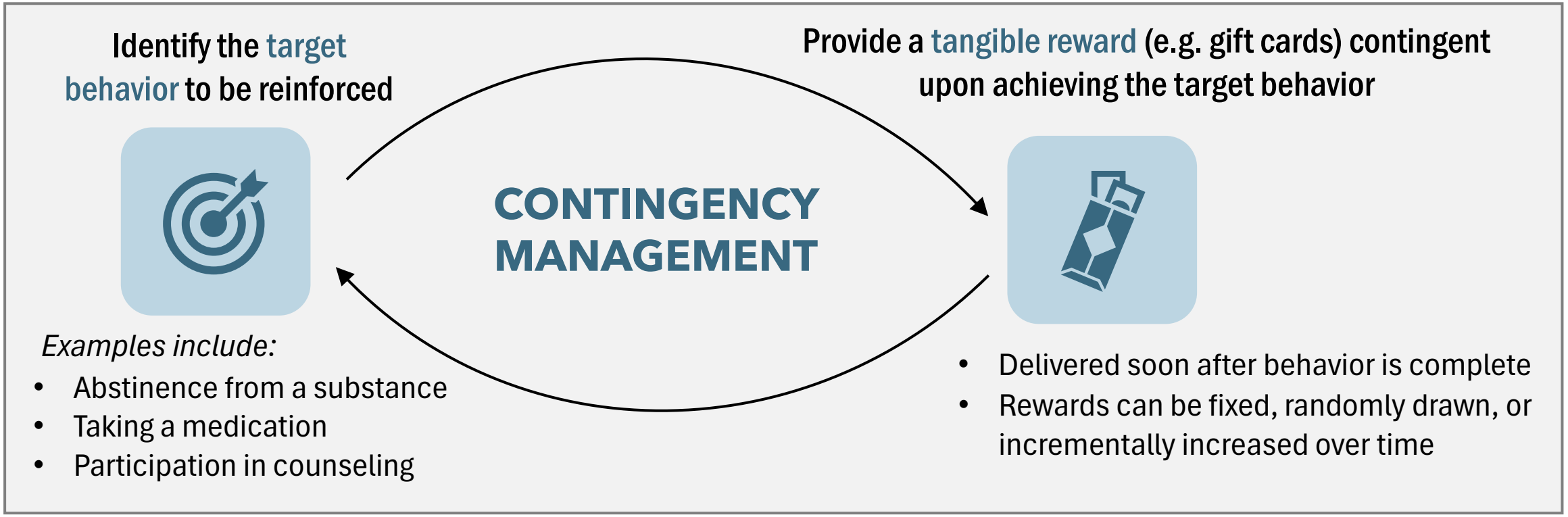
- San Francisco Department of Public Health (SFDPH) launched a pilot CM program in 2004, **Positive Reinforcement Opportunity Project**
- PROP was originally intended to decrease methamphetamine-associated sexual risk behaviors among men who have sex with men who use methamphetamine
- Now there are more than a dozen CM programs currently operate in SF

California's recently launched 2023 **Recovery Incentives Program** offers CM as a Medicaid benefit in SF and 23 other pilot counties, which will facilitate further expansion of CM

# What is Contingency Management?

# What is Contingency Management (CM)?

- Behavioral intervention; uses rewards to increase target behavior
- Used in conjunction with other treatment modalities for treatment of substance use disorders, including stimulant use disorder



# Examples of CM Reward Structures

## Fixed schedule reward

- Same rewards is given at a set interval (e.g., gift card after a weekly urine drug screening, or when someone attends group)

## Fishbowl (variable) reward

- Participants choose a reward randomly from a fishbowl of varying rewards, usually with some rewards more valuable than others (e.g., written praise, bus voucher, gift certificate)

## Incrementally increasing reward

- Rewards increase over time as positive behaviors are sustained (e.g., higher value incentive as goals are achieved )

# Characteristics of SF CM Programs

| | |
|---|---|
| **Reward Structure** | • Most programs use incrementally increasing rewards<br>• Three programs use the fishbowl reward structure<br>• Two programs use a fixed schedule reward structure<br>• Most programs start with an incentive of $5 or $10, with a cap ranging from $330-559 |
| **Target Behaviors** | • Every program incentivizes non-reactive urinalysis (UA)<br>• Many programs incentivize attendance at group or individual counseling<br>• A few programs incentivize other health-related behaviors, such as taking medication or not injecting drugs |
| **Program Length** | • Programs range from 5 sessions to 24 weeks in length, with most programs lasting 12 or 24 weeks |
| **Program Eligibility** | • Most current contingency management programs are only available to pre-existing clients, but people are able to be referred and become clients to access CM services<br>• Two organizations host CM programs open to anyone, pending capacity |
| **Program Size** | • Program capacity ranges from 6 to 100 people |
| **Group Programming** | • Every program offers individual counseling, linkages to care, and naloxone access<br>• Two programs also offer group programming |

# 2 The Approach

# CM Community Engagement (2024)

- Facente Consulting was brought on by SFDPH to seek the expertise of participants of CM programs to inform the future of CM in SF
  - Focus groups and interviews with nearly 50 participants across 10 programs supported, funded or run by SFDPH
  - Interviews and surveys with 15 providers
- Analyzed the data to identify key insights and themes related to CM in SF

# 3 Key Findings

# Theme 1: CM shifts the paradigm for the experience of seeking treatment

- CM participants appreciate the **positive** focus on rewarding behavior change goals
- This contrasts with their experiences in punitive or regulated residential treatment settings, where they might be kicked out for a return to use or otherwise feel punished when they don’t meet behavior change goals

> I've explained it to different types of people…it's like the opposite of what would happen if you drug test in other places. Instead of being punished for [the] negative, you're incentivized for [the] positive. It's encouraging in that way…rather than demonizing…the opposite of what has usually been done.
>
> *-CM Participant*

# Theme 2: CM rewards confer multiple layers of value for clients

- Rewards impact whether CM participants show up to the program on personally challenging days
- Rewards make a meaningful difference in material well-being
- Rewards support a sense of emotional well-being, self-worth, and self-reliance
- Rewards reframe the relationship to treatment as positive

> It helps me ingrain…day to day, actual activities, like going to Burger King and buying something to eat. It's as simple as that, going to Burger King and buying your own meal. You know what I mean?...It's ingraining in my recovery path…that I can rely on myself.
>
> *-CM Participant*

# Theme 3: Non-judgmental, welcoming, and trusted CM spaces/staff are key

- Clients & providers emphasized the need for a **non-judgmental space**, especially if clients experience a return to substance use
- Avoiding shame can keep participants moving toward their substance use goals, despite challenges along the way
- Community-building, snacks, and coffee can be provided in addition to CM programming
- Continuity of care is important to creating trust, and requires recruitment, retention, and support of high-quality staff

> The staff lets us be honest. People can come in and stop being strong. It helps just as much as therapy. We accept it if people use [drugs] – because we're able to be honest. The staff is people who understand and who don't look down at us.
>
> *-CM Participant*

# Theme 4: Need for CM models that focus on more than abstinence

- Providers emphasized the **importance of CM models across the spectrum of harm reduction**
- Rewarding positive, non-abstinence behaviors may allow CM to engage a wider population and engage them along the full continuum of treatment
- Engaging a wider population also provides opportunities to address overdose prevention and other harms related to substance use

> Historically in a lot of CM literature, [CM] has been done in programs that incentivize non-[reactive] UA only…narrowing to a smaller population who are ready to stop using and/or who have already stopped.
>
> *-CM Provider*

# Theme 5: CM participants want to be meaningfully included in CM planning

- Participants & providers emphasized the need to include clients in program planning, including repeated (rather than one-time) engagement opportunities

> The graduate group was the idea of one of the first [CM program] graduates who said – 'this cannot end; [it] has been so important to me.' The graduate group was developed as a result.
>
> *-CM Provider*

> The idea that we're able to graduate this program—our words and our thoughts should be more valued than people who are doctors.
>
> *-CM Participant*

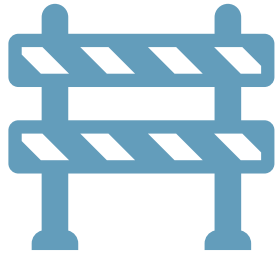
# Theme 6: Opportunity to co-locate CM programs

- Two CM programs housed at opioid use treatment programs described success in sustained engagement among people who use stimulants
- These programs also include many people who have had decades of continuous stimulant use (good candidates for CM)
- Co-location ideas parallel patient perspectives on new locations
  - Patients suggested integrating CM into spaces like housing programs, SROs, and other clinics

# Theme 7: Overcoming barriers to CM programs

Examples of barriers shared by providers included:

- CM can be complicated for people who are prescribed stimulants (requires lab-based testing)
- Consistency of attendance—key to CM programs—can be trickier during holiday schedules, leading to momentum loss
- It is challenging to find highly qualified staff who can adhere to CM best practices
- The state required 24-week cap on incentives is too short for some participants to fully benefit from CM



# Recommendations from this Needs Assessment

With additional funding, expand services through additional locations (including mobile services) and broader hours of operation.

Include CM models that reinforce behaviors across the spectrum of harm reduction, including but not limited to abstinence.

Include CM models tailored to specific populations, using targeted outreach and partnership to create spaces that are specific to race, neighborhood, gender identity, and other groups.

Provide enough funding to offer CM groups, in addition to individual CM services

Prioritize funding for strong clinical and counseling staff at CM programs.

# Recommendations from this Needs Assessment

Create opportunities for mentorship and increased training for new providers, coordinators, and peers involved in CM work.

Expand the length of time available to engage in CM programs beyond the state cap of 24 weeks.

Expand participant reward options, such as more gift card variety, funding for food, survival needs, and comfort items.

Create opportunities for aftercare following graduation from CM programs, such as non-incentivized group services hosted at the CM program site.

Create opportunities for meaningful involvement and feedback from people who are or who have been in CM programs to shape program futures.

# Questions

# Thank you!

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