BRIEF

Reporting on Addiction

Contingency Management

A Broadly Effective Treatment for Substance Use Disorders 50 Years in the Making

Treatment for substance use disorders (SUDs) commonly looks like counseling, group therapy and medications such as methadone or buprenorphine. However, overwhelming evidence shows one of the most effective interventions is contingency management (CM).

Contingency management is one of the oldest, most well-studied, and most effective interventions for substance use disorder. It is also historically one of the least utilized. Its potential to help has been held back by public perception that has driven misinformed policies.

With recent regulatory changes that allow more effective CM reward sizes, we must help the public better understand this approach. Additional work is needed to reduce barriers and increase the number of providers who offer CM.

What is CM?

CM is a behavioral intervention for SUDs. It disrupts the behavioral patterns exhibited by people who are struggling to stop using drugs or alcohol. To understand how CM works, we need to think about why people use drugs. Drugs can make us feel good by giving us pleasure or by letting us "check out" from scary situations and/or psychological and physical pain, especially when we don't have other things in our lives to help us feel safe or in less mental or physical anguish. CM acknowledges that this is why many people use drugs and offers an alternative means to achieve pleasure or relief, but only when they engage in behaviors other than using the drug they are struggling with.

At its core, CM gives people a choice: use the drug that they don't want to use anymore and receive the positive and negative consequences from continued use; or, do ***anything*** else except use that drug and receive a different set of positive consequences delivered by the treatment source.

Most often, and most effectively, the positive consequences provided by the treatment source have a monetary value. It can be gift cards, cash, or small prizes. CM has been studied and used to treat various SUDs since the 1970s, and because of this, we know a lot about what needs to happen to make it work. This research shows CM is consistently effective in helping people stop using virtually any drug (1)(2)(3), and that the most important aspect is the reward. The bigger the reward, the better the outcomes. The research on this is clear; however, public opinion and federal policy have stifled CM.

Continue reading for additional context and recommendations

How CM Works

CM addresses the complex medical-social-behavioral contributors to SUDs by providing a positive experience that may not be otherwise available in a person's social context. It also gives something (a reward) that helps offset the negatives of withdrawal or absence of drug-related relief/comfort that comes with stopping use.

There are many different ways to administer CM with varying levels of evidence. Rewards can be cash-based (e.g., gift cards, cash, or vouchers) or prizes (e.g., candles or power tools). CM that provides rewards for attendance at therapy sessions instead of drug abstinence has been shown to reduce drug use, but to a lower extent than when drug abstinence is the target (4).

Who provides CM

Like any medical treatment, CM needs to be delivered by people with training and expertise. But because of the stigma towards people who use drugs, misunderstanding about CM and the policy barriers mentioned earlier, few providers have received adequate training in implementing CM. Additionally, there is no way to search for CM services on findtreatment.gov, the federal government's online resource database. The hope is that with the new limit on CM rewards, more SUD treatment providers will offer this intervention and there will be more ways to find treatment.

There is also the matter of payment for delivering CM. Supportive policies from payer systems (e.g., Medicaid Managed Care Organizations) that incentivize delivering high fidelity CM could also help ensure effective implementation. Given CM's high effectiveness in reducing substance use and thus preventing further health consequences, value-based payment systems may help make CM more financially approachable. But for CM to affect people with a SUD, providers must be able to use it.

What can journalists do?

As a journalist, your reporting can inform audiences about CM by focusing on these key points:

- **Report on contingency management** as an evidence-based form of treatment for addiction.
- **Include treatment resources.** Many providers don't offer CM. Compiling a list of local providers that do is helpful. Use findtreatment.gov in the meantime.
- **Use person-first language.**
- **Ask an expert.**
- **Avoid both-sideism** (there is robust evidence for CM, difference between opinion and fact).
- **Avoid overly simplistic framing.** Ex. "paying people who use drugs."
- **Be thoughtful about images and headlines.** Avoid sensationalizing CM, which can create opposition to this treatment.

Continue reading for additional context and recommendations

How CM Works

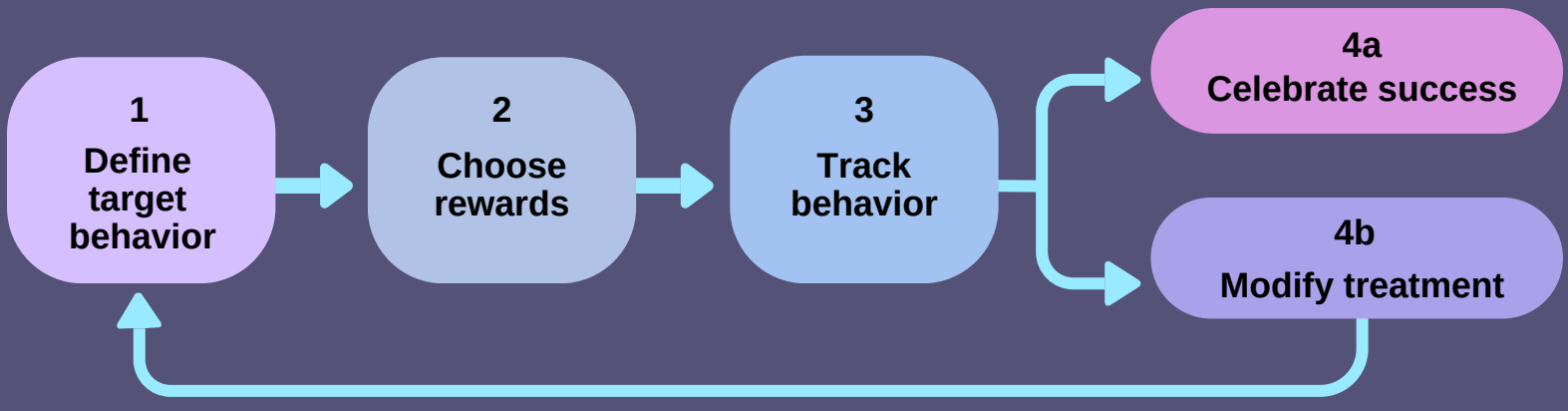
How to provide CM

CM requires elements that may be complicated to implement for some treatment providers and may present barriers to people receiving care. For example, it requires that someone frequently provide a urine or breath sample that can biochemically verify abstinence from a drug. This verification could be needed multiple times per week in effective CM interventions. This can be a barrier to people who live far from their treatment providers, have transportation or mobility limitations, childcare responsibilities, and/or are employed. Technology such as remote testing devices (like a breathalyzer that plugs into a smartphone or a home drug test kit), telehealth services, and even fully automated apps have been developed to aid in implementation. These apps can be programmed to deliver rewards quickly and accurately based on use of the app or test results, improving reward immediacy and taking some of the human error out of CM interventions.

These technologies can greatly reduce costs and improve fidelity but may not make services as accessible as it may seem. While smartphones are more ubiquitous than ever, many people with SUD still do not have them or do not have access to reliable data connections. When devices are damaged, lost or stolen, treatment progress may be difficult to retain due to delays in securing new devices or complete loss of data.

Finally, a person's SUD treatment data is sensitive and disclosure can put people at risk for discrimination and other negative repercussions. Many substance use treatment apps have serious privacy and security vulnerabilities that can put people's lives and livelihood at risk if not addressed. While technology has great potential to improve access and fidelity, further development is needed.

Contingency Management Approach to Addiction Treatment



Continue reading for additional context and recommendations

Barriers to CM

Policy

It is impossible to disentangle the policy failures that hold back CM from the stigma, but there are specific structural issues that have made CM not as widely available. Until late 2024, federal policy limited the amount of CM rewards allowed for people receiving federally-funded substance use treatment (e.g., Medicaid) to $75 per year.

Was $75 limit per year enough for CM to be effective? Simply, no.

A metanalysis (a study of other studies) found that average reward values above $5 per day were most effective at reducing drug use (5). After correcting for inflation, that's about $7-$8 per day per person in 2024 dollars. The pre-2025 limit of $75 meant a person getting effective CM in a federally-funded program could get about a week and a half of CM before hitting the $75 limit. That is simply not long enough for any treatment to impact such a complicated condition.

Stigma and Discrimination

People wrongly consider CM as simply "paying people to not use drugs." You might hear people say, "that is what they should be doing anyway." While this sentiment is understandable, it's also wrong. As journalists, we must do a better job helping people understand evidence-based treatment like CM to reduce barriers to evidence-based care.

Framing SUDs as a moral failing (i.e., paying people to do the "right thing" by paying them to not use drugs) rather than the complex medical-social-behavioral condition that it is perpetuates stigma and discrimination against people who use drugs. This creates barriers to care and contributes to drug related morbidity and mortality (disease and death). But even if CM was just paying people to not use drugs, it is a cost-effective intervention when implemented correctly – and gets more cost-effective with larger rewards (6).

Imagine if the cap on other treatments was $75 and once that limit was reached, an effective approach was out-of-reach.

There has been progress made here. In late 2024, the Biden administration made final changes to federal policy regulating CM and raised the limit on rewards in federally funded CM treatment to $750 per year per person. That equates to about 3 months of CM, which is similar to the length treatment in the research studies on CM.

After this policy win, the treatment field must turn to implementing CM correctly and accessibly.

Continue reading for additional context and recommendations

Story Tag:

We recommend you include this push to resources at the beginning and/or end of your coverage when reporting on SUD:

Recovery from addiction is possible. For help, please call the free and confidential treatment referral hotline (1-800-662-HELP), or visit findtreatment.gov

If limited space, use this condensed version:

For help, call the free and confidential treatment referral hotline (1-800-662-HELP), or visit findtreatment.gov

Reporting Resources:

- Language Style Guide
- Visual Style Guide
- Expert Database

Treatment Resources:

- For confidential support, call the free referral hotline at 1-800-662-HELP
- Visit the SAMHSA treament locator tool: findtreatment.gov

About Reporting on Addiction

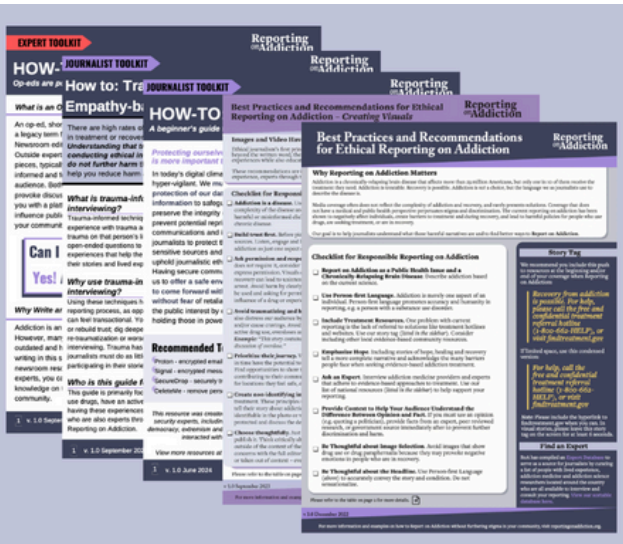
We are a 501c3-supported organization dedicated to increasing the accuracy and empathy of reporting on addiction. To accomplish this, Reporting on Addiction provides innovative training, technical assistance, and resources for journalists, journalism educators, experts through training, and experts through experience.

We work to:

- *Improve the themes/story narratives chosen by journalists.*
- *Improve the language used by journalists.*
- *Improve the images/videos created by journalists.*

Endnotes

1. Minozzi, S., Saulle, R., Amato, L., Traccis, F., & Agabio, R. (2024). Psychosocial interventions for stimulant use disorder. Cochrane Database of Systematic Reviews, 2(2), CD011866. https://doi.org/10.1002/14651858.CD011866.pub3
2. Notley, C., Gentry, S., Livingstone-Banks, J., Bauld, L., Perera, R., Conde, M., & Hartmann-Boyce, J. (2025). Incentives for smoking cessation. Cochrane Database of Systematic Reviews, 1(1), CD004307. https://doi.org/10.1002/14651858.CD004307.pub7
3. Prendergast, M., Podus, D., Finney, J., Greenwell, L., & Roll, J. (2006). Contingency management for treatment of substance use disorders: a meta-analysis. Addiction, 101(11), 1546–1560. https://doi.org/10.1111/j.1360-0443.2006.01581.x
4. Pfund, R. A., Ginley, M. K., Rash, C. J., & Zajac, K. (2022). Contingency management for treatment attendance: A meta-analysis. Journal of Substance Abuse Treatment, 133, 108556. https://doi.org/10.1016/j.jsat.2021.108556
5. Lussier, J. P., Heil, S. H., Mongeon, J. A., Badger, G. J., & Higgins, S. T. (2006). A meta-analysis of voucher-based reinforcement therapy for substance use disorders. Addiction, 101(2), 192–203. https://doi.org/10.1111/j.1360-0443.2006.01311.x
6. Sindelar, J., Elbel, B., & Petry, N. M. (2007). What do we get for our money? Cost-effectiveness of adding contingency management. Addiction, 102(2), 309–316. https://doi.org/10.1111/j.1360-0443.2006.01689.x



STYLE GUIDES
TOOLKITS
DATABASES
&MORE!

LOCATED IN THE RESOURCE LIBRARY