HOMELESS & HOUSING RESOURCE CENTER

Understanding Contingency Management:

A Foundational Webinar for Homeless Service Providers

March 11, 2025

SAMHSA
Substance Abuse and Mental Health Services Administration

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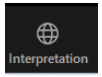
- This webinar includes live Spanish interpretation. To listen in Spanish, 

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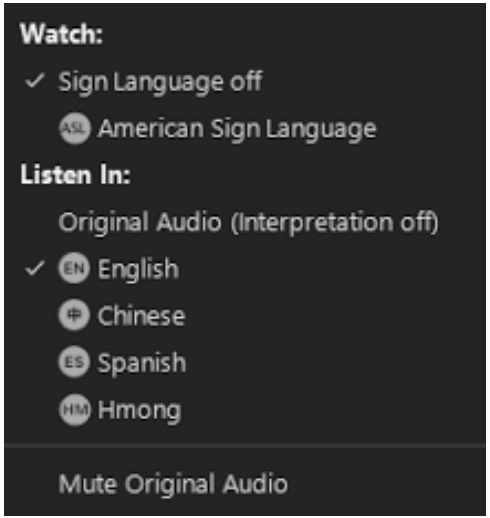

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National Health Care for the Homeless Council

Who We Are

- Since 1986, we have brought together thousands of health care professionals, medical respite care providers, people with lived experience of homelessness, and advocates. Our 200+ Organizational Members include Health Care for the Homeless programs, respite programs, and housing and social service organizations across the country.

What We Do

- We work to improve homeless health care through training and technical assistance, researching and sharing best practices, advocating for real solutions to end homelessness, and uplifting voices of people experiencing homelessness.

What You Can Do

- Learn more about how you can help support our mission.

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

Agenda

- **Understanding Contingency Management**
- **Program Experience**: San Francisco Department of Public Health, San Francisco, CA
- **Program Experience**: IDEA Exchange, Miami, FL
- **Panel**:
  - **Elizabeth Abbs**, MD – Primary Care & Addiction Medicine Provider, San Francisco Department of Public Health
  - **Maleika Edwards** – Health Worker, San Francisco Department of Public Health
  - **Edward Suarez** Jr. PsyD, LMHC, MBA – Program Director, IDEA Exchange
  - **Emilie Ashbes** – Outreach Coordinator, IDEA Exchange

Harm Reduction-Based Contingency Management:

Basics, Program Development, Implementation and Evaluation

Elizabeth Abbs
Maleika Edwards

San Francisco Department of Public Health

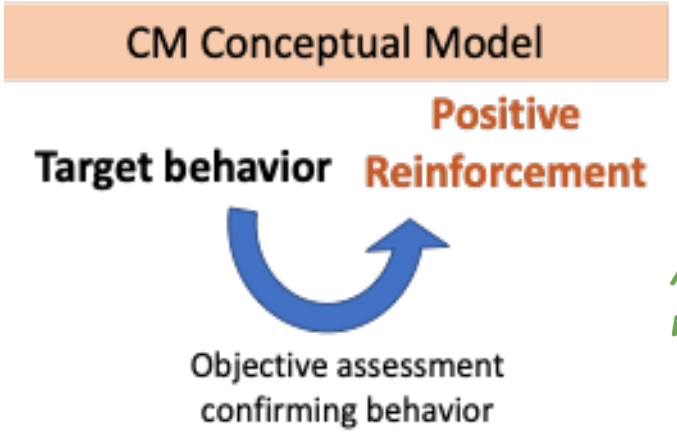
No disclosures

Overview

- Contingency management overview - 20 minutes
- Development and implementation of contingency management programs across San Francisco: Community Engagement to Stimulant Cessation to Medication Retention – 20 minutes

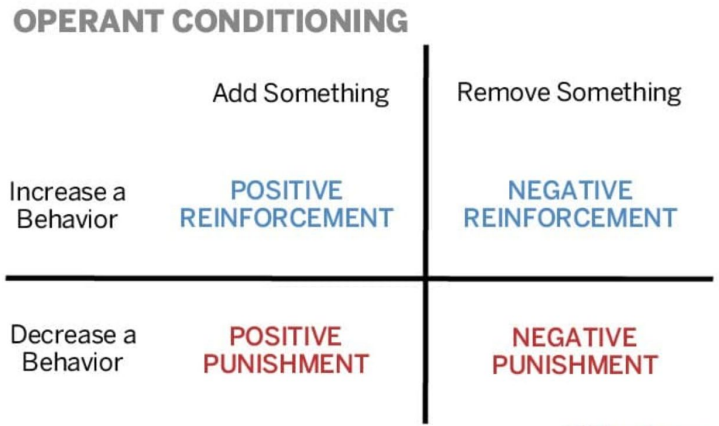
What is contingency management?

A behavioral treatment program using principles of **operant conditioning**: creating and strengthening associations between voluntary behavior and a consequence.



Abstinence = negative UDS

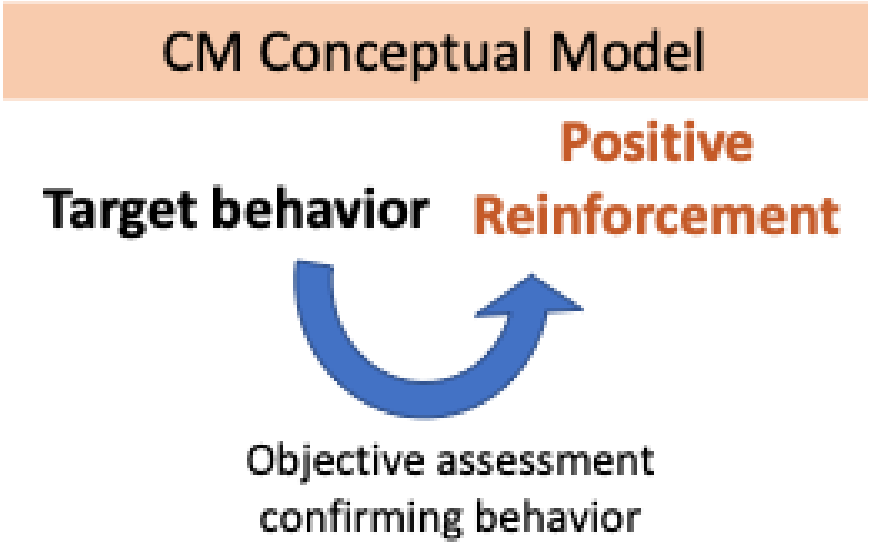
Rewards = usually monetary



How are Contingency Management Programs Designed?

Checklist:	
Target Behavior	Specific behavior that can be objectively measured, and matches the goals of participants
Target Population	Reaches participants' needs that are otherwise not being met
Incentive Magnitude	Incentive should be worthwhile to participants
Incentive Proximal to Behavior	Incentive should be given as soon as possible after objective evidence of target behavior
Immediacy of Incentive	Incentive should be delivered frequently, and reliably and consistently maintained over time
Duration of Intervention	

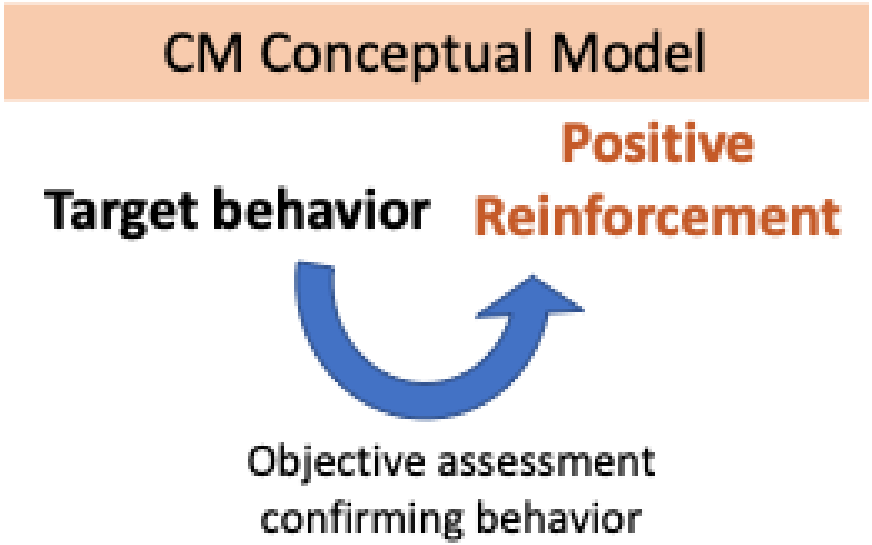
STEP 1: Define the target behavior to be supported.



*Specific
*Measurable
*Patient-centered

(1) Reduce stimulant use
(2) Increased engagement in care
(3) Adherence to medication

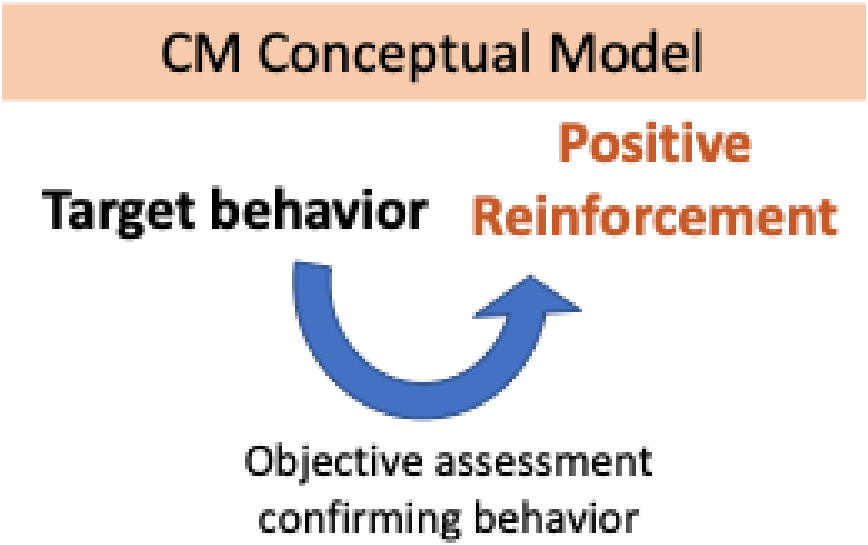
STEP 2: How will the behavior be assessed?



*Objective
*Frequent
*Point-of-care

(1) POC urine toxicology negative for substance
(2) Attendance
(3) POC urine toxicology positive for medication

STEP 3: How will the behavior be reinforced?



*Tangible
*Immediately following assessment
*Patient-centered

Voucher or Fishbowl draw for Safeway gift cards; 50% reward pulls ($5-100), 50% affirmations

Variable Magnitude of Reinforcement “Fishbowl”

- Participant draws from a fishbowl
  - 500 slips of paper
    - 50% with written affirmation
    - 42% confer a $5 gift card
    - 8% confer a $10 gift card
    - 0.2% confer a $100 gift card
- Increasing #s of draws for continuing the desired behavior
- Priming Draw (prove it’s real)

Voucher Method

- Structured payments that start small and escalate the longer desired behaviors are maintained
- Vouchers might be reimbursed for cash, gift cards, or other prizes
- Voucher amounts are usually under $20

What are key features of contingency management?

1) **frequent monitoring**

2) **tangible, immediate positive reinforcement**

3) **positive reinforcement withheld** if behavior of interest not demonstrated

Best evidence: Contingency Management

- Several systematic reviews supporting CM as the most effective treatment for methamphetamine and stimulant use disorders
- Is effective at reinforcing several types of behaviors, including abstinence, treatment attendance, medication adherence
- Has also been studied with other substances, including tobacco, opioids and alcohol

Ronsley C, Nolan S, Knight R, et al. Treatment of stimulant use disorder: A systematic review of reviews. PloS One. 2020;15(6):e0234809. doi:10/gn7563.

The ASAM/AAAP Clinical Practice Guideline on the Management of Stimulant Use Disorder. Journal of Addiction Medicine. 2024

Barriers to Contingency Management Implementation

- **Funding**
  - Patient recruitment
  - Supplies
  - Incentives
  - Clinic space and staffing
- **Lack of Familiarity**
  - Education required for institutional buy-in and resource allocation
  - Anti-stigma work
- **Staffing and Training**
  - Who does the staffing?
  - How are they trained?
  - Are other clinical services offered?

Funding Options

- Traditional grant applications (SAMHSA, NIDA, etc)
- Internal QI awards
- Foundation support (i.e. SFGH Foundation)
- Philanthropy
- Performance improvement dollars (PIP, MIPS)
- Local health plan dollars
- Local ballot initiatives (i.e. prop C in San Francisco)
- Opioid settlements?

Evaluation and Implementation Science

- **What outcomes are most important to your stakeholders?** (program staff, patients, health system leadership, and payers)
  - Abstinence?
  - Care retention?
  - Medication adherence?
- **How will you collect data on these outcomes?**
  - Data entry from clinic staff
  - Pulling data from the electronic health record (often much harder to do than we think)
  - Interviews with staff and patients
- **Who will be collecting these data?**
  - Workflows for data collection should occur in tandem with developing clinical workflows
- **Consider applying an implementation science framework** to your evaluation
  - Some examples: CFIR, RE-AIM, PARIHS, Behavior Change Wheel, etc

- Use this data to make the argument to support long-term funding

Legality and Ethics

Ethical Questions

- Autonomy
  - Are they making this decision for themselves, or because they are living in poverty?
- Beneficence
  - Their health will improve with less drug use
- Non-maleficence
  - What if I give them a gambling disorder?
- Justice
  - Can we offer payments to all interested patients? Who decides?

The Mercury News

BREAKING NEWS FBI executes search warrant at Trump's Mar-a-Lago

NEWS › CRIME AND PUBLIC SAFETY

California man accused of 'body brokering' – receiving illegal kickbacks from sober living homes

By SEAN EMERY | Southern California News Group

PUBLISHED: March 31, 2021 at 4:53 a.m. | UPDATED: March 31, 2021 at 4:54 a.m.

Contingency Management and Harm Reduction

“Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm Reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs.” - National Harm Reduction Coalition

Discussion Questions:

- **How does CM fit within a framework of Harm Reduction?**
- **How can we design CM programs to be “aimed at reducing negative consequences associated with drug use?”**
- **How can we design CM programs to be “built on a belief in, and respect for, the rights of people who use drugs”?**

Contingency Management Landscape within Primary Care Clinic

Tenderloin, San Francisco

Incentive selection:

- Close to clinic
- Variety of products that are desirable to participants

$5 and $10

Gift card storage:

- Behind double lock, cannot be removed
- Signed in / out every time

Gift card documentation:

- Need to account for every card
- Both wet signatures and digital record of distribution
- Expect audits

Hospitality budget:

- Snacks for each session; ordered in bulk

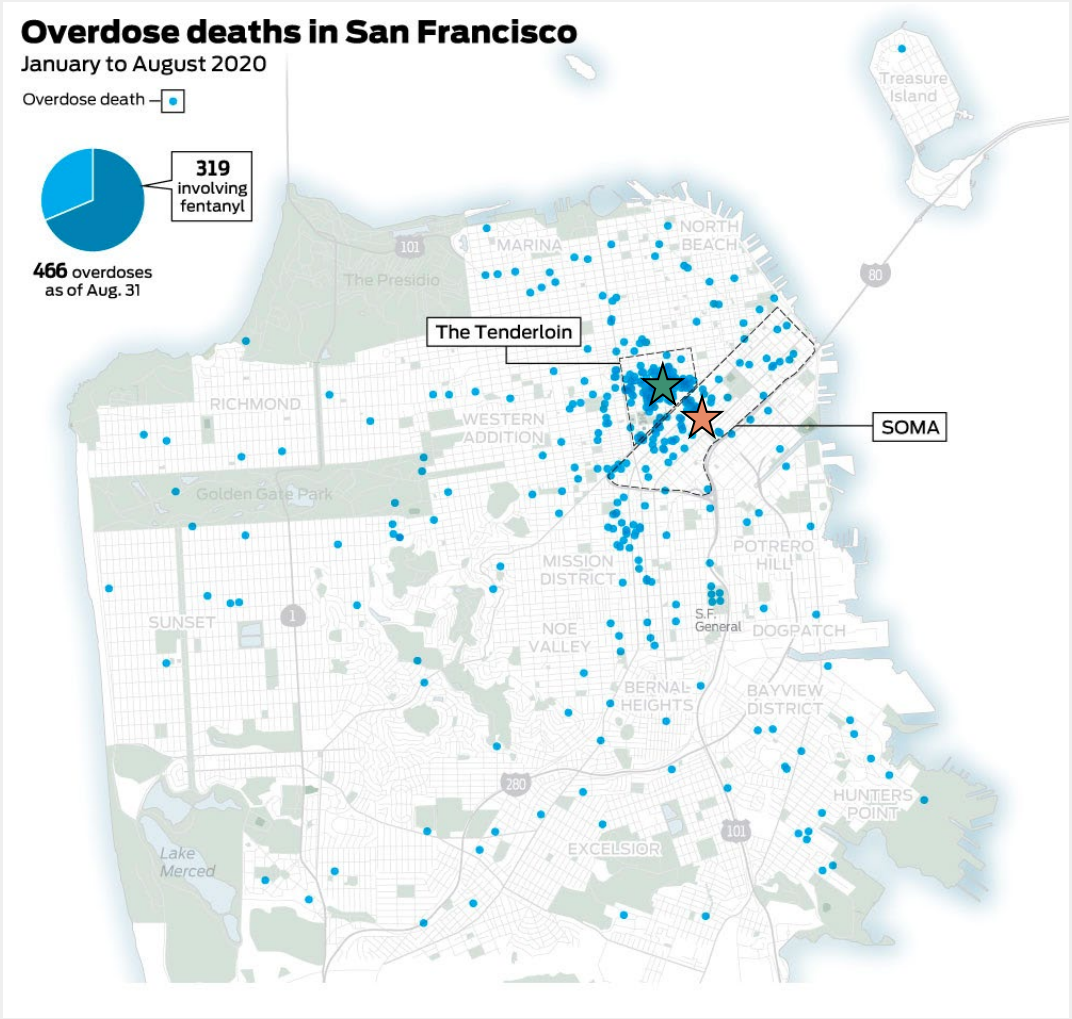
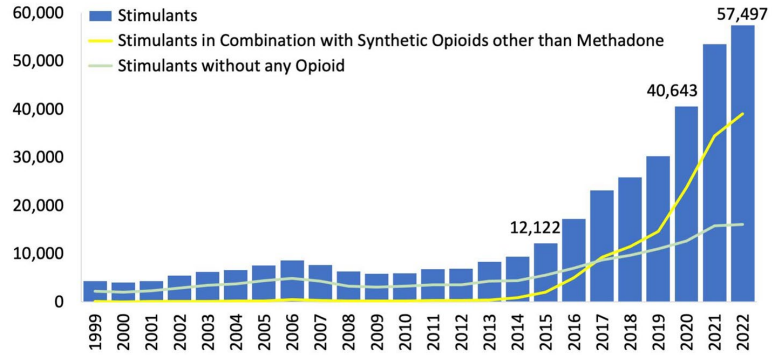


Figure 6. U.S. Overdose Deaths Involving Stimulants* (cocaine and psychostimulants with abuse potential), by Opioid Involvement, 1999-2022



*Among deaths with drug overdose as the underlying cause, the psychostimulants with abuse potential (primarily methamphetamine) category was determined by the T43.6 ICD-10 multiple cause-of-death code. Abbreviated to *psychostimulants* in the bar chart above. Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2022 on CDC WONDER Online Database, released 4/2024.

Tom Waddell Urban Health Center (TWUHC)

Maria X. Martinez Health Resource Center (MXM)

Addiction Consultation + Patient Navigation

PCP
MEA
RN
BHT
HW

Referral

Schedule Appts

ELIZABETH ABBS
Fri PM

- **Patient and Provider Support**
  - Reminders, Outreach,
  - Motivational Interviewing

Extensive Education

- **Patient Handouts**
- **Provider/Staff Inservice(s)**
- **Epic Dot phrases / Data Tracking**
- **Substance Use Support Groups**
  - EQUITY/INTEGRATON/ACCESS

Maleika Edwards
Health Worker

Model 1: Incentivize Attendance

Come As you Are – Harm Reduction Community Group

STEP 1: **Define the target behavior to be supported.**

*Specific
*Measurable
*Patient-centered

Attendance to Group

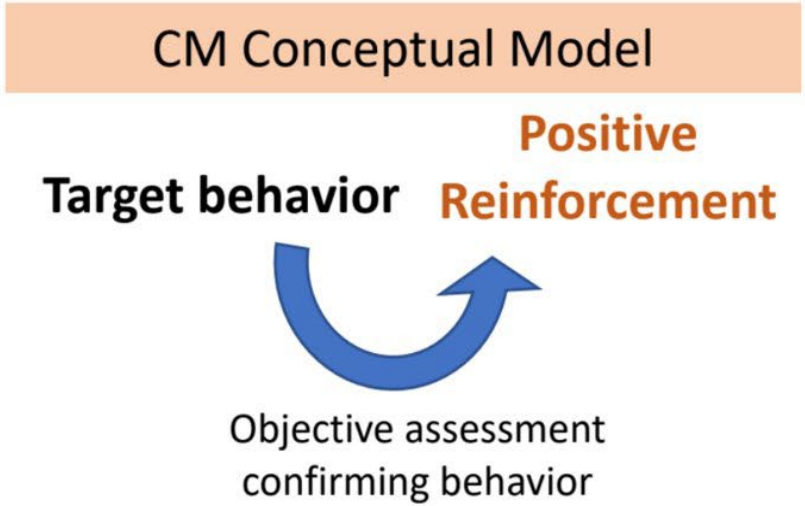
Target Behavior

STEP 3: **How will the behavior be reinforced?**

*Tangible
*Immediately following assessment
*Patient-centered

Safeway Gift Card

Reinforcement



STEP 2: **How will the behavior be assessed?**

*Objective
*Frequent
Point-of-care

Arriving to Group before 2pm

Objective Assessment

Opposite of addiction = COMMUNITY

Harm Reduction support for patients who use ANY substance

- Weekly groups since July 2023
- Earnings: $5 Safeway gift card per visit
    - Up to five draws in fishbowl for subsequent attendance (50% affirmations, 50% gift cards)

***Staffing**: Health Worker, Behavioral Health Clinician, AmeriCorps*

***Funding**: Grant money*

***Space**: Clinic conference room*

- Serves up to 25 patients actively

Progress Notes

Maleika Edwards (Health Worker)

Community Group Voucher Program Attendee

Patient attended Tom Waddell's "Come As You Are" Community Group on 02/21/25
with focus on Hobbies to Keep You Busy.

Date	**Attendance Voucher** ($5 value, last four # on card)	**Number of Attended Sessions** (in a row)	**Fishbowl Attendance Draws** (Number of drawn up to five)	**Fishbowl Attendance Vouchers / Value** (Value of card / last four # on card)	**Total Visit Earnings**	**Total Visit To-Date** (Not to exceed $600/year)
2/21/25	Included in fishbowl draw	71	5	(1) $15 3556	15	205

Come As You Are - (n = 36)*

Average age: 53
Age range: **35-71**

*29 active in last 90 days; 4 deaths

75% male

50% Black/AA

Average visits attended: 17

# sessions	1	2-10	11-20	21-40	41-50
# of attendees	5	15	10	4	2
Amt $ earned	35	945	3165	1835	599

STRUGGLES

- Connecting with patients/participants (*No telephone, telephone in/out of service, not keeping appts, not feeling well, fall off routine)*
- Losing patients to DEATH (overdose, accidents, Health Issues)
- Other Health Issues (non-ambulatory/use of walker or electric scooter/chair)
- No Transportation
- Unable to provide patients needs due to limited resources (Housing, Benefits, Food, Furniture, Security, Safety)
- Patient's past traumas and trust issue

SUCCESSES

- Getting people housed
- Developing friendships and giving people social outlets
- Helping patients connect with different parts of Medical system (HTN, Cervical Cancer, Diabetes, Behavioral Health Screenings, Cosmetic Surgery, Dental Implants, Tattoo removals)
- Encouraging patients to take up workshops/training/education

From our patient:

"This group is a place that gets me away from the boredom of being alone inside my apartment, I was reluctant at first about going to a group but have found this one to be very helpful. Group is full of people who really care and provides good advice."

Model 2: Incentivize Retention on Medication for Opioid Use Disorder (MOUD)*

*based on need to meet Quality Incentivize Performance metric for health network

Only 17% of MediCal patients with new buprenorphine, methadone or naltrexone starts retained for 180 days without 8 day gap

Offer Long Acting Injectable

ANY patient on sublingual buprenorphine could benefit from monthly injectable medication

Options:

Sublocade - first generation, inject in stomach

Brixadi - second generation, inject stomach/arm/leg

Connect to Methadone

Weekly intake hours printed every Tuesday

More similar to fentanyl; easier to start

FYI - W93: rapid titration (50mg --> 80), take homes; BAART Market: evening intakes

Consider LAI Naltrexone

Intermittent or accidental opioid use?

Stimulant and/or alcohol use?

Reinforce Connection to Care

No primary care or addiction visit for 3 months? Place flag in chart. Use outreach services. Mail letter to increase support and engagement.

SOAR (Supporting Ongoing Achievements in Recovery)

STEP 1: **Define the target behavior to be supported.**

*Specific
*Measurable
*Patient-centered

180 days (6 month) retention after new MOUD

Target Behavior

CM Conceptual Model

Target behavior — **Positive Reinforcement**

Objective assessment confirming behavior

STEP 2: **How will the behavior be assessed?**

*Objective
*Frequent
**Point-of-care*

POC Urine Reactive to Buprenorphine OR Methadone*

Objective Assessment

STEP 3: **How will the behavior be reinforced?**

*Tangible
*Immediately following assessment
*Patient-centered

Safeway Gift Card

Reinforcement

*ROI with call to MMT @ intake, 3, 6 months

Want to start

METHADONE OR BUPRENORPHINE

& get paid for it?

03

01

Complete INTAKE/PICK up MED

START

Once confirmed with a urine, you will receive a $30 gift card!

STOP FENTANYL?

At any visit, you can provide a urine and if negative for fentanyl you will get an additional $15 reward!

CONTINUE

You will get rewarded for staying on:

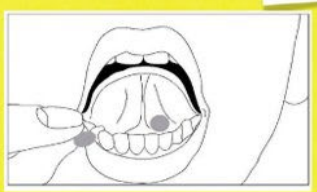
2 weeks --> $30

1 month --> $45

3 months --> $60

6 months --> $75

02



Since October 2024

SOAR (Supporting Ongoing Achievements in Recovery)

- Slower integration into addiction plan to assure ethics and address clinic staff fears/stigma
- **Funding**: grant money
- **Staffing**: no new hiring
  - Providers (MD/NP)
  - community health worker
- **Space**: Integrated into Addiction Clinic hours (afternoons twice weekly at Tom Waddell Urban Health Center)

Addendum

SOAR
CONTINGENCY MANAGEMENT FOR MEDICATIONS for OPIOID USE DISORDER

SOAR: Supporting Ongoing Achievements in Recovery

Patient is a 56 y.o. male with opioid use disorder.
Patient started on MOUD - Methadone- on 10/2/2024, at BAART MARKET.
ROI: Y

TODAY: 01/10/25

- Opioid use since last visit: Decreased; no fentanyl since first week of methadone
- Overdoses since last visit: No
- POCT UDS opioid results: + methadone, + cocaine, amphetamine, methamphetamine

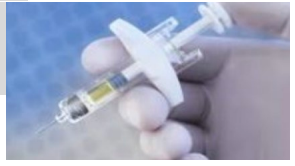
How are things going on MOUD? Now on 85 mg
Any extra-medical opioid use? (Fentanyl/heroin/pills): none; last use was when missed clinic.
Any barriers to accessing MOUD? Getting 4 TH. Still using cocaine, not sure criteria for when to get more TH.

Date	MOUD voucher	Negative Fentanyl Draws	Total Visit Earnings	Total Earnings to Date
10/10/2024	$30	N/A	$30	$30
10/22/2024	$30	+	$30	$60
10/30/2024	$45	neg	$45	$105
12/6/2024	$60	pending	$60	$165
1/10/2025	$60	N/A	$60	$225

SOAR (Supporting Ongoing Achievements in Recovery) (n = 14)

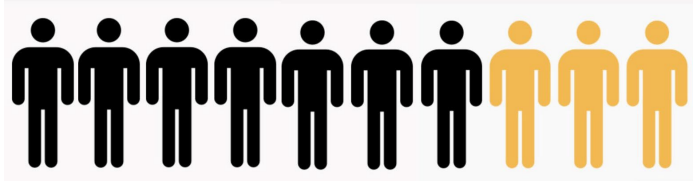
Average age: 51
Age range: **34-66**

43% methadone

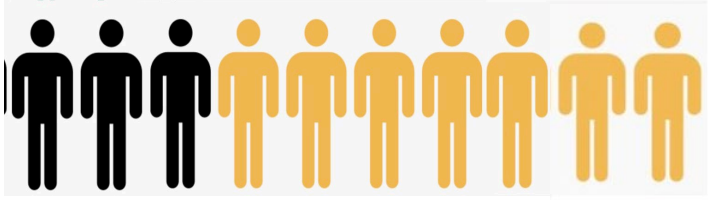


57% buprenorphine*

*88% long-acting injectable



71% male



29% Black/AA

5 — 3 lost to follow-up; 1 desire to switch MOUD; 1 new start — 3 — 2 — 2 methadone

< 2 weeks | 1 month | >3 month | >6 month

STRUGGLES

- Workflow – drop-in "for money"
- Coercion around starting MOUD?
  - Ethics?
- Patient's past traumas and mistrust of healthcare / "the system"
- New! Need to pause to rethink:
  - Timing of rewards (0, 1, 3, 6 months)
  - Evaluation plan
  - Add other goals? *Change methadone dose? fentanyl cessation? modify other substance use?*
- Limited capacity to meet/improve psychosocial stressors

SUCCESSES

- Excited to reward people for meeting goals to stay alive and break cycle of waking up in withdrawal!
- Increased engagement in clinic support – primary care, community groups, behavioral health linkage
- Unconditional "cheerleading"; can restart at any time

Model 3: Incentivize Attendance AND Stimulant Cessation

Goals of Harm Reduction-Based CM

Goal	How?
Including people who are interested in reducing use (not abstinence)	incentivize BOTH attendance and abstinence via guaranteed rewards
Lower the barrier for people experiencing homelessness or housing instability	Drop-in hours instead of appointment-based sessions
Retention in care	Increasing rewards for consistent attendance
Engaging people in care for co-occurring conditions (medical, co-occurring SUD, psychiatric)	1:1 check-ins with a medical and behavioral health provider
Creating a safe and supportive community	Community space led by peers and community health workers

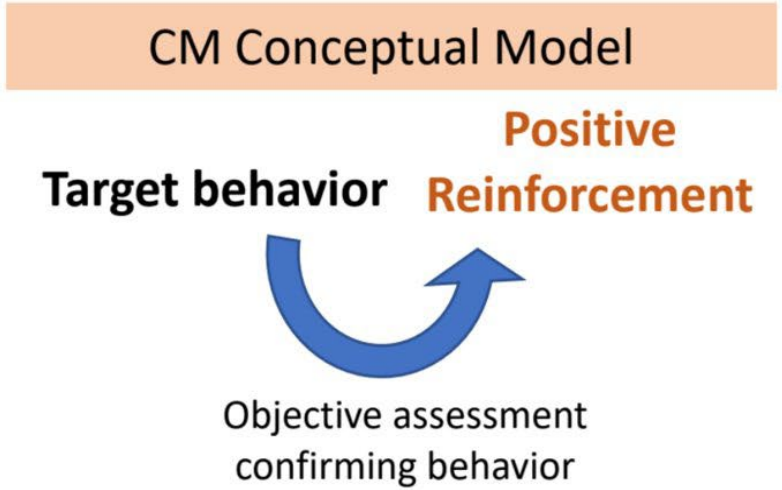
INSPIRE (INcentive Support Program for Improvement and REcovery)

STEP 1: **Define the target behavior to be supported.**

*Specific
*Measurable
*Patient-centered

STEP 3: **How will the behavior be reinforced?**

*Tangible
*Immediately following assessment
*Patient-centered



Attendance to Group 2x/week for 12 weeks

Stimulant Cessation

Target Gift Card

STEP 2: **How will the behavior be assessed?**

*Objective
*Frequent
*Point-of-care

Arriving to Group

POC Urine Non-Reactive to Stimulants

INSPIRE , Cont.

- 1 year of planning: needs assessment, creating workflow & protocols, securing funding, identifying staffing and space

- **Funding**: Funded independently through SF Department of Public Health
  - Funds allocated for overdose prevention
  - Overseen by Office of Behavioral Health Services
  - Not externally grant-funded

- **Staffing**: no new hiring
  - Available team members: Providers (MD/SW), community health worker, AmeriCorps members, peer support specialists
- **Space**: hosted at Maria X. Martinez Health Resource Center (low barrier walk-in clinic)

Referrals from both Primary Care and Street Medicine clinics

INSPIRE STRUCTURE

- Twice weekly sessions for 12 weeks
- Community group and one-on-one check-ins every session
- Gift cards for attendance and optional urine testing (negative for stimulants).

$5 for attendance

$10 for stimulant negative urine (optional)

Consistent attendance earns picks from a fishbowl: 50% gift cards, 50% affirmations

If there are 3 missed visits in a row, participant will be **disenrolled**, but can be re-referred at a later time.

The maximum number of picks is **5**.

Count resets to 1 for missed visit (excused absences are ok).

Patient A

Date	Attendance voucher	UDS voucher	Attendance Draws	Total Visit Earnings	Total Earnings to Date
5/20	-	-	-	-	-
5/23	-	-	-	-	-
5/30	$5	-	Priming	$10	$10
6/3	$5	-	2	$5	$15
6/6	$5	-	3	$5	$20
6/10	$5	$10	4	$15	$35
6/13	-	-	-	-	-
6/17	$5	$10	1	$25	$60
6/20	$5	$10	2	$15	$75
6/24	$5	$10	3	$30	$105
6/27	$5	$10	4	$25	$130
7/1	$5	$10	5	$15	$145
7/8	$5	$10	5	$40	$185
7/11	$5	$10	5	$40	$225
7/15	$5	$10	5	$30	$255
7/18	$5	$10	5	$35	$290
7/22	$5	$10	5	$50	$340
7/25	$5	$10	5	$25	$365
7/29	$5	$10	5	$35	$400
8/1	$5	$10	5	$40	$440
8/5	$5	$10	5	$30	$470
8/8	$5	$10	5	$25	$495
8/12	$5	$10	5	$30	$525
8/15	$5	$10	5	$25	$550

Patient B

Date	Attendance voucher	UDS voucher	Attendance Draws	Total Visit Earnings	Total Earnings to Date
7/11	$5	-	priming	$5	$5
7/15	$5	-	2	$10	$15
7/18	$5	-	3	$15	$30
7/22	-	-	-	-	-
7/25	$5	-	1	$5	$35
7/29	$5	-	2	$10	$45
8/1	$5	-	3	$35	$80
8/5	$5	0	4	$10	$90
8/8	$5	-	5	$15	$105
8/12	$5	-	5	$25	$130
8/15	-	-	-	-	-
8/19	-	-	-	-	-
8/22	$5	-	1	$10	$140
8/26	$5	-	2	$20	$160
8/29	$5	-	3	$10	$180
9/5	$5	-	4	$30	$210
9/9	$5	-	5	$50	$260
9/12	$5	-	5	$20	$280
9/16	$5	-	5	$20	$300
9/19	$5	-	5	$35	$335
9/23	excused	-	-	-	-
9/26	excused	-	-	-	-
9/30	$5	-	5	$10	$345
10/10	$5	-	5	$10	$355

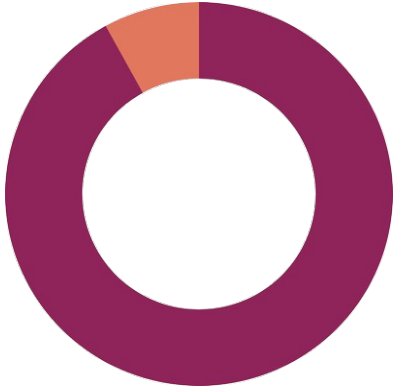
Average age: **52**
Age range: **30-64**

Average incentive earned	Range of incentives earned
$347	**$80-$599***

*max incentive is $599 for tax purposes

Average visits attended: **18 of 24 (75%)**

23% of graduates gave non-reactive UDS at any point
(Range of # of NR UDS given per participant: **1-20**)



92% of graduates reported subjective decrease in stimulant use

PARTICIPANT VOICES

I would recommend INSPIRE to many. SAFE place to be and when the meeting is over, the feeling of "I can do this," the strength I leave with is amazing.

I have been using crystal meth on and off for 30 years, and now I have been able to sustain my sobriety since beginning INSPIRE. It has done incredible things for me.

I love that not one person judged me. I felt that everyone here truly cared about me as a person and that is the greatest feeling.

Contingency Management at IDEA (Pilot Edition)

Edward Suarez, Jr.

Emilie Ashbes

Gaurika E. Mester

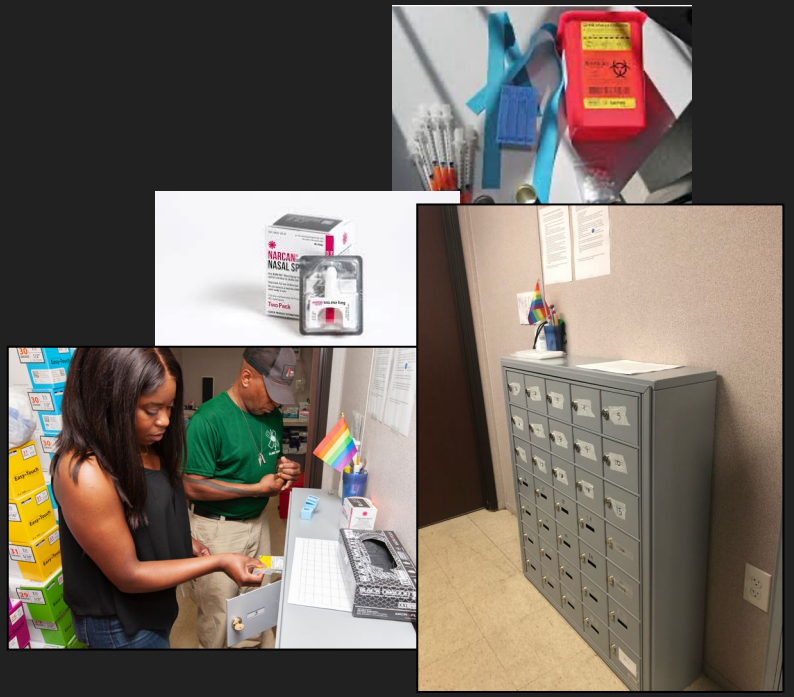
Katrina Ciraldo


AT THE INTERSECTION: Stories of Research,
Compassion, and HIV Services for People Who Use Drugs
WHAT IS HARM REDUCTION?

IDEA Exchange

- *The Infectious Disease Elimination Act (IDEA) of 2016 allows the University of Miami and its affiliates to operate a five-year pilot syringe services program (SSP) in Miami-Dade County. The IDEA Exchange SSP opened December 1, 2016, and was the first legal syringe services program in the State of Florida.*

- *Expansion of this law by the Florida Legislature in 2019 allows each county in the state to set up a syringe services program within its borders. Both the pilot program and the expansion bill stipulates a one-to-one syringe exchange and forbids the use of state or county funding to pay for the exchange of syringes.*



CM at IDEA Miami SSP

- Became a legal SSP in 2016
- Have expanded services to offer wound care, buprenorphine, STI testing, and TeleHarmReduction (THR)
- High amount of stimulant use but no FDA approved treatment
- CM is the most effective treatment for StimUD

Other Services Offered at IDEA

- Medication storage and management
- Sign up/management of Ryan White services
- Two in-person clinics weekly
- Peer support
- Paid study opportunities for participants

The beginnings of CM at IDEA

- Participants who self-reported or tested positive for a stimulant (methamphetamine, amphetamine, or cocaine) at baseline had a lower adjusted odds of retention on buprenorphine at three months (aOR = 0.29, 95% CI: [0.09, 0.93]).
- All this means, people with Stimulant Use Disorder have a hard time with linearity.
- Peer support and CM might be able to help!

› Ann Med. 2023 Dec;55(1):733-743. doi: 10.1080/07853890.2023.2182908.

Adaptation of the Tele-Harm Reduction intervention to promote initiation and retention in buprenorphine treatment among people who inject drugs: a retrospective cohort study

Edward Suarez , Jr [1], Tyler S Bartholomew [2], Marina Plesons [3], Katrina Ciraldo [4], Lily Ostrer [3], David P Serota [5], Teresa A Chueng [5], Morgan Frederick [5], Jason Onugha [6], Hansel E Tookes [5]

Affiliations + expand

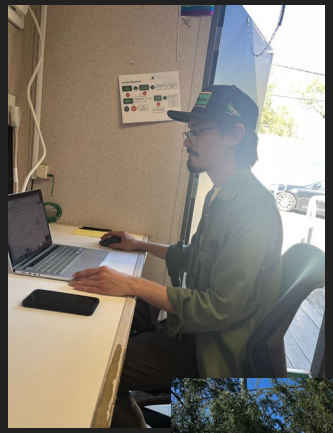
PMID: 36856571 PMCID: PMC9980015 DOI: 10.1080/07853890.2023.2182908

Our CM Protocol

- Duration & Frequency: 12 weeks, 2x/week
- UDS negative for stimulants (methamphetamines, amphetamines, cocaine, MDMA)
  - Amphetamines only with rx for amphetamines
  - Limitation: UDS does not detect synthetic cathinones (more on that later)
- Incentive type: Fishbowl prize system w/ 50% affirmations
- Escalating number of draws (up to 8 draws)

How To Qualify

- At least one stimulant + UDS in the last 365 days
- Wants to lower or completely stop use of stimulants
- Ability to make it to site/give UDS twice per week
- Be an existing participant of IDEA Exchange



How Many Successfully Completed 12 Weeks?

…Two!

One male around age 40, one female around age 65

Both housed in Camillus ISPA/post ISPA housing

Both relatively stable on MAT (not using other opioids)

One participant had to be discharged for poor behavior

Possible Factors Contributing to Noncompletion

- People in CM not exchanging needles and therefore not coming to site (this can be negative or positive)
- Relapse into heavier drug use
- Site hours co-occurring with most work hours stops more functional users from enrolling
- Feeling the incentives aren't worth the effort
- Difficulty in keeping the schedule causing anger at unexcused absences

Example of Incentives

Small= candy bar, can of soda, pair of fuzzy socks, mini flashlight

Large = power bank, thermos, $20 gift card for fast food

Jumbo = $100 gift card to store of choice

Finances

Number of Slips	Type of Slip	Maximum Value of Prize	Probability of Drawing	Cost per Draw
250	Positive affirmations	0	0.500	$0
209	Small	$2	0.418	$0.83
40	Large	$20	0.080	$1.6
1	Jumbo	$100	0.002	$0.2
Total 500 slips				Total: $2.63

Table 1. Fishbowl Composition with Cost per Draw Calculations

Maximum 164 draws possible, with an expected maximum prize value of **$431.32** per patient over 12 weeks.

Bigger Picture Barriers

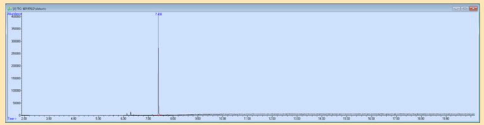
- Insufficient funding for CM incentives
  - *Approx 450$ per patient + administrative costs*
  - *SAMSHA cap at 75$ per patient despite evidence requiring higher incentive amount for efficacy*
- Perceptions that CM is a form of "bribery"
- Regulatory obstacles
  - *Maximum incentive value imposed when using federal funding (Medicare/Medicaid) due to tax requirements*
  - *Limits on incentives (cannot be used to purchase alcohol, cannabis, tobacco, any form of gambling, or firearms)*

Quality Control

The Cathinone Conundrum

A stimulant we cannot reliably test for in urine

601976



From Miami, Florida on 8/19/2024
Assumed to be cathinone (bath salts)

Only 1 major substance detected:

- **3,4-Methylenedioxy-α-Propylaminobutiophenone**

Looks = brown waxy

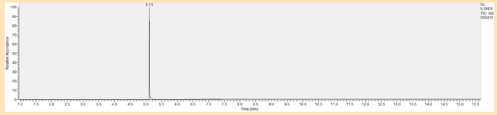
Need free supplies and advice to keep you safe? Find your nearest harm reduction program at harmreduction.org

Major substances in graph:

- Peak 7.4 = 3,4-Methylenedioxy-α-Propylaminobutiophenone

Method(s): GCMS

500410



From Miami, Florida on 2/25/2024
Assumed to be molly

Only 1 major substance detected:

- **N,N-dimethylpentylone**

Looks = white powder

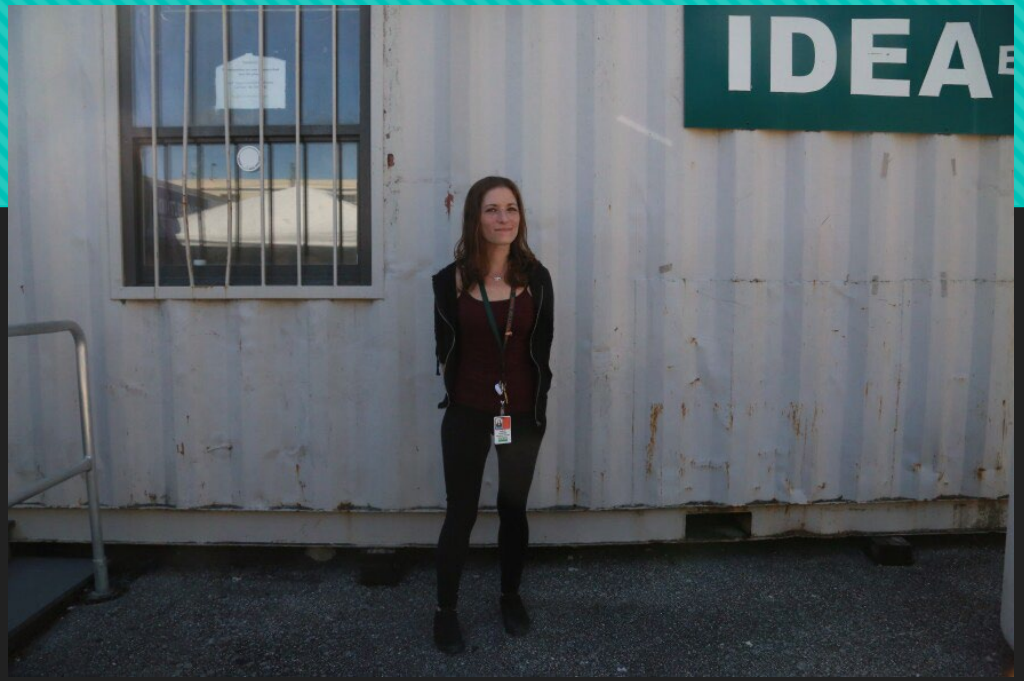
Need free supplies and advice to keep you safe? Find your nearest harm reduction program at harmreduction.org

Major substances in graph:

- Peak 5.11 = N,N-dimethylpentylone

Method(s): GCMS

Who Am I?



- A participant of the IDEA Exchange
  - IV use
  - OUD

- Now I work here as an Outreach Coordinator (peer with admin responsibilities)

Panelists

- **Elizabeth Abbs**, MD – Primary Care & Addiction Medicine Provider, San Francisco Department of Public Health
- **Maleika Edwards** – Health Worker, San Francisco Department of Public Health
- **Edward Suarez** Jr. PsyD, LMHC, MBA – Program Director, IDEA Exchange
- **Emilie Ashbes** – Outreach Coordinator, IDEA Exchange

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

Evaluation and Certificate of Participation

(If you receive an error message, try again in a few minutes)

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https://lanitek.com/P?s=586293

Spanish:
https://lanitek.com/P?s=586293&lng=Spanish

Thank You!

SAMHSA's Homeless and Housing Resource Center provides high-quality, no-cost training for health and housing professionals in evidence-based practices that contributes to housing stability, recovery, and an end to homelessness.

Contact Us:

http://hhrctraining.org/ | info@hhrctraining.org | 518-439-7415 x4

HOMELESS & HOUSING RESOURCE CENTER

PRI POLICY RESEARCH, INC.

SAMHSA Substance Abuse and Mental Health Services Administration