Vancouver CoastalHealth

LOW-BARRIER CONTINGENCY MANAGEMENT

HOW-TO GUIDE

AUGUST 2024

Welcome to the Low-Barrier Contingency Management How-To Guide. This guide was produced and shared on the unceded, occupied ancestral homelands of the xʷməθkwəy̓əm (Musqueam), Skwxwú7mesh (Squamish), and Sə̓l̓ílwətaʔ/Selilwitulh (Tsleil-Waututh), Shíshálh, Tla'amin, Wuikinuxv, Heiltsuk, Nuxalk, Kitasoo-Xai'xais, Lil'wat, Samahquam, Xa'xtsa, Skatin, N'Quatqua Nations.

The purpose of this guide is to offer instruction on how to provide a contingency management program in a low-barrier setting.

Contents

WHAT IS CONTINGENCY MANAGEMENT (CM)?

Contingency Management (CM) is an evidence based treatment model of behavioural modification theory. A key concept in contingency management is positive reinforcement. Positive reinforcement is thought to be particularly helpful for people who use stimulants. Stimulants activate reward pathways in our brains, sometimes so strongly that it's difficult to meet other goals in life. Providing tangible rewards for meeting stimulant use cessation or stimulant use abstinence goals can help "re-wire" reward pathways in our brains. Positive reward pathways help people work toward recovery, vocational, social, emotional, cultural and/or educational goals promoting health and wellness in the context of substance use.

"C" is for **Contingency**

A **contingency** is a linked event or condition; something that is liable to happen as an add-on or result of something else.

"M" is for **Management**

Management refers to supervising, supporting or overseeing something; in the case of CM this would mean overseeing the agreed upon program participation, behaviours and contingencies and offering support to those struggling with the program.

Below is a common program design for CM. However, every program should be informed by and designed to suit the community it will serve and match the service provider's resources.

Duration	12-16 weeks
Number of participants	8 - 12
Weekly sessions	Each participant usually completes: • One 15-20 minute one-to-one session with a staff member • One 30-60 group session co-facilitated by a staff and PWLLE • ***Optional:*** One PWLLE led drop-in session (great for alumni an keeping participants connected to the community and recovery goal setting)
Time of day	Ask your target participants when they would like to attend CM groups/ sessions; it may be morning, afternoon or evening
Prize draws for meeting goals	Each participant can draw up to 3 times per attended session, depending on an individual's achievements in reaching self-defined goals and your resources for prizes

In smaller communities, participants may prefer more intimate one-on-one goal setting sessions to protect privacy in the place of a group session where goals are shared with the group.

HOW DOES CONTINGENCY MANAGEMENT WORK?

A key concept (or idea) in CM is positive reinforcement (referred to as “reinforcement” through this document).

The idea of using reinforcement and consequences to shape behaviour is known as operant conditioning. Research has shown that applying consistent positive reinforcement over time can help change, shape, or teach targeted behaviours. An important tenet of CM and other behavioural approaches is that rewards work better and seem to have more lasting impact in shaping new behaviour than do punishments. In other words, the most successful strategies involve rewarding or positively recognizing achievement rather than punishing or applying negative sanctions to a lack of achievement. In CM studies with stimulant users and more specifically, people engaging in chemsex (sexualized stimulant use), rewards (reinforcers) in the form of incentives have been successfully utilized. These incentives have included extra privileges, vouchers for inexpensive prizes such as retail goods, or actual cash payments. The incentives that a program uses to reinforce participant engagement should be guided by factors such as culture, input from participants and People With Lived and Living Experience (PWLLE), program philosophy, and resources available to the program.

Your CM program will typically range in length from 12 to 16 weeks and can be flexible to meet the needs of individual participants. Some folks may miss a few sessions and need to make up their sessions at the end of the planned program. The focus of your groups and individualized sessions is around making and achieving weekly goals and planning the next week’s overall goals, substance use and recovery planning. Rewards are given according to your program design; however, most CM programs offer rewards immediately after a one-to-one session or during a group session when a participant self-reports meeting their goals. Different programs offer different kinds of incentives and rewards, and ways of winning the reward. Some programs use the fishbowl method, putting varying rewards in a bowl and having participants blind draw a token or chip that reflects the monetary value of the reward. Research shows that having a physical (not virtual) aspect to winning can increase the feeling of positive enforcement. Cash or a gift card is then provided to match the pulled denomination. This aspect of CM is determined by your resources allocated and what you have learned by engaging PWLLE and community in your program design.

Research demonstrates that the most optimal health outcomes occur when CM participants are supported through reward programs that are combined with other psychosocial supports such as group counselling and/or cognitive behavioural therapy. Engaging participants in a holistic and fulsome program can be achieved by developing partnerships to provide in-reach/outreach by PWLLE or clinicians and/or by creating an in-house role in addition to your lead facilitators.

INTEGRATING HARM REDUCTION

There has been little research on the impacts of integrating harm reduction strategies and philosophy into the CM framework, as many current programs do not offer harm reduction. However, the absence of a harm reduction approach within the CM model has potentially limited the opportunity CM groups and services provide to individuals who require lower barrier services, such as people with low socioeconomic status, those who are street-involved, precariously housed or experiencing homelessness, and who may also be involved in sex work or have sex work experience. Harm reduction is an essential component of low barrier services, and developing strategies to integrate appropriate and PWLLE led services like overdose prevention training, drug testing and providing harm reduction supplies is recommended. Your program should provide information about overdose prevention sites and substance use monitoring apps like Lifeguard and the National Overdose Response Service (NORS). Keep in mind CM participants are at risk of toxic drug poisoning (overdose) and keeping folks on track to meet their goals around reduced stimulant use and abstinence needs to include harm reduction.[1]

Some ways to integrate harm reduction philosophy and strategies into your CM group:

- Leave out safer use supplies (meth pipes, naloxone, safer smoking kits, injection equipment) and safer sex supplies (condoms, lube) at all CM drop-ins
- Start all groups with a reminder that your space is one that includes a myriad of substance use recovery goals including reduction of use, safer use, and abstinence from stimulant use, and that everyone will be met and celebrated where they are at without judgment
- Integrate harm reduction into your group discussions and content areas regularly (this will help participants see that harm reduction is embraced by group facilitators)
- drug checking information fentanyl testing strips, and information about overdose prevention sites and services

WHO ARE YOU ENGAGING?

Identifying your target population

When planning a stimulant use recovery-focused program like CM, having a clear understanding of the populations you want to engage can be informed by identifying clients/participants/members accessing other services at your agency and consulting with them. Ensuring staff and PWLLE input will help you to better understand the needs of your audience.

This How-To Guide to CM is designed to promote and support CM programing across the VCH region, bringing treatment and recovery tools that are specific to stimulant use to recovery programs, substance use services, and VCH service provider partners, so that agencies and service providers have more tools to engage and support people who use crystal methamphetamine, cocaine, and other stimulants and may or may not engage in chemsex (sex while using stimulants), sex work, or other high risk activities. Beyond this guide, reaching out to other service providers who serve similar populations may expand your reach for recruiting participants into a CM program.

To create a safe, welcoming, and culturally appropriate environment for individuals from the 2SLGBTQAI+ community, your CM facilitation team may benefit from additional training and resources. We encourage you to explore the resources below for training opportunities and health and wellness promotion tailored to the needs of this community.

Prism Services at Three Bridges
Ribbon Community
HIM Health Initiative for Men
Qmunity
Gov of BC Gender Equity & 2SLGBTQIA+ Resources
What's on Queer Resources

INDIGENOUS CULTURAL SAFETY CM CONSIDERATIONS

Prior to contact with settlers, Indigenous Peoples across Turtle Island had extensive and robust social, economic, justice, and wellness systems that supported health and wellness through a lens of collaboration and equity.

As a result of colonialism, the colonial state was established and the Canadian government enacted a number of discriminatory policies, like the Indian Act (1867-2023), which were designed to violently suppress the rights of Indigenous Peoples and exert control over the day-to-day lives of First Nations in Canada. Severe physical and sexual abuse enacted by those tasked with caring for Indigenous children following the implementation of the Indian Residential School System (1831-1996) and Indian Hospitals (1936-1981) has contributed to a complex interplay of intergenerational, multigenerational, and historical trauma to Indigenous Peoples.

Due to the past, present, and ongoing impacts of colonialism, Indigenous Peoples continue to experience inequities and disparities across every measure of health and wellness, compared to non-Indigenous people in Canada. Most recently in British Columbia, the publication of the In Plain Sight report highlighted systemic Indigenous-specific racism in the B.C. health care system calling for immediate action to improve health outcomes for First Nations and Indigenous Peoples in British Columbia.

Learning about the past, present, and ongoing harms of colonialism is crucial to providing a culturally safe environment for Indigenous participants and their families moving forward together in a good way.

If you are unsure of the principles of Indigenous Cultural Safety, please read more here. It is crucial to promote anti-racism stances, and work towards addressing the underlying Indigenous-specific racism within our health care system by actively practicing cultural humility, and supporting access to Indigenous services and programming across the continuum of health care, including healing and recovery.

Principles for supporting Indigenous Participants in CM Programs

CONSULTATION:

Consult and include Indigenous perspectives, voices and direction during program design and delivery, and seek out an approach that fosters a decolonizing lens on treatment models. This can be achieved by engaging people in a trauma informed, culturally safe process, and inviting all voices to contribute to the design and goals of the CM program through meetings and focus groups. Ensure you demonstrate the value of this feedback by expressing verbal gratitude and offering a stipend or honorarium to people who participate and share. Listen for what types of supports are identified as valuable by Indigenous voices; what types of incentives are identified as most appreciated.

CREATING CULTURALLY SAFE SPACES:

A critical component to creating a culturally safe environment and embedding principles of Indigenous Cultural Safety is ensuring your space looks and feels welcoming to Indigenous Peoples. This can be achieved by incorporating artworks like murals from local Indigenous artists and ensuring access to Traditional Medicines in your space. A welcoming and culturally safe environment will not only support Indigenous participants, but overall participation in your CM programming. For information on traditional medicines and how to incorporate Indigenous artworks please consult with your local First Nation and/or your VCH Indigenous Health team.

CULTURAL CONSIDERATIONS:

Engage Elders and Knowledge Keepers to provide culturally safe support and ceremony as a component of your services. Plan your consultation with local Indigenous communities ahead of time to ensure you have the financial resources to support engagement with Elders and Knowledge Keepers.

PWLLE ENGAGEMENT IN CM WORK

In this guide People With Lived and Living Experience (PWLLE) is defined as a person that has used or uses illicit substances (stimulants) and has the life experience of accessing services as a substance user, procuring illicit substances on the street, maintaining housing and navigating the justice system as a substance user, may have sex work experience.

When developing an inclusive and equitable program or service, including PWLLE expertise from the outset provides the most meaningful engagement and input.

From a health equity perspective, low-barrier treatment, recovery, and harm reduction inclusive services must be accessible and accommodating. Including people with the distinct expertise of living/lived experience in all aspects of program development and delivery offers a more responsive[2], informed and culturally safe initiative which will support you to meet your program goals, retention targets and outcomes. Include PWLLE in every stage of dreaming, planning, creating, implementing, evaluating and celebrating the program.

Positions such as a PWLLE facilitator/coordinator and/or a PWLLE intake support worker can be created to ensure the faces of the program reflect the people accessing the service. Creating a PWLLE advisory group can create space for community stakeholders to provide feedback and input. Additionally, offering a weekly drop-in session inclusive of CM alumni led by a PWLLE facilitator where participants can have a snack, engage in a planned activity like watching a movie and connect with others in the program increases the number of possible contacts a participant will have with the program in a week with little impact on the budget.

For guidance in engaging, recruiting and supporting Peers or PWLLE please see these resources:

Peer Enhanced e-Placements: Unblocking the log jam with sustainable approaches
Using intervention mapping to develop 'ROSE'
BCCDC Peer Payment Standards
Island Health Principles of Peer Employment

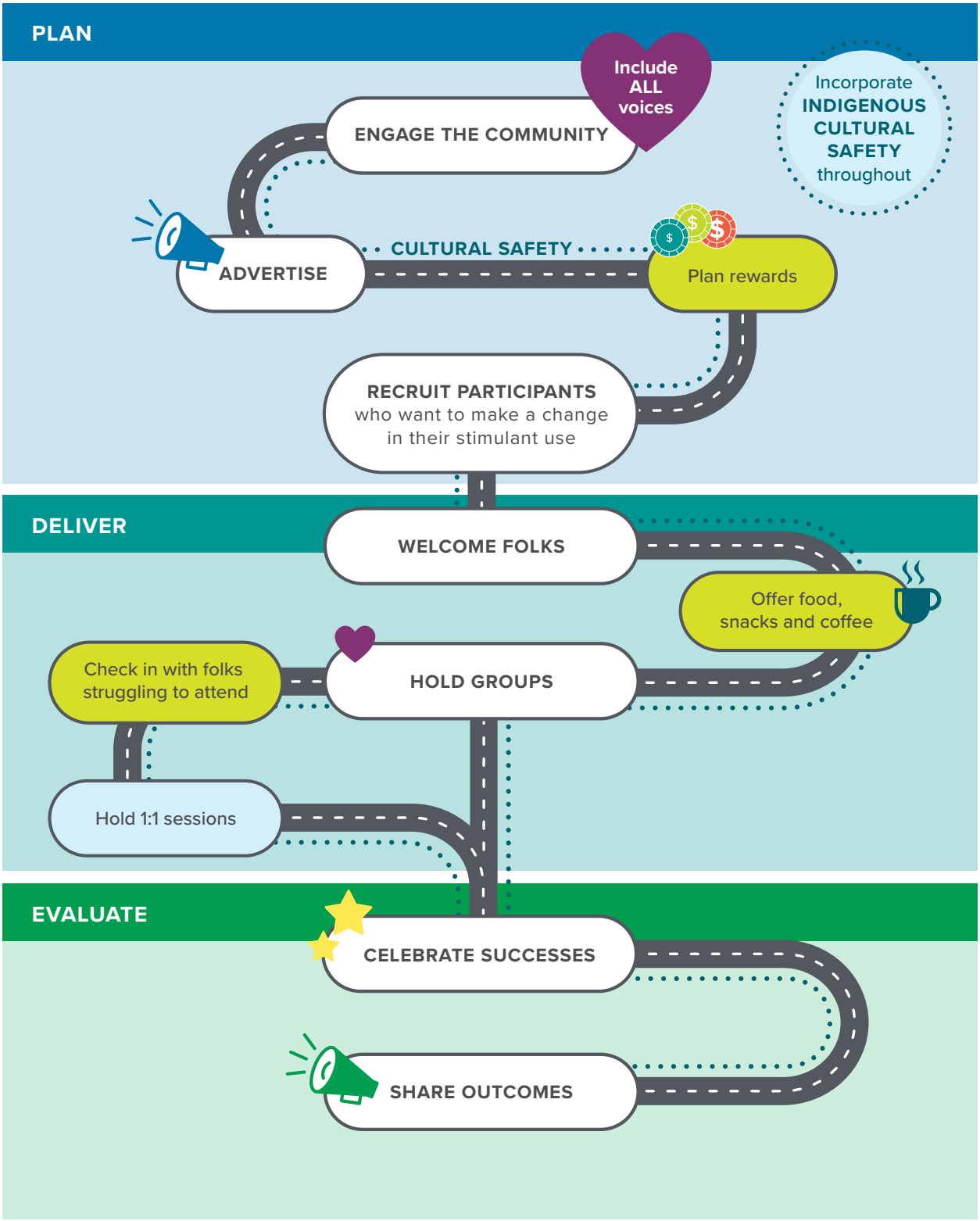
CONSIDERATIONS FOR YOUTH

The growth and development of children and youth includes not only physical changes but also changes in emotions, behaviour and thinking. Staff will treat youth who use substances with respect and offer the same care and support that is offered to adults, along with additional supports if needed. Parental consent is not required to provide youth with harm reduction supports. Creating a safe space to discuss their substance use history and goals and providing help to connect with any additional/requested services are key. Children and youth need a low barrier environment that is client centred and gender inclusive and that puts a priority on trauma and violence informed care.

Contingency Management (CM) interventions offer clear incentives that are designed to generate initial or long-term motivation[3]. Specifically, adolescents have a higher sensitivity of novelty-seeking and immediate rewards than adults[4]. Dopamine plays a role in memory and pleasurable reward and motivation. Therefore, adolescents are more responsive to competitive reinforcement of small behavioural incentives than adults when it comes to immediate rewards[4]. Low-value incentives may have greater impact when youth have limited financial resources.

CM programs are effective in reducing adolescent substance use and can be successfully implemented in a community setting with minimal cost and positive outcomes[4].

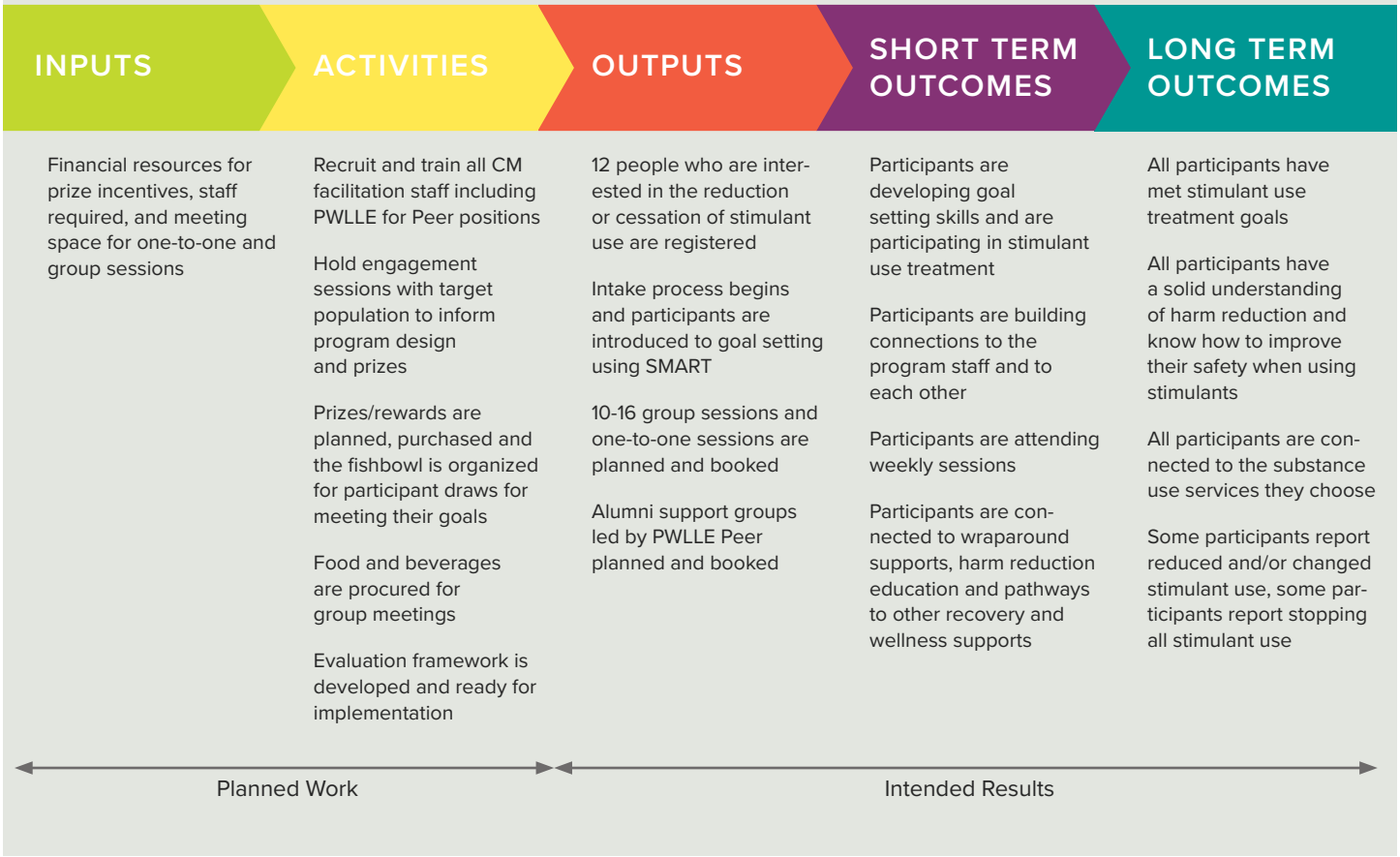
ROAD MAP


PLAN
Include ALL voices
ENGAGE THE COMMUNITY
Incorporate INDIGENOUS CULTURAL SAFETY throughout
ADVERTISE
CULTURAL SAFETY
Plan rewards
RECRUIT PARTICIPANTS who want to make a change in their stimulant use
DELIVER
WELCOME FOLKS
Offer food, snacks and coffee
Check in with folks struggling to attend
HOLD GROUPS
Hold 1:1 sessions
EVALUATE
CELEBRATE SUCCESSES
SHARE OUTCOMES

BUILDING A LOGIC MODEL FOR YOUR GROUP

Developing a logic model for your program will help you visualize and track your program's planned outputs, outcomes and activities. Please see a sample below:

SAMPLE LOGIC MODEL



PLANNING

ELIGIBILITY CRITERIA

This program is designed for:

- People who use stimulants in a way that is causing harm in their lives.
- People who want to set recovery goals with respect to reducing or stopping stimulant use.
- People who are able to participate in a 15-20 minute one-to-one session and in 30-60 minute group sessions once a week for 12-16 weeks (understanding that some participants may need to make up missed sessions).

REFERRAL PROCESS

- Develop a simple referral form and a clear referral process (example in Appendix A).
- A self-referral along with a referral process from partners will provide a lower barrier for people who use stimulants to access to CM.

MARKETING/PROMOTING THE PROGRAM

- Advertise your program so your target population is aware.
- Posters, social media, info sessions and community engagement.
- In some communities word of mouth through participant networks and PWLLE will be very effective.

PLANNING REWARDS

- Incentives/rewards need to be consistent so participants know what to expect.
- Incentive/reward types and denominations should be guided by PWLLE and participant feedback prior to purchasing and within your budgeted amount.
- Ensuring the incentives/rewards are culturally appropriate is key. Have you meaningfully engaged your target population and PWLLE and listened to their feedback?

SESSION PREPARATION

GROUP PREPARATION TIPS:

Lead facilitator roles/duties:

- Recruit a PWLLE/Peer to co-facilitate or lead both group and one-to-one sessions and Alumni groups
- Provide training and support for all staff involved including PWLLE/Peers
- Co-facilitate group and one-to-one sessions
- Record attendance, recovery goals, and milestones
- Provide prize draws for goals met
- Maintain rewards log that includes the value or cash amount of each prize
- Pre-group set up: store supplies somewhere easy to access and easy to pack up (some programs store their supplies in marked storage bins)
- Introduce the group to the evaluation framework early on to highlight the importance of participant feedback on the quality and outcomes of the program

PWLLE duties:

- Co-facilitate or lead group and one-to-one meetings, consider leading an Alumni group
- Support participants with identifying SMART recovery goals
- Snack shopping: typically around $10/group
- Support with any program records, documentation and or group planning

MATERIALS/SUPPLIES YOU WILL NEED:

- SMART goals info sheets (Appendix B)
- CM prize draw box/fishbowl and chips
- Goal setting slips (Appendix C)
- Facilitators' binder, including things like:
  - Group attendance record
  - One-to-one attendance record
  - PWLLE drop-in session attendance record
  - Individual participant goal tracking sheet
  - Incentives / $ dispensed
  - Participant notes

SAMPLE GROUP AGENDA

Tips to run a one hour group:

5 minutes: Welcome, Land Acknowledgment, check in question and introductions

2 minutes: Review of Group Guidelines

10 minutes: Review of Goals from Previous Week (may have to split into groups if more than 8 participants)

20 minutes: Goal Setting for Current Week

20 minutes: Prize Draws

If graduating, recognition circle to appreciate and celebrate the graduate.

HOW TO RECORD ACTIVITIES AND OUTCOMES:

During Group:

Keep track of goals, incentives, and attendance.

After Group:

Record attendance, create a 'GROUP NOTE'.
(e.g. participants attending Contingency Management Group today to support their recovery journey with stimulant use).

PRIZE DRAW SUGGESTIONS:

Can receive up to three draws at a max per group:

- Receive 1 draw for self-reported abstinence or reduced stimulant use
- Receive 1 draw for achieving the three goals set the previous week
- Receive 1 draw for attending three consecutive groups

GOAL SETTING:

- Use SMART model of goal setting (Appendix B)
- Set 3 goals in each group (examples: health, housing, stimulant recovery, safer stimulant use, ceremony, or connection to a cultural event)
- The focus is to have participants make goals that are individual and important to them, are achievable by next group, and keep them challenged in a strength-based and supportive way.

SUGGESTED PRIZE DISTRIBUTION/ PURCHASING

Based on a brief literature review and comparison with standard CM groups operating in Vancouver and low-barrier groups in operation throughout the VCH region, prizes are divided into small, medium, and large. When possible, prizes should reflect what your target group has indicated would be of value to them. In some cases, this is a combination of cash, gift cards, recreational passes, and personal care items.

Below is an example of a fishbowl that contains a total of 51 chips:

40 small chips
75-80% of total: $5-$10 value

10 medium chips
About 20% of total: $20-$50 value

1 large chip
Less than 5% of total: $100 value

PROGRAMMING FOR GROUP SESSIONS

Programming for your group session can be planned by engaging the people you intend to recruit into CM and asking them what kind of support groups have worked for them in the past and what hasn't. This may inform what you offer and may create an opportunity to learn about alternatives that are new to you and your team. Interventions like SMART, motivational interviewing and cognitive behavioural therapy are commonly used in CM group sessions and have proven to be useful in supporting people to meet their recovery goals and stay engaged.

Group session resources:

Smart Recovery Toolbox
CBT Worksheets
Motivational Interviewing Toolkit

TIPS FOR FACILITATORS

1. Establish a routine of **brief weekly check-in sessions** with participants to review goals, attendance, and wellness, and to reinforce harm reduction principles and to build relationships.

2. Facilitators or team members who do not identify as Indigenous and are welcomed to run groups that include Indigenous community members will benefit from **remaining curious and humble**. Taking time to include an Indigenous lens in program design and delivery improves cultural safety.

3. Keep in mind that different people have different relationships with stimulants, different reasons for use, and different recovery goals. If people are using to meet basic needs like staying awake for safety or to watch their belongings while homeless, support them in meeting their needs for housing and safety while supporting them with their stimulant use recovery goals.

TIPS FOR ORGANIZATIONS

1. Pay attention to factors of organizational readiness for a CM intervention within your program. Philosophical differences and ideas about how the protocol will be carried out **should be resolved collectively** including the voices of those with living and lived expertise.

2. CM will be most effective when the whole team is "on board," with **all staff including PWLLE receiving training** on the parameters of CM as an intervention.

3. Develop connections with social services in your area that can support basic needs like food security, shelter, and primary health care. The Overdose Outreach Team in Vancouver is one service that can help clients in the VCH region get connected to care if they do not have a primary care clinic.

GUIDELINES AND PARTICIPATION POLICIES

Guidelines and participation policies (Appendix D) should reflect those of your agency/organization/group. Confidentiality and Anti-Bullying and Harassment policies are needed for staff, PWLLE and participants.

You may want to develop a soft framework like Appendix E or a decision tool for when participants arrive too intoxicated to participate and a plan to follow if someone will be excluded from the program that day. Ask your team how they would like to be engaged and treated in those moments and develop a protocol based on meeting your participants where they are at.

Guidelines for Our Group:

Coming from a place of mutual respect and understanding, let's observe some basic meeting agreements:

Maintain confidentiality and anonymity:	What's said before, during and after the group in this space is considered confidential as well as the names of those who attend.
Respect for all:	Discrimination and prejudice of any kind will not be tolerated; a reminder to respect each other's pronouns.
One person talks at a time and share the airtime:	Everyone deserves to speak without interruption and to be included in the discussion.
Respect our experiences:	Speak from your own personal experience using "I statements" to allow differences of experience.
Minimize glorification of substance use / addictive behaviours:	We all have different relationships with different substances and addictive behaviors, and do not want to trigger one another.
Minimize trauma and violence details:	Talking about these experiences can be re-traumatizing for yourself and others. These are best kept for individual counselling.
Silence cell phones:	This is a healing space, let the group know if you are expecting an important phone call.
Be on time:	Being late can disturb the group dynamic.

BUDGET PLANNING

When designing a CM program, budget and budget management are needed to create a sustainable and equitable program. Once you have developed your PWLLE-inclusive staffing model, you will need to plan for food, program supplies and workshop content which could include guest speakers. Below is an example of the types of expenditures a CM program may have.

FACILITY COSTS	
STAFFING/ PEERS/ELDERS	
FOOD AND BEVERAGE	
INCENTIVES/ REWARDS	
PROGRAM SUPPLIES	
WORKSHOPS/ SPEAKERS	

STAFF TRAINING

It will be essential to have staff and PWLLE trained in key areas that will prepare them for the work of providing a safe and supportive CM program. Some recommended training areas are:

- Indigenous Cultural Safety*
  Learning Hub: ICS Foundations Module 1
  Learning Hub: ICS Foundations Module 2
- Trauma-Informed Practice
- Best Practices in Harm Reduction
- Overdose Prevention Training
- Peer-to-Peer Counselling Training
- Supporting Peer Workers
- Resisting Stigma on Substance Use*
- Stimulants 101
- Online Street Degree*
- Agency-Specific Confidentiality Training
- SMART Goal Setting
- Crystal Meth Resource Guide

* Note that for Learning Hub you will need to create a login to make links work.*

Additional topics to consider:

- lateral violence
- de-escalation
- motivational interviewing basics

COLLECTING FEEDBACK / EVALUATION

In order to assess your program, participant journeys, and outcomes, you may need to plan for an external evaluator to support the development of an evaluation framework. This framework can be used to evaluate the process for implementing the CM program and/or the quality and effectiveness of the program in supporting people to reduce or stop using stimulants. This can be done independently or in partnership with the program's funder.

In the event that there are limited resources, you and your team can develop a feedback tool or questionnaire for participants to fill out at the beginning, middle, and end of the 12-16 week program. Example in Appendix F.

Feedback from participants provides vital information and offers you and your team a chance to review and reflect on what worked, what didn't work, and ways to improve your program.

QUESTIONS FOR PLANNING YOUR CM

In order to get started there are a few things to consider. Below are some key questions to ask your team:

- Are we employing a decolonizing approach to CM that can help create a greater experience of **welcome, cultural safety, and inclusivity for First Nations, Inuit and Metis people?**
- Do we have a culturally safe space that is **purposely inclusive of LGBTQIA2S+ individuals?**
- How have we included **Lived and Living Experienced PWLLE** in decision processes from program design to implementation?
- How have we included **community and participant engagement** to inform program design? What do members/participants want from this initiative and how would they best engage?
- How have we explicitly included **harm reduction approaches** and philosophy into programming in ways that can be felt by participants?
- Do we have **someone who can facilitate group sessions** and one-to-one goal-setting chats, or do we need a recruitment plan?
- Do we have **PWLLE** to co-facilitate goal setting, group sessions and one-to-one, PWLLE-to-PWLLE counselling?
- Does our budget **ensure sufficient staffing, rewards, and program supplies** (food, snacks)?
- What is our **training plan** for staff and PWLLE?
- How do we **plan to track goals** and rewards and keep those records safe?
- What is our **plan for assigning incentives/rewards** that meets our budget?
- Will we use **chips/vouchers** that have varying denominations as per budget and program design?
- How do we plan to **evaluate our program**? How have we included PWLLE and participants in this evaluation?
- When required, have we included a **stakeholder and partner engagement plan** to provide in-reach psychosocial supports that address the social determinants of health?
- Do we have **other partners** and complimentary services to refer CM participants to when appropriate?

Thank you for taking the time to review this guide. The hope is you are well on your way to understanding CM and ready to explore designing and implementing CM at your agency. If you need further support please email: regionaladdictionsprogram@vch.ca

Resources

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5. https://www.emcdda.europa.eu/system/files/publications/2726/POD2014_Treatment%20for%20cocaine%20dependence.pdf

6. https://store.samhsa.gov/sites/default/files/d7/priv/tip35_final_508_compliant_-_02252020_0.pdf

7. Treatment of stimulant use disorder: A systematic review of reviews https://www.ncbi.nlm.nih.gov › articles › PMC7302911

8. Optimizing Contingency Management with Methamphetamine-Using Men who Have Sex with Men https://pubmed.ncbi.nlm.nih.gov/32461714/

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22. https://positivepsychology.com/cbt-cognitive-behavioural-therapy-techniques-worksheets/

23. https://ireta.org/resources/motivational-interviewing-toolkit/

Appendix A: **Example referral form**

CONTINGENCY MANAGEMENT GROUP REFERRAL INTAKE FORM

FAX to: _____ **Email to:** _____ **or drop off to** _____

Questions? Call _____

Date: _____

PARTICIPANT CONTACT DETAILS

Contact details: _____ Okay to leave phone message: ☐ Yes ☐ No

Address: _____ Email: _____

Emergency contact phone: _____ Relationship to participant: _____

Okay to phone/text: ☐ Yes ☐ No

In event of emergency, okay to tell them what group you were involved in? ☐ Yes ☐ No

---

ELIGIBILITY CRITERIA:

☐ Active Stimulant Use ☐ Active Stimulant Use Disorder (any severity) ☐ In Early Remission (less than 3 months)

TREATMENT GOAL: ☐ Reduce stimulant use ☐ Abstain from stimulant use

☐ Participant is group appropriate: Able to respectfully and meaningfully participate in a 1 hour co-ed session

☐ Participant is willing to commit to a 12-week group 16-week group

☐ Participant is not currently actively engaged with psychosocial supports for substance use (prioritizing those not connected)

If actively engaged, what programs: _____

REFERRAL SOURCE

Referred by: (name) _____ Organization: _____ Contact number: _____

SUBSTANCE USE HISTORY

Substance	Age of first use	Method of use	Date of last use	# Days of use in last 30 days	Typical Day amount used	Current Pattern	Stage of Change	Actions/Thoughts
Methamphetamine								
Cocaine								
Other:								

Other current substance use: ☐ Opiates ☐ Alcohol ☐ Nicotine ☐ GHB ☐ Other: _____

Appendix B: **SMART model of goal setting**

S	SPECIFIC	What do you want to do?
M	MEASURABLE	How will you track your process?
A	ATTAINABLE	How will you do it?
R	RELEVANT	Is this relevant to your life right now?
T	TIMELY	When do you want to do it?

Appendix C: **Example goal slip**

Date:	Name:
STIMULANT USE RECOVERY GOAL:	
HEALTH OR HOUSING GOAL:	
RECREATIONAL/ CULTURAL/SPIRITUAL GOAL:	

Appendix D: **Example Group Guidelines**

Coming from a place of mutual respect and understanding, let's observe some basic meeting agreements:

Maintain confidentiality and anonymity:	What's said before, during and after the group in this space is considered confidential, as are the names of those who attend.
Respect for all:	Discrimination and prejudice of any kind will not be tolerated; a reminder to respect each other's pronouns.
One person talks at a time and share the airtime:	Everyone deserves to speak without interruption and to be included in the discussion.
Respect our experiences:	Speak from your own personal experience using "I statements" to allow differences of experience.
Minimize glorification of substance use / addictive behaviours:	We all have different relationships with different substances and addictive behaviours, and do not want to trigger one another.
Minimize trauma and violence details:	Talking about these experiences can be re-traumatizing for yourself and others. These are best kept for individual counselling.
Silence cell phones:	This is a healing space, let the group know if you are expecting an important phone call.
Be on time:	Being late can disturb the group dynamic.

Appendix E: **Example: Supporting People Who Are Intoxicated Protocol**

Purpose:

This protocol outlines the procedures and guidelines for supporting people who present to a program while intoxicated. The primary aim is to ensure the safety and well-being of the intoxicated person, the other participants, and staff members while providing trauma- and violence-informed care.

1. Initial Relational Practice Visual Assessment:

Upon the arrival of an individual to the service, a staff member, ideally someone familiar with the individual, will conduct a brief assessment to determine the level of intoxication and any immediate medical or safety concerns.

If staff members notice the individual appears intoxicated (eg drowsy, slurring speech, behaving erratically), they will assess for any immediate medical or safety concerns, and call 911 if needed. It's ideal if this is done by a staff member familiar with the individual. See the SAVE ME Steps here.

Please note that signs of stroke or other medical emergencies can be confused with intoxication.

2. Safety Precautions:

Be kind, caring and respectful.

Ensure the safety of the individual who is experiencing intoxication and other participants.

If the individual is displaying disruptive behaviour, take necessary steps to de-escalate the situation by leveraging your relationship, speaking slowly and clearly and in a calm manner, and ensuring the safety of everyone.

Remove any potential hazards or dangerous objects from the vicinity to prevent accidents or injuries.

Call 9-1-1 if needed.

3. Supportive Measures:

Where possible offer a safe, private and comfortable environment for rest and recovery. This space must be easy to monitor due to risk of toxic drug poisoning.

Offer food, snacks, water, and non-alcoholic beverages.
Do not give anything by mouth to people who are drowsy or unresponsive.

Engage in a respectful and dignified conversation about other services or programs that support people who are actively using substances, and assess the individual's interests and needs and assist accordingly.

When possible offer to accompany the individual to a harm reduction-based service.

5. Referral and Follow-Up:

If the individual requires further assistance beyond what your services can provide, facilitate referrals to overdose prevention and harm reduction services, and support with system navigation to withdrawal management and/or psychosocial support services.

Provide information and resources to the person regarding available support services for substance use, mental health, or other related issues.

When possible follow up with the person to ensure continuity of care and on-going support.

Welcome people to come back to the program when they are ready to participate.

If people continually arrive to the program unable to participate, meet with them about the purpose of your program or service and the expectations for participation.

6. Documentation:

Document the details of the incident, including the individual's presentation, assessment findings, actions taken, and any referrals made. Use trauma informed language to have this conversation and support this individual with a non-judgemental approach.

Maintain confidentiality and adhere to privacy regulations when documenting sensitive information about the incident.

7. Staff Training and Support:

Provide staff members with training on recognizing the signs of intoxication, de-escalation techniques, and protocols for supporting intoxicated individuals.

Offer support and debriefing sessions for staff members involved in supporting intoxicated individuals to address any emotional or psychological impact of the experience.

8. Review and Evaluation:

Regularly review and evaluate the effectiveness of the protocol in supporting intoxicated individuals and identify areas for improvement or refinement.

Approval and Implementation:

This protocol is approved by [appropriate authority] and is effective from [effective date]. All staff members are required to familiarize themselves with this protocol and adhere to its guidelines when assisting intoxicated individuals.

Revision History:

Version 1.0 - [Effective Date]

Initial protocol implementation.

Version 1.1 - [Revision Date]

[Brief description of revisions]

[Add additional version history as needed]

Acknowledgment:

I acknowledge that I have received, read, and understand the Intoxicated Person Support Protocol.

Print Name:	**Signature:**	**Date:**
_____	_____	_____

Appendix F: **Example: CM End of Program Participant Survey**

Please fill out this confidential survey to help us evaluate CM programming for people who use stimulants. The information you share will be used to help us improve services, find out what aspects of the program are most useful to participants, and get a sense of where participants are at in their harm reduction journeys. If any of the questions are upsetting or make you feel uncomfortable, please reach out to program staff for support.

1 Since we are asking for your feedback at both the start and end of the program, please provide the following information to help us create a unique code that can be used to link your responses across surveys:

The initials of your first and last names: _____ **Your date of birth (month, day, and year):** _____

2 **Have you participated in CM before?** Please choose one option. ☐ Yes ☐ No

3 **What kept you coming to the CM Program?** You can choose multiple options.

- ☐ I was able to work on my stimulant use goals
- ☐ I had access to one-on-one support
- ☐ I enjoyed the group programming
- ☐ Peers helped run the group
- ☐ I liked the money incentives/prizes
- ☐ I liked the food/snacks
- ☐ I had access to harm reduction supplies (pipes, syringes, etc.)
- ☐ The group felt safe to me
- ☐ The program doesn't require me to be sober (to not use substances)
- ☐ I felt like I wasn't being judged for using or not using
- ☐ I had the opportunity to connect with other people who use substances
- ☐ I had the opportunity to meet new people and make new friends
- ☐ There were other aspects that I liked (please specify):_____

4 **How important is it to you now to make changes to your stimulant use?** Please choose one option.

☐ Not at all ☐ Slightly ☐ Moderately ☐ Considerably ☐ Extremely

5 **In the <u>past 3 months</u>, what has changed about how you use stimulants?** You can choose multiple options.

- ☐ I spend less money
- ☐ I use more safely
- ☐ I've changed who I use with
- ☐ I've changed how I use stimulants (e.g., smoking, injecting, etc.)
- ☐ I've changed which stimulants I use
- ☐ I use less often
- ☐ I've reduced the amount (quantity) I use
- ☐ I've stopped using stimulants
- ☐ Other (please specify): _____

6 **In the past 3 months, have you accessed any of hte following services for support with your stimulant use?**
You can choose multiple options.

- ☐ Medication for stimulant use treatment
- ☐ The emergency department in a hospital
- ☐ Social support/mutual aid groups
- ☐ Supervised consumption site or overdose prevention site
- ☐ I have not used any of the above services in the past 3 months
- ☐ I have used another service for my stimulant use (please specify):_____

7 Please choose one option for each of the following questions:

Have you experienced an overdose from stimulant use in the past 3 months? ☐ Yes ☐ No

Have you experienced overvamping from stimulant use in the past 3 months? ☐ Yes ☐ No

8 **Thinking about the past 3 months, which of the following substances have you used?**
In each column, please choose one option to indicate how frequently you have used any of these substances and the main way you have used them.

	I have used this substance:	**The main way I've used this substance is:**
Crystal/Meth/ Side/Tina	☐ Daily ☐ Weekly ☐ Monthly ☐ Less than monthly ☐ I have not used this substance in the past 3 months ☐ I have never used this substance	☐ Smoking ☐ Snorting ☐ Swallowing ☐ Injecting ☐ Booty bumping ☐ Not applicable
Coke/ cocaine powder	☐ Daily ☐ Weekly ☐ Monthly ☐ Less than monthly ☐ I have not used this substance in the past 3 months ☐ I have never used this substance	☐ Smoking ☐ Snorting ☐ Swallowing ☐ Injecting ☐ Booty bumping ☐ Not applicable
Crack cocaine	☐ Daily ☐ Weekly ☐ Monthly ☐ Less than monthly ☐ I have not used this substance in the past 3 months ☐ I have never used this substance	☐ Smoking ☐ Snorting ☐ Swallowing ☐ Injecting ☐ Booty bumping ☐ Not applicable
Mephedrone	☐ Daily ☐ Weekly ☐ Monthly ☐ Less than monthly ☐ I have not used this substance in the past 3 months ☐ I have never used this substance	☐ Smoking ☐ Snorting ☐ Swallowing ☐ Injecting ☐ Booty bumping ☐ Not applicable

	I have used this substance:	The main way I've used this substance is:
Fentanyl (check only if you **intentionally** used fentanyl)	☐ Daily ☐ Weekly ☐ Monthly ☐ Less than monthly ☐ I have not used this substance in the past 3 months ☐ I have never used this substance	☐ Smoking ☐ Snorting ☐ Swallowing ☐ Injecting ☐ Booty bumping ☐ Not applicable
Heroin	☐ Daily ☐ Weekly ☐ Monthly ☐ Less than monthly ☐ I have not used this substance in the past 3 months ☐ I have never used this substance	☐ Smoking ☐ Snorting ☐ Swallowing ☐ Injecting ☐ Booty bumping ☐ Not applicable
Benzos (not prescribed) (check only if you **intentionally** used benzos)	☐ Daily ☐ Weekly ☐ Monthly ☐ Less than monthly ☐ I have not used this substance in the past 3 months ☐ I have never used this substance	☐ Smoking ☐ Snorting ☐ Swallowing ☐ Injecting ☐ Booty bumping ☐ Not applicable
GBH/GBL	☐ Daily ☐ Weekly ☐ Monthly ☐ Less than monthly ☐ I have not used this substance in the past 3 months ☐ I have never used this substance	☐ Smoking ☐ Snorting ☐ Swallowing ☐ Injecting ☐ Booty bumping ☐ Not applicable
Another substance Please specify below.	☐ Daily ☐ Weekly ☐ Monthly ☐ Less than monthly ☐ I have not used this substance in the past 3 months ☐ I have never used this substance	☐ Smoking ☐ Snorting ☐ Swallowing ☐ Injecting ☐ Booty bumping ☐ Not applicable
If you selected "another substance" above, please specify which substance you are referring to:		

9 **Thinking about the past 3 months, how often would you say you used alcohol?** Please choose one option.

☐ Daily
☐ Weekly
☐ Monthly
☐ Less than monthly
☐ I have not used alcohol in the past 3 months

10 **Thinking about the past 3 months, how often have you experienced any of the following?**
Please choose one option for each issue.

Financial issues	☐ Never	☐ Rarely	☐ Sometimes	☐ Often	☐ Always
Friends or family voicing concerns	☐ Never	☐ Rarely	☐ Sometimes	☐ Often	☐ Always
Impacts on your job or work	☐ Never	☐ Rarely	☐ Sometimes	☐ Often	☐ Always
Impacts on your housing	☐ Never	☐ Rarely	☐ Sometimes	☐ Often	☐ Always
Impacts on your health	☐ Never	☐ Rarely	☐ Sometimes	☐ Often	☐ Always
Social isolation or avoiding people	☐ Never	☐ Rarely	☐ Sometimes	☐ Often	☐ Always

11 **Please respond to these statements.** Choose one option for each statement.

I like the program.	☐ Yes	☐ No
I found the program accessible.	☐ Yes	☐ No
Staff/Peer facilitators provided a safe space for participation.	☐ Yes	☐ No
In the program, I made new connections with other participants.	☐ Yes	☐ No
Having people with lived and living experience facilitating the program was important.	☐ Yes	☐ No
I learned how to practice safer substance use to avoid overdose.	☐ Yes	☐ No
I have used what I learned from the program to use substances more safely.	☐ Yes	☐ No
The incentives/prizes were important for helping me meet my weekly goals.	☐ Yes	☐ No
I am making positive progress towards my stimulant use recovery goals.	☐ Yes	☐ No

12 **How often did you meet the weekly goals you set during the program/group?** Please choose one option.

☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

13 **What is the most positive impact that the program/group had on you?**

_____

_____

14 **Do you have any other comments, including suggestions for improving the closed group or feedback on this survey?**

_____

_____

_____

Thank you!

Appendix G: **Crystal Meth Resource Guide**

Online courses

- **Crystal Meth E-Learning Series (St Stevens Community House):**
  Five free, short, self-directed online modules that are a great start to learning about crystal meth (~ one hour to complete all)
  https://www.youtube.com/watch?v=X1FiwWg-uFU&list=PLDbIF5zAAxztLNV99VcpdbSpSghThaiEZ&index=3

- **Crystal Meth Expert Panel (VCH):**
  Webinar for front-line staff featuring experts with clinical, community and lived experience sharing their insights on caring for people who use crystal meth (90 min)
  https://www.youtube.com/watch?v=3rAx3xY2e44

Videos

- **Chemsex video playlist from David Stuart**
  Lectures, talks and discussions about the role that crystal meth plays communities of gay, bi and men who have sex with men (GBMSM)
  https://www.youtube.com/playlist?list=PL59WY5a9gIGRlzWD3FWp9MCBj6x8hJ2qy

Factsheets / articles

- **Crystal Meth Factsheet**
  Overview of crystal meth myths, facts, harm reduction and treatment options
  https://drugpolicy.org/drug-facts/methamphetamines

- **Party and play in Canada: What is its impact on gay men's health?**
  Overview of "party and play" for GBMSM from Catie.ca
  https://www.catie.ca/prevention-in-focus/party-and-play-in-canada-what-is-its-impact-on-gay-mens-health