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EDITORIAL

Training as Implementation: Embedding Contingency Management into Medical Education

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ABSTRACT

Contingency Management is a highly effective behavioral intervention for Substance Use Disorders, yet its adoption remains limited outside of well-funded institutions—especially among marginalized populations. This editorial argues that a key barrier to Contingency Management implementation is its absence from medical education and clinical training, which perpetuates provider skepticism, ethical concerns, and poor integration into diverse care environments. Drawing from a narrative review of literature from 2000–2024, we identify systemic and provider-level obstacles to Contingency Management adoption and propose a roadmap for embedding it into the training pipeline for future healthcare providers. Our aim is to position medical education, and specifically early equity-focused training, as a critical intervention point for scaling Contingency Management use across clinical settings. We outline practical strategies such as early curricular inclusion, elective coursework, simulation-based learning, culturally responsive training modules, and interdisciplinary community partnerships. Ultimately, we argue that reimagining Contingency Management as a flexible, culturally adaptable tool embedded in medical training can help close the implementation gap and expand access to equitable addiction care.

Introduction:

Substance Use Disorders have had profound impacts on public health in the United States, contributing to rising overdose-related mortality and placing increased strain on the healthcare system.[1] Surveillance studies have reported a rise in prescription drug use—particularly opioids—alongside increasing marijuana dependence and expanded access to MDMA and heroin.[1-2] Between 2010 and 2022, unintentional overdose deaths increased by 104.9%.[1] While Substance Use Disorders occur across all demographics, factors such as family history and environmental context influence susceptibility.[3-5]

For individuals cycling through incarceration, unstable housing, and chronic relapse, conventional care models fail to address their complex needs.[6-8]

Among the various existing treatments for Substance Use Disorders, Contingency Management has emerged as a potent behavioral intervention designed to establish target behavioral change through positive and negative reinforcement.[9-10] Contingency Management has demonstrated high rates of abstinence in the short-term, particularly in promoting higher treatment adherence and initial abstinence.[11] Though supported by robust evidence in addiction care, Contingency Management's real-world use remains limited.[12-13] Given the continued public health crisis, the pressing need to expand Contingency Management to a broader range of treatment environments is ever present, including community-based settings. This editorial argues that one of the most actionable strategies to closing the implementation gap of Contingency Management from well-funded institutions to smaller, community based organizations, is reforming medical and clinical training to expose and prepare future providers to use it effectively and equitably.

Barriers to Implementation:

Contingency Management demonstrates high efficacy in Substance Use Disorder treatment,[10] yet adoption remains low due to a range of systemic and provider-level factors: Provider skepticism – Misconceptions about reward-based interventions and surrounding ethics,[14-15] lack of training – insufficient exposure in medical education,[16] structural barriers – reimbursement challenges and resource limitations.[17] Studies have found that targeted training improves provider attitudes and implementation rates.[16-19] As such, medical education can serve as a powerful and scalable vehicle for Contingency Management dissemination and utilization.

Bridging the Implementation Gap:

To effectively address the devastating effects Substance Use Disorders have inflicted in our communities, we must reframe medical education as part of the implementation infrastructure. Promising dissemination strategies include targeted provider education, systemic investment in community clinicians, and reforms that reflect evolving substance use trends.[14-17] Further, studies have suggested that implementation strategies are most effective when combined with structured training and practical, hands on support, furthering the argument to integrate it in medical education programs, which can serve as the catalyst for implementation.[19]

We propose that integrating Contingency Management into clinical training, beginning in medical school and continuing through residency programs, can help bridge the gap between research and real-world practice. Among our proposed solutions is offering medical students an elective course in Contingency Management that can increase awareness of this evidence-based tool, and even promote its applicability and integration across specialities. Further, embedding early and ongoing education in Contingency Management principles during residency can improve the implementation gap. Workshops during addiction medicine rotations focused on review of key studies, didactic sessions, and case discussions can reinforce the concept of Contingency Management and its efficacy. Simulation exercises for residents in which they design and execute Contingency Management treatment plans, followed by feedback with mentors, can build provider confidence in independently applying Contingency Management.

Fostering interdisciplinary and community partnerships among providers can also help bridge the implementation gap. Encouraging residents to collaborate with community-based providers and observe Contingency Management in practice, particularly within harm reduction settings, can deepen their understanding and promote future integration.

Critically, training should emphasize cultural competence and social equity. Many patients with Substance Use Disorders navigate recovery while grappling with racism, poverty, stigma, and trauma.[20] The nuances and complexities of a patient's intersecting identities means addiction treatment must be adaptable and responsive to these intersecting challenges. Incorporating modules on culturally responsive care, social determinants of health, and system-level advocacy can equip providers to use Contingency Management not only effectively, but ethically. Moreover, teaching residents to translate evidence into policy messaging can institute change in a broader context.

Conclusion:

Bridging the gap between Contingency Management's proven efficacy and real-world practice requires more than technical expertise– it demands a cultural and structural shift in how we train medical providers and value addiction care. As overdose deaths climb and treatment adherence remains precarious, the urgency to act is undeniable, and embedding Contingency Management into medical training serves as a practical, scalable solution. Many individuals with Substance Use Disorders face repeated recidivism, caught in cycles of temporary recovery and relapse, often compounded by stigma, incarceration, poverty, and institutional neglect.

Training providers to implement Contingency Management could serve as a powerful lever for change and instill in them a care philosophy rooted in harm reduction, compassion, and flexibility. It would broaden their awareness of the tool, encourage its adoption in high-risk and under-resourced communities, lay the groundwork for sustainable funding and policy support, and equip future providers to be advocates of evidence-based, equity-driven addiction treatment. To realize

Contingency Management's full potential, future efforts must reimagine medical education and training not as separate from implementation, but as one of its most powerful tools. This editorial calls for bold investment in training, interdisciplinary collaboration, and policy alignment to bring Contingency Management to the frontlines of care, where it belongs.

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