FEBRUARY 2024

ADDICTION TECHNOLOGY TRANSFER CENTER (ATTC)
CONTINGENCY MANAGEMENT TASK FORCE

SAMHSA GUIDANCE FOR IMPLEMENTATION OF CONTINGENCY MANAGEMENT TRAINING AND TECHNICAL ASSISTANCE

ATTC
Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

The opinions expressed herein are the view of Contingency Management Task Force convened by the Addiction Technology Transfer Center Network Coordinating Office (ATTC NCO) and do not reflect the official position of the Department of Health and Human Services (DHHS), SAMHSA. No official support or endorsement of DHHS, SAMHSA, for the opinions described in this document is intended or should be inferred. This work is supported by grant 6UR1TI080205-02M002 from the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

Prepared 2023; published 2024

Table of Contents

SECTION 1. PURPOSE AND DESCRIPTION OF CONTINGENCY MANAGEMENT (CM) TASK FORCE

The Addiction Technology Transfer Center Network Coordinating Office (ATTC NCO) convened the Contingency Management Task Force (CM Task Force) in April 2023 at the request of the Substance Abuse and Mental Health Services Administration (SAMHSA). The purpose of the CM Task Force meetings and products is to: "define the key components of CM that will facilitate consistent evidence-based training and implementation, and to scale CM in a manner that is meaningful, permissible, and scientific. The insights gathered will help SAMHSA's [Training and Technical Assistance (TTA) Centers] to offer technical guidance, resources, partnerships, and infrastructure to support the expansion of CM to stakeholders in the field of addiction and recovery. This initial meeting is crucial in developing a shared vocabulary and an evidence-based approach to CM education and training platforms, with the goal of incorporating metrics to measure effectiveness." (Quotation from CM Task Force Meeting proceedings, April 11, 2023, Dr. Robert Baillieu opening remarks; *Appendix B*)

The CM Task Force includes experts from research, academic, implementation, and TTA backgrounds. The CM Task Force acknowledges gaps in the CM Task Force membership with respect to persons with lived experience, persons with significant experience with legal or fiscal issues, app and technology experts, and although represented, there are fewer individuals who provide CM in a clinical capacity on the Task Force.

The present CM Task Force Report and the U.S. Department of Health and Human Services (HHS) Contingency Management for the Treatment of Substance Use Disorders Report were developed at the same time with some overlap in personnel. Therefore, there are similar elements to the reports, highlighting the consistent nature of and messaging of CM implementation recommendations.

The CM Task Force and this report serve to provide key information on components and considerations for facilitating CM TTA, including:

1. Key areas of considerations relating to implementation guidance (Section 2)
2. Recommendations pertaining to the development and rollout of implementation guidance (Section 3)
3. Proposed chapter titles and topics to be used in the possible development of a *Contingency Management Implementation Guidance* Document (Section 4)
4. Publicly available resources (Section 5)
5. Selected references (Section 6)

Timeline:

- January 11, 2023: Virtual meeting convened by SAMHSA
- January 29, 2023: ATTC request for recommendations for CM Task Force members
- March 22, 2023: Virtual introduction session
- April 11, 2023: In-person meeting at SAMHSA, Rockville, MD (strategic juncture workshop resulting in chapters for CM Guidance)
- June 23, 2023: Virtual session review summary of work from in-person meeting
- July – August 2023: ATTC NCO prepares draft report
- September 2023: ATTC NCO delivers draft report to SAMHSA
- February 2024: Report finalized, incorporating SAMHSA's feedback

CM Task Force Members*:

Ibis Carrion, H. Westley Clark, Dominick DePhilippis, Mitchell Doig, Thomas Freese, Holly Hagle, Bryan Hartzler, Maxine Henry, Katherine Hirchak, Michael Knabel, Laurie Krom, Lena Marceno, Mike McDonell, Sara Parent, James Peck, Carla Rash, Richard Rawson, Mat Roosa, Beth Rutkowski, Amy Shanahan, Nick Szubiak, Van Wilson, and Rachel Witmer

*Note: Not all task force members participated in all meetings.

SECTION 2. KEY CONSIDERATIONS AS RELATED TO IMPLEMENTATION

Although the ultimate outcome of the CM Task Force is included in Section 4 (proposed chapters), the CM Task Force also discussed several key considerations that may assist with conceptualization, development, and delivery of TTA materials.

Implementation and Training Strategies

- There is evidence about how CM works, but less about TTA implementation of CM.
- Two questions to consider: *Who is the customer? What implications does that have for the training and materials?* The customer may be the state, the patient, the provider, and/or the community. Consider ways to incorporate patient-centered thinking into providing TTA implementation and support for providers (e.g., involving persons with lived/living experience to join TTA planning committees).
- Challenges related to risk, fidelity, and inclusion must be addressed as part of the TTA implementation infrastructure.
- Providing TTA on CM implementation is a large undertaking.
    - Pre-implementation support involves many systems (e.g., the ATTCs, the Opioid Response Network [ORN], the Provider's Clinical Support System [PCSS]) and personnel (e.g., trainers, trainers-of-trainers, coaches, subject-matter experts, technology transfer specialists) providing TTA to conduct assessments, matching TTA requests with appropriate personnel, ensure personnel understand relevant CM protocols and the common language and how to define and perform their roles, and so on.
    - Ongoing post-implementation support is also required to assist with continued evaluation monitoring, fidelity, addressing barriers, and so on.

Concerns with Implementation and Scaling Up

- There are many aspects to balance when considering CM implementation. For example, balancing high risk management and high fidelity; high fidelity with high inclusion; adherence with flexibility. For example:
    - Two sides of the coin: (1) Implement an evidence-based version without moving away from the evidence to make it more clinic-friendly or more flexible; (2) Consider adaptations to meet the needs of our audiences, clinics, and communities that are disproportionately impacted by this work.
    - Behavioral health and substance use interventions and approaches and providers consider the whole person and therefore are responsive to cultural adaptations, de-stigmatizing approaches, and promoting patient-centered care. These often involve adaptations and/or flexibility.
- Looking at inequities due to race and access to care, a one-size-fits-all protocol does not solve those issues and can even drive disparities. Flexibility is needed.
- The Veterans Administration (VA) has been used as an example of successful CM implementation. For example, the Veterans Canteen Service Coupon System has leverage because access to coupons is contingent on a site using them exclusively for CM, participating in the coaching, and providing coaches with implementation data. To get coupons, CM must be done correctly. One consideration of this model and potential difficulties of implementation and/or scaling up may be related to funding given the VA has the funding and control over the funding and the training.

CM Implementation Protocols

- The CM Task Force discussed treatment protocols (e.g., voucher-based protocol; prize-based protocol; see HHS Contingency Management Report for additional information on protocols), concluding that it is optimal to limit the number of protocols available while allowing for customization (to individual setting, population, or desired behavior change).

    - The challenge with protocols is having enough flexibility and/or protocols to give patients/clients a choice and meet their unique needs, while not having too many that they lack evidence base.
    - Limiting the number of protocols can aid in consistency and manageability of implementation and implementation support for trainers and providers. One example could be one prize protocol and one voucher protocol, that each lend themselves to customization.
    - Limiting the number of protocols also minimizes the need for train-the-trainers and helps users to advance through decision points.
    - Pre-implementation preparation is essential, including conducting a needs assessment or pre-implementation checklist of organizational-level components (e.g., staff roles; staff training; resources) that are necessary to implement CM.
- SAMHSA's *Appendix J* may help routinize a protocol (see Section 7, Appendix A of this document).
- There needs to be consensus about TTA implementation for CM.
    - It is important to note that there is less research in this area, relative to research on CM itself.
    - A question to consider: Are there other models in addition to the train-the-trainers model?
    - Implementation consensus and plans following SAMHSA guidance document is important.
- Additional rationale for the use of protocols includes the role they play in *legal compliance*. More specifically, protocols created from an evidence base and then vetted for fidelity in practice may aid in legal compliance. Higher fidelity can also positively impact CM quality and patient outcomes.

Legal and Fiscal Considerations

- Addressing legal and fiscal aspects is essential because they are currently barriers for many implementers. In addition to clinical fidelity, the approaches to implementation must be legal, and there must be funding incentives for implementation and fiscal resources for TTA on a larger scale. With those barriers appropriately addressed, protocols and implementation can move forward.
- As TTA is provided to Tribal entities, it is important to consider how sovereignty and cultural humility intersects with other laws/policies and regulations in both the material/program development and TTA activities.
- Fraud considerations in the development of implementation materials:
    - There is currently a poor understanding of fraud prevention guidelines. Fraud information and prevention will be useful for TTA providers to understand because it will be useful information for the recipients of TTA.
    - If there are cases of fraud (even if unintentional), this could impact the future of CM negatively.
- There needs to be clear training and guidance for TTA providers on when to involve legal/compliance departments within an organization. TTA providers may be concerned about liability if fraud were to occur after a training; therefore, support in training TTA providers and providing resources/guidance ahead of TTA is important.

Workforce Issues

- Our current workforce is overwhelmed and needs additional support and training.
- CM needs to be better described and taught at medical and professional schools to foster a workforce grounded in evidence, and ready to work with clients.
- In general, we need to bring new members to the SUD treatment workforce to increase capacity and support CM sustainability.

Harm Reduction and Abstinence

- SAMHSA has recently released their draft report outlining their harm reduction framework. SAMHSA's expanded efforts to provide TTA on harm reduction is an opportunity to demonstrate how harm reduction and CM can work together and to be prepared to address any philosophical differences.
- When we include all approaches to care, including harm reduction and abstinence-focused services, we can enhance consistent messaging across TTA providers. This reinforces people's dignity and choice as it relates to their recovery pathway.

SECTION 3. GENERAL RECOMMENDATIONS TO ADVANCE TTA GUIDANCE TOOLS

1. **Preparation, Dissemination, and Packaging**
   - 1.1. Involve TTA providers in the writing and review of a formal TTA Guidance document.
   - 1.2. Documents and tools should include executive summary, accompanying slide deck, and asynchronous webinar.
   - 1.3. Materials should be detailed enough to be useful, but not verbose.
   - 1.4. Inclusion of modules (e.g., chapters as suggested) may increase understanding.
   - 1.5. Inclusion of interactive elements on a website may be advantageous.
   - 1.6. Create separate, related resources and educational manuals (e.g., PowerPoints, tables, infographics) that can be used and modified as necessary by trainers and TTA providers.
   - 1.7. TTA Guidance documents should be publicly available.

2. **Implementation (Guidance, Support, and Protocols)**
   - 2.1. Include resources for high-quality coaching.
   - 2.2. Include resources for implementation support and ongoing support.
   - 2.3. Standardizing protocols is important to maintain evidence base.
   - 2.4. Limit the number of available protocols while still allowing for some flexibility.

3. **Audiences**
   - 3.1. Various audiences may use this TTA guidance, such as clinical sites, Federally Qualified Health Centers (FQHCs), government, or policymakers. Consider materials that promote education and promote CM to meet the needs of various audiences accessing the materials.

4. **Law and Policy**
   - 4.1. Provide clear guidance and support for TTA implementation and support related to law and policy aspects.

5. **Timeline**
   - 5.1. TTA Guidance Tools and Documents are needed as soon as possible.
   - 5.2. For those using the TTA Guidance and implementing CM, it is important that they be oriented to the expected timelines, given that CM is a multiyear, longitudinal process.

SECTION 4. PROPOSED OUTLINE FOR *SAMHSA GUIDANCE FOR CM IMPLEMENTATION* DOCUMENT

4.1 GUIDANCE OVERVIEW

This section includes proposed chapters and respective topics for a potential *Contingency Management Implementation Guidance* Document. These chapters, topics, and considerations were developed during consensus-building exercises by the CM Task Force. Additional details can be found in the full description of the in-person Task Force Meeting document (*Summary Report of in-person meeting, April 11, 2023*), in the Appendices (Section 7.2, Appendix B). These proposed topics were developed as the groundwork for consistent, evidence based TTA efforts and guidance moving forward. An implementation guide would provide trainers and learners (implementers) in the community with a consistent set of tools to use in the TTA process.

The suggested order of the chapter is presented in this document and in the table of contents. Task Force members have also recommended an alternate ordering of chapters, which may aid in addressing certain concerns with implementation earlier in the process (e.g., legal concerns, cultural and linguistic adaptations, workforce sustainability). The alternate chapter order follows:

Chapter 1. Groundwork
Chapter 2. Readiness
Chapter 3. Understanding the Implementing Partner
Chapter 4. Why Contingency Management Works
Chapter 5. Elements for Success
Chapter 6. Legal Compliance
Chapter 7. Ongoing Coaching
Chapter 8. Monitoring, Evaluating, and Quality Improvement
Chapter 9. Quality Assurance

Each chapter comprises three parts. First, a brief overview of the chapter is provided. Next, the suggested chapter contents, in the form of headers, is provided. Finally, if applicable, “additional considerations” are provided to give further context as implementation guidance is developed. These are points that add nuance to the suggested topics (e.g., reminders and/or important details related to current substance use disorder (SUD) workforce issues) and/or that might change the content based on outcomes of policies or other decisions (e.g., clarity needed on incentive caps).

4.2 CHAPTER 1: GROUNDWORK

Chapter Overview
The work conducted ahead of CM implementation is essential. This chapter outlines the groundwork needed to support the development of an implementation plan and CM implementation. The following topics cover internal capacity-building (staff, technical assistance), factors associated with outer context (policy, community, legal considerations), funding, and intervention characteristics.

Topics to Cover

1. Workforce and Staffing
   1.1. Internal capacity-building (e.g., enhancing workforce capacity such as staff training)
   1.2. Sustainable workforce considerations
2. Funding
   2.1. Executive sponsorship
   2.2. Long-term, *sustainable* funding

2.3. Consider funding sources to meet need (e.g., braided funding, an 1115 waive, private sources, or settlement funds)

3. Intervention Considerations and Technical Assistance/Support, Protocol Development
   3.1. Sustainability of intervention
   3.2. Cultural responsiveness
   3.3. Balancing asynchronous (self-paced) and synchronous learning
   3.4. Asynchronous learning can standardize risk management
   3.5. Planning for how to approach clients and discuss CM
   3.6. Consider technical assistance on application writing for clinical sites
   3.7. How to maintain fidelity to the evidence base as the program develops and expands
   3.8. As protocol is developed, need stakeholder input to foster buy-in. Stakeholders include practitioners, those with lived experience, educators, policymakers, implementation science experts
4. Outer Context
   4.1. Legal landscape
   4.2. Need to educate policymakers, particularly in regard to cost, process and outcomes
   4.3. Foster interest through community and state policymaker education. This facilitates sustainable funding streams.
5. Readiness (also see *Chapter 2*)
   5.1. Readiness assessments – site readiness to implement CM; ensuring sites understand evidence-based CM.

Additional Considerations as Guidance is Developed

- The funder (e.g., the State, the site) is important to groundwork and readiness. Funding is tied to policy and promotes sustainability of implementation.

4.3 CHAPTER 2: READINESS

Chapter Overview

In addition to Groundwork (Chapter 1), assessing general readiness at the level of the organization (system, individual implementers) and considering the readiness of the organization to implement CM specifically are important. The goal for implementing partners is to create CM programs that are effective and compliant.

Topics to Cover

1. Pre-Implementation Work
   1.1. Implementing CM is a multiyear, longitudinal process. It is essential to orient treatment communities to this from the very beginning.
2. The Who, What, When, Where, and How of the Intervention (e.g., Is the program reinforcing abstinence or attendance?)
3. Assessing a Program's Readiness to Implement the Intervention
4. Pre-Implementation Readiness and Assessment
   4.1. Inclusion of a needs assessment/evaluation
5. Phase Zero Decision-Maker Consultation
6. Phase Zero Readiness Checklist
7. Guide for Training and Technical Assistance Decision Tree
   7.1. Train-the-trainer elements can help with workforce considerations (including staff turnover).
   7.2. The regulatory environment leads to hesitancy, and training needs to reinforce the importance of following a protocol.
8. Readiness System of the Organizational Provider

8.1. Need to fully identify roles and responsibilities of implementing partners so that training is delivered seamlessly.

Additional Considerations as Guidance is Developed

- Regarding evaluation, guidance should consider what processes are in place to encourage *continued monitoring/evaluation* to ensure fidelity to the evidence base and law.

4.4 CHAPTER 3: UNDERSTANDING THE IMPLEMENTING PARTNER

Chapter Overview

Topics in this chapter span aspects of understanding and connecting with the partner(s) who will ultimately be implementing CM. This information is important to early phases of the process (e.g., groundwork) and should be considered early on during groundwork and pre-implementation phases.

Topics to Cover

1. Inclusion of Diverse Communities and Partners
2. Phase 1: Why Am I Here? (The provider in attendance at the seminar)
3. Consumer-Oriented/Common Language

Additional Considerations as Guidance is Developed

- It is important to identify implementing staff and define their roles, so that training can focus on those with responsibility for delivering the CM services (this also assists with sustainability).
- One example of defined staff roles and respective training needs can be seen in the California Recovery Incentives Program model. For example, the team approach includes a CM coordinator, backup coordinator, and supervisor, all of whom can deliver CM. TTA can focus on training needs respective to these roles.

4.5 CHAPTER 4: WHY CONTINGENCY MANAGEMENT WORKS

Chapter Overview

The goal of this chapter content is to provide educational and contextual information about CM and its components: what it is, why and how it works, and the research basis for CM as a treatment. Also see the selected references provided in *Section 6* for foundational articles and meta-analyses demonstrating CM efficacy.

Topics to Cover

1. Attention to Principles of Behavioral Change
2. Research and Evidence of CM
   1.1. CM is a foundational therapy with a long history.
   1.2. CM buy-in needs to happen before implementation (behavioral principles, research evidence).

Additional Considerations as Guidance is Developed

- There should be an “Overview” training and an “Implementation” training that are appropriate for different audiences. There are limits to a one-model approach, so allowing for flexibility to meet the training participants’ needs is important.
  - Consider how much detail to provide about behavioral principles, positive reinforcement, research in the training and TTA materials.
- Detail about the CM protocol(s) should be provided in the implementation training.

- The foundational content can be provided at universal or basic TTA levels, whereas the CM implementation will be more targeted and intensive TTA.

4.6 CHAPTER 5: ONGOING COACHING

Chapter Overview
This chapter includes topics surrounding coaching to the implementer/implementing site, which is a complex and resource-intensive process, rather than a one-time training only.

Topics to Cover

1. Coaching as an Investment
   1.1. Coaching takes more expertise than training and it takes significant time and resources.
2. Coaching at Multiple Levels
   2.1. Such as leadership, supervisors, clinicians, administrative staff, program evaluator
3. Longevity of TTA and Coaching
4. Community of Practice
5. How to Fail Fast (e.g., know how to recognize and fix it)
6. De-Implementation
   6.1. Define: What is de-implementation?
   6.2. Describe the process of deciding what to scale down or stop in order to have bandwidth to implement evidence-based CM.
7. Importance of Experiential Learning

Additional Considerations as Guidance is Developed

- Create room for disclosure/conversation.
- Provide tools and logistical recommendations, such as:
  - Tracking notes during coaching calls (both for data purposes and to help keep track of the moving parts and remember “who is who” for the next coaching call)
  - Train coaches on billing and contracts because coaching calls often have questions on such topics.
- Incorporate an approach that enables site leadership to support/coach their own staff during turnover.
- Provide reports and library of resources to help create institutional consistency going forward.

4.7 CHAPTER 6: MONITORING, EVALUATING, AND QUALITY IMPROVEMENT

Chapter Overview
This chapter should cover how to use data, evaluation, and monitoring processes to inform implementation (coaching), de-implementation, and sustainability. Other key considerations include considering burden as to not impede implementation. Other chapters also include some aspects of evaluation; therefore, natural overlap is expected given the content of various phases of implementation and training.

Topics to Cover

1. Why are Measurement and Assessment of Outcomes Critical?
2. Ways to Measure and Assess Outcomes
   2.1. During Implementation
   2.2. During De-implementation
3. Including Qualitative Data and Feedback Loop
4. Program Evaluation and Data-Informed Sustainability

Additional Considerations as Guidance is Developed

- It is important to avoid the data collection burden that impedes implementation. Therefore, data collected to inform coaching can also be used for program evaluation and vice versa. Plan program evaluation with *burden* and *goals* in mind.

4.8 CHAPTER 7: QUALITY ASSURANCE

Chapter Overview

This chapter covers various topics related to quality assurance, including procedural aspects of clinical fidelity, protocols, implementation monitoring and feedback, and important issues regarding the intersections of resources/finances and fidelity, as well as the "cap" and CM implementation and fidelity.

Topics to Cover

1. Attention to Procedural Applications of the Principles
2. Process Infrastructure
   2.1. Distinguish between the process and content (e.g., the what and the how)
3. Protocols (including session-by-session details)
4. Protocol Fidelity (for example, check: Does it include reinforcements that are meaningful to the individual?)
5. Feedback Loops

Additional Considerations as Guidance is Developed

- Two protocols need to be developed: one prize-based protocol and one voucher-based protocol.
- Considerations with monitoring: How can supervisors monitor for quality assurance?
- Medicaid-funded providers might believe that CM at a high-fidelity model will be too costly to implement to fidelity.
- Providers should be encouraged to only implement CM if they have the resources.
- A mechanism for payment is needed so clinics do not have to pay out of pocket.
  - Maintaining a "cap" to spending is contrary to evidence about the effectiveness of CM (e.g., the $75/$15).
  - To date, SAMHSA has issued Funding Opportunity Announcements (FOAs) that require evidence-based practices, that include CM, but that put caps on spending, which is not evidence-based.

4.9 CHAPTER 8: ELEMENTS FOR SUCCESS

Chapter Overview

This chapter should include topics central to the success of training and implementing CM, including cultural and linguistic adaptations to the protocol (and how should we assess for fidelity), and workforce sustainability and factors impacting continued workforce success around implementation.

Topics to Cover

1. Cultural and Linguistic Adaptations while Assessing for Fidelity
   1.1. Including person-centered reinforcements that consider gender, age, culture, housing status, economic status, and optimizing patient choice (e.g., do they prefer a cabinet of prizes or a gift card?) will empower the patient to make the choice that is most meaningful for them.
2. Workforce Sustainability

2.1. Ongoing staff development is needed. Continued coaching and training is important across the board for workforce sustainability.
2.2. Report out success to staff for continued buy-in.
2.2.1. Data points to highlight with staff: negative screens, sessions attended, longest duration of abstinence (worth mentioning as a concept but not as a metric), retention rates of patients.
2.2.2. It is important for providers to see the successes, and success is reliant on following CM fidelity and evidence-based model.
2.3. The spirit of MI is useful in working with teams and can build trust among team members.

4.10 CHAPTER 9: LEGAL COMPLIANCE

Chapter Overview
This chapter should cover guidance on auditing processes (what and how) as well as legal/policy direction generally and specific to states on any implementation guidance, including incentive caps.

Topics to Cover
1. Legal and Policy Landscape
   1.1. Federal level -- Clarity is needed on policies regarding incentive caps (not forgetting that caps hinder fidelity). Also see information in *Key Considerations, Chapter 7. Quality Assurance* for additional details.
   1.2. State level
2. Auditing
   2.1. Important to audit treatment protocols for fidelity, and monetary prizes (from purchase to incentives).

SECTION 5. PUBLICLY AVAILABLE RESOURCES

Below are CM resources, documentation, and/or training documents that can be useful in the development and implementation of TTA materials. This list is not comprehensive.

1. HHS and SAMHSA Resources Referenced in this Report
   1.1. U.S. Department of Health and Human Services. *Contingency Management for the Treatment of Substance Use Disorders: Enhancing Access, Quality, and Program Integrity for an Evidence-Based Intervention*. (2023, November 7). https://aspe.hhs.gov/reports/contingency-management-treatment-suds
   1.2. Substance Abuse and Mental Health Services Administration: *Harm Reduction Framework*. (2023). Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/sites/default/files/harm-reduction-framework.pdf

2. Recovery Incentives Program: California's Contingency Management Benefit Materials
   2.1. Overview and Policy documents: https://www.dhcs.ca.gov/Pages/DMC-ODS-Contingency-Management.aspx
   2.2. CM Training materials: https://uclaisap.org/recoveryincentives/

3. Northwest ATTC Materials: https://attcnetwork.org/centers/northwest-attc/news/new-online-course-contingency-management-healthcare-settings

4. University of Vermont Center on Rural Addiction, video series: https://www.youtube.com/@uvmcenteronruraladdiction6519/videos
   4.1. Contingency Management Provider Training Video, Non-Interactive: https://www.youtube.com/watch?v=4cc1VbeUzqk

5. The Addiction Technology Transfer Center (ATTC) Network Products and Resources Catalog features numerous training resources on CM. Search for available resources using "contingency management" or other relevant keywords here: https://attcnetwork.org/centers/global-attc/products-resources-catalog

6. *HealtheKnowledge* Online Education platform features free courses for health and behavioral health professionals, including a five-part training series, "Contingency Management for Healthcare Settings". Visit this link to register for a free account and search the title to access the course: https://healtheknowledge.org/

SECTION 6. SELECTED REFERENCES

Below is a list of selected research articles about contingency management (CM). This list was curated for TTA purposes such that these references might be useful in providing educational information to implementers/systems during TTA guidance. For example, there is a significant amount of research literature supporting the efficacy of CM (see Efficacy and Effectiveness sections below), which may be useful information in the early (Groundwork, Chapter 1) phases of CM implementation and TTA support. References in the Implementation-Related Articles section can provide useful information on key considerations in the implementation process (e.g., the utility and role of ongoing coaching and supervision as related to implementation) that may aid in the TTA guidance process.

This list is neither comprehensive nor exhaustive. Rather, it is intended to serve as a reference point for additional information for SAMHSA in the development of TTA guidance, as well as to be used as reference points within the developed guidance, as appropriate. Please note that not all references included in this list are open access/publicly available.

General

1. U.S. Department of Health and Human Services. (2023, November 7). *Contingency Management for the Treatment of Substance Use Disorders: Enhancing Access, Quality, and Program Integrity for an Evidence-Based Intervention*. https://aspe.hhs.gov/reports/contingency-management-treatment-suds
2. Substance Abuse and Mental Health Services Administration: *Harm Reduction Framework*. (2023). Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/sites/default/files/harm-reduction-framework.pdf

Implementation-Related Articles

D&I Science/Overview

1. Hartzler, B., Lash, S. J., & Roll, J. M. (2012). Contingency management in substance abuse treatment: a structured review of the evidence for its transportability. *Drug and Alcohol Dependence*, *122*(1-2), 1-10. https://doi.org/10.1016/j.drugalcdep.2011.11.011
2. Hartzler, B. (2015). Building a bonfire that remains stoked: Sustainment of a contingency management intervention developed through collaborative design. *Substance Abuse Treatment, Prevention, and Policy*, *10*, 1-9. https://doi.org/10.1186/s13011-015-0027-0
3. Oluwoye, O., Kriegel, L., Alcover, K. C., McPherson, S., McDonell, M. G., & Roll, J. M. (2020). The dissemination and implementation of contingency management for substance use disorders: A systematic review. *Psychology of Addictive Behaviors*, *34*(1), 99. https://doi.org/10.1037/adb0000487
4. Petry, N. M. (2011). Contingency management: What it is and why psychiatrists should want to use it. *The psychiatrist*, *35*(5), 161-163. https://doi.org/10.1192/pb.bp.110.031831
5. Petry, N. M., & Simcic Jr, F. (2002). Recent advances in the dissemination of contingency management techniques: Clinical and research perspectives. *Journal of substance abuse treatment*, *23*(2), 81-86. https://doi.org/10.1016/S0740-5472(02)00251-9
6. Rash, C. J., Stitzer, M., & Weinstock, J. (2017). Contingency management: New directions and remaining challenges for an evidence-based intervention. *Journal of Substance Abuse Treatment, 72*, 10–18. https://doi.org/10.1016/j.jsat.2016.09.008
7. Rawson, R. A., Erath, T. G., Chalk, M., Clark, H. W., McDaid, C., Wattenberg, S. A., Roll, J. M., McDonell, M. G., Parent, S., & Freese, T. E. (2023). Contingency management for stimulant use disorder: Progress, challenges, and recommendations. *The Journal of Ambulatory Care Management, 46*(2), 152–159. https://doi.org/10.1097/JAC.0000000000000450
8. Walker, R., Rosvall, T., Field, C. A., Allen, S., McDonald, D., Salim, Z., Ridley, N., & Adinoff, B. (2010). Disseminating contingency management to increase attendance in two community substance abuse treatment centers: Lessons learned. *Journal of Substance Abuse Treatment, 39*(3), 202–209. https://doi.org/10.1016/j.jsat.2010.05.010

Implementation Strategies and Outcomes

9. Becker, S. J., DiClemente-Bosco, K., Rash, C. J., & Garner, B. R. (2023). Effective, but underused: lessons learned implementing contingency management in real-world practice settings in the United States. *Preventive Medicine, 176*, 107594. https://doi.org/10.1016/j.ypmed.2023.107594
10. Becker, S. J., Kelly, L. M., Kang, A. W., Escobar, K. I., & Squires, D. D. (2019). Factors associated with contingency management adoption among opioid treatment providers receiving a comprehensive implementation strategy. *Substance Abuse, 40*(1), 56-60. https://doi.org/10.1080/08897077.2018.1455164
11. DePhilippis, D., Petry, N. M., Bonn-Miller, M. O., Rosenbach, S. B., & McKay, J. R. (2018). The national implementation of Contingency Management (CM) in the Department of Veterans Affairs: Attendance at CM sessions and substance use outcomes. *Drug and Alcohol Dependence*, *185*, 367-373. https://doi.org/10.1016/j.drugalcdep.2017.12.020
12. Hartzler, B., Gray, K., Marx, M., Kirk-Lewis, K., Payne-Smith, K., & McIlveen, J. W. (2023). Community implementation of contingency management to address stimulant use. *Journal of Substance Use and Addiction Treatment, 151*, 208941. https://doi.org/10.1016/j.josat.2022.208941
13. McCart, M. R., Henggeler, S. W., Chapman, J. E., & Cunningham, P. B. (2012a). System-level effects of integrating a promising treatment into juvenile drug courts. *Journal of Substance Abuse Treatment, 43*(2), 231–243. https://doi.org/10.1016/j.jsat.2011.10.030
14. Petry, N. M. (2000). A comprehensive guide to the application of contingency management procedures in clinical settings. *Drug and alcohol dependence*, *58*(1-2), 9-25. https://doi.org/10.1016/S0376-8716(99)00071-X
15. Rash, C. J., Alessi, S. M., & Zajac, K. (2020). Examining implementation of contingency management in real-world settings. *Psychology of Addictive Behaviors: Journal of the Society of Psychologists in Addictive Behaviors, 34*(1), 89–98. https://doi.org/10.1037/adb0000496

Training and Technical Assistance

16. Hartzler, B., Beadnell, B., & Donovan, D. (2017). Predictive validity of addiction treatment clinicians' post-training contingency management skills for subsequent clinical outcomes. *Journal of Substance Abuse Treatment*, *72*, 126-133. https://doi.org/10.1016/j.jsat.2015.11.010
17. Hartzler, B., Hinde, J., Lang, S., Correia, N., Yermash, J., Yap, K., ... & Garner, B. R. (2022). Virtual training is more cost-effective than in-person training for preparing staff to implement contingency management. *Journal of technology in behavioral science*, 1-10. https://doi.org/10.1007/s41347-022-00283-1
18. Hartzler, B., Jackson, T. R., Jones, B. E., Beadnell, B., & Calsyn, D. A. (2014). Disseminating contingency management: Impacts of staff training and implementation at an opiate treatment program. *Journal of Substance Abuse Treatment*, *46*(4), 429-438. https://doi.org/10.1016/j.jsat.2013.12.007
19. Helseth, S. A., Janssen, T., Scott, K., Squires, D. D., & Becker, S. J. (2018). Training community-based treatment providers to implement contingency management for opioid addiction: Time to and frequency of adoption. *Journal of Substance Abuse Treatment, 95*, 26-34. https://doi.org/10.1016/j.jsat.2018.09.004
20. Henggeler, S. W., Chapman, J. E., Rowland, M. D., Sheidow, A. J., & Cunningham, P. B. (2013). Evaluating training methods for transporting contingency management to therapists. *Journal of Substance Abuse Treatment, 45*(5), 466-474. https://doi.org/10.1016/j.jsat.2013.06.008
21. Parent, S. C., Peavy, K. M., Tyutyunnyk, D., Hirchak, K. A., Nauts, T., Dura, A., ... & McDonell, M. G. (2023). Lessons learned from statewide contingency management rollouts addressing stimulant use in the Northwestern United States. *Preventive Medicine*, 107614. https://doi.org/10.1016/j.ypmed.2023.107614
22. Rash, C. J., DePhilippis, D., McKay, J. R., Drapkin, M., & Petry, N. M. (2013). Training workshops positively impact beliefs about contingency management in a nationwide dissemination effort. *Journal of Substance Abuse Treatment*, *45*(3), 306-312. https://doi.org/10.1016/j.jsat.2013.03.003

Attitudes and Perceptions

23. Bride, B. E., Abraham, A. J., & Roman, P. M. (2010). Diffusion of contingency management and attitudes regarding its effectiveness and acceptability. *Substance Abuse, 31*(3), 127-135. https://doi.org/10.1080/08897077.2010.495310
24. Bride, B. E., Kintzle, S., Abraham, A. J., & Roman, P. M. (2012). Counselor attitudes toward and use of evidence-based practices in private substance use disorder treatment centers: A comparison of social workers and non-social workers. *Health & Social Work, 37*(3), 135-145. https://doi.org/10.1093/hsw/hls022
25. Ducharme, L. J., Knudsen, H. K., Abraham, A. J., & Roman, P. M. (2010). Counselor attitudes toward the use of motivational incentives in addiction treatment. *The American Journal on Addictions, 19*(6), 496–503. https://doi.org/10.1111/j.1521-0391.2010.00081.x
26. Gagnon, M., Guta, A., & Payne, A. (2020). "Setting people up for success and then failure"—health care and service providers' experiences of using prize-based contingency management. *Substance Abuse Treatment, Prevention, and Policy, 15(*1), https://doi.org/10.1186/s13011-020-00316-z
27. Hartzler, B., Donovan, D. M., Tillotson, C. J., Mongoue-Tchokote, S., Doyle, S. R., & McCarty, D. (2012). A multilevel approach to predicting community addiction treatment attitudes about contingency management. *Journal of Substance Abuse Treatment*, *42*(2), 213-221. https://doi.org/10.1016/j.jsat.2011.10.012
28. Hartzler, B., & Garrett, S. (2016). Interest and preferences for contingency management design among addiction treatment clientele. *The American journal of drug and alcohol abuse*, *42*(3), 287-295. https://doi.org/10.3109/00952990.2015.1096365
29. Hartzler, B., & Rabun, C. (2013). Community opioid treatment perspectives on contingency management: perceived feasibility, effectiveness, and transportability of social and financial incentives. *Journal of substance abuse treatment*, *45*(2), 242-248. https://doi.org/10.1016/j.jsat.2013.01.014

Feasibility

30. Godley, S. H., Godley, M. D., Wright, K. L., Funk, R. R., & Petry, N. M. (2008). Contingent reinforcement of personal goal activities for adolescents with substance use disorders during post-residential continuing care. *The American Journal on Addictions, 17*(4), 278–286. https://doi.org/10.1080/10550490802138798
31. Green, B., Parent, S., Ware, J., Hasson, A. L., McDonell, M., Nauts, T., ... & Rawson, R. (2023). Expanding access to treatment for stimulant use disorder in a frontier state: A qualitative study of contingency management and TRUST program implementation in Montana. *Journal of Substance Use and Addiction Treatment*, 209032. https://doi.org/10.1016/j.josat.2023.209032

Protocol Design and Modifications

32. Rash, C. J. (2023). Implementing an evidence-based prize contingency management protocol for stimulant use. *Journal of Substance Use and Addiction Treatment*, 209079. https://doi.org/10.1016/j.josat.2023.209079
33. Stitzer, M., & Petry, N. (2006). Contingency management for treatment of substance abuse. *Annu. Rev. Clin. Psychol.*, *2*, 411-434. https://doi.org/10.1146/annurev.clinpsy.2.022305.095219

Specific Applications

34. Cosottile, D. W., & DeFulio, A. (2020). The compatibility of employment-based contingency management and vocational services at the Department of Veterans Affairs. *Psychology of Addictive Behaviors: Journal of the Society of Psychologists in Addictive Behaviors, 34*(1), 111–116. https://doi.org/10.1037/adb0000479
35. Freese, T. E., Rutkowski, B. A., Peck, J. A., Urada, D., Clark, H. W., Bland, A. N., Friedman, J., & Rawson, R. A. (2023). Recovery incentives program: California's contingency management benefit. *Preventive Medicine, 176*, 107703. https://doi.org/10.1016/j.ypmed.2023.107703

36. Rash, C. J., & DePhilippis, D. (2019). Considerations for implementing contingency management in substance abuse treatment clinics: The veterans affairs initiative as a model. *Perspectives on Behavior Science*, *42*, 479-499. https://doi.org/10.1007/s40614-019-00204-3

Other (Digital Applications, Ethical Considerations, Evaluation and Methodology, Regulatory/Legal)

37. Clark, H. W., & Davis, M. (2023). Federal legal and regulatory aspects of contingency management incentives. *Preventive Medicine, 176*, 107726. https://doi.org/10.1016/j.ypmed.2023.107726
38. Dallery, J., DeFulio, A., & Raiff, B. R. (2023). Digital Contingency Management in the Treatment of Substance Use Disorders. *Policy Insights from the Behavioral and Brain Sciences*, *10*(1), 51-58. https://doi.org/10.1177/23727322221144648
39. DeFulio, A., Brown, H. D., Davidson, R. M., Regnier, S. D., Kang, N., & Ehart, M. (2023). Feasibility, acceptability, and preliminary efficacy of a smartphone-based contingency management intervention for buprenorphine adherence. *Behavior Analysis in Practice*, *16*(2), 450-458. https://doi.org/10.1007/s40617-022-00730-8
40. Gagnon, M., Payne, A., & Guta, A. (2021). What are the ethical implications of using prize-based contingency management in substance use? A scoping review. *Harm Reduction Journal, 18*(1), 82. https://doi.org/10.1186/s12954-021-00529-w
41. Hartzler, B. (2015). Adapting the helpful responses questionnaire to assess communication skills involved in delivering contingency management: Preliminary psychometrics. *Journal of substance abuse treatment*, *55*, 52-57. https://doi.org/10.1016/j.jsat.2015.02.006
42. Husky, M. M., Mazure, C. M., Carroll, K. M., Barry, D., & Petry, N. M. (2008). Using the experience sampling method in the context of contingency management for substance abuse treatment. *Journal of Applied Behavior Analysis, 41*(4), 635–644. https://doi.org/10.1901/jaba.2008.41-635

Efficacy and/or Effectiveness Articles

General/Overview

1. Coughlin, L. N., Salino, S., Jennings, C., Lacek, M., Townsend, W., Koffarnus, M. N., & Bonar, E. E. (2023). A systematic review of remotely delivered contingency management treatment for substance use. *Journal of Substance Use and Addiction Treatment, 147*, 208977. https://doi.org/10.1016/j.josat.2023.208977
2. Davis, D. R., Kurti, A. N., Skelly, J. M., Redner, R., White, T. J., & Higgins, S. T. (2016). A review of the literature on contingency management in the treatment of substance use disorders, 2009-2014. *Preventive Medicine, 92*, 36–46. https://doi.org/10.1016/j.ypmed.2016.08.008
3. DePhilippis, D., Khazanov, G., Christofferson, D. E., Wesley, C. W., Burden, J. L., Liberto, J., & McKay, J. R. (2023). History and current status of contingency management programs in the Department of Veterans Affairs. *Preventive Medicine, 176*, 107704. https://doi.org/10.1016/j.ypmed.2023.107704
4. Dutra, L., Stathopoulou, G., Basden, S. L., Leyro, T. M., Powers, M. B., & Otto, M. W. (2008). A meta-analytic review of psychosocial interventions for substance use disorders. *American Journal of Psychiatry*, *165*(2), 179-187. https://doi.org/10.1176/appi.ajp.2007.06111851
5. Forster, S. E., DePhilippis, D., & Forman, S. D. (2019). “I’s” on the prize: A systematic review of individual differences in Contingency Management treatment response. *Journal of Substance Abuse Treatment, 100*, 64–83. https://doi.org/10.1016/j.jsat.2019.03.001
6. Ginley, M. K., Pfund, R. A., Rash, C. J., & Zajac, K. (2021). Long-term efficacy of contingency management treatment based on objective indicators of abstinence from illicit substance use up to 1 year following treatment: A meta-analysis. *Journal of Consulting and Clinical Psychology*, *89*(1), 58. https://doi.org/10.1037/ccp0000552

7. Kelly, T. M., Daley, D. C., & Douaihy, A. B. (2014). Contingency management for patients with dual disorders in intensive outpatient treatment for addiction. *Journal of Dual Diagnosis, 10*(3), 108–117. https://doi.org/10.1080/15504263.2014.924772
8. 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
9. Petry, N. M., Alessi, S. M., Olmstead, T. A., Rash, C. J., & Zajac, K. (2017). Contingency management treatment for substance use disorders: How far has it come, and where does it need to go? *Psychology of Addictive Behaviors: Journal of the Society of Psychologists in Addictive Behaviors, 31*(8), 897–906. https://doi.org/10.1037/adb0000287
10. Pfund, R. A., Ginley, M. K., Boness, C. L., Rash, C. J., Zajac, K., & Witkiewitz, K. (2022). Contingency management for drug use disorders: Meta-analysis and application of Tolin's criteria. *Clinical Psychology: Science and Practice*. https://doi.org/10.1037/cps0000121
11. 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
12. 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
13. Rawson, R. A., Erath, T. G., & Clark, H. W. (2023). The fourth wave of the overdose crisis: Examining the prominent role of psychomotor stimulants with and without fentanyl. *Preventive Medicine, 176*, 107625. https://doi.org/10.1016/j.ypmed.2023.107625
14. Stitzer, M. L., Petry, N. M., & Peirce, J. (2010). Motivational incentives research in the national drug abuse treatment clinical trials network. *Journal of Substance Abuse Treatment, 38* Suppl 1, S61–S69. https://doi.org/10.1016/j.jsat.2009.12.010
15. Stitzer, M. L., & Vandrey, R. (2008). Contingency management: Utility in the treatment of drug abuse disorders. *Clinical Pharmacology and Therapeutics, 83*(4), 644–647. https://doi.org/10.1038/sj.clpt.6100508

Alcohol

16. Novak, M. D., Toegel, F., Holtyn, A. F., Rodewald, A. M., Arellano, M., Baranski, M., Barnett, N. P., Leoutsakos, J. M., Fingerhood, M., & Silverman, K. (2023). Abstinence-contingent wage supplements for adults experiencing homelessness and alcohol use disorder: A randomized clinical trial. *Preventive Medicine, 176*, 107655. https://doi.org/10.1016/j.ypmed.2023.107655
17. Petry, N. M., Martin, B., Cooney, J. L., & Kranzler, H. R. (2000). Give them prizes and they will come: Contingency management for treatment of alcohol dependence. *Journal of consulting and clinical psychology*, *68*(2), 250. https://doi.org/10.1037/0022-006X.68.2.250

Stimulants

18. Breland, H., Larkins, S., Antonini, V., Freese, T., McGovern, M., Dunn, J., & Rawson, R. (2023). Stimulant use among patients in opioid treatment settings: Provider perspectives. *Journal of Substance Use and Addiction Treatment, 151*, 209012. https://doi.org/10.1016/j.josat.2023.209012
19. Brown, H. D., & DeFulio, A. (2020). Contingency management for the treatment of methamphetamine use disorder: A systematic review. *Drug and Alcohol Dependence*, *216*, 108307. https://doi.org/10.1016/j.drugalcdep.2020.108307
20. De Crescenzo, F., Ciabattini, M., D'Alò, G. L., De Giorgi, R., Del Giovane, C., Cassar, C., ... & Cipriani, A. (2018). Comparative efficacy and acceptability of psychosocial interventions for individuals with cocaine and amphetamine addiction: A systematic review and network meta-analysis. *PLoS Medicine*, *15*(12), e1002715. https://doi.org/10.1371/journal.pmed.1002715
21. Higgins, S. T., Budney, A. J., Bickel, W. K., Foerg, F. E., Donham, R., & Badger, G. J. (1994). Incentives improve outcome in outpatient behavioral treatment of cocaine dependence. *Archives of General Psychiatry*, *51*(7), 568-576. https://doi.org/10.1001/archpsyc.1994.03950070060011

22. Tardelli, V. S., Lago, M. P. P. do, Mendez, M., Bisaga, A., & Fidalgo, T. M. (2018). Contingency Management with pharmacologic treatment for stimulant use disorders: A review. *Behaviour Research and Therapy, 111*, 57–63. https://doi.org/10.1016/j.brat.2018.10.002

Opioids

23. Bolívar, H. A., Klemperer, E. M., Coleman, S. R., DeSarno, M., Skelly, J. M., & Higgins, S. T. (2021). Contingency management for patients receiving medication for opioid use disorder: A systematic review and meta-analysis. *JAMA Psychiatry*, *78*(10), 1092-1102. https://doi.org/10.1001/jamapsychiatry.2021.1969
24. DeFulio, A. (2023). Dissemination of contingency management for the treatment of opioid use disorder. *Perspectives on Behavior Science*, *46*(1), 35-49. https://doi.org/10.1007/s40614-022-00328-z
25. Griffith, J. D., Rowan-Szal, G. A., Roark, R. R., & Simpson, D. D. (2000). Contingency management in outpatient methadone treatment: A meta-analysis. *Drug and Alcohol Dependence*, *58*(1-2), 55-66. https://doi.org/10.1016/S0376-8716(99)00068-X

Cannabis

26. Johnson, S., Rains, L. S., Marwaha, S., Strang, J., Craig, T., Weaver, T., McCrone, P., King, M., Fowler, D., Pilling, S., Marston, L., Omar, R. Z., Craig, M., Spencer, J., & Hinton, M. (2019). A contingency management intervention to reduce cannabis use and time to relapse in early psychosis: The CIRCLE RCT. *Health Technology Assessment (Winchester, England), 23*(45), 1–108. https://doi.org/10.3310/hta23450
27. Kaminer, Y., Burleson, J. A., Burke, R., & Litt, M. D. (2014). The efficacy of contingency management for adolescent cannabis use disorder: A controlled study. *Substance Abuse, 35*(4), 391–398. https://doi.org/10.1080/08897077.2014.933724
28. Stanger, C., Ryan, S. R., Scherer, E. A., Norton, G. E., & Budney, A. J. (2015). Clinic- and Home-Based Contingency Management Plus Parent Training for Adolescent Cannabis Use Disorders. *Journal of the American Academy of Child & Adolescent Psychiatry, 54*(6), 445-453.e2. https://doi.org/10.1016/j.jaac.2015.02.009

Intervention (Cost, Incentives, Attendance)

29. Andraka-Christou, B., Williams, M., Buksbaum, S., Karkkainen, J., Stein, B. D., Batchelder, S. R., Peck, K., Heil, S. H., Rawson, R., & Sigmon, S. C. (2023). US state laws relevant to incentives for health behavior: A qualitative analysis. *Preventive Medicine, 176*, 107645. https://doi.org/10.1016/j.ypmed.2023.107645
30. Branson, C. E., Barbuti, A. M., Clemmey, P., Herman, L., & Bhutia, P. (2012). A pilot study of low-cost contingency management to increase attendance in an adolescent substance abuse program. *The American Journal on Addictions, 21*(2), 126–129. https://doi.org/10.1111/j.1521-0391.2011.00204.x
31. Cunningham, C., Stitzer, M., Campbell, A. N. C., Pavlicova, M., Hu, M.-C., & Nunes, E. V. (2017). Contingency management abstinence incentives: Cost and implications for treatment tailoring. *Journal of Substance Abuse Treatment, 72*, 134–139. https://doi.org/10.1016/j.jsat.2015.08.010
32. Petry, N. M., Alessi, S. M., Rash, C. J., Barry, D., & Carroll, K. M. (2018). A randomized trial of contingency management reinforcing attendance at treatment: Do duration and timing of reinforcement matter? *Journal of Consulting and Clinical Psychology, 86*(10), 799-809. https://doi.org/10.1037/ccp0000330

Special Populations

33. Higgins, S. T. (2023). Behavior change, health, and health disparities 2023: Contingency management for treating substance use disorders and promoting health in vulnerable populations. *Preventive Medicine, 176*, 107746. https://doi.org/10.1016/j.ypmed.2023.107746
34. Leickly, E., Skalisky, J., Angelo, F. A., Srebnik, d., McPherson, S., Roll, J. M., Ries, R. K., & McDonell, M. G. (2019). Perspectives on a contingency management intervention for alcohol use among consumers with serious mental illness. *Psychiatric Rehabilitation Journal, 42*(1), 26-31. https://doi.org/10.1037/prj0000330

35. Norton, B. L., Bachhuber, M. A., Singh, R., Agyemang, L., Arnsten, J. H., Cunningham, C. O., & Litwin, A. H. (2019). Evaluation of contingency management as a strategy to improve HCV linkage to care and treatment in persons attending needle and syringe programs: A pilot study. *International Journal of Drug Policy, 69*, 1-7. https://doi.org/10.1016/j.drugpo.2019.02.009
36. Stanger, C., Lansing, A. H., & Budney, A. J. (2016). Advances in research on contingency management for adolescent substance use. *Child and Adolescent Psychiatric Clinics of North America, 25*(4), 645–659. https://doi.org/10.1016/j.chc.2016.05.002
37. Stanger, C., & Budney, A. J. (2019). Contingency management: Using incentives to improve outcomes for adolescent substance use disorders. *Pediatric Clinics of North America, 66*(6), 1183–1192. https://doi.org/10.1016/j.pcl.2019.08.007
38. Hirchak, K. A., Echo-Hawk, H., Parent, S., Peavy, K. M., Webb, K., Bajet, K., Richardson, M., Granbois, A., Herron, J. L., Catron, K., King, K., Parsells, E., Freese, T. E., Thomas, L. R., Rawson, R., Clark, H. W., Roll, J., & McDonell, M. G. (2023). The urgent need for contingency management among Tribal communities in the United States: Considerations for implementation, policy, and sovereignty. *Preventive Medicine, 176*, 107662. https://doi.org/10.1016/j.ypmed.2023.107662
39. Campbell, A. N. C., Rieckmann, T., Pavlicova, M., Choo, T. H., Molina, K., McDonell, M., West, A. E., Daw, R., Marsch, L. A., & Venner, K. L. (2023). Culturally tailored digital therapeutic for substance use disorders with urban Indigenous people in the United States: A randomized controlled study. *Journal of Substance Use and Addiction Treatment, 155*, 209159. https://doi.org/10.1016/j.josat.2023.209159

Other

40. Alessi, S. M., Rash, C. J., & Pescatello, L. S. (2020). Reinforcing exercise to improve drug abuse treatment outcomes: A randomized controlled study in a substance use disorder outpatient treatment setting. *Psychology of Addictive Behaviors: Journal of the Society of Psychologists in Addictive Behaviors, 34*(1), 52–64. https://doi.org/10.1037/adb0000517
41. López, G., Orchowski, L. M., Reddy, M. K., Nargiso, J., & Johnson, J. E. (2021). A review of research-supported group treatments for drug use disorders. *Substance Abuse Treatment, Prevention, and Policy, 16*(1), 51. https://doi.org/10.1186/s13011-021-00371-0
42. Ribeiro, A., Pinto, D. G. A., Trevisol, A. P., Tardelli, V., Arcadepani, F., Bosso, R. A., Ribeiro, M., & Fidalgo, T. M. (2023). Can Contingency Management Solve the Problem of Adherence to Antiretroviral Therapy in Drug-Dependent Individuals? *Health Education & Behavior, 50*(6), 738-747. https://doi.org/10.1177/10901981221148966
43. Sung, M. L., Viera, A., Esserman, D., Tong, G., Davidson, D., Aiudi, S., Bailey, G. L., Buchanan, A. L., Buchelli, M., Jenkins, M., John, B., Kolakowski, J., Lame, A., Murphy, S. M., Porter, E., Simone, L., Paris, M., Rash, C. J., & Edelman, E. J. (2023). Contingency Management and Pre-Exposure Prophylaxis Adherence Support Services (CoMPASS): A hybrid type 1 effectiveness-implementation study to promote HIV risk reduction among people who inject drugs. *Contemporary Clinical Trials, 125*, 107037. https://doi.org/10.1016/j.cct.2022.107037

SECTION 7. APPENDICES

7.1 APPENDIX A. SAMHSA STATE OPIOID RESPONSE GRANT, NOTICE OF FUNDING OPPORTUNITY, "APPENDIX J – CONTINGENCY MANAGEMENT"

To mitigate the risk of fraud and abuse, while also promoting evidence-based practice, recipients who plan to implement contingency management (CM) interventions as part of their SAMHSA grant award will be required to comply with the following conditions:

1. The type of CM model chosen will be consistent with the needs of the population of focus.

2. To ensure fidelity to evidence-based practice, staff who will implement, administer, and supervise CM interventions are required to undergo CM-specific training prior to implementing CM. Training should be delivered by an advanced-degree holder who is experienced in the implementation of evidence-based contingency management activities. Training should be easily accessible, and it can be delivered live or through pre-recorded training sessions. When participants receive training through pre-recorded sessions, they should have an opportunity to pose questions and to receive responses in a timely manner.

Education must include the following elements:

- The core principals of contingency management
- Target behavior;
- The population of focus;
- Type of reinforcer (incentive);
- Magnitude (or amount) of reinforcer;
- Frequency of reinforcement distribution;
- Timing of reinforcement distribution; and,
- Duration reinforcement(s) will be used
- How to describe contingency management to eligible and ineligiblepatients
- Evidence-based models of contingency management and protocols to ensure continued adherence to evidence-based principles
- The importance of evidence-based practice on patient outcomes
- Testing methods and protocols for target substance use disorders and/or behaviors
- Allowable incentives, appropriate selection of incentives, storage ofincentives, the distribution of incentives, and immediacy of awards
- Integration of contingency management into comprehensive clinical activities and program design. Contingency management should be integrated into services, counseling and treatment activities that provide ongoing support to the clients
- Documentation standards
- Roles and responsibilities, including the role of the supervisor, decision- maker, and direct care staff
- Techniques for supervisors to provide on-going oversight and coaching

Within **90 days of grant award**, you must submit your plan to ensure: (1) that sub-awardees receive appropriate education on contingency management priorto implementation; and (2) oversight of sub-awardee contingency management implementation and operation.

The CM Incentive is offered or furnished pursuant to an evidence-based CMintervention.

3. The recipient's organization must maintain written documentation in the patient'smedical record that includes:

    3.1. The type of CM model and incentives offered that are recommended by the client's licensed health care professional;
    3.2. A description of the CM incentive furnished;
    3.3. An explanation of the health outcome or target behavior achieved; and
    3.4. A tally of incentive values received by the patient to confirm that perincentive and total incentive caps are observed.

4. Receipt of the CM Incentive is contingent upon achievement of a specified targetbehavior, consistent with the beneficiary's treatment plan that has been verified with objective evidence.

5. The CM Incentive is recommended by the client's treating clinician, who islicensed under applicable state law.

6. The CM Incentive is not cash, but may be tangible items, vouchers, or payment of bills that are of equivalent value to the individual's total or accrued incentive earnings.

7. No person markets the availability of a CM Incentive to induce a patient to receive federally reimbursable items or services or to receive such items and services from a particular provider or supplier.

7.2 APPENDIX B. SUMMARY REPORT OF IN-PERSON MEETING, APRIL 11, 2023

Summary report of the meeting proceedings available here.