SAMHSA ADVISORY
Substance Abuse and Mental Health Services Administration

January 2025

USING SAMHSA FUNDS TO IMPLEMENT EVIDENCE-BASED CONTINGENCY MANAGEMENT SERVICES

Contingency management (CM) is a proven health care intervention with demonstrated effectiveness in treating a variety of substance use disorders (SUDs) among diverse populations. To advance the provision of evidence-based CM services that promote abstinence from a specific substance, or encourage treatment attendance or medication adherence, the Substance Abuse and Mental Health Services Administration (SAMHSA) now allows those recipients of a SAMHSA grant that authorizes SAMHSA-approved CM activities in treating SUDs, to provide a motivational incentive value of up to $750 per patient, per year, subject to the requirements and safeguards set forth in this document. To promote program integrity and effectiveness, CM incentives should take the form of items, or vouchers or gift cards for items and services, that support patient well-being and recovery – cash payments are not permitted.

SAMHSA grant programs that authorize a CM intervention support the implementation of either escalating voucher CM or prize-based CM in an evidence-based manner. While there is no set limit on the value of each motivational incentive to reinforce a specific behavior, SAMHSA encourages those grantees eligible to implement CM services under the terms of their grant to appropriately budget for the proposed duration of the CM services. It is essential that grantees adhere to evidence-based CM principles and models, and ensure that all participants in a CM intervention have equal opportunity to receive the same incentive amounts.

Background

CM is a health care intervention in which tangible reinforcers, or motivational incentives, are given to participants contingent on objective evidence of change in a specific, incentivized behavior. CM is widely studied and has been successful in treating a variety of SUDs in diverse populations, and with demonstrated long-term benefit (a median of 24 weeks after reinforcement ended) beyond other active, evidence-based treatments such as cognitive behavioral therapy, 12-Step facilitation, as well as community-based intensive outpatient treatment (Ginley et al., 2021). It is designed to promote positive behavior change through immediate reinforcing contingencies (in the form of incentives) when the incentivized behavior occurs and withholding or reducing those incentives when the incentivized behavior does not occur.

Incentives that have been described in the literature include vouchers, gift certificates, tangible objects chosen by participants, or provision of non-treatment services such as housing or workplace access. Reinforcing the new behavior with timely incentives has been shown to increase the likelihood of success.

Importantly, CM is particularly effective in treating people with stimulant use disorders (SAMHSA, 2021a). In the absence of any U.S. Food and Drug Administration (FDA)-approved medications to treat stimulant use disorders, CM is considered a primary and potentially life-saving intervention for the over 4 million people who meet diagnostic criteria for a stimulant use disorder (a substance use disorder involving cocaine, methamphetamine, or prescription stimulants [SAMHSA, 2024]).

CM is equally effective among those with concurrent stimulant and opioid use disorder, as well as in promoting abstinence from cannabis use (SAMHSA, 2021a). Among those with concurrent stimulant and opioid misuse, CM might focus on the use of stimulants, or be used to promote treatment adherence among those receiving medications for opioid use disorder (MOUD). CM has been shown to reduce use of other drugs and to improve treatment attendance and medication adherence among people receiving MOUD (Bolivar et al., 2021). Compared to other approaches, CM produces significantly better adherence to prevention, diagnosis, and medical interventions for hepatitis, HIV, and tuberculosis. In this way, CM consistently produces positive effects across many types of SUDs and other health conditions (Haug et al., 2006; Herrmann et al., 2017).

Based on informal feedback from SAMHSA grant awardees, the widespread implementation of CM interventions funded in whole or in part by SAMHSA grants has been limited by concerns regarding the federal anti-kickback statute and the belief that certain guidance published by the U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) imposed a CM incentive value cap of $75 per patient, per year. HHS-OIG has clarified its views on this point in guidance.*

Previous SAMHSA Notice of Funding Opportunities limited per patient, per year CM incentive values to $75. SAMHSA has determined that a higher per patient, per year incentive value can be offered by grant programs that include CM activities, provided that those activities meet the conditions set forth in this advisory document, which mirror those found in the HHS Report to Congress on Contingency Management for the Treatment of Substance Use Disorders. Within this framework, providers have the flexibility to implement evidence-based CM services that provide effective and life-saving treatment, so long as in doing so, providers demonstrate fidelity to existing evidence-based models of CM. This requirement ensures that grantees use federal funds for permissible purposes and that patients are receiving equitable and evidence-based care.

Other considerations and requirements discussed in this document include:

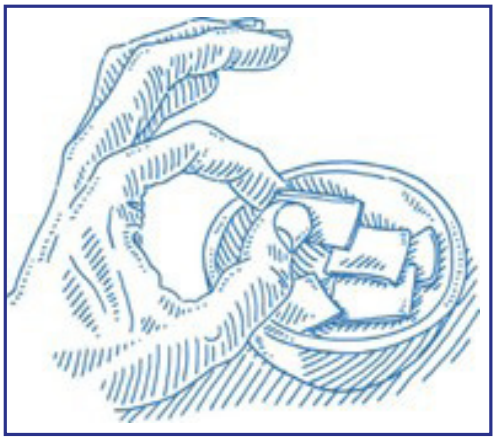
- Evidence-based models of CM, their structure, and potential per patient cost;
- Ramifications for the clinical setting, including the benefits of offering CM in conjunction with other interventions, population-focused service design, education, and information resources; and
- Guardrails that must be observed in implementing CM interventions.

* See 85 Fed. Reg. 77,684, 77,791-92 (Dec. 2, 2020), available at https://www.federalregister.gov/documents/2020/12/02/2020-26072/medicare-and-state-health-care-programs-fraud-and-abuse-revisions-to-safe-harbors-under-the. Although the highest allowed value permitted by this guidance—$750 per patient, per year—would fall outside the safe harbor specified by the current regulation ($605 per patient, per year for 2025), see https://oig.hhs.gov/compliance/safe-harbor-regulations/annual-inflation-updates/, the preamble of the regulation clarifies that "if a contingency management incentive that implicates the Federal anti-kickback statute, Beneficiary Inducements CMP, or both does not satisfy an existing safe harbor or exception (as applicable), that does not mean that such incentive automatically violates the statutes and is illegal." (Id. at 77,792).

Evidence-Based Models of Contingency Management

In clinical practice, two CM reinforcement methods are most common: prize-based and voucher-based. Both approaches have moderate impacts on treatment outcomes (Benishek et al., 2014; Dutra et al., 2008), with no differences in outcomes noted in head-to-head comparison of these two reinforcement methods (Petry et al., 2007; Petry et al., 2005a). A wide range of specific reinforcers have been used in research and treatment settings. Some lower-cost items offered as incentives have included movie passes, transportation vouchers (such as metro cards), discount coupons (that exclude purchase of intoxicants such as alcohol or over-the-counter preparations that contain potential intoxicants (for example, cough syrup with dextromethorphan), tobacco products, weapons, pornographic materials, gambling-related items (e.g., lottery tickets), or other products inconsistent with recovery), calendars, gift certificates for major department stores and music outlets, tools, clothes, books, microwaves, water bottles, sunglasses, supplies for children, toiletries, recreational activities, food, and candy (Kellogg et al., 2005; Petry et al., 2000). Incentive values earned in Voucher or Prize CM models may be spent on smaller items immediately or saved (accumulated) for larger items. The provision of immediate material incentives has been shown to be at least as equally reinforcing as accumulated vouchers, which are later exchanged for tangible items or non-treatment services, in changing behavior (Petry et al., 2005a).

In most existing research with incentives, individuals have been able to accumulate vouchers or prize values and receive tangible incentives for having substance-negative drug tests. Individuals frequently identify the incentives in advance, and can use accumulated incentives to fund the purchase of a desired item. Incentives can range in value, so long as the desired item is consistent with positive recovery behavior (e.g., no weapons, no tobacco products). Typically, individuals request to obtain clothing, electronic equipment, sporting or hobby items, or recreational items (Lussier et al., 2006). Incentives should be given regularly—on a fixed schedule—each time a specific behavior is verified. Incentives should also be disbursed on an escalating schedule, with the incentive gradually increasing every time the behavior of focus is achieved. If a specific behavior is not achieved, the incentive value should "reset" back to the original value, and the escalating schedule begins again. The size and timing of the incentive is important in eliciting positive outcomes, with higher-value, more frequent incentives generally leading to more positive behavior changes (such as abstinence) than lower-value, less frequent incentives (Stitzer et al., 2020; Lussier et al., 2006; Petry et al., 2012).



Prize-Based Model: This approach, often referred to as the Fishbowl Model, is used to provide incentives on a variable schedule (Petry et al., 2000). Individuals demonstrating the identified specific behavior receive draws from a fishbowl in a systematic manner, with an escalating schedule (e.g., one draw for the first negative sample, two draws for the second consecutive negative sample, three draws for the third). Chance is introduced via an intermittent reinforcement schedule in which some draws are winning (a "small prize," "medium prize," or "jumbo prize") and others have no financial value (a chit saying "good job" and verbal praise from the therapist). Prize-based CM can be used to provide a similar outcome to voucher-based CM, but with the possibility of a smaller average outlay for incentives (Petry et al., 2000). Instead of a physical bowl, some modern CM programs use software to randomly select virtual "slips" in the same manner as a patient would from a fishbowl, as described below.

A typical fishbowl is comprised of 500 slips, about half of which have monetary value, varying in magnitude from $1 to $100, with the majority of such slips comprised of the smallest amount ($1). A smaller number provide large magnitude (e.g., $20 value) incentives, and one slip in the bowl is the maximum incentive ($100 value). Slips with a monetary value are exchanged for gift certificates, credit with validated online vendors, or items selected from an onsite cabinet. Slips are replaced for each draw when escalating draws are used. As such, patients always have a chance to obtain this jumbo amount.

Average maximum possible per patient incentive totals have typically ranged in value, in the literature, between $250–$450 over 12 weeks (Peirce et al., 2006; Petry et al., 2012; Petry et al., 2005b). Experts believe that the presence of a jumbo prize, available for random draw every time the patient demonstrates a desired behavior, sustains motivation. In many tested prize-based CM studies, researchers have used a "prize closet" so individuals can see actual prizes they may request. These must be secured and should be refilled pursuant to patient interest. Alternatively, clinicians may shop for prizes or allow the patient to "shop" virtually, although this should happen in a timely manner. Incentives must be furnished to patients immediately after they demonstrate the desired behavior. The immediacy of rewards is central to promoting the behavior of focus.

A Fishbowl Model Case Example in Action

The U.S. Department of Veterans Affairs (VA) has included CM among its treatment options since 2011. Since VA commenced its enterprise-wide implementation of CM in 2011, more than 100 VA medical centers have made CM available to veterans; and more than 6,000 individuals have benefited from this intervention (De Philippis et al., 2023). Treatment programs in the VA health care system employ the Fishbowl Model to offer incentives that vary in scope and size, from a simple note saying, "Good job!" to a small incentive of $3 value or a "jumbo" incentive of $100 value. The cost over 12 weeks is approximately $250 per participant, and incentive amounts are converted to coupons that can be redeemed for merchandise at any Veterans Canteen Service retail store, cafeteria, or coffee shop. Additional information about VA's highly successful national program is discussed in the HHS Report to Congress on Contingency Management for the Treatment of Substance Use Disorders.

Voucher-Based Model: This approach is represented in the work of Higgins and colleagues (2004) and Silverman and colleagues (1996). Voucher methods offer a set reinforcement amount when individuals meet specific behaviors (e.g., $5 value per substance-negative urine sample) and typically escalate with consecutive demonstration of the behavior (e.g., $5 value for the first negative sample, $10 value for the second consecutive negative sample, $15 value for the third, and so on). Accumulated voucher amounts are exchanged for goods or services selected by the patient, and while individuals do not have unlimited choice, they do have a variety of options, which helps to increase the power of the incentives (Higgins et al., 2004). Voucher systems and prize-based systems are often administered on an escalating schedule, with "resets" that start reinforcement over at the next session when behavior runs counter to treatment goals.

Studies of escalating voucher contingencies have indicated maximum possible incentive values per patient of almost $1,000 over 12 weeks and a minimum value of $250 (Festinger et al., 2014; Higgins et al., 2000; Higgins et al., 2003). Evidence demonstrates that an initial, low magnitude voucher-based intervention is effective in promoting attendance at weekly counseling sessions among patients in opioid treatment programs (Hartzler et al., 2014).

A Voucher-Based Model Case Example in Action

Researchers at the University of Vermont implemented a voucher-based CM intervention to treat patients with cocaine use disorder in outpatient settings (Higgins and Silverman, 1999). Using a three-times-per-week urinalysis (UA) schedule, patients received "points" for each cocaine-negative specimen. These "points" were recorded on vouchers, which were given to the patient. Each point was worth $0.25 and negative specimens gained in value for each consecutive negative result (the first negative specimen was worth 10 points, the second consecutive negative specimen was worth 15 points). Bonuses were given for longer sequences of consecutively negative UA results. However, a cocaine-positive UA would "reset" the voucher value back 10 points. The vouchers could be used to secure retail or needed items identified by the patient, with clinic staff making each purchase.

SAMHSA has set the total per-patient CM incentive value limit at $750 per year, with no per incentive cap, so that grant recipients have flexibility in choosing the type of CM model to implement. Research suggests that very few patients will reach this limit.

Implications for the Clinical Setting

CM is most often provided in conjunction with other treatment approaches, and grantees should offer CM in combination with other interventions and services that are applicable to their populations of focus (De Crescenzo et al., 2018). This is consistent with evidence-based principles, a comprehensive and person-centered approach to care, and recognizes the importance of providing a range of treatment interventions that support recovery. In this way, the provision of CM can enhance motivation to participate in treatment (Budney et al., 2006) or promote abstinence, particularly among those with stimulant use disorders (Ronsley et al., 2020).

While there is evidence for the use of CM as an adjunct to widely implemented and highly effective treatment strategies among American Indian and Alaska Native (AI/AN) communities (Hirchak et al., 2022; McDonnell et al., 2021; Venner et al., 2021), the implementation of CM should allow community leaders and clients the opportunity to design protocols that are consistent with cultural and community norms and values (SAMHSA, 2022). SAMHSA and HHS recognize that a variety of psychological and community methods can effectively reinforce treatment and recovery-related behaviors on their own. Therefore, SAMHSA encourages each implementing site to engage communities and community leaders as they design CM protocols and consider potential incentives.

Immediacy of incentives is a key component of CM interventions. If the CM intervention focuses on abstinence, then rapid point of care (POC) tests should be used to test for the substance of interest. The test chosen should be FDA-approved, Clinical Laboratory Improvements Act of 1988 (CLIA)-waived, and sufficiently sensitive to detect possible use of the substance in the days that the patient is away from clinic. Indeed, CM interventions that focus on abstinence typically occur two to three times weekly, meaning that the POC test must be sufficiently sensitive to detect possible use of the substance of interest 2 to 3 days prior to administration of the test.

Based on current rapid POC testing technology, stimulant use disorder is well suited for the use of abstinence as an incentivized behavior. To this end, rapid POC urine tests for stimulants demonstrate a high degree of sensitivity up to 2 to 3 days following use, thereby allowing for thrice-weekly assessment of the incentivized behavior. Cannabis POC tests may have a long window of detection (i.e., weeks) during chronic cannabis use—this potentially complicates the use of abstinence as an incentivized behavior early in the course of CM treatment for cannabis use disorder. Conversely, for certain substances, POC testing may not provide a long enough window of detection. The most widely used rapid POC tests for alcohol use disorder, for example, are breath tests that can only detect alcohol for up to 12 hours following use, which limits the use of abstinence as an incentivized behavior in CM for alcohol use disorder. After review of current POC testing availability and evidence, SAMHSA will only permit abstinence as an incentivized behavior for stimulant use disorders or cannabis use disorders.

CM services should not be used to promote abstinence from opioids, both due to testing limitations (current rapid POC urine tests for opioids do not reliably identify fentanyl and its analogues, and do not reliably distinguish opioid agonists and partial agonists used for opioid use disorder [OUD] treatment), and safety considerations (as people abstain from using opioids for longer periods of time, their tolerance decreases, and they are more vulnerable to overdose in the event that opioid use recurs). MOUD remains the gold standard treatment for OUD.

While CM might focus on abstinence, clinicians may also use it to reinforce attendance at treatment sessions. Where permissible under the terms of a grant, CM might be used to reinforce attendance at treatment sessions among those with stimulant use disorder, OUD, cannabis use disorder, alcohol use disorder, or tobacco use disorder. CM can also be used to reinforce adherence to long-acting injectable medications for OUD (buprenorphine and naltrexone) and can be considered to reinforce adherence to long-acting injectable naltrexone for alcohol use disorder.

Not all SAMHSA grants allow for CM services, and this Advisory does not authorize or permit new CM activities. Grantee eligibility for the increased CM incentive value limit described in this Advisory should be confirmed by the grant's government project officer prior to any implementation planning. While SAMHSA permits certain grant funds to be used for CM incentive values up to $750 per patient, per year, eligible grantees may also wish to augment or supplement the per patient amount with funding from other non-federal sources. In such instances, grantees must ensure that they are aligning with permissible, evidence-based practices and that each patient receiving the CM intervention has the opportunity to receive the same incentive amount. Further, supplemental funding should be secured in advance of patient enrollment in the CM intervention to facilitate implementation of an evidence-based CM model. This guidance does not address legal limitations on the use of funding from non-federal sources or any potential implications under the Anti-Kickback Statute.

Program and Staffing Considerations

The successful implementation of CM comes from two forces: leadership support and idea champions at the clinic level. Both leadership and clinicians should work together to design the CM intervention, consider appropriate staffing, identify safe storage of the prizes or vouchers, and determine limits on and means of acquiring incentives.

People who may benefit from CM interventions must not be recruited into the clinical environment specifically for such treatment or with the promise of incentives resulting from involvement in CM. In other words, CM should not be used to advertise a practice. This safeguard is to reduce the risk of improper steering or inappropriate utilization of CM intervention or other services.

The majority of CM models described in the scientific literature operate for 3 months. Some studies demonstrate that longer treatment of up to 1 year positively impacts certain groups. Decisions about the duration of CM should consider available funding, the population of focus, the individual's treatment goals, their strengths and challenges to engaging in CM, and the availability of supportive services and supports or other complementary interventions, such as case management and counseling.

CM can focus on abstinence or other recovery behaviors, such as reinforcing treatment program attendance or reinforcing adherence to long-acting injectable medications for alcohol use disorder (naltrexone) or OUD (buprenorphine and naltrexone). Decisions about CM intervention design should be made based on the needs of the population of focus, the ability to train clinicians to identify and document patient goals, and the patient's ability to provide objective evidence of the specific behavior. Such considerations may also include the use of telehealth—treatment attendance as an incentivized behavior may be delivered via telemedicine and other related evidence-based technological interventions (e.g., quitlines), provided that the research evidence supports such a delivery platform, attendance can be verified, and that reinforcement can be provided immediately and remotely.

When the focus is abstinence, the number of CM sessions offered each week is usually three as this allows for appropriate monitoring using FDA-approved POC testing that is waived under the CLIA. SAMHSA requires that CM using abstinence as an incentivized behavior (i.e., for people with stimulant or cannabis use disorders) conduct rapid POC drug testing in-person, using a CLIA-waived test with a high level of accuracy.

The evidence-based manner in which CM is delivered is central to outcomes, which makes training and ongoing supervision important. Accordingly, staff should be provided appropriate time to engage in training, coaching (regular review, conversations and feedback on CM implementation with a trained colleague that can be used to strategize, overcome concerns, celebrate success and plan ongoing treatment activities), as well as continuing education.

Learn more about the major components of CM and how to implement it by reviewing the following:

- SAMHSA's Addiction Technology Transfer Center (ATTC) Network online course "Contingency Management for Healthcare Settings"
- The Motivational Incentives Suite, which is a collection of tools and other resources to help organizations understand and implement CM
- NIDA's Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition), Contingency Management Interventions/Motivational Incentives (Alcohol, Stimulants, Opioids, Marijuana, Nicotine)
- UCLA's Recovery Incentives Program: California's Contingency Management Benefit
- Yale University's Psychotherapy Development Center's Contingency Management: Using Motivational Incentives to Improve Drug Abuse Treatment

Required Safeguards for SAMHSA Grantees Using Grant Funding to Support CM Incentives

As stated previously, SAMHSA grant programs that authorize CM interventions can now provide incentive values of up to $750 per individual patient, per year. Not all SAMHSA grants allow for CM services, and this Advisory does not authorize or permit new CM activities. Grantees must consult their government project officer, prior to implementation planning, to ensure that their grant's terms and conditions have been updated to include the increased incentive limit and the requirements described in this Advisory.

To mitigate the risk of fraud and abuse by providers or clinics, while also promoting evidence-based practice, grantees proposing to implement CM interventions as part of their SAMHSA grant award will be required to comply with the following conditions:

1. Grantees must use an evidence-based protocol for delivering CM that is consistent with the needs of the population of focus and aligns with the following requirements:
   - Either prize-based or voucher-based protocols are permitted
   - Abstinence, SUD treatment attendance, and medication adherence are allowed to be used as incentivized behaviors
   - Receipt of the CM incentive is contingent upon achievement of a specified behavior, consistent with the patient's treatment plan, which has been verified with objective evidence
   - The minimum required duration of treatment is 12 weeks
   - Incentive magnitudes must align with what has been found effective in the research literature (with adjustments for economic factors, such as high cost of living) to ensure that incentives sufficiently motivate achievement of the incentivized behavior
   - Caps on the cumulative annual value of incentives per patient (below the $750 limit) must be high enough to accommodate incentives of a sufficient magnitude and to minimize the likelihood that patients being treated with prize-based CM have to prematurely discontinue treatment because they exceed the cap after receiving multiple high-value incentives
   - Incentives must be provided immediately following verification that the incentivized behavior is achieved
2. CM interventions that use abstinence as an incentivized behavior must conduct rapid POC drug testing in person using an FDA-approved, CLIA-waived test to verify the behavior. Offices or facilities using CLIA-waived tests must comply with all applicable laws and regulations, including CLIA certification requirements from the Centers for Medicare & Medicaid Services.
3. CM interventions that use SUD treatment attendance as an incentivized behavior may be delivered via telemedicine and other related evidence-based technological interventions (e.g., quitlines).
4. Assessment of whether incentivized behaviors are achieved (i.e., through POC testing or confirmation of treatment attendance or medication adherence) and the provision of incentives must be conducted by a health care practitioner who is authorized to provide SUD treatment services in that state. Peer specialists are not permitted to deliver CM, as many components of the intervention fall outside of their traditional scope of activities and can place them in a role of authority that conflicts with the peer-to-peer relationship. Peer specialists are nonetheless important members of the overall SUD care team and may provide other services to individuals receiving CM as authorized by the state in which they practice.

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Required Safeguards for SAMHSA Grantees Using Grant Funding to Support CM Incentives, *continued*

5. Recipients of CM services must be 18 years of age or older.
6. Each office or facility that offers CM must designate one or more individuals to act as "champions" for CM implementation. The "champion" is responsible for:
   - Overseeing implementation of CM interventions at their facility or office
   - Securing the necessary training for clinicians and staff
   - Monitoring for fidelity to evidence-based practice
   - Connecting CM providers with coaching as needed
   - Monitoring the safe storage of tangible CM incentives, and tracking the release of incentives based on objective evidence of achieving the desired behavior
   - Documentation and record-keeping related to the disbursement of CM incentives
7. To ensure fidelity to evidence-based practice, those who will implement, administer, and supervise CM interventions must participate in CM-specific training prior to services starting. Training should be delivered by an advanced degree holder who is experienced in the implementation of evidence-based CM. 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. Training should contain the following elements:
   - The core principles of CM, including:
     - Behavior of focus;
     - Population of focus;
     - Type and value (or amount) of reinforcer (incentive);
     - Frequency of reinforcement distribution;
     - Timing of reinforcement distribution; and
     - Duration of reinforcement(s) use.
   - How to describe CM to eligible and ineligible patients
   - Evidence-based models of CM and protocols to ensure continued adherence to evidence-based principles
   - Testing methods and protocols for specific substances and/or behaviors, including opportunities to challenge test results
   - Allowable incentives, appropriate selection of incentives, storage of incentives, and immediacy of awards (as proximal to the behavior or test as feasible)
   - Integration of CM into clinical activities and program design
   - Documentation standards
   - Roles and responsibilities, including the roles of the supervisor, decision maker, and direct care staff
   - Techniques for clinical supervisors to provide ongoing oversight and coaching

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Required Safeguards for SAMHSA Grantees Using Grant Funding to Support CM Incentives, *continued*

8. The grantee's organization must maintain written documentation in the patient's medical record that includes the following:
   - The type of CM model and incentives offered that are recommended by the patient's licensed health care professional;
   - A description of the CM incentive furnished;
   - An explanation of the health outcome or specific behavior achieved; and
   - A tally of incentive values received by the patient, to confirm that per incentive and total incentive caps are observed.
9. CM is delivered to patients for whom it is recommended by their treating clinician, who is licensed under applicable state law.
10. The CM incentive may be tangible items or vouchers or gift cards with purchase restrictions. Cash, unrestricted cash equivalents, parenting time, and enhanced or expedited access to SUD treatment or recovery support services are not permitted as incentives. Additionally, the following items are not permitted as incentives and must be restricted from purchase using vouchers or gift cards:
    - Weapons
    - Intoxicants (e.g., alcohol)
    - Over-the-counter preparations containing possible intoxicants (e.g., dextromethorphan)
    - Tobacco/nicotine products
    - Pornographic materials
    - Gambling-related items (e.g., lottery tickets)
11. CM is intended to be a one-time intervention. However, repeat courses of CM are permissible if:
    - At least 12 months have elapsed since the completion of the person's last CM course;
    - The treating clinician believes that, based on changes in the individual's clinical status, circumstances, or environment, a repeat course of CM is now more likely to achieve sustained benefit; and
    - Other evidence-based treatment options have been considered.
12. No person markets the availability of a CM incentive to encourage a patient to receive federally reimbursable items or services or to receive such items and services from a particular provider or supplier.
13. Patients will be informed that they are not permitted to enroll in more than one CM service, and that this includes CM services offered by different agencies or entities.

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Required Safeguards for SAMHSA Grantees Using Grant Funding to Support CM Incentives, *continued*

14. Prior to the start of CM services, grantees must provide, either through the grant application or in a manner prescribed by the Project Officer, a readiness attestation that describes:
    - The role of individuals in delivery and monitoring of CM services
    - Incentivized behaviors, and the approach to verification
    - The type of CM services to be offered
    - Process for monitoring fidelity to evidence-based practices
    - How training requirements will be met
    - Plan for implementing and monitoring adherence to the safeguards described above

In addition to the above requirements and safeguards, grantees should read the HHS Report to Congress on Contingency Management for the Treatment of Substance Use Disorders and comply with all recommendations under the *Enhancing Clinical Approaches to CM Delivery and Provider and Organizational Standards to Promote Evidence-Based Practices for CM* sections.

SAMHSA's Evidence-Based Resource Guide, *Treating Concurrent Substance Use Among Adults,* describes the effectiveness of CM, when combined with other psychosocial and medical interventions, in treating individuals who have multiple SUDs. Concurrent substance misuse is a growing public health concern leading to adverse health outcomes, including overdose and death. Similarly, the misuse of stimulants is on the rise (SAMHSA, 2021b). SAMHSA's updated *TIP 33: Treatment for Stimulant Use Disorders* and Evidence-Based Resource Guide on *Treatment of Stimulant Use Disorders* provide further information and evidence on the use of CM for stimulant use disorders, as well as the clinical context.

Grant recipients have the flexibility to decide the type of CM model they implement, assuming all requirements outlined in this Advisory and in the terms and conditions of award, are met and appropriate safeguards, storage of incentives, and monitoring of each patient's aggregate incentive amounts are in place.

Conclusion

The body of evidence supporting the use of CM to promote lasting behavior change across a variety of populations with different SUDs is expanding rapidly. Promoting this health care intervention and offering it in conjunction with other treatment approaches that are applicable to populations of focus, is of the utmost importance given the increasing prevalence of SUDs and the need for effective treatments.

The provision of CM interventions that adhere to evidence-based practice is crucial. By providing services in an evidence-based manner, providers adhere to an important core principle of CM and individuals receive equitable, effective, and evidence-based, person-centered care. As the prevalence of SUDs increases, CM is an important intervention with life-changing and life-saving potential.

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