2024

Contingency Management in San Francisco

STRENGTHS AND OPPORTUNITIES FOR IMPLEMENTATION AND EXPANSION OF CONTINGENCY MANAGEMENT PROGRAMS

San Francisco
Department of Public Health

Report developed by:
FACENTE CONSULTING
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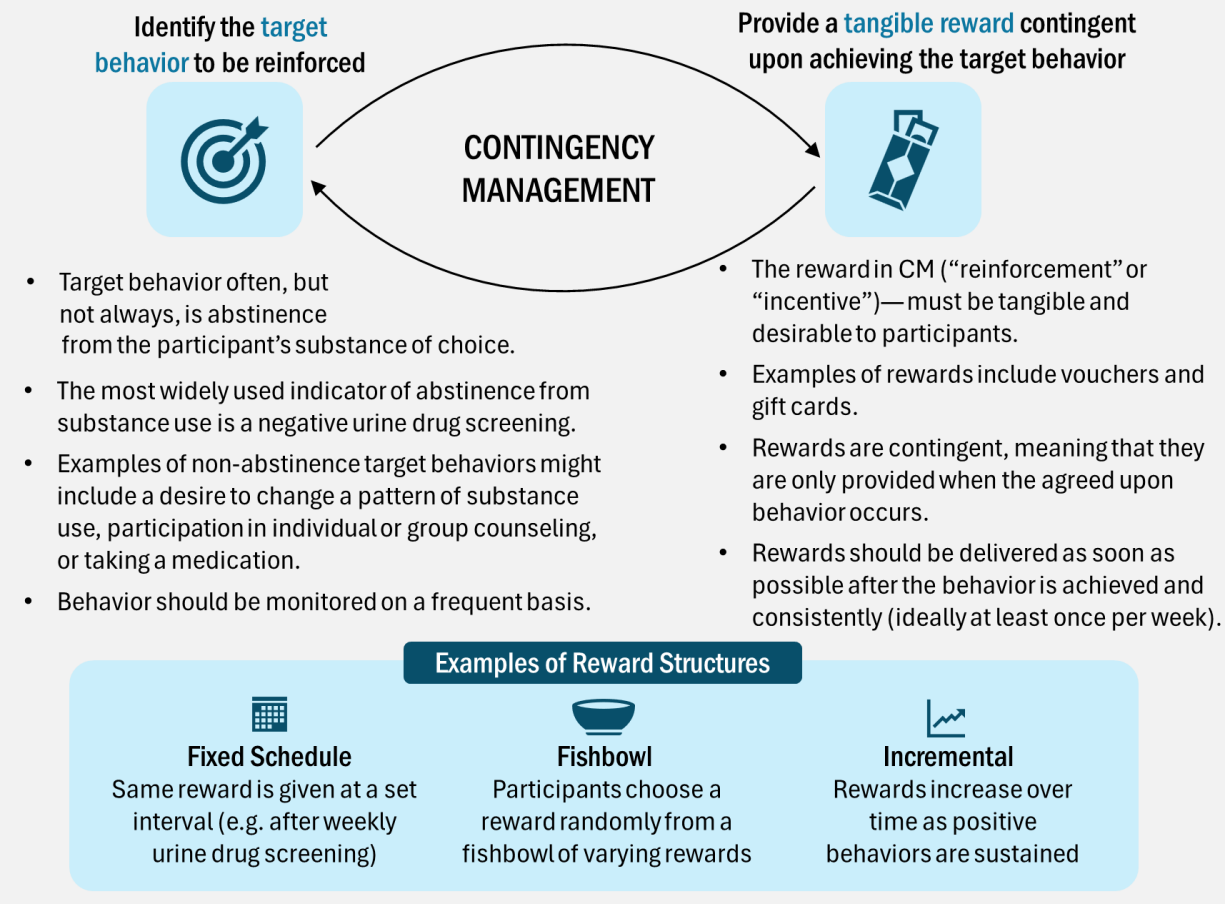
1. Background: Contingency Management in San Francisco

WHAT IS CONTINGENCY MANAGEMENT?

Contingency Management (CM) is a **behavioral intervention** used in conjunction with other treatment modalities to treat substance use disorders, including stimulant use disorder.[1,2] As shown in **Figure 1**, CM involves **immediate, tangible rewards** to individuals to **reinforce positive behavior change.** The reward is **contingent upon completing a goal or behavior**, such as stopping stimulant use or engaging in treatment. As a result, the target behavior is **more likely to be repeated,** and treatment outcomes are more likely to be achieved. CM is distinct from simply giving incentives because target behaviors and reward systems are communicated clearly at the start of participation in the program.

Figure 1. Core Elements of Contingency Management (CM)



[1] Unlike opioid use disorder and alcohol use disorder, no FDA-approved medications exist to treat stimulant disorder; however, evidence-based practices like CM and cognitive behavioral therapy (CBT) have been shown to be efficacious. Longer CM treatment periods are associated with better treatment outcomes.

[2] De Crescenzo, Franco, et al. "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 (2018): e1002715

CM IN SAN FRANCISCO

California is the first state in the country to offer CM as a Medicaid benefit through the **Recovery Incentives Program**.[3] Since 2023, California has been implementing CM services[4] in 24 participating pilot counties that cover 88% of the Medi-Cal population, including in San Francisco.

San Francisco's embrace and utilization of CM pre-dates the launch of the Recovery Initiatives Program. Notably, in 2003, SFDPH launched a pilot CM program, known as the **Positive Reinforcement Opportunity Project (PROP)**, designed as a programmatic public health response to increases in methamphetamine-associated sexually transmitted infections—such as syphilis and HIV—in San Francisco. Between December 2003 and December 2005, the PROP pilot showed promising results for both substance use treatment and sexually transmitted infection prevention.

- First, PROP yielded a 35% 90-day completion rate, which is similar to graduation rates from traditional treatment programs.
- Second, while PROP had graduation rates comparable to traditional treatment programs, it cost far less than traditional treatment programs, with an approximate cost of $1,000 per participant.
- Finally, while many of the 178 men who participated in the PROP pilot self-reported risk behaviors for acquiring and transmitting sexually transmitted infections, including HIV, a significant proportion of men who completed PROP reduced their sexual risk behaviors while enrolled.

PROP still operates two decades later, with the San Francisco AIDS Foundation awarded to continue the program through a Request for Proposals (RFP) process. PROP has also expanded to allow access for a wider audience. In addition to PROP, San Francisco hosts more than a dozen CM programs that were launched outside of California's Recovery Incentives Program pilot.[5] Figure 2 (next page) shows common characteristics of the subset of CM programs run or funded by SFDPH.

SFDPH's continued implementation and expansion of CM through the Recovery Incentives Program aligns with the State's efforts to address harms associated with stimulant use and improve CM access through Medi-Cal coverage. Understanding the perspectives of key CM stakeholders—including participants and providers—can help SFDPH maximize the impact of current and future CM programs.

[3] See: https://www.dhcs.ca.gov/Pages/DMC-ODS-Contingency-Management.aspx

[4] When utilizing Medi-Cal for reimbursement, CM programs must meet certain criteria, including a cap on time (24 weeks incentives enrollment) and a total cap of $599 in incentives for non-reactive urinalysis (UA).

[5] Appendix A shows the San Francisco Health Network Contingency Management Referral Guide

Figure 2. Characteristics of the Subset of Contingency Management Programs Run or Funded by SFDPH.[6]

Reward Structure	• Most programs use incrementally increasing rewards • Three programs use the fishbowl reward structure • Two programs use a fixed schedule reward structure • Most programs start with an incentive of $5 or $10, with a cap ranging from $330-559
Target Behaviors	• Every program incentivizes non-reactive urinalysis (UA) • Many programs incentivize attendance at group or individual counseling • A few programs incentivize other health-related behaviors, such as taking medication or not injecting drugs
Program Length	• Programs range from 5 sessions to 24 weeks in length, with most programs lasting 12 or 24 weeks
Program Eligibility	• Most current contingency management programs are only available to pre-existing clients, but people are able to be referred and become clients to access CM services • San Francisco AIDS Foundation and HealthRIGHT360 host CM programs open to anyone, pending capacity
Program Size	• Program capacity ranges from 6 to 100 people
Group Programming	• Every program offers individual counseling, linkages to care, and naloxone access • Two programs also offer group programming

[6] **Note**: This figure does not encompass all CM programs in San Francisco, and given the Recovery Incentives Program, additional CM programs may be emerging.

2. Methods: Engaging stakeholders with expertise in CM

From May – August 2024, SFDPH designed a **community engagement process** to understand current strengths and opportunities in San Francisco's CM programs. The process sought the perspectives of CM participants and CM providers who represented the subset of CM programs that are either run or funded by SFDPH.

2A. METHODS TO ENGAGE CM PARTICIPANTS

SFDPH hired Facente Consulting to design, conduct, and analyze **in-person focus groups and interviews with 47 CM participants** from CM programs funded by SFDPH (Figure 3). Focus groups were approximately one hour long, while interviews lasted 30 minutes. All focus group and interview participants were compensated with $50 in cash. Facente Consulting staff recorded, transcribed, and analyzed interviews using a deductive coding approach.

Figure 3. CM Participant Engagement Methods

How CM participants were engaged:

- 5 focus groups at five of SFDPH's CM sites
- 3 one-on-one interviews with CM participants at two of the SFDPH CM sites that did not have focus groups

2B. METHODS TO ENGAGE CM PROVIDERS

SFDPH also sought perspectives of **CM providers** through **key informant interviews** and **surveys** with SF's CM programs. Key informant interviews and surveys were conducted by SFDPH staff with subject matter experts (SMEs) from CM programs run or funded by SFDPH. Facente Consulting reviewed interview and survey data to identify key components of these CM programs—such as eligibility criteria and program structure—as well as lessons learned at each CM program from the provider perspective.

3. Key insights from CM participants

The 47 focus group and interview participants who had engaged in CM programs run or funded by SFDPH shared several key insights about the impact of CM on their substance use journey.

3A. CHARACTERISTICS AND TREATMENT HISTORIES OF FOCUS GROUP PARTICIPANTS

The 44 people who participated in focus group discussions had come to CM from various backgrounds and were at different stages in the CM process.

- People heard about the program through three main sources: (i) harm reduction programming and educational materials, (ii) directly from their provider, and (iii) word of mouth from other CM participants.
- CM participants were at different points in their programs, ranging from those who were on their very first day to those who had already graduated. On average, participants had been in their CM programs for 10 weeks.
- Nearly every CM participant had tried other treatment modalities in the past, with the most common being residential treatment. Additional treatment modalities that participants had tried included taking medications like buprenorphine, methadone, and naltrexone, and participating in 12-step meetings.
- Notably, many CM participants reported **negative experiences with traditional residential treatment programs**. Due to strict regulatory oversight, residential treatment programs often have rules that create barriers to access, such as requiring people to sign in and out of activities and minimal tolerance for a return to substance use while in the program. Some CM participants felt infantilized by these rules, and negative experiences were especially common among CM participants who experienced a return to substance use while engaged in residential programs. Beyond those common barriers to accessing residential treatment, a few CM participants reported being treated so poorly in residential programs that they left the program.

> **"I'm an adult…I have a hard time having someone that's younger than me…tell me what to do. I don't need to sign in and sign out."**
>
> ***CM Participant***

> **"If you relapse, while you're [in residential] treatment, it's: 'let me show you the door', right? I appreciate the safety net comfort zone [in CM programs], knowing that okay, if I make a mistake, I'm not going to be thrown out to the wolves."**
>
> ***CM Participant***

3B. CM FLIPS THE SCRIPT ON THE EXPERIENCE OF SEEKING TREATMENT

When asked how they would describe the CM model to people in their lives, participants frequently spoke about the way that CM stands out from alternative treatment programs—which tend to be punitive and "looking for the bad"—by offering, a non-judgmental space that rewards positive behavior change. For many CM participants—even those who had begun CM simply for the

incentives—**the inclusivity they perceived through CM became the primary reason they continued to engage**. Others emphasized how different CM felt from other treatment programs, where they might be kicked out for having a reactive drug test or forced to take urine samples (often observed) in the first place. This **paradigm shift from punishing undesired behavior changes to rewarding desired behavior changes** felt intuitive and valuable to CM participants. One participant described their experience in CM as "light-years" ahead of any other treatment program.

> **"Well, the first time [I explained CM to someone] I said, 'I found a place that they give you money if you go three times a week and you test negative.' …But now I will explain that it's a program about having a safe space to ask questions about drugs without any judgment and also a place to build community."**
>
> *CM Participant*

> **"I've explained it to different types of people…it's like the opposite of what would happen if you drug test in other places. Instead of being punished for [the] negative, you're incentivized for [the] positive. It's encouraging in that way…rather than demonizing…So, yeah, just kind of…the opposite of what has usually been done."**
>
> *CM Participant*

> **"If you're not 100% abstinent, they don't cut you off. They don't stop you. They are giving you opportunities to get your life together—not just the money, but it's just an incentive in itself."**
>
> *CM Participant*

3C. INCENTIVES CONFER MULTIPLE LAYERS OF VALUE

CM participants shared that incentives offered several types of value, ranging from program engagement to material well-being to a general sense of emotional well-being and self-sufficiency.

With respect to CM program engagement, several participants noted that the availability of an incentive could **make the difference in whether or not they showed up to the program on a personally challenging day**. In turn, showing up on that challenging day because of the incentive—compared to not showing up at all—could improve the longer-term trajectory of progress toward their behavior goals.

> **"And then there'll be a week period where you're really low, and nothing's causing it. It's just part of it. And if you have incentives and things like that to help you through that peak, then you're going to make it for another year after."**
>
> *CM Participant*

For many participants, the incentives provided through CM made a **meaningful difference in their material well-being**. Participants described purchasing everyday items, such as socks, shampoo, and dresses. Some had saved up or planned to save up incentives for larger purchases, such as one CM participant who planned to buy a tool kit to support their future employment and another who had gotten new teeth using money saved through CM.

> **"This incentive program really opened my eyes to, well, now I could buy a rocking chair for AA groups. I mean, it'd be really comfortable at an AA group just chilling in my own rocking chair, or whatever, you know…also at the beach and in the front yard. I really just appreciate it, because I have nothing right now, and to have just a little bit of something actually, really does make a difference."**
>
> *CM Participant*

CM participants also described the role that incentives played in improving their **emotional well-being and self-worth**. For example, one person described hugging themselves after meeting a behavior change goal because the process of receiving the incentive was so affirming. Another participant shared how they felt worthy enough to call their mother because the program helped prevent them from getting high. Several participants described the ability to care for others due to incentives, such as saving money to bring gifts to relatives in Mexico, or providing better care for one's dog.

> **"It helps me engrain…day to day, actual activities, like going to Burger King and buying something to eat. It's as simple as that, going to Burger King and buying your own meal. You know what I mean?...It's engraining in my recovery path…that I can rely on myself."**
>
> ***CM Participant***

Finally, as already described in section 3B, a core value conferred via CM incentives was the **reframing of a negative relationship to treatment** to a rewarding relationship with treatment.

3D. NON-JUDGMENTAL, FLEXIBLE APPROACHES STRENGTHEN CM

Beyond flipping the script to positively reinforce target behaviors rather than punish undesired behaviors, CM participants shared how a non-judgmental approach in CM was central to establishing trust. CM programs were described as **safe, caring, and guilt-free**. As a result, participants were able to open up more about their substance use and build trusting, sustainable relationships with staff and peers.

> **"The staff lets us be honest. People can come in and stop being strong. It helps just as much as therapy. We accept it if people use [drugs] – because we're able to be honest. The staff is people who understand and who don't look down at us."**
>
> ***CM Participant***

> **"It helped me to start being more open, and then I started making friends. I love to go there; it is one of my favorite things in the week."**
>
> ***CM Participant***

Participants also found a non-judgmental approach **helpful to reaching substance use goals**. For example, many CM participants had abstinence goals related to their stimulant use; these participants appreciated non-reactive drug screenings being compensated, and they also felt trust that they would be supported and retained in the program through any struggles or return to use. By meeting people where they are, CM programs provide a space to be honest about one's situation and work through challenges, with the reassurance that staff will be ready to embrace and support rather than criticize. CM participants emphasized that feelings of shame or critique can drive substance use, making the welcoming, non-judgmental approach of CM key to supporting their substance use goals.

> **"They don't give up on [you], you know. So you just like pick up yourself and keep going."**
>
> ***CM Participant***

> **"The harm reduction-based thing, that's the most important…if you come in there, come as you are. That's what I liked about it; I don't have to show up here with my hair pulled back or, you know, suit on and tie, you know, I can come as I am; they accept me. So that's just a beautiful thing."**
>
> ***CM Participant***

3E. EXPANDING AND STRENGTHENING CM BASED ON PARTICIPANT INPUT

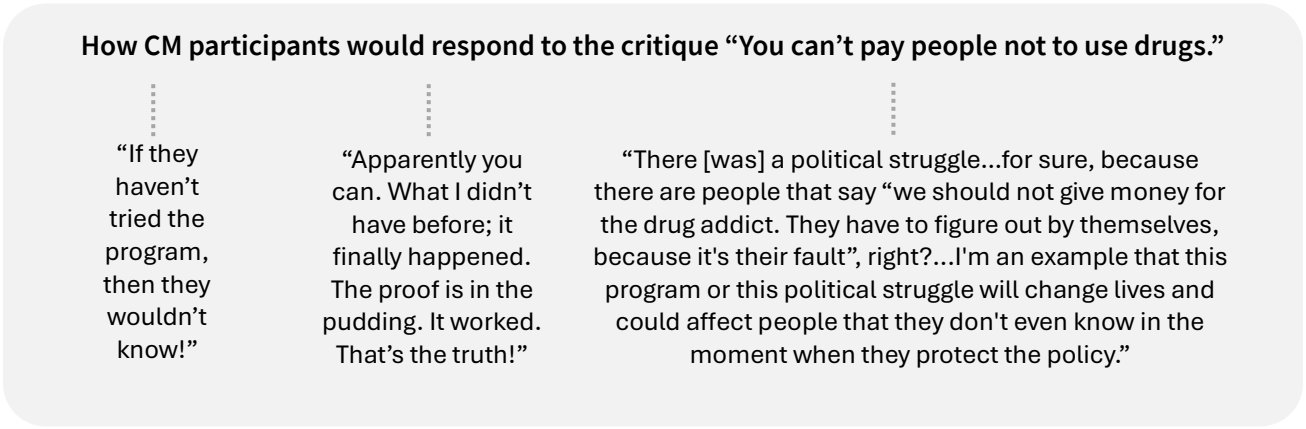
Given the overall positive experience in programs and limited current accessibility for new participants, CM participants unanimously supported the expansion of CM programming.

Ideas for expansion included:

- More hours to allow for participation on different days
- More opportunities to check in with supportive staff
- Greater variety of gift cards
- Opportunity to save up gift cards for cash at graduation
- Improved publicity so that CM opportunities spread beyond word-of-mouth channels
- Expansion of CM structures valued by participants, such as:
    - Integration of CM programs within clinics, SROs, and housing programs
    - Options to engage in group sessions in CM programs to support relationships and community-building with peers

In promoting CM programming, CM participants had several ideas of how to counter narratives that critiqued the idea of paying people to engage in substance use treatment (**Figure 4**).

Figure 4. Countering critiques of CM, in the words of CM participants



Finally, CM participants appreciated SFDPH's dedication to CM and want to be **meaningfully included and consulted** as CM programs are revisited and expanded. They emphasized the importance of repeated (versus one-time) engagement of CM participants as experts in CM programming to ensure that programs adapt to changes in the CM participant community.

"The idea that we're able to graduate this program—our words and our thoughts should be more valued than people who are doctors, and it's nothing against them…But the fact we've done this…there's a certain point where I think the City needs to have regular feedback of what is broken, what needs to be worked on."

CM Participant

4. Key findings from CM provider focus group discussions and survey

Mirroring CM participant perspectives, SF CM providers were enthusiastic about the CM model, committed to expansion, and aware of the need for CM programs that meet participants where they were at—whether participants sought abstinence or not.

4A. THE NEED TO INCLUDE MODELS THAT FOCUS ON MORE THAN ABSTINENCE

Providers shared that centering **harm reduction was lifesaving and crucial**. In CM, centering harm reduction means reinforcing any positive behavior change, which may include abstinence or another target behavior. In practice, CM can reward behaviors beyond abstinence (typically measured via urinalysis (UA)), such as taking medication or engaging in individual or group counseling.

> **"Historically in a lot of CM literature, [CM] has been done in programs that incentivize non-[reactive] UA only…narrowing to a smaller population who are ready to stop using and/or who have already stopped."**
>
> *CM Provider*

Providers who implemented low-barrier harm reduction models noted that this approach allowed CM to engage a larger number of patients and reinforce positive behavior change along the full continuum of treatment rather than just working with the narrow segment of patients who are ready for abstinence. Engagement of people not ready for abstinence in CM models also provides opportunities to provide education and tools to reduce overdose risk and other harms associated with substance use.

> **"I feel strongly that CM is a powerful method of not only treating stimulant use disorder, but also reducing overdose risk and engaging participants in harm reduction."**
>
> *CM Provider*

4B. CREATING WELCOMING, TRUSTED, AND INCLUSIVE SPACES FOR CM

Mirroring participant insights, several providers noted the importance of a **warm, welcoming, and hospitable space** for CM. Providing coffee and snacks created space for community-building, in addition to the CM programming itself. Providers also felt that **continuity of care**, in which the same providers were involved throughout the process, was important to foster trust and engagement. The need to recruit, retain, and support high quality staff was essential to supporting continuity of care. In addition, several providers felt that their CM programs have benefitted from and should continue to support **meaningful inclusion of CM participants in shaping the CM process**.

> **"The graduate group was the idea of one of the first graduates who said – 'this cannot end; [it] has been so important to me.' The graduate group was developed as a result."**
>
> *CM Provider*

4C. CO-LOCATION WITH OTHER SUBSTANCE USE TREATMENT PROGRAMS

At the two San Francisco CM programs housed at opioid use treatment programs (one at a methadone clinic and another at a buprenorphine induction clinic), providers reported success in sustained engagement of people with stimulant disorders. One CM provider noted that the CM program dropout rate is much lower—approaching zero—when methadone treatment is paired with contingency management. Another provider noted that many people engaged in their opioid use treatment program have had decades of continuous stimulant use, making them good candidates for CM.

4D. OVERCOMING BARRIERS IN CURRENT CM PROGRAMS

While CM providers overwhelmingly discussed the successes and opportunities for CM programs, they also reported unique clinical and programmatic sticking points that would benefit from troubleshooting and/or the development of best practices. **Examples of barriers shared by providers included**:

- CM can be complicated for people who are prescribed stimulants. Point of care urinalysis testing can't differentiate prescribed versus non-prescribed stimulants well, requiring lab-based testing.
- The consistency of attending CM sessions is a large part of the program; however, consistency can be trickier during holiday schedules, leading to momentum loss among clients.
- Staff expressed that it was challenging to find highly qualified staff who can adhere to the best practices outlined in this report
- The 24-week cap on incentives, required by the state of California, is not always a good fit for participants; many would benefit from an expanded timeline of CM engagement.

6. Recommendations for SFDPH's future CM planning

As shown in **Figure 5**, insights from CM participants and providers support several recommendations for the future of SF's CM programming:

Figure 5. Recommendations for SF's CM Programming

In addition to illuminating specific areas where the success of CM programs can be strengthened, a key finding from this report is **the critical role of CM as a positive—rather than punitive—framework** for substance use treatment. While many CM participants mentioned incentives as important, what ultimately kept them engaged was the way that CM programs met them where they were at, stuck with them even when they did not reach a behavior change goal, and rewarded positive steps toward change.

> **"[CM] changes the paradigm from being punitive to incentive based. We are used to being looked at as…a behavior problem; there's something wrong with us. Even in rehab, you come across the punitive…you run across staff members sometimes that they feel like it's their job [to] catch us doing something bad, right? [CM] changes…the entire dialogue."**
>
> ***CM Participant***

Appendix A: San Francisco Health Network CM Referral Guide (next three pages)

San Francisco Health Network

Contingency Management in San Francisco

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Clinic Name	Administrative Details	Program Specifics
HOUDINI LINK Hospital Opioid Use Disorder Treatment Initiation and Linkage to Care **Zuckerberg San Francisco General Hospital** Building 90, 5th floor 995 Potrero Ave, San Francisco, CA, 94110	**Referrals:** Participants must be enrolled during their ED visit or hospital admission at SFGH. Referrals can be made by emailing alexandra.haas@ucsf.edu or calling 628-206-3010. There is also a a consult order at SFGH for providers referring from the ED or inpatient units. **Program Length:** 6 months **Eligibility:** Current patient at SFGH, interested in starting medication for opiate use disorder, 18 or older, SF resident experiencing homelessness, English or Spanish speaking, no plans to leave SF within 6 months **Appointment Type:** Drop-in or appointment **Hours of Operation:** 8:00AM--5:00PM Monday through Friday	**Targeted Goal:** Reduction or cessation of opiopid use, engagement in counseling, achievement of health-related behaviors, and/or medication adherance **Services Offered:** Individual counseling, linkage to care, transportation, Naloxone access, trainings, snacks **Are alumni/aftercare services offerred?** No, but there is potential to repeat the program and/or recieve referral to alternate programs
RISE at Bridge Clinic Recovery Incentives for Stimulant Escape **Zuckerberg San Francisco General Hospital** Building 80 995 Potrero Ave,, 5th Floor, San Francisco, CA 94110	**Referrals:** Bridge Clinic patients are referred by UCSF ward, the UCSF Adolescent Medicine Clinic, assessment clinics at LPPH, and community clinicians **Program Length:** 12 weeks **Eligibility:** Member of San Francisco Health Network and recently discharged from the hospital and in need of outpatient treatment, or are in treatment, but require more intensive services. **Appointment Type:** Group visit **Hours of Operation:** 10:00AM--12:00PM Wednesday	**Targetd Goal:** Reduction or cessation of stimulant use and/or group attendance **Services Offered:** Groups and linkage to care **Are alumni/aftercare services offerred?** Yes
PROP Positive Opportunities Reinforcement Program **San Francisco AIDS Foundation** 940 Howard San Francisco, CA 94103	**Referrals:** Contact Tyrone Clifford @ 415-699-2930 or tclifford@sfaf.org. Alternately, contact main Stonewall line at 415-487-3100. **Program Length:** 12 weeks / 36 sessions total **Eligibility:** Identify as MSM, transgender, or gender non-conforming with interest in changing use of stimulants, opioids, or other substances **Appointment Type:** Drop-in **Hours of Operation:** Monday, Wednesday, Friday; 1:00PM–2:30PM	**Targeted Goal:** Reduction or cessation of stimulant, opioid, or other substance use and health-related behavioral changes **Services Offered:** Group counseling, individual counseling, linkage to care, HIV/HCV testing, STI testing **Are alumni/aftercare services offerred?** Yes

Clinic Name	Administrative Details	Program Specifics
PROP 4 ALL Positive Opportunities Reinforcement Program for All **San Francisco AIDS Foundation** 940 Howard San Francisco, CA 94103	**Referrals:** Contact Wayne Rafus @ 415-919-8787 or wrafus@sfaf.org. Alternately, contact main Stonewall line at 415-487-3100 **Program Length:** 12 weeks / 36 sessions total **Eligibility:** Interest in changing use of stimulants, opioids, or other substances **Appointment Type:** Drop-in **Hours of Operation:** 2:00PM–4:00PM Monday, Wednesday, Friday	**Targeted Goal:** Reduction or cessation of stimulant, opioid, or other substance use; health-related behavioral changes; and/or attendance **Services Offered:** Group counseling, individual counseling, linkage to care, HIV/HCV testing, STI testing **Are alumni/aftercare services ofered?** Yes
OBIC Office-Based Buprenorphine Induction Clinic 1380 Howard Street, 2nd Floor San Francisco, CA 94103	**Referrals:** Contact Sabryna Moore Brock at 628-754-9200 **Program Length:** 10 weeks or 20 sessions **Eligibility:** Individuals with stimulant use disorder who are enrolled in OBIC services. Opioid use disorder is not a disqualifant. **Appointment Type:** Appointment only **Hours of Operation:** 10:30AM--11:30AM and 1:00PM--3:30PM Monday, Tuesday, Thursday, Friday	**Targeted Goal:** Reduction or cessation of stimulant use and/or individual counseling session attendance **Services Offered:** Individual counseling **Are alumni/aftercare services offered?** No, but can continue to utilize other OBIC services
INSPIRE Incentive Support Program for Improvement and Recovery **Maria X Martinez Health Resource Center** 555 Stevenson St, San Francisco, CA 94105 **Tom Waddell Urban Health Clinic** 230 Golden Gate Avenue San Francisco, CA 94102	**Referrals:** Contact Meredith Adamo at meredith.a.adamo@sfdph.org **Program Length:** Two sessions per week for 12 weeks or 24 sessions **Eligibility:** Individuals with Stimulant Use Disorder accessing primary care at either clinic. Cannot be enrolled in another SUD CM program. **Appointment Type:** Drop-in once referred. Cap of 12 participants. **Hours of Operation:** 1:00PM–3:00PM Monday and Thursday	**Targeted Goal:** Reduction or cessation of stimulant use, attendance, and/or consecutive attendance **Services Offered:** Groups, individual counseling, medication, HIV/HCV screening, STI screening, naloxone, and hospitality services **Are alumni/aftercare services offered?** Yes

Clinic Name	Administrative Details	Program Specifics
UCSF COMBO Contingency Management for Both HIV/Stimulant Use **Zuckerberg San Francisco General Hospital** Building 80 995 Potrero Avenue, 1st Floor, San Francisco, CA 94110	**Referrals:** Currently closed for enrollment with potential to open in the future. Contact Ayesha Appa at ayesha.appa@ucsf.edu for more info. **Program Length:** 12 weeks **Eligibility:** Participants with stimulant use disorder who are either HIV+ or at risk of seroconversion. Recruited from SFGH Ward 86 or BRIDGE. **Appointment Type:** One individual session weekly **Hours of Operation:** 9:00AM--12:00PM and 1:00PM--5:00PM Monday through Friday	**Targeted Goal:** Reduction or cessation of stimulant use and/or medication adherance **Services Offered:** Individual counseling, linkage to care, medication, transportation, HIV/HCV testing, STI testing, Naloxone access **Are alumni/aftercare services offerred?** Not formally
Adult OP Recovery Incentives Program **HealthRIGHT 360** 1563 Mission St. San Francisco, CA 94103	**Referrals:** Contact Andrew Dertien at 415-503-2331 or adertien@healthright360.org **Program Length:** 24 weeks **Eligibility:** Moderate to severe stimulant use disorder diagnosis with use within last 6 months. Does not have to be in a HealthRIGHT 360 outpatient program. **Appointment Type:** One individual appointment weekly **Hours of Operation:** 8:30AM--4:30pm Monday through Friday	**Targeted Goal:** Reduction or cessation of stimulant use **Services Offered:** Groups, individual counseling, linkage to care, medication, transportation, HIV/HCV testing, STI testing, Naloxone access **Are alumni/aftercare services offered?** Yes
Project ADAPT Asian Drug and Alcohol Prevention and Treatment **HealthRIGHT 360** 2020 Hayes St. San Francisco, CA 94117	**Referrals:** Contact Gerald Callahan at (415) 213-1921 or Susan Okada at (415) 559-4892 **Program Length:** 24 weeks **Eligibility:** 18+ with diagnosis of moderate or severe stimulant use disorder **Appointment Type:** Appointments are preferred with drop-in flexibility **Hours of Operation:** 8:30am--4:30pm Monday through Friday	**Targeted Goal:** Reduction or cessation of stimulant use **Services Offered:** Outpatient substance use disorder treatment, case management, therapy **Are alumni/aftercare services offered?** Yes
OTOP Recovery Incentives Program Opiate Treatment Outpatient Program **Zuckerberg San Francisco General Hospital** Ward 93 1001 Potrero Avenue, San Francisco, CA 94110	**Referrals:** Not currently accepting referrals. Contact John Dunham at john.dunham@ucsf.edu with any questions. **Program Length:** 24 weeks **Eligibility:** Current OTOP patients 18 years and older with stimulant use disorder (SUD), enrolled in Medi-Cal. Patients need to be residents of San Francisco or unhoused and not planning to leave the area for at least 6 months. Services offered in English and Spanish. **Appointment Type:** Walk-in **Hours of Operation:** 6:45AM--11:00 AM and 12:30PM--2:00 PM Monday through Friday	**Targeted Goal:** Reduction or cessation of stimulant use and/or attendance **Services Offered:** Individual counseling, linkage to care, medication, HIV/HCV testing, naloxone access **Are alumni/aftercare services offered?** Yes

Last update: 6/11/2024