alameda county behavioral health

MENTAL HEALTH & SUBSTANCE USE SERVICES

Clinical Practice Guidelines: Guidance on Evidence-Based and Best Practices

ACBH Quality Assurance

This document was created in partnership with ACBH System of Care leads and in consultation with ACBH network providers.

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Purpose

The purpose of this document is to outline a comprehensive and standardized framework for the delivery of mental health and substance use services in Alameda County. This document serves as a vital resource to guide behavioral health practitioners, administrators, and stakeholders in providing high-quality, evidence-based care to individuals in need. By adhering to these guidelines, Alameda County Behavioral Health (ACBH) is committed to ensuring that its services are consistently equitable, accessible, and culturally sensitive, thus promoting fair and inclusive treatment for all individuals seeking support.

These practice guidelines are designed to foster a collaborative and integrated approach to mental health and substance use treatment while fostering effective coordination among service providers and community partners. In essence, the document exemplifies ACBH's dedication to delivering compassionate and effective care, upholding the highest standards of practice and empowering individuals on their journey towards improved health and well-being.

In general, the clinical practices described in this document are not intended to be prescriptive, exhaustive, or definitive. When determining clinical services, practitioners must always account for the individual's unique characteristics, culture, and preferences.

ACBH will develop and update these guidelines and recommended best practices as is appropriate to meet the needs of the beneficiaries we serve and to remain current in guidance. ACBH welcomes feedback from all stakeholders on the content and guidance provided and when updating will take into consideration feedback received.

Practice Guidelines Requirements

ACBH is required by state[1] and federal regulation[2] to adopt practice guidelines that meet the following requirements:

1. Are based on valid and reliable clinical evidence or a consensus of providers in the particular field.
2. Consider the needs of all ACBH beneficiaries.
3. Are adopted in consultation with network providers.
4. Are reviewed and updated periodically as appropriate.

Additionally, ACBH must disseminate the guidelines to all affected providers and, upon request, to beneficiaries and potential beneficiaries.

ACBH must also ensure that all decisions for utilization management, beneficiary education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

ACBH's Overarching Practice Guideline Values

All behavioral health services provided by ACBH and its subcontractors are committed to be respectful of the unique needs of our beneficiaries' cultures and communities. Clinical services are informed by culturally

[1] 9 CCR § 1810.326 Practice Guidelines, DHCS DMC-ODS Interagency Agreement
[2] 42 CFR 438.236 -- Practice guidelines

responsive, trauma-informed and recovery-oriented concepts. The following sections of these guidelines describe these principles and reflect ACBH's commitment to them.

Culture, Community, and Other Considerations

ACBH is fully committed to providing services that meet the diverse needs of all our community members. We would like to acknowledge that universal and national standards may not fully consider local and community needs and may have historical and/or institutional biases. While ACBH has attempted to provide information and guidance that considers these factors, we understand that research, guidance, and ultimately what are considered best practices, are fluid and ever evolving. It is our intention that the information in this manual be considered recommended guidance and that providers retain clinical flexibility to provide safe, effective, and culturally attune services when appropriate.

Culturally and Linguistically Appropriate Services (CLAS) Standards

The National CLAS Standards[3] are a set of action steps intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health care organizations to implement culturally and linguistically appropriate services.

More information about CLAS Standards can be found here:

- https://www.minorityhealth.hhs.gov/
- https://thinkculturalhealth.hhs.gov/clas

Recovery-Oriented Care[4]

Recovery-oriented care signals a dramatic shift in the expectation for positive outcomes for individuals who experience mental and substance use conditions or the co-occurring of the two.

SAMHSA's working definition of recovery defines recovery as a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential.

Today, when individuals with mental and/or substance use disorders seek help, they are met with the knowledge and belief that anyone can recover and/or manage their conditions successfully. The value of recovery and recovery-oriented systems of care is widely accepted by states, communities, health care providers, peers, families, researchers, and advocates including the U.S. Surgeon General, the National Academy of Medicine (NAM), and others.

Guiding Principles:

Hope, the belief that these challenges and conditions can be overcome, is the foundation of recovery. A person's recovery is built on their strengths, talents, coping abilities, resources, and inherent values. It is holistic, addresses the whole person and their community, and is supported by peers, friends, and family members.

[3] https://thinkculturalhealth.hhs.gov/clas/standards
[4] https://www.samhsa.gov/find-help/recovery

The process of recovery is highly personal and occurs via many pathways. It may include clinical treatment, medications, faith-based approaches, peer support, family support, self-care, and other approaches. Recovery is characterized by continual growth and improvement in one's health and wellness and managing setbacks. Because setbacks are a natural part of life, resilience becomes a key component of recovery.

Supporting recovery requires that mental health and addiction services:

- Be responsive and respectful to the health beliefs, practices, and cultural and linguistic needs of diverse people and groups.
- Actively address diversity in the delivery of services.
- Seek to reduce health disparities in access and outcomes.

Cultural responsiveness describes the ability of an individual or organization to interact effectively with people of different cultures. To produce positive change, practitioners must understand the cultural context of the community that they serve and have the willingness and skills to work within this context. This means drawing on community-based values, traditions, and customs, and working with knowledgeable people from the community to plan, implement, and evaluate recovery activities.

Individuals, families, and communities that have experienced social and economic disadvantages are more likely to face greater obstacles to overall health. Characteristics such as race or ethnicity, religion, low socioeconomic status, gender, age, mental health, disability, sexual orientation or gender identity, geographic location, or other characteristics historically linked to exclusion or discrimination are known to influence health status.

Learn more about recovery-oriented care:

- Learn how to implement recovery-oriented principles and practices in a variety of real-world practice settings and with diverse groups of people diagnosed with behavioral health conditions. Learn more at https://samhsa.gov/recovery-to-practice.
- Recovery to Practice Webinars by SAMHSA
- American Psychiatric Association: This set of training materials for psychiatrists is intended to provide a basic understanding of recovery from mental illness and substance use disorders and recovery-oriented care, and to contribute to bringing recovery-oriented practice into the mainstream of professional practice. Learn more at: https://www.psychiatry.org/psychiatrists/practice/professional-interests/recovery-oriented-care
- Waldemar AK, Arnfred SM, Petersen L, Korsbek L. Recovery-Oriented Practice in Mental Health Inpatient Settings: A Literature Review. Psychiatr Serv. 2016 Jun 1;67(6):596-602.
- Davidson L, Rowe M, DiLeo P, Bellamy C, Delphin-Rittmon M. Recovery-Oriented Systems of Care: A Perspective on the Past, Present, and Future. Alcohol Res. 2021 Jul 22;41(1):09.

Outreach and Engagement

Outreach and engagement are critical interventions that are often needed to support a person with mental health and/or substance use challenges choose to accept and use treatment services that are being offered to them. Outreach can include an array of activities including but not limited to: physically going out in the community to find an individual, repeatedly meeting with the individual to develop a relationship and understand their person

narrative and helping them meet their basic needs. Outreach seeks to establish a personal connection that provides the spark to participate in one's recovery process.

Engagement often occurs through outreach or through the development of building a trusting relationship. Engagement often means the person is actively using treatment services, making their appointments and generally showing up in their efforts to move forward in their recovery.

Outreach and engagement are often thought of as activities completed by mental health and substance use employees at the beginning of a client's treatment to begin the treatment process. While this is true, outreach and engagement strategies can be necessary and beneficial at any treatment stage. Individuals with mental health and/or substance use needs may initially engage in treatment but later disengage for a variety of reasons. It is important for mental health and substance use workers to assess clients' levels of engagement throughout treatment and provide active outreach and engagement interventions that match the client's current need.

It is important to avoid placing the burden of success or failure of engagement on individuals with mental health conditions or substance use problems or their family or supporters. Instead, it is important to understand engagement as a two-way process that includes a determination to hold hope and not give up. Engagement has multiple dimensions and must embrace the whole person in the context of family, language, culture and community. Engagement goes beyond traditional medical goals of symptom reduction and functioning to include wellness and connection to loved ones, community, faith, school, and work.

Learn more about Outreach and Engagement:

- Assessing the Evidence: What We Know About Outreach and Engagement
- Improving Quality of Care: Clinician Tip Sheet (nhchc.org) National HealthCare for the Homeless, 2014
- Practicing Recovery: Outreach and Engagement, SAMHSA, 2015
- Engagement: A New Standard for Mental Health Care. NAMI, 2016
- Treatment engagement of individuals experiencing mental illness: review and update

Practice Guidelines and Evidence Based Practices

Evidence-Based Practices (EBPs) in the context of behavioral health treatment refer to therapeutic interventions and approaches that have been scientifically validated through rigorous research and have demonstrated effectiveness in treating various mental health and behavioral disorders. EBPs are grounded in empirical evidence and adhere to the principles of evidence-based medicine and psychology.

Substance Use Disorder (SUD)/DMC-ODS providers are required to implement at least two of the following EBPs, per provider, per service modality:

- Motivational Interviewing
- Cognitive Behavioral Therapy
- Psychoeducation
- Relapse Prevention
- Trauma-Informed Treatment

ACBH will ensure providers have implemented EBPs and are delivering the practices to fidelity.

Additionally, DHCS has developed practice guidelines for adolescent and pregnant/perinatal individuals and peer providers. ACBH SUD providers who serve these individuals must adhere to the guidelines as described in the current edition of these documents:

- DHCS Perinatal Practice Guidelines
- DHCS Adolescent Substance Use Disorder Best Practices Guide
- What Are Peer Recovery Support Services? (SAMHSA)
- Working with Child Protective Services to Support Pregnant and Parenting People, Their Infants, and Families Affected by Substance Use Disorders: A Factsheet for Health Care Providers | SAMHSA Publications and Digital Products

ASAM's clinical practice guidelines and level of care designations are available through the American Society of Addiction Medicine (ASAM). ACBH encourages all SUD providers to familiarize themselves with The ASAM Criteria and use it as the foundation of SUD treatment services.

The sections below highlight the Practice Guidelines and EBPs that were adopted by ACBH, in consultation with network providers, and disseminated to all affected providers. Many other EBPs exist and may be appropriate for the beneficiaries served in our system. This document intentionally does not list all potential EBPs to allow providers latitude to assess for and determine the best course of care.

Additional information about EBPs can be found from organizations such as the California Evidence-Based Clearinghouse and the SAMHSA Evidence-Based Practices Resource Center. EBPs must only be used by practitioners with the education, training, and experience to use them.

SMHS and DMC-ODS Practice Guidelines and EBPs

Cognitive-Behavioral Therapy (CBT)

Description: Cognitive Behavioral Therapy (CBT) is a widely recognized and evidence-based psychotherapy approach that addresses the intricate connection between thoughts, emotions, and behaviors. It is rooted in the understanding that our thoughts significantly influence our feelings and actions. Through CBT, practitioners collaborate with clients to identify and challenge negative thought patterns or cognitive distortions that contribute to emotional distress and maladaptive behaviors. By fostering greater self-awareness and empowering individuals to replace unhelpful thoughts with more balanced and constructive ones, CBT equips clients with effective coping skills to manage challenges and improve their overall well-being. CBT is known for its structured and time-limited nature, making it a versatile and practical intervention for various mental health concerns, including anxiety, depression, trauma, and stress-related disorders.

In CBT, clients work collaboratively with a therapist to set specific treatment goals and develop practical strategies to address their challenges. The therapist helps individuals become aware of their automatic thoughts and beliefs and encourages them to question the validity of those thoughts. Through homework assignments and skill-building exercises, clients learn coping skills and techniques to manage stress, anxiety, depression, and other mental health issues.

CBT has been extensively studied and has shown effectiveness in treating a wide range of mental health disorders, including depression, generalized anxiety disorder, social anxiety disorder, panic disorder, obsessive-compulsive

disorder (OCD), post-traumatic stress disorder (PTSD), and others. It is often used as a standalone treatment or in combination with other therapeutic approaches.

Population of focus: CBT is recommended for mental health disorders such as depression, anxiety, obsessive compulsive disorder, post-traumatic stress disorder, substance use disorders, eating disorders, insomnia, bipolar disorder, schizophrenia, and certain personality disorders.

DMC-ODS providers may select CBT as one of their required EBPs.

Examples of use:

> A therapist treating an individual with depression helps identify and challenge negative thought patterns, such as "I'm worthless," by exploring evidence for and against these thoughts and developing more balanced, constructive beliefs.
>
> A therapist assists individuals with anxiety disorders in recognizing and managing their anxious thoughts and behaviors by teaching relaxation techniques, such as deep breathing and progressive muscle relaxation.
>
> In a group setting, individuals with social anxiety disorder practice exposure therapy by taking turns speaking in front of the group, gradually reducing their fear of social situations and enhancing their confidence in interpersonal interactions.

Learn more about CBT:

- https://www.apa.org/ptsd-guideline/patients-and-families/cognitive-behavioral
- Hofmann, S. G., Asnaani, A., Vonk, I. J., Sawyer, A. T., & Fang, A. (2012). The Efficacy of Cognitive Behavioral Therapy: A Review of Meta-analyses. Cognitive Therapy and Research, 36(5), 427-440.
- Butler, A. C., Chapman, J. E., Forman, E. M., & Beck, A. T. (2006). The empirical status of cognitive-behavioral therapy: A review of meta-analyses. Clinical Psychology Review, 26(1), 17-31.
- National Institute for Health and Care Excellence. (2018). Depression in adults: Recognition and management. Clinical guideline [CG90].
- https://beckinstitute.org/

Motivational Interviewing (MI) & Stages of Change

Description: Motivational Interviewing (MI) is a client-centered therapeutic approach designed to explore and resolve ambivalence towards change. Developed by William R. Miller and Stephen Rollnick, MI aims to evoke and strengthen an individual's intrinsic motivation to make positive behavioral changes. It involves empathic listening, reflective statements, and open-ended questions to help clients explore their values and goals, weigh the pros and cons of change, and build self-efficacy. MI is widely used in physical and behavioral health settings.

MI has been found to be effective in promoting positive behavioral changes in diverse populations and has been integrated into numerous evidence-based interventions. It is essential for practitioners to receive proper training and ongoing supervision to effectively implement MI techniques and maximize its benefits for clients.

MI incorporates concepts of the Transtheoretical Model, often referred to as Stages of Change. Stages of Change is a theoretical framework developed by Prochaska and DiClemente in 1983 to describe the process individuals go through when making positive behavioral changes. These stages include Precontemplation, Contemplation, Preparation, Action, Maintenance, and Termination, and they reflect the progression from being unaware of or resistant to change to successfully maintaining a new behavior.

Population of focus: Motivational Interviewing (MI) is recommended for individuals who may be contemplating, ambivalent, or resistant to making changes, such as those with substance use disorders, unhealthy behaviors, as well as individuals with various mental health concerns where enhancing motivation for change is beneficial. DMC-ODS providers may select MI as one of their required EBPs.

Examples of use:

> A psychiatrist uses MI techniques with a beneficiary who is ambivalent about taking their psychotropic medications.
>
> A Mental Health Rehabilitation Specialist (MHRS) uses motivational interviewing to engage an individual with depression in exploring their ambivalence about treatment, facilitating a conversation that encourages the client's intrinsic motivation to engage in services.
>
> A family partner who has been trained in MI, employs motivational interviewing techniques to collaborate with parents who have children with behavioral issues, helping them explore their concerns and goals for their child's well-being, encouraging them to take proactive steps to support their child's well-being.

Learn more about Motivational Interviewing:

- https://motivationalinterviewing.org/
- https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-02-014.pdf
- Miller, W. R., & Rollnick, S. (2012). Motivational interviewing: Helping people change (3rd ed.). Guilford Press.
- Lundahl, B., & Burke, B. L. (2009). The effectiveness and applicability of motivational interviewing: A practice-friendly review of four meta-analyses. Journal of Clinical Psychology, 65(11), 1232-1245.
- Hettema, J., Steele, J., & Miller, W. R. (2005). Motivational interviewing. Annual Review of Clinical Psychology, 1, 91-111.
- Vansteenkiste, M., Sheldon, K. M., & Lens, W. (2006). Motivating learning, performance, and persistence: The synergistic effects of intrinsic goal contents and autonomy-supportive contexts. Journal of Personality and Social Psychology, 90(2), 246-260.
- https://www.cebc4cw.org/program/motivational-interviewing/

Psychoeducation

Description: Psychoeducation is a therapeutic approach that involves providing individuals and their families with education, information, and resources about their behavioral health conditions, treatment options, coping strategies, and self-management techniques. Psychoeducation interventions help beneficiaries work better with their mental health team, for overall better outcomes.

Psychoeducation sessions may cover topics such as understanding the nature of mental health conditions, medication management, recognizing warning signs of relapse, stress reduction techniques, and building a support network.

By increasing knowledge and awareness, psychoeducation empowers individuals and families to actively participate in their treatment, make informed decisions about their care, and enhance their overall well-being. It is a valuable component of comprehensive mental health treatment and is widely used in various therapeutic settings.

Population of focus: Psychoeducation is appropriate for individuals with mental health conditions, their families, and support networks, as well as those seeking to learn more about mental health, coping strategies, and managing specific psychological challenges. DMC-ODS providers may select psychoeducation as one of their core EBPs.

Examples of use:

A mental health therapist explains the signs and symptoms of depression to an adolescent beneficiary. The therapist provides the beneficiary with resources to learn more about their diagnosis, such as articles to read, films to watch, links to informational websites, and other information about mental health and substance use diagnoses.

When working with an individual with depression, a MHRS educates the client about the causes and symptoms of depression, as well as teaching coping strategies such as cognitive-behavioral techniques to challenge negative thought patterns and improve mental well-being.

A SUD counselor leading a group session provides information about the neurological effects of drugs and alcohol, helping participants understand how substance use can impact the brain and addiction development, empowering them to make informed choices regarding their substance use.

Learn more about Psychoeducation:

- Lukens, E. P., & McFarlane, W. R. (2004). Psychoeducation as evidence-based practice: Considerations for practice, research, and policy. Brief Treatment and Crisis Intervention, 4(3), 205–225.
- Sarkhel S, Singh OP, Arora M. Clinical Practice Guidelines for Psychoeducation in Psychiatric Disorders General Principles of Psychoeducation. Indian J Psychiatry. 2020 Jan; 62(Suppl 2)
- Mueser, K. T., Corrigan, P. W., Hilton, D. W., Tanzman, B., Schaub, A., Gingerich, S., & Essock, S. M. (2002). Illness management and recovery: A review of the research. Psychiatric Services, 53(10), 1272-1284.
- Dixon L, McFarlane WR, Lefley H, Lucksted A, Cohen M, Falloon I, Mueser K, Miklowitz D, Solomon P, Sondheimer D. Evidence-based practices for services to families of people with psychiatric disabilities. Psychiatr Serv. 2001 Jul;52(7):903-10.
- Bäuml J, Froböse T, Kraemer S, Rentrop M, Pitschel-Walz G. Psychoeducation: a basic psychotherapeutic intervention for patients with schizophrenia and their families. Schizophr Bull. 2006 Oct;32 Suppl 1(Suppl 1):S1-9.

Trauma-Informed Treatment

Trauma-informed treatment is a comprehensive approach that recognizes and responds to the effects of trauma on individuals and promotes safety, trustworthiness, and empowerment in the treatment process. This approach acknowledges the impact of trauma on individuals and emphasizes creating a safe and supportive environment within the organization or system of care. It is guided by the understanding that trauma can affect individuals' well-being and behaviors across various settings. Trauma-informed treatment promotes healing and empowerment by integrating trauma-sensitive practices into the organization's policies, procedures, and interactions with clients.

Trauma-informed treatment is required in mobile crisis[5] and therapeutic foster care and may be selected as a required EBP by DMC-ODS providers.

Learn more about trauma-informed treatment:

- https://alamedacountytraumainformedcare.org/
- Substance Abuse and Mental Health Services Administration (SAMHSA). (2014). SAMHSA's concept of trauma and guidance for a trauma-informed approach. HHS Publication No. (SMA) 14-4884. Rockville, MD.
- https://www.apa.org/ptsd-guideline

Medication Support Services

Description: Medication Support Services include an evidence-based approach using psychotropic medications for the treatment of mental health disorders. Medication Support Services are available for the treatment of Mood Disorders, Anxiety Disorders, Psychotic Disorders, Substance use Disorders as well as other conditions.

Medication Support Services involve the use of FDA-approved medications, often in combination with non-medication treatment modalities. These medications help to reduce symptoms, improve quality of life and increase overall levels of functioning. Medication Support Services may also enhance the ability of the individual to engage in additional recovery focused behavioral health services. Medication Support Services have been shown to improve treatment outcomes, increase retention in treatment and reduce the likelihood of psychiatric hospitalization.

Population of focus: Medication Support Services are currently available within the Specialty Mental Health Plan and, to a limited extent, within the DMC-ODS.

Examples of use:

> A beneficiary is diagnosed with Schizophrenia. They are referred to a psychiatrist or other prescriber (e.g., Psychiatric Mental Health Nurse Practitioner, Pharmacist, Physician Assistant) who confirms the beneficiary meets appropriate indications for treatment with medication. The beneficiary is assessed for current symptoms and past treatment history. Included in the assessment will be consideration of potential risks, benefits and side effects associated with potential therapies. Following this assessment, and with the consent of the individual or their guardian, a prescription may be given for an antipsychotic medication. During medication treatment, the prescriber will continue to assess for risks, benefits, and side effects. Certain health parameters will be measured and followed (e.g., weight, blood glucose) and

[5] DHCS BHIN 23-025

treatment will be adjusted accordingly. Over time, adjustments may be made in specific medications, dosage, and treatment offered to mitigate side effects. Single medications may be offered.

Learn more about Medication Support Services:

Medication Support Services have been recognized as an essential component of comprehensive treatment for many (although not all) behavioral health conditions. The integration of Medication Support Services into behavioral healthcare systems can significantly improve outcomes for individuals and make engagement in other therapies and recovery services possible.

Alameda County Behavioral Health Care Services Office of the Medical Director along with the Pharmacy and Therapeutics Committee keep track of new medications and prescribing trends. The Office maintains and publishes a Medication and Pharmacy Users Guide, that can be found in Section 7 of the QA Manual page on the provider website. This guide includes essential information about medication support service practice guidelines and monitoring protocols and has been shared with the ACBH community of prescribers.

SMHS Only Best Practice Guidelines

Assertive Community Treatment (ACT)

Description: Assertive Community Treatment (ACT) is a comprehensive and evidence-based team-based delivery model designed to provide intensive and individualized support to individuals with serious mental health challenges. ACT teams are multidisciplinary and consist of clinicians, housing specialists, co-occurring disorder specialists, employment specialists, nurses, and psychiatrists. The primary goal of ACT is to provide ongoing, community-based treatment and support to help individuals with mental health challenges live successfully in their communities, reduce hospitalizations, and enhance their overall quality of life. Within the ACBH network, ACT is used by Full Service Partnerships (FSPs).

Key features of Assertive Community Treatment (ACT) include:

Intensity and Frequency: ACT teams provide frequent and flexible support, often on a daily basis, to meet the diverse needs of clients.

Outreach and Engagement: ACT teams actively reach out to clients in their homes, shelters, or other community settings, fostering a strong therapeutic alliance.

Holistic Approach: ACT addresses various aspects of a person's life, including therapy, housing, employment, co-occurring disorder support, and psychiatry.

24/7 Availability: ACT teams offer crisis support and interventions around the clock to prevent hospitalizations and stabilize individuals during challenging times.

Low Caseloads: ACT teams maintain small caseloads to ensure that each client receives personalized and comprehensive care.

Evidence-Based Interventions: ACT incorporates evidence-based practices, such as medication management, psychosocial interventions, and supported employment, to address individual needs effectively.

Population of focus: In Alameda County, ACT is available for young adults, adults, and older adults who struggle to maintain stability in the community and have multiple hospitalizations and/or jail admissions related to their mental health symptoms.

Examples of use:

> All ACBH contracted Full Service Partnerships (FSPs) serving transition-aged youth (TAY), adults, older adults, homeless adults, and individuals with frequent involvement with the criminal justice system (forensic) utilize the ACT model.
>
> An ACT team works closely with an elderly individual, visiting their home daily to monitor medication compliance, provide therapy, assist with daily living skills, and offer support in managing symptoms and stressors. Through this intensive community-based approach, the client experiences improved stability, reduced hospitalizations, and enhanced overall mental health and well-being.
>
> An ACT team works with a homeless individual diagnosed with schizophrenia, offering intensive support, including assistance securing stable housing, medication management, therapy, and assistance with daily living to help the individual stabilize their symptoms of schizophrenia and transition to supportive housing.

How does ACT benefit our beneficiaries: ACT provides a multidisciplinary team and seeks to create a "hospital without walls model." Peer reviewed and empirically studied, ACT shows consistent reductions in hospitalizations and incarceration and significant improvement in housing stability, employment, and quality of life.

Learn more about ACT:

- https://www.institutebestpractices.org/act/description/
- https://mhttcnetwork.org/centers/northwest-mhttc/event/introduction-assertive-community-treatment-act-year-5
- https://www.samhsa.gov/resource/ebp/assertive-community-treatment-act-evidence-based-practices-ebp-kit
- https://preventionservices.acf.hhs.gov/programs/483/show

Individualized Placement and Support (IPS) Model

Description: Supported Employment and Education (SEE) programs assist individuals with mental health or substance use issues in gaining and maintaining competitive employment or pursuing educational goals. SEE programs use the Dartmouth Individualized Placement and Support (IPS) Model which is an evidence-based practice with years of research demonstrating positive results. The SEE/IPS model places an emphasis on the following areas:

- **Zero exclusion and rapid job search:** Individuals are not excluded from the program based upon active substance abuse, housing instability, justice involvement, and mental health symptoms. If an individual expresses that they want to find employment or pursue education, then they are offered support immediately toward their stated goals.

- **Job development, competitive employment, and worker preferences:** Employment specialists meet with at least six employers face to face every week to develop a network of opportunities that are based upon their caseload preferences. These are for competitive jobs that are open to all in the community.

- **Integrated services, benefits planning, and time unlimited supports:** IPS is a collaborative model that works with mental health professionals to create a team that can benefit the individual around their mental health needs so that they may pursue their Employment and Education goals. Services are offered for as long as the individual wants to continue having them. Services also include support around managing benefits while being employed.

All county children's clinics (ages 16 and older), Adult Service teams (CBOs and county clinics), TAY Early Psychosis Program, and Adult and Forensic Full Service Partnerships (FSP) utilize the IPS model.

Population of focus: SEE programs are appropriate for individuals with mental health conditions, including mental illnesses like schizophrenia, bipolar disorder, and major depressive disorder, who may face challenges in gaining and maintaining competitive employment or pursuing education due to their mental health symptoms and related barriers. These programs provide individualized support to help individuals achieve their vocational and educational goals.

Examples of use:

A vocational specialist helps an individual with schizophrenia identify job opportunities aligned with their interests and abilities, providing ongoing support in job search, skill development, and workplace integration to facilitate successful employment.

A MHRS assists an individual with severe depression in identifying and obtaining part-time employment while offering ongoing support to enhance their vocational skills and self-confidence, promoting both mental health recovery and employment success.

Learn more about Supported Education and Employment (SEE):

- https://ipsworks.org/

Wraparound Treatment

Description: Wraparound is a team-based planning process intended to provide individualized and coordinated family-driven care. Wraparound is designed to meet the complex needs of children who are involved with several child and family-serving systems (e.g., mental health, child welfare, juvenile justice, special education, etc.), who are at risk of placement in institutional settings, and who experience emotional, behavioral, or mental health difficulties. The wraparound process requires that families, providers, and key members of the family's social support network collaborate to build a creative plan that responds to the particular needs of the child and family. Team members then implement the plan and continue to meet regularly to monitor progress and make adjustments to the plan as necessary. The team continues its work until members reach a consensus that a formal wraparound process is no longer needed.

The values associated with wraparound require that the planning process itself, as well as the services and supports provided, be individualized, family driven, culturally competent and community based. Additionally, the wraparound process should increase the "natural support" available to a family by strengthening interpersonal relationships and utilizing other resources that are available in the family's network of social and community

relationships. Finally, wraparound should be "strengths-based," helping the child and family recognize, utilize, and build talents, assets, and positive capacities.

Population of focus: Wraparound treatment is utilized by contracted FSPs that serve beneficiaries under the age of 18. Additionally, wraparound treatment is available for probation and child welfare involved youth.

Examples of use:

> Wraparound services are frequently used with families who are involved with multiple systems and have difficulty navigating outpatient services without additional support.
>
> A teenager with a history of trauma receives individualized support from a team of professionals, including trauma-focused therapists, a case manager, and school counselors, who work together to create a comprehensive strategy to address the teenager's complex mental health symptom picture, familial challenges, and educational needs.

Learn more about Wraparound Treatment:

- https://nwi.pdx.edu/
- http://nwic.org/
- https://www.cebc4cw.org/program/wraparound/

DMC-ODS Only EBPs

The EBPs described in the following section are only available for use in the Drug-Medi-Cal Organized Delivery System (DMC-ODS).

Contingency Management (CM) / Recovery Incentives (RI)

Description: Contingency Management (CM) (aka Recovery Incentives) is an evidence-based treatment that provides motivational incentives to treat individuals living with stimulant use disorder and support their path to recovery. It recognizes and reinforces individual positive behavioral change, as evidenced by drug tests that are negative for stimulants. CM is the only treatment that has demonstrated robust outcomes for individuals living with stimulant use disorder, including reduction or cessation of drug use and longer retention in treatment.

CM is intended to complement substance use disorder (SUD) treatment services and other evidence-based practices for stimulant use disorder already offered by DMC-ODS providers. Eligible Medi-Cal beneficiaries will participate in a structured 24-week outpatient CM service, followed by six or more months of additional treatment and recovery support services without incentives. The initial phase of CM consists of a series of incentives for meeting treatment goals, specifically abstinence from stimulants objectively verified by urine drug tests negative for stimulant drugs (e.g., cocaine, amphetamine, and methamphetamine). The incentives consist of cash-equivalents (e.g., gift cards), consistent with evidence-based clinical research for treating SUD. CM is offered alongside other therapeutic interventions, such as cognitive behavioral therapy and motivational interviewing.

Population of focus: CM/RI is currently only available at DMC-ODS outpatient programs as specified by their contract. Expected start date of ACBH's CM pilot is Fall 2023.

Example of use:

A beneficiary with a history of stimulant use (e.g., methamphetamine) participating in the program receives a Target gift card immediately after urinalysis indicates the beneficiary tested negative for stimulants.

Learn more about Contingency Management and Recovery Incentives:

- https://www.dhcs.ca.gov/Pages/DMC-ODS-Contingency-Management.aspx
- https://www.dhcs.ca.gov/CalAIM/Documents/CM-Fact-Sheet.pdf
- https://www.uclaisap.org/recoveryincentives/

Medication-Assisted Treatment (MAT)

Description: Medication-Assisted Treatment (MAT) is an evidence-based approach for treating substance use disorders, most commonly opioid and alcohol use disorders. MAT involves the use of FDA-approved medications, such as methadone[6], buprenorphine, naltrexone, disulfiram, naloxone, and others in combination with behavioral therapies and counseling. These medications help to reduce withdrawal symptoms, cravings, and illicit drug use, supporting individuals in their recovery journey. MAT has been shown to improve treatment outcomes, reduce overdose risk, and increase retention in treatment.

MAT has been recognized as a critical component of comprehensive treatment for substance use disorders, and its integration into healthcare systems can significantly improve outcomes for individuals seeking recovery. It is essential to ensure that individuals have access to MAT services and that healthcare providers are equipped to deliver evidence-based medications and counseling support to address the complex needs of those struggling with substance use disorders.

Population of focus: MAT for SUD is currently available within DMC-ODS, CA Bridge, FQHCs, primary care, and at other healthcare providers.

Examples of use:

A beneficiary is determined to have an Opioid Use Disorder. They are referred to an Opioid Treatment Program (OTP), who confirms the beneficiary meets requirements for treatment. The beneficiary is given a long-acting injection of buprenorphine.

A beneficiary meets with a physician at an outpatient SUD program that provides MAT services and is given a prescription for naltrexone to help them stop drinking alcohol. The beneficiary gets the prescription filled at their local pharmacy using the Medi-Cal pharmacy benefit.

A beneficiary residing at a SUD residential program is assessed as having an untreated opioid use disorder, the residential program does not provide MAT services in-house, but instead refers and coordinates care with the beneficiary's medical provider, who is part of a FQHC. For the duration of the individual's admission to SUD residential services, the residential program helps coordinate care with the FQHC and provides transportation to appointments, helps refill prescriptions, reminds the beneficiary to take their medication as prescribed, and shares progress with the medical provider.

[6] Methadone is only available for OUD MAT treatment at Opioid/Narcotic Treatment Programs (OTP/NTPs)

Learn more about MAT:

- https://californiamat.org/
- https://www.dhcs.ca.gov/individuals/Documents/MAT_Toolkit_for_Counselors.pdf
- https://www.dhcs.ca.gov/provgovpart/Documents/DMC-ODS_Waiver/08_02_2018_DMC_ODS_MAT_FAQs.pdf
- CalAIM DMC-ODS MAT Policy: DHCS BHIN 23-001 (p. 22)
- https://www.fda.gov/drugs/information-drug-class/information-about-medication-assisted-treatment-mat
- National Institute on Drug Abuse (NIDA). (2020). Medications for Opioid Use Disorder. https://www.drugabuse.gov/drug-topics/opioids/medications-treat-opioid-use-disorder
- Substance Abuse and Mental Health Services Administration (SAMHSA). (2020). Medication-Assisted Treatment (MAT). https://www.samhsa.gov/medications-substance-use-disorders
- Mattick, R. P., Breen, C., Kimber, J., & Davoli, M. (2014). Methadone maintenance therapy versus no opioid replacement therapy for opioid dependence. Cochrane Database of Systematic Reviews, (2).

Relapse Prevention

Description: Relapse prevention is a therapeutic approach designed to help individuals who have experienced substance use disorders or other addictive behaviors maintain their recovery and prevent relapse. The focus of relapse prevention is on identifying high-risk situations, triggers, and coping strategies to minimize the risk of returning to unhealthy behaviors. This approach aims to develop adaptive coping skills, enhance self-awareness, and build a strong support network to promote sustained recovery.

Relapse prevention strategies are widely used in addiction treatment programs and have demonstrated effectiveness in reducing relapse rates and promoting long-term recovery. The incorporation of relapse prevention techniques can vary depending on the individual's specific needs and circumstances, with the goal of providing a comprehensive and personalized approach to maintaining sobriety and preventing relapse.

Population of focus: DMC-ODS providers are required to utilize relapse prevention as one of their core EBPs.

Examples of use:

> A beneficiary attends a relapse prevention group at an ACBH contracted SUD outpatient provider. During the group sessions the group the beneficiary learns coping strategies from other group members, reduces feelings of loneliness and isolation, and is encouraged by peers to abstain from alcohol use.
>
> A SUD counselor helps a beneficiary in recovery from alcohol addiction by identifying triggers (stress, anxiety in social situations), offering strategies such as deep breathing exercises and assertive communication scripts to decline alcohol offers, and creating a personalized relapse prevention plan that includes daily affirmations, coping techniques, and contact information for a sober support network, enabling the client to effectively manage situations that could lead to alcohol relapse.

Learn more about Relapse Prevention:

- Marlatt, G. A., & Donovan, D. M. (Eds.). (2005). Relapse prevention: Maintenance strategies in the treatment of addictive behaviors. Guilford Press.
- Irvin, J. E., Bowers, C. A., Dunn, M. E., & Wang, M. C. (1999). Efficacy of relapse prevention: A meta-analytic review. Journal of Consulting and Clinical Psychology, 67(4), 563-570.
- Witkiewitz, K., Marlatt, G. A., & Walker, D. (2005). Mindfulness-based relapse prevention for alcohol and substance use disorders. Journal of Cognitive Psychotherapy, 19(3), 211-228.
- https://www.samhsa.gov/find-help/prevention
- https://store.samhsa.gov/?f%5B0%5D=publication_category%3A6039&f%5B1%5D=treatment_prevention_and_recovery%3A5539