



SAN MATEO COUNTY HEALTH

BEHAVIORAL HEALTH & RECOVERY SERVICES

BHRS Practice Guidelines Manual for Specialty Mental Health and Drug Medi-Cal Organized Delivery System Services

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Table of Contents

BHRS Practice Guidelines Manual for Specialty Mental Health and Drug Medi-Cal Organized Delivery System Services.....	1
BHRS MISSION, VISION & VALUES	3
Our Vision:	3
Our Mission:	3
Our Values:	3
ABOUT BHRS SERVICES	3
PURPOSE.....	4
Practice Guidelines Requirements.....	6
BHRS’s Overarching Practice Guideline Values	6
Culture, Community, and Other Considerations	7
Culturally and Linguistically Appropriate Services (CLAS) Standards	7
Recovery-Oriented Care	8
Outreach and Engagement.....	9
Practice Guidelines and Evidence Based Practices.....	11
SMHS and DMC-ODS Practice Guidelines and EBPs	12
Assertive Community Treatment (ACT):	13
Child-Parent Psychotherapy (CPP):.....	14
Cognitive Behavioral Therapy (CBT):	15
Dialectal Behavior Therapy (DBT):.....	16
Eye Movement Desensitization and Reprocessing (EMDR) Therapy:	17
Medication Support Services:	17
Medications to Treat Addiction (often referred to as MAT):.....	18
Motivational Interviewing (MI) & Stages of Change:.....	20
Neurosequential Model of Therapeutics (NMT):	21
Psychoeducation:	22
Trauma-Informed Treatment:.....	23
Vocational Rehabilitation Services Model:	24
Wraparound Treatment:	25
DMC-ODS Practices.....	26
Contingency Management (CM) / Recovery Incentives (RI).....	26
Relapse Prevention:	27

BHRS MISSION, VISION & VALUES

Our Vision: We envision safer communities for all where individuals may realize a meaningful life and the challenges of mental health and/or substance use are addressed in a respectful, compassionate, holistic, and effective manner. Inclusion and equity are valued and central to our work. Our diverse communities are honored and strengthened because of our differences.

Our Mission: We provide prevention, treatment, and recovery services to inspire hope, resiliency, and connection with others to enhance the lives of those affected by mental health and/or substance use challenges. We are dedicated to advancing health and social equity for all people in San Mateo County and for all communities. We are committed to being an organization that values inclusion and equity for all.

Our Values:

- **Person and Family Centered:** We promote culturally responsive person-and-family centered recovery.
- **Potential:** We are inspired by the individuals and families we serve, their achievements and potential for wellness and recovery.
- **Power:** The people, families, and communities we serve, and the members of our workforce guide the care we provide and shape policies and practices.
- **Partnerships:** We can achieve our mission and progress towards our vision only through mutual and respectful partnerships that enhance our capabilities and build our capacity.
- **Performance:** We use proven practices, opportunities, and technologies to prevent and/or reduce the impacts of mental illness, substance use, and to promote the health of the individuals, families, and communities we serve.

ABOUT BHRS SERVICES

The Behavioral Health and Recovery Services (BHRS) division of San Mateo County Health provides mental health and substance use services across the core continuum of behavioral health services including prevention and early intervention, wellness and recovery supports, outpatient and inpatient treatment, residential, rehabilitation, detoxification, medication assisted treatment, and other services. BHRS is committed to supporting treatment of the whole person to achieve wellness and recovery, and promote the physical and behavioral health of individuals, families, and communities of all ages in San Mateo County including the uninsured and undocumented. BHRS strives to provide integrated and culturally responsive services and employs mental health clinicians, psychiatrists, alcohol and drug counselors, peers, family partners and other professionals through county clinics, contracts with community agencies and a network of private providers.

BHRS is the designated Mental Health Plan (MHP) as well as the Drug Medi-Cal Organized Delivery System (DMC-ODS) Plan for San Mateo County. The Department of Health Care Services (DHCS) administers California's Medicaid program, known as Medi-Cal, and contracts with behavioral health counties HPs across the State to provide or arrange for Medi-Cal Specialty Mental Health Services (SMHS) and substance use disorder (SUD) treatment services.

As the MHP and DMC-ODS provider, BHRS is responsible for SMHS and SUD services to San Mateo County uninsured and Medi-Cal beneficiary adults living with Serious Mental Illness (SMI) or children living with Serious Emotional Disturbance (SED) and Substance Use Disorder (SUD) treatment services. For mild-to-moderate mental health service needs, the Health Plan of San Mateo (HPSM) and Kaiser Permanente are the Medi-Cal managed care plans (MCP) in San Mateo County. During 2007- 2021, BHRS served as the mild-to-moderate mental health and substance use disorder provider, as delegated at the time by the HPSM.

BHRS standards of care outline principles for the provision of treatment for individuals receiving recovery services. The Standards are based on prevailing evidence-based practices, ethical considerations, and professional expertise. They represent the County's core values and mission, as well as baseline expectations for all recovery services providers in San Mateo County. The Standards set a vision for quality, effective, and cost-efficient care.

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 San Mateo 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, San Mateo County Behavioral Health & Recovery Services (BHRS) 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 BHRS'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.

Over the past decade, there have been a wide range of significant changes impacting behavioral health recovery services. These include:

- Clients struggling with increasingly powerful, addictive, & lethal drugs
- The legalization of cannabis (with a coinciding increase in potency)

- Changes in funding streams, including an expansion of the Affordable Care Act, introduction of the Drug Medi-Cal Organized Delivery System (DMC-ODS) pilot in California and a transition to CalAIM and fee for service payment reform; the transformation of the Mental Health Services Act (MHSA) to the Behavioral Health Services Act (BHSA) with a increasing focus on high acuity, co-occurring clients, and housing supports with the reduction of county BHRS MHSA prevention funds.
- A shift in oversight from The California Department of Alcohol and Drugs (DADP) to The California Department of Health Care Services (DHCS)
- Increased research and awareness of the nature of trauma and its impact on persons struggling with substance use disorders and recovery
- A new generation of evidenced based pharmaceutical interventions for opioids, alcohol and other drugs
- Workforce recruitment and retention challenges
- Advancing technology and evidence based or promising clinical practices
- An increased focus on the importance of diversity, equity, and inclusion
- The COVID-19 pandemic which increased both isolation and rates of return to use, along with affecting how some treatment services may be administered
- An increasing number of older adults
- A lack of youth residential treatment options, as well as a low number of youths engaging in any recovery services

It is an expectation that providers of services in San Mateo County (SMC) make best use of the system of care, develop a well-trained and professional workforce, respect and honor the dignity and unique needs of diverse populations, develop an approach to care that understands addiction as chronic, and work to understand clients' full biopsychosocial complexity. These issues require continued and consistent focus, and even new approaches.

Programs will work to help clients understand and have access to the entire San Mateo County Continuum of Care. Clients should routinely be educated about and linked to a range of services, including mental health, substance use disorder, primary care, and a full range of prevention, early intervention, and treatment services as indicated. Programs will work with one another to function as a seamless system of care, in partnership with other agencies to provide support and resources for vocational, mental health, substance use disorder, medical, educational, AIDS/HIV, legal, financial, housing/transportation, family, and childcare services, among others. Comprehensive, strength-based case management and collaboration between agencies is necessary to provide a seamless, concurrent, integrated continuum of care.

When determining clinical services, practitioners must always account for the individual's unique characteristics, culture, and preferences. BHRS will develop and update these guidelines and recommended best practices as appropriate to meet the needs of the beneficiaries we serve and to remain current in guidance. BHRS welcomes feedback from all stakeholders on the content and guidance provided and when updating will take into consideration feedback received.

Practice Guidelines Requirements

BHRS is required by state¹ and federal regulation² 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 BHRS beneficiaries.
3. Are adopted in consultation with network providers.
4. Are reviewed and updated periodically as appropriate.

Additionally, BHRS must disseminate the guidelines to all affected providers and, upon request, to beneficiaries and potential beneficiaries. BHRS 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. Program staff will have sufficient training in modern, evidence-based substance use treatment and be certified, and/or licensed. Programs will provide ongoing professional development opportunities, supervision and monitor credentials and license/certification compliance. Staff understand the rationale and theoretical foundation of the program in which they are employed and are skilled in its service delivery. To promote successful partnerships throughout the system of care, staff are expected to treat others, and be treated, with professionalism, courtesy, and respect.

BHRS's Overarching Practice Guideline Values

All behavioral health services provided by BHRS and its subcontractors are committed to being respectful of the unique needs of our beneficiaries, regardless of age, culture, and physical/behavioral health issues. It is understood that these standards are not new and are already accepted and being applied throughout BHRS. Clinical services are informed by evidence-based, culturally responsive, trauma-informed, and recovery-oriented concepts. Staff training and programs will be individually tailored to client-driven treatment, while balancing the health, safety, and integrity of the program. Ongoing review of the client's progress and adjustment of treatment interventions will be implemented as often as necessary to address the evolving nature of mental illness, addiction and recovery. Client-Centered Care is anchored in and demonstrated by:

- **Trauma Informed Practices:** Programs understand the impact of trauma and strive to create treatment environments and interventions that are transparent, flexible, clinically accommodating and strengths-based.
- **Co-Occurring Expectation:** Programs will be engaged in continuously improving their capability to serve individuals with complex needs including co-occurring mental health and

¹ 9 CCR § 1810.326 Practice Guidelines, DHCS DMC-ODS Interagency Agreement

² 42 CFR 438.236 -- Practice guidelines

substance use disorders. Policies, procedures, programming, and staff competencies are designed to meet the anticipated needs of individuals with co-occurring disorders. Within BHRS and contracted treatment agencies, the provision of co-occurring care is the expectation throughout the service continuum.

- **Crisis Readiness:** Ability to respond to environmental and client crises to maximize the safety and well-being of staff and clients. Crisis management preparation and training occurs and is tracked on a regular basis.

The following sections of these guidelines describe these principles and reflect BHRS's commitment to them.

Culture, Community, and Other Considerations

BHRS 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 BHRS 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.

Every attempt should be made to avoid discharging clients to an unhoused/unsheltered environment; clients should not be discharged to homelessness. Discharge planning should occur early in treatment, and all planning should include a housing or shelter plan.

The Criminal Justice System and Court Mandated Care programs strive to maintain professional integrity and educate clients of the limits of confidentiality & the benefits of coordinated care. Staff work to maximize each client's opportunity to thrive in the least restrictive environment and maximize success within both treatment and criminal justice systems.

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 attuned services when appropriate. Service providers are expected to be culturally responsive to the experiences and needs of each client. This includes treating clients in the context of their language, culture, ethnicity, geographic area, socioeconomic status, level of education, gender, age, sexual orientation, religion, spirituality, and any physical or cognitive disabilities.

Culturally and Linguistically Appropriate Services (CLAS) Standards

The National CLAS Standards 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 Standards³ can be found here:

³ [CLAS Standards - Think Cultural Health \(hhs.gov\)](https://www.hhs.gov/ohrt/standards)

- minorityhealth.hhs.gov/
- thinkculturalhealth.hhs.gov/clas

Recently, BHRS adopted Policy 18-01: Cultural Humility, Equity and Inclusion Framework. The policy is intended to inform on existing and ongoing organizational efforts to embrace diversity, improve quality, and eliminate health disparities that align with the National Standards for Cultural and Linguistically Appropriate Services (CLAS). BHRS abides by the County's Bilingual Salary Differential Allowance Policy for non-supervisory employees required to use a second language critical to day-to-day operations and the Americans with Disability Act (ADA) Policies and Procedures to enable universal access to information. CLAS related policies and practices are listed at the end of this document.

Recovery-Oriented Care⁴

Recovery-oriented care signals a dramatic shift in the expectation for positive outcomes for individuals who experience mental health or substance use conditions, or the co-occurring of the two. Concentrated, measurable efforts will be made to reduce stigma associated with addiction, mental illness and any other disabling condition, including among homelessness and marginalized communities. Treatment services, including medication assisted treatment (MAT) and other psychopharmacological interventions, will be uniformly offered to all individuals in a professional, fact-based and supportive manner.

The Substance Abuse and Mental Health Services Administration (SAMHSA) 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 health 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.

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 substance use services:

⁴ [Recovery and Recovery Support | SAMHSA](#)

- 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 [SAMHSA Recovery Resource Center | 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: [Psychiatry.org - Recovery-Oriented Care in Psychiatry](#)
- Waldemar AK, Arnfred SM, Petersen L, Korsbek L. Recovery-Oriented Practice in Mental Health Inpatient Settings: A Literature Review. *Psychiatry 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. Outreach can include an array of activities including but not limited to: physically going out in the community to find an individual, meeting with the individual multiple times to develop a relationship and understand their personal 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 a trusting relationship. Engagement often means the person is actively using treatment services, attending their scheduled

appointments, and generally showing up in their efforts to move forward in their recovery. Programs will utilize strategies specific for engagement and retention of clients and their families. Program staff will work to establish warm and welcoming environments, and support both harm reduction and abstinence approaches to care, where applicable, utilizing the continuum of care to ensure clients are engaged in the correct level of care to promote retention. All services are provided in the spirit of working in an empowered partnership with clients and families.

Outreach and engagement are often thought of as activities completed by mental health and substance use service providers to begin a client's 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 service providers 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 experiencing mental health or substance use conditions, 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.

Programs will provide for a client's physical and emotional safety and create an engaging and predictable environment. Staff at all levels of the organization will have a foundational knowledge of trauma informed care (TIC), consistently practice TIC approaches, and contribute to a welcoming environment. Attention to the creation of an environment that minimizes re-traumatization will be a priority. The environment will be protective, respectful, and sensitive to a client's needs. The physical environment will be clean, secure, welcoming, and accessible. Welcoming materials appropriate to gender, language, culture, and an individual's complex needs will be visible and available.

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](#)
- [American Society of Addiction Medicine. Engagement and Retention of Nonabstinent Patients in Substance Use Treatment: Clinical Considerations. October 2024](#)
- [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](#)
- Dixon, L, Holoshitz, Y, & Nossel, I (2016). Treatment engagement of individuals experiencing mental illness: review and update. World Psychiatry, Feb 1; 15(1), 15-20.

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 substance use disorders. EBPs are grounded in empirical evidence and adhere to the principles of evidence-based medicine and psychology.

Providers will offer treatment based on acknowledged best practices for all clients. Evidence-based practices (EBPs) and promising practices will be utilized during all phases of treatment with an awareness and intention that interventions be provided in a culturally sensitive manner.

A best practice is a technique or methodology that, through experience and research, has proven to reliably lead to a desired result. Best practices in health promotion are those sets of processes and activities that are consistent with health promotion values/goals/ethics, theories/beliefs, evidence, and understanding of the environment and that are most likely to achieve health promotion goals in a given situation (Interactive Domain Model). Programs will refer to the BHRS “[Best Practices Resources for Behavioral Health](#)” document. Mental Health and Substance Use Disorder providers are encouraged to utilize evidence-based practices where appropriate; and promising or community standard of care practices where allowed. The following list is not all inclusive of practices that may be appropriate for client care. Many other EBPs exist and may be appropriate for the beneficiaries served in our system. Providers must be trained in the use of specific modalities either through ongoing training or academic preparation. Continuing education will be required to maintain skills; and to acknowledge and support use of promising or evolving MH or SUD practices.

Certain practices may not be approved at this time due to lack of sufficient evidence, potential for risk, or lack of regulatory approval within this context. For example, the use of Ketamine Assisted Therapy (KAT) is not supported within these guidelines due to insufficient evidence, potential risks, and lack of regulatory approval within this context. Any provider within BHRS or contracted provider engaging in such practices is considered a violation of these standards and may result in professional review or corrective action. Providers should consult with their supervisor, leadership teams, or BHRS Administration to ensure a practice is approved.

The following list is not all inclusive of practices that may be appropriate for client care. Many other EBPs exist and may be appropriate for the beneficiaries served in our system. Providers must be trained in the use of specific modalities either through ongoing training or academic preparation.

Continuing education will be required to maintain skills; and to acknowledge and support use of promising or evolving MH or SUD practices.

As regulations or State/Federal guidance change, this document will be updated to reflect new requirements. BH-CONNECT, (Behavioral Health Community-Based Organized Networks of equitable Care and Treatment) was approved on December 16, 2024. This program will require BHRS to institute additional EBP's, or adapt current practices to promote fidelity to EBP's.

The EBP's eligible for participation in BH-CONNECT include:

- Assertive Community Treatment (ACT)
- Forensic ACT
- Coordinated Specialty Care for First Episode Psychosis
- Individual Placement and Support model of Supported Employment
- Clubhouse Services
- Enhanced Community Health Worker Services
- Peer Support Services including a forensic specialization
- Multisystemic Therapy*
- Functional Family Therapy*
- Parent Child Interaction Therapy*
- High Fidelity Wraparound*
- Enhanced Care Management

The sections below highlight the Practice Guidelines and EBPs that were adopted by BHRS, in consultation with network providers, and disseminated to all affected providers. 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

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

BHRS will ensure SUD providers have implemented the required EBPs and are delivering the practices to fidelity. Additionally, DHCS has developed practice guidelines for adolescent and pregnant/perinatal individuals and peer providers. **BHRS 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](#)

ASAM's clinical practice guidelines and level of care designations are available through the [American Society of Addiction Medicine \(ASAM\)](#) and the [DHCS Level of Care designations](#). BHRS requires all SUD providers to familiarize themselves with these criteria and to use it as the foundation of SUD treatment services.

Assertive Community Treatment (ACT):

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 San Mateo 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 SMCBHRS 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-communitytreatment-act-year-5> • <https://www.samhsa.gov/resource/ebp/assertive-community-treatment-act-evidence-based-practicesebp-kit> • <https://preventionservices.acf.hhs.gov/programs>

Child-Parent Psychotherapy (CPP):

Description: CPP is a treatment modality designed to provide therapy to young children (age 0-5 years) and their parents/caregivers that will support the dyad/family and address trauma. These events may include the loss of a loved one, separation, serious medical procedures, abuse, or violence in the home or in the community as well as addressing children who show difficult behavior, children who have a change of placement or caregivers, family members with physical health or mental health difficulties to help with improving the parent-child relationship. Through the dyad, the trauma is addressed while the provider works on strengthening the relationship, thus leading to a healthier attachment. Interventions include joint narrative of the traumatic event and to identify and address traumatic triggers that lead to dysregulated behaviors and affect.

Population of focus: CPP is recommended for young individuals (0-5yrs old) who have had exposure to trauma and who have a parent/caregiver that can participate in this treatment modality.

Examples of use:

A 4 year old child is referred by CFS (Children & Family Services) for therapy after learning that she and her siblings have been exposed to domestic violence. The child shows aggressive behaviors at home and at her preschool. At the programmatic level, the beneficiary is assessed and once safety is established, the provider can begin CPP to address the impact of the domestic violence.

A baby (1month old) is referred by CFS (Children & Family Services) after being removed from the family due to being born with a positive drug test. CPP modality is used to help the foster/adoptive parent and the baby in building a strong attachment.

Learn more about child-parent psychotherapy treatment:

- [About CPP – Child-Parent Psychotherapy \(childparentpsychotherapy.com\)](http://childparentpsychotherapy.com)
- [Research – Child-Parent Psychotherapy \(childparentpsychotherapy.com\)](http://childparentpsychotherapy.com)
- [Microsoft Word - CPP research fact sheet one page Jan 2018.docx \(childparentpsychotherapy.com\)](#)

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 two 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/>

Dialectal Behavior Therapy (DBT):

Description: Dialectal Behavior Therapy (DBT) is an evidence-based form of cognitive-behavioral therapy (CBT) developed by Dr. Marsha Linehan in the late 1980s. It was originally created to treat individuals with borderline personality disorder (BPD), especially those experiencing chronic suicidal ideation, but has since been adapted for a broader range of mental health conditions. DBT combines standard CBT techniques for emotion regulation and reality testing with concepts of mindfulness, distress tolerance, and acceptance, which are rooted in Eastern meditative practices. The term “dialectical” refers to the synthesis or integration of opposites, particularly the seemingly contradictory ideas of acceptance and change.

Population of focus: DBT is recommended for mental health disorders of borderline personality disorder, individuals who present with suicidal and self-harming behavior, adolescents with emotional dysregulation, substance use disorders, eating disorders (especially bulimia and binge eating), post-traumatic stress disorder, mood and anxiety disorders and individuals with high emotional sensitivity and difficulty managing relationships.

Examples of use:

A therapist in a residential or outpatient program using DBT to help an adolescent with self-harm behavior who experiences intense emotional swings to help teach healthy coping skills.

DBT can be used in a substance use recovery setting to help understand triggers, regulate emotions and reduce relapse.

DBT used in a mental health outpatient clinic to help an individual with PTSD, by identifying mindfulness and distress tolerance skills can be especially useful for managing trauma symptoms.

Learn more about Dialectical Behavior Therapy:

- Boritz, T., McMain, S., Vaz, A., Rousmaniere, T. (2023). Deliberate Practice in Dialectical Behavior Therapy.
- <https://dialecticalbehaviortherapy.com>
- <https://behavioraltech./knowledge-center/>
- <https://www.psychologytoday.com/us/therapy-types/dialectical-behavior-therapy>

Eye Movement Desensitization and Reprocessing (EMDR) Therapy:

Description: EMDR therapy is a mental health treatment technique. The method includes moving the eyes in a specific way while processing traumatic memories. The goal of EMDR is to help individuals heal from trauma or other distressing life experiences. This modality of therapy does not require the beneficiary to talk in detail about the distressing issue; rather, EMDR helps focus on changing the emotion, thought or behavior that results from a distressing issue or trauma. EMDR relies on the Adaptive Information Processing (AIP) model, which is a theory about how the brain stores memories.

Population of focus: EMDR can be beneficial for a range of mental health conditions and can be used for adolescents, young adults, and adults of all ages.

Examples of use:

A beneficiary war veteran with PTSD symptoms was able to receive EMDR therapy from a BHRS provider with special certification. The beneficiary was triggered by loud unexpected noises and used that trigger while working with the provider. After 4 sessions, the beneficiary was able to experience the benefits of EMDR and reported feeling less activated by loud noises.

Learn more about EMDR treatment:

- [Eye Movement Desensitization and Reprocessing \(EMDR\) Therapy \(apa.org\)](https://www.apa.org/ptsd-guidelines/assessment/treatment/eye-movement-desensitization-and-reprocessing-therapy)
- [What is EMDR? - EMDR Institute - Eye Movement Desensitization and Reprocessing Therapy](https://www.emdrinstitute.com/what-is-emdr/)

Medication Support Services:

Description: Medication Support Services include an evidence-based approach using - medications for the treatment of mental health disorders and substance use 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, incarceration, and death.

Population of focus: Medication Support Services are currently available within the Specialty Mental Health Plan and within the Drug Medi-Cal Organized Delivery System Plan.

Examples of use:

A beneficiary is diagnosed with Schizophrenia. They are referred to a psychiatrist or other prescriber (e.g., Nurse Practitioner, 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 treatment will be adjusted accordingly. Over time, adjustments may be made in specific medications, dosage, and treatment offered to mitigate side effects. Long-acting 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 more effective.

BHRS and the Medical Director, along with the Pharmacy and Therapeutics Committee, keep track of new medications and prescribing recommendations. This guide includes essential information about medication support service practice guidelines and monitoring protocols and can be reviewed at: [BHRS Medical & Pharmacy Information - San Mateo County Health \(smchealth.org\)](https://www.smchealth.org/medical-pharmacy-information).

Medications to Treat Addiction (often referred to as MAT):

Description: Medications to Treat Addiction (MAT) is an evidence-based approach for treating substance use disorders, most commonly opioid, alcohol, and nicotine use disorders. MAT involves the

use of FDA-approved medications, such as methadone⁵, buprenorphine, naltrexone, disulfiram, acamprosate, and others in combination with behavioral therapies and counseling. These medications help to reduce withdrawal symptoms, cravings, and substance use, supporting individuals in their recovery journey.

MAT has been shown to improve treatment outcomes, reduce incarceration, 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.

There will be discussion of the availability and potential efficacy of MAT with all clients that promotes a supportive and non-judgmental approach to all pharmaceutical interventions. In accordance with state regulations, each program will have a consistent methodology and clearly written processes for screening and educating all clients about MAT options and providing or referring clients to a qualified MAT provider. Providers will implement strategies to minimize risks of misuse and overdose and coordinate with MAT service providers to ensure timely care and transportation needs are met.

Population of focus: Individuals with substance use disorders including opioid and alcohol use disorders. MAT for SUD is currently available within DMC-ODS, CA Bridge, Federally Qualified Health Centers (FQHCs), specialty mental health clinics, 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.

Learn more about MAT:

⁵ Methadone is only available for OUD MAT treatment at Opioid/Narcotic Treatment Programs (OTP/NTPs)

- <https://californiamat.org/>
- [https://www.dhcs.ca.gov/individuals/Documents/MAT Toolkit for Counselors.pdf](https://www.dhcs.ca.gov/individuals/Documents/MAT_Toolkit_for_Counselors.pdf)
- [https://www.dhcs.ca.gov/provgovpart/Documents/DMCODS Waiver/08_02_2018_DMC_ODS_MAT FAQs.pdf](https://www.dhcs.ca.gov/provgovpart/Documents/DMCODS_Waiver/08_02_2018_DMC_ODS_MAT_FAQs.pdf)
- DMC-ODS MAT Policy: [DHCS BHIN 24-001](#) (p.18)
- [DHCS BHIN 23-054](#): DHCS MAT Policy Services Requirements for SUD Treatment Facilities.
- <https://www.fda.gov/drugs/information-drug-class/information-about-medication-assisted-treatmentmat>
- 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).

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 and 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 two 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/>
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Neurosequential Model of Therapeutics (NMT):

Description: The Neurosequential Model of Therapeutics (NMT) is a comprehensive framework for understanding and addressing the impact of trauma on child development and integrates principles from neuroscience, developmental psychology, and trauma-informed care to help create an individualized treatment plan that is based on brain mapping assessments. NMT is a groundbreaking approach to trauma treatment that helps providers better understand the child's brain development and function to bring tailored interventions that can highly benefit the child. An example of a tailored intervention informed by a brain map can include, but is not limited to the following:

- Rhythmic Auditory Stimulation (RAS)
- Melodic Intonation Therapy (MIT)
- Patterned Sensory Enhancement (PSE)
- Musical Speech Stimulation
- Interventions from allied fields such as occupational therapy

Population of focus: NMT can be highly beneficial to children who have been exposed to trauma. The use of NMT with adults is currently limited, although there's a strong theoretical basis to predict that adult beneficiaries could benefit from the NMT approach.

Examples of use:

A five-year-old beneficiary is referred for SMHS and the provider conducts an NMT assessment that helped identify severe dysregulation through the brain map. The provider was able to seek out other interventions such as referring the beneficiary for Occupational Therapy, where he learned how to better self-regulate, especially through vestibular swinging and using other interventions that otherwise would have not been discovered.

Learn more about NMT:

- [San Mateo County Adult NMT Pilot Final Evaluation Report, 2016-2020 \(smchealth.org\)](https://www.smchealth.org)
- [Neurosequential Model of Therapeutics \(NMT\) - Attachment and Trauma Network \(attachmenttraumanetwork.org\)](https://attachmenttraumanetwork.org)

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 also select psychoeducation as one of their two 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, films, 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.

Learn more about child-parent psychotherapy treatment:

- [About CPP – Child-Parent Psychotherapy \(childparentpsychotherapy.com\)](http://childparentpsychotherapy.com)
- [Research – Child-Parent Psychotherapy \(childparentpsychotherapy.com\)](http://childparentpsychotherapy.com)
- [Microsoft Word - CPP research fact sheet one page Jan 2018.docx \(childparentpsychotherapy.com\)](#)

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. Programs understand the impact of trauma and strive to create treatment environments and interventions that are transparent, flexible, clinically accommodating and strength based.

Trauma-informed treatment is required in mobile crisis⁶ and therapeutic foster care and may be selected as a required EBP by DMC-ODS providers.

Learn more about trauma-informed treatment:

- 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>
- [Seeking Safety - Treatment Innovations](#)
- [Trauma Recovery and Empowerment Model](#)

Vocational Rehabilitation Services Model:

Description: San Mateo County's Vocational Rehabilitation Services (VRS) serves County residents with disabilities and other barriers to employment, creating pathways towards self-sufficiency through vocational counseling and assessment, case management, job training and job placement.

For more than 40 years, VRS has partnered with private industry to provide career opportunities for thousands of county residents. Together with our community partners, VRS offers paid training and transitional work experience, hands-on job training, job coaching and mentoring. We are dedicated to enhancing our clients' self-esteem, dignity, and job readiness, and creating opportunities for self-sufficiency.

Through the VRS Work Center and Catering Connection, our workforce provides excellent service, quality, and value to our business partners. The Work Center production facility, and our fully equipped Catering Connection professional kitchen, allows individuals to gain vocational and soft skills to prepare for community employment.

All county children's clinics (ages 18 and older), Adult Service teams (CBOs and county clinics), TAY Early Psychosis Program, and Adult and Forensic Full-Service Partnerships (FSP) utilize the VRS model.

Population of focus: VRS programs are appropriate for individuals with mental health conditions, including mental illnesses such as schizophrenia, bipolar disorder, and major depressive disorder, who may face challenges in gaining and maintaining competitive employment 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.

⁶ DHCS BHIN 23-025

A provider 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 VRS Model

- [Vocational Rehabilitation Services | County of San Mateo, CA \(smcgov.org\)](https://www.smcgov.org/vrs)

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 needs of the child and family. Team members then implement the plan and continue to meet regularly to monitor progress and adjust 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 Full-Service Partnerships (FSPs) that serve beneficiaries under the age of 18 and for Transitional Aged Youth age 18-25. Additionally, wraparound treatment is available for probation and child welfare involved youth.

Examples of use:

Wraparound services are frequently used for 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 Practices

Some practices are only appropriate for use with clients who experience substance use disorders. (see below, Contingency Management and Relapse Prevention). Other practices may have more effectiveness for individuals with co-occurring disorders.

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.

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/>

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 a BHRS's contracted SUD outpatient provider. During the group sessions, 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>
- [SAMHSA Library](#)

