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

San Francisco Department of Public Health

Behavioral Health Services

This document was created in partnership with SFDPH BHS Quality Assurance and System of Care, and in consultation with network providers.

Published on May 20, 2024.

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Purpose

The purpose of this document is to demonstrate a comprehensive and standardized framework for the delivery of mental health and substance use services at the San Francisco Department of Public Health's Behavioral Health Services (SFDPH BHS). This document serves as a vital resource to guide system of care leaders, behavioral health practitioners, administrators, and key stakeholders in providing exceptional, evidence-based services to consumers in need. By adhering to these standards, BHS is committed to ensuring that our services are inclusive, equitable, accessible, culturally responsive, and sensitive, thus helping all individuals in need of support. The practice guidelines aim to create a collective and unified approach to substance use and mental health treatment. This document embodies BHS's dedication to providing intentional and thoughtful evidence-based care.

The clinical practices shared in this document are not intended to be exhaustive, prescriptive, or definitive. When providing clinical services, providers must always consider the individual's culture and lived experiences, seek their feedback, and monitor their responses to interventions. BHS will continue to update and develop the guidelines and suggested best practices to meet the needs of members and remain adherent to state guidelines and regulations.

Practice Guidelines Requirements

BHS is required by federal[1] and state[2] regulations to implement clinical practice guidelines that meet the following requirements:

1. Are accurate, up to date, evidence-based and considers the needs of all BHS members[3].
2. Are implemented in collaboration with network providers. The guidelines will be disseminated through existing mechanisms to all affected providers and, upon request, to members and potential members.
3. Additionally, BHS will ensure that all decisions for peer audit tools, member education, and overview of services to which the guidelines apply are consistent with the guidelines.

BHS Mission, Vision, and Who We Serve

Our Vision

For all San Franciscans to experience mental and emotional well-being and participate meaningfully in the community across lifespans and generations.

Our Mission

To provide equitable, effective substance use and mental health care and promote behavioral health and wellness among all San Franciscans.

Who We Serve

We serve San Franciscans (children, youth, and adults) who are experiencing mental health and substance use disorders and have low incomes, are uninsured, and/or qualify for Medi-Cal.[4]

[1] Code of Federal Regulations (ecfr.gov)
[2] California Code of Federal Regulations (govt.westlaw.com)
[3] ***Member(s)*** – Member is broadly defined as any recipient of Behavioral Health Services from San Francisco Department of Public Health.
[4] BHS – About Us (sf.gov)

Race and Behavioral Health Needs in SF

Ensuring that our members feel safe, respected, and cared for is the foundation of the services provided by SFDPH. Historically marginalized communities have been ignored and are more likely to receive unequitable and inaccessible care. This section summarizes the FY2022-23 Mental Health Services Act (MHSA) annual report, by sharing information and reflecting data on marginalized communities in San Francisco, experiences of poorer health outcomes, and the steps SFDPH is taking to combat the systemic challenges faced by its members.[5]

San Francisco is made up of diverse populations, with people of color accounting for almost 60% of the total population. San Francisco's mental health crisis coupled with homelessness, overdose and housing insecurity has worsened due to the high cost of living and compounding impact of systemic racism.

As stated in the MHSA report, "In 2020, there were 711 overdose deaths, 61% more than the 441 overdose deaths recorded in 2019." In addition, individuals of African descent are more likely to die from overdose due to systemic factors such as lack of access to equitable resources, and are more likely to experience poverty, trauma, racism, and discrimination.

To further highlight the behavioral health needs in San Francisco, the report goes on to state, "other behavioral health indicators point to a mental health crisis in the City, and in the country as whole. In San Francisco, the number of hospitalizations among adults due to major depression exceeds that of asthma or hypertension, and the City's per capita suicide rate is twice as high as its homicide rate, with suicide being the 12th leading cause of death. BHS reported a 33% citywide increase in member suicide attempts (requiring and not requiring emergency service interventions) and a 13% increase in deaths among adult and older adult members, most of which are expected to be related to increased suicide and mental health-related issues upon further investigation. Community-based social service providers report seeing increased numbers of members with mental health and substance use issues."

[5] FY2022-2023-Annual-Update.pdf (sfdph.org)

To meet the marginalized community members' needs, BHS aims to improve overall wellbeing by expanding mental health and substance use treatment services.

The Administrative Code to establish Mental Health San Francisco (MHSF) was passed by a Board of Supervisors ordinance on December 6, 2019. "This program is designed to expand access to mental health services, substance use treatment, and psychiatric medications to adult San Francisco residents with serious mental illness and/or substance use disorder who are homeless, uninsured, or enrolled in Medi-Cal or Healthy San Francisco. The Ordinance establishes a Mental Health SF Implementation Working Group to advise policymakers – via formal recommendations – on the design and implementation of Mental Health SF efforts."

In addition to the Mental Health SF Implementation work group, there are also culturally congruent services offered to members of various cultural backgrounds. This is designed to increase access to equitable health care and trust for members who have been historically marginalized:

1) Culturally Congruent Initiatives to Address Racial Disparities 16-Week Equity Executive Fellowship (May 2023)
2) Training on understanding the roots of racism and bias for BHS leadership team with NY Times Best Seller, Robin DeAngelo, and Assistant Professor at Mayo Clinic School of Medicine, Dante King. Mental Health Services Act (MHSA) Innovation Intervention (June 2023)
3) Test and evaluate culturally responsive behavioral health interventions for Black/African American clients at four civil service clinics.
4) Recently hired four health workers and four behavioral health clinicians Equity-Based Maternal Health RFP Awarded (Fall 2023)
5) $6M/per year RFP in partnership with Maternal Child and Adolescent Health (MCAH) to fund four community-based organizations to support Black/African American pregnant, perinatal, and postpartum people through mental health care screenings, linkages, and more.
6) Awarded funding: RAMS, Rafiki, Homeless Children's Network, and UCSF EMBRACE Program.

7) Universal Talk Therapy - Partnership and collaboration with the Human Rights Commission on providing a universal talk therapy program for Black/African Americans via the UCSF EMBRACE Program.[6]

Trauma Informed Care

Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being[7]. Trauma can affect people of every race, ethnicity, age, sexual orientation, gender, psychosocial background, and geographic region. A traumatic experience can be a single event, a series of events, and/or a chronic condition (e.g., childhood neglect, domestic violence). Traumas can affect individuals, families, groups, communities, specific cultures, and generations. It generally overwhelms an individual's or community's resources to cope, and it often ignites the "fight, flight, or freeze" reaction at the time of the event(s). It frequently produces a sense of fear, vulnerability, and helplessness.

Integrating Trauma Informed Care (TIC) into behavioral health services provides many benefits not only for members, but also for their families and communities, and for behavioral health service organizations and their staff. Trauma-informed services bring to the forefront the belief that trauma can pervasively affect an individual's well-being, including physical and mental health. For behavioral health service providers, trauma-informed practice offers many opportunities. It reinforces the importance of acquiring trauma-specific knowledge and skills to meet the specific needs of members; of recognizing that individuals may be affected by trauma regardless of its acknowledgment; of understanding that trauma likely affects many people who are seeking behavioral health services; and of acknowledging that organizations and providers can retraumatize individuals through standard or unexamined policies and practices.

[6] San Francisco Department of Public Health Division of Behavioral Health Services A presentation to the Health Commission October 19, 2021 (sf.gov)

[7] Trauma-Informed Care: A Sociocultural Perspective - Trauma-Informed Care in Behavioral Health Services - NCBI Bookshelf (nih.gov)

TIC stresses the importance of addressing the person individually rather than applying general treatment approaches.

At SFDPH BHS, implementing trauma-informed services improves the screening and assessment processes, treatment planning, and placement while also decreasing the risk for re-traumatization for its members. The implementation may enhance communication between the member and treatment provider, thus decreasing risks associated with misunderstanding the member's reactions and presenting problems or underestimating the need for appropriate referrals for evaluation or trauma-specific treatment. Organizational investment in developing or improving trauma-informed services may also translate to cost effectiveness, in that services are more appropriately matched to clients from the outset.

Evidence Based Practices

Clinical Practice Guidelines for the Use of Evidence-Based and Culturally Responsive Practices

BHS's practice guidelines for the use of evidence-based practices provide recommendations to improve the assessment, diagnosis, and treatment of behavioral health conditions for members in San Francisco. The population served is primarily Black, Indigenous, and People of Color (BIPOC), including Latina/o/x/e, Black/African American, and Asian American, Native Hawaiian, and Pacific Islander communities. As such, these guidelines promote the use of evidence-based practices balanced with culturally responsive and equity-centered care. The vision is for equitable access to high-quality, effective, and culturally affirming behavioral healthcare leading to positive [8]outcomes and addressing disparities (Alegría et al., 2018).

BHS guidelines are informed by recommendations on evidence-based practices from national organizations including the American Psychological Association (APA), Substance Abuse and Mental Health Services Administration (SAMHSA), American Psychiatric Association, and the American Academy of Child and Adolescent Psychiatry (AACAP). However, issues around cultural relevance and barriers to engagement exist when applying evidence-based treatments. Augmenting them with culturally responsive and equity-centered approaches is vital for implementation success in predominantly minority communities.

Using Evidence-Based Practices. Evidence-based practices should be considered the first-line treatment, as research supports their effectiveness for outcomes like reducing symptoms and improving functioning (Drake et al., 2001)[9]. To promote successful implementation, providers undergo ongoing training and consultation to deliver evidence-based practices with high fidelity (e.g., annual Transdiagnostic CBT training and DBT-informed training). Available implementation supports like videos, treatment manuals, and expert consultation

[8] Social Determinants of Mental Health: Where We Are and Where We Need to Go | Current Psychiatry Reports (springer.com)
[9] Implementing Evidence-Based Practices in Routine Mental Health Service Settings | Psychiatric Services (psychiatryonline.org)

should also be utilized. **BHS utilizes a practice website** (see TIPs website) that serves as a hub of evidence-based practice resources for providers. Member outcomes should also be consistently monitored using validated tools to evaluate effectiveness. Barriers to engagement that may be cultural or systemic must be identified and addressed proactively. Aspects of evidence-based practices' content or delivery can be adapted to enhance cultural relevance if it does not compromise core components. Principles from evidence-based engagement approaches should also be integrated into services.

Enhancing Cultural Responsiveness and Centering Equity. Culturally adapting and enhancing interventions is crucial to effectively treating BIPOC clients (Griner & Smith, 2006)[10]. Equity-centeredness should also be integrated. Providers should participate in ongoing staff training vital to cultural competence, humility, and equity through the annual Anti-Racist and Culturally Humble (ARCH) learning and training academy (see here). Clinical practices must counteract bias, racism, and discrimination. Conducting a cultural assessment of each member will facilitate understanding their identity, strengths, and needs to integrate into treatment. Treatment should be offered in the member's preferred language.

Following these clinical practice guidelines on the use of evidence-based and culturally responsive practices will promote positive outcomes equitably for our behavioral members served. While evidence-based practices provide the foundation, enhancing cultural relevance and centering equity is vital to successful implementation and effectiveness in predominantly minoritized communities. Ongoing evaluation and quality improvement initiatives also ensure appropriate adaptation and responsiveness when serving historically marginalized populations.

Cognitive Behavioral Therapy

Clinical Practice Guidelines for the Use of Cognitive Behavioral Therapy (CBT)

Cognitive behavioral therapy (CBT) is an evidence-based treatment found to be effective for a wide range of mental and behavioral health conditions (Hofmann et al., 2012)[11]. As such, CBT should be considered a frontline treatment for clients in public behavioral health settings. However, given that the BHS member population is predominantly Black, Indigenous, and People of Color (BIPOC), delivering CBT in a culturally-responsive manner is vital for engagement

[10] Culturally adapted mental health intervention: A meta-analytic review. (apa.org)

[11] Brief Culturally adapted CBT (CaCBT) for depression: A randomized controlled trial from Pakistan - ScienceDirect

and outcomes. These guidelines are informed by recommendations on evidence-based practices from national organizations including the American Psychological Association (APA), Substance Abuse and Mental Health Services Administration (SAMHSA), American Psychiatric Association, and American Academy of Child and Adolescent Psychiatry (AACAP). As core CBT components have shown some cultural limitations (Naeem et al., 2015)[12], these guidelines provide recommendations for addressing cultural relevance when implementing CBT-based interventions.

Using Core Components of CBT. Providers should use CBT techniques with the strongest evidence-base, including cognitive restructuring, to identify and dispute distorted thinking patterns, problem-solving training to improve coping abilities, somatic management techniques to target physiological symptoms, exposure methods to gradually face fears, and behavioral activation to increase engagement in meaningful activities (Beck, 2011)[13]. When delivering CBT, providers should receive ongoing training (i.e., by attending BHS' annual Transdiagnostic CBT training) and supervision in CBT models relevant to population needs. Member progress should be consistently monitored using validated assessment tools. BHS utilizes a practice website (see TIPs website) that serves as a hub of evidence-based practice resources for providers, which includes extensive CBT-informed resources (see here) as well as CBT-informed practice guidelines specific to various behavioral health presentations (see here).

Enhancing Cultural Responsiveness. To provide culturally responsive CBT, assessing client cultural identities, strengths, and barriers early on is key (Hays, 2009; Bernal & Rodríguez, 2012)[14][15]. Treatment should be offered in the member's preferred language through bilingual staff or interpreters when possible. Cultural views on healing and wellness should be incorporated into CBT concepts. Cognitive restructuring can relate to cultural values around mindfulness or spirituality when appropriate. Problem solving approaches should align with cultural and contextual realities. Somatic management should acknowledge cultural factors influencing physiology. Exposures can incorporate meaningful cultural practices. Behavioral activation should involve accessible and meaningful activities. Finally, providers should participate in ongoing staff training vital to

[12] Brief Culturally adapted CBT (CaCBT) for depression: A randomized controlled trial from Pakistan - ScienceDirect
[13] Cognitive behavior therapy: Basics and beyond, 2nd ed. (apa.org)
[14] Culturally adapted mental health intervention: A meta-analytic review. (apa.org)
[15] Integrating evidence-based practice, cognitive–behavior therapy, and multicultural therapy: Ten steps for culturally competent practice. (apa.org)

culturally-adapting CBT and CBT-based practices such as DBT and TF-CBT, through BHS' annual Anti-Racist and Culturally Humble (ARCH) learning and training academy (see here).

Applying core CBT components with cultural responsiveness promotes engagement and outcomes when treating our behavioral health members. Following these guidelines, informed by national organizations, will allow CBT to be delivered in a culturally responsive manner. Evaluation and adaptation processes must also ensure appropriate cultural fit.

Motivational Interviewing

The heart of motivational interviewing is the ability to build partnership through conversation between members and providers rooted in compassion and respect, rather than being directive or inferring judgement. With motivational interviewing, practitioners can also identify the type of dialogue that will best match the member's readiness for change and support treatment planning rooted in the member's self-identified goals and motivations. [16]. Motivational interviewing is an important intervention because it centers the member as the expert of their own life and allows clients, patients, and families to provide information pertinent to their lived experiences and care in a way that is empowering. Motivational interviewing is used within programs across BHS by practitioners who work with various populations and across all ages. This therapeutic approach is useful in strengthening motivation for change, advancing treatment goals, and strengthening the therapeutic rapport.

Psychoeducation

Psychoeducation combines therapeutic interventions such as cognitive behavior therapy (CBT) with education. The basic goal is to provide the client with knowledge about various facets of their illness and treatment options. Providing this education allows the client to work together with mental health professionals for a better overall outcome. Psychoeducation can include information given verbally in a therapy session, handouts, guides, and homework tasks where

[16] Motivational Interviewing in Healthcare: 10 Strategies (healthcatalyst.com)

clients are encouraged to discover information for themselves. BHS utilizes psychoeducation to support members to better understand their mental health and/or substance use challenges while providing treatment options based on the member's goals. This includes psychoeducation from medical staff regarding medication interventions for members who are ambivalent about medication use. Using psychoeducation can empower members to make informed decisions about their illness and treatment, which often results in better outcomes.

Clinical Practice Guidelines for Whole Person Care and Wrap Around Treatment

BHS's practice guidelines for providing whole person care and wrap around treatment using the Integrated Core Practice Model (ICPM) aim to improve the assessment, coordination, and delivery of comprehensive services for behavioral health clients, particularly system-involved members in San Francisco. The population served is primarily Black, Indigenous, and People of Color (BIPOC), including Latina/o/x/e, Black/African American, and Asian American, Native Hawaiian, and Pacific Islander communities. These guidelines promote the use of the ICPM model, an evidence-informed practice that emphasizes integration, coordination, and cultural responsiveness in serving clients with complex needs (California Department of Social Services, 2018)[17].

Using the Integrated Core Practice Model (ICPM): The ICPM model is the foundational framework for delivering whole person care and wrap around services. ICPM is a strengths-based, needs-driven approach that brings together service providers, natural supports, and the client/family to develop and implement a unified service plan (California Department of Social Services, 2018). Key components include comprehensive assessment, intensive care coordination, child and family teaming, home-based services, and culturally relevant interventions. Providers receive training and coaching in the ICPM model to ensure high-quality implementation. Fidelity to the model is aimed to be monitored regularly using established tools like the ICPM Practice Fidelity Assessment (California Department of Social Services, 2018). Client and family outcomes are consistently measured to evaluate effectiveness. Barriers to

[17] Integrating evidence-based practice, cognitive–behavior therapy, and multicultural therapy: Ten steps for culturally competent practice. (apa.org)

engagement, including cultural and systemic factors, are also proactively addressed.

Enhancing Cultural Responsiveness and Centering Equity: Culturally adapting whole person and wrap around services using ICPM is essential for effectively engaging and treating BIPOC clients (Griner & Smith, 2006)[18]. Equity must be centered throughout service delivery. Providers should participate in ongoing cultural humility, anti-racism, and equity training, such as through BHS' annual Anti-Racist and Culturally Humble (ARCH) learning and training academy (see details here). Clinical practices should actively counteract bias and discrimination. Conducting a thorough cultural assessment with each client/family facilitates understanding their identities, strengths, needs, and preferences to integrate into services. Interventions and supports are offered in the member's preferred language and align with their cultural beliefs and values.

Coordinating and Integrating Services: A hallmark of the ICPM model is coordinating and integrating services to meet the comprehensive needs of the client and family (California Department of Social Services, 2018). Child and Family Teams (CFT) are established to bring together the client/family, service providers, and natural supports to collaboratively develop a single, cross-system care plan. The CFT meets regularly to monitor progress and adjust as needed. Intensive care coordination by a dedicated facilitator is key to ensuring the care plan is implemented effectively. Service providers must also communicate and collaborate closely to provide seamless, well-coordinated care.

Promoting Client and Family Voice, Choice and Natural Supports: Ensuring that the client and family's voice, choice and natural supports are centered is a core principle of ICPM model (California Department of Social Services, 2018). The client and family are actively involved in all aspects of the teaming and care planning process. Their strengths, needs, and preferences should drive the development of the care plan. Providers coach and model skills to enhance the client and family's self-advocacy abilities. Natural supports, such as extended family and community members, are actively engaged as key partners in supporting the client/family.

Providing Home and Community-Based Services: Delivering services in home and community-based settings is an important aspect of the ICPM model (California Department of Social Services, 2018). Providing interventions where

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[18] Culturally adapted mental health intervention: A meta-analytic review. (apa.org)

the client/family lives allow for more contextually relevant and generalizable treatment. It also reduces barriers to access and promotes engagement. Providers must have the capacity and flexibility to offer services outside of the clinic setting.

Following these clinical practice guidelines on implementing whole person care and wrap around treatment using the ICPM model promotes positive and equitable outcomes for our system- involved behavioral health members. The ICPM model provides an evidence-informed framework emphasizing integration, coordination, and cultural responsiveness. Augmenting it by centering equity, coordinating and integrating services, promoting youth/family voice, choice and natural supports, and providing home and community-based services enhances successful implementation and effectiveness in predominantly minoritized communities. Ongoing evaluation and quality improvement processes also ensures the appropriate provision of ICPM to our historically marginalized member population.

Medication for Substance Use Treatment

BHS has multiple guidelines addressing medication treatments for substance use disorders[19]. These guidelines are developed by the Behavioral Health Services Medication Use Improvement Committee (MUIC), a multidisciplinary team of civil service and contracted providers. The guidelines are written with the intent of the audience being both members as well as practitioners. These guidelines are updated every three years and include evidence-based recommendations as well as local resources. BHS also has medication treatment guidelines for the treatment of alcohol use disorder, opioid use disorder, nicotine use disorder, and cannabis use disorder. The medication guidelines are e-mailed out to all medical staff when they are updated, posted on the BHS public website, and distributed to staff through the pharmacy manual yearly.

Start Medication Treatment for Opioid Use Disorder Information

[19] BHS Medication Guidelines (sf.gov)

Relapse Prevention

Relapse Prevention is a skills-based, cognitive-behavioral approach that requires members and their clinicians to identify situations that place the person at greater risk for relapse – both internal experiences (e.g., positive thoughts related to substance use or negative thoughts related to sobriety that arise without effort, called "automatic thoughts") and external cues (e.g., people that the person associates with substance use)[20]. At BHS, relapse prevention is used to help members maintain their sobriety.[21]

Below are resources SFDPH provides to those in need of relapse prevention support:

1. LifeRing Secular Recovery
2. Intercounty Fellowship of Alcoholics Anonymous – San Francisco and Marin
3. Find Recovery - AA Meetings in San Francisco
4. San Francisco Area of Narcotics Anonymous
5. Find Recovery – NA Meetings in San Francisco

Harm Reduction

Harm reduction treats individuals with substance use disorders (SUD) with dignity and respect using a social justice and health equity lens. Harm Reduction International describes it as "policies, programs, and practices that aim to minimize negative health, social and legal impacts associated with drug use, drug policies, and drug laws."[22]

More simply, harm reduction is an approach to services to meet people where they are at while also supporting them in moving towards health and wellness. Harm reduction incorporates a spectrum of behaviors from abstinence, reduction in use, to overdose risk reduction. Harm reduction respects that all individuals seek health and should have access to treatment and services regardless if they are seeking to stop using substances.

[20] Relapse Prevention (recoveryanswers.org)
[21] BHS Medication Guidelines (sf.gov)
[22] Harm Reduction Principles | National Harm Reduction Coalition

Below are harm reduction resources provided at BHS for individuals struggling with substance use:

1. **Get access to naloxone (overdose reversing medication), fentanyl test strips, syringe access and disposal.**

   To get a free nasal naloxone kit and training and/or up to 10 fentanyl test strips, visit:

   Behavioral Health Services Pharmacy
   1st floor at 1380 Howard St
   San Francisco, CA 94103
   M-F 9am-6:30pm
   Sat-Sun 9am–12pm and 1pm-4:00pm

2. **Naloxone and fentanyl test strips for groups**

   Request naloxone for your community organization, business, or group to distribute in the community. Email overdoseprevention@sfdph.org or visit the BHS Pharmacy.

   For community organizations, business, and groups seeking bulk quantities of fentanyl test strips, please make a request by filling out this form: https://forms.office.com/g/KKDhqX1ACM

   Please note that an attestation of training (materials are provided on the request form) will be required. The request will take 1-2 weeks to fulfill and instructions for pickup will be provided once the other is ready.

   Download the syringe access and disposal schedule
   Syringe Access Collaborative Overview (more details on services)
   Syringe Access & Disposal Schedule

3. Drug Checking services from the San Francisco Aids Foundation Schedule
4. Pre -Exposure Prophylaxis
   a. PrEP & PEP - San Francisco AIDS Foundation (sfaf.org)
5. Low barrier access to medications and treatment of HIV and HCV
   a. Hepatitis C Testing, Treatment & Navigation - San Francisco AIDS Foundation (sfaf.org)

b. [HIV Support & Health Navigation - San Francisco AIDS Foundation (sfaf.org)]

Appendix A - Definitions

Member(s) – Member is broadly defined as any recipient of Behavioral Health Services from San Francisco Department of Public Health.