NATIONAL COUNCIL *for* Mental Wellbeing

HEALTHY MINDS STRONG COMMUNITIES

2022 CCBHC Impact Report

Expanding Access to Comprehensive, Integrated Mental Health & Substance Use Care

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Introduction

Faced with decades of underfunding, ongoing struggles to recruit and retain staff, and dual mental health and substance use crises nationwide, the behavioral health system has long needed significant investment and transformation to meet the true needs of communities across the country.

The Certified Community Behavioral Health Clinic (CCBHC) model is delivering the resources our nation needs to change the care landscape. CCBHCs are clinics – either certified by their states as CCBHCs or recipients of a federal CCBHC grant – that receive flexible funding to expand the scope of mental health and substance use services in their community. They serve anyone who walks through the door, regardless of ability to pay.

The CCBHC model was originally implemented in eight states through a Medicaid demonstration program, with two states added to the demonstration in 2020. Since 2018, grants from the Substance Abuse and Mental Health Services Administration (SAMHSA) have funded clinics in dozens of states to take on the activities and services of a CCBHC. These grants have proven to be a vital springboard to CCBHC implementation, positioning clinics and states for further delivery system transformations as they implement the CCBHC model in their Medicaid programs. Under the 2022 Bipartisan Safer Communities Act, the demonstration will expand to include 10 new states every two years, starting in 2024 – and will ultimately offer all states the opportunity to translate their grantees' work into a new, sustainable nationwide model of care.

Since 2017, the National Council for Mental Wellbeing has surveyed CCBHCs and grantees annually to glean insights into their activities and outcomes. This year's report adds to our knowledge about the success of these clinics to expand access to care, hire and retain staff, and enable integrated care partnerships with federally qualified health centers (FQHCs), schools, hospitals, and law enforcement to help get people care when and where they need it – in effect, transforming how people access high-quality mental health and substance use care in America.

CCBHCs are changing the landscape, proving that when evidence-based clinical care is supported with effective financing, clinics can dramatically increase access to care and provide comprehensive and lifesaving services nationwide to people whose needs were often previously unmet.

Status of Participation in the CCBHC Model

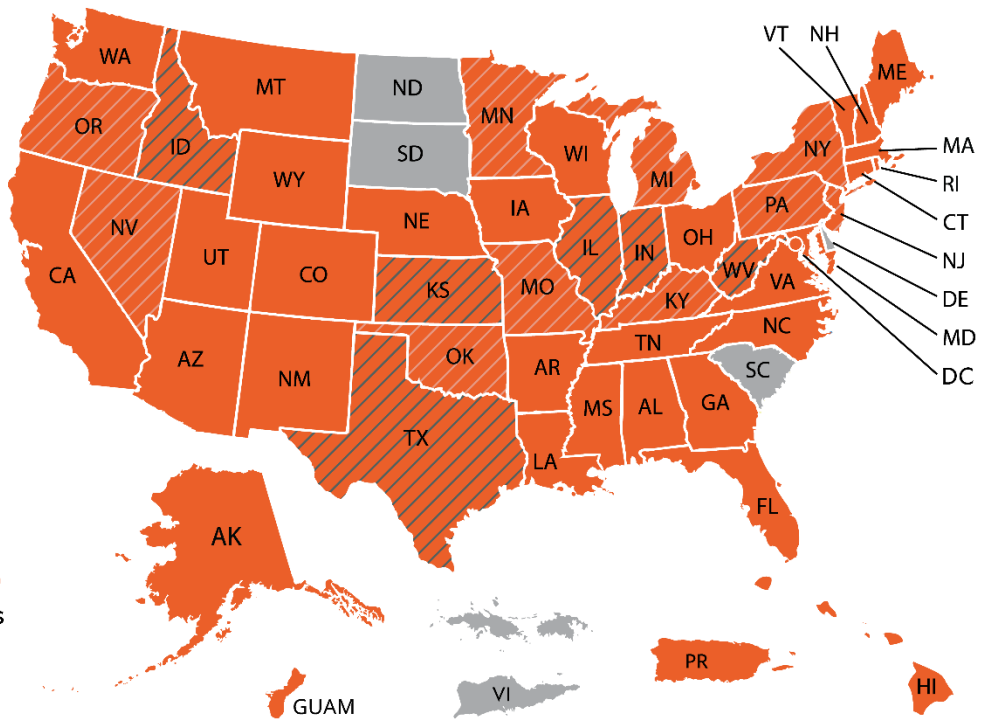
States where clinics have received expansion grants

States selected for the CCBHC demonstration

Current (or working toward) independent statewide implementation

No CCBHCs

There are **500+ CCBHCs** in the U.S., across 46 states, plus Washington D.C., Puerto Rico, and Guam



Today, there are more than 500 CCBHCs and CCBHC grantees in 49 states and territories, including new grantees awarded in September 2022. This report contains data collected from CCBHCs and grantees that were active as of August 2022, covering 249 of 450 sites.

A note on terminology: Throughout this report, the term "CCBHC" or "state-certified clinic" is used to describe CCBHCs that are participating in the Medicaid demonstration, a CCBHC Medicaid State Plan Amendment, or a Medicaid Section 1115 waiver. These clinics receive a Medicaid payment rate based on reasonable estimates of their cost of doing business. Some, but not all, state-certified sites have also received a CCBHC Expansion Grant from SAMHSA. States with state-certified clinics are: Kansas, Kentucky, Michigan, Minnesota, Missouri, Nevada, New Jersey, New York, Oklahoma, Oregon, Pennsylvania, and Texas. Many of these states also have grantee-only clinics.

The term "grantee" refers to clinics that have only received SAMHSA CCBHC grant funding to date and are not certified as CCBHCs by their states. These clinics do not receive the special CCBHC Medicaid payment rate and instead rely on federal grant funding to implement the CCBHC model of care. Since the grant program began in 2018, grants have been awarded to clinics in 46 states; Washington D.C.; Guam; and Puerto Rico.

While state-certified CCBHCs and grantees reported broadly similar experiences, the survey data reveal some differences between the two types of clinics, providing insights as to how the Medicaid demonstration can further scale innovations and improvements initiated under the grant program.

Differences Between the Medicaid CCBHC Demonstration and SAMHSA CCBHC Expansion Grants

Medicaid CCBHC Demonstration	SAMHSA CCBHC Expansion Grants
Currently active in 10 states; will be open to 10 additional states every 2 years beginning in July 2024.	Open to individual clinics in all states.
Administered by state Medicaid and Behavioral Health Authorities within guidelines set by SAMHSA and the Centers for Medicare and Medicaid Services (CMS).	Administered by SAMHSA.
States determine certification criteria using SAMHSA guidance as a baseline.	Grantees must meet SAMHSA baseline CCBHC certification criteria.
CCBHCs are certified by their states.	CCBHCs are funded by SAMHSA and do not receive state certification.
CCBHCs receive special Medicaid payment methodology (known as PPS).	CCBHCs receive up to $4M for a four-year term and continue to bill Medicaid and other payers per usual

CCBHCs' Impact at a Glance

EXPANDING ACCESS TO CARE

CCBHCs and grantees are closing the treatment gap that leaves millions of Americans with unmet mental health and substance use needs[1], bringing thousands of new clients into care.

- **1.2 million** people are currently served across **249** responding clinics, which means that an estimated **2.1 million** people[2] are served nationwide by all **450** CCBHCs and grantees active as of August 2022.
    - This estimated total represents an increase of about **600,000 clients**[3] compared to the estimated total number of individuals served by all CCBHCs in 2021.
- CCBHCs and grantees are, on average, serving more than **900** more people per clinic than prior to CCBHC implementation, representing a **23%** increase.

INVESTING IN THE WORKFORCE

The CCBHC model is alleviating the impact of the community-based mental health and substance use workforce shortage by enabling clinics to increase hiring.

- Responding clinics hired **6,220** new staff positions, or an average of **27** new staff per clinic, as a result of becoming a CCBHC.
- An estimated **11,240** new staff positions[4] were added across all 450 active CCBHCs and grantees active as of August 2022.

EXPANDING ACCESS TO MEDICATION-ASSISTED TREATMENT

CCBHCs and grantees are addressing the nation's opioid crisis by dramatically expanding access to medication-assisted treatment (MAT), which when combined with counseling and behavioral therapy to provide a "whole patient" approach, is considered to be one of the most effective ways to treat substance use disorder (SUD).

- **82%** of CCBHCs and grantees use one or more forms of MAT for opioid use disorder, compared to only **56%** of substance use clinics nationwide that provide any MAT services[5].
- An estimated **69,400** clients[6] nationwide are engaged in MAT across the 450 CCBHCs and grantees that were active as of August 2022.
- **65%** of CCBHCs and grantees have increased the number of clients engaged in MAT since becoming a CCBHC, including **27%** who say the increase has been significant.

COORDINATION AND INTEGRATION WITH PRIMARY CARE

CCBHCs and grantees work closely with primary care partners, using multiple strategies to coordinate and integrate care.

- **81%** of respondents report increasing the number of referrals to primary care since becoming a CCBHC.
- CCBHCs also engage in numerous activities to coordinate and integrate care, from electronic information sharing with care coordination partners (**94%** currently do this or plan to) to co-locating physical health services on site (**88%** currently do this or plan to) and more.

MAKING CRISIS SERVICES AND SUPPORTS AVAILABLE TO ALL

Nearly all respondents deliver crisis support services in their communities, which helps divert people in crisis from hospitals, emergency departments and jails. CCBHCs and grantees' crisis response activities make them natural partners in states' 988 implementation efforts.

- Either directly or through referral, **98%** of respondents offer access to 24/7 crisis lines, **97%** offer access to mobile crisis response, and **94%** offer access to crisis stabilization services.
- Since gaining CCBHC status, about half of CCBHCs and grantees (**49%**) have added crisis response services or partnerships, an indication of the expansion of access to crisis care under this model.
- CCBHCs and grantees engage in a wide variety of activities aimed at improving crisis response, which can divert individuals from law enforcement involvement, such as operating a crisis drop-in center (**38%**), dispatching mobile teams to respond to 911 calls instead of police (**30%**), and more.
- **98%** of respondents report engaging in one or more collaborative activities with hospitals and emergency departments, which can improve linkages to community-based care and reduce readmission.

IMPROVING COLLABORATION WITH CRIMINAL JUSTICE AGENCIES

CCBHCs and grantees work with law enforcement agencies and other partners to improve outcomes for people who are involved with or are at risk of involvement with the criminal justice system.

- The vast majority of CCBHCs and grantees (**96%**) are actively engaged in one or more innovative activities in partnership with criminal justice agencies, such as providing services in partnership with courts (**86%**), training law enforcement officers in Mental Health First Aid or other awareness training (**65%**), or providing re-entry support to individuals returning to the community from incarceration (**64%**).

MEETING CHILDREN, YOUTH AND FAMILIES WHERE THEY ARE

The CCBHC model supports clinics to provide comprehensive services beyond the four walls of the clinic to meet community members when and where they need care.

- **94%** deliver services directly to children and youth; **79%** deliver services on site at schools.

ADDRESSING HEALTH DISPARITIES

Universally, responding clinics indicate that CCBHC status has helped them serve more people of color, improve access to care and reduce health disparities in their communities.

- Since becoming a CCBHC, **100%** report taking steps to improve access to care, reduce health disparities among, and serve people of color or other historically marginalized populations; at the top of the list is staff training on culturally sensitive/competent care (**94%**).
- Nearly three in five (**58%**) are currently engaged, or plan to engage, in work related to affordable housing by providing services at a site that provides affordable or supportive housing.

Expanding Timely Access to Care

Mental health and substance use services remain in high demand, yet it is well-documented that a large majority of Americans continue to be unable to access the services they need. There is a profound need to reduce barriers to access, with **43%** of U.S. adults who say they needed substance use or mental health care in the past 12 months reporting they did not receive that care[7].

CCBHCs and grantees are filling this gap in care, with the majority (**77%**) reporting their organization's caseload has increased since becoming a CCBHC. On average, these increases have resulted in respondents serving more than **900** additional unduplicated clients per clinic each year.

1.2 MILLION CLIENTS

are currently served by 249 responding CCBHCs and grantees

Estimated

2.1 MILLION

people currently served across all 450 active CCBHCs and grantees

This represents a steep increase from the estimated 1.5 million people served across 224 active CCBHCs as of 2021.

77%

CCBHCs & GRANTEES

say their caseload has increased since becoming a CCBHC

Nearly

180,000

total new clients served by these clinics

This represents a 23% increase since becoming a CCBHC

Increases in client caseloads were significantly greater among state-certified CCBHCs (who reported an average **30%** increase in client caseloads per clinic) than among grantees (who reported an average increase of **18%**). Several factors may influence this, including clinics' length of time as a CCBHC or grantee. Most importantly, state-certified CCBHCs have access to a special payment rate through Medicaid[8], designed to support the costs associated with expanding access to care. Medicaid funding, because it is tied to enrollees' clinical encounters, can flex with increases in need or client volume, supporting clinics in assertive outreach efforts to bring clients with previously unmet needs into care. In contrast, grantees receive a fixed amount of funding for the grant period. While this capped funding mechanism supports important access expansions—as reflected in the large caseload increases experienced by grantees—it can constrain grantees' ability to further expand services when their funding is exhausted.

Differences in the magnitude of state-certified CCBHCs' and grantees' caseload expansions suggest states that implement the CCBHC model through Medicaid may expect to build upon grantees' initial successes with further increases to the number of individuals served.

CCBHCs are also improving access by reducing wait times, enabling clients to receive care more quickly. Almost nine in 10 (**87%**) report seeing patients for routine needs within **10** days of the initial call or referral, **71%** offer access within one week or less, and one-third (**32%**) offer same-day access to services*. This is in contrast to the national average of **48** days between a client's first outreach/referral until their first appointment– as cited in an MTM Services analysis of 10,000 care access protocol flowcharts collected from 1,000 community mental health centers engaged in initiatives to measure and reduce wait times for care in 47 U.S. states[9].

**Year over year comparisons for this question are not supported due to differences in question wording.*

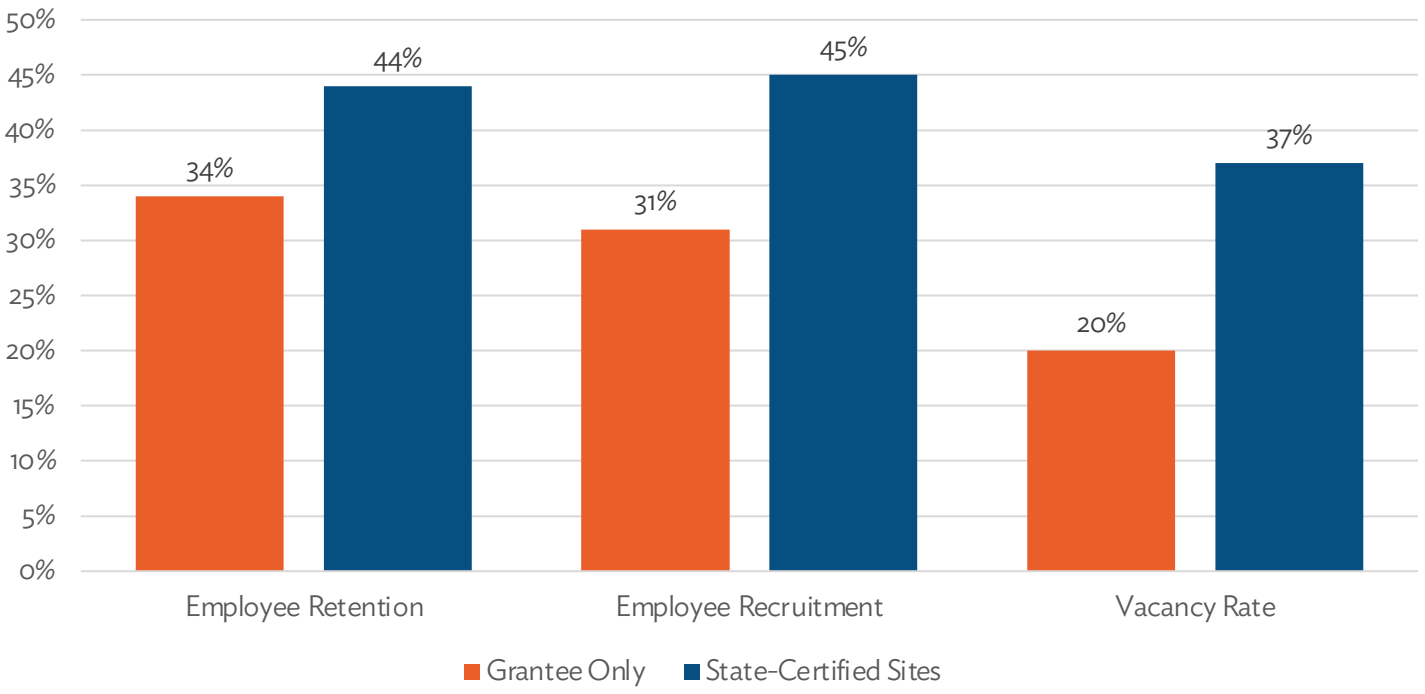
Investing in the Workforce

In the midst of the ongoing mental health and substance use workforce shortage clinics have struggled to hire and retain sufficient staff to meet their communities' needs, often losing staff to other employers or fields that can offer more competitive salaries. However, CCBHCs and grantees have been able to leverage their Medicaid payment structure and/or grant funding to recruit and retain highly qualified staff.

The most common strategy CCBHCs and grantees are using to mitigate the effects of the workforce shortage is raising salaries or offering bonuses (**92%**). Many respondents noted in the qualitative comments that their CCBHC funding has enabled them to offer more competitive pay relative to other providers and industries in their area.

Hiring was greater among state-certified sites, with an average of **44** new positions per clinic, than among grantee sites, with an average of **20** positions, and state-certified sites were also more likely to report they are raising salaries or offering bonuses to help mitigate the effects of the workforce shortage (**97%** vs. **89%**). Similarly, state-certified sites were more likely than grantees to report that since becoming a CCBHC they have had a better experience with employee recruitment (**45%** vs. **31%**), and vacancy rates (**37%** vs. **20%**). These differences are likely attributable to the different funding mechanisms for each clinic type: while both types of CCBHCs have enhanced financial resources to support workforce investment, the Medicaid payment available to state-certified CCBHCs is expressly designed to support the costs of bringing on new staff to meet their communities' needs. A number of grantee respondents shared in the qualitative comments that transitioning to state-certified status and payment would enable them to further increase hiring.

Improvement in Workforce Issues Since Becoming a CCBHC



6,220
STAFF HIRED

Across the 249 responding CCBHCs and grantees as a result of becoming a CCBHC

Estimated
11,240
STAFF HIRED

across all 450 active CCBHCs as of August 2022

27
NEW POSITIONS PER CLINIC

on average since becoming a CCBHC

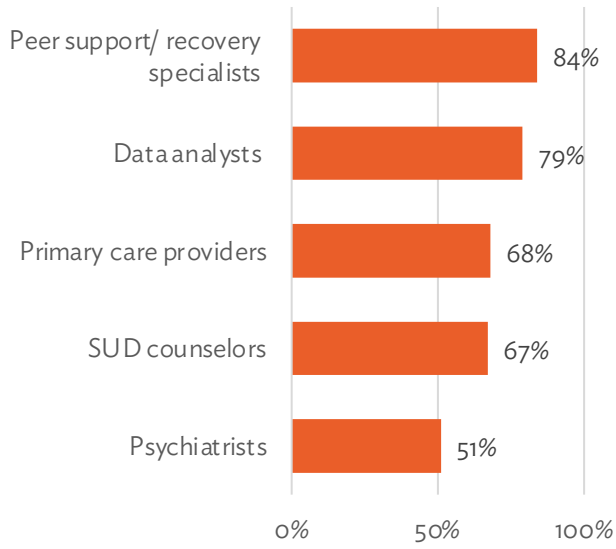
(82% of organizations have created at least 10 new staff positions)

Beyond addressing staff pay, the vast majority of CCBHCs and grantees are also actively engaged in a variety of other strategies to mitigate the effects of the workforce shortage, including engaging in staff wellbeing efforts, revamping employee benefits, and other strategies to improve staff satisfaction and retention (**86%**). Other strategies include partnerships with clinician training programs (**62%**), revising job descriptions and care teams to allow staff to practice at the top of their license (**59%**), and enhancing provision of integrated behavioral health and primary care so more needs can be addressed in a single visit (**57%**). Fort-six percent of respondents serve as a National Health Service Corps-eligible site for loan repayment, and **35%** participate in other kinds of loan repayment programs.

Peer support specialists were cited as the most commonly hired type of staff, with **84%** of respondents reporting they had added peers to their staff. Other commonly hired staff included data analysts (**79%**); primary care providers (**68%**); substance use disorder counselors (**67%**); and psychiatrists (**51%**).

Beyond their ability to increase hiring, numerous respondents shared comments about the impact of CCBHC status on workforce retention. By providing a source of funding for critical client care activities such as outreach, client engagement, care coordination, and internal team consultation/support, the CCBHC model supports flexibility in how staff engage with clients and with one another. Many respondents commented that this contributes to a more-desirable working environment and has reduced staff turnover. On the other hand, burdens associated with enhanced paperwork were cited by several respondents as contributing to staff burnout.

Most Common Types of Staff Hired/ Looking to Hire Since Becoming a CCBHC



Effects of CCBHC Model on Workforce Recruitment and Retention

"[Being a] CCBHC allowed us to better pay our staff which in return decreased our turnover rate significantly. It has also increased client retention because they keep the same therapist for the duration of treatment."
- Pathways Inc. (Kentucky)

"Becoming a CCBHC allowed us to make significant salary increases and improve benefits to all staff. While COVID is very detrimental... I cannot imagine where we'd be without having become a CCBHC."
- NorthCare (Oklahoma)

"We have only been a CCBHC since May. In the past few months, we have seen an increase in new hires coupled with fewer resignations. For the first time since COVID hit, we are seeing more staff coming in the door than exiting and have reduced our vacancy rate by 50%."
- Wyandot Center for Community Behavioral Healthcare (Kansas)

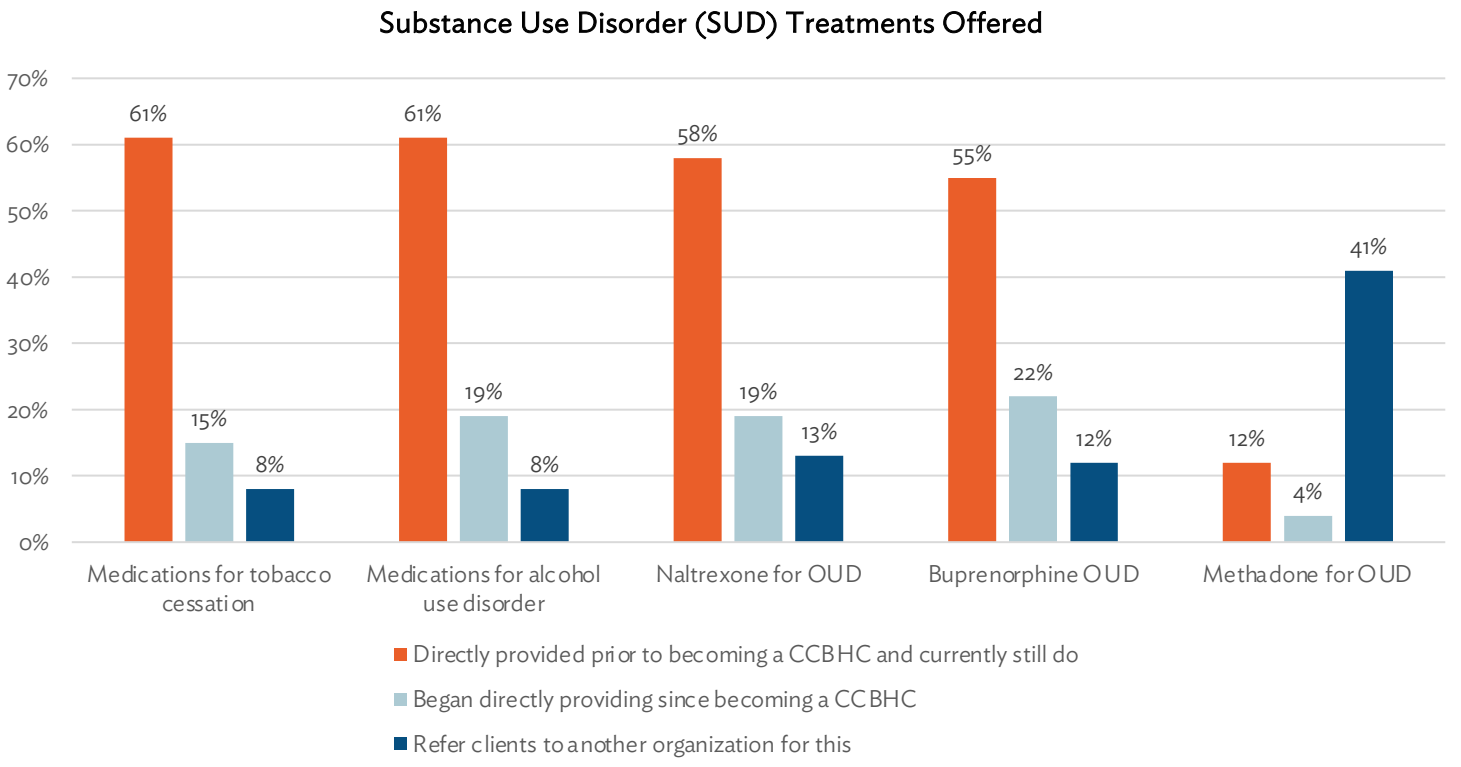
"We have several positions to fill, but once filled, we are retaining employees for longer periods of time. We are finally more competitive with other area behavioral health agencies/positions/schools. We've had an increased interest in practicums, so much so that we don't have room for all of the interested students!"
- Central Kansas Mental Health Center (Kansas)

"Recruitment continues to be a struggle with the workforce shortage, but once we hire employees, they enjoy the structure of the CCBHC services provided and see the benefit happening to the patients, this helps with employee retention - seeing a positive change for the work they are doing."
- High Point Treatment Center, Inc. (Massachusetts)

Expanding Access to Medication-assisted Treatment Services

In response to the ongoing overdose crisis that resulted in more than **107,000** deaths (**80,800** involving opioids[10]) in 2021, substance use treatment is a core component of CCBHCs and grantees' service array. Among the advances in expanding access to substance use care, CCBHC status has supported clinics in increasing their capacity to provide medication-assisted treatment (MAT), a highly effective substance use treatment that combines the use of medications with cognitive and behavioral therapies.

Most CCBHCs and grantees (**94%**) directly provide medications for substance use disorder (SUD) treatment, including opioid use disorder, alcohol use disorder, and tobacco use. Many respondents added access to these medications as a direct result of becoming a CCBHC.



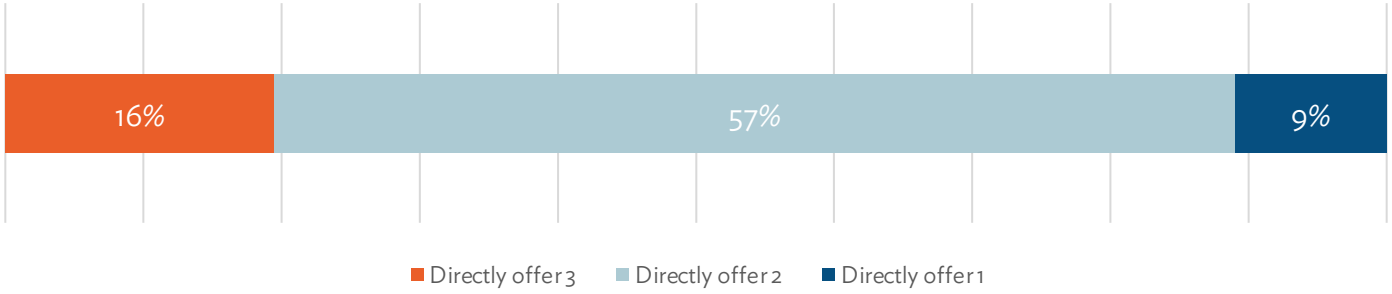
The **249** survey respondents reported engaging **38,396** individuals with SUD in MAT (including those who receive MAT via a referral to a partner organization). At each CCBHC there are about **150** clients, on average, who are currently engaged in MAT. This ranges from fewer than **50** (**39%**) to **100+** (**41%**) across the responding CCBHCs and grantees. An estimated **69,400** total CCBHC clients with SUD are currently engaged in MAT across all **450** CCBHCs and grantees active as of August 2022. For most clinics, the number of clients engaged in MAT continues to grow; most (**65%**) have seen an increase since CCBHC implementation.

There are three main forms of MAT for opioid use disorder (OUD). Eighty-two percent of CCBHCs directly offer at least one type of MAT for OUD, compared to **56%** nationwide[11]. Sixteen percent of CCBHCs directly offer all three forms, compared to **4%** nationwide[12].

CCBHCs also report high levels of access to MAT for other substance use conditions, with **80%** reporting they directly offer MAT for alcohol use disorder (an additional **8%** make it available via referral and **8%** plan to offer it in the future) and **76%** directly offering MAT for tobacco cessation (an additional **8%** make it available via referral and **12%** plan to offer it in the future). Nineteen percent of respondents indicated they added access to MAT for alcohol use disorder since becoming a CCBHC, and **15%** added access to MAT for tobacco cessation since becoming a CCBHC- indicators of the CCBHC model's role in supporting expanded access to these important treatment options.

To support the delivery of SUD treatment, **45%** of respondents have hired new or additional buprenorphine prescribers, **67%** have hired substance use counselors, and **84%** have hired peer support specialists.

Number of MAT Offerings for OUD



82% of CCBHCs directly offer at least one type of MAT for OUD vs. 56% nationwide

38,396 CLIENTS

with substance use disorder currently engaged in MAT across responding clinics

Estimated

69,400 CLIENTS

nationwide engaged in MAT across all 450 active CCBHCs.

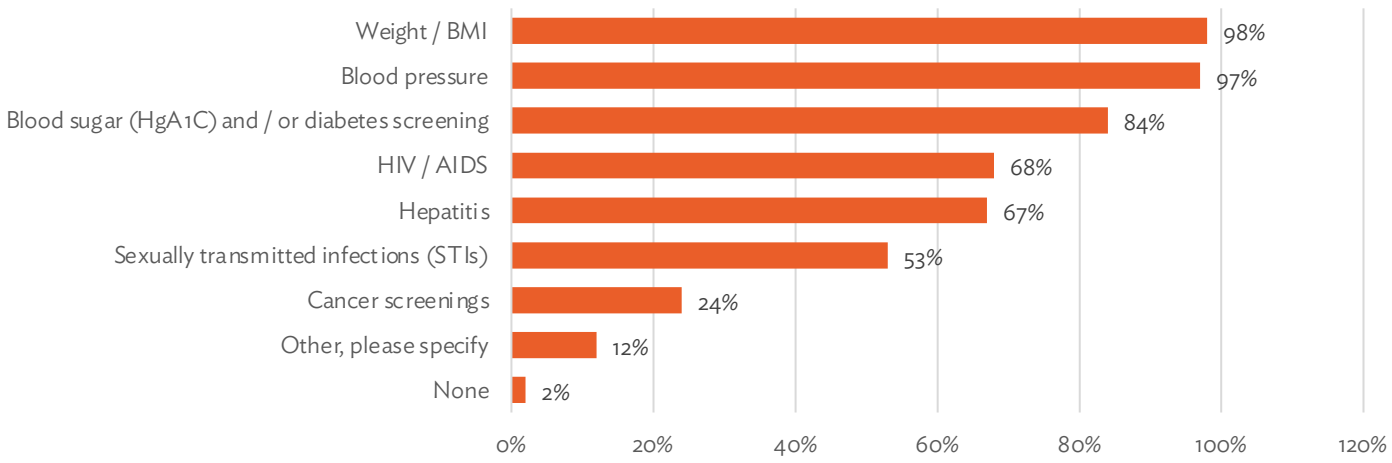
Coordination and Integration with Primary Care

People with mental health and substance use challenges have shorter life expectancy than the general population[13] —largely due to untreated and preventable chronic illness exacerbated by health disparities and health inequity[14]. The CCBHC model emphasizes the importance of a whole health approach through coordination and integration of mental and physical health. The CCBHC scope of services includes screening and monitoring basic physical health indicators to ensure risk factors for chronic conditions are flagged early for referral and/or monitoring; CCBHCs also coordinate with primary care providers to meet clients' physical health needs. The model offers flexibility for clinics to go beyond basic requirements by delivering further integrated care in collaboration with primary care partners.

Almost three-quarters of CCBHCs and grantees (**73%**) meet the primary care screening and monitoring requirement by delivering primary care screening and monitoring directly, a third (**32%**) partner with one or more federally qualified health centers (FQHCs) as a designated collaborating organization (DCO), and **9%** partner with another kind of primary care provider as a DCO. Nearly one in five (**17%**) do both – providing some screening and monitoring services directly while partnering with a primary care provider for others.

Specific physical health screenings may vary based on the needs of the communities CCBHCs serve, with the most common reported screenings being weight/BMI (**98%**) and blood pressure (**97%**).

Physical Health Indicators Screened for or Monitored Directly or Through a DCO

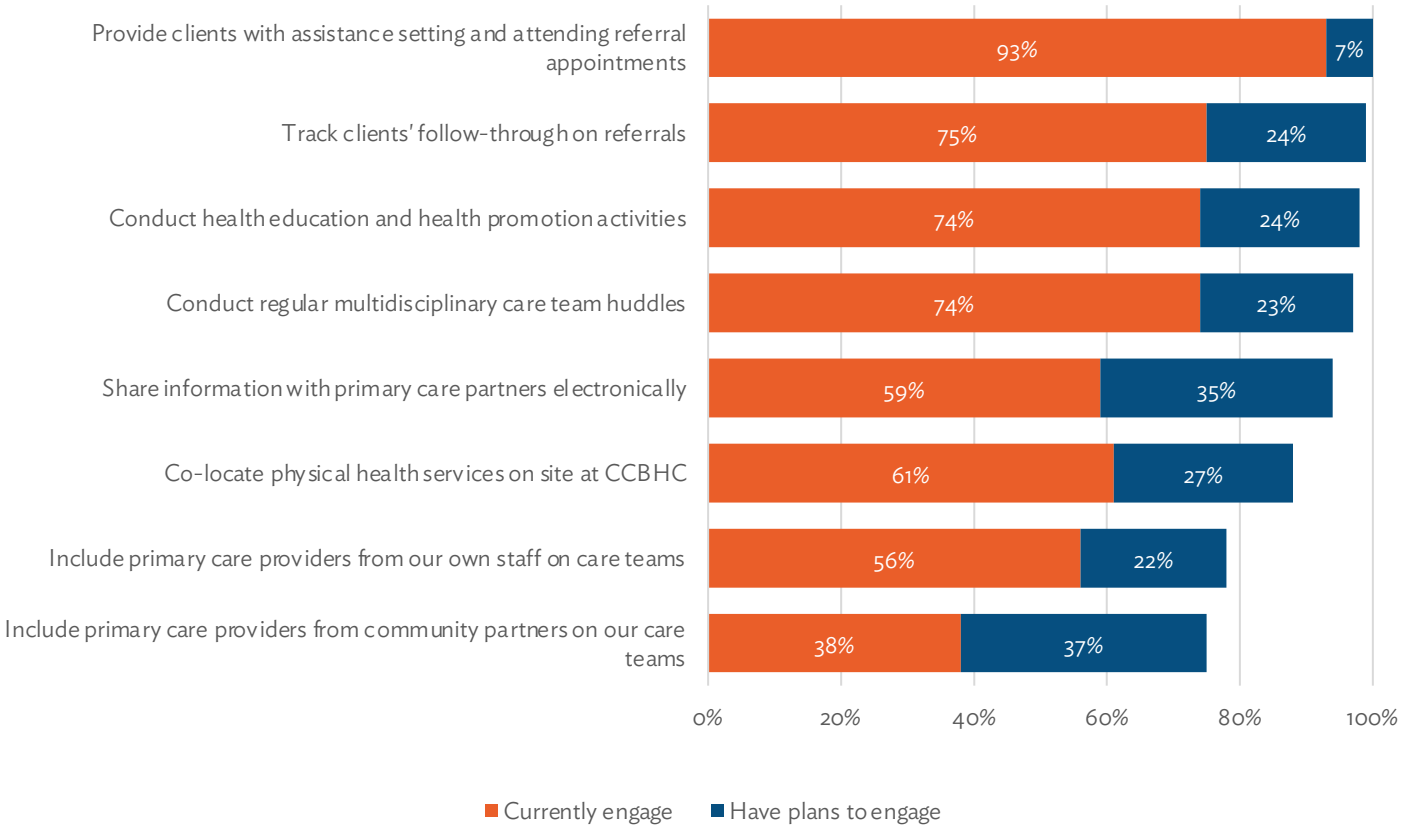


With enhanced focus on physical health screening and monitoring, CCBHCs and grantees have also increased their referrals to primary care, with **81%** reporting that referrals have increased since becoming a CCBHC. Nearly all (**93%**) report they provide clients with assistance setting and attending referral appointments. CCBHCs also monitor and track client's follow-through on appointments: **88%** have developed systematized methods for tracking referrals (electronically or on paper) and **75%** monitor referrals to ensure clients follow through.

> "We now have a more intentional and ongoing conversations with our partners and PCP's [primary care providers]. We want to make sure everyone we see has a provider and that they are using them. Through this it has greatly increased our communication and ongoing relationships with those in our communities."
> - *Red Rock (Oklahoma)*

CCBHCs are also engaging in numerous activities to coordinate and integrate care, from electronic information sharing with care coordination partners (**94%** currently do this or plan to) to co-locating physical health services on site (**88%** currently do this or plan to). Many of these activities go beyond the minimum required in the CCBHC criteria, an indication of CCBHCs' and grantees' commitment to leveraging the model to embrace a whole health approach and ensure positive outcomes for their clients. While the CCBHC payment structures provide a solid foundation for improved care coordination and integration efforts, survey results show room for growth in a number of these beneficial but non-required activities, demonstrating a need for resources to further support and incentivize higher levels of collaboration.

Integrated Care or Care Coordination Activities



Focus on Clients' Physical Health as a Result of CCBHC Model

"As an agency we've always focused on monitoring our clients' physical health. Becoming a CCBHC has enabled us to emphasize data and use it to track clinical outcomes."
– Genesee Health System (Michigan)

"We have trained staff to take blood pressures and monitor different areas related to physical health. Every client's treatment plan has a physical health goal. The Wellness Director, an RN, meets with every new employee to review how to screen and assist clients with their physical health needs."
– The Guidance Center (Pennsylvania)

"Since becoming a CCBHC, we have taken more steps in screening for chronic health conditions such as metabolic syndrome. We now screen all clients for Hepatitis and HIV and have a relationship with a nearby center to accept those clients who are screened positive. We created a Wellness Initiative to improve clients' level of self determination by providing them with scales and blood pressure monitors so they can use the information for better decision making."
– Federation of Organizations for the NY State Mentally Disabled, Inc. (New York)

"Our crisis locations are a field site for the medical residency program at the hospital. The medical residents, both the primary care residents and psychiatric residents, are now doing rotations at our crisis sites. We also have a nursing education program as well, and the nursing students also rotate through and go out on crisis calls."
– Catholic Charities, Diocese of Trenton (New Jersey)

Making Crisis Services and Supports Available to All

The ideal mental health and substance use crisis system is more than a single program[15]. It is a continuum of structures, processes and services that address increasing intensity of needs and connect individuals to care both during and beyond the moment of crisis[16]. CCBHCs services span this continuum, offering prevention services, direct crisis response, and post-crisis care. Clinics have the option to provide **24/7** crisis response care directly via internal staff, or contract with a state-sanctioned crisis response network as a designated collaborating organization (DCO).

What is a DCO?

A DCO is an organization that works with a CCBHC to deliver the full array of required services. CCBHCs and DCOs establish formal agreements ensuring delivery of care in alignment with the federal criteria. The DCO relationship represents an opportunity to align and integrate other community providers under the "umbrella" of the CCBHC model.

Elements of the SAMHSA CCBHC criteria related to provision of crisis care[17]:

Prevention

- Early engagement in care
- Crisis prevention planning
- Outreach & support outside the clinic

Crisis Response

- 24/7 mobile teams
- Crisis stabilization
- Suicide prevention
- Detoxification
- Coordination with law enforcement & hospitals

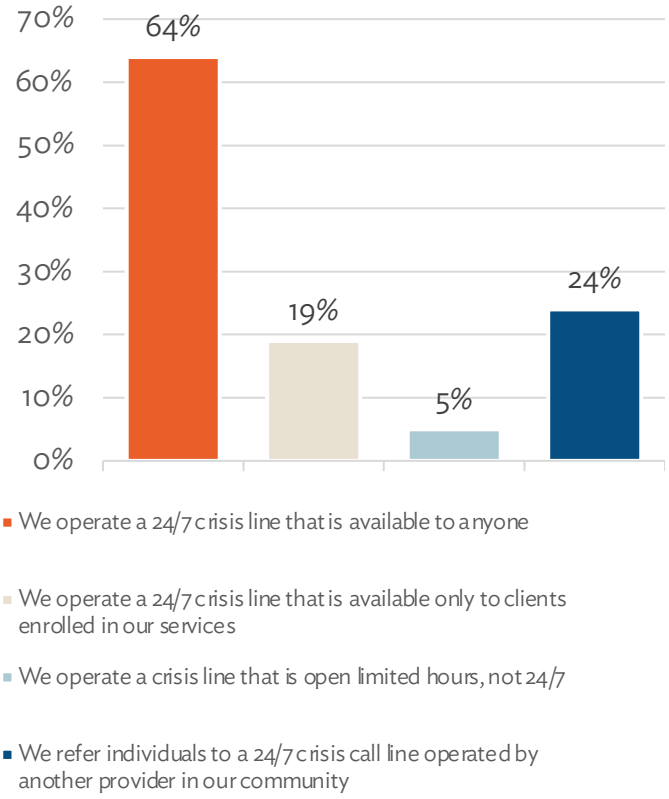
Post-crisis Care

- Discharge/release planning, support & coordination
- Comprehensive outpatient MH & SUD care

With the 988 Suicide & Crisis Lifeline (formerly known as the National Suicide Prevention Lifeline) accessible via a three digit dialing code (988) as of July 2022, CCBHCs will play an even more important role in crisis response through their mobile response and crisis stabilization abilities as call volume continues to rise[18], requiring 988 call centers to be able to link callers with urgent, on-the-ground support. Ultimately, the continued expansion of CCBHCs can help reduce police involvement in mental health and substance use crises and offer people services from professionals best equipped to provide crisis-focused care.

While not a required element of the CCBHC model, the majority of respondents (**64%**) directly operate a **24/7** crisis call line available to anyone in their community. CCBHCs also operate **24/7** call lines available only to their clients (**19%**) or crisis lines with limited hours (**5%**). Twenty-four percent report they refer individuals to **24/7** call lines operated by other entities in their community. Notably, clinics may offer access through more than one of these options. Twenty-five percent of respondents reported that they added call line services or partnerships as a result of becoming a CCBHC. The high prevalence of crisis call lines among CCBHCs suggests they may be ideal partners for states seeking to build out their 988 call center networks.

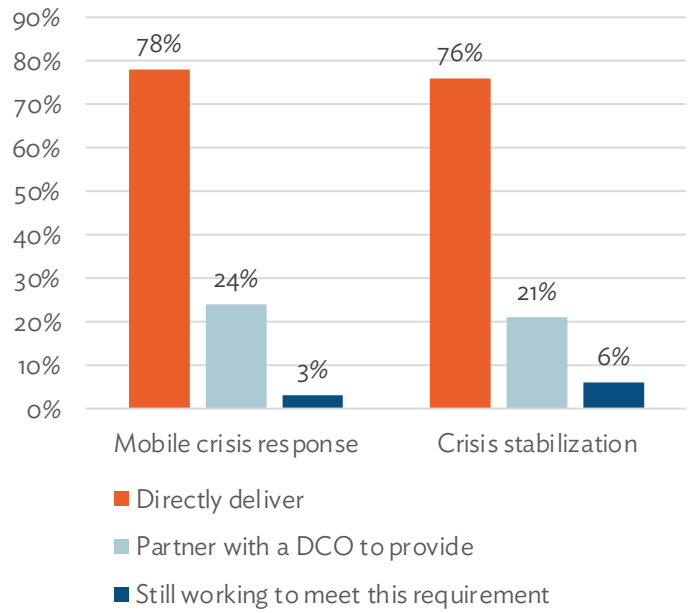
CCBHCs and Grantees Providing 24/7 Call Line(s)



While many individuals' needs can be fully addressed during a call to a crisis line, others may require more intensive on-the-ground support – typically either mobile crisis response or crisis stabilization services delivered by behavioral health professionals[19]. In the absence of these services, law enforcement officers and emergency departments become the front lines of crisis response, often leading to individuals' incarceration, hospitalization, or other potentially avoidable negative outcomes.

CCBHCs and grantees are building out behavioral health crisis response capacity in their communities. Most CCBHCs and grantees provide mobile crisis response and crisis stabilization, either directly or through DCO partnership. For about half, at least one of these services was added since becoming a CCBHC – mobile crisis response (**40%**) and crisis stabilization (**26%**), an indication of expanded availability of crisis care and expanded coordination with crisis service providers in these communities.

CCBHCs and Grantees Providing Access to Selected Crisis Services



"Our crisis team is doing some innovative stuff right now to be more like an Uber-type experience where you can request a crisis response and be able to track it - from [when the request was made], to when [you've] been assigned a provider, to how far away they are. It's more user friendly from the customer experience, especially when you're in crisis. The smoother the better."

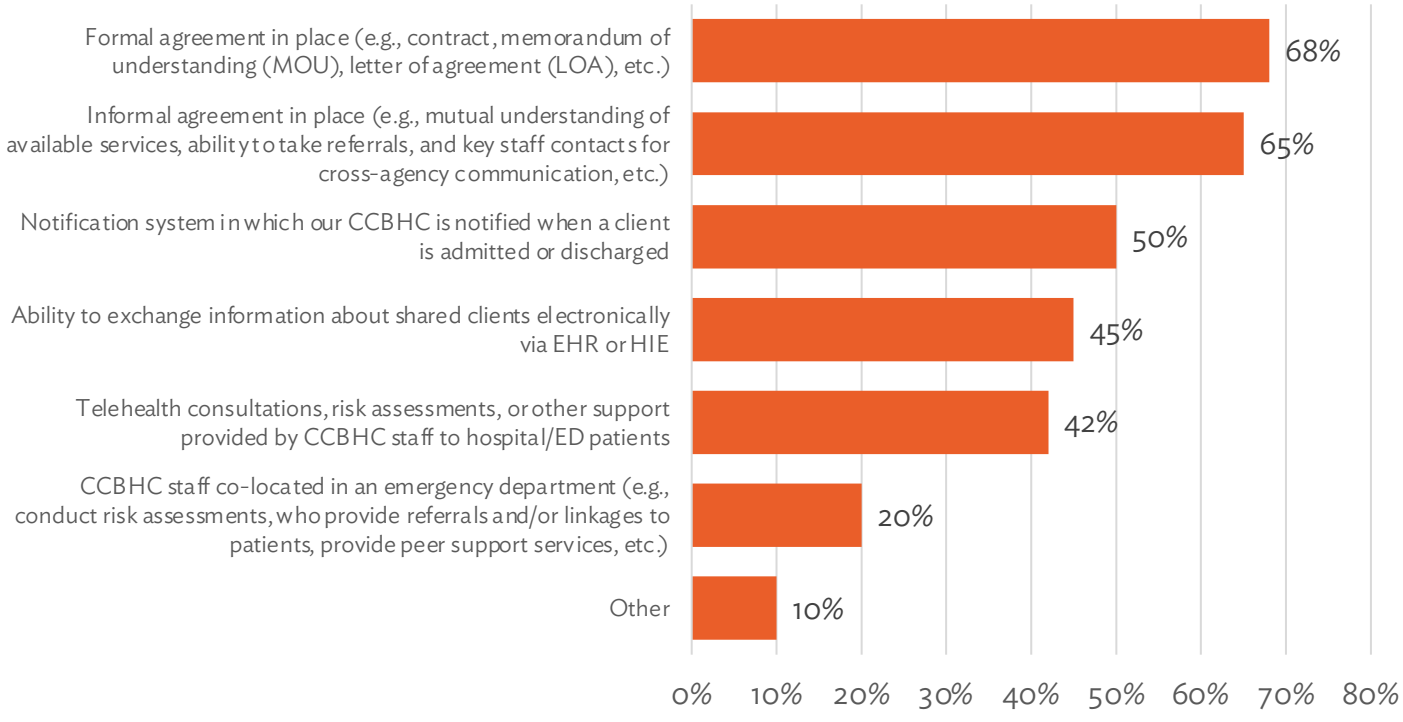
– Pacific Clinics (California)

Nearly all (**97%**) survey respondents report a number of common crisis response activities that are aimed at reducing law enforcement involvement, improving post-crisis linkages to community-based care, and more. Notably, **67%** partner with statewide, regional or local crisis call lines to take referrals for non-urgent or post-crisis care, with more than 4 in 5 (**83%**) offering post-crisis wraparound services—making CCBHCs ideal partners for 988 call centers seeking post-crisis or ongoing treatment and support options for callers in need.

Innovative Practices in Crisis Response	Percentage of participating CCBHCs
Offers post-crisis wrap around services to facilitate linkage and follow-up	**83%**
Partners with statewide, regional, or local crisis call line to take referrals for non-urgent or post-crisis care	**67%**
Has mental health and substance use provider co-respond with police / EMS	**45%**
Operates a crisis drop-in center or similar non-hospital facility for crisis stabilization	**38%**
Has mobile mental health and substance use teams respond to relevant 911 calls instead of police / EMS	**30%**
Partners with 911 to have relevant 911 calls screened and routed to CCBHC staff	**22%**
Other	**18%**

Nearly all (**98%**) CCBHCs and grantees are also working to improve collaboration with local hospitals and/or emergency departments, which can ensure individuals have a smooth transition into community-based care and reduce readmissions – either post-crisis or when hospitalization occurs for other reasons. While more than two-thirds of respondents (**68%**) have formal agreements in place with their hospital/ED partners, the near-universal adoption of these activities indicates that enhanced collaboration does not have to wait for establishment of a formal agreement.

Activities in Place With Local Hospitals and/or Emergency Departments



Despite their strides toward expanding access to timely and robust crisis services, **99%** of respondents report a number of remaining needs when it comes to their ability to participate in or coordinate with local/state crisis systems, including efforts emerging from 988 implementation. The most valuable types of support they say they need include: securing additional financing to support hiring, technology and other needs (**79%**); staff training (**64%**); stakeholder alignment such as cross-sector workgroups or local/state/national convenings (**55%**); building tools and staff capacity to leverage data (**53%**); and learning or sharing high-impact innovations (**53%**).

Partnering with Law Enforcement & Criminal Justice Agencies

Individuals living with serious mental illness or SUDs are overrepresented in the criminal justice system. Roughly **20%** of adults in America have a mental illness[20], and yet an estimated **44%** of those in jail and **37%** of those in prison have a mental illness. In addition, it is estimated that **63%** of people in jail and **58%** in prison have a substance use disorder[21]. Upon release, many individuals lose access to mental health and substance use services, which increases the likelihood of re-arrest. A recent study also indicated that "offenders with a substance use disorder were at higher risk of recidivism than offenders without a substance use disorder," making it more important that clinics work with the criminal justice system to help divert people from corrections toward community-based services[22].

Clinics have flexibility within the CCBHC model to implement programs that best meet the needs of their community within the federal criteria. The vast majority of CCBHCs and grantees (**96%**) are actively engaged in one or more innovative activities in partnership with criminal justice agencies to improve outcomes for people who have criminal legal system involvement or are at risk of being involved with the criminal legal system.

Activities Conducted in Partnership With Criminal Justice Agencies to Improve Outcomes for People who Have Criminal Legal System Involvement or are at Risk of Being Involved With the Criminal Legal System	**Percentage of participating CCBHCs**
Collaboration with court systems: Provide services or take referrals in partnership with courts	86%
Outreach and engagement: Increase outreach and / or access to individuals who have criminal legal system involvement or are at risk of being involved with the criminal legal system	77%
Training: Train law enforcement or corrections officers in Mental Health First Aid, CIT, or other mental health / SUD awareness training	65%
Re-entry support: Provide pre-release screening / referrals or engage in related activities to ensure continuity of care upon re-entry to the community from jail or prison	64%
Community supervision support: Embed services within parole / probation agencies or coordinate with these agencies	41%
Data-sharing: Initiated data or information sharing with law enforcement or local jails / prisons to support improved collaboration	36%
Technology: Provide telehealth support to law enforcement officers responding to mental health / SUD calls	33%

Outcomes of CCBHC Efforts with Local Law Enforcement

"We've had more than 386 mobile calls with a 92% inpatient diversion rate. We've also had 41 jail diversions resulting in at least $92,250 saved for the county."
– Pines Behavioral Health Services (Michigan)

"Our system created, trains, and funds Mental Health Deputy Programs in partnership with local Sheriff Offices in 4 of our 8 counties - improving our jail diversion rate from 23% to 71% over the last 4 years. [We] created a Diversion Center allowing for law enforcement to triage and drop-off individuals experiencing mental health crises so the officer may return to the community - decreasing the average length of stay waiting in emergency departments from 39 hours to 2.5 hours."
– Bluebonnet Trails Community Center, Texas

"Until July 25, 2022, all mobile crisis calls were responded to with police. Responses went to 979 in 2021 from 495 in 2020, a 98% increase that was unsustainable. Now, with additional resources and new protocols, teams consisting of peer support specialists and behavioral health therapists are responding without police as guided by the protocol. Already, we have reports of decreasing response times and police are freed up to focus on criminal activity while maintaining the safety of the clinical staff."
– Montgomery County, Maryland

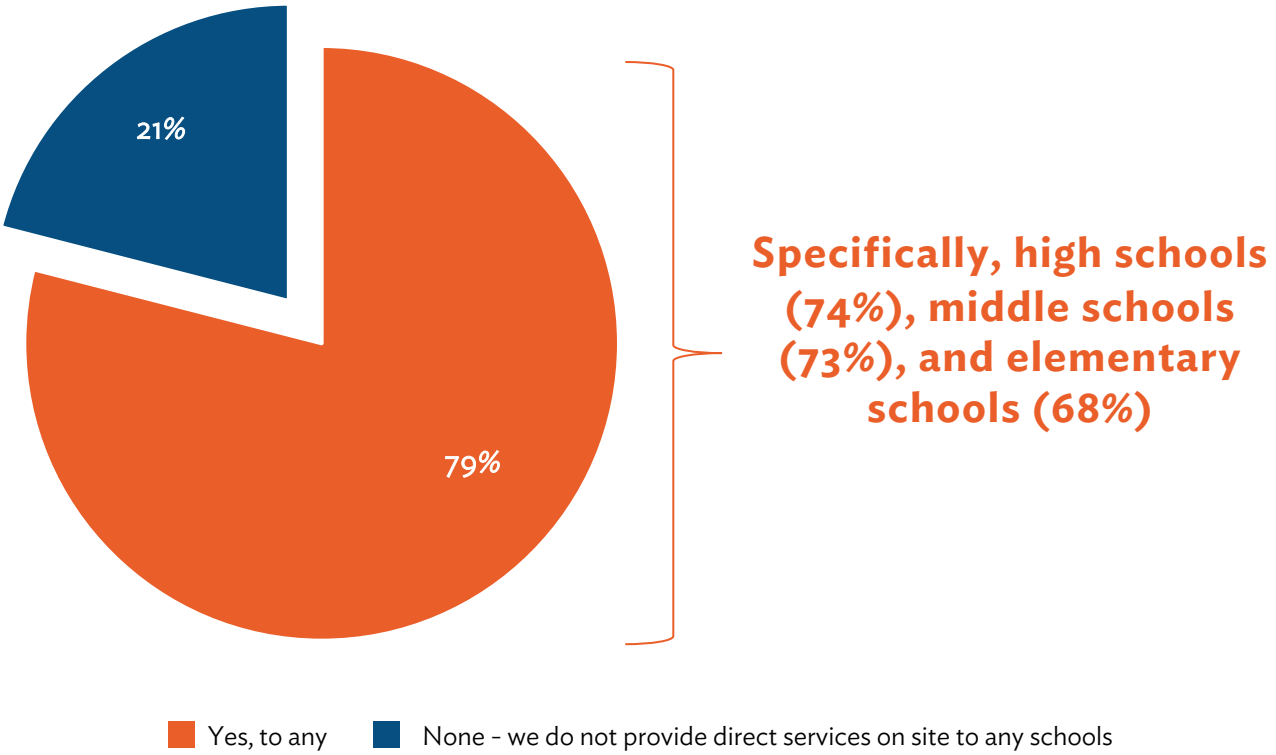
"We work with clients who have exited the prison system and are reintegrating into society with multiple requirements to maintain upon release. We partner with in our agency to support these clients with employment, housing, recovery support, and behavioral healthcare services."
– Village for Families and Children, Connecticut

Meeting Children, Youth & Families Where They Are

In December 2021, U.S. Surgeon General Vivek Murthy M.D., MDA, issued a Surgeon General's Advisory highlighting the urgent need to address the nation's youth mental health crisis. The CCBHC model supports clinics in providing comprehensive services beyond the four walls of the clinic to meet community members when and where they need care. In addition to directly providing services to children and youth, CCBHCs are partnering with schools and other social service systems to reach children, youth, and their families where they are.

The vast majority of CCBHCs and grantees (**94%**) deliver services to children and youth directly, while **8%** collaborate with a DCO for child/youth services. Notably, clinics can do both—providing some services directly while also working with a DCO for others. Nearly four in five (**79%**) offer direct services on site, across high schools (**74%**), middle schools (**73%**) and elementary schools (**68%**).

CCBHCs Providing Direct Services on Site at Schools



Addressing Health Disparities & Social Determinants of Health

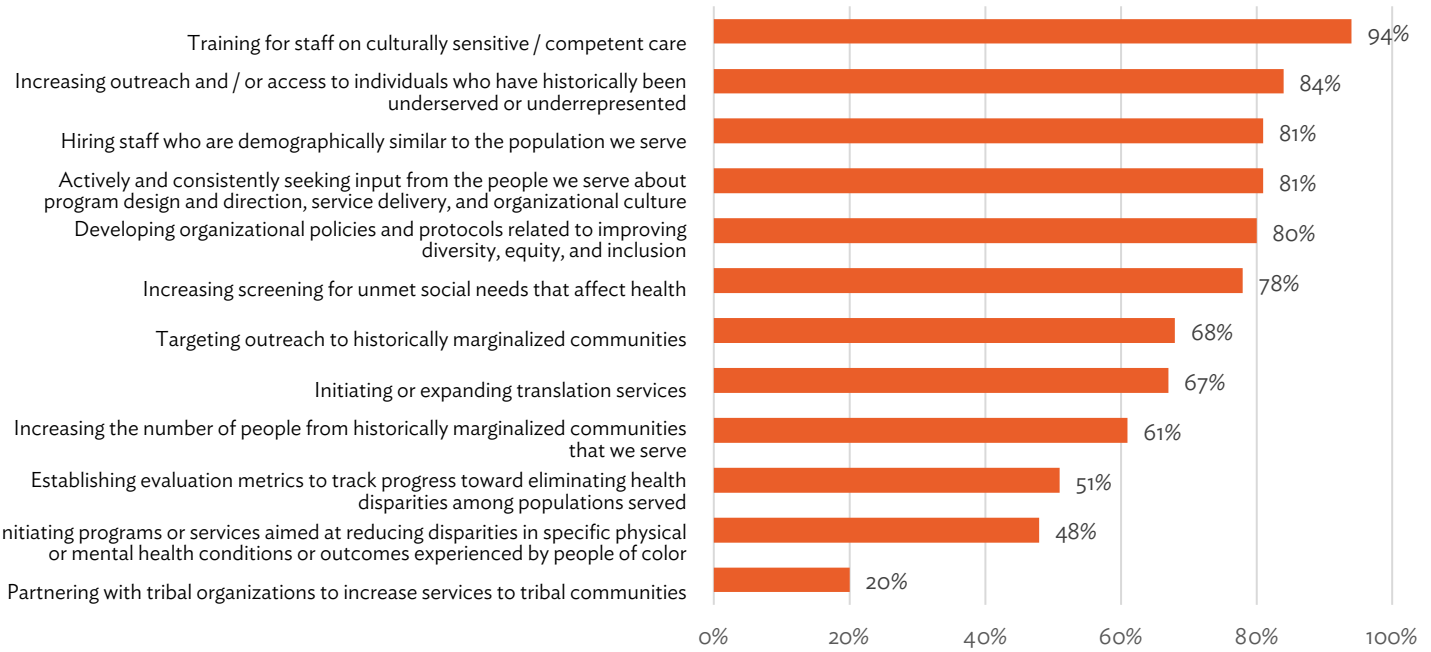
Despite some progress, inequities remain in mental health and substance use care access for Black, Indigenous, and people of color (BIPOC); Asian Americans and Pacific Islanders (AAPI); and lesbian, gay, bisexual, transgender and queer (LGBTQ+) individuals and other historically marginalized populations. The CCBHC model supports clinics in providing targeted outreach services to underserved communities and also supports clinics' data collection and evaluation activities to better understand their service delivery to underserved populations.

Since becoming a CCBHC, a large majority of organizations have initiated, continued or expanded work to improve access to care for, reduce health disparities among, and serve people of color or other historically marginalized populations.

100% OF RESPONDING CLINICS

indicate that CCBHC status has helped them in some way to serve people of color, improve access to care and reduce health disparities in their communities

Activities to Improve Access to Care, Reduce Health Disparities Among, and Serve People of Color or Other Historically Marginalized Populations



67%

report increasing outreach to have the potential to have the greatest impact for historically marginalized populations

65%

believe actively seeking input from historically marginalized populations would have the greatest impact

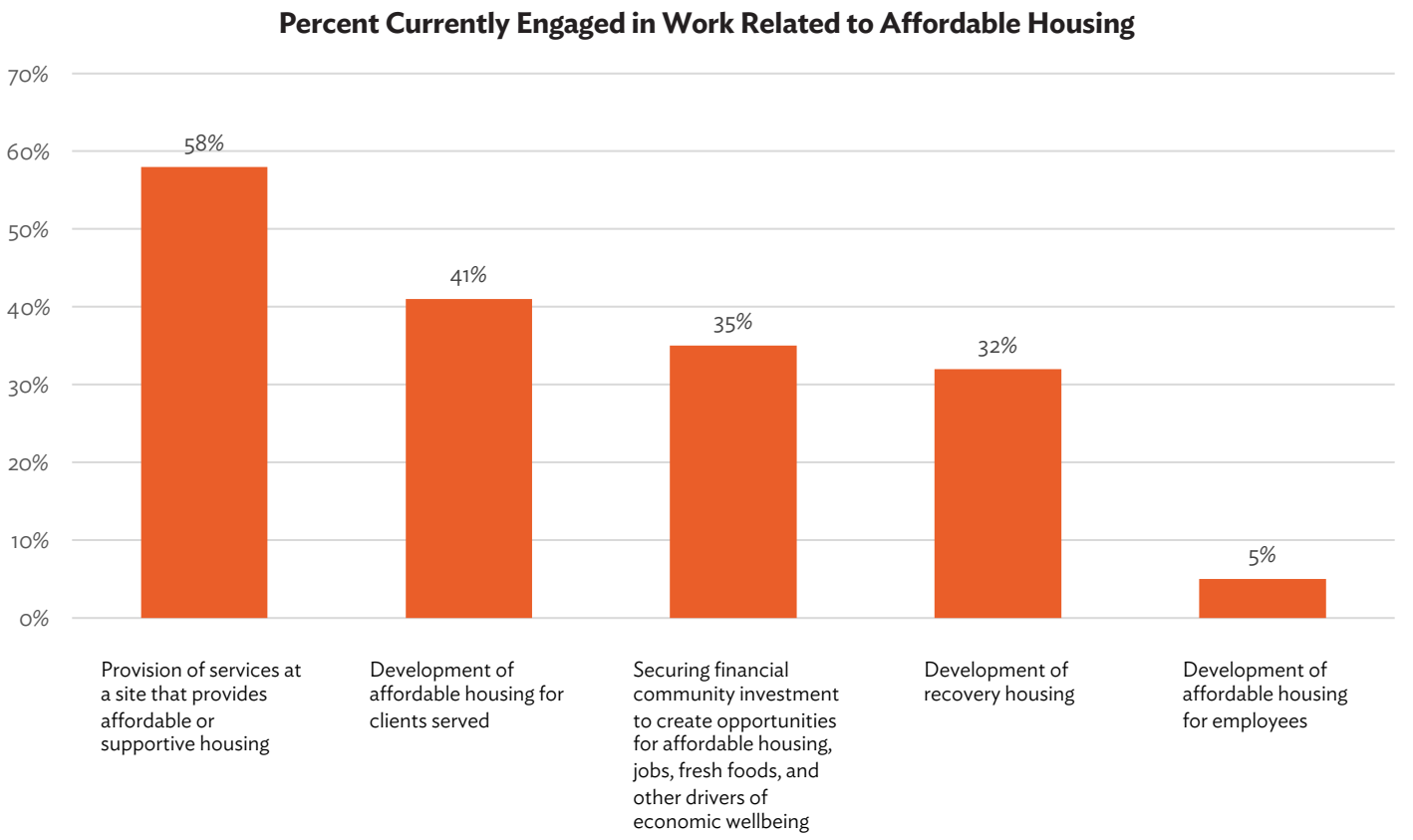
"Our CCBHC is specifically designed to serve the Hispanic Community as an underserved population- we work to ensure we have bilingual, bicultural staff to provide services, we have information and outreach materials in English and Spanish, we offer some basic needs support for those who need it, etc."
– Catholic Charities – Hartford (Connecticut)

"Our locations are embedded in areas that are primarily populated by underserved populations. This is a strategic initiative to be able to overcome some logistical barriers to access to care-transportation, etc. We are located on public transportation systems, we focus on diversity in our employees and have a dedicated team to make sure that we maintain culturally competent practices both as an employer and as an agency."
– Adult & Child Health (Indiana)

"Our CLAS committee in conjunction with our Communications Director has created/produced a variety of professional outreach materials describing all Adapt Integrated Health Care services in Spanish. We subscribe to, and utilize, remote translation service providers for live video interpretation of ASL or languages other than English, in both emergent and routine care. We are also active in developing regional LGBTQIA resource networks, and we seek to employ bilingual employees and persons of color and diversity as much as possible."
– ADAPT (Oregon)

"We utilize a culturally competent, team-based approach. All System Navigators (SNs) hired had similar backgrounds as the majority of the CCBHC consumer base (e.g., Latina, Spanish-speaking), and they provided critical initial outreach/engagement services to help consumers feel comfortable with the treatment team... We are also adjusting our training for [primary care providers] to address stigma... We regularly review data reports regarding program outcomes by race, ethnicity, and LGBT status with CCBHC clinical and management staff to identify successes and challenges."
– Greater Cincinnati Behavioral Health Services (Ohio)

Most CCBHCs and grantees are also currently engaged or planning to engage in work related to affordable housing, an important social determinant of health. More than half (**58%**) deliver services at a site that provides affordable or supportive housing, with an additional **18%** reporting they plan to do so in the future. Other common activities include development of affordable housing for clients served (**41%** currently do this and **18%** plan to); securing financial community investment to create opportunities for affordable housing, jobs, fresh foods and other drivers of economic wellbeing (**35%** currently do this and **29%** plan to); and development of recovery housing (**32%** currently do this and **18%** plan to).



Despite this, nearly all (**94%**) still face challenges in expanding access to care for historically marginalized populations. The most commonly reported barriers include stigma, discrimination, or social/cultural norms influencing willingness to seek care (**73%**) and practical barriers such as the cost of transportation, childcare coverage and limited service hours (**64%**). The survey did not solicit information on the degree to which service recipients' or community members' input informed clinics' responses to this question, meaning the results cannot provide clarity on whether they share clinics' perceptions of the greatest barriers to care. Nonetheless, these findings suggest CCBHCs and grantees continue to have work ahead of them in addressing barriers that prevent historically marginalized populations from accessing care.

By far, the organizational supports that are seen as being most needed to advance respondents' ability to address health disparities in their service area involve: securing additional financing to support hiring, technology and other needs (**67%**) and building tools and staff capacity to leverage data (**61%**).

Conclusion

CCBHCs have proven to be successful in expanding access to comprehensive mental health and substance use treatment services. The model's ability to increase access while supporting and expanding the workforce is a blueprint for the future of the behavioral health system.

SAMHSA-funded CCBHC expansion grants will continue to serve as a springboard to CCBHC implementation for countless clinics. Helping sustain and scale those efforts, the recent expansion of the CCBHC Medicaid demonstration through the Bipartisan Safer Communities Act[23] will bring the model nationwide, permanently changing how people access mental health and substance use treatment in their communities. By 2030, every state in the country will have the opportunity to join the demonstration – a transformational opportunity to bring lifesaving mental health and substance use care to millions of Americans in need.

Survey Method Statement

The research was conducted online in the United States by The Harris Poll on behalf of the National Council for Mental Wellbeing among 249 certified community behavioral health clinics (CCBHCs and grantees). The survey was conducted July 14th – August 26th, 2022.

Raw data were not weighted and are therefore only representative of the individuals who completed the survey.

Respondents for this survey were among the 449 total participating CCBHCs and grantees who were asked to participate – of which 249 participated in our survey and are included in the final results. The sampling precision of Harris online polls is measured by using a Bayesian credible interval. For this study, the sample data is accurate to within + 6.2 percentage points using a 95% confidence level. This credible interval will be wider among subsets of the surveyed population of interest.

All sample surveys and polls are subject to other multiple sources of error which are most often not possible to quantify or estimate, including, but not limited to coverage error, error associated with nonresponse, error associated with question wording and response options, and post-survey weighting and adjustments.

Endnotes

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2. Estimate based on survey responses indicating 249 respondents served 1,188,856 clients annually as of the date of the survey.

3. Estimate based on the difference between 2022 and 2021 annual client estimate.

4. Estimate based on survey responses indicating 249 respondents had 6,220 newly created staff positions as a result of becoming a CCBHC as of the date of the survey.

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6. Estimate based on survey responses indicating 249 respondents indicating 38,396 clients with SUD are currently engaged in MAT as of the date of the survey.

7. Survey conducted online by The Harris Poll on behalf of the National Council of Mental Wellbeing from April 26-28, 2022 among 2,053 adults in the U.S. ages 18+. More than 4 in 10 U.S. Adults Who Needed Substance Use and Mental Health Care Did Not Get Treatment - National Council for Mental Wellbeing (thenationalcouncil.org)

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