

NATIONAL
COUNCIL
*for Mental
Wellbeing*

HEALTHY MINDS
STRONG COMMUNITIES



CCBHC

Certified Community
Behavioral Health Clinic

LEADING A BOLD SHIFT IN MENTAL HEALTH & SUBSTANCE USE CARE

CCBHC IMPACT REPORT, 2021



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Introduction

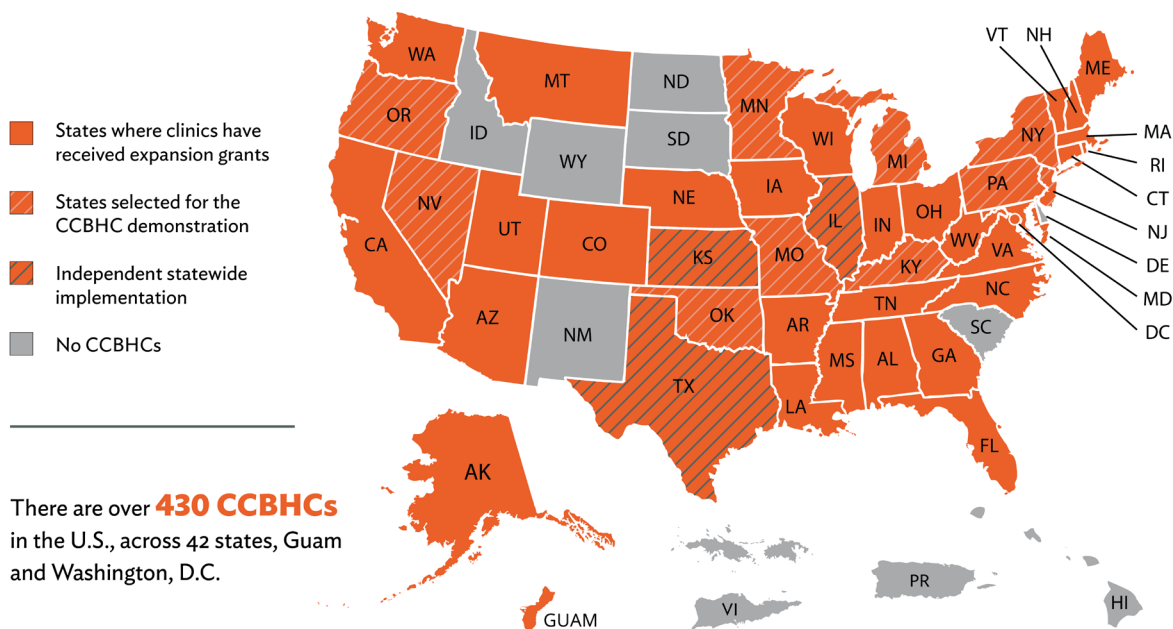
The Certified Community Behavioral Health Clinic (CCBHC) model alleviates decades-old challenges that have led to a crisis in providing access to mental health and substance use care across the nation. CCBHCs have dramatically increased access to mental health and substance use disorder treatment, expanded states' capacity to address the overdose crisis and established innovative partnerships with law enforcement, schools and hospitals to improve care, reduce recidivism and prevent hospital readmissions.

Thanks to federal and state investment, the CCBHC program has seen significant growth since its inception in 2017. **Today, over 430 CCBHCs are operating in 42 states, Washington, D.C., and Guam.**

WHAT IS A CCBHC?

A CCBHC is a specially-designated clinic that receives flexible funding to expand the scope of mental health and substance use services available in their community. CCBHCs provide care for people with unmet needs.

Status of Participation in the CCBHC Model



NOTE: This map reflects the total number of CCBHCs as of August 2021, including new clinics announced after our survey was conducted.

Since 2017, the National Council for Mental Wellbeing has regularly surveyed CCBHCs to learn more about their activities and impact.¹ Our prior surveys – as well as other published CCBHC evaluations² – have exclusively covered the CCBHC Medicaid demonstration and have been limited to the first two years of the program (2017–2019), leaving a gap in information about CCBHC expansion grantees as well as all CCBHCs' activities in the last two years.

This report contains data collected from CCBHCs that were active as of January 2021, covering 128 of 224 sites and including both demonstration sites as well as CCBHC Expansion grantees.³



CCBHCs' Impact at a Glance

EXPANDING ACCESS TO CARE

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

- **851,565 people** currently served across 128 responding clinics, with an estimated **1.5 million people** served nationwide by all 224 CCBHCs active as of January 2021.⁴
- CCBHCs are, on average, serving **17% more people** than prior to CCBHC implementation.

DECREASING WAIT TIMES FOR CARE

CCBHCs have improved access to treatment by sharply reducing wait times for services, which reach an average of 48 days nationwide.⁵

- **50%** of responding CCBHCs provide **same-day access** to care.
- **84%** see clients for their first appointment **within one week**.
- **93%** see clients **within 10 days**.

INVESTING IN THE WORKFORCE

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

- Responding clinics hired **5,201 new staff positions** as a result of becoming a CCBHC, with an **estimated 9,000 new staff positions** added across all active CCBHCs as of January 2021.⁶
- On average, this resulted in **41 new jobs per clinic**.

EXPANDING ACCESS TO MEDICATION-ASSISTED TREATMENT

CCBHCs are addressing the nation's opioid crisis by dramatically expanding access to medication-assisted treatment (MAT), the "gold standard" in substance use care.⁷

- **89% of CCBHCs offer one or more forms of MAT**, compared to only 56% of substance use clinics⁸ nationwide.
- An estimated **37,000+ clients nationwide are engaged in MAT** across the CCBHCs that were active at the time of this survey.
- **60% of clinics added MAT services for the first time** as a result of becoming a CCBHC, and **31% were able to offer more forms of MAT** after CCBHC implementation than before.



MAKING CRISIS SERVICES AND SUPPORTS AVAILABLE TO ALL

All responding CCBHCs deliver crisis support services in their communities, helping to divert people in crisis from hospitals, emergency departments and jails.

- **91% of CCBHCs** are engaging in one or more innovative practices in crisis response in partnership with hospitals, first responders and others.
- **79% coordinate with hospitals and emergency departments** to prevent avoidable admissions when individuals are in crisis.

IMPROVING COLLABORATION WITH CRIMINAL JUSTICE AGENCIES

CCBHCs are required to work with law enforcement agencies and other criminal justice partners to reduce incarceration and improve crisis response.

- **95% of CCBHCs** are engaged in one or more innovative practices in collaboration with law enforcement and criminal justice agencies (e.g., police, jails and courts).

ADDRESSING HEALTH DISPARITIES

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

- **75% of CCBHCs** reported increasing screening for unmet social needs that affect health, like housing, income, insurance status, transportation and more.



Expanding Timely Access to Care

The nation's crisis in access to mental health and substance use care is well documented, with large majorities of Americans in need of services unable to access them each year.⁹ CCBHCs are closing this treatment gap by expanding the number of clients they serve and decreasing wait times. Expanding caseloads and reducing barriers to accessing care is particularly critical during the COVID-19 pandemic, when the Centers for Disease Control and Prevention (CDC) has reported “considerably elevated” levels of need for mental health and substance use services.¹⁰

Notably, status as a Medicaid demonstration CCBHC appears to be correlated with significant caseload increases. Demonstration sites saw a 41% increase in client caseloads after CCBHC implementation compared to a 10% increase in caseloads among clinics receiving their CCBHC funding solely through SAMHSA expansion grants. Among the factors that may contribute to this difference: 1) demonstration sites have been operating for longer than grantees (four years for the demonstration sites compared to one-to-two years for grantees), giving them more time to engage new clients in care and 2) the Medicaid prospective payment system (PPS) available to demonstration sites can more readily flex to support expanded caseload capacity.

851,565 CLIENTS

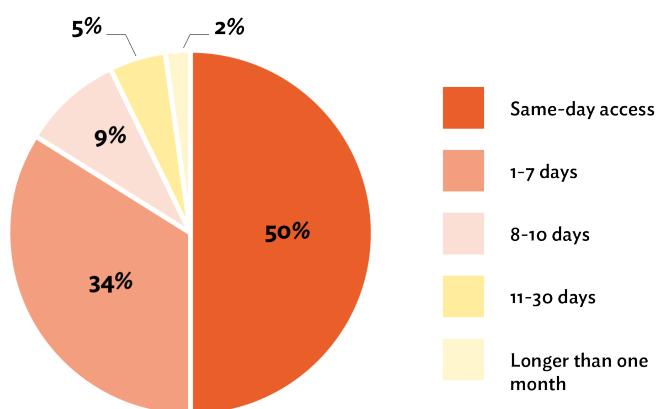
are currently served by 128
responding CCBHCs

Estimated

1.5 MILLION

people currently served across
all 224 active CCBHCs¹⁸

Wait Times at CCBHCs From Initial Outreach
or Referral to First Appointment



With mental health and substance use services in increasingly high demand across the nation, CCBHCs are leading the way in decreasing wait times for individuals to access care. The national average length of time between a client's first outreach or referral until their first mental health or substance use appointment is 48 days.⁵ **In contrast, 93% of surveyed CCBHCs report being able to see clients for their first appointment within 10 days of their outreach, as required by the CCBHC standards.** Half of the surveyed CCBHCs provide same-day access to care and 84% see clients within one week.

These reductions in wait times to access care are one of the major successes in the CCBHC program, described as “earth-shattering in the mental health world” and “facilitat[ing] consumer engagement from the outset,” contributing to improved outcomes.



Investing in the Workforce

With the nation in the throes of a mental health and substance use workforce shortage,¹² 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. CCBHCs have leveraged their grant funding and/or Medicaid payment structure to train, recruit and retain highly qualified staff. The 128 CCBHC survey respondents reported that **5,201 total staff were hired as a result of becoming a CCBHC**, representing an average of 41 new positions per clinic.

Demonstration sites were able to hire many more staff members than expansion grantees: demonstration sites hired an average of 117 new staff positions each, with a median of 43; while expansion grantees hired an average of 19 new staff, with a median of 16. As with the expansions in client caseloads, these differences are likely due to the difference in funding mechanisms. Medicaid PPS enables demonstration sites to establish a forward-looking payment rate that supports anticipated hiring and offers security to clinics that new hires will not have to be laid off after the end of a grant period.

5,201 STAFF HIRED

as a result of becoming a CCBHC

Estimated
9,000 STAFF HIRED

across all 224 active CCBHCs¹⁸

41

NEW POSITIONS PER CLINIC

on average since becoming a CCBHC



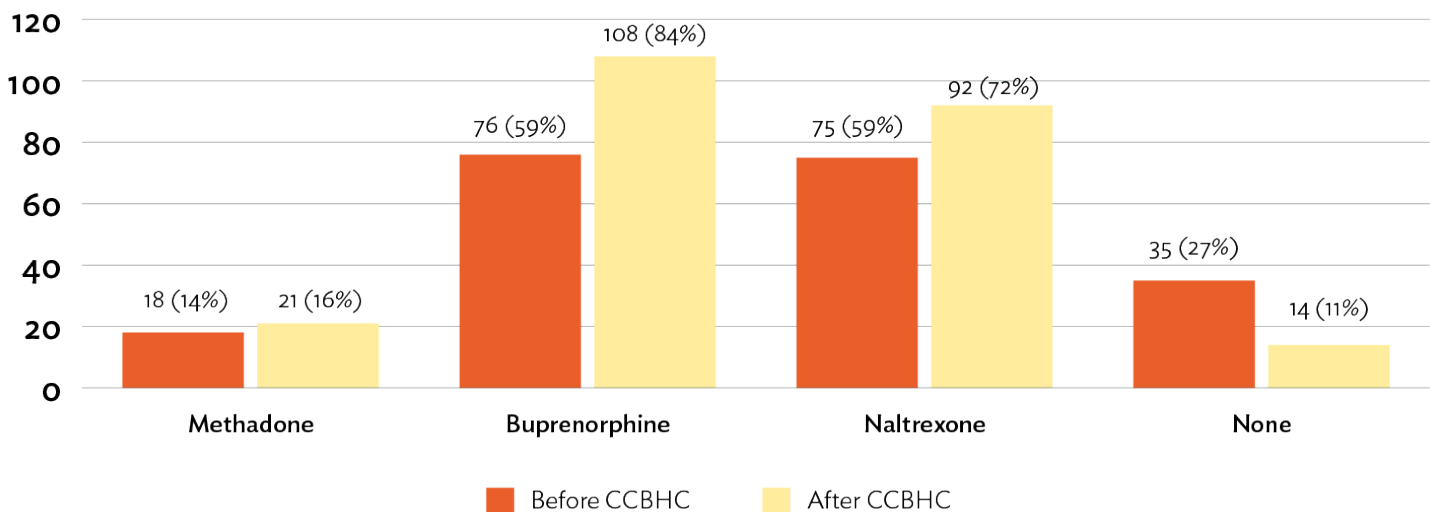
“CCBHC status has afforded us the ability to hire health care coordinators to bridge the gap in care between physical health and behavioral health. Their services are not typically billable in a traditional behavioral health space. Having these staff during the pandemic has been instrumental in helping our consumers navigate their health care needs in a new way, as well as ensure they have the support from primary care if exposed to COVID-19 etc. Our population has historically been underserved by the health care system. **So having these staff onboard to help ensure we are paying attention to clients' entire wellbeing and helping break barriers during a time of rapid change in the system has been invaluable.**” — *Lifeworks NW (Oregon)*



Expanding Access to Medication-assisted Treatment Services

In response to the ongoing opioid crisis that is predicted to result in 90,000 overdose deaths in 2020,¹³ substance use treatment is a core component of CCBHCs' required service array. Because of the CCBHC program, participating clinics have implemented major expansions of the substance use treatment services available to all community members. As a result, nearly all CCBHCs have increased the number of patients with substance use disorders they serve, either by taking on new patients, improving screening protocols to identify at-risk substance use among existing patients, or both.¹⁴

Opioid Use Disorder Medications Offered

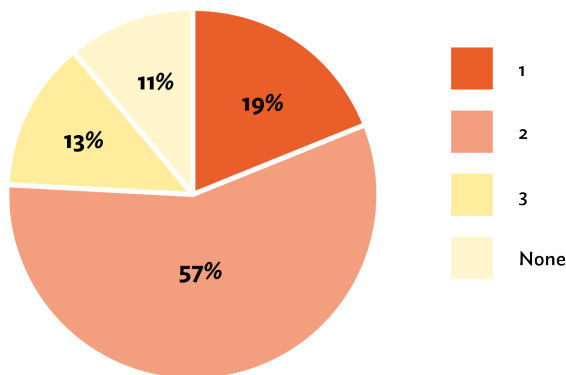


NOTE: Respondents could select multiple options – percentages do not total 100%. Of the 14 respondents that do not offer OUD medications following CCBHC status, 71% received their grant funding in 2020 and are in the process of fully implementing their programs, meaning the percent of CCBHCs offering MAT is likely to rise in the future. Typically, organizations that do not directly offer MAT will establish a partnership with a local MAT provider,¹⁵ ensuring universal access to MAT for all CCBHC clients.

Among their major advances in expanding access to substance use care, CCBHC status has supported clinics in increasing their capacity to provide MAT, a highly effective substance use treatment that combines the use of medications with cognitive and behavioral therapies. MAT is the gold standard for treating opioid use disorder (OUD). **Sixty percent of responding clinics added MAT services for the first time as a result of becoming a CCBHC. Additionally, 31% of all responding clinics were able to offer more forms of MAT after CCBHC implementation than before.**



How Many MAT Options Does Your Clinic Offer After Implementing the CCBHC Model?



This increase in MAT options at CCBHCs far surpasses the current national benchmark. Among organizations that provide substance use disorder treatment to individuals receiving health coverage through Medicaid, only **56% offer any form of MAT, compared to 89% of responding CCBHCs**. Only 7% of those organizations offer all three forms of MAT, compared to 13% of CCBHCs.¹⁶

Across the 128 responding CCBHCs, 21,162 clients with substance use disorders (SUDs) are currently engaged in MAT. **The National Council estimates that more than 37,000 CCBHC clients nationwide are engaged in MAT across the CCBHCs that were active at the time of this survey.** These numbers continue to grow with the expansion of the CCBHC model to more clinics. In a prior National Council survey, an estimated 9,144 patients were engaged in MAT at a CCBHC as of November 2018.¹⁷ **Of responding CCBHCs, 55% saw an increase in the number of clients engaged in MAT after CCBHC implementation.**

21,162 CLIENTS

with substance use disorder
currently engaged in MAT across
responding clinics

Estimated
37,000 CLIENTS

nationwide to be engaged in MAT
across all 224 active CCBHCs.¹⁸



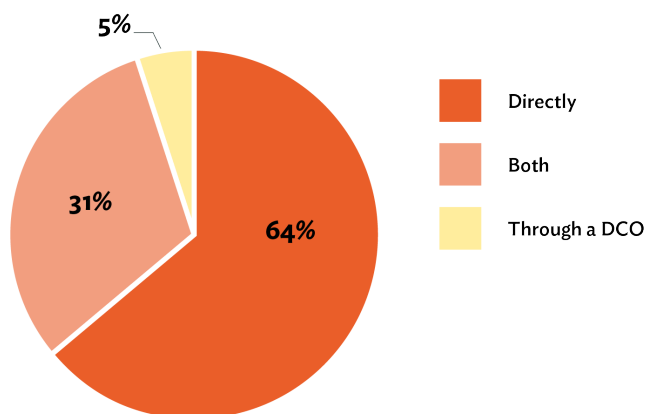
Making Crisis Services and Supports Available to All

Recognizing the critical importance of crisis response in alleviating pressures on the health care and criminal justice systems, a number of crisis response activities are among the core set¹⁹ of federally required CCBHC services. Clinics have the option to provide 24/7 crisis response care directly via internal staff, or contract with another local agency called a designated collaborating organization (DCO) to meet this requirement. Clinics are developing innovative partnerships with emergency departments, local law enforcement and more to ensure that community members have access to support services when they experience a mental health or substance use crisis 24 hours a day, 7 days a week.

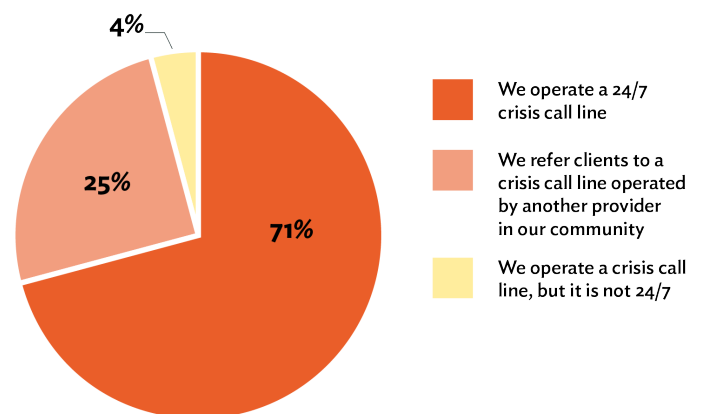
To meet the CCBHC requirements, 64% of respondents provide crisis services directly through their organization, 5% contract exclusively with a designated collaborating organization and 31% provide some services directly and partner with a DCO to provide the rest of the required services.²⁰

Many CCBHCs go above and beyond the required services to provide access to crisis call lines that community members can contact to de-escalate their mental health or substance use crisis and/or receive dispatched services to meet them where they are. **One hundred percent of responding CCBHCs either operate a crisis line themselves or are able to refer individuals to another crisis line within the community.**

How CCBHCs deliver crisis services



Crisis Call Lines Offered by CCBHCs





Clinics have flexibility within the CCBHC model to implement programs that best meet the needs of their community within **the federally mandated requirements.**²¹

Ninety-one percent of CCBHCs are engaged in one or more innovative practices in crisis response:

Innovative Practices in Crisis Response	Percentage of participating CCBHCs
Coordinates with hospitals/emergency departments to support diversion from emergency departments and inpatient care	79%
Behavioral health provider co-responds with police/EMS (e.g., clinician or peer embedded with first responders)	38%
Operates a crisis drop-in center or similar non-hospital facility for crisis stabilization (e.g., 23-hour observation)	33%
Member of the National Suicide Prevention Lifeline network	21%
Mobile behavioral health team responds to relevant 911 calls instead of police/EMS (e.g., CAHOOTS or similar model)	19%
Partners with 911 to have relevant 911 calls screened and routed to CCBHC staff	13%



“In just the first 72 days of [CCBHC] operations, our team did 50 hospital diversions, six arrest diversions, had direct contact with 95 people and reached out to 89 more. Hospital emergency department visits are estimated at \$500 per visit and an admission at \$10,000 so we estimate **we saved at least \$372,500** for just the hospital diversions if approximately 70% were admitted. **Annually that would work out to approximately \$1.8 million in savings.** Additional savings to the system were realized from the six arrest diversions as well in the first few weeks of the program and measurement period.” — **Endeavor Health Services (New York)**

“We have **prevented over 1,000 visits yearly to area emergency rooms** by providing psychiatric medication bridges for persons in care with external psychiatric providers, who otherwise would have gone to the emergency department to get a temporary medication bridge.”
— **Access: Supports for Living (New York)**

“We have more than 20 care coordination agreements in place, which has led to **greater than 50% diversion rate from jail** when mobile response happens.” — **Seasons Center (Iowa)**



Partnering with Law Enforcement & Criminal Justice Agencies

Individuals living with serious mental illness or SUDs are overrepresented in the criminal justice system, typically for non-violent crimes or low-level offenses, suggesting that lack of access to treatment for serious mental illness (SMI) and SUD is a factor in incarceration risk. Upon release, many individuals lose access to mental health and substance use services, which increases the likelihood of re-arrest.

CCBHCs are creating cutting-edge partnerships with their local law enforcement and criminal justice agencies to meet this need for crisis intervention and diversion from corrections.

95% of CCBHCs are engaged in one or more innovative practices in collaboration with law enforcement (LE) and criminal justice (CJ) agencies:

Innovative Practices in LE & CJ Collaboration	Percentage of participating CCBHCs
Specialty courts: Participate in mental health court, drug court or veterans' court	76%
Training: Train law enforcement or corrections officers in Mental Health First Aid (MHFA), Crisis Intervention Team (CIT) or other mental health/SUD awareness training	72%
Care coordination: Provide pre-release screening, referrals or other activities to ensure continuity of care upon re-entry to the community from jail	70%
Enhanced outreach and service delivery: Increased outreach and/or access to individuals who have criminal legal system involvement or are at risk of being involved with the criminal legal system	63%
Data-sharing: Initiated data or information sharing with law enforcement or local jails to support improved collaboration	34%
Co-response: Embed a clinician or peer support specialist with law enforcement officers responding to mental health/SUD calls, to provide onsite support	32%
Technology: Provide telehealth support to law enforcement officers responding to mental health/SUD calls (via tablets/iPads or other mechanisms)	20%



“We have a qualified mental health practitioner in the jail, and in the year after she was placed there, the jail **reduced their admissions to inpatient mental health from over 100 the previous year to zero.**”

— ***Family Guidance Center (Missouri)***

“Due to ensuring local law enforcement officers have direct access to our 24/7 crisis center, unnecessary emergency department visits have been curtailed. Officers spend less time in transit and less time waiting in emergency departments. **Our 24/7 crisis units have decreased need for psychiatric inpatient hospitalization by 93%.**”

— ***Grand Lake Mental Health Center (Oklahoma)***

“Crisis Intervention Team (co-response unit consisting of police officers and mental health professionals responded to behavioral health related 911 calls or other events) from March 2020–December 2020: Total number of individuals served: 2,557, total number of encounters: 2,989, **hospital diversion rate: 63%, jail diversion rate: 98%.**”

— ***Emergence Health Network (Texas)***

“Red Rock Drug Court programs served over 280 participants and provided over 18,193 services. The program averaged more than **11% decrease in the number of arrests within the past month.**”

— ***Red Rock Behavioral Health Services (Oklahoma)***

“Since October 2020, the recidivism rates were as follows for the three county jails in our tri-county area: **Eaton: 5.7%, Clinton: 20.8% and Ingham: 9.5%.** This is compared to the national recidivism rate of 83% within nine years following release from a state prison.”

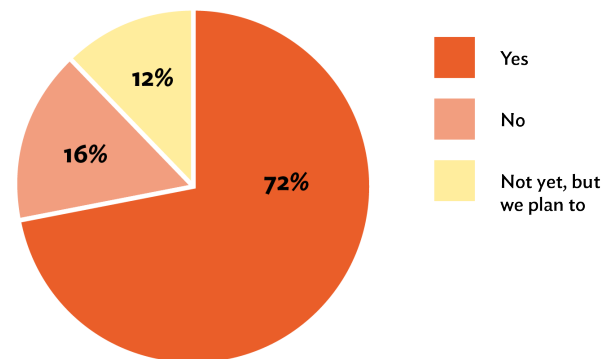
— ***Community Mental Health Authority of Clinton, Eaton and Ingham Counties (Michigan)***



Meeting Children, Youth & Families Where They Are

Many communities have segmented mental health and substance use treatment services with various agencies, meeting narrow needs for specific populations. 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. CCBHCs are building partnerships with a number of social service systems to reach children, youth and their families in schools-based settings and beyond. With rising levels of need among young people, schools are an important place to engage them and their families to offer services and supports.

CCBHCs Providing Direct Services On Site at Elementary, Middle and High Schools



84% OF CCBHCS

either already provide direct services on site at elementary, middle and high schools or plan to in the future

63%

engage in suicide prevention programming targeted to children, youth and/or teens

42%

provide Mental Health First Aid training to middle or high school teachers/staff

20%

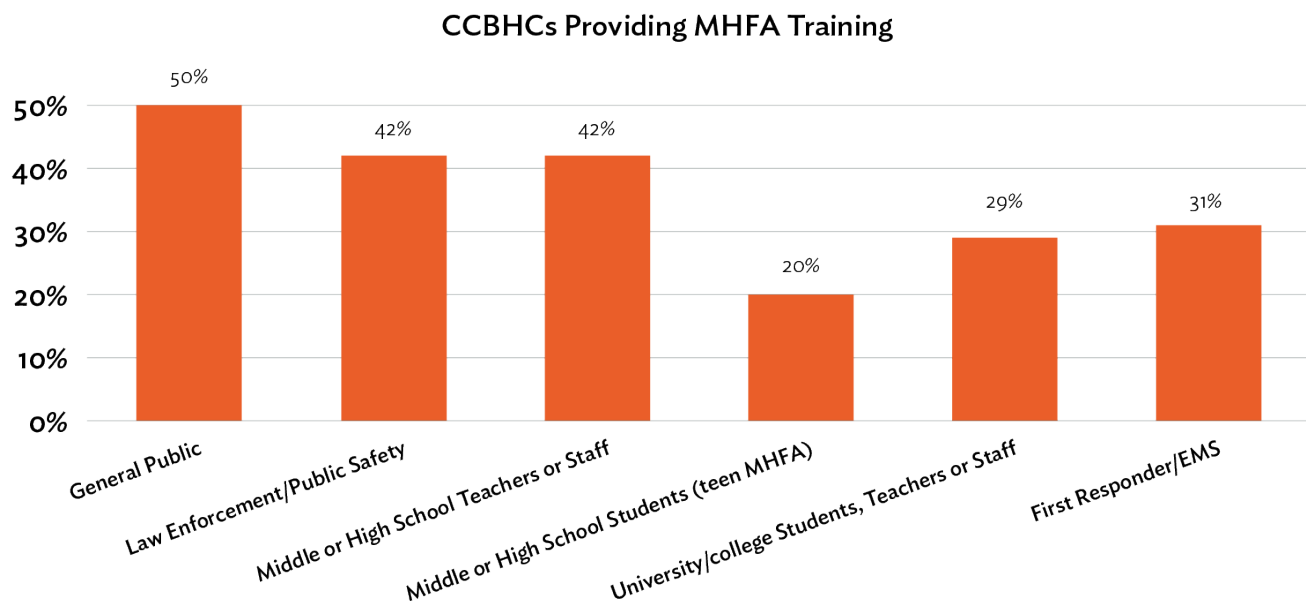
provide Mental Health First Aid training to middle or high school students



Engaging Communities to Raise Awareness

Mental Health First Aid (MHFA)²² is a course that teaches community members how to identify, understand and respond to signs of mental illness and substance use disorders. The training gives individuals the skills they need to reach out and provide initial help and support to someone who may be developing a mental health or substance use problem or who is experiencing a crisis. This public education program has the added benefit of helping trainees learn about resources available in their communities and assists training organizations to build partnerships with other agencies and organizations that work with individuals in need of mental health and substance use care. CCBHCs are extending their reach beyond the four walls of the clinics and providing this evidence-based training to various audiences while building these partnerships to improve their communities' wellbeing.

57%
OF RESPONDING CCBHCS
offer at least one form of
MHFA training to members of
their communities.



NOTE: Respondents could select multiple options – percentages do not total 100%.

CCBHCs also mentioned providing Mental Health First Aid training to veterans and veterans service organizations, religious organizations such as churches, local government officials and private companies.



Addressing Health Disparities & Social Determinants of Health

Despite some progress, inequities remain in mental health and substance use access and supports for Black, Indigenous, People of Color (BIPOC), lesbian, gay, bisexual, transgender and queer (LGBTQ+) individuals and other underserved populations. Racism, discrimination and other social determinants of health too often determine individuals' access to care and dictate the quality of that care. CCBHC status supports clinics in providing targeted outreach services to underserved communities, creating internal policies to uplift BIPOC and LGBTQ+ staff members and clients, increasing wrap-around supports for individuals with unmet social needs and more to begin addressing these disparities. The financial flexibility that CCBHCs receive also supports clinics' data collection and evaluation activities to better understand their service delivery to underserved populations, which can help focus hiring and recruitment efforts on building a staff that more closely aligns with the demographics in the communities they serve.

Other common activities aimed at reducing health disparities include: expanding services to veterans, Native Americans and Latino communities; increasing diversity among leadership; developing partnerships with other community entities; providing services in homeless shelters; providing cultural competency training for staff; and more.

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

75%

increased screening for unmet social needs that affect health, like housing, income, insurance status, transportation and more

67%

developed organizational policies and protocols related to improving diversity, equity and inclusion

60%

hired staff who are demographically similar to the populations their clinics serve

53%

initiated or expanded translation services



“CCBHC status has allowed us to make **unprecedented progress in public education, destigmatizing mental illness and increasing awareness** about access to care. This is a very understated advantage of CCBHC because access to care is meaningless without awareness of that access.” — **Burrell Behavioral Health (Missouri)**

“Becoming a CCBHC allowed us to **hire staff who reflect the communities that we serve**. The ability to have peer advocates, family peer advocates, targeted case managers, as well as the ability to hire more counselors opened our agency to many more consumers. We were also able to enact rapid access to treatment so all our consumers can get the help they need as soon as they need it. The ability to hire nurses and their aid in helping our consumers manage health monitoring has been invaluable, making the CCBHC a ‘one stop shop’ for physical and behavioral health needs.” — **BestSelf Behavioral Health (New York)**

“We established a **pay differential for bilingual providers** after recognizing we were underserving consumers identified as being of Hispanic ethnicity. We also formed a **new partnership with the Veterans of Foreign Wars** and developed a CCBHC workgroup focused on cultural competency.”
— **Four County Mental Health Center, Inc. (Kansas)**

“We host an annual Central Texas African American Family Support Conference to promote health and wellness in the community. Integral Care also launched the Diversity Council 2020 – 2022 priorities and evaluation plan, with **goals related to the provision of culturally competent and trauma-informed care** that fits the unique needs of people from different backgrounds and cultures and **recruiting and retaining a workforce that reflects the communities we serve**. As a result of CCBHC expansion grant funds, Integral Care hired a population health administrator in 2019 to focus on developing data profiles of individuals and subpopulations based on factors such as high-risk health behaviors, physical and mental health diagnoses, social determinations of health and cost of care across the health continuum.” — **Integral Care (Texas)**

“We established an **LGBTQ+ workgroup** that identifies methods to reduce trauma for patients and provide a more inviting space.” — **Helio Health, Inc. (New York)**

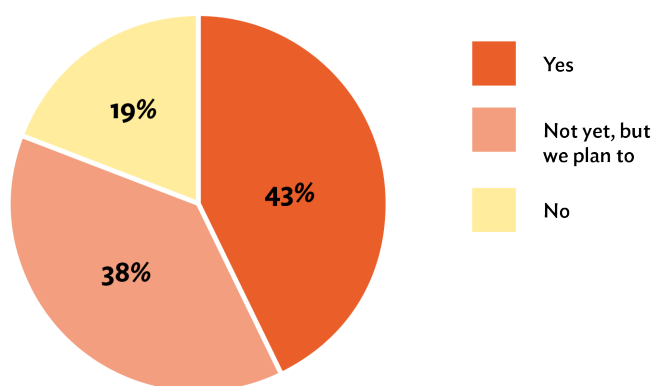


Paving the Way for Value-based Mental Health & Substance Use Financing

Across the country, states and health care payers are increasingly moving away from fee-for-service payment systems toward value-based payment (VBP) arrangements, which incentivize high-quality, cost-effective care. While this shift has been slower for mental health and substance use services,²³ the CCBHC model has begun laying the groundwork for this movement.

Due to historical funding constraints, the mental health and substance use systems have lacked the ability to develop infrastructure to support participation in VBP arrangements. The CCBHC payment structure has provided financial support and programmatic requirements that build the foundation for participation in VBP arrangements. Clinics receiving CCBHC funding have been upgrading their electronic health record (EHR) systems, improving their knowledge of and ability to report on costs of care, improving data collection, increasing interoperability of electronic systems and data sharing with other community partners and stakeholders.²⁴

CCBHCs - Negotiating PPS or Alternative Payment Models w/ Private Payers



The PPS included in the CCBHC demonstration incorporates elements of VBP such as quality incentive payments, payments stratified by population risk and some states have moved toward embedding elements of downside risk in their payment model to further advance along the continuum of VBP.

While the field at large remains in the early stages of moving toward VBP, survey data indicate CCBHCs are leveraging the model and the supports it provides to establish innovative payment models with payers. Additional research is needed in this space and the National Council will continue to survey CCBHCs to better understand these shifts.



Endnotes

- 1 Previous National Council CCBHC data collection efforts are reflected in the following reports: [Hope for the Future: CCBHCs Expanding Mental Health and Addiction Treatment](#) (2020); [Data Highlights: Certified Community Behavioral Health Clinics](#) (2019); [CCBHCs: Bridging the Addiction Treatment Gap](#) (2018); [CCBHC Demonstration: Early Results Show Expanded Access to Care, Increased Scope of Services](#) (2017).
- 2 Evaluations from the U.S. Department of Health and Human Service Assistant Secretary for Planning and Evaluation include the following: [Implementation Findings from the National Evaluation of the Certified Community Behavioral Health Clinic Demonstration](#) (2020); [Preliminary Cost and Quality Findings from the National Evaluation of the Certified Community Behavioral Health Clinic Demonstration](#) (2020); [Certified Community Behavioral Health Clinics Demonstration Program: Report to Congress](#) (2019); [Certified Community Behavioral Health Clinics Demonstration Program: Report to Congress](#) (2018).
- 3 The survey was administered to the 224 CCBHCs across 33 states that were active demonstration sites, grantees or state-certified CCBHCs as of January 2021. Survey responses were collected from January through March 2021, with 128 CCBHCs from 31 states submitting responses, for a response rate of 57%. Among respondents, 22% were CCBHC demonstration sites and 78% were CCBHC Expansion grantees. Organizations that were both demonstration sites and grantees are categorized as demonstration sites in this analysis, since they benefit from the demonstration's prospective payment rate. Respondents' length of time in the CCBHC program varied; demonstration sites have been active CCBHCs since 2017, whereas grantees may have received their initial year of funding in 2018, 2019 or 2020.
- 4 Estimate based on survey responses indicating 128 respondents served 851,565 clients as of the date of the survey.
- 5 Interview with Joy Fruth, Lead Process Change Consultant, MTM Services. (May, 2021). Data extracted from 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.
- 6 The 128 survey respondents identified 5,210 new staff positions. Estimate is based on all 224 active CCBHCs at the time of the survey.
- 7 Medication-assisted Treatment of Opioid Use Disorder: Review of the Evidence and Future Directions. (March/April, 2015). Retrieved from https://journals.lww.com/hrpjournal/Fulltext/2015/03000/Medication_Assisted_Treatment_of_Opioid_Use.2.aspx
- 8 Opioid & Health Indicators Database (2021). Retrieved from https://opioid.amfar.org/indicator/Med_AMAT_fac
- 9 A [2018 survey](#) from the National Council for Mental Wellbeing and the Cohen Veterans Network estimates that 141 million American adults (56%) have sought or wanted to seek mental health treatment either for themselves or for a loved one. Additionally, 53 million (21%) have wanted to see a mental health care professional for themselves at some point, but were unable to for reasons outside of their control, including high costs, insufficient insurance coverage, limited options, long wait times and more.
- 10 Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24–30, 2020. (August, 2020). Retrieved from <https://www.cdc.gov/mmwr/volumes/69/wr/mm6932a1.htm>
- 11 Implementation Findings from the National Evaluation of the Certified Community Behavioral Health Clinic Demonstration (September, 2020). Retrieved from <https://aspe.hhs.gov/system/files/pdf/263986/CCBHCImpFind.pdf>
- 12 As of April 2021, the [Health Resources and Services Administration \(HRSA\) estimates](#) that 124 million Americans live in areas where there are not enough mental health treatment providers to meet the need for treatment, known as health provider shortage areas (HPSAs). Almost 6,500 practitioners would be needed to fill those gaps in treatment. Some of these gaps are likely to grow in the coming years with HRSA projecting a nationwide shortfall of over 12,500 adult psychiatrists and over 11,500 substance use counselors by the year 2030.



- 13 Vital Statistics Rapid Release: Provisional Drug Overdose Count Deaths. (April, 2021). Retrieved from <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm>
- 14 Bridging the Addiction Treatment Gap: Certified Community Behavioral Health Clinics (August, 2019). Retrieved from <https://www.thenationalcouncil.org/wp-content/uploads/2019/09/CCBHC-Addictions-Treatment-Impact-survey-report-updated-8-29-19.pdf?daf=375ateTbd56>
- 15 For example, the formal evaluation of the CCBHC demonstration conducted by the Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, found that 92% of CCBHC demonstration sites offered MAT either directly or through a “Designated Collaborating Organization,” 53% had a formal relationship with a MAT provider in their community and 38% had an informal relationship with a MAT provider in their community. Source: Implementation Findings from the National Evaluation of the Certified Community Behavioral Health Clinic Demonstration. (September, 2020). Retrieved from <https://aspe.hhs.gov/system/files/pdf/263986/CCBHCImpFind.pdf>
- 16 Opioid & Health Indicators Database (2021). Retrieved from https://opioid.amfar.org/indicator/Med_AMAT_fac
- 17 Hope for the Future: CCBHCs Expanding Mental Health and Addiction Treatment (March, 2021). Retrieved from <https://www.thenationalcouncil.org/wp-content/uploads/2020/03/2020-CCBHC-Impact-Report.pdf?daf=375ateTbd56>
- 18 National Council projection based on numbers reported by 128 of 224 responding clinics.
- 19 Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics (May, 2016). Retrieved from https://www.samhsa.gov/sites/default/files/programs_campaigns/ccbhc-criteria.pdf
- 20 Note: Respondents had the option to provide further context for their answer to this question in a free-response section. Respondents who mentioned that they contract with an organization to provide crisis line services were grouped into the “we operate a 24/7 crisis line” and “we operate a crisis line, but it is not 24/7” categories as appropriate.
- 21 Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics. (2015). Retrieved from: https://www.samhsa.gov/sites/default/files/programs_campaigns/ccbhc-criteria.pdf
- 22 Mental Health First Aid Website. <https://www.mentalhealthfirstaid.org/>
- 23 Behavioral Health Provider Participation in Medicaid Value-based Payment Models: An Environmental Scan and Policy Considerations (September, 2019). Retrieved from <https://www.thenationalcouncil.org/wp-content/uploads/2019/09/Behavioral-Health-Provider-Participation-in-Medicaid-Value-based-Payment-Models-An-Environmental-Scan-and-Policy-Considerations.pdf?daf=375ateTbd56>
- 24 Implementation Findings from the National Evaluation of the Certified Community Behavioral Health Clinic Demonstration (September, 2020). Retrieved from <https://aspe.hhs.gov/system/files/pdf/263986/CCBHCImpFind.pdf>