

CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC (CCBHC)

Evidence-based Practice Reference Guide

NATIONAL
COUNCIL
*for Mental
Wellbeing*



CCBHC-E National Training & Technical Assistance Center

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INTRODUCTION

The Certified Community Behavioral Health Clinic (CCBHC) model is designed to ensure access to coordinated, comprehensive behavioral health care. A key element of the CCBHC criteria is that clinics utilize their needs assessment to determine which evidence-based practices (EBPs) are most impactful and appropriate for the communities they serve. In addition, states certifying CCBHCs must establish a minimum set of EBPs required of CCBHC. The [CCBHC-Expansion Grantee National Training and Technical Assistance Center \(CCBHC-E NTTAC\)](#) hosted several listening sessions with CCBHC grantees who noted many hours spent individually researching EBPs and training and implementation tools. A reoccurring theme in these conversations was that a central depository of brief information on key EBPs would be of significant value.



This resource serves as a brief reference for CCBHCs on the most commonly required or implemented EBPs across CCBHCs – identifying the target populations, staffing considerations and training and fidelity resources available to aid them in implementation. It is important to note that this resource is not a comprehensive digest of all EBPs nor an endorsement or recommendation for selection of these EBPs or any specific trainings. CCBHC selection of EBPs should be guided by the needs assessment and needs of the community being served and state requirements and regulations.

COMMON EVIDENCE-BASED PRACTICES EMPLOYED BY CCBHCS

An analysis was conducted of the EBPs most commonly required or recommended for CCBHCs, utilizing open access materials such as available state guidelines and implementation manuals for CCBHC clinics. This analysis identified the following EBPs as the most commonly required for CCBHC implementation. The full analysis crosswalk can be found in

Appendix.

Most commonly **required** EBPs for CCBHCs:

- Assertive Community Treatment (ACT)
- Dialectic behavioral therapy (DBT)
- Individual Placement and Support (IPS)
- Integrated Dual Disorder Treatment (IDDT)
- Medication-assisted treatment (MAT)
- Motivational interviewing (MI)
- Screening, brief intervention and referral to treatment (SBIRT)
- Supportive Housing
- Trauma-focused cognitive behavioral therapy (TF-CBT)

EBP QUICK REFERENCE LIST

This section of the guide serves as a quick reference for key elements and resources of common EBPs employed by CCBHCs. By EBP, this includes the following information:

- Definition and key elements
- Target or most appropriate audiences
- Staffing considerations
- Links to training and/or fidelity resources





Assertive Community Treatment (ACT)

What It Is

Assertive Community Treatment (ACT) is an evidence-based, multidisciplinary team approach that provides comprehensive, community-based care to individuals with serious mental illness (SMI), with services available 24/7. As a highly integrated outpatient model, ACT delivers a coordinated set of evidence-based treatment, rehabilitation, case management, and support services through a mobile, multidisciplinary behavioral health treatment team. Grounded in recovery-oriented practice, ACT aims to support individuals in achieving stability, independence, and a meaningful life in the community beyond the limitations of their mental health condition.

ACT is characterized by a (SAMHSA, 2008):

- **Team Approach:** ACT team members with various professional training and general life skills work closely together to blend their knowledge and skills.
- **In Vivo Services:** Services are delivered in the places and contexts where they are needed.
- **Small Caseload:** A team of 10 to 12 staff serves approximately 100 consumers, resulting in a staff-to-consumer ratio of approximately 1 to 10.
- **Time Unlimited Services:** A service is provided as long as needed, not according to pre-set timelines.
- **Shared Caseload:** ACT team members do not have individual caseloads; rather, the team as a whole is responsible for ensuring that consumers receive the services they need to live in the community and reach their personal goals.
- **Flexible Service Delivery:** The team meets daily to discuss how consumers are doing. The team can quickly adjust the services they are providing to respond to changes in consumers' needs.
- **Fixed Point of Responsibility:** Rather than sending consumers to various providers for services, the team provides the services consumers need. If using another provider cannot be avoided (e.g., medical care), the team makes certain that consumers receive the services they need.
- **24/7 Crisis Availability:** Services are available 24 hours a day, 7 days a week. Team members often find, however, that they can anticipate and avoid crises.

Target/Most Appropriate Audiences

ACT is designed for individuals with the highest levels of need — estimated to be 20% to 40% of people living with serious mental illness (SMI) (SAMHSA, 2008). Eligibility typically includes individuals with conditions such as schizophrenia or bipolar disorder that significantly impair daily functioning in the community. ACT programs prioritize those who have not benefited from traditional outpatient services or who may have difficulty engaging in care due to the severity of their symptoms, ensuring they receive intensive, tailored support.

ACT is particularly appropriate for individuals who may have an (SAMHSA, 2008):

- Inability to perform practical tasks required for basic functioning in the community
- Inability to be consistently employed or to carry out homemaker roles
- Inability to maintain a safe living situation

Staffing Considerations

ACT is staffed by dedicated, transdisciplinary teams of 10–12 staff. ACT teams bring together professionals from multiple disciplines, blending knowledge and skills to deliver coordinated and integrated care (SAMHSA, 2008). Teams are typically comprised of a team leader, mental health professionals including psychiatrists, psychologists, social workers, and substance use specialists (or dually certified staff), nursing staff, case managers, peer support staff, and other non-health-related supports such as housing or employment. ACT teams give consumers a decisive voice in which services they receive and how they receive them.

ACT teams typically have a caseload of about 50–100 individuals and a ratio of about 10 clients per staff member (SAMHSA, 2008). Teams should have 24/7 crisis availability and flexible service delivery. Team members should be coordinating regularly to align and adjust to individual plans and needs.

ACT teams are organized around a shared goal: supporting recovery and reducing the need for hospitalization (New York State Office of Mental Health, n.d.). Rather than fitting individuals into a fixed service model, ACT is designed to be flexible and responsive, tailoring services to each person's unique goals, preferences, and needs.

Transdisciplinary Team Model Approach Includes (SAMHSA, 2008)

- Team members conduct comprehensive assessments together
- Consumers are active and participating team members
- Team members and consumers develop plans together
- The team is jointly responsible for implementing and monitoring the plan
- Regular team meetings with ongoing transfers of information, knowledge, and skills shared among team members
- Team members make a commitment to teach, learn, and work together across disciplinary boundaries in all aspects to implement unified service plans
- An integral component of working across disciplines and team building





Resources

- **[SAMHSA: Assertive Community Treatment \(ACT\) Evidence-Based Practices \(EBP\) KIT](#)**: This SAMHSA brochure provides an overview of the ACT model and how it delivers a full range of community-based supports for people with serious mental illness. It highlights key features such as a multidisciplinary team approach, in-the-community (“in vivo”) service delivery, individualized and time-unlimited support, small caseloads, and continuous/flexible care that can respond when needs change.
- **[SAMHSA Training Frontline Staff](#)**: This SAMHSA workbook is designed to help ACT leaders train team members on the principles, core processes, and day-to-day skills needed to deliver effective ACT services. It covers essential elements of the ACT model, the theory behind ACT, core team practices (e.g., engagement, assessment, and service planning), and the major types of services ACT staff provide, and can be used both for group training sessions and as a desk reference.
- **[Tool for Measurement of ACT \(TMACT\)](#)**: The Tool for Measurement of ACT (TMACT) is a contemporary evaluation tool used to assess how well a program is implementing critical elements of Assertive Community Treatment (ACT). It includes a summary scale, protocols, and team survey instruments.
- **[New York State Office of Mental Health](#)**: New York State OMH’s Adult and Young Adult ACT Program Guidelines describe how ACT teams should be structured and operated to deliver intensive, community-based, recovery-oriented services to people with serious mental illness. The document outlines eligibility/admission and discharge expectations, required service components and intensity (including crisis response), and core team processes such as daily team communication and person-centered assessment/service planning. It also provides staffing requirements, roles/qualifications, and training/competency expectations to support fidelity and quality improvement.

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- Substance Abuse and Mental Health Services Administration. (2008). Training frontline staff [Workbook]. <https://library.samhsa.gov/sites/default/files/sma08-4344-trainingfrontlinestaff.pdf>



Individual Placement and Support (IPS)

What It Is

Individual Placement and Support (IPS) is an evidence-based model of supported employment that helps individuals with serious mental illness (SMI) and co-occurring conditions obtain and maintain competitive, integrated employment in the community. IPS is grounded in the belief that anyone who expresses a desire to work is eligible for services, regardless of symptoms, substance use or work readiness. Rather than requiring extensive pre-employment training, IPS emphasizes rapid job search and placement, followed by ongoing, individualized support. (SAMHSA, 2025)

IPS is guided by eight core principles (SAMHSA, 2025):

- **Focus on competitive employment:** Jobs are regular positions in the community that are open to anyone, rather than sheltered or set-aside roles.
- **Eligibility based on client choice:** Individuals are not excluded based on diagnosis, symptoms, substance use or perceived readiness to work.
- **Integration with mental health and treatment services:** Employment specialists work closely with clinical teams to ensure coordinated, whole-person care.
- **Attention to client preferences:** Job searches are guided by the individual's interests, strengths and experiences.
- **Work incentives planning:** Individuals receive support in understanding how employment may impact benefits (e.g., SSI/SSDI).
- **Rapid job search:** The job search process begins soon after program entry, rather than after lengthy preparation.
- **Systematic job development:** Employment specialists build relationships with employers based on client preferences and local labor market needs.
- **Time-unlimited, individualized support:** Ongoing support is provided as long as the individual desires it, adapting to changing needs over time.

Target/Most Appropriate Audiences

IPS is designed for individuals with serious mental illness, including those with co-occurring substance use disorders, who express a desire to work. It is widely implemented in community mental health settings, including Certified Community Behavioral Health Clinics (CCBHCs), and has been successfully applied across diverse populations and geographic settings. (SAMHSA, 2025)

IPS is particularly appropriate for:

- Individuals who have experienced barriers to employment due to mental health or substance use conditions
- Organizations seeking to integrate recovery-oriented, person-centered services into care
- Multidisciplinary teams aiming to improve outcomes related to employment, recovery and community integration

Staffing Considerations

Effective IPS implementation requires dedicated employment specialists who are integrated into clinical teams and maintain small caseloads to provide individualized support. These specialists collaborate regularly with clinicians, case managers and leadership to align employment goals with treatment planning. (IPS Employment Center, n.d.)

Organizations should consider:

- Providing specialized IPS training and ongoing coaching for employment specialists
- Ensuring regular team-based communication between employment and clinical staff
- Supporting supervision that reinforces adherence to the IPS fidelity model
- Allocating resources for benefits counseling to help individuals make informed decisions about employment

As with other evidence-based practices, successful IPS implementation depends on ongoing training, supervision and fidelity monitoring rather than one-time training efforts. Programs that adhere closely to the IPS model demonstrate stronger employment outcomes. (SAMHSA IPS Fidelity Scale, 2025)

Training and Fidelity Resources



- [Individual Placement and Support \(IPS\) Employment Center at the Rockville Institute](#): IPS Employment Center is an online library of IPS tools, manuals, webinars and implementation resources to support training and high-fidelity IPS program delivery.
- [SAMHSA: Individual Placement and Support Evidence-Based Practice Resource Guide](#): This SAMHSA guide describes the IPS model, core principles, evidence base and practical steps for planning, implementing and sustaining IPS services.
- [SAMHSA IPS Fidelity Scale](#): This standardized fidelity assessment tool is used to measure how closely a program follows the IPS model and to guide quality improvement.

References

IPS Employment Center. (n.d.). IPS Employment Center: Library. Retrieved April 6, 2026, from <https://ipsworks.org/index.php/library/>

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Substance Abuse and Mental Health Services Administration. (n.d.). IPS fidelity scale (PEP25-01-002). Retrieved April 6, 2026, from <https://library.samhsa.gov/sites/default/files/ips-fidelity-scale-pep25-01-002.pdf>



Medication-assisted Treatment

What It Is

Medication-assisted treatment (MAT), sometimes referred to as medications for addiction treatment, is the use of medications, often in combination with counseling and behavioral therapies, to provide a “whole-patient” approach to the treatment of substance use disorders. Currently there are medications approved for the treatment of addiction to opioids, including heroin and prescription pain medications, that include opiates, treatment of alcohol use disorder (AUD) and tobacco use.¹ Commonly used medications to treat AUD are acamprosate, disulfiram and naltrexone. Commonly used medications to treat opioid use disorder (OUD) are buprenorphine, methadone and naltrexone.² Commonly used medications for smoking cessation are nicotine replacement therapies, varenicline and bupropion.

Research has found MAT, in combination with therapy, to be successful in sustaining recovery and/or preventing or reducing overdose, as well as decreasing substance use and criminal activity among people with substance use disorders, increasing patients’ ability to gain and maintain employment, improving birth outcomes among women who have substance use disorders and are pregnant, and contributing to lowering patient’s risk of contracting HIV or hepatitis C by reducing potential for relapse.³

Target/Most Appropriate Audiences

Screening and assessment are critical steps to identifying individuals who might benefit from medications. As with any medication, when working with an individual to determine the best treatment option, considerations should be made for a patient’s past experience with MAT treatments, beliefs and opinions about which may be most helpful: level of motivation, medical status and contraindications for each medication and history of medication adherence.

For those experiencing OUD, medications combined with behavioral health services and supports is the standard of care. Clinicians should engage in shared decision-making around various treatment options and factors that contribute to decision on what medication is best, such as current use, if they are experiencing withdrawal, access to various treatment locations and frequency of visits.⁴ For alcohol use, individuals who are dependent on alcohol, have stopped drinking but are experiencing challenges such as cravings or relapse and/or have not found psychosocial approaches alone to drive improvement are candidates clinicians should be engaging in shared decision making with to consider MAT.⁵ Similar considerations can be taken for tobacco use.

Staffing Considerations

Staffing and practice considerations for MAT vary by medication, since some are categorized as controlled substances, as well as treatment setting. Regardless of setting, it is recommended to discuss the individual’s potential need for additional supports such as drug and alcohol counseling, mental health services, case management, peer recovery supports and other non-health related needs and aid in referrals or coordination of care.⁶

On December 29, 2022, the Consolidated Appropriations Act of 2023, removes the [federal requirement](#) for practitioners to submit a Notice of Intent (have a waiver) to prescribe medications, like buprenorphine, for the treatment of opioid use disorder (OUD). This means that the special waiver (e.g., a DATA-Waiver) for prescribers is no longer required to treat patients with opioid use disorder (OUD).

Additionally, the Consolidated Appropriations Act of 2023 enacted a new **one-time, eight-hour training** requirement for all Drug Enforcement Administration (DEA)-registered practitioners on the treatment and management of patients with opioid or other substance use disorders. Beginning on June 27, 2023, all prescribers will need to complete 8-hours of SUD training ([or provide evidence of previous relevant trainings](#)) before initial and renewed DEA registrations.

- Methadone for OUD: Only federally certified, accredited [opioid treatment programs \(OTPs\)](#) can dispense methadone to treat OUD.



Training and Fidelity Resources

- [SAMHSA Treatment Improvement Protocol 63: Medications for Opioid Use Disorder](#): This resource includes guidance on OUD screening, assessment, treatment and referral as well as information and tools for health-care professionals who prescribe, administer or dispense OUD medications or treat other illnesses in patients who take these medications.
- [Practice Guidelines for the Administration of Buprenorphine for Treating Opioid Use Disorder](#): The practice guidelines highlight the exemptions that allows practitioners to expand treatment for OUD.
- [Opioid Response Network \(ORN\)](#): The ORN has local consultants in all 50 states and nine territories to respond to local needs by providing free educational resources and training to states, communities and individuals in the prevention, treatment and recovery of OUD and stimulant use.
- [Become a Buprenorphine Waivered Practitioner](#): This resource page lists information and application process on how qualified practitioners can offer buprenorphine to treat OUD.

Other Resources

- [TIP 63: Medications for Opioid Use Disorder – Full Document](#)
- [Use of Medication-assisted Treatment in Emergency Departments](#)
- [Medication for the Treatment of Alcohol Use Disorder: A Brief Guide](#)
- [Clinical Interventions to Treat Tobacco Use and Dependence Among Adults](#)



Motivational Interviewing

What It Is

Motivational interviewing (MI) is a particular way of talking with people about change and growth to strengthen their own motivation and commitment. It is a method of communication rather than an intervention, sometimes used on its own or combined with other treatment approaches. MI is practiced with an underlying spirit comprised of four ways of being with people: partnership, acceptance, compassion and evocation.⁷

- Partnership is an active collaboration between provider and client. A client is more willing to express concerns when the provider is empathetic and shows genuine curiosity about the client's perspective. In this partnership, the provider gently guides the client, but the client drives the conversation.
- Acceptance is the act of demonstrating respect for and understanding of the client's point of view and experience. Providers use MI's four components of acceptance — absolute worth, accurate empathy, autonomy support and affirmation — to help them appreciate the client's situation and decisions.
- Compassion refers to the provider actively promoting the client's welfare and prioritizing the client's needs.
- Evocation is the process of eliciting and exploring a client's existing motivations, values, strengths and resources.⁸

MI also includes the use of core skills such as asking open-ended questions, offering reflections, softening sustain talk and encouraging change talk. The conversation is guided through a process of engaging, focusing, evoking and planning.

Target/Most Appropriate Audiences

MI is taught and practiced around the world in more than 50 languages and more than 2,000 published controlled trials. It has been applied across a broad range of settings (e.g., health care, education, corrections) and topics (e.g., mental health disorders and/or psychosocial disorders, oral health, physical activity, nutrition, medication adherence, substance use disorders, supervision, organizational leadership). It is a technique that can be used to engage individuals who have any level of interest in change, including no interest in change, to begin engaging them the change process.

Staffing Considerations

Learning MI takes time, practice and discipline. Gaining competence requires a high degree of self-reflection about using the skills in relation to the needs of and “language of change” from the client. An organization may choose to provide MI training only to certain providers. However, as increasingly more programs, including CCBHCs, adopt a client-centered treatment philosophy and MI as an evidence-based approach, organizations are encouraged to provide MI training to all staff.⁹ Research indicates that “one-shot” trainings don't create competence; rather a combination of workshops, coaching and feedback is one of the more effective ways to transfer learning into more sustained practice.¹⁰



Training and Fidelity Resources:

- [TIP 35: Enhancing Motivation for Change in Substance Use Disorder Treatment](#): This updated TIP includes the latest evidence on motivation-enhancing approaches and strategies. It describes how substance use disorder treatment providers can use these approaches and strategies to increase participation and retention in substance use disorder treatment.
- [Institute for Research, Education and Training in Addiction \(IRETA\) Motivational Interviewing Toolkit](#): This resource lists supplementary materials for MI training. IRETA also offers consulting and training services for organizations on MI.
- [Addiction Technology Transfer Center Network Motivation Interviewing Trainings](#): A resource page that lists several different MI trainings (including introductory and advanced levels, groups, managers) and intensive technical assistance through the Northwestern Addiction Technology Transfer Center.

Resources:

- [Motivational Enhancement Therapy Manual](#)
- [Providers Clinical Support System's Motivational Interviewing: Talking with Someone Struggling with Opioid Addiction](#)
- [Motivational Interviewing Network of Trainers](#)



Trauma-focused Cognitive Behavioral Therapy

What It Is

Trauma-focused cognitive behavioral therapy (TF-CBT) aims to reduce negative emotions and behaviors by addressing beliefs and attributions related to abuse or trauma.¹¹ The goal of each TF-CBT session is to build therapeutic relationship while providing education, coping skills (including parenting skills for nonoffending parents) and safe environment to address and process traumatic experiences.¹²

Target/Most Appropriate Audiences

TF-CBT is commonly used among youth, ages 3-21, who experienced at least one trauma (i.e., child maltreatment, community violence, loss of a loved one) and who experience mental health symptoms including post-traumatic stress disorder, elevated levels of depression, anxiety, shame and/or trauma-related behavioral challenges. TF-CBT is also shown to benefit adults who had traumatic childhood experiences, including nonoffending parents and caregivers.¹³

Staffing Considerations

TF-CBT is a short-term treatment typically provided in 12 to 16 weekly sessions and implementation includes TF-CBT clinicians, clinical supervision and fidelity monitoring. At a minimum, those providing TF-CBT should be in graduate school or have a master's degree in a mental health-related discipline and participate in training.¹⁴ It is recommended that those providing the service are TF-CBT certified. Criteria for certification includes a master's degree or above in a mental health discipline, permanent professional license with the state they are serving, participation in training and follow-up consultation or supervision for a set period of time and use of a standardized instrument.¹⁵ Details on certification and requirements can be accessed [here](#).

Training and Fidelity Resources



- [Trauma-focused Cognitive Behavioral Therapy \(TF-CBT\): National Therapist Certification Program](#): The certification program page includes registration for upcoming trainings. The [resource page](#) includes implementation manuals for various populations as well as other implementation resources.
- [Trauma-Focused Cognitive Behavioral Therapy \(TF-CBT\) Training Guidelines](#): This fact sheet includes requirements, recommendations, standards and other considerations on TF-CBT treatments, training, implementation, consultation and case completion requirements.

Resources

- [TF-CBT Military Implementation Manual](#)
- [TF-CBT Telehealth Resources](#)



Screening, Brief Intervention and Referral to Treatment

What It Is

Screening, brief intervention and referral to treatment (SBIRT) is the delivery of early intervention and treatment services for persons with substance use challenges and persons at risk of developing substance use disorders.

- Screening is a universal, systematic way of identifying level of risk associated with substance use using a standardized, reliable and valid tool.
- Brief intervention is for persons who scored moderate to high risk for substance use challenges. These are short, timely conversations to increase insight and awareness regarding substance use and options for change.
- Referral to treatment provides persons in need of a higher level of care with guidance and assistance to appropriate programs or treatments.¹⁶

Target/Most Appropriate Audiences

It is recommended that universal screening for unhealthy alcohol and other drug use be conducted at least annually for individuals ages 12 and older. Screening results will guide the level of brief intervention or referral to treatment.^{17, 18} Because SBIRT is an early intervention, it typically targets persons who do not yet meet the substance use disorder criteria¹⁹.

Staffing Considerations

SBIRT can be employed in various settings and is most commonly implemented in primary care, emergency departments, integrated care settings and mental health organizations. Some settings in some states have billable SBIRT codes which will inform which staff can perform which tasks. Staffing is ideally through a team-based approach, with clear roles and responsibilities across the workflow to ensure efficient and effective delivery of the components. It may be helpful to appoint a staff member as an SBIRT program lead to evaluate and refine the workflow over time and identify staff champions to support the implementation process to fidelity.²⁰ Together this core SBIRT team should codify the process with organizational policy and protocols, including documentation requirements, coding/billing processes and data/evaluation metrics. Consider staff and training needs across the stages of SBIRT:

- Screening can often be self-administered by clients and built into existing screening protocols or workflows where they exist; for example, medical assistants could have individuals complete screenings on paper or tablets while taking vital signs.
- Staff members providing brief intervention and referral to treatment can benefit from MI training and access to onsite or community partners with specialization in substance use disorders. These staff will vary by setting, but could include primary care providers and behavioral health clinicians²¹

Training and Fidelity Resources



- [University of Missouri-Kansas City SBIRT Training and Tools](#): Includes open access screening and brief intervention tools, as well as virtual training courses.
- [Institute for Research, Education and Training in Addiction \(IRETA\) SBIRT Toolkit](#): This resource lists supplementary materials for SBIRT training. IRETA also offers consulting and training services for organizations on SBIRT.

Other Resources

- [TAP 33: Systems-Level Implementation of Screening, Brief Intervention and Referral to Treatment \(SBIRT\)](#)



Dialectic Behavioral Therapy

What It Is

Dialectical behavior therapy (DBT) is a contextual behavioral therapy that seeks to address individuals' ability to regulate their emotions, behavior, interpersonal functioning, thoughts and actions. It seeks to increase capabilities in these domains by teaching and reinforcing skilled behavior while supporting improved motivation for change and generalizations of skills in the context of daily life. A central component of DBT is the balance between acceptance and change. The goal is to achieve balance in thoughts, emotions and actions. It utilizes the modalities of group skills training, individual psychotherapy and between session consultation/coaching.

Target Populations/Populations of Focus

DBT was originally developed for the treatment of borderline personality disorder (BPD). However, it has been shown to be effective in the treatment of individuals who present with the features of dysregulation described above. As a result, it has been utilized in the treatment of various conditions, including eating disorders, treatment-resistant depression, suicidal and non-suicidal self-injury and substance use disorders.²² Research has also found success in adaptation for youth and adolescents, DBT focusing on treating youth with repeated self-harm and symptoms of BPD and including parents in treatment through multi-family group skills training and family sessions.²³

Staffing Considerations

DBT can be delivered by mental health practitioners, including licensed behavioral health professionals such as psychiatrists, psychologists and therapists. Some studies have also included post-doctoral students, psychiatry fellows and graduate students as DBT practitioners, in addition to licensed therapists and clinical workers.²⁴

DBT treatment is typically facilitated within the context of a team who meet for weekly consultation. DBT skills training groups often feature two clinicians, functioning as a leader and co-leader. Individual sessions and 'in the moment' coaching are conducted by a therapist who may also be one of the group facilitators or may be another member of the team. While DBT skills training is typically conducted in a group setting, it is feasible to teach skills individually. In such cases it is recommended that the independent clinician seeks to join a consultation team of other DBT therapists.²⁵

Training and Fidelity Resources



- [DBT-Linehan Board of Certification](#): DBT-Linehan oversees DBT certification and includes a directory of certified clinicians and programs as well as additional resources.
- [DBT Fidelity Scale](#): The fidelity scale utilized by Linehan Board of Certification to assess all programs.
- [Behavioral Tech](#): Founded by the developer of DBT, Marsha Linehan, PhD, ABPP, Behavioral Tech provides multiple live and virtual training options, as well as individualized consultation and resources.
- [Psychwire](#) offers online DBT training courses, free training videos and a DBT newsletter.

Other Resources

- [DBT Skills Resources](#)
- [Northwest Mental Health Technology Transfer Center's 16-lesson DBT Steps Online Lessons for Youth](#)



Integrated Dual Disorder Treatment (IDDT)

What It Is

Integrated Dual Disorder Treatment (IDDT) is an evidence-based practice designed to support individuals with co-occurring mental health and substance use disorders (Case Western Reserve University Center for Evidence-Based Practices, n.d.). It is grounded in the understanding that meaningful, lasting change — such as improved symptom management, sobriety, and increased independence — happens gradually through a series of small, overlapping steps over time. IDDT uses a stages-of-change approach, tailoring interventions to each individual's readiness and unique life circumstances.

IDDT promotes recovery by equipping service organizations with structured, integrated strategies for delivering care that addresses both mental health and substance use needs simultaneously (Case Western Reserve University Center for Evidence-Based Practices, n.d.). Its implementation supports change at multiple levels, including service delivery systems, organizational practices, and clinical care. IDDT is built upon the following core treatment components:

- Multidisciplinary Team
- Stage-Wise Interventions (stages of change, stages of treatment)
- Access to Comprehensive Services (e.g., residential, employment, etc.)
- Time-Unlimited Services
- Assertive Outreach
- Motivational Interventions
- Substance Abuse Counseling
- Group Treatment
- Family Psychoeducation
- Participation in Alcohol and Drug Self-Help Groups
- Pharmacological Treatment
- Interventions to Promote Health
- Secondary Interventions for Non-Responders to Substance Abuse Treatment

Target/Most Appropriate Audiences

IDDT is designed for individuals with co-occurring serious mental illness and substance use disorders (Kubek et al., 2003). It is particularly well-suited for those who require intensive, long-term support and may have difficulty engaging in traditional treatment. IDDT uses a staged approach to care, meeting individuals where they are and supporting gradual, sustained progress over time.

Staffing Considerations

The IDDT model views all activities of life as part of the recovery process. Therefore, a variety of service providers support each individual in all aspects of life. The service team consists of the following (Kubek et al., 2003):

- Team leader
- Nurse
- Case manager
- Employment specialist
- Substance abuse specialist
- Housing specialist
- Counselor
- Criminal justice specialist
- Physician/psychiatrist



Resources

- [Case Western Reserve University Center for Evidence-Based Practices](#): The Case Western Reserve University Center for Evidence-Based Practices explains the IDDT evidence-based model for people with co-occurring severe mental illness and substance use disorders, including key principles, outcomes, and core elements of integrated care.
- [Case Western Reserve University Integrated Dual Disorder Treatment](#): This downloadable PDF “IDDT Overview” booklet (trifold-style) provides an at-a-glance description of IDDT, its purpose, expected outcomes, and the core components needed for implementation.
- [Integrated Treatment for Co-Occurring Disorders EBP KIT](#): This SAMHSA toolkit document focuses on building and sustaining an integrated treatment program for co-occurring disorders, with implementation guidance for authorities, administrators, and program leaders.

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Supportive Housing

What It Is

Permanent supportive housing is an intervention that combines affordable housing assistance with voluntary support services to address the needs of people who are homeless or unstably housed. The services are designed to build independent living and tenancy skills and connect people with community-based health care, treatment and employment services. Residents of supportive housing are linked to intensive case management and voluntary, life-improving services like health care, workforce development and child welfare.²⁹ The key elements of permanent supportive housing include:

- Tenants have a lease in their name with full rights of tenancy.
- Participation in services is voluntary.
- Housing rules are similar to those found in the general community.
- Housing is not time-limited, and the lease is renewable.
- Tenants are offered housing based on preferences.
- Housing is affordable, with tenants paying no more than 30% of income.
- Housing is integrated.
- Tenants have choices in the support services they receive.³⁰

Target Populations/Populations of Focus

Permanent supportive housing programs in this context are primarily intended for people with serious mental illness who need assistance to live in the community. More broadly, many federally funded “Supportive Housing” programs are designed specifically for individuals who are homeless. This intervention has been found effective for people who have been homeless, have spent time in hospitals, correctional facilities, nursing homes, group homes or other institutional settings. Organizations may choose to establish their permanent supportive housing program to target one or more “at-risk” populations or serve only people with certain life circumstances or subpopulations, depending on resources and the needs of their community.³¹

Staffing Considerations

Staffing patterns for permanent supportive housing programs vary depending on the needs of tenants, size of the program, service delivery approach and design, service array and funding requirements. Programs often arrange staffing patterns to allow for support to be available during the evenings and weekends, in addition to weekdays. Case management is the foundational to the design of the program and programs typically target a staff-to-resident ratio between 10:1 and 20:1. As such, programs often include the following social service roles:

- Supervisor and team leader
- Case manager
- Vocational counselor
- Job developer
- Peer specialist
- Substance use specialist
- Recreational specialist
- Activities of daily living specialist

Programs that have incorporated (rather than partnered with) property management functions often include the following: property or resident manager, assistant manager, superintendent, maintenance staff, intake specialist and accountant.³²



Training and Fidelity Resources

- [SAMHSA Permanent Supportive Housing Evidence-based Practice Kit](#): This toolkit outlines the essential components for supportive housing services and programs for people living with mental illness disorders. The toolkit includes eight booklets on program development, staff training modules and evaluation and fidelity tools.
- [SAMHSA Permanent Supportive Housing Kit – Evaluating Your Program](#): This booklet includes a fidelity scale and scoresheet.
- [CSH Supportive Housing Training Center](#): The training center offers interactive training solutions that support building and high-quality supportive housing in the community. Offerings include hundreds of webinars and webinar series, self-paced online classes and videos.





Intensive Care Coordination Using Wraparound

What It Is

Wraparound is not a service, but rather a structured approach to service planning and care coordination for individuals with complex needs (most often children, youth and their families). According to the National Wraparound Implementation Center, “Wraparound is a process relying on a series of practice steps in order to bring a group of people together to craft and match services, supports and interventions to meet unique family needs. Often referred to as a process rather than a service or particular type of intervention, wraparound integrates and builds on a variety of concepts from a range of sources. This integrative nature makes wraparound particularly adaptive to the organization, context and people involved in implementation.”³³

Target Populations/Populations of Focus

Wraparound is most appropriate to support children and youth whose needs exceed the resources and expertise of any one provider organization or child- and family-serving system. States implementing the model may have defined criteria or target population definitions.³⁴

Staffing Considerations

Wraparound is a team-based care planning approach that builds upon strengths to identify appropriate formal and informal supports to address needs and root causes of challenges. Although states implementing the model may have different criteria for staffing composition of “wrap teams,” implementing wraparound typically includes **wraparound facilitators (or care coordinators), family support partners and youth support partners**. Other professionals that may be part of the “wrap team” or have roles in supporting the Wraparound process include **clinicians trained on research-based practices to address psychosocial needs, in-home behavioral support specialists, resource coordinators** and others.³⁵

Training and Fidelity Resources



Wraparound is a complex process involving many different skill sets. Those serving in key roles of wraparound implementation require substantial training, ongoing coaching and supervision to ensure that they have the knowledge and skills they need.

[National Wraparound Implementation Center \(NWIC\)](#): NWIC provides wraparound training to states and sites at any stage of implementation. Training offerings include virtual training and a virtual coaching platform.

[Training, Coaching and Supervision for Wraparound Facilitators](#): These guidelines address the three phases in the professional development of wraparound facilitators.

[Wraparound Fidelity Assessment System \(WFAS\)](#): WFAS is a multi-method approach to assessing the quality of individualized care planning and management for children and youth with complex needs and their families. The instruments that comprise the WFAS can be used individually, or to provide a more comprehensive assessment, in combination with one another. **The WFAS measures are proprietary tools and require licensure for use.**

Other Resources

- [Wraparound Implementation and Practice Quality Standards](#)
- [Intensive Care Coordination for Children and Youth with Complex Mental and Substance Use Disorders: State and Community Profiles](#)

GENERAL RESOURCES

[SAMHSA EBP Resource Center](#): The Evidence-Based Practices Resource Center provides communities, clinicians, policymakers and others with the information and tools to incorporate evidence-based practices into their communities or clinical settings.

[Mental Health Technology Transfer Center \(MHTTC\)](#): Funded by SAMHSA, the MHTTC includes a network of centers providing resource development and dissemination, training and technical assistance and workforce development to strengthen the capacity of the mental health field in delivering effective evidence-based practices to individuals. Each MHTTC has chosen an area of focus.

- **National American Indian and Alaska Native MHTTC:** [Context-aware evidence-based practices in treatment and assessment of mental health disorders in Native populations.](#)
- **National Hispanic and Latino MHTTC:** [Mental health promotion, prevention, intervention and recovery support services for Hispanic and Latino populations.](#)
- **New England MHTTC:** [Recovery-oriented practices, including recovery support services, within the context of recovery-oriented systems of care.](#)
- **Northeast and Caribbean MHTTC:** Evidence-based practices for serious mental illness (SMI), including [supported employment, illness management and recovery, supportive housing](#) and [supported education.](#)
- **Central East MHTTC:** [Suicide prevention within the context of age and social background.](#)
- **Southeast MHTTC:** [Population-based approaches to managing SMI. Addressing mental health in public health initiatives.](#)
- **Great Lakes MHTTC:** [Process improvement for mental health care delivery systems \(including change leader academies\).](#)
- **South Southwest MHTTC:** [Early childhood mental health.](#)
- **Mid-America MHTTC:** [Integration of primary and mental health care.](#)
- **Mountain Plains MHTTC:** [Rural mental health.](#)
- **Pacific Southwest MHTTC:** [Youth and young adults of transitional age with or at risk for SMI](#) (with a focus on outreach, engagement, intervention and treatment approaches that ensure seamless care across adolescent and adult services).
- **Northwest MHTTC:** [Evidence-based practices for psychosis including cognitive behavioral therapy for psychosis and assertive community treatment.](#)

[Addiction Technology Transfer Center \(ATTC\)](#): Funded by SAMHSA, the ATTC includes a network of centers that support the adoption and implementation of evidence-based and promising addiction treatment and recovery-oriented practices and services and build the skills of a workforce that addresses the needs of people with substance use or other behavioral health disorders. Upcoming trainings and events from the ATTC Network may be accessed [here](#).

APPENDIX

Crosswalk of Most Commonly Required/Recommended EBP for CCBHCs

Note: **REQ** = **Required**; **REC** = *Recommended*

EBP	Alabama (AL)	Illinois (IL)	Indiana (IN)	Iowa (IO)	Kansas (KS)	Kentucky (KY)	Maine (ME)	Michigan (MI)	Minnesota (MN)	Missouri (MO)	New Hampshire (NH)	New Mexico (NM)	New York (NY)	New Jersey (NJ)	Nevada (NV)	Oklahoma (OK)	Oregon (OR)	Rhode Island (RI)	Texas (TX)	Vermont (VT)	Total (REQUIRED EBPs)	Total (Recommended EBPs)
Cognitive Behavioral Therapy (CBT) - Group or Individual	REQ	REQ	REQ	x	REQ	REQ	REQ	REQ	REQ	REQ	x	x	REQ	REQ	REQ	REQ	REQ	REQ	REQ	REQ	17	0
Motivational Interviewing (MI)	REQ	REQ	REQ	REQ	x	x	REQ	REQ	REQ	REQ	REQ	REC	REQ	REQ	x	REQ	REQ	REQ	REQ	REQ	16	1
Assertive Community Treatment (ACT)	REQ	REQ	REQ	REQ	REQ	REQ	REQ	REQ	x	REQ	REQ	REC	REC	REQ	REQ	REC	x	REQ	REQ	x	14	3
Medication-assisted treatment (MAT)/MOUD	REQ	x	x	REQ	REQ	REQ	REQ	REQ	x	REQ	x	REQ	REQ	REQ	x	REQ	x	REQ	x	REQ	13	0
Trauma-focused CBT (TF-CBT)	REQ	REQ	REQ	REQ	x	REQ	REQ	REQ	REQ	x	REQ	REC	x	REQ	REQ	REQ	x	x	REQ	x	13	1
Integrated Treatment for Co-occurring Disorders (ITCD)/Integrated Dual Disorder Treatment (IDDT)	REQ	x	REQ	x	REQ	REQ	x	REQ	x	REQ	x	x	REQ	x	REQ	x	x	REQ	REQ	x	10	0
Dialectical Behavioral Therapy (DBT)	REC	REQ	REQ	x	x	REQ	REC	REQ	x	REQ	x	REC	REC	x	REQ	REC	REQ	REQ	x	REQ	9	5
Individual Placement and Support (IPS)	REQ	x	x	x	REQ	REQ	REQ	REC	x	x	REQ	x	REQ	x	x	REQ	x	REQ	REQ	x	9	1
Screening, Brief Intervention, and Referral to Treatment (SBIRT)	x	x	x	REQ	x	REQ	REQ	REQ	x	x	x	x	REQ	REQ	x	x	x	REQ	REQ	x	8	0
Supported Employment	REQ	REQ	x	x	REQ	x	REQ	REC	x	REC	REQ	x	REC	x	x	x	REQ	x	x	REQ	7	3
Eye Movement Desensitization and Reprocessing (EMDR)	x	REQ	x	x	x	REQ	REQ	x	REQ	REQ	x	REC	x	x	x	x	x	x	x	x	5	1

EBP	Alabama (AL)	Illinois (IL)	Indiana (IN)	Iowa (IO)	Kansas (KS)	Kentucky (KY)	Maine (ME)	Michigan (MI)	Minnesota (MN)	Missouri (MO)	New Hampshire (NH)	New Mexico (NM)	New York (NY)	New Jersey (NJ)	Nevada (NV)	Oklahoma (OK)	Oregon (OR)	Rhode Island (RI)	Texas (TX)	Vermont (VT)	Total (REQUIRED EBPs)	Total (Recommended EBPs)
Family Psychoeducation	x	x	x	x	REQ	REQ	x	x	x	x	x	x	REQ	x	x	x	x	REQ	x	x	4	0
High Fidelity Wraparound (HFW)	REC	x	x	x	x	REQ	REC	x	x	x	x	x	x	REQ	x	REQ	x	x	REQ	x	4	2
Multidimensional Family Therapy (MDFT)	x	x	x	REQ	x	REQ	REQ	x	x	x	x	x	REQ	x	x	x	x	x	x	x	4	0
Multisystemic Therapy	REC	x	REC	REQ	x	x	x	x	x	REQ	x	REC	REQ	REQ	x	x	x	x	x	x	4	3
Cognitive Processing Therapy (CPT)	x	x	x	x	x	REQ	REC	x	x	x	x	x	REQ	x	x	x	x	x	REQ	x	3	1
Collaborative Assessment and Management of Suicidality (CAMS)	x	x	x	x	x	x	REQ	x	x	x	x	x	x	x	x	REQ	x	x	x	REQ	3	0
Coordinated Specialty Care for First Episode Psychosis (CSC)	REC	x	REC	x	x	REQ	REC	x		x	x	REC	x	REQ	x	x	x	REQ	x	x	3	4
Functional Family Therapy	x	x	REC	REQ	x	x	REQ	x	x	x	x	REC	REQ	x	x	REC	x	x	x	x	3	3
Illness Management and Recovery	x	x	REC	x	x	REQ	x	x	x	x	x	x	x	x	REQ	x	x	x	REQ	x	3	1
Parent Management Training (PMTO) or PTC	REC	x	REQ	x	x	x	x	REQ	x	REC	x	x	REQ	x	x	x	x	x	x	x	3	2
Seeking Safety	REC	x	REC	x	x	x	REC	x	x	x	x	x	x	REQ	x	REQ	x	x	REQ	x	3	3
Seven Challenges	x	x	x	x	x	x	x	x	x	x	REQ	x	REQ	x	x	x	x	REQ	x	x	3	0
Trauma-informed Care	x	x	x	x	x	x	x	REC	x	REQ	x	x	REQ	x	x	x	x	REQ	x	x	3	1
Wellness Recovery Action Plan (WRAP)	x	REQ	x	x	x	REQ	REC	x	x	x	x	x	x	x	REQ	REC	x	x	x	x	3	2
Enhanced Illness Management and Recovery (e-IMR)	x	x	x	x	x	x	x	x	x	REC	REQ	x	REC	x	x	REQ	x	x	REQ	x	2	2

EBP	Alabama (AL)	Illinois (IL)	Indiana (IN)	Iowa (IO)	Kansas (KS)	Kentucky (KY)	Maine (ME)	Michigan (MI)	Minnesota (MN)	Missouri (MO)	New Hampshire (NH)	New Mexico (NM)	New York (NY)	New Jersey (NJ)	Nevada (NV)	Oklahoma (OK)	Oregon (OR)	Rhode Island (RI)	Texas (TX)	Vermont (VT)	Total (REQUIRED EBPs)	Total (Recommended EBPs)
Forensic Assertive Community Treatment (FACT)	x	x	x	x	REQ	x	x	x	x	x	x	x	x	REQ	x	x	x	x	x	x	2	0
Housing First	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	REQ	x	REQ	x	x	2	0
Nurturing Parent Training	x	x	x	x	x	REQ	x	x	x	x	x	x	x	x	x	x	x	x	REQ	x	2	0
Peer and Family Support	REQ	x	x	x	x	x	x	x	x	x	REQ	x	x	x	x	x	x	x		x	2	0
Person Centered Recovery Planning	x	x	x	x	x	REQ	x	x	x	x	x	x	x	x	x		x	x	x	REQ	2	0
Supportive Housing	x	REQ	x	x	x	x	x	REC	x	REC	x	x	REC	x	x	x	x	x	REQ	x	2	3
Zero Suicide Academy	x	x	x	x	x	x	REC	x	x	REQ	x	x	x	x	x	x	x	REQ	x	x	2	1
"Air Traffic Control"	x	x	x	x	x	x	x	REQ	x	x	x	x	x	x	x	x	x	x	x	x	1	0
Accelerated Resolution Therapy (ART)	x	x	x	x	x	REQ	x	x		x	x	x	x	x	x	x	x	x	x	x	1	0
Acceptance and Commitment Therapy	x	x	x	x	x	x	REC	x	x	x	x	x	REQ	x	x	x	x	x	x	x	1	1
Behavior Management Strategies	x	x	REQ	x	x	x	x	x		x	x	x	x	x	x	x	x	x	x	x	1	0
Brief Strategic Family Therapy (children/adolescents)	x	x	REQ	x	x	x	x	x		x	x	x	x	x	x	x	x	x	x	x	1	0
Critical Time Intervention	x	x	x	x	x	x	x	x	x	x	REQ	x	x	x	x	REC	x	x	x	x	1	1
First Episode Psychosis	x	x	x	x	x	x	x	x	x	REQ	x	x	x	x	x	x	x	x	x	x	1	0
Infant Mental Health	x	x	x	x	x	x	x	REQ	x	x	x	x	x	x	x	x	x	x	x	x	1	0
Integrated Community Based Treatment	x	x	REQ	x	x	x	x	x		x	x	x	x	x	x	x	x	x	x	x	1	0

EBP	Alabama (AL)	Illinois (IL)	Indiana (IN)	Iowa (IO)	Kansas (KS)	Kentucky (KY)	Maine (ME)	Michigan (MI)	Minnesota (MN)	Missouri (MO)	New Hampshire (NH)	New Mexico (NM)	New York (NY)	New Jersey (NJ)	Nevada (NV)	Oklahoma (OK)	Oregon (OR)	Rhode Island (RI)	Texas (TX)	Vermont (VT)	Total (REQUIRED EBPs)	Total (Recommended EBPs)
Interpersonal Therapy	x	x	x	x	x	x	x	x	x	x	x	x	REQ	x	x	x	x	x	x	x	1	0
Medication-assisted Recovery (MAR)	x	REQ	x	x	x	x	x	x		x	x	x	x	x	x	x	x	x		x	1	0
Motivational Enhancement Therapy	x	x	x	x	x	x	x	x	x	x	x	x	REQ	x	x	REC	x	x	x	x	1	1
Parent Child Interaction Therapy		x	REC	x	x	x	x	x	x	REQ	x	x	x	x	x	x	x	x	x	x	1	1
Stages of Change (Transtheoretical Model)	x	x	x	x	x	x	x	x	REQ	x	x	x	x	x	x	x	x	x	x	x	1	0
Systemic, Therapeutic, Assessment, Resources, and Treatment (START) Model	x	x	REC	x	x	x	REQ	x	x	x	x	x	x	x	x	x	x	x	x	x	1	1
Twelve Step Facilitation Therapy	x	x	x	x	x	x	x	x	x	x	x	x	REC	x	x	x	x	REQ	x	x	1	1
Applied Behavior Analysis (ABA)		x		x	x	x	REC	x		x	x	x	x	x	x	x	x	x	x	x	0	1
Behavioral Couples Therapy	x	x	x	x	x	x	x	x	x	x	x	x	REC	x	x	x	x	x	x	x	0	1
Celebrating Families Program	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	REC	x	x	x	x	0	1
Community Psychiatric Rehabilitation (CPR)	x	x	x	x	x	x	x	x	x	REQ	x	x	x	x	x	x	x	x	x	x	0	0
Community Reinforcement Approach (CRA)	x	x	x		x	x	REC	x		x	x	x	x	x	x	x	x	x	x	x	0	1
Comprehensive Behavioral Intervention for Tics (CBITS)		x	REC	x	x	x	x	x		x	x	x	x	x	x	x	x	x	x	x	0	1
Crisis Intervention Team (CIT) Model	x	x	x	x	x	x	x	x	x	x	x	x	REC	x	x	x	x	x	x	x	0	1

EBP	Alabama (AL)	Illinois (IL)	Indiana (IN)	Iowa (IO)	Kansas (KS)	Kentucky (KY)	Maine (ME)	Michigan (MI)	Minnesota (MN)	Missouri (MO)	New Hampshire (NH)	New Mexico (NM)	New York (NY)	New Jersey (NJ)	Nevada (NV)	Oklahoma (OK)	Oregon (OR)	Rhode Island (RI)	Texas (TX)	Vermont (VT)	Total (REQUIRED EBPs)	Total (Recommended EBPs)
Long-acting injectable medications	REC	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	0	1
Matrix Model	x	x	REC	x	x	x	x	x	x	x	x	x	REC	x	x	REC	x	x	x	x	0	3
OnTrackNY - First episode early intervention for psychosis	x	x	x	x	x	x	x	x	x	x	x	x	REC	x	x	REC	x	x	x	x	0	2
Solution-Focused Brief Therapy	x	x	REC	x	x	x	x	x		x	x	x	x	x	x	x	x	x	x	x	0	1
Transition to Independence (TIP Model)	x	x	x	x	x	x	x	REC	x	x	x	x	x	x	x	REC	x	x	x	x	0	2
Trauma Recovery and Empowerment Model (TREM)	x	x	x	x	x	x	REC	x	x	x	x	x	x	x	x	x	x		x	x	0	1
Trauma Systems Therapy for Refugees (TST-R)	x	x	x	x	x	x	REC	x	x	x	x	x	x	x	x	x	x		x	x	0	1
Wellness Management and Recovery (WMR)	x	x	x	x	x	x	x	x	x	x	x	x	REC	x	x	x	x	x	x	x	0	1

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