NATIONAL COUNCIL for Mental Wellbeing

NATIONAL ASSOCIATION of COUNTIES NACo®

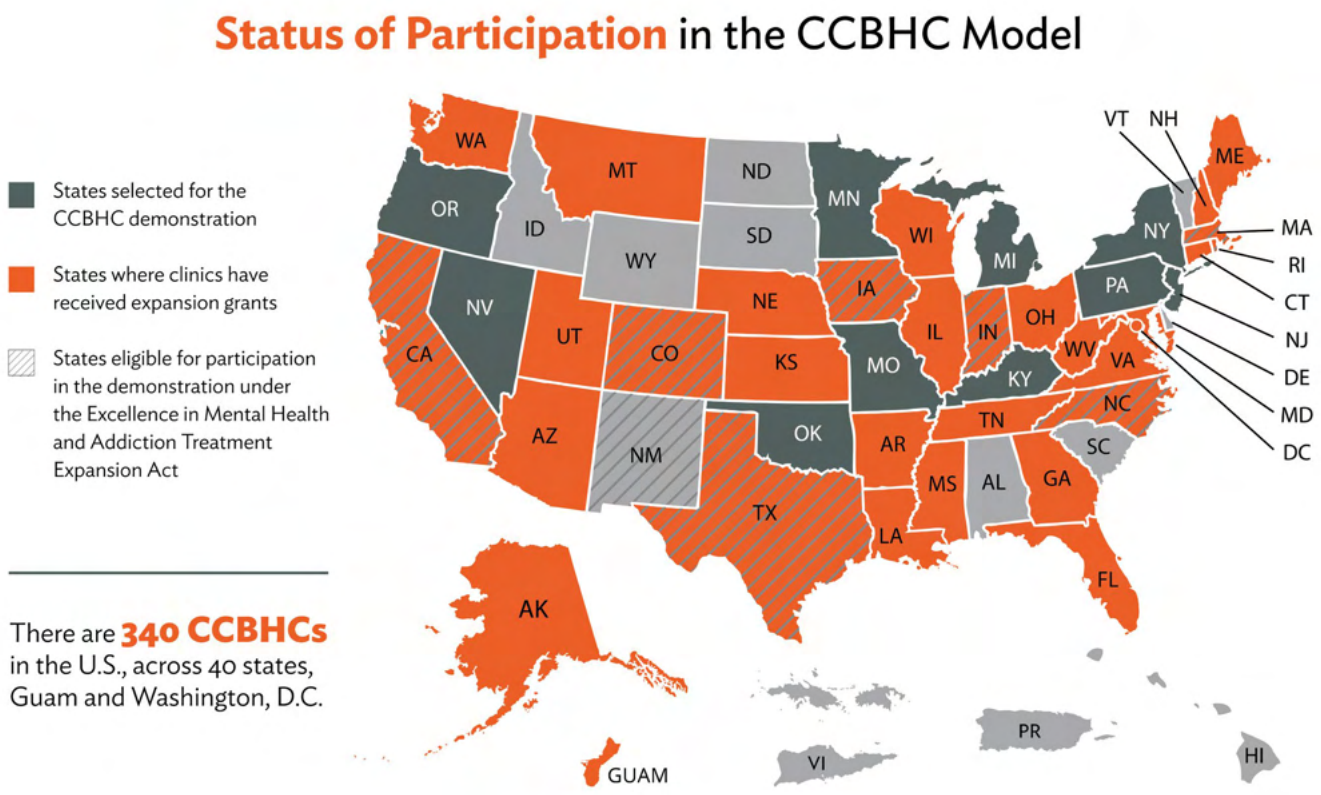
CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS AND COUNTY GOVERNMENTS

A National Model Tailored for Local Mental Health and Substance Use Care

MARCH 2021

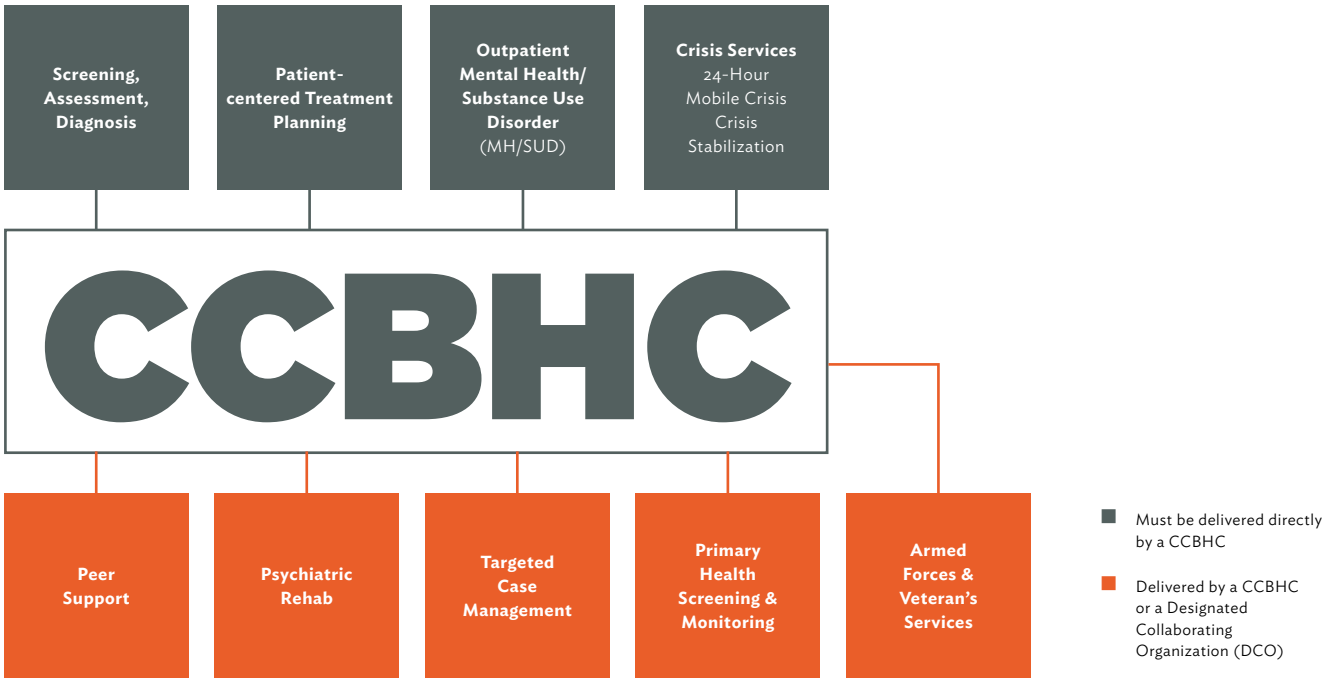
America's 3,069 counties are integral to the nation's behavioral health system, making fiscal investments in both community health systems and behavioral health services, while also coordinating and delivering services for those with mental illnesses and substance use conditions. From the county to the federal level, there is growing concern about the COVID-19 pandemic's long-term impacts on mental health and substance use and the threat of an ever-growing epidemic of deaths of despair from substance use and suicide. The Certified Community Behavioral Health Clinic (CCBHC) model is well-placed to respond to this anticipated surge with high-quality care that connects locally provided services to support treatment of a patient and the overall wellness of a community.

The CCBHC model launched in 2017 with 66 clinics across eight demonstration states leveraging Medicaid funding to support CCBHCs' costs of expanding access to new services and populations. Since 2018, Congress has appropriated funding that the Substance Abuse and Mental Health Services Administration (SAMHSA) awards directly to local providers to become CCBHC grantees, many of which are county-based mental health and substance use providers. As of March 2021, there are 10 CCBHC demonstration states and 340 county and non-profit CCBHCs in 40 states, Guam and the District of Columbia – astonishing program growth in just four years. Not only are CCBHCs delivering high-quality care, they are collecting data and establishing innovative partnerships with other entities in the community to help ensure people can achieve recovery. Visit the National Council for Mental Wellbeing's CCBHC Locator to find if there are CCBHCs operating in your county.



How CCBHCs Are Different from Other Community Providers

The CCBHC model aligns financing with the ideal clinical care model, founded on person-centered treatment, care coordination and integration, evidence-based practice, timely access to care including 24/7 crisis response and the flexibility to deliver support outside the four walls of the clinic. CCBHCs must meet standardized criteria that includes, but is not limited to, staffing, timeliness of access, quality reporting and scope of services (outlined in the following chart) While many of these services are available at other community-based organizations, few traditional providers (e.g., community mental health center, opioid treatment program, Federally Qualified Health Center) are able to offer the entire array of CCBHC services and supports, largely due to historical health care financing constraints. Special funding – either grant funds or a Medicaid cost-related payment rate – supports CCBHCs in the full anticipated costs of carrying out these activities.



CCBHCs are required to offer a comprehensive scope of services and may partner with existing community-based organizations (known as designated collaborating organizations) to fulfill this requirement.

Linking Federal Policy to County Efforts

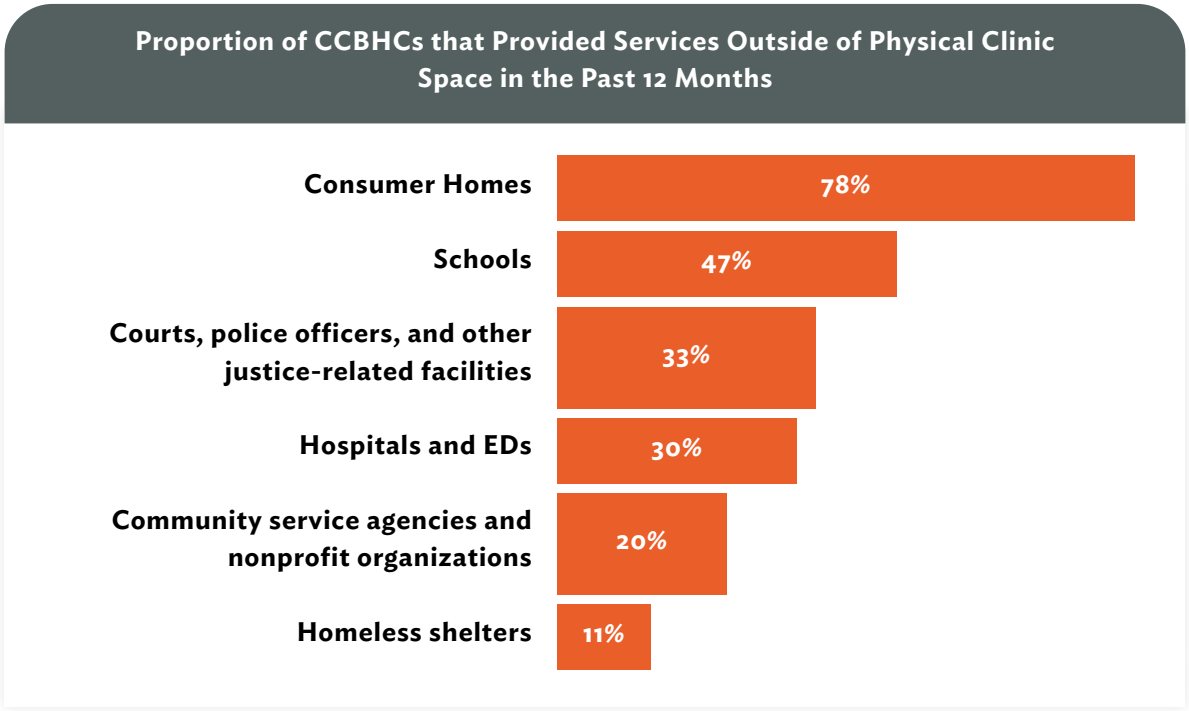
The federal government provided a minimum framework and definition for CCBHCs, with opportunities for states and clinics to customize the model to local needs. Central to this process is a needs assessment, which states and/or CCBHCs conduct to understand what populations are underserved, what staff trainings are necessary to deliver appropriate care specific to these populations and what partnerships with other local health and social service providers should be formalized to ensure there are no wrong doors to care. Because all communities have different needs and the CCBHC model provides the ability to tailor innovations to meet those needs, participating communities have made tremendous progress in expanding access to services and supports most critical for their own populations. According to data from the first years of the program, CCBHCs are:

- **Expanding Access to Addiction Care and Strengthening Response to the Opioid Crisis** — All CCBHCs have either launched new addiction treatment services or expanded the scope of their addiction care and 92%[1] offer medication-assisted treatment (MAT) for opioid use disorders (OUD). These actions include providing the support for prescribers to be buprenorphine-waivered or hiring ones who already can prescribe the OUD medication.
- **Serving More People Needing Mental Health Services, Including Youth** — In the first year alone, patient caseloads increased by nearly 25% based on expanded staff capabilities and new programs, with the greatest increase coming from individuals seeking services for the first time. Clinics also shared an increase in access for children and youth. For example, New York expanded access to care among children and youth by 24% in communities served by CCBHCs statewide.[2]
- **Reducing Wait Times to Access Treatment** — Most CCBHCs (78%) can offer an appointment within a week after an initial call or referral, in contrast to a national average wait time of 48 days. CCBHCs in Texas have eliminated waitlists.[3] Similar findings have been shared in other states with CCBHCs.

Counties Leveraging CCBHC Partnerships to Increase Access

Policymakers at the local and state levels are looking to CCBHCs to provide increased access to mental health and addiction treatment because the model addresses the longstanding gap in unmet need for care that far too often leaves police, jails and emergency departments as the primary responders to people with mental health or substance use needs. CCBHCs may have formalized partnerships with non-health entities within a county or region such as schools, public welfare programs and law enforcement (e.g., police, prosecutors, jails courts). Public and private human and social services agencies often partner through CCBHCs to directly provide

[1] https://aspe.hhs.gov/system/files/pdf/263966/CCBHCRptCong19.pdf
[2] https://engage.thenationalcouncil.org/HigherLogic/System/DownloadDocumentFile.ashx?DocumentFileKey=ae172324-d007-4e20-8133-fccb4366e7e6
[3] https://www.thenationalcouncil.org/?api&do=attachment&name=ccbhcs-a-new-model-for-behavioral-health-gaining-momentum-in-states&index=0&type=webinars



meaningful programs, coordinate with other service providers and provide referrals to other external resources. While these partnerships are vital to ensuring programs are connected and dollars are used well, meeting patients where they live is common and may occur through referrals with these other health and non-health partners. Nearly all (93%) CCBHCs provided services outside the four walls of the clinic, in locations such as consumers' homes, schools, courts, hospitals, community service agencies and more (see graph above).[4]

According to the National Association of Counties (NACo), counties annually invest more than $100 billion in community health systems, including mental health and addiction services, and county-based behavioral health services exist in 23 states that represent 75% of the U.S. population. Through 750 behavioral health authorities and community providers, county governments plan and operate community-based services for people with mental illnesses and substance abuse conditions. Counties also help finance Medicaid, the largest source of funding for behavioral health services in the U.S., and serve as the local safety-net, administering wrap-around human services supports. Counties also finance schools, jails and hospitals, as well as many other local entities with which CCBHC may partner. These partnerships provide a return on investment (ROI).For every $1 invested in substance use care, data show a $4 to $7 return in one year's time.[5] For mental health conditions like depression and anxiety, the ROI is $1 to $3 initially and grows to $7 over time.[6] These dollars assess broad general fund allocations. While health and human services may invest these funds, the impact or return is felt in other areas as well such as criminal justice, education and workforce development. Specifically, for justice-involved persons, data show that for every $1 invested in evidence-based efforts, up to a $40 return can be achieved.[7]

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[4] Breslau, Joshua, J. Scott Ashwood, Courtney Ann Kase, Harold Alan Pincus, and Susan L. Lovejoy, Evaluation Design Recommendations for the Certified Community Behavioral Health Clinic Demonstration Program. Santa Monica, CA: RAND Corporation, 2016. https://www.rand.org/pubs/research_reports/RR1439.html.

[5] https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/frequently-asked-questions/drug-addiction-treatment-worth-its-cost#:~:text=Drug%20addiction%20treatment%20reduces%20drug,criminal%20justice%20costs%2C%20and%20theft.

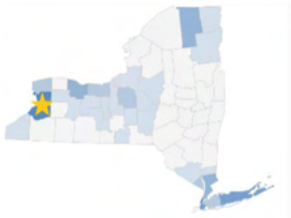
[6] https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(16)30024-4/fulltext

[7] https://openminds.com/market-intelligence/executive-briefings/roi-serving-justice-involved-consumers/

CCBHCs support county and state efforts to allocate existing dollars more efficiently in ways that engage people in treatment early, keep them from developing poor health outcomes, go beyond episodic crisis response to models that link people in crisis to a full care continuum, improve care coordination and integration to adequately address physical health conditions among people with behavioral health diagnoses, strengthen partnerships and referral relationships across social service systems and build capacity in the behavioral health safety-net to respond to rising community needs.

Six Local Innovations in Partnership with Criminal Justice Agencies[8]

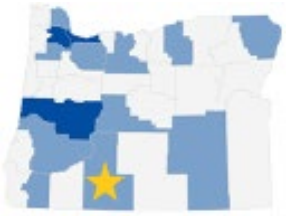
Among the most important partnerships CCBHCs have established are those with courts, law enforcement officers, jails and other justice-related facilities. CCBHCs and their criminal justice partners are working to divert individuals from arrest to treatment, provide support to incarcerated people upon re-entry and support emergency crisis response.



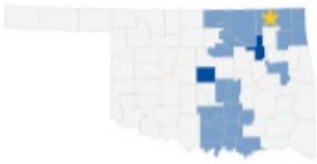
BestSelf (Erie County, N.Y.) *provides counseling and education services in the Niagara County jail, along with MAT. This CCBHC also operates a mobile unit staffed by a counselor, a peer support specialist and access to a doctor and nurse via telemedicine. The mobile unit meets inmates upon their release from incarceration and can transport individuals with opioid addiction to their first medication-assisted treatment appointment. The county's jail administrator stated, "Now, because of our collaboration with BestSelf, we have seen reductions in recidivism among Erie County residents who were incarcerated here in Niagara County."*[9]

[8] The following examples highlight clinics that are certified by their state or granted by SAMHSA. The counties are colored shades of blue to identify the concentration of CCBHCs or CCBHC services in the county. A gold star identifies where the CCBHC example is located.

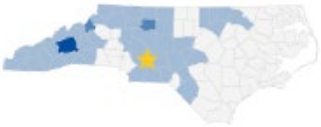
[9] https://www.thenationalcouncil.org/wp-content/uploads/2018/12/Daniel-Engert-statement_FINAL-PRINT-VERSION.pdf?daf=375ateTbd56



Klamath Basin Behavioral Health (Klamath County, Ore.) *provides onsite services in partnership with a local jail, beginning with daily copies of booking reports, following up with clients who have a treatment history and conducting check-ins with anyone who has been incarcerated. This CCBHC works to link individuals to services in the community, complete behavioral health assessments and develop or adjust treatment plans. Klamath County now has the lowest recidivism rate in Southern Oregon and estimates they are saving the state $2.5 million in prison beds.*[10]

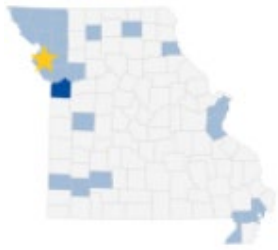


Grand Lakes Mental Health Center (Nowata County, Okla.), *which serves 12 counties, provides its rural law enforcement officers with tablets that automatically connect a person with a trained mental health counselor who can deliver support the moment an officer is called to respond to a person in crisis. Grand Lakes also established a crisis stabilization center where officers can take people for immediate care rather than attempting to find a hospital bed for them. The clinic estimates they have saved officers more than 6,000 hours driving. Their efforts have cut the emergency psychiatric hospitalization rate by 95% since the beginning of the program.*[11]

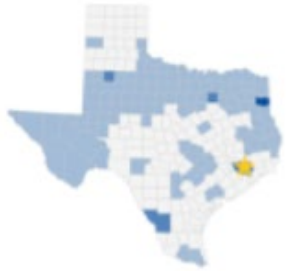


Monarch (Stanly County, N.C.) *launched an EMS Rapid Opioid Overdose Team, a collaboration between Monarch and Stanly County EMS to administer buprenorphine in the field, connect individuals to peer support during the moment of emergency response and link them to appropriate treatment. Over a two-year period, this team was able to provide support to 120 people in their community who had experienced an overdose. Monarch's Peer Support was utilized as the key engagement piece to build relationships and connect people in the community with the right level of care needed for each individual.*[12]

[10] https://www.thenationalcouncil.org/wp-content/uploads/2020/03/2020-CCBHC-Impact-Report.pdf?daf=375ateTbd56
[11] ibid
[12] ibid



Family Guidance Center (Buchanan County, Mo.) *serves nine counties in Northwest Missouri. The clinic created a law enforcement center liaison, a full-time position located in their local jail, to work as a discharge planner with individuals who are set to be released from incarceration. The liaison also completes assessments, connects individuals to needed behavioral health treatment and provides crisis services or mental health services onsite at the correctional facilities. This effort is part of a statewide model to embed CCBHC staff into law enforcement settings likes jails and courts to prevent incarceration and recidivism.*[13]



The Harris County Center for Mental Health and Intellectual Development Disorder (Harris County, Texas) *diverted 3,069 people with mental illness from the Harris County Jail in its first two years of operation. Prior evidence from 2016 showed that of 4,585 defendants booked into the jail for trespassing charges, 85% of them had a mental health and/or homelessness issue. Through the clinic's diversion effort, there was a 50% reduction in bookings. Researchers through the University of Houston found that for every $1 spent on diversion, the county avoided spending $5.54 on criminal justice.*[14]

Robust services and supports delivered through a CCBHC can provide a lifeline to individuals with mental health and substance use conditions and can greatly improve long-term outcomes. CCBHCs continue to grow and coordinate with a variety of local and county partners. Partnerships with law enforcement organizations have shown a significant impact in cost saving as well as increased access to care.

States can implement the CCBHC model through a Medicaid state plan amendment or waiver, with a growing number of states moving toward this option. Counties can work with their states to advocate for the CCBHC model, including by making the case that Medicaid CCBHC implementation offers a sustainable funding mechanism for the grant-funded (but time-limited) CCBHC activities currently taking place in their communities. The National Council for Mental Wellbeing and the National Association of Counties are available for more information as a resource.

Visit the National Council's CCBHC Success Center or the National Association of Counties to learn more.

[13] ibid
[14] https://www.nasmhpd.org/content/ta-coalition-webinar-innovation-collaboration-and-partnership-between-crisis-services-and