

The Role of Certified Community Behavioral Health Clinics in Improving Outcomes for Children and Families Using the System of Care Approach

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TAKEAWAYS

- **Certified Community Behavioral Health Clinics (CCBHCs)** are well-positioned to provide coordinated behavioral health services tailored for children, youth, and their families, aligned with **System of Care (SOC)** core values and principles.
- The **SOC approach** — grounded in family- and youth-driven, community-based, and adaptive and individualized care — offers a proven framework for improving outcomes for children, youth, and their families through a coordinated and comprehensive array of home- and community-based services and supports by cross-system collaboration.
- This brief explores the critical role CCBHCs play in improving outcomes for children, youth, and their families as a partner in delivering coordinated services within an SOC framework and identifies opportunities to align SOC values and principles with CCBHC certification criteria.

The System of Care (SOC) approach is an effective model for delivering comprehensive, coordinated behavioral health services to improve outcomes for children, youth, and families.¹ This approach provides a framework for a comprehensive array of services and supports for children, youth, and their families, sustained through a cross-system infrastructure and anchored by a set of core values and principles (*see sidebar, next page*). The SOC approach is a key component of the Substance Abuse and Mental Health Services Administration's (SAMHSA) Children's Mental Health Initiative (CMHI).² SAMHSA has issued CMHI grants to jurisdictions seeking to improve children's behavioral health services by supporting the development of a comprehensive SOC for over 30 years.³

Community-based providers — such as Certified Community Behavioral Health Clinics (CCBHCs) — that put the core values and principles of the SOC approach into practice can play a key role in implementing the approach. CCBHCs provide accessible, coordinated, and comprehensive behavioral health services to anyone who needs them, regardless of their age, ability to pay, or place of residence.⁴



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While CCBHCs serve a broad population, they are a key partner in addressing the unique needs of children and their families, which differ significantly from those of adults.

There are more than 500 CCBHCs funded through Section 223 Medicaid demonstrations, other Medicaid authorities (i.e., 1115 waiver or state plan), or SAMHSA expansion grants, operating in 46 states, the District of Columbia, and Puerto Rico.^{5,6,7} Regardless of funding source, all CCBHCs are required by law to provide **nine core services** (see *Exhibit 1, page 4*) directly or through a formal agreement with a designated collaborating organization (DCO).⁸

This brief, informed by a review of academic and other reports and resources, outlines the critical role that CCBHCs can play in supporting the delivery of comprehensive children’s behavioral health services within an SOC framework.

The brief provides recommendations for policymakers and community providers implementing CCBHC certification criteria, as updated in 2023, in alignment with SOC values and principles to ensure CCBHCs meet their obligation to effectively address the unique needs of children and families.¹⁹

Opportunities for CCBHCs to Support Systems of Care

By aligning service delivery with both CCBHC requirements and the SOC approach, policymakers and community providers are well-positioned to serve all populations (as required by the CCBHC certification criteria), including children, youth, and families, which can help reduce the need for intensive, high-cost care and improve outcomes. The following section outlines where CCBHCs naturally align with key SOC principles (see *sidebar, above*) and highlights opportunities for the SOC approach to better support children and families within the CCBHC model.

System of Care Core Values and Principles*

Core Values



1. Family- and youth-driven



2. Community-based



3. Adaptive and individualized*

Select Guiding Principles

- Comprehensive array of services and supports
- Individualized, strengths-based services and supports
- Evidence-based practices and practice-based evidence
- Trauma-informed
- Least restrictive natural environment
- Partnerships with families and youth
- Interagency collaboration
- Care coordination
- Physical health-mental health integration
- Developmentally appropriate services and supports
- Public health approach
- Data driven and accountability
- Rights protection and advocacy



* The System of Care core values and principles listed are adapted from *The Evolution of the System of Care Approach* by Beth Stroul, Gary Blau, and Justine Larsen, published in 2021.

¹ To view the 2023 CCBHC certification criteria, visit <https://www.samhsa.gov/communities/certified-community-behavioral-health-clinics/ccbhc-certification-criteria>

- **Leverage whole-population and public health approaches.** By embracing the whole-population, family-centered, and prevention-focused strategies at the core of the SOC approach, states can support the role of CCBHCs as partners in cross-system collaboration. Because CCBHCs are required to serve all children and families — regardless of age, ability to pay, or where they live — they can implement a whole-population approach by serving all children and youth with behavioral health needs at varying intensities. Given the broad scope of populations served, CCBHCs have a unique opportunity to support the entire family unit. Supporting the behavioral health and overall well-being of children requires addressing the needs, strengths, and circumstances of their families. In accordance with a public health approach, CCBHCs can be an effective community partner in delivering behavioral health services alongside state and other local agencies.
- **Provide care coordination.** Additionally, CCBHCs are required to coordinate an array of services. This support — helping families navigate multiple systems — can help mitigate challenges in accessing and receiving behavioral health care from fragmented and often siloed child-serving systems. This aligns directly with the guiding principle of care coordination in the SOC approach. Almost half (46 percent) of CCBHCs have established partnerships with child- and youth-serving organizations, such as school districts, family support centers, and specialty behavioral health providers, among others, to provide care coordination.¹⁰
- **Ensure a comprehensive array of services and supports.** CCBHCs must offer a broad array of services and supports to the communities they serve. Too often, adult-focused models and practices are used for all populations, which may not meet the unique needs of children, youth, and their families. Many CCBHCs have taken steps to tailor their service array for children and families, with over 70 percent of CCBHCs and DCOs using child- and youth-focused models and practices, such as coordinated specialty care for first episode psychosis, youth peer support, and specialized mobile response for youth.^{11,12} Exhibit 1 (*next page*) provides a crosswalk of services and supports designed specifically for children and families that align with the SOC approach and can be implemented to meet CCBHC service requirements.
- **Offer community-based services in the least restrictive environment.** CCBHCs are designed to offer services in communities. Clinics can expand their reach by partnering with schools, family and youth-run organizations, state or county government child-serving agencies, and community providers, aligning with the SOC principle of offering services in the least restrictive setting — the child’s home and community. Over 80 percent of CCBHCs provide services within at least one school, childcare facility, or other entity that serves youth, and more than 35 percent of CCBHCs partner with a school-based health center, providing greater accessibility for children and youth in the community.¹³

Exhibit 1. Crosswalk of CCBHC-Required Services with Service Options Aligned with the SOC Approach

CCBHC-Required Services	SOC Recommended Service/Support Model
1. Crisis services, including 24-hour mobile crisis teams, emergency crisis intervention, and crisis stabilization	<ul style="list-style-type: none"> Mobile response and stabilization services¹⁴
2. Screening, diagnosis, and risk assessment [‡]	<ul style="list-style-type: none"> Standardized screening and assessment through family and youth-centered tools, like the Child and Adolescent Needs and Strengths (CANS) Assessment and Child and Adolescent Level of Care/Service Intensity Utilization System (CALOCUS-CASII)^{15,16}
3. Person- and family-centered treatment planning, including risk assessment and crisis planning	<ul style="list-style-type: none"> High-Fidelity Wraparound Model or the Transition to Independence Process (TIP) Model^{17,18}
4. Outpatient mental health and substance use services	<ul style="list-style-type: none"> Individual, family, and group therapy Play therapy School-based mental health services
5. Outpatient primary care screening and monitoring	<ul style="list-style-type: none"> Partnership with primary care physicians specializing in pediatric care
6. Targeted case management	<ul style="list-style-type: none"> Intensive care coordination using the High-Fidelity Wraparound Model or the TIP Model^{19,20,21}
7. Psychiatric rehabilitation services	<ul style="list-style-type: none"> Intensive home-based treatment²² Therapeutic mentoring Therapeutic foster homes Residential treatment
8. Peer support and counselor services and family support	<ul style="list-style-type: none"> Family and youth peer support partners
9. Intensive community-based mental health care for armed forces and veterans [§]	<ul style="list-style-type: none"> Intensive home-based treatment²³ Intensive care coordination using the High-Fidelity Wraparound Model or the TIP Model^{24,25,26}

SOC Values



Family- and youth-driven:

Designed, developed, and delivered in partnership with individuals receiving services.



Community-based:

Focuses on maintaining the least restrictive environment for children, youth, and families.



Adaptive and individualized:

Meets the unique needs of each child or youth and their family.

[‡] Note that this aligns with behavioral health screening and treatment requirements for Medicaid-eligible children under 21 per CMS' [Early and Periodic Screening, Diagnostic and Treatment \(EPSDT\)](#).

[§] The authors recognize that the 18.3 million veterans and 1.27 million active-duty members of the armed forces in the U.S. are a critical part of family units, and many parents, siblings, and young adults are veterans. It is noted that one percent of veterans and 43 percent of the armed forces were ages 17 to 24 in 2023. (source: [US Department of Veterans Affairs](#) and [US Department of Defense](#)).

Recommendations for CCBHCs to Ensure Services are Appropriately Tailored to the Needs of Children and Families

Exhibit 2 (*below*) is organized into topic areas and summarizes recommendations for implementing the certification criteria to ensure services are tailored to the needs of children and families. For a more detailed crosswalk of relevant CCBHC criteria and recommendations, see the [Appendix](#) of this brief.

Exhibit 2. Recommendations for CCBHCs to Ensure Services are Tailored to the Needs of Children and Families

Topic Area	Recommendation	Applicable 2023 SAMHSA CCBHC Criteria**
Child-, Youth-, and Family-Centered Services	Ensure services are family- and youth-driven, with active involvement of families and youth in planning and decision-making, and are adapted to the unique needs of the child or youth and their family.	3.d.1 4.b.1–4.b.2 4.e.1–4.e.5
	Ensure access to and the delivery of screenings, assessments, and services tailored to children, youth, and young adults, such as those outlined in Exhibit 1 (<i>page 4</i>), and ensure alignment with state-established screening and assessment processes for specific child and youth populations (e.g., children involved with child welfare or justice systems, children who are unhoused, children with intellectual or developmental disabilities (I/DD)), when possible.	2.b.1 4.d.1–4.d.8 4.f.1–4.f.3
	Coordinate with schools, early childhood programs (e.g., HeadStart, home visiting), state and local child- and family-serving agencies (e.g., Medicaid, child welfare, juvenile justice, education, Indian Health Services), family- and youth-run organizations, specialty care management organizations, and other child and family providers (e.g., residential treatment facilities, therapeutic group and therapeutic foster homes, health homes, partial hospitalization programs, mobile response and crisis services) to effectively complete required assessments and offer services.	1.a.1 2.a.3 2.c.1–2.c.6 3.a.1 3.c.3 4.d.1
	Provide or develop a DCO agreement with an existing provider of crisis services tailored to children and youth — ideally, a provider of Mobile Response and Stabilization Services with someone to contact (available 24/7), someone to respond (available 24/7/365 for in-person response within one hour), and a system to support (in-home or community stabilization services for up to eight weeks after crisis). ²⁷	2.c.1–2.c.6 4.c.1
Care Coordination and Treatment Planning	Use the High-Fidelity Wraparound Model or the TIP Model for intensive care coordination, referral and linkage, treatment planning, discharge planning, and crisis planning for children and youth with complex needs. ^{28,29,30}	3.a.4 3.d.1–3.d.2 4.e.1–4.e.7 4.h.1
	Partner with organizations providing targeted case management to children, youth, and their families (e.g., care management entities or other DCOs already providing intensive care coordination). ³¹	3.c.1–3.c.5 3.d.1–3.d.2 4.h.1
	Include a child’s, youth’s, and family’s natural supports in care planning and incorporate these supports into service delivery, as appropriate.	3.d.1 4.e.2 4.e.4

** These criteria were originally published by SAMHSA in 2023; portions of this guidance may not be in alignment with the current administration’s Executive Orders.

Topic Area	Recommendation	Applicable 2023 SAMHSA CCBHC Criteria**
Workforce, Rates, and Staffing	Orient and provide ongoing training to all staff on SOC core values and principles, along with the specific services and supports appropriate for addressing the unique developmental needs of children, youth, and young adults.	1.c.1 1.c.3
	Recruit, employ, or contract staff with lived experience navigating children’s behavioral health systems, as well as staff with professional expertise in child and youth behavioral health and ensure availability of psychiatric consultation from a board-certified child psychiatrist.	1.a.2–1.a.3 1.b.2 4.j.1
	Include family peer and youth peer specialists, ideally connected to or employed by family- or youth-run organizations, in addition to adult peer specialists, as part of care teams and outreach activities.	1.b.2 2.a.6 4.j.1
	Ensure family peer and youth peer specialists have clear job descriptions, supervision, and support.	1.b.2 1.c.2–1.c.3
	Establish or designate leadership and management roles to oversee child and family services.	1.a.2–1.a.3
	Align rates and payment mechanisms with broader child- and youth-focused Medicaid managed care and value-based payment strategies being implemented in the jurisdiction and incentivize high-quality care for children, youth, and families. ³²	2.d.3
Access to and Continuity of Care	Ensure access to and continuity of services for children and youth involved in the child welfare and juvenile justice systems. Protocols may allow CCBHCs to continue serving children and youth involved with the child welfare system, even if they have been placed out of the catchment area of the CCBHC, if critical to maintaining treatment gains.	2.d.1 2.e.1–2.e.2 3.a.1 3.c.3
	Ensure access to and continuity of care through policy, protocols, care coordination, and tracking mechanisms for youth transitioning into and out of out-of-home treatment settings or transitioning to adult systems.	2.e.2 3.a.1 3.c.2–3.c.5
IT and Data Systems	Ensure data systems are designed to capture child- and youth-specific data related to clinical and functional outcomes (e.g., CMS’ Core Set of Children’s Health Care Quality Measures, educational progress, school attendance and performance, daily functioning, system involvement, length of stay in out-of-home treatment settings). ³³	3.b.1–3.b.2 5.a.1
	Monitor child and family outcomes, satisfaction, and prescription of psychiatric medication for children, at minimum, and use data to inform quality improvement initiatives.	3.b.1–3.b.2 5.a.1–5.a.2 5.b.1–5.b.2
Partnership with Youth and Family	Engage youth, young adults, parents, and caregivers early and often in the development, planning, and evaluation of CCBHC services and ensure there is an ongoing and open feedback loop for continuous quality improvement.	4.e.1 6.b.1
	Ensure governing or advisory board representation reflects the youth and families being served by the CCBHC and includes youth and family voices representing multiple perspectives.	6.b.1–6.b.2 6.b.4
	Cultivate a workplace culture that values the lived experience of families and youth who have navigated behavioral health systems and invites constructive disagreement. ³⁴	1.c.1 6.b.1

Key Takeaways and Conclusion

Both policymakers and community providers play a critical role in ensuring the behavioral health needs of children, youth, and families are met. By embedding SOC values and principles into infrastructure, guidance, and everyday practice, they can strengthen cross-system collaboration, enhance service delivery, and ensure more responsive, community-based care.

For Jurisdictions with CMHI Grants and State Agencies

Using the SOC approach, policymakers can take steps to support providers like CCBHCs in more effectively meeting the needs of children, youth, and families in community settings.

- 1. Create infrastructure to support cross-system collaboration.** It is essential to partner with and facilitate partnership among state and local child- and family-serving agencies, family-run and youth-run organizations, child- and family-providers (including CCBHCs and DCOs), youth and families with lived experience, and other stakeholders to successfully implement the SOC approach and build a coordinated service array for children and youth with behavioral health needs.
- 2. Embed SOC values and principles in policies, procedures, and communications, as well as provider contracts and manuals.** Incorporating language that reflects SOC values into state policies, procedures, and communications with partners, as well as contracts, provider manuals, and evaluations (including those for CCBHCs and DCOs) can help reinforce commitment to serving children, youth, and families.
- 3. Promote or require standardization of children's behavioral health screening and assessments.** Screening and assessment through family and youth-centered tools, like the CANS Assessment and CALOCUS-CASII, can be used across providers and systems (including CCBHCs and DCOs) to improve consistency in language and communication among systems and with families and youth.^{35,36} Streamlining screening and assessments across systems also assists SOC governance structures and policymakers in analyzing data for continuous quality improvement efforts.

For CCBHCs

By strengthening alignment with the SOC approach in their state, CCBHCs can improve quality of care for all populations, anticipate future state-level expectations, and position themselves as leaders in child- and family-centered care, ensuring sustainable outcomes.

- 1. Strengthen and support cross-system collaboration.** CCBHCs are a key partner in the SOC service array and are encouraged to partner with schools, family- and youth-run organizations, state and local agencies, and other child and family providers to extend their reach and ensure effective, coordinated care for children, youth, and their families.
- 2. Tailor services to children and families, rather than relying on adult models.** Children and families have unique needs that require specific attention in service development and delivery. The SOC approach can be used to ensure a focus on children, youth, and their families in CCBHCs. For example, CCBHCs can ground training and quality improvement processes in SOC values and principles.

3. Embed SOC values and principles in procedures, communications, service delivery, and training.

CCBHCs can lead with SOC core values and principles in their communications, partnerships, and service delivery. CCBHCs can integrate SOC principles into internal policies, procedures, staff development frameworks (including onboarding and supervision), and contracts. This may include updating policy manuals to reflect SOC core values, prioritizing provider training and continuing education aligned with the SOC approach, and embedding SOC practices, whether the CCBHC or a DCO delivers those services.

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a policy design and implementation partner devoted to improving outcomes for people enrolled in Medicaid. CHCS supports partners across sectors and disciplines to make more effective, efficient, and equitable care possible for millions of people across the nation. For more information, visit chcs.org.

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ABOUT THE NATIONAL TRAINING & TECHNICAL ASSISTANCE CENTER FOR CHILD, YOUTH, AND FAMILY MENTAL HEALTH (NTTAC)

NTTAC is a SAMHSA-funded initiative to increase access to, effectiveness of, and dissemination of evidence-based mental health services for young people and their families, including young people experiencing serious mental illness or serious emotional disturbance. NTTAC supports Children’s Mental Health Initiative grantees and provides an array of trainings, technical assistance, and resources to providers, organizations, and agencies from across the system of care. For more information, visit nttacmentalhealth.org.

Appendix. Detailed Crosswalk of Select 2023 SAMHSA CCBHC Criteria and Recommendations for Ensuring Services are Tailored to Children and Families³⁷

Program Requirement 1: Staffing

This program requirement describes:

- General staffing requirements, community needs assessment, and staffing plan
- Licensure and credentialing of providers
- Training related to cultural competence, trauma-informed care, and other areas
- Linguistic competence

Authority: Section 223 (a)(2)(A) of PAMA

The statute requires the published criteria to include criteria with respect to the following: “Staffing requirements, including criteria that staff have diverse disciplinary backgrounds, have necessary State required license and accreditation, and are culturally and linguistically trained to serve the needs of the clinic’s patient population.

2023 SAMHSA CCBHC Criteria*	Recommendation
<p>1.a.1 - As part of the process leading to certification and recertification, and before certification or attestation, a community needs assessment (see Appendix A: Terms and Definitions for required components of the community needs assessment) and a staffing plan that is responsive to the community needs assessment are completed and documented (<i>To view appendix A and the full list of certification criteria, visit https://www.samhsa.gov/communities/certified-community-behavioral-health-clinics/ccbhc-certification-criteria</i>). The needs assessment and staffing plan will be updated regularly, but no less frequently than every three years. Certifying states may specify additional community needs assessment requirements.</p>	<p>The needs assessment should specifically address the needs of the child, youth, and young adult (i.e., transition age, 18-26) populations and staffing requirements specific to serving children, youth, and young adult populations and their families. Preparation and updating of the needs assessment and staffing plan should include active participation from families, youth, and young adults with varying perspectives and lived experience in navigating behavioral health and other child-serving systems.</p>
<p>1.a.2 - The staff (both clinical and non-clinical) is appropriate for the population receiving services, as determined by the community needs assessment, in terms of size and composition and providing the types of services the CCBHC is required to and proposes to offer.</p> <p>Note: See criteria 4.k relating to required staffing of services for veterans</p>	<p>The size and composition of the staff should encompass a sufficient number of staff trained in child and adolescent behavioral health and includes families.</p>

*These criteria were originally published by SAMHSA in 2023; portions of this guidance may not be in alignment with the current administration’s Executive Orders.

2023 SAMHSA CCBHC Criteria*	Recommendation
<p>1.a.3 - The Chief Executive Officer (CEO) of the CCBHC, or equivalent, maintains a fully staffed management team as appropriate for the size and needs of the clinic, as determined by the current community needs assessment and staffing plan. The management team will include, at a minimum, a CEO or equivalent/Project Director and a psychiatrist as Medical Director. The Medical Director need not be a full-time employee of the CCBHC. Depending on the size of the CCBHC, both positions (CEO or equivalent and the Medical Director) may be held by the same person. The Medical Director will provide guidance regarding behavioral health clinical service delivery, ensure the quality of the medical component of care, and provide guidance to foster the integration and coordination of behavioral health and primary care.</p> <p>Note: If a CCBHC is unable, after reasonable efforts, to employ or contract with a psychiatrist as Medical Director, a medically trained behavioral health care professional with prescriptive authority and appropriate education, licensure, and experience in psychopharmacology, and who can prescribe and manage medications independently, pursuant to state law, may serve as the Medical Director. In addition, if a CCBHC is unable to hire a psychiatrist and hires another prescriber instead, psychiatric consultation will be obtained regarding behavioral health clinical service delivery, quality of the medical component of care, and integration and coordination of behavioral health and primary care.</p>	<p>The CCBHC leadership and management team should include a Director of Child and Youth Services with experience in navigating behavioral health and child-serving systems who will ensure the implementation of a system of care approach to services, supports and coordination for children, youth, young adults, and their families.</p> <p>CCBHC should ensure availability of psychiatric staffing or consultation from a board-certified child and adolescent psychiatrist.</p>
<p>1.b.2 - The CCBHC staffing plan meets the requirements of the state behavioral health authority and any accreditation standards required by the state. The staffing plan is informed by the community needs assessment and includes clinical, peer, and other staff. In accordance with the staffing plan, the CCBHC maintains a core workforce comprised of employed and contracted staff. Staffing shall be appropriate to address the needs of people receiving services at the CCBHC, as reflected in their treatment plans, and as required to meet program requirements of these criteria. CCBHC staff must include a medically trained behavioral health care provider, either employed or available through formal arrangement, who can prescribe and manage medications independently under state law, including buprenorphine and other FDA approved medications used to treat opioid, alcohol, and tobacco use disorders. This would not include methadone, unless the CCBHC is also an Opioid Treatment Program (OTP). If the CCBHC does not have the ability to prescribe methadone for the treatment of opioid use disorder directly, it shall refer to an OTP (if any exist in the CCBHC service area) and provide care coordination to ensure access to methadone. The CCBHC must have staff, either employed or under contract, who are licensed or certified substance use treatment counselors or specialists. If the Medical Director is not experienced with the treatment of substance use disorders, the CCBHC must have experienced addiction medicine physicians or specialists on staff, or arrangements that ensure access to consultation on addiction medicine for the Medical Director and clinical staff. The CCBHC must include staff with expertise in addressing trauma and promoting the recovery of children and adolescents with serious emotional disturbance (SED) and adults with serious mental illness (SMI). Examples of staff include a combination of the following: (1) psychiatrists (including general adult psychiatrists and subspecialists), (2) nurses, (3) licensed independent clinical social workers, (4) licensed mental health counselors, (5) licensed psychologists, (6) licensed marriage</p>	<p>Permit CCBHCs to contract for their family and youth peer staff through a family- or youth-run organization. Require that family and youth peer specialists, if employed by the CCBHC, be connected to a family- or youth-run organization where possible for ongoing coaching, supervision, and support.</p>

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2023 SAMHSA CCBHC Criteria*	Recommendation
<p>and family therapists, (7) licensed occupational therapists, (8) staff trained to provide case management, (9) certified/trained peer specialist(s)/recovery coaches, (10) licensed addiction counselors, (11) certified/trained family peer specialists, (12) medical assistants, and (13) community health workers.</p> <p>The CCBHC supplements its core staff as necessary in order to adhere to program requirements 3 and 4 and individual treatment plans, through arrangements with and referrals to other providers.</p> <p>Note: Recognizing professional shortages exist for many behavioral health providers: (1) some services may be provided by contract or part-time staff as needed; (2) in CCBHC organizations comprised of multiple locations, providers may be shared across locations; and (3) the CCBHC may utilize telehealth/telemedicine, video conferencing, patient monitoring, asynchronous interventions, and other technologies, to the extent possible, to alleviate shortages, provided that these services are coordinated with other services delivered by the CCBHC. The CCBHC is not precluded by anything in this criterion from utilizing providers working towards licensure if they are working under the requisite supervision. Certifying states should specify which staff disciplines they will require as part of certification.</p>	
<p>1.c.1 - The CCBHC has a training plan for all CCBHC employed and contract staff who have direct contact with people receiving services or their families. The training plan satisfies and includes requirements of the state behavioral health authority and any accreditation standards on training required by the state. At orientation and at reasonable intervals thereafter, the CCBHC must provide training on:</p> <ul style="list-style-type: none"> ● Evidence-based practices ● Cultural competency (described below) ● Person-centered and family-centered, recovery-oriented planning and services ● Trauma-informed care ● The clinic’s policy and procedures for continuity of operations/disasters ● The clinic’s policy and procedures for integration and coordination with primary care ● Care for co-occurring mental health and substance use disorders <p>At orientation and annually thereafter, the CCBHC must provide training on risk assessment; suicide and overdose prevention and response; and the roles of family and peer staff. Trainings may be provided online. Training shall be aligned with the National Standards for Culturally and Linguistically Appropriate Services (CLAS) to advance health equity, improve quality of services, and eliminate disparities. To the extent active-duty military or veterans are being served, such training must also include information related to military culture. Examples of training and materials that further the ability of the clinic to provide tailored training for a diverse population include, but are not limited to, those available through the HHS website, the SAMHSA website, the HHS Office of Minority Health, or through the website of the Health Resources and Services Administration.</p> <p>Note: See criteria 4.k relating to cultural competency requirements in services for veterans.</p>	<p>The training plan should address training specific to services and supports for child, youth, and young adult populations.</p> <p>Ensure training emphasizes a workplace culture that values the experience of families and youth and invites open dialogue and feedback.</p>

*These criteria were originally published by SAMHSA in 2023; portions of this guidance may not be in alignment with the current administration’s Executive Orders.

Program Requirement 2: Availability and Accessibility of Services

This program requirement describes:

- General requirements of access and availability
- Requirements for timely access to services and assessment
- Access to Crisis Management Services
- Provision of services regardless of ability to pay and residence

Authority: Section 223 (a)(2)(B) of PAMA

The statute requires the published criteria to include criteria with respect to the following: “Availability and accessibility of services, including: crisis management services that are available and accessible 24 hours a day, the use of a sliding scale for payment, and no rejection for services or limiting of services on the basis of a patient’s ability to pay or a place of residence.”

2023 SAMHSA CCBHC Criteria*	Recommendation
<p>2.a.3 - Informed by the community needs assessment, the CCBHC provides services at locations that ensure accessibility and meet the needs of the population to be served, such as settings in the community (e.g., schools, social service agencies, partner organizations, community centers) and, as appropriate and feasible, in the homes of people receiving services.</p>	<p>To the extent possible in accordance with state Medicaid program or other funding requirements, CCBHCs should provide services at locations suitable for children, youth, and young adults and their families, such as schools, early childhood settings (e.g., Head Start), and in their own homes.</p>
<p>2.a.6 - Informed by the community needs assessment, the CCBHC conducts outreach, engagement, and retention activities to support inclusion and access for underserved individuals and populations.</p>	<p>CCBHCs should employ family and youth peers to assist families, youth, and young adults in accessing services and for the provision of informal support.</p>
<p>2.b.1 - All people new to receiving services, whether requesting or being referred for behavioral health services at the CCBHC, will, at the time of first contact, whether that contact is in person, by telephone, or using other remote communication, receive a preliminary triage, including risk assessment, to determine acuity of needs. That preliminary triage may occur telephonically. If the triage identifies an emergency/crisis need, appropriate action is taken immediately (see 4.c.1 for crisis response timelines and detail about required services), including plans to reduce or remove risk of harm and to facilitate any necessary subsequent outpatient follow-up.</p> <ul style="list-style-type: none"> • If the triage identifies an urgent need, clinical services are provided, including an initial evaluation within one business day of the time the request is made. • If the triage identifies routine needs, services will be provided and the initial evaluation completed within 10 business days. • For those presenting with emergency or urgent needs, the initial evaluation may be conducted by phone or through use of technologies for telehealth/telemedicine and video conferencing, 	<p>For child, youth, and young adult populations, CCBHCs should utilize standardized screening and risk assessment instruments that are specific to these populations and align with other screening and risk assessments used in the state when possible.</p> <p>For children and youth, a comprehensive family and youth driven treatment plan that is adaptive to the cultural and linguistic context of children, youth, and families should be developed within 30 days of enrollment. This shortened time frame is more appropriate for children because their developmental and social needs shift more rapidly than adults.</p>

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2023 SAMHSA CCBHC Criteria*	Recommendation
<p>but an in-person evaluation is preferred. If the initial evaluation is conducted telephonically, once the emergency is resolved, the person receiving services must be seen in person at the next subsequent encounter and the initial evaluation reviewed. The preliminary triage and risk assessment will be followed by: (1) an initial evaluation and; (2) a comprehensive evaluation, with the components of each specified in program requirement 4. At the CCBHC’s discretion, recent information may be reviewed with the person receiving services and incorporated into the CCBHC health records from outside providers to help fulfill these requirements. Each evaluation must build upon what came before it. Subject to more stringent state, federal, or applicable accreditation standards, all new people receiving services will receive a comprehensive evaluation to be completed within 60 calendar days of the first request for services. If the state has established independent screening and assessment processes for certain child and youth populations or other populations, the CCBHC should establish partnerships to incorporate findings and avoid duplication of effort. This requirement does not preclude the initiation or completion of the comprehensive evaluation, or the provision of treatment during the 60-day period.</p> <p>Note: Requirements for these screenings and evaluations are specified in criteria 4.d.</p>	
<p>2.c.1 - In accordance with program requirement 4.c, the CCBHC provides crisis management services that are available and accessible 24 hours a day, seven days a week.</p>	<p>If there is already a statewide mobile response and stabilization service system tailored to children and families in the jurisdiction the CCBHC is located in, the CCBHC should connect to the existing system and providers using a DCO.³⁸ If there is not, the CCBHC should seek to ensure the following when developing mobile response and crisis services to ensure they are appropriately tailored to children and families, either directly or through a DCO:</p> <ul style="list-style-type: none"> • The ability to serve children, youth, young adults, adults, members and veterans of the Armed Forces and their families, and older adults; • Partnership with local law enforcement, schools, EDs, early childhood programs, and child welfare providers; • Crisis Hotline, available 24 hours per day, 7 days per week, continually staffed by a trained and qualified specialist, able to triage the call to determine risk of harm and
<p>2.c.2 - A description of the methods for providing a continuum of crisis prevention, response, and postvention services shall be included in the policies and procedures of the CCBHC and made available to the public.</p>	
<p>2.c.3 - Individuals who are served by the CCBHC are educated about crisis planning, psychiatric advanced directives, and how to access crisis services, including the 988 Suicide & Crisis Lifeline (by call, chat, or text) and other area hotlines and warmlines, and overdose prevention, if risk is indicated, at the time of the initial evaluation meeting following the preliminary triage. Please see 3.a.4 for further information on crisis planning. This includes individuals with LEP or disabilities (i.e., CCBHC provides instructions on how to access services in the appropriate methods, language(s), and literacy levels in accordance with program requirement 1.d).</p>	
<p>2.c.4 - In accordance with program requirement 3, the CCBHC maintains a working relationship with local hospital emergency departments (EDs). Protocols are established for CCBHC staff to address the needs of CCBHC people receiving services in psychiatric crisis who come to those EDs.</p>	

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2023 SAMHSA CCBHC Criteria*	Recommendation
<p>2.c.5 - Protocols, including those for the involvement of law enforcement, are in place to reduce delays for initiating services during and following a behavioral health crisis. Shared protocols are designed to maximize the delivery of recovery-oriented treatment and services. The protocols should minimize contact with law enforcement and the criminal justice system, while promoting individual and public safety, and complying with applicable state and local laws and regulations.</p> <p>Note: See criterion 3.c.5 regarding specific care coordination requirements related to discharge from hospital or ED following a psychiatric crisis.</p>	<p>calibrate, from immediate response through the mobile crisis team to a scheduled visit within 48 hours;</p> <ul style="list-style-type: none"> • Mobile response teams who: <ul style="list-style-type: none"> ▶ Are available 24 hours per day/7 days a week; ▶ Provide face-to-face response in home- and community based settings within 1 hour of initial crisis contact; ▶ Coordinate with law enforcement as needed for safety; ▶ De-escalate the family-defined crisis; ▶ Assess for risk to self and others; ▶ Identify crisis precipitants to assist in developing or revising an individualized and family crisis plan; ▶ Provide mobile crisis intervention services, for up to 72 hours, providing immediate and direct intervention (in person or telephonically) and connections to ensure follow-up regarding referrals to community services; ▶ Facilitate access to CCBHC follow-up appointment with therapist within 24 hours of crisis response; and ▶ Offer peer support services to the youth and family. • Crisis stabilization, including in-home services and supports, referrals to services, and medication management, available for a period of 6-8 weeks after the initial response to family-defined process.
<p>2.c.6 - Following a psychiatric emergency or crisis, in conjunction with the person receiving services, the CCBHC creates, maintains, and follows a crisis plan to prevent and de-escalate future crisis situations, with the goal of preventing future crises.</p> <p>Note: See criterion 3.a.4 where precautionary crisis planning is addressed.</p>	
<p>2.d.1 - The CCBHC ensures: (1) no individuals are denied behavioral health care services, including but not limited to crisis management services, because of an individual’s inability to pay for such services (PAMA § 223 (a)(2)(B)); and (2) any fees or payments required by the clinic for such services will be reduced or waived to enable the clinic to fulfill the assurance described in clause (1).</p>	<p>CCBHCs should ensure access to behavioral health services for children, youth, and families, including youth and families involved with the child welfare and juvenile justice systems.</p>
<p>2.d.3 - The fee schedules, to the extent relevant, conform to state statutory or administrative requirements or to federal statutory or administrative requirements that may be applicable to existing clinics; absent applicable state or federal requirements, the schedule is based on locally prevailing rates or charges and includes reasonable costs of operation.</p>	<p>Align rates and payment mechanisms with broader Medicaid managed care and value-based payment strategies being implemented in the jurisdiction and incentivize high-quality care for children, youth, and families.</p>

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2023 SAMHSA CCBHC Criteria*	Recommendation
<p>2.e.1 - The CCBHC ensures no individual is denied behavioral health care services, including but not limited to crisis management services, because of place of residence, homelessness, or lack of a permanent address.</p>	<p>CCBHCs may not deny services to children or youth who are involved with other public systems, such as child welfare and juvenile justice.</p>
<p>2.e.2 - The CCBHC has protocols addressing the needs of individuals who do not live close to the CCBHC or within the CCBHC service area. The CCBHC is responsible for providing, at a minimum, crisis response, evaluation, and stabilization services in the CCBHC service area regardless of place of residence. The required protocols should address management of the individual’s on-going treatment needs beyond that. Protocols may provide for agreements with clinics in other localities, allowing the CCBHC to refer and track individuals seeking noncrisis services to the CCBHC or other clinics serving the individual’s area of residence. For individuals and families who live within the CCBHC’s service area but live a long distance from CCBHC clinic(s), the CCBHC should consider use of technologies for telehealth/telemedicine, video conferencing, remote patient monitoring, asynchronous interventions, and other technologies in alignment with the preferences of the person receiving services, and to the extent practical. These criteria do not require the CCBHC to provide continuous services, including telehealth, to individuals who live outside of the CCBHC service area. CCBHCS may consider developing protocols for populations that may transition frequently in and out of the services area, such as children who experience out-of-home placements and adults who are displaced by incarceration or housing instability.</p>	<p>CCBHCs should have protocols in place to ensure continuity of care for children involved with the child welfare system whose placement changes may affect CCBHC catchment area qualification. Protocols may allow the CCBHC to continue serving children even if they have been placed out of the catchment area to maintain continuity of care and further treatment gains.</p>

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Program Requirement 3: Care Coordination

This program requirement describes:

- General requirements of care coordination
- Health information systems
- Agreements to support care coordination
- Treatment team, planning, and care coordination activities

Authority: Section 223 (a)(2)(C) of PAMA

The statute requires the published criteria to include criteria with respect to the following: “Care coordination, including requirements to coordinate care across settings and providers to ensure seamless transitions for patients across the full spectrum of health services, including acute, chronic, and behavioral health needs. Care coordination requirements shall include partnerships or formal contracts with the following:

- Federally-qualified health centers (and as applicable, rural health clinics) to provide Federally-qualified health center services (and as applicable, rural health clinic services) to the extent such services are not provided directly through the certified community behavioral health clinic.
- Inpatient psychiatric facilities and substance use detoxification, post detoxification step-down services, and residential programs.
- Other community or regional services, supports, and providers, including schools, child welfare agencies, and juvenile and criminal justice agencies and facilities, Indian Health Service youth regional treatment centers, State licensed and nationally accredited child placing agencies for therapeutic foster care service, and other social and human services.
- Department of Veterans Affairs medical centers, independent outpatient clinics, drop in centers, and other facilities of the Department as defined in Section 1801 of title 38, United States Code.
- Inpatient acute care hospitals and hospital outpatient clinics.”

2023 SAMHSA CCBHC Criteria*	Recommendation
<p>3.a.1 - Based on a person-centered and family-centered treatment plan aligned with the requirements of Section 2402(a) of the Affordable Care Act and aligned with state regulations and consistent with best practices, the CCBHC coordinates care across the spectrum of health services. This includes access to high-quality physical health (both acute and chronic) and behavioral health care, as well as social services, housing, educational systems, and employment opportunities as necessary to facilitate wellness and recovery of the whole person. The CCBHC also coordinates with other systems to meet the needs of the people they serve, including criminal and juvenile justice and child welfare.</p> <p>Note: See criteria 4.k relating to care coordination requirements for veterans.</p>	<p>CCBHCs should coordinate with juvenile justice agencies, youth peer support organizations, family support organizations, and natural supports. CCBHCs may also coordinate with specialty care management arrangements in states, for example, care management entities designed for children and youth.³⁹</p> <p>Care coordination requirements should be clear that the CCBHC may use DCOs for care coordination for particular populations of children, youth, and young adults, for example, Care Management Entities providing intensive care coordination using a High Fidelity Wraparound model, Transition to Independence model, or health homes.^{40,41,42,43}</p>

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2023 SAMHSA CCBHC Criteria*	Recommendation
<p>3.a.2 - The CCBHC maintains the necessary documentation to satisfy the requirements of HIPAA (Pub. L. No. 104-191, 110 Stat. 1936 (1996)), 42 CFR Part 2, and other federal and state privacy laws, including patient privacy requirements specific to the care of minors. To promote coordination of care, the CCBHC will obtain necessary consents for sharing information with community partners where information is not able to be shared under HIPAA and other federal and state laws and regulations. If the CCBHC is unable, after reasonable attempts, to obtain consent for any care coordination activity specified in program requirement 3, such attempts must be documented and revisited periodically.</p> <p>Note: CCBHCs are encouraged to explore options for electronic documentation of consent where feasible and responsive to the needs and capabilities of the person receiving services. See standards within the Interoperability Standards Advisory.</p>	<p>CCBHCs should ensure that consent policies are consistent with the state’s consent or assent policies for youth under 18 or 21.</p>
<p>3.a.4 - The CCBHC shall coordinate care in keeping with the preferences of the person receiving services and their care needs. To the extent possible, care coordination should be provided, as appropriate, in collaboration with the family/caregiver of the person receiving services and other supports identified by the person. To identify the preferences of the person in the event of psychiatric or substance use crisis, the CCBHC develops a crisis plan with each person receiving services. At minimum, people receiving services should be counseled about the use of the National Suicide & Crisis Lifeline, local hotlines, warmlines, mobile crisis, and stabilization services should a crisis arise when providers are not in their office. Crisis plans may support the development of a Psychiatric Advanced Directive, if desired by the person receiving services.</p> <p>Psychiatric Advance Directives, if developed, are entered in the electronic health record of the person receiving services so that the information is available to providers in emergency care settings where those electronic health records are accessible.</p>	<p>For children, youth, and young adults, care coordination activities can reflect SOC values and principles (see page 2) and align with a High Fidelity Wraparound model that incorporates crisis and safety planning as part of care plan development and monitoring.⁴⁴</p> <p>Child/youth and family team (care planning) meetings should take place in locations most convenient for families and youth (i.e., community or home) and include both formal service providers and natural supports and helpers (e.g., coaches, clergy, family, friends identified by youth and family).</p>
<p>3.b.1 - The CCBHC establishes or maintains a health information technology (IT) system that includes, but is not limited to, electronic health records.</p>	<p>The CCBHC health IT system should have the ability to capture structured information specific to children, youth, young adults, and their families, including standardized assessment scores and other clinical and functional outcomes (e.g., CMS’ Core Set of Children’s Health Care Quality Measures, educational progress, school attendance and performance, daily functioning, system involvement, length of stay in out-of-home treatment settings). The system should also have the ability to support prescription monitoring of psychiatric medications to children and youth and outcomes specific to the child/youth population.</p>

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2023 SAMHSA CCBHC Criteria*	Recommendation
<p>3.b.2 - The CCBHC uses its secure health IT system(s) and related technology tools, ensuring appropriate protections are in place, to conduct activities such as population health management, quality improvement, quality measurement and reporting, reducing disparities, outreach, and for research. When CCBHCs use federal funding to acquire, upgrade, or implement technology to support these activities, systems should utilize nationally recognized, HHS-adopted standards, where available, to enable health information exchange. For example, this may include simply using common terminology mapped to standards adopted by HHS to represent a concept such as race, ethnicity, or other demographic information. While this requirement does not apply to incidental use of existing IT systems to support these activities when there is no targeted use of program funding, CCBHCs are encouraged to explore ways to support alignment with standards across data-driven activities.</p>	<p>Health IT system activities should include a discrete focus on children, youth, and young adult populations and their families. Data captured should be monitored and used to inform quality improvement initiatives.</p>
<p>3.b.5 - The CCBHC develops and implements a plan within two-years from CCBHC certification or submission of attestation to focus on ways to improve care coordination between the CCBHC and all DCOs using a health IT system. This plan includes information on how the CCBHC can support electronic health information exchange to improve care transition to and from the CCBHC using the health IT system they have in place or are implementing for transitions of care. To support integrated evaluation planning, treatment, and care coordination, the CCBHC works with DCOs to integrate clinically relevant treatment records generated by the DCO for people receiving CCBHC services and incorporate them into the CCBHC health record. Further, all clinically relevant treatment records maintained by the CCBHC are available to DCOs within the confines of federal and/or state laws governing sharing of health records.</p>	<p>The plan should include activities specific to the care coordination and care transition needs of children, youth, and young adults and their families (e.g., transitioning to adult systems/providers where needed).</p>
<p>3.c.2 - The CCBHC has partnerships that establish care coordination expectations with programs that can provide inpatient psychiatric treatment, OTP services, medical withdrawal management facilities and ambulatory medical withdrawal management providers for substance use disorders, and residential substance use disorder treatment programs (if any exist within the CCBHC service area). These include tribally operated mental health and substance use services, including crisis services that are in the service area. The clinic tracks when people receiving CCBHC services are admitted to facilities providing the services listed above, as well as when they are discharged, unless there is a formal transfer of care to a non-CCBHC entity. The CCBHC has established protocols and procedures for transitioning individuals from EDs, inpatient psychiatric programs, medically monitored withdrawal management services, and residential or inpatient facilities that serve children and youth, such as Psychiatric Residential Treatment Facilities and other residential treatment facilities, to a safe community setting. This includes transfer of health records of services received (e.g., prescriptions), active follow-up after discharge, and, as appropriate, a plan for suicide prevention and safety, overdose prevention, and provision for peer services.</p>	<p>CCBHC care coordination agreements should include a process for discharge/transition planning that begins at the time a child or youth is admitted to a facility. Discharge/transition planning for children, youth, and their families reflects SOC values and principles (see page 2) and ideally through a care management entity that uses High Fidelity Wraparound model or the Transition to Independence model.^{45,46,47,48}</p>

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2023 SAMHSA CCBHC Criteria*	Recommendation
<p>Note: These partnerships should be supported by a formal, signed agreement detailing the roles of each party. If the partnering entity is unable to enter into a formal agreement, the CCBHC may work with the partner to develop unsigned joint protocols that describe procedures for working together and roles in care coordination. At a minimum, the CCBHC will develop written protocols for supporting coordinated care undertaken by the CCBHC and efforts to deepen the partnership over time so that jointly developed protocols or formal agreements can be developed. All partnership activities should be documented to support partnerships independent of any staff turnover. Certifying states are encouraged to find ways to incentivize inpatient treatment facilities to partner with CCBHCs to establish protocols and procedures for transitioning individuals, including real time notification of discharge and record transfers that support the seamless delivery of care, maintain recovery, and reduce the risk of relapse and injury during transitions.</p>	
<p>3.c.3 - The CCBHC has partnerships with a variety of community or regional services, supports, and providers. Partnerships support joint planning for care and services, provide opportunities to identify individuals in need of services, enable the CCBHC to provide services in community settings, enable the CCBHC to provide support and consultation with a community partner, and support CCBHC outreach and engagement efforts. CCBHCs are required by statute to develop partnerships with the following organizations that operate within the service area: schools; child welfare agencies; juvenile and criminal justice agencies and facilities (including drug, mental health, veterans, and other specialty courts); Indian Health Service youth regional treatment centers; state licensed and nationally accredited child placing agencies for therapeutic foster care service; other social and human services.</p> <p>CCBHCs may develop partnerships with the following entities based on the population served, the needs and preferences of people receiving services, and/or needs identified in the community needs assessment. Examples of such partnerships include (but are not limited to) the following:</p> <ul style="list-style-type: none"> • Specialty providers including those who prescribe medications for the treatment of opioid and alcohol use disorders • Suicide and crisis hotlines and warmlines • Indian Health Service or other tribal programs • Homeless shelters • Housing agencies • Employment services systems • Peer-operated programs • Services for older adults, such as Area Agencies on Aging • Aging and Disability Resource Centers • State and local health departments and behavioral health and developmental disabilities agencies • Substance use prevention and harm reduction programs • Criminal and juvenile justice, including law enforcement, courts, jails, prisons, and detention centers • Legal aid 	<p>CCBHC care coordination agreements should include a process for care planning, incorporating treatment goals and progress without duplicating treatment plans that vary across providers. The agreements should reflect SOC values and principles (see page 2).</p> <p>In addition to those entities specified in §223(a)(2)(C), CCBHCs should coordinate care with the following child and youth providers:</p> <ul style="list-style-type: none"> • Psychiatric Residential Treatment Facilities; • Residential Treatment Centers; • Therapeutic group and therapeutic foster homes; • Partial Hospitalization/Day Treatment/Intensive Outpatient Treatment Programs; • Behavioral Health Diagnostic Facilities; • Family and youth/young adult peer support organizations; • Programs and services for families with young children, including Infants & Toddlers, WIC, Home Visiting Programs, and Early Head Start/Head Start; • State and local, child- and family-serving government agencies, including: behavioral health, developmental disabilities, juvenile justice, Medicaid, child welfare, and education, and specialized Care Management Entities; and

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2023 SAMHSA CCBHC Criteria*	Recommendation
<ul style="list-style-type: none"> • Immigrant and refugee services • SUD Recovery/Transitional housing • Programs and services for families with young children, including Infants & Toddlers, WIC, Home Visiting, Early Head Start/Head Start, and Infant and Early Childhood Mental Health Consultation • Coordinated Specialty Care programs for first episode psychosis • Other social and human services (e.g., intimate partner violence centers, religious services and supports, grief counseling, Affordable Care Act Navigators, food and transportation programs) <p>In addition, the CCBHC has a care coordination partnership with the 988 Suicide & Crisis Lifeline call center serving the area in which the CCBHC is located.</p> <p>Note: These partnerships should be supported by a formal, signed agreement detailing the roles of each party or unsigned joint protocols that describe procedures for working together and roles in care coordination. At a minimum, the CCBHC will develop written protocols for supporting coordinated care undertaken by the CCBHC and efforts to deepen the partnership over time so that jointly developed protocols or formal agreements can be developed. All partnership activities should be documented to support partnerships independent of any staff turnover. Certifying states may require CCBHCs to establish additional partnerships.</p>	<ul style="list-style-type: none"> • Health homes.
<p>3.d.1 - The CCBHC treatment team includes the person receiving services and their family/caregivers, to the extent the person receiving services desires their involvement or when they are legal guardians, and any other people the person receiving services desires to be involved in their care. All treatment planning and care coordination activities are person- and family-centered and align with the requirements of Section 2402(a) of the Affordable Care Act. All treatment planning and care coordination activities are subject to HIPAA (Pub. L. No. 104-191, 110 Stat. 1936 (1996)), 42 CFR Part 2, and other federal and state laws, including patient privacy requirements specific to the care of minors.</p>	<p>CCBHC care coordination agreements should include a process for care planning, incorporating treatment goals and progress without duplicating treatment plans that vary across providers. The agreements should reflect SOC values and principles (see page 2). The CCBHC requirements should be clear that treatment team, treatment planning, and care coordination may be contracted to a DCO, such as a care management entity that is already providing these functions for certain populations of children and youth, such as those with significant behavioral health needs.⁴⁹</p>

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2023 SAMHSA CCBHC Criteria*	Recommendation
<p>3.d.2 - The CCBHC designates an interdisciplinary treatment team that is responsible, with the person receiving services and their family/caregivers, to the extent the person receiving services desires their involvement or when they are legal guardians, for directing, coordinating, and managing care and services. The interdisciplinary team is composed of individuals who work together to coordinate the medical, psychiatric, psychosocial, emotional, therapeutic, and recovery support needs of the people receiving services, including, as appropriate and desired by the person receiving services, traditional approaches to care for people receiving services who are American Indian or Alaska Native or from other cultural and ethnic groups.</p> <p>Note: See criteria 4.k relating to required treatment planning services for veterans.</p>	<p>In states using High Fidelity Wraparound or Transition to Independence care coordination models, CCBHCs should use this capacity for care planning, incorporating treatment goals and progress without duplicating treatment plans that vary across providers, for designated subpopulations of children and youth through specific DCO arrangements.^{50,51}</p>

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Program Requirement 4: Scope of Services

This program requirement describes services delivered by CCBHCs directly or through its DCOs:

- Crisis services
- Screening, assessment, and diagnosis
- Person-centered and family-centered treatment planning
- Outpatient mental health and substance use services
- Primary care screening and monitoring
- Targeted case management services
- Psychiatric rehabilitation services
- Peer supports and family/caregiver supports
- Community care for uniformed service members and veterans

Authority: Section 223 (a)(2)(D) of PAMA

The statute requires the published criteria to include criteria with respect to the following: “Provision (in a manner reflecting person-centered care) of the following services which, if not available directly through the certified community behavioral health clinic, are provided or referred through formal relationships with other providers: (I) Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization. (II) Screening, assessment, and diagnosis, including risk assessment. (III) Patient-centered treatment planning or similar processes, including risk assessment and crisis planning. (IV) Outpatient mental health and substance use services. (V) Outpatient clinic primary care screening and monitoring of key health indicators and health risk. (VI) Targeted case management. (VII) Psychiatric rehabilitation services. (VIII) Peer support and counselor services and family supports. (IX) Intensive, community-based mental health care for members of the armed forces and veterans, particularly those members and veterans located in rural areas, provided the care is consistent with minimum clinical mental health guidelines promulgated by the Veterans Health Administration, including clinical guidelines contained in the Uniform Mental Health Services Handbook of such Administration.”

2023 SAMHSA CCBHC Criteria*	Recommendation
<p>4.a.1 - Whether delivered directly or through a DCO agreement, the CCBHC is responsible for ensuring access to all care specified in PAMA. This includes, as more explicitly provided and more clearly defined below in criteria 4.c through 4.k the following required services: crisis services; screening, assessment and diagnosis; person-centered and family-centered treatment planning; outpatient behavioral health services; outpatient primary care screening and monitoring; targeted case management; psychiatric rehabilitation; peer and family supports; and intensive community-based outpatient behavioral health care for members of the U.S. Armed Forces and veterans. The CCBHC organization will deliver directly the majority (51% or more) of encounters across the required services (excluding Crisis Services) rather than through DCOs.</p>	<p>CCBHCs serving children, youth and young adults should provide (directly or through a DCO), at a minimum, the following services, and incentivize the provision of services in the home, school and community-based settings:</p> <ul style="list-style-type: none"> • Intensive Care Coordination using a High Fidelity Wraparound or Transition to Independence model;^{52,53,54} • Family and Youth Peer Support Services, provided by individuals with lived experience; • Intensive In-Home Services;

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2023 SAMHSA CCBHC Criteria*	Recommendation
	<ul style="list-style-type: none"> • Respite Services; • Mobile Response and Stabilization Services;⁵⁵ • Flexible/Discretionary Funds (Customized Goods & Services); • Trauma-informed, evidence-based practices to address behavioral health and substance use disorders, including co-occurring disorders, Autism Spectrum Disorder, and first episode psychosis.
<p>4.a.4 - DCO-provided services for people receiving CCBHC services must meet the same quality standards as those provided by the CCBHC. The entities with which the CCBHC coordinates care and all DCOs, taken in conjunction with the CCBHC itself, satisfy the mandatory aspects of these criteria.</p>	<p>DCO child and youth providers must, at a minimum, have the same quality standards as the CCBHC and may have higher quality standards.</p>
<p>4.b.1 - The CCBHC ensures all CCBHC services, including those supplied by its DCOs, are provided in a manner aligned with the requirements of Section 2402(a) of the Affordable Care Act. These reflect person-centered and family-centered, recovery-oriented care; being respectful of the needs, preferences, and values of the person receiving services; and ensuring both involvement of the person receiving services and self-direction of services received. Services for children and youth are family-centered, youth-guided, and developmentally appropriate. A shared decision-making model for engagement is the recommended approach.</p> <p>Note: See program requirement 3 regarding coordination of services and treatment planning. See criteria 4.k relating specifically to requirements for services for veterans.</p>	<p>CCBHC services for children, youth, and families should be family and youth driven in alignment with SOC values (see page 2).</p>
<p>4.b.2 - Person-centered and family-centered care is responsive to the race, ethnicity, sexual orientation and gender identity of the person receiving services and includes care which recognizes the particular cultural and other needs of the individual. This includes, but is not limited to, services for people who are American Indian or Alaska Native (AI/AN) or other cultural or ethnic groups, for whom access to traditional approaches or medicines may be part of CCBHC services. For people receiving services who are AI/AN, these services may be provided either directly or by arrangement with tribal organizations.</p>	<p>CCBHC services for children, youth, and families should be family and youth driven and be adaptive and individualized to the unique and specific needs of the youth and family (see page 2).</p>
<p>4.c.1 - The CCBHC shall provide crisis services directly or through a DCO agreement with existing state-sanctioned, certified, or licensed system or network for the provision of crisis behavioral health services. HHS recognizes that state-sanctioned crisis systems may operate under different standards than those identified in these criteria. If a CCBHC would like to have a DCO relationship with a state-sanctioned crisis system that operates under less stringent standards, they must request approval from HHS to do so. Certifying states must request approval from HHS to certify CCBHCs in their states that have or seek to have a DCO relationship with a state-sanctioned crisis system with less stringent standards than those included in these criteria.</p>	<p>If there is already a statewide mobile response and stabilization service system tailored to children and families in the jurisdiction the CCBHC is located in, the CCBHC should connect to the existing system and providers using a DCO.⁵⁶ If there is not, the CCBHC should seek to ensure the following when developing mobile response and crisis services to ensure they are</p>

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2023 SAMHSA CCBHC Criteria*	Recommendation
<p>PAMA requires provision of these three crisis behavioral health services, whether provided directly by the CCBHC or by a DCO:</p> <ul style="list-style-type: none"> • Emergency crisis intervention services: The CCBHC provides or coordinates with telephonic, text, and chat crisis intervention call centers that meet 988 Suicide & Crisis Lifeline standards for risk assessment and engagement of individuals at imminent risk of suicide. The CCBHC should participate in any state, regional, or local air traffic control (ATC) 23 systems which provide quality coordination of crisis care in real-time as well as any service capacity registries as appropriate. Quality coordination means that protocols have been established to track referrals made from the call center to the CCBHC or its DCO crisis care provider to ensure the timely delivery of mobile crisis team response, crisis stabilization, and post-crisis follow-up care. • 24-hour mobile crisis teams: The CCBHC provides community-based behavioral health crisis intervention services using mobile crisis teams twenty-four hours per day, seven days per week to adults, children, youth, and families anywhere within the service area, including at home, work, or anywhere else where the crisis is experienced. Mobile crisis teams are expected to arrive in-person within one hour (2 hours in rural and frontier settings) from the time that they are dispatched, with response time not to exceed 3 hours. Telehealth/telemedicine may be used to connect individuals in crisis to qualified mental health providers during the interim travel time. Technologies also may be used to provide crisis care to individuals when remote travel distances make the 2-hour response time unachievable, but the ability to provide an in-person response must be available when it is necessary to assure safety. The CCBHC should consider aligning their programs with the CMS Medicaid Guidance on the Scope of and Payments for Qualifying Community-Based Mobile Crisis Intervention Services if they are in a state that includes this option in their Medicaid state plan. • Crisis receiving/stabilization: The CCBHC provides crisis receiving/stabilization services that must include, at minimum, urgent care/walk-in mental health and substance use disorder services for voluntary individuals. Urgent care/walk-in services that identify the individual’s immediate needs, de-escalate the crisis, and connect them to a safe and least-restrictive setting for ongoing care (including care provided by the CCBHC). Walk-in hours are informed by the community needs assessment and include evening hours that are publicly posted. The CCBHC should have a goal of expanding the hours of operation as much as possible. Ideally, these services are available to individuals of any level of acuity; however, the facility need not manage the highest acuity individuals in this ambulatory setting. Crisis stabilization services should ideally be available 24 hours per day, 7 days a week, whether individuals present on their own, with a concerned individual, such as a family member, or with a human service worker, and/or law enforcement, in accordance with state and local laws. In addition to these activities, the CCBHC may consider supporting or coordinating with peer-run crisis respite programs. The CCBHC is encouraged to provide crisis receiving/stabilization services in accordance with the SAMHSA National Guidelines for Behavioral Health Crisis Care. 	<p>appropriately tailored to children and families — either directly or through a DCO:</p> <ul style="list-style-type: none"> • The ability to serve children, youth, young adults, adults, members and veterans of the Armed Forces and their families, and older adults; • Partnership with law enforcement, schools, EDs, early childhood, and child welfare providers; • Crisis Hotline, available 24/7, continually staffed by a trained and qualified specialist, able to triage the call to determine risk of harm and calibrate from immediate response through the mobile crisis team to a scheduled visit within 48 hours; • Mobile response teams who: <ul style="list-style-type: none"> ▶ Are available 24 hours per day/7 days a week; ▶ Provide in home- and community-based response within 1 hour of initial crisis contact; ▶ Coordinate with law enforcement as needed for safety; ▶ De-escalate the family-defined crisis; ▶ Assess for risk to self and others; ▶ Identify crisis precipitants to assist in developing or revising an individualized and family crisis plan; ▶ Provide mobile crisis intervention, for up to 72 hours, providing immediate and direct intervention (in-person or telephonically) and connections to ensure follow-up regarding referrals to community services; ▶ Facilitate access to CCBHC follow-up appointment with therapist within 24 hours of crisis response; ▶ Offer peer support services to the youth and family. • Crisis stabilization, including in-home services and supports, referrals to services, and medication

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2023 SAMHSA CCBHC Criteria*	Recommendation
<p>Services provided must include suicide prevention and intervention, and services capable of addressing crises related to substance use, including the risk of drug- and alcohol-related overdose and support following a non-fatal overdose after the individual is medically stable. Overdose prevention activities must include ensuring access to naloxone for overdose reversal to individuals who are at risk of opioid overdose, and as appropriate, to their family members. The CCBHC or its DCO crisis care provider should offer developmentally appropriate responses, sensitive de-escalation supports, and connections to ongoing care, when needed. The CCBHC will have an established protocol specifying the role of law enforcement during the provision of crisis services. As a part of the requirement to provide training related to trauma-informed care, the CCBHC shall specifically focus on the application of trauma-informed approaches during crises.</p> <p>Note: See program requirement 2.c regarding access to crisis services and criterion 3.c.5 regarding coordination of services and treatment planning, including after discharge from a hospital inpatient or emergency department following a behavioral health crisis.</p>	<p>management, available for a period of 6-8 weeks after the initial response to family-defined process.</p>
<p>4.d.1 - The CCBHC directly, or through a DCO, provides screening, assessment, and diagnosis, including risk assessment for behavioral health conditions. In the event specialized services outside the expertise of the CCBHC are required for purposes of screening, assessment, or diagnosis (e.g., neuropsychological testing or developmental testing and assessment), the CCBHC refers the person to an appropriate provider. When necessary and appropriate screening, assessment, and diagnosis can be provided through telehealth/telemedicine services.</p> <p>Note: See program requirement 3 regarding coordination of services and treatment planning</p>	<p>If the state has established independent screening and assessment processes for certain child and youth populations, the CCBHC should have partnerships in place to engage with those processes and not duplicate existing processes.</p>
<p>4.d.3 - The initial evaluation (including information gathered as part of the preliminary triage and risk assessment, with information releases obtained as needed), as required in program requirement 2, includes at a minimum:</p> <ol style="list-style-type: none"> 1. Preliminary diagnoses 2. The source of referral 3. The reason for seeking care, as stated by the person receiving services or other individuals who are significantly involved 4. Identification of the immediate clinical care needs related to the diagnosis for mental and substance use disorders of the person receiving services 5. A list of all current prescriptions and over-the-counter medications, herbal remedies, and dietary supplements and the indication for any medications 6. A summary of previous mental health and substance use disorder treatments with a focus on which treatments helped and were not helpful 	<p>The assessment for children, youth, and young adults should include identification of whether the child is involved in the child welfare, juvenile justice, or special education systems and/or is without housing.</p>

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2023 SAMHSA CCBHC Criteria*	Recommendation
<p>7. The use of any alcohol and/or other drugs the person receiving services may be taking and indication for any current medications</p> <p>8. An assessment of whether the person receiving services is a risk to self or to others, including suicide risk factors</p> <p>9. An assessment of whether the person receiving services has other concerns for their safety, such as intimate partner violence</p> <p>10. Assessment of need for medical care (with referral and follow-up as required)</p> <p>11. A determination of whether the person presently is, or ever has been, a member of the U.S. Armed Services</p> <p>12. For children and youth, whether they have system involvement (such as child welfare and juvenile justice)</p>	
<p>4.d.6 - The CCBHC uses standardized and validated and developmentally appropriate screening and assessment tools appropriate for the person and, where warranted, brief motivational interviewing techniques to facilitate engagement.</p>	<p>For children, youth, and young adults, CCBHCs should use standardized and validated screening and assessment tools designed for the child and youth populations (such as the CANS or CALOCUS-CASII).^{57,58} Tools used are administered or communicated in the primary language of children, youth, and young adults to ensure accurate screening and assessment.</p>
<p>4.e.2 - The CCBHC develops an individualized treatment plan based on information obtained through the comprehensive evaluation and the person receiving services’ goals and preferences. The plan shall address the person’s prevention, medical, and behavioral health needs. The plan shall be developed in collaboration with and be endorsed by the person receiving services; their family (to the extent the person receiving services so wishes); and family/caregivers of youth and children or legal guardians.</p> <p>Treatment plan development shall be coordinated with staff or programs necessary to carry out the plan. The plan shall support care in the least restrictive setting possible. Shared decision making is the preferred model for the establishment of treatment planning goals. All necessary releases of information shall be obtained and included in the health record as a part of the development of the initial treatment plan.</p>	<p>For children, youth, and young adults and their families, care should include natural and social supports.</p>
<p>4.e.3 - The CCBHC uses the initial evaluation, comprehensive evaluation, and ongoing screening and assessment of the person receiving services to inform the treatment plan and services provided.</p>	<p>Treatment plans and services for children, youth, and young adults should be informed by assessments tailored to families, youth, and young adults.</p>
<p>4.e.4 - Treatment planning includes needs, strengths, abilities, preferences, and goals, expressed in a manner capturing the words or ideas of the person receiving services and, when appropriate, those of the family/caregiver of the person receiving services.</p>	<p>For children, youth, and young adults and their families, care should include natural and social supports.</p>

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2023 SAMHSA CCBHC Criteria*	Recommendation
<p>4.e.7 - The person’s health record documents any advance directives related to treatment and crisis planning. If the person receiving services does not wish to share their preferences, that decision is documented. Please see 3.a.4., requiring the development of a crisis plan with each person receiving services. Consistent with the criteria in 4.e.1 through 4.e.7, certifying states should specify other aspects of person-centered and family-centered treatment planning they will require based upon the needs of the population served. Treatment planning components that certifying states might consider include: prevention; community inclusion and support (housing, employment, social supports); involvement of family/caregiver and other supports; recovery planning; and the need for specific services required by the statute (i.e., care coordination, physical health services, peer and family support services, targeted case management, psychiatric rehabilitation services, tailored treatment to ensure cultural and linguistically appropriate services).</p>	<p>Consider using High Fidelity Wraparound or Transition to Independence as models for intensive care coordination for children and youth.^{59,60,61}</p>
<p>4.f.1 - The CCBHC directly, or through a DCO, provides outpatient behavioral health care, including psychopharmacological treatment. The CCBHC or the DCO must provide evidence-based services using best practices for treating mental health and substance use disorders across the lifespan with tailored approaches for adults, children, and families. SUD treatment and services shall be provided as described in the American Society for Addiction Medicine Levels 1 and 2.1 and include treatment of tobacco use disorders. In the event specialized or more intensive services outside the expertise of the CCBHC or DCO are required for purposes of outpatient mental and substance use disorder treatment the CCBHC makes them available through referral or other formal arrangement with other providers or, where necessary and appropriate, through use of telehealth/telemedicine, in alignment with state and federal laws and regulations. The CCBHC also provides or makes available through a formal arrangement traditional practices/treatment as appropriate for the people receiving services served in the CCBHC area. Where specialist providers are not available to provide direct care to a particular person receiving CCBHC services, or specialist care is not practically available, the CCBHC professional staff may consult with specialized services providers for highly specialized treatment needs. For people receiving services with potentially harmful substance use, the CCBHC is strongly encouraged to engage the person receiving services with motivational techniques and harm reduction strategies to promote safety and/or reduce substance use.</p> <p>Note: See also program requirement 3 regarding coordination of services and treatment planning. Based upon the findings of the community needs assessment as required in program requirement 1, certifying states must establish a minimum set of evidence-based practices required of the CCBHCs. Among those evidence-based practices states might consider are the following: Motivational Interviewing; Cognitive Behavioral Therapy (CBT); Dialectical Behavior Therapy (DBT); Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP); Seeking Safety; Assertive Community Treatment (ACT); Forensic Assertive Community Treatment (FACT); Long-acting injectable medications to treat both mental and substance use disorders; Multi-Systemic Therapy; Trauma-Focused Cognitive Behavioral Therapy (TF-CBT); Cognitive Behavioral Therapy for psychosis (CBTp); High-Fidelity Wraparound; Parent Management</p>	<p>CCBHCs should provide outpatient evidence-based and promising practices designed for children, youth, and young adult populations or ensure availability through arrangements with DCOs and other providers.</p>

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2023 SAMHSA CCBHC Criteria*	Recommendation
<p>Training: Effective but underutilized medications such as clozapine and FDA-approved medications for substance use disorders, including smoking cessation. This list is not intended to be all inclusive. Certifying states are free to determine whether these or other evidence-based treatments may be appropriate as a condition of certification.</p>	
<p>4.h.1 - The CCBHC is responsible for providing directly, or through a DCO, targeted case management services that will assist people receiving services in sustaining recovery and gaining access to needed medical, social, legal, educational, housing, vocational, and other services and supports. CCBHC targeted case management provides an intensive level of support that goes beyond the care coordination that is a basic expectation for all people served by the CCBHC. CCBHC targeted case management should include supports for people deemed at high risk of suicide or overdose, particularly during times of transitions, such as from a residential treatment, hospital emergency department, or psychiatric hospitalization. CCBHC targeted case management should also be accessible during other critical periods, such as episodes of homelessness or transitions to the community from jails or prisons. CCBHC targeted case management should be used for individual with complex or serious mental health or substance use conditions and for individuals who have a short-term need for support in a critical period, such as an acute episode or care transition. Intensive case management and team-based intensive services, such as through Assertive Community Treatment, are strongly encouraged but not required as a component of CCBHC services. Based upon the needs of the population served, states should specify the scope of other CCBHC targeted case management services that will be required, and the specific populations for which they are intended.</p>	<p>In states that have specialty Targeted Case Management arrangements for child and youth populations (for example, through care management entities), CCBHCs should develop partnerships with these entities. For CCBHCs providing Targeted Case Management directly, CCBHCs should provide intensive care coordination using a High Fidelity Wraparound model or Transition to Independence model for children and youth with complex needs.^{62,63,64,65}</p>
<p>4.i.1 - The CCBHC is responsible for providing directly, or through a DCO, evidence-based rehabilitation services for both mental health and substance use disorders. Rehabilitative services include services and recovery supports that help individuals develop skills and functioning to facilitate community living; support positive social, emotional, and educational development; facilitate inclusion and integration; and support pursuit of their goals in the community. These skills are important to addressing social determinants of health and navigating the complexity of finding housing or employment, filling out paperwork, securing identification documents, developing social networks, negotiating with property owners or property managers, paying bills, and interacting with neighbors or coworkers. Psychiatric rehabilitation services must include supported employment programs designed to provide those receiving services with on-going support to obtain and maintain competitive, integrated employment (e.g., evidence-based supported employment, customized employment programs, or employment supports run in coordination with Vocational Rehabilitation or Career One-Stop services). Psychiatric rehabilitation services must also support people receiving services to:</p> <ul style="list-style-type: none"> • Participate in supported education and other educational services; • Achieve social inclusion and community connectedness; 	<p>Psychiatric rehabilitation services for children and youth may include intensive in-home services, behavioral management consultation, therapeutic mentoring and adjunctive therapies, among others.</p>

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2023 SAMHSA CCBHC Criteria*	Recommendation
<ul style="list-style-type: none"> • Participate in medication education, self-management, and/or individual and family/caregiver psycho-education; and • Find and maintain safe and stable housing. <p>Other psychiatric rehabilitation services that might be considered include training in personal care skills; community integration services; cognitive remediation; facilitated engagement in substance use disorder mutual help groups and community supports; assistance for navigating healthcare systems; and other recovery support services including Illness Management & Recovery, financial management, and dietary and wellness education. These services may be provided or enhanced by peer providers.</p> <p>Note: See program requirement 3 regarding coordination of services and treatment planning. Certifying states should specify which evidence-based and other psychiatric rehabilitation services they will require based upon the needs of the population served above the minimum requirements described in 4.i.</p>	
<p>4.j.1 -The CCBHC is responsible for directly providing, or through a DCO, peer supports, including peer specialist and recovery coaches, peer counseling, and family/caregiver supports. Peer services may include: peer-run wellness and recovery centers; youth/young adult peer support; recovery coaching; peer-run crisis respites; warmlines; peer-led crisis planning; peer navigators to assist individuals transitioning between different treatment programs and especially between different levels of care; mutual support and self-help groups; peer support for older adults; peer education and leadership development; and peer recovery services. Potential family/caregiver support services that might be considered include: community resources education; navigation support; behavioral health and crisis support; parent/caregiver training and education; and family-to-family caregiver support.</p> <p>Note: See program requirement 3 regarding coordination of services and treatment planning. Certifying states should specify the scope of peer and family services they will require based upon the needs of the population served.</p>	<p>In states where the development of family and youth peer support capacity is lodged with another entity — for example, a family-run or youth-run organization — CCBHCs should enter into partnerships with those entities for provision of peer support.</p>

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Program Requirement 5: Quality and Other Reporting

This program requirement describes:

- Data collection, reporting, and tracking
- Continuous quality improvement planning

Authority: Section 223 (a)(2)(E) of PAMA

The statute requires the published criteria to include criteria with respect to the following: “Reporting of encounter data, clinical outcomes data, quality data, and such other data as the Secretary requires.”

2023 SAMHSA CCBHC Criteria*	Recommendation
<p>5.a.1 - The CCBHC has the capacity to collect, report, and track encounter, outcome, and quality data, including, but not limited to, data capturing: (1) characteristics of people receiving services; (2) staffing; (3) access to services; (4) use of services; (5) screening, prevention, and treatment; (6) care coordination; (7) other processes of care; (8) costs; and (9) outcomes of people receiving services. Data collection and reporting requirements are elaborated below and in Appendix B. <i>(To view appendix B and the full list of certification criteria, visit https://www.samhsa.gov/communities/certified-community-behavioral-health-clinics/ccbhc-certification-criteria). Where feasible, information about people receiving services and care delivery should be captured electronically, using widely available standards.</i></p> <p>Note: See criteria 3.b for requirements regarding health information systems.</p>	<p>Data collection should include clinical and functional measures specific to children, youth, and young adults, (e.g., including living at home with family, involvement with juvenile justice, placement stability within child welfare system, educational progress, school attendance, daily functioning, CMS' Core Set of Children's Health Care Quality Measures)</p>
<p>5.b.1 - In order to maintain a continuous focus on quality improvement, the CCBHC develops, implements, and maintains an effective, CCBHC-wide continuous quality improvement (CQI) plan for the services provided. The CCBHC establishes a critical review process to review CQI outcomes and implement changes to staffing, services, and availability that will improve the quality and timeliness of services. The CQI plan focuses on indicators related to improved behavioral and physical health outcomes and takes actions to demonstrate improvement in CCBHC performance. The CQI plan should also focus on improved patterns of care delivery, such as reductions in emergency department use, rehospitalization, and repeated crisis episodes. The Medical Director is involved in the aspects of the CQI plan that apply to the quality of the medical components of care, including coordination and integration with primary care.</p>	<p>The annual CCBHC CQI plan should prioritize improvements to supports and services for children, youth, and young adults and their families.</p>
<p>5.b.2 - The CQI plan is to be developed by the CCBHC and addresses how the CCBHC will review known significant events including, at a minimum: (1) deaths by suicide or suicide attempts of people receiving services; (2) fatal and non-fatal overdoses; (3) all-cause mortality among people receiving CCBHC services; (4) 30 day hospital readmissions for psychiatric or substance use reasons; and (5) such other events the state or applicable accreditation bodies may deem appropriate for examination and remediation as part of a CQI plan.</p>	<p>Specific events indicators should be broken out by child/youth versus adult populations. For example, admissions to and coordination of care for children and youth in Psychiatric Residential Treatment Facilities (PRTF) and readmission to PRTF. Detention in the juvenile justice system and reentry to the community should be included as specific events to be addressed by the CQI plan.</p>

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Program Requirement 6: Organizational Authority, Governance, and Accreditation

This program requirement describes:

- Organizational authority and financing
- Governance

Authority: Section 223 (a)(2)(F) of PAMA

The statute requires the published criteria to include criteria with respect to the following: “Criteria that a clinic be a nonprofit or part of a local government behavioral health authority or operated under the authority of the Indian Health Service, an Indian Tribe, or Tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service pursuant to the Indian Self-Determination Act (25 U.S.C. 450 et seq.), or an urban Indian organization pursuant to a grant or contract with the Indian Health Service under title V of the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.)

2023 SAMHSA CCBHC Criteria*	Recommendation
<p>6.b.4 - Members of the governing or advisory boards will be representative of the communities in which the CCBHC’s service area is located and will be selected for their expertise in health services, community affairs, local government, finance and accounting, legal affairs, trade unions, faith communities, commercial and industrial concerns, or social service agencies within the communities served. No more than one half (50 percent) of the governing board members may derive more than 10 percent of their annual income from the health care industry.</p>	<p>CCBHCs should have a balanced number of board members representing a range of ages (adolescent, young adult, adult, older adult, parent/caregiver) for both the youth/family representatives and the non-youth members, ensuring there is balanced expertise on the board. CCBHCs should include youth and families/caregivers of children with varied experiences and perspectives.</p>

*These criteria were originally published by SAMHSA in 2023; portions of this guidance may not be in alignment with the current administration’s Executive Orders.

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- ⁵¹ The California Evidence-Based Clearinghouse, (2016).
- ⁵² National Wraparound Initiative, (2017).
- ⁵³ The California Evidence-Based Clearinghouse, (2016).
- ⁵⁴ SAMHSA, (2019).
- ⁵⁵ SAMHSA, (2022).
- ⁵⁶ SAMHSA, (2022).
- ⁵⁷ The Praed Foundation. (2023).
- ⁵⁸ The American Academy of Child and Adolescent Psychiatry (AACAP) & The American Association for Community Psychiatry (AAP), (2022).
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