Office of Mental Health | Office of Addiction Services and Supports | Department of Health

New York State (NYS)
Certified Community Behavioral Health Clinic (CCBHC)
Provider Manual
Re-Issued March 2024

This CCBHC Provider Manual is not intended to replace existing New York State (NYS) Office of Mental Health (OMH) or Office of Addiction Services and Supports (OASAS) Regulations and Guidance Documents. It is meant to be used as a resource for NYS CCBHC Demonstration Providers along with the Substance Abuse and Mental Health Services Administration (SAMHSA) CCBHC Criteria found here: Certified Community Behavioral Health Clinic (CCBHC) Certification Criteria Updated March 2023 (samhsa.gov).

Questions or comments pertaining to the NYS CCBHC Provider Manual may be directed to the CCBHC Mailbox.

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I. Background

The CCBHC model was established on April 1, 2014, by Congress through the passage of the Protecting Access to Medicare Act (PAMA) of 2014 (Section 223 of P.L. 113-93, as amended laying the groundwork for the establishment of CCBHCs). The purpose of a CCBHC is to improve health outcomes through increased access to quality care for all individuals, reduce avoidable hospital use and complications, foster diverse health system partnerships, and provide behavioral health care entities in underserved areas with more financial stability through enhanced Medicaid reimbursement. On July 1, 2017, thirteen providers throughout NYS implemented the program model. The Substance Abuse and Mental Health Services Administration (SAMHSA) extended the federal Demonstration through September 2025 and issued guidance effective February 21, 2023, enabling additional providers to be added to the NYS Demonstration program. In addition, SAMHSA updated the CCBHC Certification Criteria (March 2023) with an implementation date of July 1, 2024.

II. Key Elements

The CCBHC program model is based on the following key elements:

- Equitable and timely access to high-quality comprehensive, coordinated mental health and substance use services developmentally appropriate for individuals across the life span.
- Planning and interventions driven and informed by the needs and preferences of people receiving services and their families.
- An evidence-based and data-informed approach to care that is responsive to, and commensurate with, the needs and characteristics of the communities within the program service area.

- Programming that accounts for the reduction in disparities in access, quality of care, and treatment outcomes regardless of an individual's diagnosis, place of residence, or ability to pay.

III. Values/Core Principles

Services are guided by the following values and core principles to enhance the behavioral health system in NYS and uphold the model of the CCBHC program:

- **Integrated Care:** A comprehensive array of behavioral health services is offered so that individuals do not need to seek care from multiple providers to get the support they need. Treatment teams are multi-disciplinary and cross-trained to treat individuals who are dually diagnosed with mental health and substance use disorders.
- **Person-Centered Care**: Person-centered care reflects the individual's goals and emphasizes shared decision-making approaches, whenever possible, that empower, provide choice, and promote recovery. Services should be self-directed, include family (as defined by the individual engaged in services) members and other key natural supports based on the individual's wishes, emphasizing wellness and attention to the person's overall well-being, and promote recovery in all its forms. It emphasizes shared decision-making approaches to empower the family, provide choice, minimize stigma and establish individualized and family-driven goals. The family participates as full partner to the extent possible and appropriate, in all stages of planning and decision-making including treatment implementation, monitoring and evaluation.
- **Family-Centered Care**: Services are family-focused, emphasizing the important role of family in the service planning delivery process across the lifespan. For children, families are a true partner in the decision-making process. For adults, family as defined and determined by the individual, can be a tremendous natural support and resource. Family-centered care promotes the wellbeing and developmental needs of the child and provides voice and choice from a trauma lens across the lifespan.
- **Recovery-Oriented:** Recovery-oriented services incorporate a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Recovery-oriented care builds upon an individual's assets, strengths, and competence to promote and sustain a person's recovery from a behavioral health disorder. Care providers work to support the individual in their recovery process while regaining a meaningful, constructive sense of membership in the broader community.
- **Cultural and Linguistic Competency:** Awareness and responsiveness to cultural identities and diversity is integral to effective care. Services are delivered in a manner that recognizes and respects the culture and practices of the individual and family, including the awareness and understanding of cultural groups' experiences. Such experiences include but are not limited to: self-identified strengths, oppression within the historical and current landscape and social diversity with respect to race, ethnicity, sex, sexual orientation, gender identity or expression, disability, religion, immigration status and its impact on engagement and perception of care.
- **Evidence-Based:** Services utilize evidence-based and evidence-informed practices and provide or enable continuing education activities to promote commitment to these practices.
- **Trauma-Informed:** Trauma-informed services are based on an understanding of the impact of trauma including individuals, families, staff, and others, which may be

exacerbated through more traditional service delivery approaches, so that these services and programs can be more trauma sensitive, supportive and avoid re-traumatization. A trauma-informed approach to care is utilized throughout the course of services. Treatment planning and all aspects of service delivery incorporate principles of safety, trustworthiness/transparency, collaboration, empowerment, and respect for cultural and gender differences. The assessment and treatment planning process demonstrate an understanding of the interconnection between cultural factors and the experience of trauma and trauma reactions. The treatment plan and services, as appropriate, addresses the impact of trauma and associated behavioral health symptoms as well as resilience and protective factors for individual and family. Collaboration across providers and systems in treatment planning and ongoing care addresses the prevention of re-traumatization.

- **Coordination and Collaboration:** Coordination activities are the foundation of the CCBHC, along with fostering and promoting clear and timely communication, deliberate coordination, and seamless care with a goal of individual responsibility for health awareness. These characteristics guide all aspects of treatment and rehabilitation to support effective partnerships among the individual, family and other key natural supports and service providers. Services are integrated, addressing both physical and behavioral health needs of individuals.
- **Accessible and Available:** CCBHCs are proficient in delivering services in the community. Services are flexible and adapt to the specific and changing needs and preferences of each individual. Services take place in settings that are the most appropriate and natural for the individual or family, and are the least restrictive and intrusive available, to draw from formal and informal support to promote successful participation in the community. Community resources include not only mental health and substance use treatment professionals and provider agencies, but also social, spiritual, cultural organizations and other natural community support networks.
- **Data-Driven:** Providers use data to identify outcomes and to monitor performance and adherence to the model to inform best practices, evidence-based modalities, and service delivery with an overall goal of sustainability. Performance metrics reflect a broad range of health and recovery indicators beyond those related to acute care.

IV. CCBHC Community Needs Assessment

The foundation of a CCBHC is the Community Needs Assessment. The Community Needs Assessment is a systematic approach to identifying community and population needs. CCBHCs conduct, or conduct with community stakeholders, a Community Needs Assessment to identify current community and population needs, resources, and desired services across the lifespan within the identified service area based on data and input from key community stakeholders. NYS defines the entire county, or counties, identified by the CCBHC as the service area to be served and addressed in the Community Needs Assessment. Community Needs Assessments must be completed as part of the certification process and updated regularly, but no less than every three years.

For new Demonstration Providers, if a separate Community Needs Assessment was completed in the last year, the CCBHC may decide to augment, or build upon the information to ensure all CCBHC requirements are collected.

For more information on Community Needs Assessment elements and requirements, see SAMHSA's Certified Community Behavioral Health Clinic (CCBHC) Certification Criteria

[Updated March 2023 (samhsa.gov)]

As a *data resource*, see the OMH Office for Population Health Evaluation (OPHE) Community Needs Assessment guidance document when conducting a Community Needs Assessment, [Mental Health and Substance Use Disorders Community Needs Assessments Data Resources (ny.gov)].

V. Designated Collaborating Organization (DCO):

A DCO is an entity that is not under the direct supervision of the CCBHC but is engaged in a formal relationship with the CCBHC to deliver one or more of (or elements of) the required services as described below. The CCBHC organization will directly deliver the majority (51% or more) of encounters across the required services (excluding crisis services) rather than through DCOs. CCBHC services provided through a DCO must conform to the relevant applicable CCBHC criteria. The formal relationship is evidenced by a contract, Memorandum of Agreement (MOA), Memorandum of Understanding (MOU), or such other formal, legal arrangements describing the parties' mutual expectations and establishing accountability for services to be provided and funding to be sought and utilized.

All required services, if provided directly through the CCBHC or through a DCO, must be reasonably accessible to the populations noted in the Community Needs Assessment. In addition, these services are consistent with the freedom, values and preferences of the individual receiving services to choose providers within the CCBHCs and its' DCOs. DCOs must meet the same quality standards as those provided by the CCBHC.

CCBHCs must have the capacity to directly provide Screening, Assessment, and Diagnosis; Person-Centered and Family-Centered Treatment Planning; and Outpatient Mental Health & Substance Use Services.

NYS allows for DCO of the following services:

- Crisis Services
- Primary Care Screening and Monitoring
- Targeted Case Management
- Psychiatric Rehabilitation Services
- Peer Supports/Peer Counseling/Family/Caregiver Supports
- Intensive Community-Based Mental Health Care for Members of the Armed Forces and Veterans
- Some specialized Mental Health & Substance Use Services (as approved by OMH & OASAS)

CCBHCs should have clear policies and procedures outlining processes for DCO arrangements, including frequent review of these arrangements, data collection processes and plans for updating when needed.

Guidance on State-Sanctioned Crisis Behavioral Health Programs
CCBHC's are encouraged to utilize existing State Sanctioned Crisis Behavioral Health Programs, including those licensed and funded by NYS (e.g., 988, county-run Mobile Crisis, Crisis Stabilization Centers, Home-Based Crisis Intervention, etc.) to ensure appropriate coverage across a CCBHCs service area or for providing population-specific crisis services such as: adults, children, mental health, substance use, etc. In the event that

the Designated State Sanctioned Crisis Behavioral Health Programs do not provide all service components, the contracting CCBHC must build capacity to meet the remaining components to provide 24-hour, 365 day per year coverage, delivered within three hours.

VI. Staffing

CCBHC staffing plans are directly reflective of the results of the Community Needs Assessment and are part of the process leading to CCBHC certification and recertification. CCBHC staffing plans, and any DCO providers that deliver services under arrangement with the CCBHC, must meet the requirements of OMH and OASAS in addition to any accreditation standards required by NYS. For OMH and OASAS staffing requirements see: OMH Part 599 MHOTRS Regulations Sections 599.4(b) and 599.9, OASAS Part 822 Regulations Section 822.7(k), OMH Part 598 Integrated Outpatient Services and OASAS Part 825 Integrated Outpatient Services, Sections 598.12 and 825.12 respectively.

The staff and staffing levels must be appropriate for serving the lifespan and range of need in alignment with communities within the CCBHC service area and meet the size, composition, and the service purview of the CCBHC. As with the Community Needs Assessment, the staffing plan must be updated regularly, but no less than every three years.

Specific to CCBHCs, staffing must be comprised of:

- **A. Chief Executive Officer (CEO) of the CCBHC**, **or equivalent** – This individual maintains a fully staffed management team, as appropriate for the size and needs of the CCBHC, as determined by the Community Needs Assessment and staffing plan.
- **B. Management Team** – Includes, at minimum, the CEO or equivalent **and** a Medical Director. Depending on the size of the organization, both positions may be held by the same person.
- **C. Medical Director** – The Medical Director provides guidance on behavioral health clinical service delivery, ensuring the quality of the medical components of care and provides guidance to integrate and coordinate behavioral health and primary care.

  It is strongly encouraged that this position be held by a psychiatrist and the position need not be full time. If the CCBHC is unable to employ or contract with a psychiatrist, the provider will consult with The Offices to review next steps. 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.

  a. **If a CCBHC is unable, after reasonable efforts, to employ or contract with a psychiatrist,** a medically trained behavioral health care professional with prescriptive authority and appropriate education, licensure, and experience with psychopharmacology, and who can prescribe and manage medications independently, pursuant to state law, may serve as Medical Director.

  b. **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 medical component of care, and integration and coordination of behavioral health and primary care.
- **D. Medically trained behavioral health care provider** – This staff can prescribe and manage medications independently under NYS law, including FDA approved medications used to treat opioid, alcohol and tobacco use disorders. (This would not

include methadone and then would refer to an Opioid Treatment Program (OTP), unless the CCBHC is also an OTP.) Consultation should be sought when expertise in a specific population or need is not directly available by staff prescriber. This staff member can be either employed by the CCBHC or available through formal arrangement.

E. **Certified Substance Use Treatment Counselors or Specialists** – CCBHCs, as part of integrated care, need to employ these staff. OASAS 822 Regulations require at least one (1) full-time staff with a Credentialed Alcoholism and Substance Abuse Counselor (CASAC). See OASAS Part 822 Regulations for additional information.

F. **Licensed Clinical Treatment Staff** – These staff must have expertise in addressing trauma and promoting recovery of children, adolescents, adults, and older adults. Staffing may include Psychiatrists, Licensed clinical social workers, licensed mental health counselors, licensed psychologists, licensed psychoanalysts, licensed creative arts therapists, licensed marriage and family therapists, and Credentialed Alcoholism and Substance Abuse Counselors. Student interns receiving education in these areas and unlicensed practitioners working toward licensure may provide clinical services under requisite supervision.

G. **Primary Care Staff** – These staff can be comprised of medical doctors, nurse practitioners, physician assistants, registered nurses, psychiatric registered nurses, and licensed practical nurses who are under the supervision of any of the aforementioned medical staff.

H. **Peer Specialists and Peer Advocates** – CCBHCs are required to provide Peer Support Services across the lifespan based on the needs of their service area. This includes Peer staff with the following credentials:

- one New York Certified Peer Specialist (NYCPS), and
- one OASAS Certified Recovery Peer Advocate (CRPA), and
- one Credentialed Family Peer Advocate (FPA-C), and
- one Credentialed Youth Peer Advocate (YPA-C) is strongly encouraged.

Peer Specialists/Advocates can provide Medicaid billable services with a provisional Peer Certification/Credential. Upon employment, it is expected that peers will be in the process of obtaining their certification/credential within the specified timeframe for their certification/credential.

CCBHCS are encouraged to hire more Peer Specialists/Advocates to best meet the needs of the individuals and families served. All Peer roles may be hired directly by the CCBHC or via DCO.CCBHCs should ensure that all Peer Specialists/Advocates have access to in-discipline supervision, mentoring and support from Peer Specialists/Advocates. This can be accomplished by connecting Peer Specialists/Advocates within the organization and supporting regular convenings. This can also be established in collaboration with local agencies or via contracting with peer-run agencies. CCBHCs should endeavor to promote Peer Specialists/Advocates to supervise Peer Specialists/Advocates. In the event Peer supervisors are not available within the CCBHC, Peer Specialists and Advocates should be supervised by someone who has received specialized training in the supervision of Peers.

I. **Targeted Case Management (TCM) Case Managers**- Case Managers must be at least 18 years of age and have a high school diploma or equivalent. They may be unlicensed staff. Case Managers must be trained and demonstrate a basic

knowledge and understanding of working with populations targeted by this service.

J. **Psychiatric Rehabilitation Services (PRS) Staff** – PRS staff must be at least 18 years of age and have a high school diploma, high school equivalency preferred, or a State Education Commencement Credential (e.g., SACC or CDOS); and 1-3 years of relevant work experience in a behavioral health setting or a bachelor's degree. The practice of PSR by unlicensed individuals does not include those activities that are restricted under Title VIII (nysed.gov).

K. **Staffed Trained in Intensive Community-Based Behavioral Health Care for Members of the Armed Forces and Veterans** - Any staff who is not a veteran should have training about military and veterans' culture in order to be able to understand the unique experiences and contributions of those who have served their country.

Staff Training Requirements

CCBHC Staff Training Plans – Employed or contracted staff must satisfy NYS OMH and OASAS requirements and any accreditation standards, in addition to the training parameters outlined in SAMHSA's Certified Community Behavioral Health Clinic (CCBHC) Certification Criteria Updated March 2023 (samhsa.gov).

At orientation and at reasonable intervals thereafter, the CCBHC must provide training on:

- Evidence-based practices
- Cultural competency aligned with the National Standards for Culturally and Linguistically Appropriate Services (CLAS)
- 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.

At orientation and annually thereafter, the CCBHC must provide training on:

- Risk assessment
- Suicide and overdose prevention and response
- The roles of family and peer staff

Additional training and resources will be made available to all staff of the CCBHC to develop and enhance competencies in alignment with community need. These trainings may include but are not limited to, child and adult-serving system literacy, early childhood and family specialized training (e.g., age-appropriate assessment tools, normative developmental tasks and intervention strategies for each age, dyadic treatment, attachment theory, etc.), safety in the community, etc. To the extent active-duty military or veterans are being served, such training must also include information related to military culture.

CCBHCs must regularly assess the skills and competency of staff providing services and offer ongoing in-service training and education to meet those needs.

Linguistic Competence Requirements

CCBHCs must take reasonable steps to provide meaningful access to services. To address language assistance and/or language-based disabilities, interpretation/translation services

must be readily available and appropriate for the size/needs of the Limited English Proficiency CCBHC population. When interpreters are used, such service providers are trained to function in a medical and, preferably, a behavioral health setting.

Documents or information vital to the ability of the individual and their families receiving services to access CCBHC services are available in **paper format and online**, in languages commonly spoken by the community served, considering literacy levels. Materials are provided in a timely manner at intake and throughout the time the individual is served by the CCBHC. For more information, see SAMHSA's Certified Community Behavioral Health Clinic (CCBHC) Certification Criteria Updated March 2023 (samhsa.gov).

NOTE: Providers have an obligation to provide free language access services to limited English proficient clients if they receive Medicaid. Despite this, families may still request to have a family member (even their child) serve as an interpreter due to comfort or dialect differences. It is strongly recommended that nontrained interpreters (including family) not be used in service provision. Significant problems can arise from the use of family members, friends, and in particular, children rather than trained professionals as interpreters. These situations are significantly more likely to have potential clinical consequences than interpreting provided by trained interpreters. Using trained interpreters can ensure confidentiality, prevent conflict of interest, and ensure clinical terms are interpreted correctly. In addition, a trained interpreter will help with not just the interpretation, but will also help the provider understand mannerisms, cultural practices, expectations, slang and body language. **The use of untrained interpreters, including family interpreters, in service provision should be limited to emergency circumstances only.**

VII. Care Coordination Partnerships

CCBHCs coordinate care for individuals across the lifespan and the spectrum of health services, including behavioral health, physical health, as well as determinants of health to promote wellness and recovery of the whole person and family. CCBHCs assist individuals with accessing and receiving external services and resources to best meet their individual needs and preferences. CCBHCs also coordinate with other social systems, including but not limited to educational, vocational, housing, medical health, child welfare, wellness and recovery, and juvenile/adult justice systems.

CCBHCs must secure partnerships to provide coordinated care for individuals across the lifespan. Such partnership agreements must minimally include protocols with:

- The 988 Suicide and Crisis Lifeline call center for the service area(s) in which the CCBHC serves, as determined by their Community Needs Assessment.
- Federally Qualified Health Centers and as applicable Rural Health Clinics
- Inpatient Acute-Care Hospitals in the Service Area and the Associated Services/Facilities*
- Inpatient Psychiatric Treatment and their Associated Services/Facilities*
- Opioid Treatment Programs *
- OASAS Certified Crisis Detoxification Services*
- OASAS Certified Inpatient Rehabilitation Services*
- OASAS Certified Residential Services
- OASAS Certified Residential Rehabilitation Services for Youth
- Department of Veterans Affairs' medical centers, clinics, drop-in centers, or other facility of the Department

- Schools
- Child Welfare Agencies
- Juvenile and Adult Justice Agencies and Facilities
- Indian Health Services
- State licensed and Accredited Child Placing Agencies for Therapeutic Foster Care Service
- Other Social and Human Services

*CCBHCs are required to track when individuals receiving CCBHC services are admitted to these facilities, including when they are discharged, unless there is a formal transfer of care to a non-CCBHC entity. Further the CCBHC will work with the discharging facility prior to discharge to ensure a seamless transition and will contact individuals receiving CCBHC services who are discharged from these settings within 24 hours of discharge. For individuals receiving CCBHC services discharged from these facilities who are at risk of suicide or overdose, the care coordination agreement will include a requirement to coordinate consent and follow-up services with the individual within 24 hours of discharge and continues until the individual is linked to services or assessed to be no longer at risk. Also see joint OMH and DOH Guidance issued October 2023, found here: OMH – DOH Evaluation and Discharge Guidance (ny.gov)

Additional Recommended Partnerships include:

- Resources for Unhoused Individuals
- Other addiction services, i.e., Problem Gambling Resource Centers
- Residential Programs

These care coordination partnerships will be supported by formal signed agreements detailing the roles of each party. If unable to enter into formal agreements, the CCBHCs will work with the partner to develop unsigned joint protocols that describe the procedures for working together and care coordination roles. All partnerships, as well as efforts to partner, for coordinated care undertaken will be documented to support partnerships independent of staff turnover.

In addition, CCBHCs will develop other community and regional care coordination partnerships based on the social system resources available, their population served, the needs and preferences of people receiving services, and/or needs identified in the Community Needs Assessment.

For more information on required and recommended partnerships, as well as required protocols, see SAMHSA's Certified Community Behavioral Health Clinic (CCBHC) Certification Criteria Updated March 2023 (samhsa.gov)

VIII. Scope of Services

CCBHCs are responsible for providing the required 9 services directly, or through a DCO (see list of allowable DCO services, section V. Designated Collaborating Organization (DCO)), reflecting person and family-centered care. Whether provided directly or through a DCO, the CCBHC is responsible for ensuring access to all 9 CCBHC services.

All CCBHC required services must be reasonably accessible to communities identified in the Community Needs Assessment. In NYS, reasonable accessibility is defined as 30 miles/30 minutes (or the lesser of the two) to access all nine required services.

Note: Any variations beyond this parameter of a reasonably accessible location of services must be approved by NYS OMH and OASAS Central Office and Field/Regional Offices to review current resources in the geographic area, accessibility for all nine required CCBHC services and to ensure it meets SAMHSA's crisis response timeframe. Telehealth only *cannot* be the solution for determining reasonably accessible services, as individuals may require or prefer in-person services.

Timely Access to Services and Initial and Comprehensive Evaluation:

At the time of first contact with CCBHCs, individuals will receive a preliminary triage assessment, including risk assessment to determine acuity of needs.

- If the triage identifies emergency/crisis (life threatening) need, see Crisis Behavioral Health Services below.
- If the triage identifies an urgent need (non-life threatening but evidence of distress), clinical services are provided, including initial evaluation within one business day of the time the request is made.
- If the triage identifies routine needs, CCBHC services will be provided, and the initial evaluation completed within ten business days.

A. Crisis Behavioral Health Services

The CCBHC will provide the following 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:

1. **Emergency crisis intervention services**: The CCBHC provides and coordinates with NYS 988 Suicide and Crisis Lifeline Contact Centers. These centers meet the standards for risk assessment and engagement of individuals in imminent risk**.** Quality coordination of crisis care is provided by the CCBHC, with protocols in place to track referrals made from the call center to the CCBHC or its DCO crisis provider.

2. **24-hour mobile crisis teams**: The CCBHC delivers community-based behavioral health crisis intervention services using mobile crisis teams 24 hours a day, 7 days a week to adults, children, youth, and families anywhere within the service area. Mobile crisis teams are ideally to arrive in person within 1 hour (2 hours in rural and frontier settings) and not to exceed arrival within 3 hours.

   Providers with prior state approval to provide telehealth/telemedicine may do so to provide crisis care to individuals by qualified behavioral health professionals during the interim travel time when remote travel distances make the 2-hour response time unachievable. However, an in-person response must be available when it is necessary to assure safety.

3. **Crisis receiving/stabilization**: The CCBHC must provide crisis receiving/stabilization services that includes at a minimum, urgent care/walk-in mental health and substance use disorder services for individuals seeking services voluntarily. These services identify the individual's immediate needs, de-escalate the crisis and connect individuals 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 ideally include evening hours of operation seven days a week.

Note:
If a non-established/individual new to the CCBHC receives a crisis service, the crisis service IS covered upon the completion of a crisis assessment (which includes a preliminary triage screening and risk assessment).

If a non-established/individual new to the CCBHC receives a crisis service by a provider through a DCO agreement, the crisis service IS ONLY covered upon receipt of:

- A crisis assessment (which includes a preliminary triage screening and risk assessment), AND
- Another of the nine required services as delivered by the CCBHC.

B. Screening, Assessment, and Diagnosis

The CCBHC directly provides screening, assessment, and diagnosis, including risk assessment, for behavioral health conditions.

Following the preliminary triage and risk assessment screening, an initial evaluation must be completed within 10 days and comprehensive evaluation completed within 60 calendar days from initial contact or 30 days from date of admission, whichever comes first.

The CCBHC develops a crisis prevention plan with each person receiving services to identify the preferences of the person in the event of psychiatric or substance use crisis. 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 prevention plans may support the development of a Psychiatric Advanced Directive, if desired by the person receiving services. Planning 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 providing access to naloxone for overdose reversal to individuals who are at risk of opioid overdose, and as appropriate, to their family members.

The assessment results in a clinical formulation and recommendations which inform the treatment plan. For initial evaluation and comprehensive assessment minimum requirements, see SAMHSA's Certified Community Behavioral Health Clinic (CCBHC) Certification Criteria Updated March 2023 (samhsa.gov) and Appendix C.

C. Person-Centered and Family-Centered Treatment Planning

The CCBHC directly provides person-centered and family-centered treatment planning based on completed comprehensive assessments. Treatment planning and service delivery is reflective of the individuals' needs, preferences, and values. These services are responsive to the culture, race, ethnicity, sexual orientation, and gender identity of the individual. This includes trauma-informed and culturally competent service provision.

For the provision of CCBHC services, a treatment plan is required for every enrolled

individual. A treatment plan is a dynamic document that is current, reflects the unique strengths and needs of the individual and family, establishes the individual and family's goals and identifies the services and interventions needed to assist in accomplishing these goals. It also includes a means for determining when goals have been met, and the criteria for appropriate discharge and/or transition to other needed services.

Treatment planning is a person-centered, family-focused and recovery-oriented therapeutic process that engages the individual and family in defining their desired goals and the action steps by which to achieve them. Developing and implementing a treatment plan requires the participation and partnership of the individual, family and any appropriate collaterals. The treatment plan is an agreement between the provider, individual and family to understand and document needed changes, the services and participants to help achieve those changes, and how progress toward those changes will be measured.

In addition, a treatment plan serves as a tool to promote and document effective communication between collaborative providers to deliver integrated, well-coordinated care.

Treatment Plans are reviewed and updated as needed when changes occur with the status of the individual receiving services, based on response to treatment, and when there are changes in treatment goals. Updates and reviews will be completed by the treatment team and with the individual receiving services. Treatment Plans must be reviewed and updated no less frequently than every 6 months.[1]

The CCBHC program model is designed to foster and promote the health and wellness of children/youth, adults, and their families. Treatment planning and service delivery should include the following principles:

- *Strength-based:* Strengths-based practice relies upon a collaborative process between the provider, individual and family, enabling them to work together to determine a plan that draws on their strengths and assets. In doing so, the quality of the relationship between the provider, individual and family is strengthened to enhance the quality and efficacy of care. Working in a collaborative way promotes the opportunity for individuals and families to be active participants rather than solely consumers of services. The strengths identified through the assessment process are incorporated into the treatment planning process, the treatment plan, and service delivery. This includes the identification of family members and significant others (collaterals) who provide support and have a meaningful role in the individual's ongoing care or development. This may also include interventions and activities which build upon the individual or family's competencies, interests, beliefs, values and practices that serve as a source of support or growth.
- *Developmentally Appropriate:* A recommendation for CCBHC is based on an assessment that is relevant to an individual's cognitive abilities or a child's stage of development. Services and interventions included within a treatment plan are provided in a manner that is not only appropriate for an individual's age, but anchored to an individual's developmental, social and emotional stage, and attuned to the relationship between the individual and family/caregiver. As an individual's needs indicate, the scope of service and interventions enable the family/caregiver's active involvement and are reflected in the plan. When the clinical focus of treatment indicates the parent/family or caregiver are needed as co-participants or for family-based interventions, this is

[1] Per the SAMHSA CCBHC Criteria, the treatment plan must be reviewed and updated no less frequently than every 6 months, unless the state, federal, or applicable accreditation standards are more stringent.

reflected in the plan and implemented using interventions consistent with the individual's stage of development (i.e., dyadic or attachment-based treatment for young children, or family-based interventions addressing needs related to family reunification, trauma, recovery, etc.).

D. Outpatient Mental Health and Substance Use Services

The CCBHC is responsible for and must have the capacity for directly providing integrated outpatient mental health and substance use services designed to treat an individual's mental health and/or substance use disorder in a manner consistent with the individual's preferences, phase of life and development. Integrated outpatient mental health and substance use services, with early detection, can improve outcomes and quality of life by reducing or eliminating substance use; improving mental health functioning; successful simultaneous treatment and recovery; reducing hospitalization; and stability in life roles. Consideration should be taken for serving children, adolescents, transition-age youth, and older adults as distinct groups for whom life stage and functioning may affect treatment.

The provision of outpatient mental health and substance use services is informed and determined by the preliminary triage screening, assessment, and diagnosis process. Outpatient services will utilize a trauma informed approach and a person and family-centered treatment plan. Outpatient services shall incorporate evidence-based or best practices and maintain consistency with the needs of individuals, children/youth and family/caregivers. A list of both required and recommended evidence-based practices to incorporate into services are included in Appendix A.

For individuals with a substance use and/or problem gambling disorder diagnosis, the Level of Care for Alcohol and Drug Treatment Referral (LOCADTR)is a required web-based tool to assist providers in determining the most appropriate level of care. Levels of care within the LOCADTR tool are consistent with American Society of Addiction Medicine (ASAM) levels of care. Please reference the LOCADTR Manual for additional resources: This tool must be used during initial and ongoing clinical assessments, or when considering an alternate level of care. *Note: No tool can replace clinical judgment, and there is an option within the tool to override the recommended level of care based on clinical judgment.*

For individuals receiving services with potentially harmful substance use, the CCBHC is strongly encouraged to engage the individual receiving services with motivational techniques and harm reduction strategies to promote safety and/or reduce substance use.

Amid the continuing national overdose crisis, SAMHSA has strengthened several areas of care to increase the focus on substance use disorder (SUD) and overdose prevention. CCBHC's must have the capacity to prescribe medication for addiction treatment (MAT) which are FDA approved medications used to treat SUD which include but are not limited to opioid, alcohol, and tobacco use. MAT is used to reduce withdrawal symptoms, recurrence of use, and cravings. It may be used alone, or in combination with counseling and behavioral therapies.

The treatment of SUD with MAT must be offered to those who are entering a CCBHC. The prescribing provider must determine the appropriateness of said medication with collaboration and consent from the patient. If the patient entering the CCBHC is being

treated with MAT outside of the CCBHC then the provider must collaborate with the existing provider or practitioner to maintain MAT through the course of treatment.

If the CCBHC does not have the ability to prescribe methadone for the treatment of opioid use disorder (OUD) directly, it should provide referral to an OTP with care coordination to ensure access to methadone and coordination with other services in the scope of their facility's legal ability to do so.

MAT should also be offered to minors entering the CCBHC. The prescribing provider should collaborate with and obtain consent from the minor and their parent or guardian before initiation of any medications. Please refer to Mental Hygiene Law Section 22.11 in regard to the treatment of minors without parental consent. *Note: See this resource for more information.*

CCBHCs shall provide outpatient mental health and substance use services consistent with the regulations and standards of care required under the NYS OMH Part 599, OASAS Part 822, and if applicable Integrated Outpatient Services Licenses (Parts 598 & 825) for Mental Health (OMH) and Substance Use (OASAS) services.

Note: Co-enrollment should not occur between a CCBHC and a regular article 31 Mental Health Outpatient Treatment and Rehabilitative Service (MHOTRS) program or an article 32 Substance Use Disorder Outpatient Clinic Program. Programs should contact OMH/OASAS to consider exceptions.

E. Outpatient Clinic Primary Care Screening and Monitoring

The CCBHC is responsible for ensuring outpatient primary care screening and monitoring of key health indicators and health risk are received timely, whether provided directly or through a DCO.

The Medical Director will establish protocols that conform to screening recommendations A and B of the US Preventive Services Task Force Recommendations (uspreventiveservicestaskforce.org), which includes but is not limited to:

- HIV and Viral Hepatitis screening
- Basic vitals, medical history, and current physical health symptoms
- BMI, BMI percentile (children and youth) and Nutrition/Exercise levels
- Chronic diseases screening
- Additional Quality Measure screenings as required by NYS

See additional Primary Care monitoring guidance outlined in SAMHSA's Certified Community Behavioral Health Clinic (CCBHC) Certification Criteria Updated March 2023 (samhsa.gov)

F. Targeted Case Management (TCM) Services

The CCBHC is responsible for providing directly, or through a DCO, TCM 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 TCM provides an intensive level of support. TCM should be used for individuals with complex or serious mental health or substance use conditions and for individuals who

have a short-term need for support during critical periods, such as an acute episode or care transition. CCBHC TCM includes supports for people deemed at high risk due to health-related social needs, suicide or overdose and particularly during times of transitions such as from a residential treatment, hospital emergency department, incarceration, or psychiatric hospitalization.

NYS does not impose a TCM caseload size for CCBHCs. Supervisory staff must closely monitor caseloads as well as the efficacy of these services to determine staffing requirements.

If an individual is currently receiving Care Coordination through the Health Home, the CCBHC must make the appropriate care linkage and conduct care coordination efforts solely with the Health Home. Individuals cannot receive TCM through the CCBHC and Health Home care management at the same time.

G. Psychiatric Rehabilitation Services (PRS)

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 enhance 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 health-related social needs and navigating complex life activities and roles. These services may be provided or enhanced by peer providers.

PRS must include supported employment services designed to provide those receiving services with initial and on-going support to obtain and maintain competitive, integrated employment. PRS supported employment services follow the evidence-based Individual Placement and Support (IPS) model.

NYS does not impose a PRS caseload size for CCBHCs. Supervisory staff must closely monitor caseloads as well as the efficacy of these services to determine staffing requirements.

For understanding the allowable CCBHC/Community Oriented Recovery and Empowerment (CORE) service combinations, see the following Memorandum: CORE Services and CCBHC Allowable Service Combinations (ny.gov)

H. Peer Supports, Peer Counseling, and Family/Caregiver Supports

The CCBHC is responsible for providing directly, or through a DCO, peer supports, including peer specialist and recovery coaches, peer services, and family/caregiver supports.

Adult Peer services may include:

- recovery coaching
- warmlines
- peer-led crisis planning
- peer navigators to assist individuals transitioning between different treatment programs and especially between different levels of care

- peer-led support to assist individuals with community connections and natural supports.
- mutual support and self-help groups
- mentoring, self-advocacy and self-efficacy
- peer support for older adults
- peer education and leadership development, and
- peer recovery services
- engagement, bridging and transition supports
- pre-crisis and crisis support services

Potential family/caregiver support services that might be considered include:

- community resources education
- community connections and natural supports
- navigation support
- behavioral health and crisis support
- parent/caregiver recovery support and education, and
- family-to-family caregiver support
- engagement, bridging and transition supports
- self-advocacy, self -efficacy and personal empowerment
- parent skill development

Youth Peer Services may include:

- skill building
- coaching
- engagement, bridging and transition support
- mentoring self-advocacy, self-efficacy and empowerment
- facilitating community connections and natural supports

NYS does not impose a caseload size for peers within CCBHCs. Supervisory staff must closely monitor caseloads as well as the efficacy of these services to determine staffing requirements.

The CCBHC should clearly define Peer Specialists/Advocates' roles and responsibilities and distribute this information to relevant staff. Training should be required of all relevant agency staff and supervisors regarding peer roles and their work as a member of an integrated care team.

Note: If peer services are the initial service an individual receives by the CCBHC, or through a provider with a DCO agreement, those services ARE covered upon the CCBHC completing:

- the preliminary triage screening and risk assessment AND
- identifying and payment information.

For additional guidance regarding Peer Support Services, in Part 599 MHOTRS Programs see the NYS OMH Mental Health Outpatient Treatment and Rehabilitative Services Guidance on Youth, Family, Adult, and Older Adult Peer Support Services and OASAS Peer Advocate Services in OASAS Certified Programs Settings.

I. Intensive Community-Based Mental Health Care for Members of the Armed Forces

and Veterans

The CCBHC is responsible for ensuring community-based mental health care for members of the armed services and veterans are received timely, whether provided directly or through DCO. The CCBHC will follow the service protocol outlined for Members of the Armed Forces and Veterans, see Certified Community Behavioral Health Clinic (CCBHC) Certification Criteria Updated March 2023 (samhsa.gov).

IX. Quality Measures, Other Reporting and Continuous Quality Improvement

CCBHCs must have the capacity to collect, report, and track encounter, outcome, and quality data. CCBHCs will maintain their Electronic Health Record (EHR) to accurately collect and track reporting requirements. The CCBHC is responsible for updating their EHR, as needed, to meet SAMHSA and NYS reporting requirements and to conduct activities such as population health management, quality improvement, quality measurement and reporting, reducing disparities.

Clinic-Collected and State-Collected quality measures are required by SAMHSA and NYS and include:

CLINIC-COLLECTED QUALITY MEASURES

SAMHSA REQUIRED:

- Time to Services (ISERV)
- Depression Remission at 6 months (DEP-REM-6)
- Unhealthy Alcohol Use: Screening and Brief Counseling (ASC)
- Screening for Clinical Depression and Follow-Up Plan (separated into age groups: CDF-CH and CDF-AD)
- Screening for Social Drivers of Health (SDOH)

NYS REQUIRED:

- Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC)
- Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA) (SRA-A)
- Adult Major Depressive Disorder: Suicide Risk Assessment (SRA) (SRA-C)

STATE-COLLECTED QUALITY MEASURES

SAMHSA REQUIRED:

- Patient Experience of Care Survey
- Youth/Family Experience of Care Survey
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)
- Follow-Up After Hospitalization for Mental Illness (adults: FUH-AD, children: FUH-CH)
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD)
- Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD and FUM-CH)
- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA-CH and FUA-AD)
- Plan All-Cause Readmissions Rate (PCR-AD)

- Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication (ADD-CH)
- Antidepressant Medication Management (AMM-BH)
- Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)
- Hemoglobin A1c Control for Patients with Diabetes (HBD-A)

NYS REQUIRED:

- Suicide Attempts
- Housing Status
- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)
- Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)

CCBHCs must work collaboratively with NYS OMH Office of Population Health and Evaluation (OPHE), who provides technical assistance on the collection and submission of this data. Additional reporting may be requested by NYS OMH or OASAS and is required.

CCBHCs must develop a CCBHC-wide continuous quality improvement (CQI) plan for the services provided and data results. CCBHCs will engage in continuous and ongoing efforts to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality improvement.

X. Organizational Authority, Governance, and Accreditation

Organizational Authority

The CCBHC maintains documentation establishing the CCBHC conforms to at least one of the following statutorily established criteria:

- Is a non-profit organization, exempt from tax under Section 501(c)(3) of the United States Internal Revenue Code
- Is part of a local government behavioral health authority
- Is 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.)
- Is 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.)

Note: A CCBHC is considered part of a local government behavioral health authority when a locality, county, region, or state maintains authority to oversee behavioral health services at the local level and utilizes the clinic to provide those services.

To the extent CCBHCs are not operated under the authority of the Indian Health Service, an Indian tribe, or tribal or urban Indian organization, CCBHCs shall reach out to such entities within their geographic service area and enter into arrangements with those entities to assist in the provision of services to tribal members and to inform the provision of services to tribal members. To the extent the CCBHC and such entities jointly provide services, the CCBHC and those collaborating entities shall, as a whole, satisfy the requirements of these criteria.

Governance

CCBHC governance must be informed by representatives of the individuals and families being served by the CCBHC in terms of demographic factors such as geographic area, race, ethnicity, sex, gender identity, disability, age, sexual orientation, and in terms of health and behavioral health needs. The CCBHC must incorporate meaningful participation from individuals with lived experience of mental and/or substance use disorders and their families, including youth.

This may be achieved through one of two options:

- Option 1: At least fifty-one percent of the CCBHC governing board is comprised of individuals with lived experience of mental and/or substance use disorders and families.
- Option 2: Other means are established to demonstrate meaningful participation in board governance involving people with lived experience (such as creating an advisory committee that reports to the board). The CCBHC provides staff support to the individuals involved in any alternate approach that are equivalent to the support given to the governing board.

Accreditation
The CCBHC will adhere to any applicable state accreditation, certification, and/or licensing requirements. Further, the CCBHC is required to participate in SAMHSA Behavioral Health Treatment Locator.

CCBHCs are designated by NYS for a period of time determined by NYS but not longer than three years before re-designation is required. NYS can de-designate an agency providing CCBHC for some or all services due to non-compliance to the attestations, policies, procedures, and/or claiming requirements.

XI. Terms and Definitions

Behavioral Health: In this context means the promotion of mental health, resilience and wellbeing; the treatment of mental and substance use disorders; and the support of those who experience and/or are in recovery from these conditions, along with their families and communities.

Capacity: The ability of a CCBHC to directly provide mental health and substance use services to individuals with serious mental illness and serious emotional disorders as well as developmentally appropriate mental health and substance use care for children and youth separate from any DCO relationship. NYS operationalizes capacity as the provision of integrated treatment by holding an Article 31 Part 599 Mental Health Outpatient Treatment and Rehabilitation (MHOTRS) clinic license, Article 32 Part 822 Substance Use Disorder Outpatient Programs clinic certification, an Integrated Outpatient Services (IOS) License and a Commissioner's Waiver.

CCBHC Satellite: An additional site(s) of a CCBHC, operated under the governance and financial oversight of that CCBHC, that offers any of the CCBHC services. Prior to adding any additional sites, the CCBHC must obtain approval from the Offices to ensure services are reasonably accessible and meet the SAMHSA requirements (see SAMHSA Payment Satellite Restriction).

SAMHSA Payment Satellite Restriction: For CCBHCs participating in the Section 223

Demonstration, the Protecting Access to Medicare Act (PAMA) of 2014 stipulates that "no payment shall be made to a satellite facility of a CCBHC established after April 1, 2014, under this Demonstration" when the site offers all of the following four core CCBHC services: Crisis Services, Screening, Assessment and Diagnosis, Person Centered Treatment Planning and Outpatient Mental Health and Substance Use Services.

Encounter: Any of the nine services outlined in the scope of services that is provided by the CCBHC.

Established Date: The date a clinic is licensed by either NYS OMH or NYS OASAS. CCBHCs must seek Central Office approval to modify an established date for unique situations, including when a clinic was previously under a different provider name, a licensed clinic address change or a license clinic merger.

Harm reduction: An evidence-based approach that is critical to engaging with people who use drugs and equipping them with life-saving tools and information to create positive change in their lives and potentially save their lives. Harm reduction strategies include: increased naloxone access and training; syringe services programs; access to drug test strips; overdose prevention education; removal of stigma and barriers to treatment and to medications for treatment; Deterra medication disposal bags; anti-stigma work; increased public awareness and education; and grassroots work by peers, recovery supports, and prevention coalitions.

Reasonably Accessible: All CCBHC services must be accessible to the service area(s) noted in the CCBHC's Community Needs Assessment. NYS defines reasonably accessible as services that are either within 30 miles or 30 minutes (or lesser of the two) to the communities outlined in the Community Needs Assessment service area.

For locations and services provided outside of these parameters, they must be approved by NYS OMH and OASAS Central Office and Field/Regional Offices to review current resources in the geographic area, accessibility for all nine required CCBHC services and to ensure it meets SAMHSA's crisis response timeframe. Telehealth only *cannot* be the solution for determining reasonably accessible services, as some individuals will require or prefer in person services.

Service Area: The county or counties served by the CCBHC, as defined in the CCBHCs Community Needs Assessment.

Serving Lifespan: CCBHCs are required to serve individuals across the lifespan. Not all CCBHC satellite sites must serve *all populations.* If the site serves only a specific population and does not offer all 9 CCBHC services to all populations, those other required CCBHC services must be reasonably accessible. Telehealth only *cannot* be the solution for determining reasonably accessible services, as services must be delivered based on the preferences of the individual.

XII. Appendix

A. CCBHC Evidence-Based Practices

A CCBHC may demonstrate it is meeting the following requirements through the

provision of training and/or credentialing/certification of staff members. Where an EBP requires credentialing/certification to be delivered, one or more staff members who delivers treatment must be credentialed/certified or seeking credentialing/certification as demonstrated by enrollment in such a process.

The NYS Provider Manual currently requires the following EBPs for the treatment of both mental health and substance use disorders across the lifespan:

- Evidence-based Treatment for Co-occurring Mental and SUD
- Screening, Brief Intervention, and Referral to Treatment (SBIRT)
- Evidence-based Psychotherapy for Post Traumatic Stress Disorder (PTSD), e.g.,
  - Cognitive Processing Therapy (CPT)
  - Prolonged Exposure Therapy
- Evidence-based Psychotherapy for Depression and Anxiety Disorders, e.g.,
  - Cognitive Behavioral Therapy (CBT)
  - Acceptance and Commitment Therapy (ACT)
  - Interpersonal Therapy
  - Dialectical Behavioral Therapy
- Evidence-based Treatment for Addiction, e.g.,
  - Cognitive Behavioral Therapy
  - Motivational Interviewing
  - Community Reinforcement
  - Functional Family Therapy
  - Twelve Step Facilitation
  - Matrix Model
  - HepC and HIV support
  - Dialectical Behavioral Therapy
  - Trauma-informed model of care
  - Pharmacological Treatment for Substance Use Disorders
- Evidence-Based Treatment for Families with Children/Youth, e.g.,
  - Family Psychoeducation
  - Parent Management Training
  - The Seven Challenges
  - Motivational Enhancement Therapy/Cognitive Behavioral Therapy (MET/CBT)
  - Adolescent Community Reinforcement Approach (A-CRA)
  - Motivational Interviewing
  - Multidimensional Family Therapy
  - Functional Family Therapy
  - Brief Strategic Family Therapy
  - Multisystemic Therapy
- Evidence-Based Support for Employment, e.g.,
  - Individual Placement and Support (IPS)
- Modifications of Evidence-based Treatment to Serve Individuals for Co-occurring Mental and/or SUD with Intellectual/Developmental Disabilities, e.g.,
  - Cognitive Behavioral Therapy modified with more visual supports

The NYS Provider Manual offers the following recommendations for additional EBPs to consider for the treatment of both mental health and substance use disorders across the lifespan:

- Evidence-based Treatment for Serious Mental Illness, e.g.,
  - First episode early intervention for psychosis (OnTrackNY)
  - Wellness Management and Recovery (WMR)
  - Illness Management and Recovery
- Evidence-Based Treatment for Suicide Prevention, e.g.,
  - Cognitive Therapy for Suicide Prevention
- Evidence-Based Treatment for Couples, e.g.,
  - Behavioral Couples Therapy
- Evidence-Based Treatment for Early Childhood, e.g.,
  - Parent-Child Interaction Therapy
  - Child Parent Psychotherapy
- Evidence-Based Pharmacological Treatment for SMI, e.g.,
  - Clozapine for refractory schizophrenia
- Evidence-based Treatment for Co-occurring Mental and/or SUD with Physical Health Issues, e.g.,
  - Pre-Exposure Prophylaxis for individuals at risk for HIV
  - Routine screening for Hepatitis C and rapid referral to treatment.
- Evidence-based systemic protocols for enhanced community partnerships
  - Crisis Intervention Team (CIT) Model
  - System of Care Framework for Children and Families

B. Recommended Screening Tools

Children	Adults
PHQ-9: Modified for Teens | Official web site of the U.S. Health Resources & Services Administration (hrsa.gov) is a common, validated screening tool to identify depression, that was modified for adolescents	PHQ-9 depression scale.pdf (nih.gov) is a common, validated screening tool to identify depression. It is available in Spanish, as well as in a modified two item questionnaire: PHQ-2.
Alcohol Use Disorders Identification Test (AUDIT) (nih.gov) is a validated screening tool used to identify unsafe alcohol consumption. It is available in a modified three item questionnaire: AUDIT-C (nih.gov)	Alcohol Use Disorders Identification Test (AUDIT) (nih.gov) is a validated screening tool used to identify unsafe alcohol consumption. It is available in a modified three item questionnaire: AUDIT-C (nih.gov)
Columbia-Suicide Severity Rating Scale (C-SSRS) | Official web site of the U.S. Health Resources & Services Administration (hrsa.gov) is a screening tool used for suicide assessment. It is available in 114 different languages.	GAD-7_Anxiety-updated_0.pdf (adaa.org) is a common, validated screening tool used in the assessment for anxiety.
cans_manual.pdf (ny.gov) is a comprehensive multisystem assessment used for children and adolescents.	Microsoft Word - Mental Health Screener by UMass.doc (thenationalcouncil.org) is a tool adapted from the PHQ-9, GAD-7, PC-PTSD, and AUDIT and used to screen for behavioral health symptoms.

beck-anxiety-inventory.pdf (jolietcenter.com) is a self-report tool used to evaluate anxiety symptoms. Beck's Depression Inventory (ismanet.org) is a self-report tool used to evaluate depression symptoms.	DAST-10 (nih.gov) is a self-report tool used to evaluate drug use.
CRAFFT_2.1_Provider-Manual_2021.10.28.pdf is an alcohol and drugs screening tool recommended for youth ages of 14-21.	Columbia-Suicide Severity Rating Scale (C-SSRS) | Official web site of the U.S. Health Resources & Services Administration (hrsa.gov) is a screening tool used for suicide assessment. It is available in 114 different languages.
Teens Screening Tool: Screening to Brief Intervention (S2BI) (nih.gov) is an alcohol and drugs screening tool recommended for youth ages of 12-17.	The Primary Care PTSD Screen for DSM-5 (PC-PTSD-5) (va.gov) is screening tool currently used by the VA to identify PTSD in veterans.
NIAAA_AlcoholScreening_Youth_Guide.pdf (nih.gov) is an intervention recommended for youth ages of 9-18.	Microsoft Word - PTSD CheckList & Scoring.doc (va.gov) is checklist used to screen for PTSD in civilians (non-military).
Adverse Childhood Experience Questionnaire for Adults (acesaware.org) screens for a history of trauma.	World Health Organization Disability Assessment Schedule 2.0 - Self (WHODAS-self) (novopsych.com.au) is an assessment instrument for functioning, disability, and health. It is available in 60 different languages.
	CMH Assessment (ny.gov)
	beck-anxiety-inventory.pdf (jolietcenter.com) is a self-report tool used to evaluate anxiety symptoms. Beck's Depression Inventory (ismanet.org) is a self-report tool used to evaluate depression symptoms.
	Adverse Childhood Experience Questionnaire for Adults (acesaware.org) screens for a history of trauma.

C. Initial Evaluation and Comprehensive Assessment Minimum Requirements

Assessment/Evaluation Components	Must be completed within 10 business days	Must be completed within 60 calendar days of the first request for services or 30 days after admission-whichever timeframe

		is sooner
1. Preliminary diagnosis.	X	
2. The source of referral.	X	
3. The reason for seeking care, as stated by the individual or other individuals who are significantly involved.	X	
4. Identification of the individual's immediate clinical care needs related to the diagnosis for mental and substance use disorders.	X	
5. A list of all current prescriptions and over-the counter medications, herbal remedies, and dietary supplements and the indication for any medications.	X	
6. A summary of previous mental health and substance use disorder treatments with a focus on which treatments helped and were not helpful.	X	
7. The use of any alcohol and/or other drugs the individual receiving services may be taking and indication for any current medications.	X	
8. An assessment of whether the individual receiving services is a risk to self or to others, including suicide risk factors.	X	
9. An assessment of whether the individual receiving services has other concerns for their safety, such as intimate partner violence.	X	
10. Assessment of need for medical care (with referral and follow-up as required). Level of Care for Alcohol and Drug Treatment Referral - LOCADTR (as deemed appropriate)	X	
11. A determination of whether the individual presently is, or ever has been, a member of the U.S. Armed Services.	X	
12. For children and youth, whether they have system involvement (such as child welfare and juvenile justice).	X	
13. Development of a crisis prevention plan with each individual receiving services to identify the preferences of the person in the event of psychiatric or substance use crisis. At a minimum, individuals 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 prevention plans may support the development of a Psychiatric Advanced Directive, if desired by the person receiving services.	X	
14. Reasons for seeking services at the CCBHC, including information regarding onset of symptoms, severity of symptoms, and circumstances leading to the presentation to		X

the CCBHC of the individual receiving services.		
15. An overview of relevant social supports; social determinants of health; and health-related social needs such as housing, vocational, and educational status; family/caregiver and social support; legal issues; and insurance status.		X
16. A description of cultural and environmental factors that may affect the treatment plan of the individual receiving services, including the need for linguistic services or supports for people with LEP.		X
17. Pregnancy and/or parenting status.		X
18. Behavioral health history, including trauma history and previous therapeutic interventions and hospitalizations with a focus on what was helpful and what was not helpful in past treatments.		X
19. Relevant medical history and major health conditions that impact current psychological status.		X
20. A medication list including prescriptions, over-the counter medications, herbal remedies, dietary supplements, and other treatments or medications of the individual receiving services. Include those identified in a Prescription Drug Monitoring Program (PDMP) that could affect their clinical presentation and/or pharmacotherapy, as well as information on allergies including medication allergies.		X
21. An examination that includes current mental status, mental health (including depression screening, and other tools that may be used in ongoing measurement-based care) and substance use disorders (including tobacco, alcohol, and other drugs).		X
22. Basic cognitive screening for cognitive impairment.		X
23. Assessment of imminent risk, including suicide risk, withdrawal and overdose risk, danger to self or others, urgent or critical medical conditions, and other immediate risks including threats from another person.		X
24. The strengths, goals, preferences, and other factors to be considered in treatment and recovery planning of the individual receiving services. A description of attitudes and behaviors, including cultural and environmental factors, that may affect the individual's treatment plan.		X
25. Assessment of the need for other services required by the statute (i.e., peer and family/caregiver support services, targeted case management, psychiatric rehabilitation services).		X

26. Assessment of any relevant social service needs of the individual receiving services, with necessary referrals made to social services. For children and youth receiving services, assessment of systems involvement such as child welfare and juvenile justice and referral to child welfare agencies as appropriate.		X
27. An assessment of need for a physical exam or further evaluation by appropriate health care professionals, including the primary care provider (with appropriate referral and follow-up) of the individual receiving services. This provision is depending on whether the CCBHC directly provides Outpatient Clinic Primary Care Health Indicators and Health Risk.		X
28. The preferences of the individual receiving services regarding the use of technologies such as telehealth/telemedicine, video conferencing, remote patient monitoring, and asynchronous interventions.		X
29. Screening for problem gambling		X

D. Resources:

1. Certified Community Behavioral Health Clinic (CCBHC) Certification Criteria Updated March 2023 (samhsa.gov)
2. OASAS Part 822 Regulations
3. OASAS Part 825 Integrated Outpatient Services
4. OMH Part 599 MHOTRS Regulations
5. OMH Part 598 Integrated Outpatient Services
6. NYS OMH Certified Community Behavioral Health Clinic (CCBHC) Webpage
7. NYS OMH CCBHC Prospective Payment System (PPS)
8. NYS OMH Mental Health Outpatient Treatment and Rehabilitative Services Guidance on Youth, Family, Adult, and Older Adult Peer Support Services
9. Peer Advocate Services in OASAS Certified Programs Settings
10. OPHE Mental Health and Substance Use Disorders Community Needs Assessments Data Resources (ny.gov)