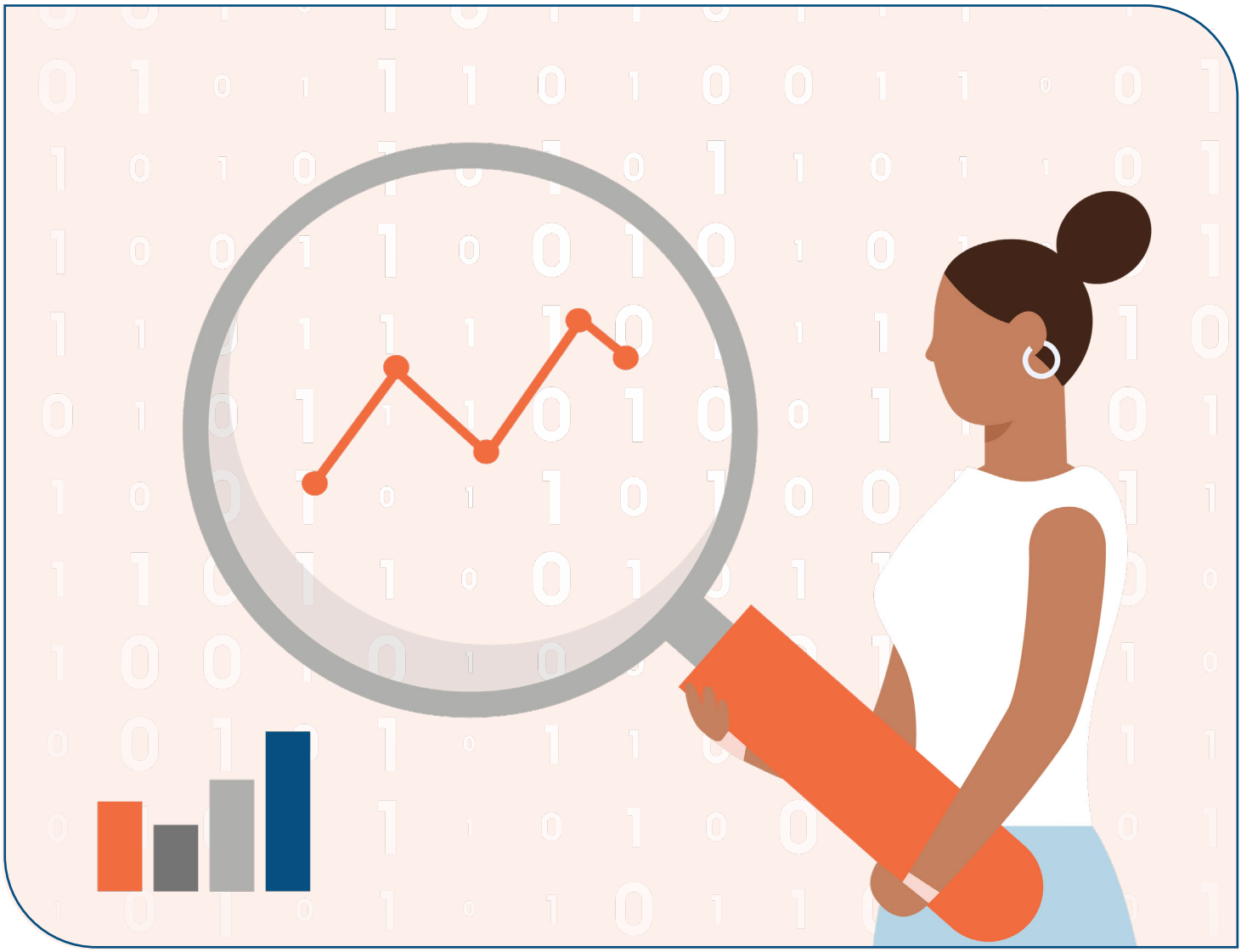
CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC (CCBHC)

Evidence-based Practice Reference Guide

NATIONAL COUNCIL *for* Mental Wellbeing



CCBHC-E National Training & Technical Assistance Center

Funded by Substance Abuse and Mental Health Services Administration and operated by the National Council for Mental Wellbeing

This publication was made possible by Grant Number 1H79SM085856 from the Substance Abuse and Mental Health Services Administration (SAMHSA). Its contents are solely the responsibility of the authors and do not necessarily represent the official views, opinions, or policies of SAMHSA, or the U.S. Department of Health and Human Services (HHS).

TABLE OF CONTENTS

INTRODUCTION

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

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

COMMON EVIDENCE-BASED PRACTICES EMPLOYED BY CCBHCS

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

Most commonly **required** EBPs for CCBHCs:

- Integrated treatment for co-occurring disorders/ integrated dual disorder treatment (ITCD)
- Medication-assisted treatment (MAT)
- Motivational interviewing (MI)
- Screening, brief intervention and referral to treatment (SBIRT)
- Trauma-focused cognitive behavioral therapy (TF-CBT)

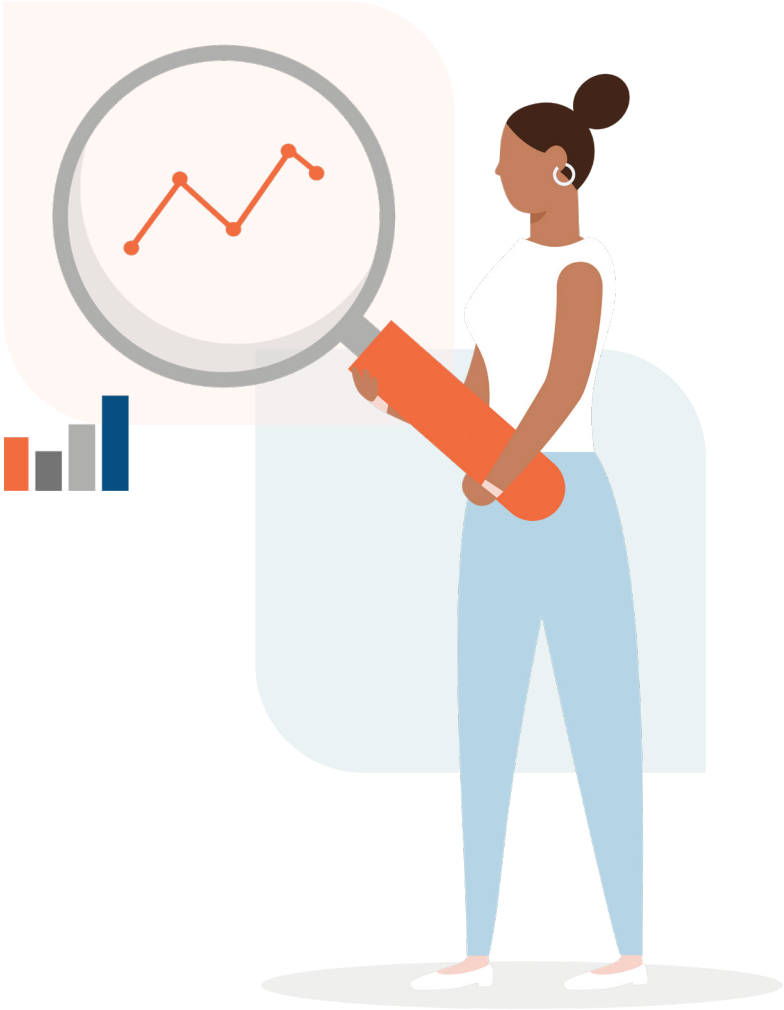
Most commonly **recommended** EBPs for CCBHCs:

- Dialectic behavioral therapy (DBT)
- Permanent supportive housing

EBP QUICK REFERENCE LIST

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

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



Medication-assisted Treatment

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

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

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

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

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

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

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

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

Training and Fidelity Resources

SAMHSA Treatment Improvement Protocol 63: Medications for Opioid Use Disorder: This resource includes guidance on OUD screening, assessment, treatment and referral as well as information and tools for health-care professionals who prescribe, administer or dispense OUD medications or treat other illnesses in patients who take these medications.

Practice Guidelines for the Administration of Buprenorphine for Treating Opioid Use Disorder: The practice guidelines highlight the exemptions that allows practitioners to expand treatment for OUD.

Opioid Response Network (ORN): The ORN has local consultants in all 50 states and nine territories to respond to local needs by providing free educational resources and training to states, communities and individuals in the prevention, treatment and recovery of OUD and stimulant use.

Become a Buprenorphine Waivered Practitioner: This resource page lists information and application process on how qualified practitioners can offer buprenorphine to treat OUD.

Other Resources

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

Motivational Interviewing

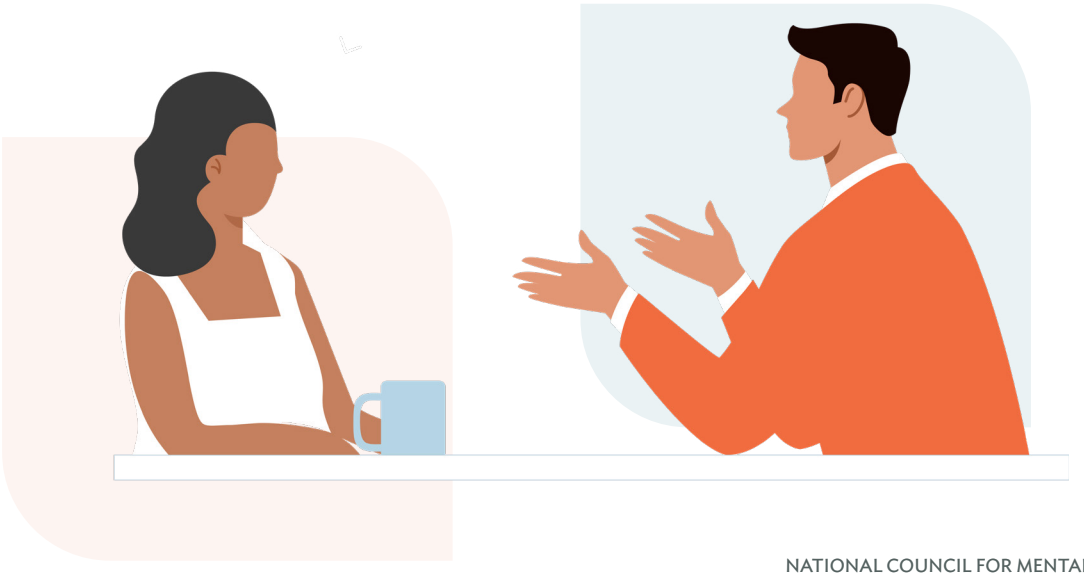
What it is: Motivational interviewing (MI) is a particular way of talking with people about change and growth to strengthen their own motivation and commitment. It is a method of communication rather than an intervention, sometimes used on its own or combined with other treatment approaches. MI is practiced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

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

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

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

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



Training and Fidelity Resources:

TIP 35: Enhancing Motivation for Change in Substance Use Disorder Treatment: This updated TIP includes the latest evidence on motivation-enhancing approaches and strategies. It describes how substance use disorder treatment providers can use these approaches and strategies to increase participation and retention in substance use disorder treatment.

National Council Motivational Interviewing Training and Consulting: Organizational training and coaching tailored to specific population and staff needs, also regularly scheduled virtual training opportunities for individuals.

Institute for Research, Education and Training in Addiction (IRETA) Motivational Interviewing Toolkit: This resource lists supplementary materials for MI training. IRETA also offers consulting and training services for organizations on MI.

Addiction Technology Transfer Center Network Motivation Interviewing Trainings: A resource page that lists several different MI trainings (including introductory and advanced levels, groups, managers) and intensive technical assistance through the Northwestern Addiction Technology Transfer Center.

Resources:

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

Trauma-focused Cognitive Behavioral Therapy

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

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

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

Training and Fidelity Resources:

Trauma-focused Cognitive Behavioral Therapy (TF-CBT): National Therapist Certification Program: The certification program page includes registration for upcoming trainings. The resource page includes implementation manuals for various populations as well as other implementation resources.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) Training Guidelines: This fact sheet includes requirements, recommendations, standards and other considerations on TF-CBT treatments, training, implementation, consultation and case completion requirements.

Resources:

- TF-CBT LGBTQ Implementation Manual
- TF-CBT Military Implementation Manual
- TF-CBT Telehealth Resources

Screening, Brief Intervention and Referral to Treatment

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

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

Target/most appropriate audiences: It is recommended that universal screening for unhealthy alcohol and other drug use be conducted at least annually for individuals ages 12 and older. Screening results will guide the level of brief intervention or referral to treatment.[17, 18] Because SBIRT is an early intervention, it typically targets persons who do not yet meet the substance use disorder criteria[19].

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

- Screening can often be self-administered by clients and built into existing screening protocols or workflows where they exist; for example, medical assistants could have individuals complete screenings on paper or tablets while taking vital signs.
- Staff members providing brief intervention and referral to treatment can benefit from MI training and access to onsite or community partners with specialization in substance use disorders. These staff will vary by setting, but could include primary care providers and behavioral health clinicians[21]

Training and Fidelity Resources

University of Missouri-Kansas City SBIRT Training and Tools: Includes open access screening and brief intervention tools, as well as virtual training courses.

National Council SBIRT Training and Consulting: Implementation planning, training, workflow development and ongoing coaching tailored to the organization's population and staff needs.

Institute for Research, Education and Training in Addiction (IRETA) SBIRT Toolkit: This resource lists supplementary materials for SBIRT training. IRETA also offers consulting and training services for organizations on SBIRT.

Other Resources

- TAP 33: Systems-Level Implementation of Screening, Brief Intervention and Referral to Treatment (SBIRT)
- National Council's Improving Adolescent Health: Facilitating Change for Excellent in SBIRT Change Package
- National Council's Adult SBIRT Change Package

Dialectic Behavioral Therapy

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

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

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

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

Training and Fidelity Resources

DBT-Linehan Board of Certification: DBT-Linehan oversees DBT certification and includes a directory of certified clinicians and programs as well as additional resources.

DBT Fidelity Scale: The fidelity scale utilized by Linehan Board of Certification to assess all programs.

Behavioral Tech: Founded by the developer of DBT, Marsha Linehan, PhD, ABPP, Behavioral Tech provides multiple live and virtual training options, as well as individualized consultation and resources.

Psychwire offers online DBT training courses, free training videos and a DBT newsletter.

Other Resources

- DBT Skills Resources
- Northwest Mental Health Technology Transfer Center's 16-lesson DBT Steps Online Lessons for Youth

Integrated Treatment for Co-occurring Disorders/Integrated Dual Disorder Treatment

What it is: Integrated treatment for co-occurring disorders (ITCD) organizes services so that consumers receive integrated treatment for mental illnesses and substance use disorders from the same practitioner or treatment team. Integrated treatment programs are based on a core set of practice principles:

- Mental health and substance use treatment are integrated to meet the needs of people with co-occurring disorders.
- Integrated treatment specialists are trained to treat both substance use disorders and serious mental illnesses.
- Co-occurring disorders are treated in a stage-wise fashion with different services provided at different stages.
- Motivational interventions are used to treat consumers in all stages, but especially in the persuasion stage.
- Substance use counseling, using a cognitive-behavioral approach, is used to treat consumers in the active treatment and relapse prevention stages.
- Multiple formats for services are available, including individual, group, self-help and family.
- Medication services are integrated and coordinated with psychosocial services.[26]

Target Populations/Populations of Focus: ITCD is intended for individuals with co-occurring serious mental illness and substance use disorders. Research has found treatment to be effective for individuals with a wide range of backgrounds regardless of age, race and ethnicity, and gender. Studies have also found effective outcomes for individuals experiencing housing instability and/or homelessness.[27]

Staffing Considerations: Integrated treatment programs typically consist of a program leader and one or more integrated treatment specialists, although this can vary depending on the number of clients the organization plans to serve. Program leaders oversee the program and hire, train and supervise integrated treatment specialists, so are recommended to be mid-level managers who have both administrative and clinical skills and have the authority to make or suggest administrative changes within the agency.

Integrated treatment specialists work with multidisciplinary teams to develop integrated treatment plans. They have knowledge of both substance use disorders and serious mental illnesses, understand the complexity of interactions between disorders and are trained in skills that effective in treating consumers with co-occurring disorders. Since mental health and substance use practitioners are not often cross-trained during their professional training and certification, many organizations choose to select current staff practitioners to receive intensive training to serve in this role. Integrated treatment specialists should participate in multidisciplinary treatment teams and be assigned to each treatment team in the organization. They can cross-train other treatment team members to disseminate information and skills about treating consumers with co-occurring disorders.[28]

Training and Fidelity Resources

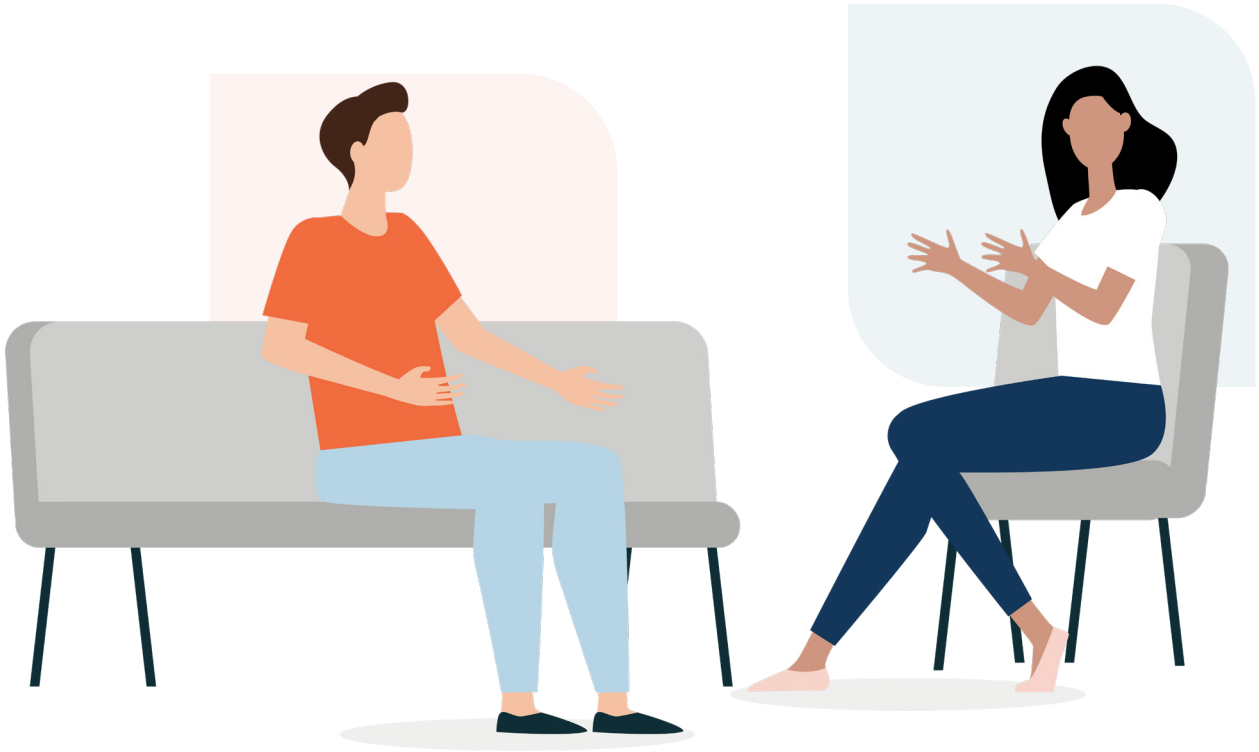
SAMHSA Evidence-based Practice Toolkit: Training Frontline Staff – Integrated Treatment for Co-Occurring Disorders: This toolkit serves as a workbook for mental health practitioners to become integrated treatment specialists. It introduces basic principles and skills to deliver effective integrated treatment to consumers with co-occurring disorders.

NAADAC: Integrating Co-occurring Disorders —An Introduction to What Every Addiction Counselor Needs to Know: This open access skill-based training program is designed to support addiction counselors to improve their ability to assist clients who have co-occurring disorders, within their scope of practice. This educational program is designed for those who do not have a significant background with co-occurring disorders.

Ohio Substance Abuse and Mental Illness Coordinating Center of Excellence: IDDT Fidelity Scale: The fidelity scale is designed to guide service organizations in their implementation of Integrated Dual Disorder Treatment (IDDT).

Resources

- SAMHSA Evidence-Based Practice Toolkit: Integrated Treatment for Co-Occurring Disorders
- Case Western Reserve University – Center for Evidence-Based Practices: Integrated Dual Disorder Treatment Resources
- Implementing IDDT: A Step-by-Step Guide to Stages of Organizational Change



Supportive Housing

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

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

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

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

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

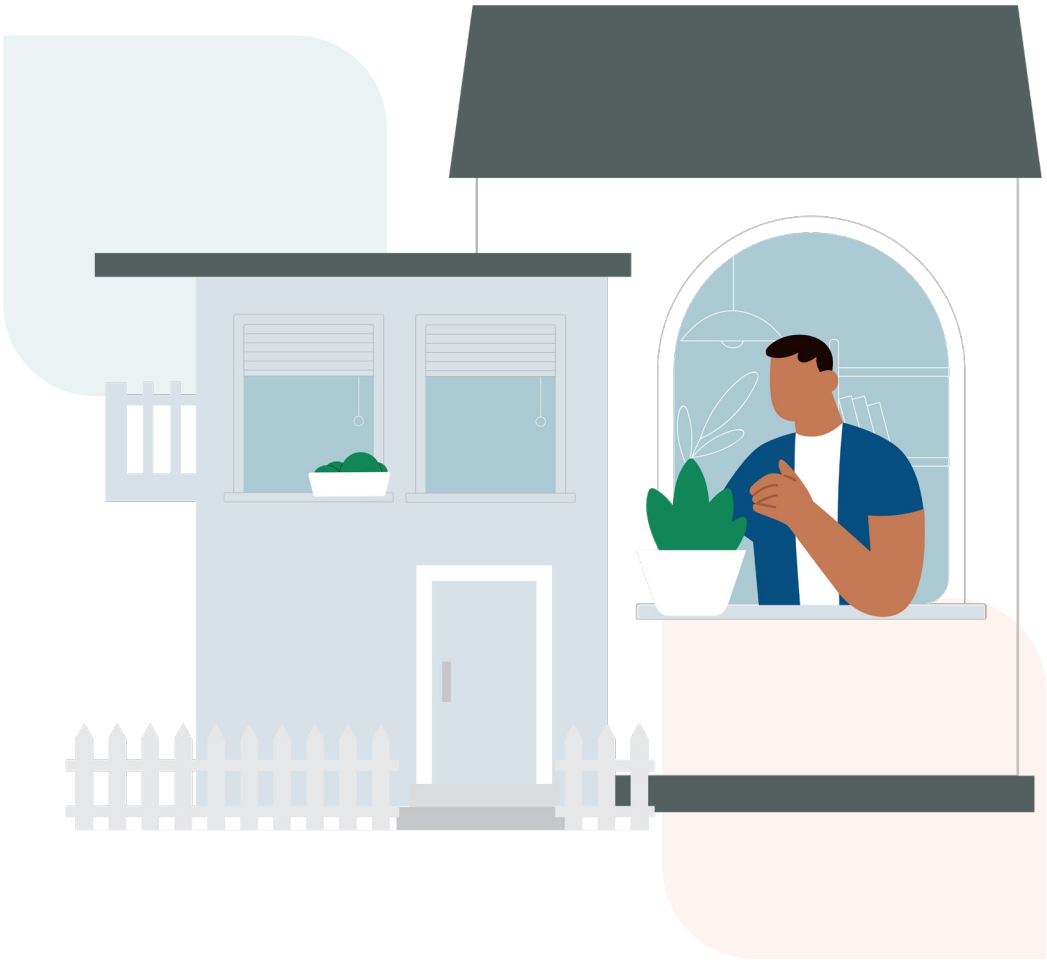
Programs that have incorporated (rather than partnered with) property management functions often include the following: property or resident manager, assistant manager, superintendent, maintenance staff, intake specialist and accountant.[32]

Training and Fidelity Resources

SAMHSA Permanent Supportive Housing Evidence-based Practice Kit: This toolkit outlines the essential components for supportive housing services and programs for people living with mental illness disorders. The toolkit includes eight booklets on program development, staff training modules and evaluation and fidelity tools.

SAMHSA Permanent Supportive Housing Kit – Evaluating Your Program: This booklet includes a fidelity scale and scoresheet.

Corporation for Supportive Housing Supportive Housing Training Center: The training center offers interactive training solutions that support building and high-quality supportive housing in the community. Offerings include hundreds of webinars and webinar series, self-paced online classes and videos.



Intensive Care Coordination Using Wraparound

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

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

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

Training and Fidelity Resources

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

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

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

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

Other Resources

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

GENERAL RESOURCES

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

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

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

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

APPENDIX A: Crosswalk of Most Commonly Required/Recommended EBPs for CCBHCs

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

Report Type (Source)	EBP	Michigan (MI) [36]	Missouri (MO) [37]	New York (NY) [38]	Oklahoma (OK) [39]	Texas (TX)[40]	Minnesota (MN)[41]	Total (Required EBPs)	Total (Recommended EBPs)
ASPE[42]	**Community wraparound services for youth/children**	x	x	x	**REQ**	**REQ**	x	2	0
ASPE	**Dialectical behavioral therapy (DBT)**	**REQ**	*REC*	*REC*	*REC*	x	x	1	3
ASPE	**Evidence-based medication evaluation and management**	x	x	x	x	x	x	0	0
ASPE	**Group Cognitive Behavioral Therapy**	x	x	x	x	x	x	0	0
ASPE	**Individual Cognitive Behavioral Therapy**	x	x	x	x	x	x	0	0
ASPE	**Medication-assisted treatment for alcohol and opioid use (MAT)**	**REQ**	**REQ**	**REQ**	**REQ**	x	x	4	0
ASPE	**Motivational Interviewing (MI)**	**REQ**	**REQ**	**REQ**	**REQ**	**REQ**	**REQ**	6	0
ASPE	**Multisystemic Therapy**	x	x	*REC*	x	x	x	0	1
INDIVIDUAL REPORT	**"Air Traffic Control"**	**REQ**	x	x	x	x	x	1	0
	Cognitive Behavioral Therapy *Not specified if group or individual	**REQ**	**REQ**	**REQ**	**REQ**	**REQ**	**REQ**	6	0
	Acceptance and Commitment Therapy	x	x	**REQ**	x	x	x	1	0
	Assertive Community Treatment (ACT)	**REQ**	*REC*	*REC*	x	x	x	1	2
	Behavioral Couples Therapy	x	x	*REC*	x	x	x	0	1
	Cognitive Behavioral Therapy for Suicide Prevention	x	x	*REC*	**REQ**	x	x	1	1
	Celebrating Families Program	x	x	x	*REC*	x	x	0	1

INDIVIDUAL REPORT	**Cognitive Processing Therapy (CPT)**	x	x	**REQ**	x	**REQ**	x	2	0
	Collaborative Assessment and Management of Suicidality (CAMS)	x	x	x	**REQ**	x	x	1	0
	Community Psychiatric Rehabilitation (CPR)	x	**REQ**	x	x	x	x	0	0
	Crisis Intervention Team (CIT) Model	x	x	*REC*	x	x	x	0	1
	Critical Time Intervention	x	x	x	*REC*	x	x	0	1
	Dialectical Behavior Therapy for Adolescents (DBT-A)	*REC*	x	x	x	x	x	0	1
	Enhanced Illness Management and Recovery (e-IMR)	x	*REC*	*REC*	**REQ**	**REQ**	x	1	2
	Eye Movement Desensitization and Reprocessing (EMDR)	x	**REQ**	x	x	x	**REQ**	2	0
	Family Psychoeducation	x	x	**REQ**	x	x	x	1	0
	Functional Family Therapy	x	x	*REC*	x	x	x	0	1
	Housing First	x	x	x	**REQ**	x	x	1	0
	Individual Placement and Support (IPS)	*REC*	x	**REQ**	**REQ**	x	x	2	1
	Infant Mental Health	**REQ**	x	x	x	x	x	1	0
	Integrated Dual Disorder Treatment (IDDT)	**REQ**	x	x	x	x	x	1	0
	Integrated Treatment for Co-occurring Disorders (ITCD)	x	**REQ**	**REQ**	x	**REQ**	x	3	0
	Interpersonal Therapy	x	x	**REQ**	x	x	x	1	0
	Matrix Model	x	x	*REC*	*REC*	x	x	0	2
	Motivational Enhancement Therapy	x	x	*REC*	*REC*	x	x	0	2
	My Way to Health	x	*REC*	x	x	x	x	0	1

INDIVIDUAL REPORT	**Nurturing Parent Training**	x	x	x	x	**REQ**	x	1	0
	OnTrackNY — First episode early intervention for psychosis	x	x	*REC*	*REC*	x	x	0	2
	Parent Management Training (PMTO) or PTC	**REQ**	*REC*	x	x	x	x	1	1
	Peer Recovery Support Specialists (PRSS)	x	x	x	**REQ**	x	x	1	0
	Program of Assertive Community Treatment	x	x	x	*REC*	x	x	0	1
	Recovery-oriented Cognitive Therapy	x	x	x	*REC*	x	x	0	1
	SAMHSA Permanent Supportive Housing	*REC*	*REC*	*REC*	x	**REQ**	x	1	3
	Screening, Brief Intervention and Referral to Treatment (SBIRT)	**REQ**	x	**REQ**	x	**REQ**	x	3	0
	Seeking Safety	x	x	x	**REQ**	x	x	1	0
	Seven Challenges	x	x	*REC*	x	x	x	0	1
	Stages of Change (Transtheoretical Model)	x	x	x	x	x	**REQ**	1	0
	Supported Employment	x	*REC*	*REC*	x	x	x	0	2
	Therapeutic Foster Care	x	x	*REC*	x	x	x	0	1
	Tobacco Treatment Specialists (TTS)	x	**REQ**	x	x	x	x	1	0
	Transition to Independence (TIP Model)	*REC*	x	x	x	x	x	0	1
	Trauma-focused CBT (TF-CBT)	**REQ**	x	x	**REQ**	**REQ**	**REQ**	4	0
	Trauma-informed Care	*REC*	**REQ**	x	x	x	x	1	1
	Twelve Step Facilitation Therapy	x	x	*REC*	x	x	x	0	1
	Wellness Management and Recovery (WMR)	x	x	*REC*	x	x	x	0	1
	Zero Suicide Academy	x	**REQ**	x	x	x	x	1	0

ENDNOTES

1. Recovery Research Institute. (2019, June 14). Pharmacotherapy – medications. https://www.recoveryanswers.org/resource/pharmacotherapy-medication-assisted-treatments/
2. Substance Abuse and Mental Health Services Administration. (2023, February 2). Medications for substance use disorders. https://www.samhsa.gov/medication-assisted-treatment
3. Substance Abuse and Mental Health Services Administration. (2023, February 2). Medications for substance use disorders. https://www.samhsa.gov/medication-assisted-treatment
4. Substance Abuse and Mental Health Services Administration. (2021). Medications for opioid use disorder. Treatment Improvement Protocol (TIP 63). Series 63. Publication No. PEP21-02-01-002. https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP21-02-01-002.pdf
5. Substance Abuse and Mental Health Services Administration and National Institute on Alcohol Abuse and Alcoholism (2015). Medication for the treatment of alcohol use disorder: A brief guide. HHS Publication No. (SMA) 15-4907. https://store.samhsa.gov/sites/default/files/d7/priv/sma15-4907.pdf
6. Substance Abuse and Mental Health Services Administration. (2021). Medications for opioid use disorder. Treatment Improvement Protocol (TIP 63). Series 63. Publication No. PEP21-02-01-002. https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP21-02-01-002.pdf
7. Miller, W. R., & Rollnick, S. (2013). Motivational interviewing: Helping people change (3rd ed.). Guilford.
8. Substance Abuse and Mental Health Services Administration. (2021). Using motivational interviewing in substance use disorder treatment. SAMHSA Advisory. https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-02-014.pdf
9. Substance Abuse and Mental Health Services Administration. (2019). Enhancing motivation for change in substance use disorder treatment. Treatment Improvement Protocol (TIP 35). Series No. 35. SAMHSA Publication No. PEP19-02-01-003. https://store.samhsa.gov/sites/default/files/d7/priv/tip35_final_508_compliant_-_02252020_0.pdf
10. Miller, W. R., & Rollnick, S. (2013). Motivational interviewing: Helping people change (3rd ed.). Guilford.
11. Menschner, C. & Maul, A. (April 2016). Key ingredients for successful trauma-informed care implementation. Center for Health Care Strategies & the Robert Wood Johnson Foundation. https://www.samhsa.gov/sites/default/files/programs_campaigns/childrens_mental_health/atc-whitepaper-040616.pdf
12. Child Welfare Information Gateway. (2018). Trauma-focused cognitive behavioral therapy: A primer for child welfare professionals. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.
13. Child Welfare Information Gateway. (2018). Trauma-focused cognitive behavioral therapy: A primer for child welfare professionals. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.
14. The National Child Traumatic Stress Network. (2016). Trauma-focused cognitive behavioral therapy (TF-CBT) training guidelines. https://www.nctsn.org/sites/default/files/interventions/tfcbt_training_guidelines.pdf
15. Trauma-focused Cognitive Behavioral Therapy. National Therapist Certification Program. https://tfcbt.org/certification
16. Substance Abuse and Mental Health Services Administration. (2022, August 12). Screening, brief intervention and referral to treatment. https://www.samhsa.gov/sbirt
17. National Council for Mental Wellbeing. (2021). Improving adolescent health: facilitating change for excellence in SBIRT. https://www.ysbirt.org/wp-content/uploads/2021/11/2021.11.10_NC_SBIRT_ChangePackage.pdf
18. National Council for Behavioral Health. (2018). Implementing care for alcohol & other drug use in medical settings: An extension of SBIRT. https://www.thenationalcouncil.org/wp-content/uploads/2021/04/Implementing_Care_for_Alcohol_and_Other_Drug_Use_In_Medical_Settings_-_An_Extension_of_SBIRT.pdf

19. Substance Abuse and Mental Health Services Administration. (2013). Systems-level implementation of screening, brief intervention and referral to treatment. Technical Assistance Publication (TAP 33) Series 33. HHS Publication No. (SMA) 13-4741. https://store.samhsa.gov/sites/default/files/d7/priv/sma13-4741.pdf
20. Substance Abuse and Mental Health Services Administration. (2013). Systems-level implementation of screening, brief intervention and referral to treatment. Technical Assistance Publication (TAP 33) Series 33. HHS Publication No. (SMA) 13-4741. https://store.samhsa.gov/sites/default/files/d7/priv/sma13-4741.pdf
21. Substance Abuse and Mental Health Services Administration. (2013). Systems-level implementation of screening, brief intervention and referral to treatment. Technical Assistance Publication (TAP 33) Series 33. HHS Publication No. (SMA) 13-4741. https://store.samhsa.gov/sites/default/files/d7/priv/sma13-4741.pdf
22. Behavioral Research and Therapy Clinics. (n.d.). Dialectical behavior therapy. https://depts.washington.edu/uwbrtc/about-us/dialectical-behavior-therapy/
23. Substance Abuse and Mental Health Services Administration. (2020). Treatment for suicidal ideation, self-harm and suicide attempts among youth. SAMHSA Publication No. PEP20-06-01-002, Rockville, MD: National Mental Health and Substance Use Policy Laboratory. https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-06-01-002.pdf
24. Central Toronto Youth Services. (2018). Central Toronto Youth Services (CTYS): Our annual report 2017-2018. https://ctys.org/wp-content/uploads/2022/11/CTYS_Annual_Report_2017-2018_Rev_10.26_Email.pdf
25. Behavioral Tech. (n.d.). What is dialectical behavior therapy (DBT)? https://behavioraltech.org/resources/faqs/dialectical-behavior-therapy-dbt/
26. Substance Abuse and Mental Health Services Administration. (2009). Integrated treatment for co-occurring disorders: Building your program. DHHS Pub. No. SMA-08-4366, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. https://store.samhsa.gov/sites/default/files/d7/priv/ebp-kit-building-your-program-10112019.pdf
27. Substance Abuse and Mental Health Services Administration. (2009). Integrated treatment for co-occurring disorders: Building your program. DHHS Pub. No. SMA-08-4366, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. https://store.samhsa.gov/sites/default/files/d7/priv/ebp-kit-building-your-program-10112019.pdf
28. Substance Abuse and Mental Health Services Administration. (2009). Integrated treatment for co-occurring disorders: Building your program. DHHS Pub. No. SMA-08-4366, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. https://store.samhsa.gov/sites/default/files/d7/priv/ebp-kit-building-your-program-10112019.pdf
29. The Corporation for Supportive Housing. (n.d.). Supportive housing 101. https://www.csh.org/supportive-housing-101
30. Substance Abuse and Mental Health Services Administration. (2010). Permanent supportive housing: Building your program. HHS Pub. No. SMA-10-4509, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. https://store.samhsa.gov/sites/default/files/d7/priv/buildingyourprogram-psh.pdf
31. Substance Abuse and Mental Health Services Administration. (2010). Permanent supportive housing: Training frontline staff. HHS Pub. No. SMA-10-4509, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. https://store.samhsa.gov/sites/default/files/d7/priv/trainingfrontlinestaff-psh.pdf
32. Substance Abuse and Mental Health Services Administration. (2010). Permanent supportive housing: Building your program. HHS Pub. No. SMA-10-4509, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. https://store.samhsa.gov/sites/default/files/d7/priv/buildingyourprogram-psh.pdf

33. Substance Abuse and Mental Health Services Administration. (2019, June). Intensive care coordination for children and youth with complex mental and substance use disorders: State and community profiles. SAMHSA Publication No. PEP19-04-01-001. Rockville, MD: Substance Abuse and Mental Health Services Administration. https://store.samhsa.gov/sites/default/files/d7/priv/samhsa-state-community-profiles-05222019-redact.pdf
34. Substance Abuse and Mental Health Services Administration. (2019, June). Intensive care coordination for children and youth with complex mental and substance use disorders: State and community profiles. SAMHSA Publication No. PEP19-04-01-001. Rockville, MD: Substance Abuse and Mental Health Services Administration. https://store.samhsa.gov/sites/default/files/d7/priv/samhsa-state-community-profiles-05222019-redact.pdf
35. National Wraparound Initiative. (n.d.). What are the implementation requirements for Wraparound. https://nwi.pdx.edu/wraparound-basics/#whatareimplementation
36. Michigan Department of Health and Human Services Behavioral Health and Development Disabilities Administration. (2021). MI Certified Community Behavioral Health Clinic (CCBHC) handbook (Version 1.2).
37. Missouri Department of Mental Health. (n.d.). List of required evidence-based practices. https://dmh.mo.gov/media/pdf/list-required-evidence-based-practices
38. New York State Office of Mental Health. (2017, December). New York State Certified Community Behavioral Health Clinic (CCBHC) scope of services provider manual. https://omh.ny.gov/omhweb/bho/ccbhc-scope-of-services-manual.pdf
39. Oklahoma Department of Mental Health. (2020, July). Oklahoma Certified Community Behavioral Health Clinics (CCBHC). http://www.odmhsas.org/picis/Documents/CCBHC%20Manuals/CCBHC%20Manual%20Final%20SPA.pdf
40. Texas Council of Community Centers. (2018, August). Texas Certified Community Behavioral Health Clinics (CCBHCs): Certification criteria overview and clarification guide. https://intranet.txcouncil.com/wp-content/uploads/2019/02/CCBHC-Certification-Guidance_Final-Draft_September-2018.pdf
41. Minnesota Department of Human Services. (n.d.). Minnesota CCBHC, part 2 attachment – description of required evidence-based practices.
42. ASPE Office of the Assistant Secretary for Planning and Evaluation. (2020, September). Implementation finds from the national evaluation of the Certified Community Behavioral Health Clinic demonstration. https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//196051/CCBHCImpFind.pdf