For the last several years, increasing rates of mental illness and barriers to treatment for adults and youth have challenged states. In response, legislatures have worked to help strengthen and align behavioral health and public health systems. Common policy actions include improving statewide data systems, promoting cross-sector engagement and partnerships, establishing spending levels and coordinating funding sources.

Now states also face adverse mental and behavioral health conditions due to COVID-19. The Centers for Disease Control and Prevention has reported an increase in people presenting with symptoms of anxiety, depression, suicidal ideations and substance use due to the stress of the pandemic.

At any given time, about 1 in 5 adults and 1 in 6 youth ages 6-17 will report experiencing a mental health disorder. Mental health conditions also disproportionately affect specific populations, including youth and young adults, Hispanic people, Black people, essential workers, unpaid caregivers and rural communities.

This four-part series explores the national behavioral health landscape and a variety of state legislative actions to increase access to mental and behavioral health-related services, including preventive interventions for all ages and innovations related to suicide prevention.
Evidence shows integrating physical and behavioral health care may improve chronic health outcomes. State and local public health and behavioral health departments administer a range of programs to address physical and mental health conditions, as well as substance misuse, but the types and quality of services can vary across and within state agencies. To address gaps, coordinate care and streamline physical and behavioral health services, some state lawmakers are pursuing a new model of care known as a Certified Community Behavioral Health Clinic, or CCBHC.

Certified Community Behavioral Health Clinic Model

CCBHCs integrate behavioral health with physical health care by connecting behavioral health clinics to local primary care and hospital partners, and building coalitions with criminal justice entities, health advocates and others. CCBHCs are nonprofit organizations, local government behavioral health agencies or tribal organizations offering a wide range of mental health and substance use disorder services for people with complex health needs.

Signed into law in 2014 as part of the Protecting Access to Medicare Act, Section 223 created the Community Behavioral Health Clinics Demonstration Program to pilot this framework and evaluate its success. Eight states started the demonstration in 2017 and another 16 states were awarded CCBHC planning grants through the Substance Abuse and Mental Health Services Administration, also known as SAMHSA. Today, about 430 CCBHCs operate in over 40 states, Washington, D.C., and Guam.

CCBHCs developed under SAMSHA and those created through Medicaid have different funding mechanisms. Medicaid funds the demonstration, and participating states receive enhanced reimbursements to support their CCBHCs. States that have been awarded grant funding through SAMSHA receive $2 million per year paid directly to clinics. States that receive funding through the Medicaid demonstration may not apply for grant funding through SAMSHA.

Currently, 10 states participate in the Medicaid demonstration and, in 2021, SAMHSA awarded 100 grants totaling $250 million. An important note is that the grant funding comprised $115 million in COVID-19 relief funds, $77 million allocated from the American Rescue Plan Act and $58 million in annual appropriations. Without further congressional appropriations, CCBHCs funded through SAMSHA grants may need state support. The Medicaid demonstration will end in 2023.
States that do not participate in the demonstration or receive SAMHSA grant funding can implement CCBHCs by submitting a Medicaid 1115 waiver or state plan amendment to the Center for Medicare and Medicaid Services.

The demonstration program emphasizes that CCBHCs must provide high-quality care using evidence-based practices. Qualified CCBHCs provide nine types of services, either directly or by contracting with partner organizations: outpatient mental health and substance use treatment, primary care screening and monitoring, and behavioral health crisis resources. CCBHCs aim to improve the availability of and access to these services, as well as coordinate care across them, without increasing federal spending.

For an organization to participate as a CCBHC, it must meet program requirements under six categories: staffing; availability and accessibility of services; care coordination; scope of services; quality reporting; and organizational authority. CCBHC certification standards within these criteria are primarily determined by states, but states might need to submit a plan amendment for CMS approval.

CCBHCs are required to provide nine types of services:

- Crisis mental health services including 24-hour mobile crisis teams, emergency crisis intervention and crisis stabilization.
- Screening, assessment and diagnosis.
- Patient-centered treatment planning.
- Outpatient mental health and substance use disorder services.
- Primary care screening and monitoring.
- Targeted case management.
- Psychiatric rehabilitation services.
- Peer support services and family support services.
- Services for members of the armed services and veterans.

**Status of Participation in the CCBHC Model**

There are over 430 CCBHCs in the U.S., across 42 states, Guam and Washington, D.C.

- States where clinics have received expansion grants
- States selected for the CCBHC demonstration
- Independent statewide implementation
- No CCBHCs

Source: National Council for Mental Wellbeing
Some states report that coordinating services across CCBHCs has saved money while helping patients achieve better outcomes. For example, research has shown that people living with mental health or substance use disorders typically have higher rates of emergency department usage and hospitalizations. The CCBHC model reduces use of those high-cost services. One CCBHC in Missouri indicated a 66% decrease in requests for crisis intervention services, while 85% of those referred for inpatient hospitalization were diverted to community care options. In Oregon, a CCBHC partnership with a local jail estimated a savings of $2.5 million in prison costs. Furthermore, connecting 988—the national suicide prevention and mental health crisis call number—to CCBHCs could be vital to ensuring continuity of care, as well as demonstrating return on investment.

To help states and the federal government assess the impact of the CCBHC program, state agencies and CCBHCs involved in the demonstration must annually report to the U.S. Department of Health and Human Services on 21 separate quality measures. However, one analysis cited limitations to this data, including a lack of baseline information, making evaluation of the CCBHC model difficult for now.

State Actions: Funding Mechanisms and Implementation Models

CCBHC funding and implementation can look different from state to state. For instance, Texas developed a CCBHC framework with SAMSHA grant funding in 2015. The state continues to support the CCBHC model through an approved 1115 Medicaid waiver and general fund allocations.

While some states, including Minnesota, Missouri, Nevada and Oklahoma, pursued CCBHC models through an approved SPA, other states have addressed CCBHCs via legislation. For example, Kansas enacted a law to establish a new CCBHC program, and measures passed in Indiana and West Virginia will continue or expand efforts in those states. In Illinois, the CCBHC program received funding, and Maine provided funding to hire staff to explore the plan amendment process. Idaho, one of the states without a CCBHC framework, will use $12 million of ARPA funds to develop a CCBHC model.

State lawmakers who wish to pursue a CCBHC model may want to start by engaging local public health and behavioral health officials to find out more about behavioral health services in their state and how they are accessed. Legislators might also consider which funding mechanism and policy process makes the most sense for their state.

Colleen Becker is a project manager in NCSL’s Health Program.

Additional Resources

- Behavioral Health Overview, NCSL
- State Actions on Coronavirus Relief Funds, NCSL
- Certified Community Behavioral Health Clinics and Federally Qualified Health Centers: Opportunities for Collaboration, NCSL webinar
Peer Support Specialists: Connections to Mental Health Care

By Kelsie George

Peer Support Specialist Services

As health care extenders, peer support specialists are nonclinical health professionals who work in behavioral health settings with people diagnosed with mental health or substance use disorders. Also known as peer support workers or peer mentors, peer support specialists use their lived experience of recovery from mental illness or substance use disorders, along with formal training, to promote mind-body recovery and resiliency.

Peer support specialist roles often include:

- Advocating for people in recovery.
- Sharing resources and building skills.
- Building community and relationships.
- Leading recovery groups.
- Mentoring and setting goals.

Roles may also include providing training, supervising other peer workers, developing resources, administering programs or agencies, and educating the public and policymakers.

State Action

TRAINING AND CERTIFICATION

To protect patients, states regulate aspects of training and certification for health professionals, including peer support specialists. Training and certification programs vary widely across states in terms of curriculum, requirements and continuing education standards. In addition to state-run programs, third-party organizations also offer peer support specialist certification or guidelines for states.
As of June 2020, 48 states and Washington, D.C., had established training and certification programs for peer support specialists, through state-run programs or third-party organizations. A 2019 report from the University of Michigan Behavioral Health Workforce Research Center found that certification for peer support specialists requires an average of about 50 hours of specialized training and 550 hours of volunteer experience. Florida requires certified recovery peer specialists to complete 3,000 hours of supervised work or volunteer experience and 40 hours of training, or a certificate of completion from a program approved by Mental Health America. Oregon requires peer wellness specialists to complete 80 hours of training and peer support specialists to complete 40 hours of training.

REIMBURSEMENT AND FINANCING

The growth of peer support services has largely been facilitated by reimbursement through Medicaid, which is the largest payer of mental health services in the United States. The Centers for Medicare and Medicaid Services released guidance in 2007 authorizing Medicaid reimbursement for peer services based on research identifying peer support as an evidence-based model of care.

As of 2019, at least 39 states require Medicaid reimbursement for mental health peer services. These services can be provided through several mechanisms, such as rehabilitative services under Section 1905(a)(13) of the Social Security Act, home health state plan options under Section 2703 of the Affordable Care Act, a state plan amendment or a Medicaid waiver. Wisconsin enacted legislation to provide reimbursement for peer recovery coach services under Medicaid as long as peer coaches are supervised by competent mental health professionals and services are coordinated with Medicaid recipients’ individual treatment plans, among other conditions.

Outside of Medicaid, states also use general funds, grant funding or dedicated funds from governors’ commissions or task forces to implement and sustain peer support programs. Minnesota appropriated $2 million in fiscal years 2022 and 2023 for Recovery Community Organization Grants to pay for community-based peer recovery support services otherwise not eligible for reimbursement.

REMOVING BARRIERS TO HEALTH CARE ACCESS

In addition to barriers within the health care system—workforce shortages, lack of insurance coverage for services—individuals seeking care may face barriers including stigma associated with diagnosis, distrust of health care systems and previous poor experiences.

To facilitate access to behavioral health services and expand the reach of existing health care providers, several states are utilizing peer support specialists in a variety of ways. In addition to updating training and certification processes and increasing reimbursement opportunities for peer services, states are exploring how peer support specialists with lived experience may facilitate health care access for other populations, including those living with HIV or experiencing housing instability or homelessness.

Research shows that peer support with routine medical care promotes better health outcomes than routine clinical follow-up for individuals living with HIV. Several states, including Florida, New York and Wisconsin, use peer support specialists to facilitate connections to care and encourage the maintenance of treatment among patients living with HIV. Peer support specialists who have lived experience with HIV are uniquely positioned to understand the stigma and foster dialogue with others living with HIV.

Peer-staffed or peer-led interventions are also shown to have a positive impact on health outcomes for individuals experiencing housing insecurity and homelessness. Washington has appropriated funding since 2014 to establish Housing and Recovery Through Peer Services teams including a managed care health professional, a supervisor or clinical oversight professional and two certified peer counselors. Approximately 1,500 individuals, including 219 experiencing a substance use disorder, remained housed between July 2019 and June 2020.

Supporting emerging health professionals such as peer support specialists is just one of several strategies states can use to address behavioral health workforce issues. Legislators continue to look for ways that health care professionals can remove barriers and enhance access to health care, especially in rural and underserved communities.

Kelsie George is a policy associate in NCSL’s Health Program.

Additional Resources

- Scope of Practice Policy Website, NCSL
- Meeting Health Care Needs With an Emerging Workforce, NCSL
- National Certified Peer Specialist Certification, Mental Health America
- National Certified Peer Recovery Support Specialist, NAADAC
- National Practice Guidelines for Peer Specialists and Supervisors, National Association of Peer Supporters
Since children and adolescents are still developing, they may express and articulate their distress differently than adults. Health care professionals use clinical guidelines, while parents, adults and peers may need to look for other cues. More apparent symptoms are generally behavioral and can appear through changes in school performance and increased frequency of nightmares, disobedience, aggression and temper tantrums. For adolescents, increased thoughts of sadness, hopelessness and suicidal ideation can be common symptoms. Commonly diagnosed disorders include:

- Anxiety.
- Depression.
- Attention deficit/hyperactive disorder (ADHD).
- Oppositional defiant disorder.
- Conduct disorder.
- Obsessive-compulsive disorder.
- Post-traumatic stress disorder.
- Tourette’s syndrome.

The American Academy of Child and Adolescent Psychiatry recommends health care providers routinely screen children for behavioral and mental health concerns. Early identification of symptoms and connection to child therapy or family therapy, or both, can reduce a child’s risk of persistent or increased mental health challenges. Adolescents who experience difficulties with anxiety or depression may benefit from cognitive behavioral therapy, which allows older children to work on new ways of thinking and reacting.

Learning to identify and treat mental health warning signs and symptoms can increase the ability of children and adolescents to develop coping and resiliency skills that help them learn, behave and handle their emotions. These skills are essential to healthy social development and help ensure children have a positive quality of life into adulthood. Mental health conditions and disorders have steadily increased among children and adolescents for years. And while the impacts of COVID-19 on child and adolescent mental health are not fully known, increased reports of anxiety, depression and emotional and physical abuse have experts calling on adults, communities and leaders to prioritize youth health through preventive intervention and treatment.
Rising Rates of Mental and Behavioral Health Disorders

Newly released public health data from the Centers for Disease Control and Prevention shows rising rates of mental, emotional and behavioral disorders among children and adolescents. From 2013-2019, ADHD and anxiety disorders were among the most common diagnoses for children ages 3-17, with approximately 1 in 11 children diagnosed. Depression and suicide were also rated as high risk for adolescents ages 12-17. During this time period, 1 in 5 adolescents experienced a major depressive episode or seriously considered suicide.

As of 2019, YRBS data shows 46.8% of lesbian, gay and bisexual youth and 43.9% of transgender youth considered suicide within the past year.

For adolescents and young adults, opioid overdose deaths have increased 500% since 1999.

The 2019 Youth Risk Behavior Survey reveals suicide attempts increased overall and that those most at risk include females, non-Hispanic whites, non-Hispanic Blacks, 12th-grade students and sexual minorities, especially LGBTQ+ youth. Suicide is the second-leading cause of death among youth ages 14-18. Adolescents who struggle with suicidal ideation or who attempt suicide usually do so as a result of a combination of individual, community and societal stressors. Suicide is often associated with people who have experienced toxic stress, which is often caused by adverse childhood experiences including child abuse and neglect, bullying, peer violence and dating or sexual violence.

Mental health disorders have been linked to substance misuse and increased risky behaviors among adolescents and young adults, especially when use is started earlier in life. Data released in 2021 shows nearly 40% of young adults have reported using illicit substances within the last year. The illicit use of alcohol, cannabis, opioids and prescription drugs is reported most among adolescents and young adults. The misuse of stimulants, opioids and depressants can have harmful effects on a developing adolescent brain and body.

A public health approach to behavioral health challenges can allow for increased and earlier identification of risk factors, increased awareness of mental health disorders, elimination or reduction of stigma and health inequities, and improved access to treatment for entire communities. Policymakers can be better equipped to make decisions without duplicating efforts and increase the likelihood of reduced cost to the overall health care system through preventive intervention and treatment, and system collaboration and alignment.

State Actions: Expanding Awareness and Access

Many states have enacted legislation to increase awareness of youth mental health needs, address adverse childhood experiences and improve access to mental health treatment. In 2021, Kentucky designated an official state mental health flag to encourage citizens, government agencies, schools, businesses, and public and private institutions to commit to increasing awareness and understanding of mental health. Maryland called for the state to add questions on adverse childhood experiences, or positive childhood experiences, to its administration of the CDC’s Youth Risk Behavior Survey. Colorado created the I Matter program, which connects anyone 18 or younger with a therapist for up to three free, virtual or in-person counseling sessions. Since its enactment the IMatter program will cover up to 6 virtual or in-person counseling sessions for adolescents as young as 12 without a parent or guardian.

Schools also continue to be an important access point for children and adolescents seeking not only physical health services but also mental and behavioral health care services. Rhode Island’s 2021 Nathan Bruno and Jason Flatt Act requires the training of teachers, students and school personnel on suicide awareness and prevention efforts. Oklahoma passed legislation to create Maria’s Law that requires all schools to include mental health education as part of health education curriculum and highlight the “interrelationship of physical and mental well-being.” The education board will also revise the state’s standards for health and physical education to include a focus on mental health with age-appropriate resources for kindergarten through 12th grade. Washington established an office within the department of health to award grants and coordinate with other agencies and entities to provide support, training and technical assistance to school-based health centers. In its research, the Legislature highlighted increasing health and academic disparities for students of color during COVID-19 and acknowledged “school-based health centers’ role in advancing equity by providing health care access and support at schools.”
Federal Funding and Support

In 2020, the Kaiser Family Foundation reported approximately 34.8% of children ages 0-18 were covered under Medicaid. Through the Early and Periodic Screening, Diagnostic and Treatment benefit, Medicaid can play a role in connecting children and adolescents to preventive health care, including mental health and developmental services. Medicaid can also support sustainable funding for school mental and behavioral health services through federal reimbursement. As of December 2021, at least 17 states have expanded Medicaid coverage of services in schools.

Medicaid can also support the use of Screening, Brief Intervention and Referral to Treatment, an early intervention practice for people who have a substance use disorder or for those at risk of developing a disorder. Experts have developed evidence-based recommendations and guidelines for health care providers specifically for children and adolescents who may be at risk of substance use or misuse.

In 2021, the Department of Health and Human Services awarded $10.7 million from the American Rescue Plan to expand pediatric mental health care access, and in March, HHS and the Office of Minority Health announced nearly $35 million in funding opportunities to strengthen and expand community mental health services and suicide prevention programs for children and young adults.

Tammy Hill is a senior policy specialist in NCSL’s Health Program.

Additional Resources

- Children’s Behavioral Health, NCSL
Suicide was the 10th-leading cause of death in the United States in 2018, accounting for more than 48,000 deaths, according to the most recent data from the Centers for Disease Control and Prevention. In the 18 years beginning in 2000, suicide rates rose 30% nationally and increased in nearly every state.

For every suicide death, there are more than 200 people who consider suicide—over 10 million Americans in 2018. More than 3 million of the 10 million would go on to make a suicide plan, and nearly 1.5 million attempted suicide.

Moreover, in the year beginning April 2020, about 100,000 people died by overdose, a nearly 29% increase from the previous year and the nation’s highest-ever rate of death due to overdose.

While state lawmakers have taken many steps to prevent deaths by suicide, overdose and other behavioral health crises, bipartisan federal legislation enacted in 2020 created new options for preventing suicides and overdoses by establishing a nationwide, three-digit behavioral health crisis call number. The Substance Abuse and Mental Health Services Administration describes the new 988 Suicide and Crisis Lifeline as a “first step” toward transforming the crisis care system, acknowledging the role the number can play in connecting individuals to community-based providers who can deliver a full range of behavioral health services.

Overview of Federal Legislation

Congress enacted the National Suicide Designation Act in 2020, establishing the 988 lifeline to take advantage of the infrastructure of the current National Suicide Prevention Lifeline (1-800-273-8255). As of July 16, 2022, the new number will respond not only to people considering suicide but also to those in crisis due to extreme mental illness or drug overdose.

The legislation provided for a two-year transition from the previous line to the new one to allow for widespread network changes and for states and call centers to prepare for the expected increase in the volume of calls. The shorter number is intended to be easier to remember and more accessible to people considering suicide or experiencing a mental health crisis or overdose. In November 2021, the Federal Communications Commission announced that the lifeline would also accept text messages.

Calls from all 50 states to 988 and the existing 800 number are routed to the National Suicide Prevention Lifeline without additional action needed from state legislatures. The federal legislation,
however, gives states the flexibility to invest in different programs to support call centers and the professionals who respond to mental health crisis calls.

Calls to the lifeline are answered by the nearest available call center in a network of over 200 accredited centers across the country. If a local call center is not available, the call is redirected to the nearest center or eventually to the national response center in New York City. People calling or texting 988 are connected to trained counselors who are part of the existing lifeline network. The counselors provide callers with support and connect them to resources whenever necessary and possible.

**Expanding the Lifeline Capacity**

States have the option, but are not required by the federal legislation, to create a surcharge fee for telecommunications service users. The legislation stipulates that this fee must be similar to those already implemented in states to provide emergency services through 911 and that the fee can only be used to support 988 lifeline services. Most states currently assess 911 fees, which, in 2018, generated $2.6 billion to support the service. Similarly, the 988 surcharges can be used to support and expand local crisis response services and enhance communities’ access to behavioral health care.

Options lawmakers may consider to support the lifeline include:

- **Expanding call center capacity**: Call centers can provide immediate support for a people in crisis, connecting them to care or providing crisis stabilization services. A 2018 evaluation found that nearly 80% of callers interviewed six to 12 weeks after calling said their calls kept them from attempting suicide, provided them with hope and helped them connect with mental health resources. Local call centers can do this more efficiently than distant ones by connecting people to community resources.

- **Empowering mobile crisis outreach teams**: Behavioral health professionals and EMTs working in teams help stabilize individuals during law enforcement encounters and during crisis situations. These units are trained to respond to behavioral health crises, improve outcomes for individuals in crisis and allow law enforcement to focus on other priorities.

- **Expanding local access to behavioral health**: Expanding access to care at crisis stabilization centers and other receiving facilities, including Certified Community Behavioral Health Clinics, creates an alternative to treating people in crisis in emergency departments, which tend to be more expensive and sometimes provide inappropriate treatment.

A number of states have enacted legislation enabling some of these options. Colorado created the 988 crisis hotline enterprise in the department of human services to fund the call number and provide outreach, stabilization and acute care to individuals calling the service. In January, the enterprise imposed a 988 surcharge of 18 cents on monthly telecommunications bills. Nevada required its health department to establish at least one support center to answer hotline calls and coordinate the response to them. The measure also allows the department to implement a service fee and encouraged the department to establish mobile crisis teams.

Washington enacted a service fee to develop triage hubs and a new interface to connect callers with care. Virginia directed its health department to develop crisis call centers, community care teams and mobile crisis teams. The state also created a 12-cent fee on postpaid wireless charges to support these programs.

**State Actions: Funding and Implementation Models**

Some states have supported 988 services without charging a service fee to telecommunications users. Utah, for example, created a statewide account charged with distributing money from the state’s general fund to crisis response programs associated with the 988 service. The programs include the lifeline call center and mobile crisis receiving centers; stabilization services; and other behavioral health crisis services. Spending from the account is tiered, prioritizing the statewide call center before it funds other 988 services.

Both Utah and Indiana took an additional step, directing their state Medicaid agencies to apply for waivers from the Centers for Medicare and Medicaid Services to allow for reimbursement of 988 services for people enrolled in Medicaid. Indiana’s proposed waiver would allow provider reimbursement for Medicaid-eligible individuals who are undertaking an initial assessment, intake or counseling in a community mental health center. It would also allow reimbursement for Medicaid rehabilitation option services concurrently with reimbursement under a residential addiction treatment program.
Still other states are reviewing the best ways to administer 988 in their communities. Alabama, Nebraska, New York and Texas created study commissions or task forces to evaluate the behavioral health care landscape and make recommendations to lawmakers on improving services using 988.

Federal Funding and Support

The Department of Health and Human Services has provided $282 million to states to help transition the National Suicide Prevention Lifeline from the current 10-digit number to the new three-digit code. This investment includes:

- **$177 million** to strengthen and expand the existing lifeline network operations and telephone infrastructure, including centralized chat/text response, backup center capacity, and special services (e.g., a line for Spanish speakers).
- **$105 million** to increase staffing across states’ local crisis call centers.

As part of this federal spending package, the Substance Abuse and Mental Health Services Administration will provide funding to states to begin building capacity for the lifeline. The funding can be used to recruit, hire and train behavioral health workforces to staff local 988 centers; engage lifeline crisis centers to unify 988 responses across states and territories; and expand the crisis center staffing and response structures needed for the successful implementation of 988.

*Charlie Severance-Medaris is a senior policy specialist in NCSL’s Health Program.*

Additional Resources

- NCSL Blog: [New National Suicide Prevention Hotline, NCSL](#)
- Legislatures Prepare for New National Suicide Prevention Lifeline, NCSL