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Research Report

Case Study of Peer Providers in the Behavioral Health Workforce: Georgia

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Executive Summary

This case study explores Georgia's development and implementation of a peer provider workforce in mental health (MH) and substance use disorders (SUD).

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines a peer provider as "*a person who uses his or her lived experience of recovery from mental illness and/or addiction, plus skills learned in formal training, to deliver services in behavioral health settings to promote mind-body recovery and resiliency*."

More background information on this topic can be found in the related document, *The Peer Provider Workforce in Behavioral Health: A Landscape Analysis*.

Methods

Georgia was identified as a leading state in the employment of peer providers in MH and SUD from a literature review and through the input of an expert panel convened in March, 2015. We communicated with Georgia state officials, certification boards, training organizations, and provider organizations to better understand the state's service model and to identify organizations to interview during a site visit that lasted 5 days. During the site visit, we visited 1 SUD advocacy and training organization; 1 MH advocacy, training, and provider organization; 3 community services boards (CSB) providing MH and SUD services; 1 non-profit MH specialty services organization; and 1 SUD specialty services organization; and interviewed 3 policy makers and staff at all organizations listed. Where feasible, we collected administrative data from peer provider sites.

Findings

- Georgia has developed Medicaid-billable roles for peer providers in mental health and substance abuse, and for Whole Health and Wellness Coaches.
    - **Training and testing for MH** Certified Peer Specialists – Mental Health (CPS-MH) is handled by a single organization, the Georgia Mental Health Consumers Network (GMHCN).
        - There were approximately 1,275 CPS-MHs as of November, 2015.

    - **Training and testing for SUD** Certified Addiction Recovery Empowerment Specialists (CARESs) (officially Certified Peer Specialist - Addictive Disease or CPS-AD)[i] is handled by a single organization, the Georgia Council on Substance Abuse (GCSA).
        - There were approximately 328 CARESs as of November, 2015.
- **Billing:** Peer support in both SUD and MH can be billed to Medicaid. This has been specified in the Georgia State plan in which peer providers are mentioned as a practitioner type. Peer support as a service can be billed under codes H0038 HQ (peer support, group), H0038 (peer support), and H0025 (Whole Health and Wellness Coaches).
    - The Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) contracts with 3 tiers of providers for behavioral health services. These include:
        - Community Services Boards, which are regional quasi-governmental comprehensive treatment and service providers;
        - Community Medicaid providers, which are private for-profit and not-for-profit organizations that receive Medicaid funds but not state funds for the uninsured; and
        - Specialty providers, which are private for-profit and not-for-profit organizations may receive a variety of funds to provide services such as peer wellness services, supported employment, and psychosocial rehabilitation.
- **Employment:** Provider organizations funded by the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) are required to hire a minimum of 2 FTE peer support specialists,[2] and certain types of services require a peer support specialist on the team. A legal case settled in 2010 between the State of Georgia and the U.S. Department of Justice mandates the provision of peer support services and sets targets for this provision.
- **Roles:** Many organizations employ both CARESs and CPSs, and some peer providers have both certifications. In addition, a growing number of CPSs are certified as Whole Health and Wellness coaches trained to help consumers set and maintain wellness goals. Many providers reported receiving support from their employer to advance their careers.
- **Acceptance:** CPSs and CARESs largely reported acceptance and some resistance from colleagues, depending on employer type. In some

[i] CARES and CPS-AD are the same certification—CPS-AD is the official name. Throughout this report we will refer CPS-MH as "CPS" and CPS-AD as "CARES".

organizations CPSs reported there was little differentiation between staff and consumers, which made their role easier.

- **Impact on Organizations:** The presence of CPSs and CARESs allow all staff to be more open about their own experiences with mental health challenges and addiction. In addition, the presence of CPSs and CARESs helps to engage consumers and create a more person-centered and recovery-oriented environment.
- **Behavioral Health/Primary Care Integration:** Georgia has created a certification for Whole Health and Wellness Coaches. Some organizations are hiring these Certified Peer Specialist-Whole Health Coaches (CPS-WHs) to work with mental health consumers to set and maintain wellness goals. Some organizations have piloted primary care integration using SAMHSA integration grants.

Conclusions

Georgia has developed Medicaid-billable positions for peer support specialists in both mental health and substance use disorders. State funded behavioral health providers are required to hire CPS-MHs and/or CARES, so persons with lived experience are employed throughout the system from regional comprehensive behavioral health agencies to specialty providers to peer-run agencies.

Georgia's behavioral health system retains separate training, certification, and roles for SUD and MH peer providers, recognizing the important distinctions between mental illness and substance use disorders. However, the agencies responsible for SUD and MH peer provider training and certification have had a collaborative relationship with one another and with staff at DBHDD, which has allowed for a relatively coordinated approach to peer workforce development.

The presence of peer providers throughout the behavioral health system is part of an attempt to transform Georgia's system to a recovery-oriented system of care. The collaborative relationship between advocates in MH and SUD recovery has been an important factor for fostering this system transformation.

Case Study of Peer Providers in the Behavioral Health Workforce: Georgia

Background and Policy Framework

This case study explores Georgia's development and implementation of a peer provider workforce in mental health (MH) and substance use disorders (SUD).

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines a peer provider as "*a person who uses his or her lived experience of recovery from mental illness and/or addiction, plus skills learned in formal training, to deliver services in behavioral health settings to promote mind-body recovery and resiliency*."[1]

More background information on this topic can be found in the related document, *The Peer Provider Workforce in Behavioral Health: A Landscape Analysis*.

Georgia has developed statewide policy on the training, certification, and employment of peer support in mental health (MH) and substance use disorders (SUD). One notable aspect of the development of the Georgia peer provider workforce is the cooperation and alliance between MH and SUD advocates and practitioners. While mental health advocates blazed the way, SUD advocates followed their lead and solicited their advice and cooperation in adding SUD peer providers to the mix. Both fields retain their independence, yet both personal and philosophical ties between the 2 main advocacy organizations have allowed them to develop a coordinated system of training and certification.

A significant development in the history of public behavioral health services in Georgia was the creation of the Georgia State Department of Behavioral Health and Developmental Disabilities (DBHDD) as a separate agency by the Governor and General Assembly in 2009. This gave behavioral health more visibility and autonomy within the state system. This change in state structure was the result of activism on the part of mental health advocates and federal pressure in response to widely-published abuses in the system.[3]

State representatives acknowledged that the development of the peer provider workforce in Georgia was driven both by advocacy and by workforce shortages in behavioral health. While there were strong advocates within the DBHDD, DBHDD representatives felt it was in the best interests of those receiving services to certify peer providers based on the trainings provided by 2 peer-driven advocacy

organizations—The Georgia Mental Health Consumers Network (GMHCN) and the Georgia Council on Substance Abuse (GCSA).

Methods

Georgia was identified as a leading state in the employment of peer providers in MH and SUD from a literature review and through the input of an expert panel convened in February, 2015. We contacted Georgia state officials, certification boards, training organizations, and provider organizations to better understand the state's service model, and to identify organizations to interview during a 5-day site visit. During the site visit, we visited and interviewed staff at 1 SUD advocacy and training organization; 1 MH advocacy, training, and provider organization; 3 community services boards (CSBs) providing MH and SUD services; 1 non-profit MH specialty services organization; and 1 SUD specialty services organization. We also interviewed 3 state government representatives. Where feasible, we collected administrative data from peer provider sites.

Mental Health

In the 1970s, Georgia, like many other states, moved to de-institutionalize persons with serious mental illnesses (SMIs), many of whom had been previously confined to psychiatric hospitals and nursing homes. However, the promised community-based services that were intended to allow these individuals to live successfully in their own communities never fully materialized. As one interviewee noted, mental health consumers realized, "If we don't figure out how to help ourselves, we are going to die." In 1993, a group of 30 mental health consumers formed the Georgia Mental Health Consumers Network (GMHCN). They went to state government administrators and successfully advocated for an office of consumer relations and recovery.[ii] In 1999 Georgia became the first state in the nation to obtain federal approval to bill Medicaid for peer support. The Medicaid State Plan was re-written to shift delivery from the Medicaid Clinic Option to the Rehabilitation option, with peer support specified as a billable service.[4]

The initial CPS trainings in 2001-2002 were funded by a grant from SAMHSA. After the first 3 successful years, the State of Georgia assumed funding responsibility. The State of Georgia, DBHDD, and the Mental Health Division of Addictive

[ii] The first director of this office was Larry Fricks, one of the founders of the GMHCN. During his time in this office, he developed one of the nation's first curricula for peer support providers. This is now the statewide curriculum used to train Certified Peer Specialists, or CPSs, in Georgia and is now used to train peer providers in many states.

Diseases partnered with the GMHCN, and eventually with the Georgia Council on Substance Abuse (GCSA), to build a peer workforce for public behavioral health services (see below).

Substance Use Disorders

The move towards a peer provider workforce and recovery-oriented system for SUD was initiated in 2011 by the Georgia Recovery Initiative (GRI), a stakeholder group composed of recovery advocates and staff from DBHDD and community behavioral health. The purpose of the GRI was to move the state towards a Recovery-Oriented System of Care (ROSC).[5] The ROSC is described as a framework for coordinating person-centered and self-directed systems, services and supports for recovery from substance use disorders.[5] Recognizing that part of this framework is peer support, one GRI participant group, the Georgia Council on Substance Abuse (GCSA), decided to develop a statewide peer provider training and certification program. The GCSA met with stakeholders, including the GMHCN, and formed an advisory group to develop a curriculum for SUD that paralleled that developed for mental health by the GMHCN. The first training for the role of Certified Addiction Recovery Empowerment Specialist (CARES or CPS-AD) took place in 2011. CARESs were added to the state plan as Medicaid billable practitioners in 2012.[6]

Training and Certification

Mental Health Peer Training and Certification

CPS-MH, or certified peer specialist - mental health, was the first certification for peer support in Georgia. These peer providers are commonly referred to as CPSs.

The GMHCN provides a 40-hour in-person CPS training, which takes place over 2 weeks for a total of 9 days. The course includes 2 sessions on documentation for Medicaid billing, as well as sessions on recovery-oriented topics such as Double Trouble in Recovery (co-occurring disorders), and WRAP (Wellness Recovery Action Plan). Course sessions include study groups and other activities to allow participants to bond.

In order to apply for the training, an individual must have a mental health diagnosis, basic literacy, and at least a GED. Applicants are ranked; those already working in the field get first priority, those in vocational rehabilitation or with a job offer are second, and those who want to take the training with no current employment connection are third.

The GMHCN is also responsible for administering the exam for certification.

CPSs are required to take 12 units of continuing education each year to maintain certification. CPSs can obtain continuing education units (CEUs) from a number of GMHCN courses and its annual conference, as well as online webinars.

An additional training, the Whole Health & Wellness Coach (CPS-WH), was added in 2012.[6] (This training is explained in more detail in sections that follow.)

As of November, 2015, there were 1,275 CPS-MHs in Georgia.[iii]

Substance Use Disorders Peer Training and Certification

Peer providers in substance use disorders are called Certified Addiction Recovery Empowerment Specialists (CARESs). Technically the certification is CPS-AD.[7]

The GCSA provides the CARES training using curriculum developed from multiple sources. Like in the MH training, these students attend a 40-hour in-person one-week basic skills training course. The training curriculum includes paths of recovery, motivational interviewing, cultural competency, ethics, and self-care.

For each session there are about 40-90 applicants; only 16-18 are accepted. In order to apply for the training, applicants must be in recovery. Those who are employed by a public or private provider of Medicaid-billable services receive first priority. Applicants go through an intensive screening process, including group interviews, and must be approved by the CARES Selection Committee in order to be accepted into the course.

As of November, 2015, there were 328 CARESs in Georgia.[iv]

Peer Employment

According to one interviewee, there are an estimated 300 CPS-MHs employed in the public behavioral health system, and another 80 in GMHCN programs. Tier 1 and Tier 2 organizations funded by DBHDD are required to hire at least 2 FTE CPSs.[2] State representatives and advocates determined that at least 2 CPS (including

[iii] Individuals may be dual certified in CPS-MH and CPS-AD. This number represents a duplicated count.

[iv] Individuals may be dual certified in CPS-MH and CPS-AD. This number represents a duplicated count.

CARES or CPS-AD) are necessary to implement a successful peer support program without making the position "token".

CPS employment is further supported by the 2010 Civil Rights of Institutionalized Persons Act (CRIPA) settlement between the state of Georgia and the Department of Justice. This settlement requires that the State of Georgia provide adequate community-based services to accommodate those who had been de-institutionalized from the state's mental hospitals. The settlement agreement stipulates that, among other services, peer support be made available and specifies interventions that require teams with at least 1 CPS, including assertive community treatment teams (ACT), community support teams (CST), and jinterventions where CPSs are recommended, if available, such as mobile crisis teams and housing services.[8]

The DBHDD is supporting this settlement with training for organizations to implement a Recovery Oriented System of Care (ROSC). Part of this training will assist organizations in improving their employment and deployment of CPSs.

Funding for Peer Support Programs

According to the Kaiser Family Foundation, Georgia ranked 41st in the nation in per capita mental health spending in 2013, at $59.33 per capita.[9] Georgia is not a Medicaid expansion state under the Affordable Care Act.

Peer support in both SUD and MH can be billed to Medicaid under a fee-for-service model. This has been specified in the Georgia State plan in which peer providers are mentioned as a practitioner type. Peer support as a service can be billed under codes H0038 HQ (peer support group), H0038 (peer support), and H0025 (whole health and wellness coaches).

The primary source of funds for most organizations we visited was state contracts through DBHDD. Medicaid was also a major funding stream for all of the provider organizations visited except 1 peer-run group, which did not bill Medicaid based on ideological grounds.

Models of Care

The Department of Behavioral Health and Developmental Disabilities (DBHDD) contracts with 3 designated tiers of providers:[10]

- **Tier 1**: **Comprehensive community services**, primarily the 26 community services boards (CSBs), which are quasi-governmental safety net providers.

These organizations provide most of the behavioral health care to the indigent, using both state funds and Medicaid. They provide essential core services and intensive in-clinic and out of clinic services. They may also provide specialty and crisis services and must deliver both mental health and addiction services. Essential core services include psychiatric evaluations and behavioral health assessments, case management and skill building, nursing evaluations, addiction services, crisis intervention, diagnostic assessment, peer support, and counseling. According to one interviewee, they receive 80% of the state's MH and SUD funding. They may cover one county, or in the case of many less populous areas, many counties.

- **Tier 2: Community Medicaid providers** provide essential core services, and may provide specialty services. They receive Medicaid funds but not state funds for the uninsured
- **Tier 3: Specialty Providers** provide specialty support and treatment such as peer wellness services, supported employment, psychosocial rehabilitation, housing, intensive family intervention, etc. Tier 3 organizations may receive special funding depending on populations served, but may also receive Medicaid.

We visited 3 Tier 1 organizations, Community Services Boards (CSBs), on this visit. The CSBs provide clinical services but have increasingly adopted recovery-oriented strategies. Each CSB had both CPS-MH and CPS-AD, and one had CPS-WH. Some of the CPS we interviewed had both CPS-MH and CPS-AD (CARES) training.

We also visited the Georgia Mental Health Consumers Network, a peer-run mental health advocacy and service provider that developed and conducts the statewide trainings for CPS-MH; a Tier 3 mental health specialty service provider engaged in peer support, supported housing, and supported employment services; a private non-profit comprehensive drug and alcohol treatment agency which was transforming part of its operations into a Recovery Community Organization (RCO);[v] and the Georgia Council on Substance Abuse, an advocacy and policy organization that developed and conducts that statewide trainings for CARES (CPS-AD).

[v] A recovery community organization (RCO) is an independent, non-profit organization led and governed by representatives of local communities of recovery. These organizations organize recovery-focused policy advocacy activities, carry out recovery-focused community education and outreach programs, and/or provide peer-based recovery support services (P-BRSS).[11]

Mental Health Roles

Services in which peers played a part included peer run respite centers, crisis stabilization, assertive community treatment, trauma informed peer support, Wellness Recovery Action Plan (rWRAP), financial planning, recreational and creative activities, warm lines, Double Trouble in Recovery (groups for the dual diagnosed), Whole Health Action Management (WHAM), intensive case management, supporting consumers in mental health court, forensic peer support in the prisons, peer support in state hospitals, helping consumers transition back into the community, and conducting the state's consumer satisfaction survey.

Substance Use Disorders Roles

SUD provider organizations we visited provided SUD treatment and residential services as well as intensive family counseling, youth and adolescent services, forensic work, HIV treatment, and domestic violence services.

Common roles for CARES included intake coordinator, engagement specialist, case manager, and peer mentor. Typical activities included leading recovery groups, 1:1 peer mentoring, leading meditation classes, sobriety check-ins by phone and in-person, forensic peer support in prisons, and patient enrollment. Some had been promoted to serve as supervisors or team leads.

Acceptance by Colleagues in Organization

Feelings of acceptance by colleagues varied by, and within, organizations. For example, one CPS noted that while she did not "feel stigmatized from anyone in this building," there was some stigma directed at people with serious mental illnesses (SMIs) from the collaborating organization where she spent a lot of her work time, as well as societal stigma in general. Another CPS noted that although generally the CPS' work was valued, "Sometimes I feel that my colleagues feel that the peer program is like the blind leading the blind. I get the impression they think I am not a professional due to my diagnosis." A few mentioned that these barriers are compounded by the fact that some organizations fail to properly integrate peers, hiring them simply to fulfill DBHDD's employment staffing requirements.

In contrast, at another organization, a CPS noted, "[Here] you can't tell the difference between staff and members. It's not an "us/them" kind of thing. This took out a whole piece of the stigma; [as a CPS] you don't have to bridge the difference between being a member versus being staff." Likewise, CARES at 2

organizations reported feeling like there was no real differentiation between themselves and other staff.

Supervisors expressed a great deal of respect for their peer support staff, noting their roles as integral to their organizational mission. One supervisor acknowledged that there were challenges with outside organizations, including the courts and primary care clinics, as well as internal challenges, which necessitated a formal education effort to the whole organization to educate all departments about the role of peer support and to address stigma.

At 2 organizations employing CARESs, managers said that they have encouraged acceptance of peer support staff by embedding CARES and CPS in all aspects of the agency rather than relegating them to a peer support department. Another method of enhancing acceptance was for senior administrators to be open about their own lived experience with mental health and substance use, and, if applicable, become CARES and/or CPS-certified themselves to set an example for other staff.

Impact on Colleagues and Roles in Organization

A major benefit noted by some colleagues was the ability for all staff to be more open and compassionate about difficulties they had experienced in their own lives. After the educational outreach effort noted above, a supervisor found that many individuals in the organization came to her with their own previously hidden stories of coping with mental illness. These staff members were encouraged to get CPS and/or CARES training because it was anticipated that this would improve the functioning of the entire organization. As one administrator noted, getting other staff, including supervisors, to discuss their experiences and get certified further broke down the "us and them" mentality.

Several interviewees appreciated the role of peer support in making their organizations more recovery-oriented and sensitive to consumer needs. As one manager said, peer support "helps us keep the focus on the client as the person; to think about their role in the family, their dreams for work, relationships, spirituality—all those recovery pieces that are more than just the symptoms."

An administrator of a treatment organization spoke of how important persuasion and role-modeling were in recovery, noting that clinical treatment options alone could not bring about that change in persons with SUDs. CARESs were aware that their presence was comforting and enhanced engagement: "When I introduce myself as a CARES with my elevator speech and say "we do recover," you see a weight being lifted off."

Training/Knowledge Gaps Identified

CPS*s* seemed satisfied with their training. As one observed, "I was more prepared to be a CPS after that 2-week training than I was after my college training to become a (professional position)." However, supervisors at 2 organizations said that it took considerable shadowing, either as a volunteer or new employee, to gain the experience necessary to do the job well.

One CPS noted that many CPSs, because of their mental health and life issues, had interrupted or minimal formal education experiences, which might make it challenging for them to meet documentation requirements in the clinical record.

CARESs interviewed for this study felt the trainings they received from both the GCSA and GMHCN were very good: "It was moving and amazing and informational, and made me look at things more closely and openly."

Professional Development and Career Aspirations

At most organizations visited, administrators said that they posted all jobs internally first. This was partially a grow-your-own strategy in response to recruitment challenges, and partially a way to demonstrate to other consumers that "recovery happens." CPSs/CARESs had been hired into other departments besides direct peer support if they met the requirements for the position.

A number of interviewees observed that many jobs were part-time, sometimes for practical reasons, but sometimes so employers could avoid paying benefits, which were very expensive. Some CPSs and CARESs were contractors, not staff. Low pay and part-time hours were cited by a number of interviewees as reasons for high turnover rates among some organizations providing peer support. Some organizations were able to offer generous benefits, compensation, and some educational support to help retain peer provider staff. (See Ahmed, et al, 2015 for more discussion of CPS compensation, benefits, and employment opportunities.[12])

CPSs reported obtaining CEUs through the GMHCN annual conference and additional training available via webinars. Many obtained additional credentials (WRAP, WHAM, CARES). One organization paid staff time to attend these trainings, but did not cover tuition. Another paid tuition and travel expenses and offered a 5% salary increase for certification. Several CPSs reported working full-time and attending college courses in order to advance their careers.

Some interviewees noted that a potential career track for CPSs is Certified Psychiatric Rehabilitation Practitioner (CPRP), which is a certification offered by the

Psychiatric Rehabilitation Association. The GMHCN is exploring ways to add a CPRP track to its training so that CPSs can more easily obtain the 6 extra credits to obtain this certification. The CPRP allows a CPS to serve as the program leader of an MH peer support program.[7] Some CAREs reported receiving financial support for becoming certified addiction counselors (CAC I)[vi] and encouragement to move up in their organization.

Implications for Integration with Primary Care

In 2012, the Whole Health & Wellness Coach (CPS-WH) was added as a Medicaid billable service. CPSs can train in Whole Health Action Management (WHAM) to bill for this service. The CPS-WH can assist individuals with SMIs in setting and maintaining health and wellness goals, accessing resources, and managing stress in coordination with a nurse or primary care provider.[6] This training was developed because of research suggesting that persons with SMIs have much shorter life spans due to chronic disease, smoking, limited access to healthcare, poor diet and nutrition, substance use, and other factors. The CPS-WH can also serve as an advocate for individuals interfacing with primary care providers.[13] As of November 2015, 439 CPS-WH have been trained.

Several CSBs in Georgia received Primary and Behavioral Health Care Integration (PBHCI) grants from SAMHSA to pilot behavioral health and primary care integration. One CSB we visited had used its PBHCI grant to build and staff an onsite primary care health home clinic, which included Whole Health and Wellness Coaches (CPS-WH). While the clinic had been successful, it closed at the end of the grant and the organization was seeking additional funding to reopen.

Implications for Policy

In 1999 Georgia became the first state in the nation to obtain federal approval to bill Medicaid for peer support. Advocacy on the part of MH and SUD champions, and lawsuits resulted in the restructuring of the state's behavioral health system, creating the Department of Behavioral Health and Developmental Disabilities. This gave behavioral health more visibility and autonomy within the state system.

Mental health advocates developed a training and certification system for peer providers in order to provide employment for consumers and to create a more person-centered and recovery-oriented system of mental health care. This training and certification is centralized in one non-governmental organization—the Georgia

[vi] The CAC I is issued by the Georgia Addiction Counselors Association.

Mental Health Consumers Network (GMHCN). This allows for standardization and consistency in curriculum, CEUs, and the certification exam.

SUD advocates followed suit, working closely with the GMHCN to develop a comparable curriculum, training, and certification protocol for peer providers. The close coordination between the Georgia Council on Substance Abuse (GCSA) and the GMHCN appears to have created a more powerful voice for recovery-oriented care and behavioral health consumers.

DBHDD staff have been allies with SUD and MH advocacy groups in this transformation, allocating a great deal of autonomy to the community-based groups to develop training and certification processes. DBHDD has in turn worked with the State Office of Medicaid Coordination to develop service definitions that allow for different types of peer provision to be covered under the rehabilitation option in the state plan, including CPS-MH, CPS-AD, CPS-WH and various certifications for family and youth. In addition, many agencies receiving DBHDD funding are required to hire at least 2 CPSs, largely due to state policy and partially as a result of a lawsuit requiring peer providers on specific types of service teams. Requiring a minimum of 2 peer providers per agency makes it more likely that an organization will develop a peer support program rather than simply hiring a token peer provider, and provides support for peer providers rather than allowing them to be isolated.

As policymakers and providers acknowledge, Georgia, like many other states, has a behavioral health workforce shortage, and peer providers are one way to fill that gap. Aside from being an available and affordable workforce, peer providers are able to enhance engagement, a factor that is vital to access to care.

Sites Visited

- Department of Behavioral Health and Developmental Disabilities (DBHDD) — Atlanta
    - Division of Addictive Diseases
    - Office of Recovery Transformation
    - Office of Medicaid Coordination and Health System Innovation
- Georgia Council on Substance Abuse- Atlanta
- Community Services Board of Middle Georgia – Dublin
- Advantage Behavioral Health Systems — Athens
- Cobb County & Douglas County Community Services Boards — Austell and Smyrna
- Community Friendship, Inc. — Atlanta
- STAND, Inc. — Decatur
- Georgia Mental Health Consumers Network — Decatur

Acronyms

ACT – Assertive Community Treatment
CAC – Certified Addiction Counselor
CARES – Certified Addiction Recovery Empowerment Specialist
CCAR - Connecticut Communities for Addiction Recovery
CEU – Continuing Education Unit
CPS – Certified Peer Specialist
CPS-AD – Certified Peer Specialist Addictive Diseases
CPS-MH – Certified Peer Specialist Mental Health
CPS-WH – Certified Peer Specialist Whole Health
CRIPA – Civil Rights of Institutionalize Persons Act
CSB – Community Services Board
CST – Community Support Teams
DBHDD – Georgia State Department of Behavioral Health and Developmental Disabilities
GCSA – Georgia Council on Substance Abuse
GMHCN – Georgia Mental Health Consumers Network
GRI – Georgia Recovery Initiative
MH – Mental Health
PBHCI - Primary and Behavioral Health Care Integration grant
PCOMS - Partners for Change Outcomes Management
RCO – Recovery Community Organization
ROSC – Recovery Oriented System of Care
SAMHSA – Substance Abuse and Mental Health Services Administration
SMI – serious mental illness

SPA – State Plan Amendment
SUD – substance use disorder
WHAM – Whole Health and Wellness Action Management
WRAP – Wellness Recovery Action Plan

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