Community Clinic and Health Center Case Study Highlights: Integrating Substance Abuse Treatment Staff and Reducing Stigma in Community Clinics and Health Centers

"I've worked with lots of teams that include staff in recovery and staff not in recovery. I personally think that the best team to have is a balanced one with both because I think each professional has something to lend the other that is really important. There is a lot you can learn about addiction and recovery, but there is something about shared experience that is very important."

Christina Andrade-Lemus, MSW, RAS
Adult Programs Supervisor, Outpatient Substance Abuse
Behavioral Health Department, CommuniCare Health Centers

Case study health centers…

…typically staff substance abuse services departments with alcohol and other drug (AOD) counselors and other staff who are dependent on grant funding for their salaries. They also employ LCSWs, and occasionally psychiatrists and psychologists.

…report that the most qualified AOD providers are those with a combination of work experience, educational and academic acumen, and lived experience. Most AOD providers are in long-term recovery themselves but it is not a job requirement.

…do not usually have defined roles for peer workers even though research studies have found that the peer role is valuable for clients in recovery.

…have created integrated care environments in which patients do not feel stigmatized when they seek services.

…have found that one of the best recruitment pipelines for AOD staff are interns who are acquiring clinical experience in the health center in order to obtain a license (i.e. LCSW) or AOD counselor certification.

…feel that more training is needed for primary care providers and staff who may have biased attitudes toward the substance abuse treatment field, and toward those working toward recovery.

Case Study Health Centers

CommuniCare Health Centers • Korean Community Services • San Diego American Indian Health Center

Sonoma County Indian Health Project • WellSpace Health

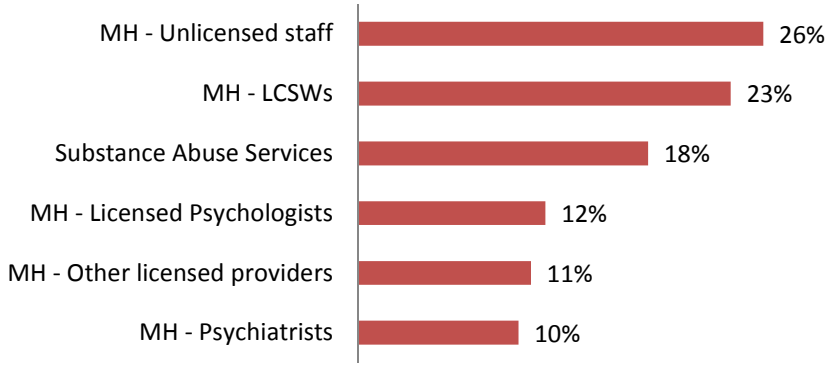
Staffing

The **Affordable Care Act** offers a framework for better serving people with substance use disorder (SUD), a group that has been significantly underserved. The Substance Abuse and Mental Health Services Administration (SAMHSA) projected that out of over 5.4 million newly covered Californians through the Medicaid Expansion or the Health Insurance Exchange, 648,588 will have a substance abuse disorder.[1] Community clinics and health centers are ideally positioned to serve the newly insured population, especially health centers with integrated behavioral health programs and patient-centered health homes in which there is more of a team approach to care, and referrals to primary care and behavioral health services are seamless.

In federally qualified health center (FQHC) behavioral health departments, social workers are the predominant licensed behavioral health discipline,[2] and form the backbone of behavioral health programs, in part because these professionals are eligible for Medi-Cal reimbursement. Some health centers augment services with psychiatrists and psychologists, though these positions are much more difficult to fill. Since Medi-Cal does not reimburse health centers for licensed marriage and family therapists (LMFTs), clinics have to obtain grant funding or find other ways to fund them. Other AOD counselors and staff are typically funded through grants as well.

As shown in **Figure 1, the third largest staff category among Health Resources and Services Administration (HRSA) grantees (i.e. FQHCs and others) is "substance abuse services" staff**, which includes certified or uncertified substance abuse workers, as well as licensed staff like psychiatric nurses, psychiatric social workers, mental health nurses, clinical psychologists, LCSWs, and LMFTs. In behavioral health departments, these individuals are dedicated to substance abuse treatment rather than mental health services.[3] **Unlicensed mental health staff** provide counseling, treatment or support services related to mental health issues, and include interns or residents gaining their practicum hours. **Other licensed *mental health* providers** include psychiatric social workers, psychiatric nurse practitioners, LMFTs, and other licensed master's degree prepared clinicians. **The prevalence of substance abuse workers further reinforces the need to clearly define and understand their roles within the context of all health center services.**

Figure 1: 2013 Composition of Behavioral Health Staffing by Position for California HRSA Grantees
Data Source: Uniform Data System (UDS)



n=882 FTE behavioral health workers

According to interviewed health centers, the most qualified AOD providers are those with a combination of work experience, academic acumen, and lived experience. AOD providers don't often work in FQHCs, partly due to the lack of adequate reimbursement for their services, and partly because many providers who are in recovery themselves are resistant to working within the medical model. Working alongside primary care providers in the health clinic setting requires a culture shift for providers in both disciplines, and a willingness to work as part of a multi-disciplinary team. In the future, more LCSWs working in behavioral health departments may be expected to have addiction treatment knowledge and experience in order to better serve the AOD population.

Figure 2 shows more detail about staffing in the case study health centers. At least four out of five health centers use LCSWs, AOD counselors and peer workers, again pointing to the need to better understand the role of these workers and to support a team approach in health centers.

Figure 2: Case Study Health Centers and their Substance Abuse Treatment Staffing

	CommuniCare Health Centers Yolo County	Korean Community Services Orange County	San Diego American Indian Health Center	Sonoma County Indian Health Project	WellSpace Health Sacramento County
Number of Behavioral Health Providers	30	30	4	11	40
Number of BH providers with expertise, training or certification in substance use treatment	30	30	4	3	4
	Staff providing substance abuse counseling, screening or treatment				
AOD Counselors	Y	Y	Y	Y	Y
Clinical Psychologists				Y	
LCSWs	Y	Y	Y	Y	
Marriage and Family Therapists	Y	Y		Y	
Nurses, NPs, Psychiatric NPs		Y			
Primary care providers		Y	Y	Y	
Psychiatrists		Y	Y	Y	
Peer workers	Y	Y – Mental Health Case Workers	Y	Y	

Interns

One of the best recruitment pipelines for AOD staff are interns who are acquiring clinical experience in the health center in order to obtain AOD certification or others obtaining a license (i.e. LCSW). Some clinics have developed mutually beneficial relationships with colleges and universities over the years, offering placement for their behavioral health students and interviewing them for open positions when they arise. **CommuniCare Health Centers**, for example, typically has 6-7 unpaid social work interns on staff at any time from California State University, Sacramento. The interns provide patient navigation and case management services. Ultimately the health center hires about 80% of the interns.

AOD Counselor Certification

In California, an individual who provides certain AOD services in a DHCS licensed or certified program must have counselor certification. These services include intake, assessment of need for services, treatment or recovery planning, or individual or group counseling to participants, patients or residents.[4]

The following facilities need to be DHCS licensed or certified, which means that AOD counselors working in these settings must have the certification:[5]

- **Residential facilities** providing detox services, counseling, and/or recovery or treatment planning. These are required to be licensed.
- **Non-residential programs**, such as those provided by some health centers, that have become **voluntarily "certified"** to show they exceed a minimal level of service quality as well as substantial compliance with DHCS's standards. These are not required to be licensed.
- **A program that is certified for Drug Medi-Cal,** meaning the clinic is authorized to provide services that have been approved by a physician as being medically necessary for those individuals eligible for Medi-Cal.

Department of Health Care Services' Certifying Organizations and their Accredited Programs

Addiction Counselor Certification Board of California (Affiliated with California Association for Alcohol/Drug Educators)
Certification offered: Certified Addiction Treatment Counselor

American Academy of Health Care Providers in the Addictive Disorders
Certification offered: Certified Addiction Specialist

Board for Certification of Addiction Specialists (affiliated with the California Association of Addiction Recovery Resources)
Certification offered: Certified Alcoholism & Other Drug Addictions Recovery Specialist

California Association of DUI Treatment Programs
Certification offered: Certified Alcohol & Other Drug Counselor

California Certification Board of Alcohol and Drug Counselors (Affiliated with the California Association of Alcoholism and Drug Abuse Counselors)
Certification offered: Certified Alcohol and Drug Counselor

Despite the certification requirement, California has not standardized licensure requirements for AOD counselors like they have for other behavioral health professions. Instead, there are currently five addiction counselor certification programs[6] (see **text box**) that have been approved by DHCS. Each approved program generally offers tiered certifications based on the educational prerequisites (i.e. associate degrees up to graduate degrees); practicum or work experience hours; and one or more standardized exams. **To obtain certification, AOD counselors must register with a DHCS-approved certifying organization within 6 months of the date of hire, and become certified within five years of registration.**

Four out of five case study health centers are licensed or certified by DHCS and therefore comply with the certification requirement. However the **lack of standardization makes it difficult for health centers to understand how best to recruit, hire and supervise AOD counselors and incorporate them into the care team.**

Under **SB 570** (DeSaulnier), *every counselor* in California providing AOD services would be required to be licensed or certified. If it becomes law, the bill would create a license for AOD counselors operating in private practice, an area that is currently unregulated, so that they would be recognized as providers under the Affordable Care Act.

Case Example: An AOD Intern Working Toward AOD Counselor Certification

Mari Sweeting is an AOD intern at **Sonoma County Indian Health Project** (SCIHP). She has a degree in criminal justice and worked in military law enforcement. She is currently enrolled in Santa Rosa Junior College's **Alcohol and Drug Career Certificate Program**, which requires 50 college units and 360 supervised internship hours. Once she completes her degree, she will begin working on becoming a **Certified Addiction Treatment Counselor** through the California Association of Alcohol and Drug Educators. This certification requires completing an addiction studies program, passing the CATC exam, and completing at least 2,240 hours of supervised work in a state-licensed AOD treatment facility, which SCIHP is. By interning at SCIHP and obtaining her AOD Counselor Certification, Mari, who is Native American, feels her work will be rewarding in large part because she will be giving back to her community.

> *"I've seen a lot of drug and alcohol abuse, mental impairment, and dual diagnosis. And I just thought, 'I want to be right there. I want to help people. They need people to work with them who are compassionate.'"*
>
> **Mari Sweeting, AOD Intern**
> **Sonoma County Indian Health Project**

Mari Sweeting, an AOD Intern, is completing her community college's Alcohol and Drug Career Certificate Program. She then plans to meet the requirements to become a Certified Addiction Treatment Counselor *(Photo credit: Alaina Dall)*

Peer Services

Community clinics and health centers typically hire AOD counselors who have lived experience themselves, but the clinics have not established a formal role for peers. Interviewed health centers reported that as many as 90% of their AOD counselors are in long-term recovery. However peer paraprofessionals, such as those who share the experience of addiction, mental health issues, or medical concerns, and have recovered, are not typically utilized.

Studies have shown, however, that recovery is greatly improved with the use of peer support specialists.[7] Research has shown that peers provide valuable services by working with clients to assure they gain access to the services they need, and to minimize experiences of stigma and discrimination. Five years ago SAMHSA and the Center for Substance Abuse Treatment funded a series of grant projects across the country to develop peer services.[8] The project considered a peer to be anyone who shared the experiences of addiction, either directly or as family members or significant others. **Peers helped people in recovery to set recovery goals, develop recovery action plans, and solve problems related to recovery, such as finding sober housing, making new friends, finding new uses of spare time and improving job skills.** In addition, peers and people with lived experience may function as advocates to ensure that consumers receive timely and comprehensive care, and are fully engaged in their treatment processes.[9] Examples of peer roles are shown in the **text box**.[10,11]

For people with **co-occurring substance abuse and mental health issues**, studies have found that peer support offered in concert with traditional mental health treatment improves outcomes. This is because people with both diagnoses respond better to peers who have experienced something similar and have recovered, and who can help them engage in substance-free activities. [12]

The *National Association of County Behavioral Health and Developmental Disability Directors* are proposing a **peer-based leadership development model** to create legitimacy for three categories of peers.[13] They are looking to establish formal roles for **recovery coaches** in the substance abuse arena; for **certified peer specialists,** who work with people with mental health issues; and for **community health workers,** who focus on physical health issues such as diabetes and hypertension. Formalizing these roles would be accomplished by establishing national certification programs, licensure and accreditation (more on this below).[14]

Types of Peer Roles

A **peer leader** in stable recovery provides social support to a peer who is trying to establish or maintain recovery.

A **peer support specialist** is a person living with a mental illness or in recovery from substance use disorder who provides mentoring, guidance, and support services to others with mental health or substance abuse issues.

A **12-step sponsor** works with the peer within the 12-step framework and focuses on providing guidance regarding the 12-step program.

A **recovery coach** links the person in recovery to others in recovery and services, helps the person remove obstacles to recovery and acts as a personal guide and mentor.

The Role of Peers in Case Study Health Centers

Only a small number of health centers surveyed for this project have a role for peers at their health center. Those that do use them in the following roles:

- Mental health case workers
- Counselors
- Co-facilitator of a small group of recovering patients
- Client engagement and outreach worker
- Emotional/peer support worker

12-step programs, a social model that relies on peer support, have been the only SUD treatment option for many individuals wanting to stop using alcohol and drugs. Treatment approaches for SUD have evolved, but there is still a strong role for 12-step programs in communities, and health centers continue to refer patients to these programs for ongoing support.

Interestingly, one interviewee commented that health centers need to be more inclusive of people *without* lived experience in their professional roles (see **text box**). She noted that everyone comes to their roles with their own experience, education and beliefs about how to treat addiction. A social worker, for example, may come with ideas about person-centered care and motivational interviewing in which a client generates their own ideas about how to recover. A staff person in recovery may have more of a 12-step focus and may want to suggest how to recover based on their own experience. A primary care provider may approach addiction treatment from a chronic disease management perspective and might also include medication-assisted therapies. The model of care has to be extremely clear in order to resolve questions about conflicting approaches as they arise, and to be supportive of the minority of providers without lived experience.

Does someone working in substance abuse treatment need to have lived experience themselves?

There was a time when people did not work in the substance abuse treatment field unless they were in recovery themselves.

Today, although the majority of staff working in the field have lived experience, those that don't are sometimes referred to by clients as “book smart” – a derogatory term suggesting they have learned about addiction through educational training programs but they have not walked in the shoes of the addict.

One clinician reported feeling that those without lived experience should make an extra effort to learn about addiction, the 12-step community, and the recovery culture.

Stigma plays a role here in that clients tend to discriminate against clinicians who haven’t “been there.” Either way, the clinician needs to have strong clinical skills to be effective with clients.

Need for Formalized Training and Certification

As of 2012, approximately 36 states have established programs that train peer workers according to a review of programs conducted by the Center for Social Work Research at the University of Austin.[15] The **figure** shows certification entities as of 2010, though not all states reported their data.[16] In most states, the authorized certification entity is the state itself, but in other cases it is a training organization, community-based organization (CBO) or university. As reported in the *Pillars of Peer Support Summit* in 2009, required training hours varied widely across states from 40 to 100 hours, reflecting a lack of uniformity.[17]

In 2001, **Georgia became the first state to provide Medicaid reimbursement to certified peer specialists (CPSs)**.[18] This was the first formal recognition of the value of peer workers in the mental health system. Since 2001, six additional states approved peer support as a Medicaid-reimbursable service, and many more states are moving toward doing so.[19]

California has training programs but no state-sanctioned certification program. **In California, since peers are not certified, training and competencies are not standardized, and there is little consistency across the state in terms of hiring practices, qualifications, duties, and supervision.**[20] A state-sanctioned certification would lend credibility and legitimacy to peer providers in California.[21] In the meantime, private non-profits offer training for peer workers in behavioral health more broadly, and may even offer a certificate of completion. This certificate may strengthen the peer's application for employment in substance abuse services program, but it does not replace a state-sanctioned certification process.

In California, the ***Working Well Together*** organization is a nonprofit agency whose goal is to increase the number of designated consumer, family member, and parent/caregiver positions in public mental health agencies. It is engaged in a comprehensive process to develop standards and a statewide certification program for peer providers, as well as strategies to bill Medi-Cal for peer-delivered services.[22]

Working Well Together believes that certification of peer specialists would help to reduce stigma and discrimination, and would increase the value placed upon using peers in the workplace.[23] However, **certification alone will not ensure that positions will be available in the workforce**. Once positions became available, co-workers and supervisors would need to be educated about how to best utilize peers and their expertise.

Peer Certification Agencies by State (2010)

Alabama	Department of Mental Health (DMH) and CBO
Arizona	State and CBO
Connecticut	Advocacy Unlimited
Florida	FL Certification Board
Georgia	GA Certified Peer Specialist Project
Hawaii	State DMH
Idaho	Office of Consumer and Family Affairs
Illinois	DHS Division of Mental Health
Indiana	Affiliated Service Providers for IN
Kansas	Wichita State University
Kentucky	Dept. for Behavioral Health and Developmental Disabilities
Massachusetts	Transformation Center
Michigan	MI Department of Community Health; Lansing College
Minnesota	MN DMH
Mississippi	State
Missouri	DMH
New Hampshire	Intentional Peer Support
New Mexico	NM Credentialing Board for Behavioral Health Professionals
North Carolina	DMH University of North Carolina School of Social Work
North Dakota	Department of Human Services, Division of Mental Health and
Oklahoma	Department of Mental Health and Substance Abuse
Oregon	Addictions and Mental Health Division certify training programs and local systems credential employees
Pennsylvania	Two approved private training vendors
South Carolina	DMH
Tennessee	TN Certified Peer Specialist Certification Program
Washington	Department of Behavioral Health and Recovery
West Virginia	Recovery Education Center
Wisconsin	State
Wyoming	Mental Health Services Division

Source: *Working Well Together*

Stigma

"When I first started here, that was my main concern: Am I going to be judged as this addict or alcoholic just coming here, and would they kick me out? That is what I was afraid of the most. People pass judgment on other people. It wasn't like that at all."

Patient, CommuniCare Health Centers

Integrating substance use disorder services in primary care is one strategy for reducing stigma. Stigma refers to *"negative beliefs (e.g., people who abuse substances lack self-control), prejudicial attitudes (e.g., desire to avoid interaction), and discrimination (e.g., failure to hire or rent property to such people.)"* [24] When people hear about stigma, they often think of **personal stigma** in which someone has negative beliefs about a person. However in health center settings, there may also be **institutional stigma**, for example between primary care departments and mental health or substance abuse services departments. This is because professionals in these areas may have different approaches to services, as well as vast differences in their professional training. They may not relate to service approaches or patients in other areas. Both personal and institutional stigma need to be addressed in order for patients to receive optimal services from health centers.

Individuals abusing substances may not seek treatment because they don't think they have a problem or they worry about the perceived stigma of being labeled as an alcoholic or addict. Because many clients are ashamed of their addiction, they delay seeking care until they are in crisis. However the same person may not hesitate to visit a primary care provider about a physical health issue. During an appointment, a doctor may suspect addiction, either through questioning or a formal screening process, and use a warm handoff to connect the person with SUD services.[25] Integrated care, like that provided in health centers to varying degrees, has the potential to improve communication and coordination among staff, and decrease stigma for patients.[26]

Further contributing to client stigma is the attitude some providers and other staff hold that addiction is not an illness but rather a choice. In order to dispel the stigma associated with substance use disorders, addiction must be viewed and treated as a chronic condition that sits on the same treatment continuum as other chronic medical conditions, such as diabetes or heart disease. Care begins at prevention and when necessary moves into treatment, relapse, self-management, and/or support. Treatment professionals, patients and the broader public will have less stigma about substance use disorders once addiction is viewed as a "brain disease" just like other diseases that need management, and not as "moral failings" or a "problem of willpower." Biological and behavioral factors influence addiction as they do other chronic diseases, and addiction can be effectively treated and managed through lifestyle change, and in some cases, the use of medication.

"It has been my experience that many clients come into our program with a great deal of shame about needed substance abuse services. Once they have been in our programs for some time, however, and are treated with respect by our staff and other clients, they realize that there is no shame in seeking help and trying to have a better life."

Anna Keiderling, Substance Abuse Services Director
KC Services/Korean Community Services

Primary care and behavioral health care providers are not always in agreement about treatment approaches for patients with chronic illness, mental health conditions, and substance use issues. The value, respect and adoption of various treatment interventions (e.g., pharmacological therapies, counseling, or social models) can place practitioners from different fields at odds when trying to work collaboratively on patient goals.[27] Continuing education, openness, and exposure to a variety of staff approaches will all strengthen care team members so they can work together in the best way possible to treat their patient.

"When you mix together primary care and substance abuse paraprofessionals, you have very educated people and then you have people who have basically been an alcoholic or addict, and there is definitely a stigma attached to any person who is in recovery from mental illness or substance use."

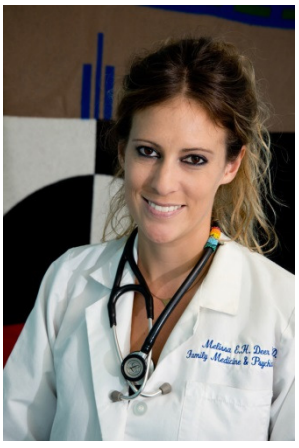
Behavioral Health Clinician

Integrating behavioral health care with primary care services is a strategy for improving access and reducing stigma.[28] Offering behavioral health services in primary health care settings encourages participation by people wanting to avoid the stigma surrounding behavioral health treatment.[29] In a national survey comparing integrated care with enhanced referral care in primary care settings, clinicians reported that integrated care contributed to improved communication and coordination among staff as well as decreased stigma for patients.[30] Behavioral health care delivered in an integrated setting not only minimizes stigma and discrimination, but it also increases opportunities to improve overall health outcomes.[31]

How to Reduce Personal and Institutional Stigma

- Introduce the public and other potential patients to more people in recovery who are willing to tell their story. They can set an example that recovery is possible.
- Conduct community outreach so people know services are available and they can seek them confidentially at the health center.
- Offer other programs to bring people into the health center, then describe the AOD, mental health and physical health services that are available.
- Hire the right people from the beginning; once staff are in place it is difficult to change their biases against substance use disorder.
- Educate providers and staff about substance use disorders, and draw their attention to their own attitudes and possible prejudices.
- Ensure that the layout of the facility supports referrals to behavioral health as well as confidentiality when patients seek services.

Source: Participating health centers



Melissa E.H. Deer, MD, believes stigma will continue to exist until providers see it as a disease process similar to that of other chronic diseases. *(Photo credit: Alaina Dall)*

"There is a tremendous amount of stigma toward addiction and it begs the question of where the disease process ends and personal responsibility begins. Until providers are trained to see addiction as a disease process, I think stigma will continue to exist."

Melissa E.H. Deer, MD, Chief Medical Officer
San Diego American Indian Health Center

Conclusion

While health centers are ideally positioned to offer integrated substance abuse services that complement primary care and mental health service offerings, AOD leadership have the dual challenge of sustaining services while addressing institutional stigma within their own organizations. In the past, AOD departments have relied largely on grant funding and block grants to pay for AOD counselors, augmented by Medi-Cal reimbursement for licensed staff such as LCSWs. Fortunately, the Affordable Care Act (ACA) offers increased funding for reimbursement of AOD services and staff, and in the next year the actual impact of these added dollars will be better understood.

Assuming the ACA will afford more consistent funding and staffing, health centers will be able to put additional measures into place to continue to enhance collaboration between departments. Executives can demonstrate their expectations of collaboration and mutual support in three important ways.

- Model a positive and inclusive attitude toward the substance abuse department and its clients.
- Create an infrastructure with joint meetings in which substance abuse, mental health and primary care providers meet to develop coordinated treatment plans or review challenging cases.
- Require training, such as how to care for a patient with a chronic disease who also has depression and abuses substances.

Reducing stigma between staff by fostering mutual understanding and support is the first step toward reducing stigma toward substance abusing clients seeking services throughout the health center.

In addition, the State of California's Department of Health Care Services needs to create state certification programs for AOD counselors and peer workers. Although the state requires AOD counselor certification, there is a lack of consistency in requirements between the five different agencies in California that offer these certifications. By committing to a single set of professional standards, the state would convey its expectation of a high level of preparedness similar to what is made explicit for other licensed behavioral health professionals. This certification would lend credibility to the role of AOD counselors, and would make clear to community health centers and others how to best utilize them. The same is true for peer workers, a role that has proven to be valuable but that currently lacks clear standards in California. More work is needed to demonstrate the value added by using peers in primary care and integrated care settings, and state certification would reinforce the value of this role. Both of these job categories should then be eligible for reimbursement from Medi-Cal and participating health plans.

Implementing the above strategies with the support of increased funding from the ACA will result in better integration of substance abuse services into health center operations, and to a reduction of both personal and institutional stigma. Ultimately the goal is to reframe "integration of behavioral health and primary care" as "health integration" where behavioral health (inclusive of mental health and substance use) is viewed as an integral part of overall health and well-being. In these models, medical, behavioral health, and peer providers recognize and appreciate the interdependence they have with each other to positively impact the healthcare outcomes of their patients.

References

[1] SAMHSA. (Undated). Enrollment under the Medicaid expansion and health insurance exchanges: A focus on those with behavioral health conditions in California. Retrieved from www.samhsa.gov/healthreform/enrollment.aspx

[2] Lardiere MR, Jones E & Perez M. (2011, January). 2010 Assessment of behavioral health services provided in federally qualified health centers. National Association of Community Health Centers.

[3] UDS Instructions for Table 5 – Staffing and Utilization, December 13, 2013, Version 1.0, p. 34.

[4] California Department of Health Care Services, Facility Licensing, Resources, Frequently Asked Questions, Revised 10/2013. Retrieved from http://www.dhcs.ca.gov/provgovpart/Documents/SUDCD_FAQs.pdf

[5] California Department of Health Care Services, Facility Licensing, Resources, Frequently Asked Questions, Revised 10/2013. Retrieved from http://www.dhcs.ca.gov/provgovpart/Documents/SUDCD_FAQs.pdf

[6] California Department of Health Care Services, Counselor Certification Organizations http://www.dhcs.ca.gov/provgovpart/Pages/CounselorCertificationOrganizations.aspx

[7] Center for Substance Abuse Treatment. (2009). What are peer recovery support services? HHS Publication No. (SMA) 09-4454. Rockville, MD: SAMHSA, U.S. Department of Health and Human Services.

[8] Center for Substance Abuse Treatment. (2009). What are peer recovery support services? HHS Publication No. (SMA) 09-4454. Rockville, MD: SAMHSA, U.S. Department of Health and Human Services.

[9] Integrated Behavioral Health Project and AGD Consulting. Peer models and usage in California behavioral health and primary care settings: Integrated care issue brief. http://www.ibhp.org/uploads/file/PeerModelsBriefRevFINAL.pdf

[10] SAMHSA. (2009). Center for Substance Abuse Treatment, What are peer recovery support services? HHS Publication No. (SMA) 09-4454. Rockville, MD.

[11] Pennsylvania Peer Support Coalition. Retrieved from http://www.papeersupportcoalition.org/peer/pps.html

[12] SAMHSA. (2011). Consumer-operated services: The evidence. HHS Pub. No. SMA-11-4633, Rockville, MD.

[13] By William White as quoted in the presentation by Phil Valentine, Association for Addiction Professionals (NAADAC), on May 1, 2014 entitled, "Understanding the Role of Peer Recovery Coaches in the Addiction Profession."

[14] Padron JM, Hardin P & Williams MG. (2014, February 27). Newsletter: Peers and leadership: An excerpt from the white paper "U.S. peer leadership and development." National Association of County Behavioral Health and Developmental Disability Directors.

[15] Kaufman L, Brooks W, Steinley-Bumgarner M & Stevens-Manser S. (2012). Peer specialist training and certification programs: A national overview. University of Texas at Austin Center for Social Work Research.

[16] Working Well Together. (2012). Certification of Consumer, Youth, Family and Parent Providers: A Review of the Research, p. 11. Report produced by Brasher, D. & Dei Rossi, L. www.inspiredatwork.net.

[17] Working Well Together. (2012). Certification of Consumer, Youth, Family and Parent Providers: A Review of the Research, p. 11. Report produced by Brasher, D. & Dei Rossi, L. www.inspiredatwork.net.

[18] Salzer MS, Schwenk E & Brusilovsky E. (2010, May). Certified peer specialist roles and activities: Results from a national survey. Psychiatric Services, v. 61(5).

[19] Salzer MS, Schwenk E & Brusilovsky E. (2010, May). Certified peer specialist roles and activities: Results from a national survey. Psychiatric Services, v. 61(5).

[20] Working Well Together. (2012). Certification of Consumer, Youth, Family and Parent Providers: A Review of the Research. Report produced by Brasher, D. & Dei Rossi, L. www.inspiredatwork.net.

[21] Technical Assistance Collaborative/Human Services Research Institute. 2012, February 29. California Mental Health and Substance Use Service System Needs Assessment –Final Report.

[22] Information obtained from web research and interviews with key informants.

[23] Working Well Together. What's Working Well Vol 1. Issue 3, Winter, 2012. www.workingwelltogether.org

[24] Clark W, Welch SN, Berry SH, Collentine AM, Collins R, Lebron D & Shearer A. (2013, May). California's historic effort to reduce the stigma of mental illness: The Mental Health Services Act. American Journal of Public Health, v. 103 (5).

[25] Padwa H, Urada D, et al. (2012 Sept – Oct). Integrating substance use disorder services with primary care: The experience in California. Journal of Psychoactive Drugs, 44(4): 299-306. Published in final edited form.

[26] Gallo, J.J., Zubritsky, C., Maxwell, J., Nazar, M., Bogner, H.R., Quijano, L.M. (2004). Primary care clinicians evaluate integrated and referral models of behavioral health care for older adults: Results from a multisite effectiveness trial (prism-e). Annals of Family Medicine, 2(4), 305-309

[27] Technical Assistance Collaborative/Human Services Research Institute (TAC/HSRI). (2012, February 29). California mental health and substance use service system needs assessment - Final report. p. 237.

[28] Ivbijaro, G. & Funk, M. (2008, September). No mental health without primary care. Mental Health in Family Medicine, 5(3), 127-128.

[29] Integrated Behavioral Health Project, www.ibhp.org

[30] Gallo, J.J., Zubritsky, C., Maxwell, J., Nazar, M., Bogner, H.R., Quijano, L.M. (2004). Primary care clinicians evaluate integrated and referral models of behavioral health care for older adults: Results from a multisite effectiveness trial (prism-e). Annals of Family Medicine, 2(4), 305-309

[31] Collins, C., Levis Hewson, D., Munger, R., & Wade T. 2010. Evolving models of behavioral health integration into primary care. NY: Milbank Memorial Fund.

About the Case Studies: The purpose of this project was to better understand the range of substance abuse services offered by experienced community clinics and health centers. Because more patients have health coverage under the Affordable Care Act, and because more substance use disorder treatment is covered, some health centers may be interested in adding or expanding services. At the time of this study, however, not much information was available about model clinic programs. In order to gather the information, the **CalMHSA Integrated Behavioral Health Project** worked in partnership with **AGD Consulting** in a two-part process. First they used statewide data to identify the highest volume substance use disorder treatment health centers, and in February 2014 asked their substance abuse services directors to complete an online survey. Thirteen out of 18 clinics responded to the survey. Secondly, the study team conducted site visits at five of those health centers in order to gather more in-depth information. A series of **"Case Study Highlights"** were developed for key topics: **Funding, Integrated Services**, **Staffing and Stigma**, and **Treatment**. The papers are available at www.ibhp.org. (October 2014)