FAMILIES USA
THE VOICE FOR HEALTH CARE CONSUMERS

Peer Supports in Behavioral Health Care: A 2022 Resource Guide for Advocates

Grim statistics on untreated mental health conditions and substance use disorders (SUD) in the United States show the pressing need for an expanded behavioral health workforce. Peer support specialists[†] — people with lived experience — play a crucial role in behavioral health care and can be part of an expanded workforce strategy.

† We use the term *peer support specialist* to include peer support workers and peer navigators. States use various names to encompass the categories of people with lived experience whom they certify to assist people with mental illness and substance use disorders.

A growing body of research and experience documents the effectiveness of trained peer workers in mental health and SUD care. Peers draw on their personal experience with mental illness or addictions to help others, bring hope, share coping and recovery skills, help people navigate the health system and obtain needed services, and help people live meaningful lives. They are not clinicians, but their work complements that of the clinical workforce.

Evidence shows peers' effectiveness in connecting people who have serious mental illness with ongoing physical and mental health care, providing recovery support for people with substance use disorders and post-traumatic stress disorders, and providing culturally centered help. As the new 988 National Suicide Prevention Lifeline rolls out across the country this summer, and as states and communities ramp up various crisis response systems, state agencies should be thoughtful about how to best utilize and support peer services. It will be important to intentionally incorporate peers into behavioral health workforce pipelines.

This paper:

1. Highlights the growing numbers of adults and youth who have untreated behavioral health conditions;

2. Notes the role that peer specialists may play as states implement the 988 National Suicide Prevention line and establish crisis response systems;

3. Describes research and state experience on the effective roles of peer specialists and peer navigators; and

4. Provides a list of questions for advocates to explore with their states or communities about how they can make effective use of peer specialists in crisis and suicide intervention and, more broadly, how they can incorporate peers into a workforce pipeline.

Growing numbers of adults and youth have serious untreated behavioral health conditions.

Statistics on mental illness, suicides and substance use overdoses and deaths document tremendous unmet behavioral health needs. As of 2020, about one in five adults had a diagnosable mental illness, yet more than half of those adults did not receive needed treatment.[1] Children and youth also experience unacceptably high levels of untreated mental illness, due in part to acute provider shortages.[2]

Unmet needs have increased over the past decade, and particularly over the last few years. Social isolation, loss and grief have contributed to anxiety and depression among children and youth during the COVID-19 pandemic, increasing their emergency room visits for mental health reasons by 24%.[3] U.S. suicide rates increased 33% over the last decade. By 2020, suicide was the 12th leading cause of death in the U.S. and the second leading cause of death among young people ages 10 to 24.[4]

*The suicide rates of African American children are
double those of white children.*

The incidence of untreated behavioral health conditions is significantly worse in communities of color. Two-thirds of African American and Latino adults, and 80% of Asian and Pacific Islander adults, report that they did not receive mental health treatment when needed.[5] American Indians and Alaska Natives have the highest suicide rates in the United States.[6] The suicide rates of African American children are double those of white children.[7]

Substance use disorder statistics are equally dire: 40 million people age 12 and older have a substance use disorder. Drug overdose deaths quadrupled from 1999 to 2019 and increased over 28% in a 12-month period from 2020 to 2021. During the COVID-19 pandemic, emergency department visits for drug overdoses rose by 36%.[8]

The nation's professional behavioral health workforce is not able to address this crisis. One-third of Americans live in areas with shortages of mental health providers, and available providers can only meet 28% of estimated need.[9] There is an urgent need to train, certify and fully utilize all types of behavioral health professionals and paraprofessionals, and to recognize the important role of peer support specialists.

As states and communities ramp up their response to behavioral health crises through the 988 National Suicide Prevention line and through mobile crises services, many will rely on peer specialists to help.

States and localities are trying to ramp up behavioral health crisis response. First, in mid-July 2022, the 988 National Suicide Prevention line will roll out across the country as an easy-to-remember national number to call for help for a mental health crisis. As envisioned, calls will be answered locally. However, as of mid-June, many communities were still struggling to staff the line.[10]

Second, many communities are also planning to increase or establish mobile crises services this year to safely help people who are experiencing a drug overdose or mental health crisis. Community and state action on this front has been catalyzed by federal funding: From 2022 to 2027, states can receive enhanced federal Medicaid matching funds to plan and operate multidisciplinary mobile crisis teams that de-escalate or resolve a crisis and connect people with immediate and ongoing behavioral and medical services.[11] Response to a mental health emergency by a trained behavioral health team instead of police can reduce harm and more appropriately get people to safety.[12] To receive enhanced Medicaid funding, crisis teams must include at least one behavioral health care professional who is qualified to provide a behavioral health assessment, along with other professional or paraprofessional staff with behavioral health expertise.

"

We believe in the power of youth-led mental health coalitions.

Although states use differing staffing patterns for suicide prevention lines and mobile crisis services, peer specialists should have important roles in both. Rhode Island recently increased the staffing of its crisis services using a "hub and spoke" model: Along with master's-level qualified mental health professionals or registered nurses, peer specialists are among the staff of the central Behavioral Health Link crisis line and triage center (soon to become 988). Communities across Rhode Island also have peer-run recovery community centers, which mobile crisis services utilize as referral sources for ongoing support and care.[13] The federal Centers for Medicare and Medicaid Services and the Substance Abuse and Mental Health Services Administration (SAMHSA) both recommend that a crisis system include trained peers with lived experience. Arizona is an example of a state that has taken up this recommendation, requiring that 25% of mobile crisis teams have a peer specialist. Washington State and Georgia encourage, but do not require, mobile crisis team providers to utilize peer support staff.[14]

Youth staffing and youth-led services are also essential in crisis support. Terrace Terrell, who works at Youthline's teen-to-teen crisis support hotline in Oregon, explains that about 18% of callers to the National Suicide Prevention Lifeline are under 25 years old. "They need to be able to press a button and be connected to another trained teen....We believe in the power of youth-led mental health coalitions."[15]

Beyond crisis response, peers have played valuable roles in recovery and in service navigation for many years. Research and state experience demonstrate the importance of peer specialists and peer navigators as part of a treatment and recovery team. Peers have unique roles in the behavioral health workforce that must be supported.

Foundational programs in Georgia and New Mexico: Georgia has been at the forefront of state peer support programs in behavioral health. Growing out of consumer movements to deinstitutionalize patients with mental health conditions, the use of peer specialists initially helped people leaving hospitals to learn skills they needed to live in the community. In 1999, Georgia became the first state to receive Medicaid reimbursement for services delivered by peers and to develop a certification system for peer specialists. Georgia now certifies four types of peer specialists (mental health, addictive disease, youth, and parent).[16] Some of Georgia's peer support centers are part of larger clinics or community service providers, while others are freestanding. Georgia requires peer support centers to be led and managed by certified peers, sets a pay scale and requires clinical supervision of the program leader.

Peers draw on their personal experience with mental illness or addictions to help others live meaningful lives.

Foundational research from New Mexico in 2013 showed that SUD treatment groups led by certified peer support specialists could be as effective as groups led by clinical counselors in decreasing post-traumatic stress disorder symptoms and substance use and craving, and in improving coping skills, mental health and physical health. The study took place in a peer-run wellness center and an inpatient substance use treatment facility in Rio Arriba County, a largely Hispanic, rural community with a shortage of mental health professionals. Group leaders came from the community they served and understood the culture and language of patients.[17]

Peers, culturally appropriate care navigation and immigrants: Studies also show that peer navigators are effective at engaging people who have serious mental illness (SMI) in access to both behavioral and physical health care, especially if they use culturally appropriate techniques. People with SMI often have co-occurring physical illnesses that lead to high hospitalization rates, disabilities or death. One pair of studies, building on an intervention that had been found effective with African-American patients, used motivational interviewing, reflective listening and strengths-based interviewing and advocacy techniques to assist Latino patients with serious mental illness. The support included setting health goals, scheduling appointments with doctors, working with doctors to help the patients get the care they needed and getting access to community resources and services. The research took place at a clinic in Chicago that offered both physical and mental health care and that sought to more fully involve people with serious mental illness in improving their physical health. Focus groups showed that, for the clinic's Latino patients, language and immigration concerns posed barriers to care, and families were often involved in decision-making. The study team therefore adapted a peer navigator training manual and worksheets to include resources on immigration, questions to ask patients about their family relationships and families' roles in health decisions and questions about non-medical treatment (such as spiritual supports) that a person might be seeking. The patients who received assistance from peer navigators who were trained in this technique had more scheduled doctors' visits than patients who did not use navigators, and reported improvements in their mental health, control of health and quality of life.[18]

A peer-led suicide prevention technique incorporates semi-structured conversations about coping with grief and loss.

"Bridging" fragmented physical and mental health care: Peer providers can help people who have serious mental illness navigate fragmented care delivery that requires them to go to different locations for mental health care and physical health care. People with serious mental illness may have symptoms or cognitive defects that limit their ability to follow treatment advice; or they may place a lower priority on physical health than on pressing mental health, housing and financial needs; or they may be put off by the stigmatizing attitudes of some providers. The "Bridge" intervention is a manualized technique to overcome some of these issues. Peer navigators use a combination of modeling, coaching and role-playing to help patients with SMI make a health care plan; set wellness goals; make appointments for preventive, primary and specialty health care services (including oral health); and communicate with providers. Peer navigator Lou Mallory explains, "At the beginning, we're doing things for the client. As time goes on, we step back and observe how they're doing and coach them when they need it."[19] A study in Southern California found that this peer-to-peer intervention resulted in people using primary care services more and emergency departments less, helped them feel more confident in managing their health, and improved the quality of their relationships with primary care providers. Their doctors diagnosed chronic diseases that had previously gone undetected.[20]

Suicide prevention: Little formal research has been completed to date on the effectiveness of peer support specialists in suicide prevention. However, research on suicide prevention and culturally appropriate care is underway.[21] A pilot study found a peer intervention called PREVAIL to be "feasible and acceptable" for people at risk of suicide, but noted the need for further research to determine its effectiveness.[22] This intervention included updating suicide safety plans and incorporating relaxation techniques, goal setting and semi-structured conversations about coping with grief and loss.[23] The Patient-Centered Outcomes Research Institute website provides information about current studies to address youth suicide.[24]

Questions to ask your state or community about planned roles for peer specialists in behavioral health

Research about the effective use of peers and about state experience suggests a number of questions that advocates might explore regarding peers' roles.

In the short term, states and localities will be making decisions regarding suicide prevention hotlines and behavioral health crisis systems, and we have focused some questions on those pressing implementation steps:

1. Will people with lived experience of mental health crises and recovery be among the staff operating suicide prevention lines? Will such peers have distinct roles in crisis response teams that enable people to deal with a drug overdose or mental health concerns without involving law enforcement?

2. Even if peers are not part of mobile crisis units or suicide prevention lines, will peer-led community-based services be among outreach and referral sources for people in crisis?

For many years, peer-run organizations in Clackamas County, Oregon have partnered with fire department paramedics, knocking on the door of someone who has recently survived an overdose to offer recovery services. Clackamas County peer organizations also provide outreach and support to people struggling with addictions and/or mental health issues in jails, emergency rooms, mobile crisis response and crisis walk-in centers.[25]

3. How will peers be encouraged and supported to use their expertise?

   a. Do peer specialists' roles allow them to listen, build trust and provide hope and help based on their own experiences?

   b. Do they receive support themselves to process emotions that their work may trigger?

Arizona's Peer and Family Career Academy is creating a statewide support network to create peer-to-peer coaching and enhanced supports to allow for personal identification of triggers and help processing emotions.[26]

   d. Do peer-led agencies have appropriate administrative support?

> *Staff at the Rhode Island Department of Behavioral Healthcare recognize the need peer led agencies have for administrative support and employ multiple strategies to assist them. The department supports peer-led agencies by helping them standardize documentation and lesson plans, identify and implement evidence based best practices, training them to collect data, and guiding them through the evaluation of their programs.*[27]

   e. Will they be using an evidence-based curriculum, as have some of the successful peer programs described above? Has the state or agency considered partnering with universities or researchers to formally evaluate what works?

4. Do peer specialists receive specific resources to assist youth, people of various cultural and linguistic backgrounds, people with serious mental illness and those with substance use disorders? Is the program prepared to help people with immigration-related concerns?

5. How will people receive support to address their physical as well as their behavioral health?

6. How will peer specialists relate to clinicians and to each other? Do agencies train other staff members to respect the important role of peers? Do peer specialists regularly connect with other peer workers and peer-led agencies doing similar work?[28]

Advocates and policymakers should also consider adequate compensation structures for peer specialists to promote their retention, growth, advancement, and wellbeing.[29]

1. How will peer specialists and peer organizations bill for their time?

> *Medicaid fee-for-service reimbursement may require billing for coded services at 15-minute intervals. Some states instead use a combination of Medicaid managed care payments and braided grant funding to contract with community-based organizations for peer services. They find that flexible payment structures allow peer workers more time to support within the situations at hand.*[30]

2. Do peers and peer-led programs have a say in the statewide policies that affect them?

> *The Oregon Health Authority's Traditional Health Worker Task Force gives peer specialists an explicit voice in state and county policies concerning their work.*[31]

3. Does the state (or do agencies) set a pay scale that recognizes peers' important role, creates a stable workforce, and provides upward mobility?[32] Can people with disabilities work part time as their health permits, retaining important disability benefits?

> *Georgia is one state that sets a pay scale for its peer support centers and workers.*[33]

4. Do peer specialists have adequate paid time off for self-care?

Are peer specialists part of a larger behavioral health workforce pipeline?

1. Starting with high school students, how do states and communities inform students about certification programs for peer support workers, specialists, navigators and community health workers? Do they inform people in various recovery programs about pathways to employment as peer specialists?[34]

2. Does the state or community have an effective way to match certified specialists with available jobs?

3. Does the state or community provide upward mobility within peer professions? For example, states can require that peers supervise and lead recovery centers.[†] This helps to create career paths for peers and ensures that peer specialists can discuss the challenges they face with others who have lived experience. Programs should develop management and leadership roles that fit organizational needs.[35]

4. Has the state or community considered ways to inform certified peers of further behavioral health professional training opportunities, such as through the Health Resources and Services Administration and SAMHSA?

5. Is the state creating its own programs of cancelable loans or scholarships for people who pursue behavioral health careers and practice in underserved areas?[36]

---

† Peers who are part of clinical treatment programs billing Medicaid must have clinical supervision by a competent mental health professional (as defined by the state), but this can be accomplished in a variety of ways. For example, outside clinical supervisors can provide clinical co-supervision, or work with peer supervisors on clinical issues rather than working with the rest of the staff directly.

Conclusion

Peer specialists are an important part of the behavioral health workforce. They are not clinicians but play a unique and effective role. Health care advocates can help ensure that their states and communities structure peer services effectively and provide peer specialists with decent compensation and an opportunity to advance in their careers.

Additional Information

For additional articles and studies about use of peers, see the Mental Health America's Center for Peer Support at https://www.mhanational.org/center-peer-support.

Endnotes

[1] "Mental Illness." National Institute of Mental Health. January 2022. https://www.nimh.nih.gov/health/statistics/mental-illness#:~:text=Mental%20illnesses%20are%20common%20in,mild%20to%20moderate%20to%20severe

[2] Whitney D.G. and M.D. Peterson. "US National and State-Level Prevalence of Mental Health Disorders and Disparities of Mental Health Care Use in Children." *JAMA Pediatr*. 2019;173(4):389–391. doi:10.1001/jamapediatrics.2018.5399

[3] "Morbidity and Mortality Weekly Report." Centers for Disease Control and Prevention. February 25, 2022. 71(8); 319–324. https://www.cdc.gov/mmwr/volumes/71/wr/mm7108e2.htm#:~:text=During%20March%E2%80%93October%202020%2C%20among,compared%20with%202019%20(2)

[4] Ehlman, D.C., E. Yard, D.M. Stone, C.M. Jones CM and K.A. Mack. "Changes in Suicide Rates — United States, 2019 and 2020." MMWR Morb Mortal Wkly Rep 2022;71:306–312. DOI: http://dx.doi.org/10.15585/mmwr.mm7108a5external icon

[5] "2021 National Healthcare Quality and Disparities Report." *Agency for Healthcare Research and Quality*, December 2021, https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrdr/2021qdr.pdf.

[6] "Racial and Ethnic Disparities." *Suicide Prevention Resource Center*, https://sprc.org/scope/racial-ethnic-disparities

[7] Caron, C.. "Why Are More Black Kids Suicidal? A Search for Answers." *New York Times*, November 17, 2021. https://www.nytimes.com/2021/11/18/well/mind/suicide-black-kids.html

[8] Government Accountability Office. Behavioral Health: Patient Access, Provider Claims Payment, and the Effects of the COVID-19 Pandemic, March 31, 2020. GAO-21-437R. https://www.gao.gov/products/gao-21-437r

[9] Bureau of Health Workforce, Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services. Designated Health Professional Shortage Areas Statistics: Designated HPSA Quarterly Summary, as of September 30, 2021 available at https://data.hrsa.gov/topics/health-workforce/shortage-areas.

[10] Sumrall, F. "988 Suicide Lifeline Facing Local, National Staffing Shortages Ahead of July 16 Launch." *MyNorthwest*, July 8, 2022. https://mynorthwest.com/3507277/988-suicide-lifeline-facing-local-national-staffing-shortages-ahead-of-july-16-launch/. Sholtis, Brett. "As 988 Hotline Goes Live in Pennsylvania, Crisis Centers Need Workers." WSKG, May 9, 2022. https://wskg.org/as-988-hotline-goes-live-in-pennsylvania-crisis-centers-need-workers/

[11] Gulley, J., et al. "Mobile Crisis Teams: A State Planning Guide for Medicaid-Financed Crisis Response Services." TAC Inc. and the California Health Care Foundation. January 2022, https://www.tacinc.org/wp-content/uploads/2022/01/CHCF-Mobile-Crisis-Services-State-Planning-Guide-2021-01-24_Final.pdf

[12] Bunts, W. "Mobile Response Services: An Investment to Decriminalize Mental Health." The Center for Law and Social Policy. April 2021. https://www.clasp.org/wp-content/uploads/2022/04/Youth20Mobile20Response20Services_0.pdf

[13] BH Link Crisis Intervention webpage. https://www.riprc.org/bh-link-behavioral-health-crisis-intervention-services/; interview with Candace Rodgers, Lead Administrator for Prevention and Recovery Services, and Sarah Saint Laurent, Peer-Based Recovery Support Services Lead, Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals. March 23, 2022.

[14] Gulley et al., op. cit.

[15] Terrence Terrell, testimony to U.S. Senate Finance Committee, February 15, 2022.

[16] "Certified Peer Specialists." Georgia Department of Behavioral Health and Developmental Disabilities. https://dbhdd.georgia.gov/recovery-transformation/cps

[17] Crisanti A., C. Murray-Krezan and J. Reno (2019). "Are Treatment Groups Led by Peers as Effective as Groups Led by Counselors for Treating Posttraumatic Stress Disorder and Substance Use Disorder?" Patient-Centered Outcomes Research Institute (PCORI). https://doi.org/10.25302/5.2019.CE.12114484

[18] Corrigan, Patrick William. "Peer-Navigator Support for Latinx Patients with Serious Mental Illness." Patient-Centered Outcomes Research Institute. September 2018, https://www.pcori.org/research-results/2013/peer-navigator-support-latinx-patients-serious-mental-illness; The Latino Peer Navigator manual is available at https://chicagohealthdisparities.org/wp-content/uploads/2020/12/Latino-Pn_manual.pdf.

[19] "Research to Help People with Serious Mental Illnesses Improve Their Health." Patient-Centered Outcomes Research Institute (blog post). October 9, 2018. https://www.pcori.org/research-results/pcori-stories/research-help-people-serious-mental-illnesses-improve-their-health

[20] Ibid.

[21] Schlichthorst, M. et al. "Lived Experience Peer Support Programs for Suicide Prevention: A Systematic Scoping Review," *Int J Ment Health Syst*, no. 14 (2020). https://ijmhs.biomedcentral.com/articles/10.1186/s13033-020-00396-1

[22] Pfeiffer, P. et al. "Development and Pilot Study of a Suicide Prevention Intervention Delivered by Peer Support Specialists," *Psychol Serv*, no. 16 (2019), https://www.power2u.org/wp-content/uploads/2021/03/Pfeiffer-2019-.pdf

[23] Ibid.

[24] "PCORI-Funded Researchers Seek Ways to Address Youth Suicide." Patient-Centered Outcomes Research Institute (blog post). September 27, 2021. https://www.pcori.org/blog/pcori-funded-researchers-seek-ways-address-youth-suicide

[25] Schrieber, E. "Clackamas County follows up after 911 overdose calls through hopeful program," KATU-2 ABC, March 24, 2022, https://katu.com/news/recover-northwest/clackamas-county-follows-up-after-911-overdose-calls-through-hopeful-program; and interview with Ally Linfoot, Peer Support Coordinator, Clackamas County Behavioral Health, March 9, 2022.

[26] Gulley et al., op cit.

[27] Interview with Candace Rodgers and Sarah St. Laurent, op. cit.

[28] See Oregon's Traditional Health Worker Commission and toolkit as an example: https://www.oregon.gov/oha/OEI/Pages/THW-Commission-Subcommittee.aspx and https://www.oregon.gov/oha/OEI/THW%20Documents/Traditional-Health-Worker-Toolkit-2019-Final.pdf

[29] One study on the effectiveness of peer navigators found that high turnover rates among peer specialists might make made them less effective than professionals in transitioning patients with mental disorders into ongoing care after an emergency discharge. Druss, B., C.A. Lally, J. Li, S. Tapscott and E.R. Walker. (2021). "Comparing Two Ways to Help Patients Get Follow-up Care after a Mental Health Visit to the Emergency Room—The EPIC Study." Patient-Centered Outcomes Research Institute. https://doi.org/10.25302/05.2021.IHS.151032431. However, program administrators and researchers could not determine whether better compensation leads to higher retention rates among peer specialists.

[30] Purington, K. "Using Peers to Support Physical and Mental Health Integration for Adults with Serious Mental Illness/" National Association of State Health Policy, 2016. https://www.nashp.org/wp-content/uploads/2016/01/Peer-Supports.pdf; Oregon Health Authority, Office of Equity and Inclusion, "Recommendations for Traditional Health Worker Payment Models." September 23, 2019. https://www.oregon.gov/oha/OEI/THW%20Documents/FINAL-Payment-Models-Grid-by-Worker-Type-with-Disclaimer-9.25.19.pdf; interview with Ally Linfoot, Peer Support Coordinator, Clackamas County Behavioral Health, Oregon, March 9, 2022; California Association of Social Rehabilitation Agencies, "Meaningful Roles for Peer Providers in Integrated Care," 2014. available on the Mental Health America website at https://www.mhanational.org/sites/default/files/Meaningful%20Roles%20for%20Peer%20Providers.pdf

[31] Oregon Health Authority, Traditional Health Worker Commission and Subcommittee/ https://www.oregon.gov/oha/OEI/Pages/THW-Commission-Subcommittee.aspx

[32] Druss et al., op. cit., citing Cronise, R., C. Teixeira, E.S. Rogers and S. Harrington. The peer support workforce: results of a national survey. *Psychiatr Rehab J.* 2016;39(3):211.

[33] Georgia Department of Behavioral Health and Developmental Disabilities, FY 2023 Provider Manual for Community Behavioral Health Providers, June 1, 2022. https://dbhdd.georgia.gov/be-connected/community-provider-manuals

[34] Rhode Island is ONE state planning for this. "Rhode Island Behavioral Health System of Care for Children and Youth DRAFT Plan–October 2021." https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2021-10/ri-childrens-system-of-care-draft-plan-oct-12-2021.pdf

[35] Interviews with Janie Gullickson, Executive Director, Mental Health & Addiction Association of Oregon, April 25, 2022, and with Candace Rogers and Sarah St. Laurent, op. cit. Georgia requires that peer support centers be led and managed by certified peers and requires clinical supervision of the program leader. Also see the resources on peer supervision on SAMHSA's "Peers" web page, https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers and Purington, Kitty, "Using Peers to Support Physical and Mental Health Integration for Adults with Serious Mental Illness," National Association of State Health Policy, 2016. https://www.nashp.org/wp-content/uploads/2016/01/Peer-Supports.pdf

[36] This could include scholarships to become a certified peer (see Capital Area Behavioral Health Collaborative webpage for an example: https://www.cabhc.org/resources/peer-support-services/peer-support-scholarship-initiative/), as well as scholarships for professional counseling careers such as those available through the Georgia Mental Health Parity Act, HB 1013, enacted April 4, 2022: https://www.legis.ga.gov/legislation/61365

FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

1225 New York Avenue NW, Suite 800, Washington, DC 20005
202-628-3030   info@familiesusa.org   FamiliesUSA.org   facebook / FamiliesUSA   twitter / @FamiliesUSA

HE2022-103