



University of California  
San Francisco

*UCSF Health Workforce Research Center  
on Long-Term Care*

## Research Report

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# Case Study of Peer Providers in the Behavioral Health Workforce: Texas

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December 17, 2015

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This research was conducted through a Cooperative Agreement with the Health Resources and Services Administration (HRSA), and funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). Opinions and recommendations do not necessarily represent those of HRSA, SAMHSA, or other government agency.

Please cite as: Spetz, J., Blash, L., Chan, K., Kogler, V., and Chapman, S. (2015). Case Study of Peer Providers in the Behavioral Health Workforce: Texas. San Francisco, CA: UCSF Health Workforce Research Center on Long-Term Care.

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## **Case Study of Peer Providers in the Behavioral Health Workforce: Texas**

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## Case Study of Peer Providers in the Behavioral Health Workforce: Texas

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### Executive Summary

This case study explores Texas'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

Texas 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 a panel of national experts convened in March, 2015. We contacted Texas 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 visit, we visited and interviewed staff at 2 SUD provider and training organizations, 3 MH provider organizations, and one MH training and certification organization, and we interviewed 4 state government policy makers. One phone interview was conducted with a certification board member. Where feasible, we collected administrative data from peer provider sites.

### Findings

- In Texas, MH and SUD services have distinct and separate systems for training and certifying peer providers.
  - **Training and certification for MH** Certified Peer Specialists (CPS) is handled by a single state-designated organization, ViaHope.
    - There were approximately 592 CPSs as of August 2015.
  - **Training for SUD** Peer Recovery Support Specialists (PRS) is administered by a geographically dispersed group of state-authorized

trainers. Certification and standards are managed by the Texas Board of Addiction Professionals.

- There were approximately 460 PRSs as of August, 2015.
- **Billing:** There is no explicit peer support benefit under the Texas Medicaid State Plan; mental health peer support can be billed under Medication Training and Support, Skills Training, and Psychosocial Rehabilitation.
  - The State Department of Health Services contracts with 39 Local Mental Health Authorities (LMHAs) to provide behavioral health services in their geographic region.
  - Until recently, CPS services were only Medicaid-reimbursable when offered or contracted through LMHAs. There are relatively few MH consumer-operated service programs (COSPs) in Texas; some of them contract peer support services to LMHAs and other agencies.
  - Funding for SUD prevention and treatment is primarily from grants.
  - There is an ongoing effort to pass a bill that would include both MH and SUD peers as a provider type.
- **Employment:** The majority of CPSs are employed by LMHAs. PRSs are employed by a diverse group of agencies, including LMHAs, treatment centers, and recovery community organizations.
- **Roles:** CPSs and PRSs play a number of roles, including educating law enforcement and clinical groups about peer support, leading support groups for those in recovery, teaching recovery classes, staffing warm lines, assisting with employment and independent living skills, working in transitional housing, staffing sober residences, and providing health coaching. The state psychiatric hospital system employs CPSs to provide support in inpatient settings, including forensic psychiatric units.
- **Acceptance:** CPSs and PRSs generally felt accepted within their organizations, but reported some resistance from licensed clinical staff.
- **Impact on Organizations:** The presence of CPSs and PRSs allowed treatment agencies to engage consumers in their own care planning, and has helped to sensitize clinicians to the experiences of those affected by addiction and or mental health crises.
- **Behavioral Health/Primary Care Integration:** Peer providers were engaged in some general health education at both SUD and MH organizations we visited, but integration with primary care is currently minimal.

## **Conclusions**

Texas has been successful in changing the culture of MH and SUD treatment agencies by supporting them to adopt a recovery-oriented framework and creating

a system for training and certifying peer providers in both fields. State agencies such as the state hospital system employ peers, as do many LMHAs. Changes in Medicaid managed care may open the door for more use of peer providers in the future, although Texas is not a Medicaid expansion state. In addition, there is an ongoing effort to pass legislation that would designate CPSs and PRSs as provider types for Medicaid billing purposes, which would likely expand the role of peer providers in the state.

## Case Study of Peer Providers in the Behavioral Health Workforce: Texas

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### Background and Policy Framework

This case study explores Texas'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."*<sup>1</sup>

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

Texas has developed statewide policy on the training, certification, and employment of peer support in mental health (MH) and substance use disorders (SUD). The development of these areas of peer support followed very different paths, although efforts are under way to provide more coordination and cohesion between the efforts.

### Methods

We conducted a 5-day site visit to Texas to examine the state's training, certification, and employment of peer providers in MH and SUD. Texas was identified as a leading state in the employment of peer providers from a literature review and through the input of a national panel of experts convened in February, 2015. We contacted Texas state officials, certification boards, training organizations, and provider organizations to better understand the state's service model, and to identify organizations to interview during the site visit. During the visit, we visited and interviewed staff at 2 SUD provider and training organizations, 3 MH provider organizations, and one MH training and certification organization. We also interviewed 4 state government representatives. Where feasible, we collected administrative data from peer provider sites. In addition, we conducted one phone interview with a certification board representative several weeks after our visit.

## ***Mental Health***

In 2009, Texas was one of just 9 states to receive a SAMHSA Mental Health Transformation State Incentive Grant intended to transform publicly-funded mental health systems into recovery-oriented systems. The grant was implemented as a partnership between several state agencies with the Department of State Health Services (DSHS) as the lead agency. The grant helped create and fund a Training and Technical Assistance Center (TTAC), which was named ViaHope.

In 2010, ViaHope, with input from other agencies and a subgroup of consumers and family members, developed and implemented a training and certification program for mental health peer providers, who were called Certified Peer Specialists (CPS). Experiences with placing this first cohort of CPSs led ViaHope to develop additional training and technical assistance programs to help organizations adopt a recovery-oriented system of care that would allow them to implement successful peer support programs. With this in mind, ViaHope created the Recovery Institute in 2012 to deliver this technical assistance along with additional training and resource options for CPS and Family Partners.<sup>i</sup>

## ***Substance Use Disorders***

In 2010, the Texas Recovery Initiative, spearheaded by individuals within the Texas State Department of Health Services (DSHS), began to engage 28 communities across Texas in developing a Recovery-Oriented System of Care (ROSC). The ROSC is described as a framework for coordinating person-centered and self-directed systems, services, and supports for recovery from substance use disorders.<sup>2</sup> Part of this planning process included developing and enhancing peer support services intended to move substance use treatment and services away from an acute care model to a recovery model.

As a result of this effort, the DSHS adopted a curriculum for training recovery coaches called Peer Recovery Support Specialists (PRS). In order to ensure

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<sup>i</sup> “Experienced parents or primary caregivers of a child/adolescent with a serious emotional disturbance. Family partners are active members of the intensive case management/wraparound team process providing peer mentoring and support to the primary caregivers; introducing the family to the treatment process; modeling self-advocacy skills; providing information, referral and non-clinical skills training; assisting in the identification of natural/non-traditional and community support systems; and documenting the provision of all family partner services, including both face-to-face and non face-to-face activities.”

<http://www.dshs.state.tx.us/mhsa/mh-child-adolescent-services/>



accountability among PRS, DSHS approached the Texas Certification Board of Addiction Professionals (TCBAP) to develop a statewide process. Statewide PRS certification was in place in 2012, and, in 2014, the International Credentialing and Reciprocity Consortium (IC&RC) approved the certification for national and international reciprocity.

In May 2014, in order to further the ROSC process, Texas's DSHS granted a total of \$4.5 million to 22 organizations to develop a recovery-oriented system of care, including peer support programs. The 22 agencies receiving grants were required to hire PRSs, and DSHS made certification mandatory for all PRSs working at these agencies. The goal is to make these PRSs eligible as Medicaid-billable providers if legislation can be passed to do so (see below).

While SUD and MH continue to be siloed, Texas House Bill 1541, which was introduced in a recent (84<sup>th</sup>) legislative session, would have directed the Texas Medicaid program administrator (Health and Human Services Commission - HHSC) to include both MH and SUD peers as provider types. This bill received considerable support in the House but has not passed the Senate. Despite a closer alliance of SUD and MH advocates, the bill was reportedly stopped by a surprise last-minute lobbying effort by members of an association of licensed counselors who expressed concern about safety and scope of practice.<sup>ii</sup> It is likely to be revisited in future sessions.

## **Training and Certification**

### ***Mental Health Peer Training and Certification***

Training and certification for mental health peer providers is handled solely by ViaHope. ViaHope was established as part of a SAMHSA Mental Health Transformation State Incentive Grant, received by the state in 2009, with the charge of developing a training and certification program. According to interviewees, ViaHope contracted with the Appalachian Consulting group of Georgia in 2010 to develop training and a curriculum for the Texas effort. ViaHope worked with Lynn Legere of the Boston University Center for Psychiatric Rehabilitation<sup>3</sup> to customize the curriculum to fit the Texas model, including the incorporation of material on trauma-informed care.

The CPS course includes 43 hours of training and a written certification exam. The title for MH peer providers after certification is Certified Peer Specialists (CPS). In

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<sup>ii</sup> The bill was supported by social workers' associations.

addition, CPSs are required to complete a total of 20 continuing education units (CEUs) every 2 years to maintain certification. Many applicants are already working or volunteering in the field prior to application to the training program. Aside from general qualifications – being 18 years of age or older, high school graduation or GED, and in recovery from mental health challenges – the successful applicant will have paid or volunteer experience as a peer specialist, and ideally will have a Wellness Recovery Action Plan (WRAP) or have served as a WRAP facilitator. The application screening process is intended to ensure that those trained are likely to be hired. There are generally at least 75 applicants for every 24 training slots.

Between March 2010 and August 2015, the ViaHope program trained 678 peer supports specialists and certified 592 CPSs.<sup>iii</sup>

### ***Substance Use Disorders Training and Certification***

The certification and designation process for SUD peer recovery coaches is handled through the Texas Certification Board of Addiction Professionals (TCBAP), which is a member of the International Credentialing and Reciprocity Consortium (IC&RC). Statewide PRS certification was instituted in 2012, and the IC&RC approved the certification for limited national and international reciprocity in 2014. Texas is one of 11 states to have adopted the IC&RC process for credentialing peer recovery coaches.<sup>4</sup> The title for these providers in Texas is Peer Recovery Support Specialists (PRS). The TCBAP also offers a designation as a peer mentor/peer recovery coach, which is a more limited credential.

According to interviewees, the training curriculum the state adopted was based on that developed by the Connecticut Community for Addiction Recovery (CCAR).<sup>5, 6</sup> In order to obtain certification or designation, students are required to complete 46 hours of training. PRSs must pass an exam and complete 500 hours of on-the-job training and 25 hours of supervised practice to receive certification. TCBAP also offers an endorsement for PRSs trained to work with transition-age youth for which the PRS must complete an additional 6 hours of specialized training.

Designated peer mentors/peer recovery coaches (PM/PRC) must complete 150 hours of supervised paid or volunteer work, but are not required to pass an exam. Designation allows the PM/PRC to work as a peer recovery coach in Texas, but PM/PRCs cannot use their designation to work as peer recovery coaches outside of Texas and may not be billable as Medicaid providers if legislation authorizing peer

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<sup>iii</sup> Some students do not obtain certification because they do not complete the class or do not pass the exam.

support as an individual provider type is implemented. Designation is often pursued by individuals who wish to work as volunteer coaches.

TCBAP provides the test for PRS certification; tracks certifications, designations, and re-certifications; and adjudicates any complaints against PRSs.

Across the state, there are approximately 180 trainers prepared and approved by the DSHS Substance Abuse Program Services. While some interviewees felt this geographic dispersal was a strength, allowing for training to take place across the state; others felt it was “fragmented” and lacked cohesion.

Between 2012 and 2015, 460 PRSs were certified. More than 800 have gone through the training for designation or certification.<sup>iv</sup>

## **Peer Employment**

### ***Mental Health Peer Employment***

According to a 2015 survey conducted by the University of Texas (UT), the state’s 39 LMHAs provide the bulk of employment for CPSs in mental health.<sup>7</sup> State hospitals also provide some employment, as do other organizations such as Managed Care Organizations (MCOs). Consumer-operated service providers are a small but growing sector of employment. The majority of CPSs are employed in traditional treatment-focused settings.<sup>7</sup>

Survey data from the 2015 UT report indicate that CPSs have an average tenure of 3 years and average wage of \$14 per hour. About half are employed full time. Relatively few (37%) CPSs reported that they were working in an organization with a career ladder. Most reported high levels of satisfaction with their work.<sup>8</sup>

### ***Substance Use Disorder Peer Employment***

The 22 organizations that were funded through the DSHS pilot in 2014 were required to hire PRSs. Interviewees reported that treatment facilities had a more difficult time adjusting to hiring peers than did other types of organizations, such as community-based organizations, but several treatment facilities achieved success in this area. Eighty-four (84) PRSs were employed as of August 2015, according to one state representative.

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<sup>iv</sup> Some students opt for designation only; others do not complete the class or do not pass the exam.

An emerging trend in PRS employment is the expansion of the number of sobering centers in Texas. According to one state representative, DSHS is providing startup funding to these types of organizations with the requirement they hire recovery coaches. In addition, one RCO, APAA, received a 2014 HRSA grant to increase the number of PRSs qualified to work with youth by 360 positions in 3 years.

### **Funding for Peer Support Programs**

According to the Kaiser Family Foundation, Texas ranked 48<sup>th</sup> in the nation in per capita mental health spending, at \$40.65 per capita in 2013.<sup>9</sup> Texas is not a Medicaid expansion state under the Affordable Care Act.

While there is no explicit peer support benefit under the Texas Medicaid state plan, mental health peer support can be billed under several codes including Medication Training and Support (H0034, H0034Q), Skills Training (H2014, H2014Q), and Psychosocial Rehabilitation (H2017, H2017Q).<sup>10</sup>

According to state representatives interviewed, an explicit peer support benefit in Texas's 1915(i) State Plan Amendment (SPA) for adults with serious mental illness and a history of extended or repeated psychiatric inpatient commitments is currently under negotiation with CMS. In addition, SUD peer support was included in the Centers for Medicare and Medicaid Services-funded Money Follows the Person Behavioral Health Pilot in several counties through 2016.<sup>11</sup>

### ***Mental Health Funding***

DSHS contracts with the 39 LMHAs to provide mental health services (and SUD services for the dually-diagnosed). The LMHAs provide services to indigent adults with SMIs, primarily bipolar disorder, schizophrenia, and major depression, and are the largest employers of CPSs. LMHAs develop policy, allocate funds, and provide services in their designated geographic areas. According to a 2011 report by the University of Texas School of Social Work, 38 percent of LMHAs indicated that their organizations bill peer support services to Medicaid as psychosocial rehabilitation services, 27 percent as skills training, and 12 percent as medication training and support.<sup>12</sup>

Some of the state's 10 psychiatric hospitals employ CPSs; the hospitals are funded by DSHS to provide inpatient services.<sup>13</sup> Some peer support services are provided by the 7 consumer-operated service providers (COSPs) in Texas, which are independent organizations operated and governed by persons with lived

experience.<sup>14</sup> COSPs are primarily grant-funded, and few are able to bill Medicaid via contract with an LMHA.

Other sources of funding for peer support services in mental health include general revenue, the federal Mental Health Block Grant (MHBG), and private foundations. Texas's Hogg Foundation focuses exclusively on mental health and has funded a number of research and implementation projects on peer support.

Texas is increasingly moving to Medicaid managed care for mental health services, including mental health rehabilitation and mental health targeted case management as of September 2014. These services were formerly only offered through the LMHAs. The MCOs may choose cover peer support if they see value in it.<sup>6</sup>

### ***Substance Use Disorder Funding***

DSHS funds a variety of treatment organizations and a number of community-based organizations to provide SUD recovery services. Although adult SUD services were added to the Medicaid state plan in 2011, SUD providers cannot bill Medicaid directly for the services of PRSs. However, one peer-run recovery community organization (RCO) was able to negotiate a contract through ValueOptions<sup>v</sup> to provide SUD recovery services, including peer support, to indigent patients in Medicaid Managed Care.<sup>vi</sup>

The Substance Abuse Prevention and Treatment (SAPT) Block Grant from the Center for Substance Abuse and Prevention at the Substance Abuse and Mental Health Services Administration continues to be a major source of funding for substance abuse prevention and treatment services in Texas, including peer support.

### **Models of Care: Mental Health**

We interviewed staff and administrators at one Consumer-Operated Service Provider (COSP), one LMHA, and one state hospital for this study. Treatment organizations, particularly state hospitals, were initially developed to provide treatment services to those in acute need. MH COSPs are primarily non-clinical in nature and focused on long-term recovery.

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<sup>v</sup> A behavioral health managed care organization.

<sup>vi</sup> This is partially due to a special 1915(b) waiver that carved out behavioral health services in the Dallas area where ValueOptions provides capitated coverage.

There is both cooperation and competition between consumer-operated service providers (COSPs) and local mental health authorities (LMHAs) around CPS employment. While some COSPs initially contracted out peer support services to treatment organizations, some treatment organizations started their own peer employment programs, eliminating a revenue source for COSPs and sometimes hiring away their peer support staff with the promise of higher wages and more secure employment.

Peer support staff must be supervised by a licensed practitioner of the healing arts (LPHA) (e.g. physician, advanced practice nurse, licensed clinical social worker, licensed marriage and family counselor, or a licensed professional counselor).<sup>14</sup>

### ***Roles***

At all 3 organizations visited, administrators and CPSs talked of the necessity of building relationships with both consumers and clinical staff within and outside of the organization. At 2 organizations, peer support staff spent some of their time orienting new clinical staff to the role of peers in the organization. Other peer responsibilities and tasks included facilitating peer support groups either in the community or on-site; teaching WRAP (Wellness Recovery Action Plan), WHAM (Whole Health Action Management) and other consumer education classes; meeting with treatment/recovery teams with consumers; organizing activities such as cooking, art, exercise, or meditation classes; staffing a telephone “warm line”; providing employment support; assisting with housing placement; teaching independent living skills; and offering some one-on-one work with consumers. One agency included programs focused on nutrition and teaching consumers how to buy and cook healthy food on a limited budget. CPSs also worked in transitional housing assisting individuals coming out of crisis and state hospital stays with finding jobs and housing and community resources.

At the COSP we visited, volunteers are extremely important to daily functioning due to lack of funding. Roles within COSPs are often fluid: office staff may be in recovery and provide some peer support; people receiving services might become volunteers or board members; volunteers might become staff if a position opens up; and all staff may provide some peer support as needed.

### ***Acceptance by Colleagues in Organization***

Within mental health treatment-oriented organizations, CPSs generally felt accepted by colleagues but some noted that it had been a struggle to gain respect. While CPSs were reported to have very low turnover rates, provider staff had high

turnover, which required ongoing orientation of new clinical staff to the role of peers in the organization. Some state hospitals are engaged in teaching health professions students, and peers are highly engaged in educating students about the roles of peer providers, both in general and specifically within the hospital. Some CPS noted that understanding of their roles has improved, partially due to having supervisors with lived experience. In the COSP, CPSs generally felt accepted but noted that some licensed counselors in collaborating agencies were concerned that the lower-paid CPSs would take their jobs.

### ***Impact on Colleagues and Roles in Organization***

Interviewees at one treatment-oriented agency noted that clinical staff's valuation of the peer role had changed as a result of observing increased activation and engagement of individuals in treatment as a result of peer support. The CPS could serve as an advocate and had more leeway, according to one interviewee, to "shake the boat" on the consumer's behalf because the CPS was not directly supervised by the provider staff.

Those interviewed believed that including CPSs on staff had many benefits for treatment-based organizations, including the ability of CPSs to engage people who were frightened, suspicious, and brought in involuntarily. As one CPS noted, "We're people that people will actually talk to." CPSs also served as translators of the consumer experience to the clinical staff. Finally, the treatment-based agencies we visited were able to provide evidence of positive outcomes resulting from CPS employment, including decreased use of restraints.

### ***Training/Knowledge Gaps Identified***

Most CPSs noted that the knowledge gained from the trainings was very useful, but several noted that the most important learning took place from applying what they learned in the field. Many peer providers in mental health received on-the-job training or at least did job shadowing prior to certification. This experience was generally required to apply for certification.

There is greater demand for the ViaHope certification course than space available. ViaHope offers training irregularly, and some service organizations reported difficulty obtaining training for individuals they thought were good candidates for employment as CPSs.



### ***Professional Development and Career Aspirations***

Some interviewees were concerned that because CPSs had few advancement opportunities except CPS supervisor positions, they might leave the field to become licensed social workers or counselors. As a result, three new positions—Certified Per Specialist I, II, and III—were added to the state job classification system in 2015. While these classifications currently pertain to the state hospital system, they provide standard job descriptions and salary ranges that can be used as a model by other employers.

### ***Implications for Integration with Physical Health***

Integration of mental health with primary care is reportedly a very new concept in Texas. According to state representatives, a major change is starting with the passage of Texas SB 58 in 2014, which requires targeted case management and mental health rehabilitative services be integrated within Medicaid managed care rather than being strictly provided through the LMHAs. This change was made to allow behavioral and physical health integration for individuals requiring both types of treatment.<sup>15</sup>

However, it is not clear how this will impact CPS employment. ViaHope provides Peer Specialist Whole Health and Resiliency endorsement training to prepare CPSs to assist consumers in setting and achieving health goals around self-care, stress management, exercise, and nutrition. Interviewees look to the state's success with Community Health Workers and *promotoras*, lay members of Hispanic/Latino communities who provide basic health education, as a model.

### **Models of Care: Substance Use Disorders**

Peer-led service providers were part of the driving force behind the state's adoption of a statewide recovery-oriented system of care (ROSC) and peer recovery support specialist (PRS) training and certification. These peer-led organizations are primarily oriented towards long-term recovery. Many peer-led SUD service providers also provide PRS training programs, so they play a role in both expanding peer employment to treatment organizations and employing PRSs directly. These organizations receive referrals from jails, drug courts, treatment centers, hospitals, and, in one case, an MCO.



Both peer-led organizations we visited are recovery community organizations (RCOs).<sup>vii</sup> As such, they depend upon both volunteer and paid PRS staff.<sup>17</sup> Some volunteer PRSs are interested in long-term employment in the field. Other volunteers are more interested in maintaining their recovery and community, and giving back to that community, rather than in obtaining employment. Volunteer hours can be used to fulfill the 500 hours of work experience required for designation or certification. Both organizations also provided community meeting space, both formal and informal, along with providing their own services.

### ***Roles***

At one organization, many PRSs worked offsite, meeting with recoverees in the community at places of work, cafes, homes, drug courts, jails, and sober living houses. At the other organization, in-house one-on-one peer mentoring and group work were more common, although PRSs also attended the drug courts with recoverees, worked as navigators with the dually-diagnosed at a psychiatric hospital, and, in one case, was working as a recovery coach at a community clinic. Interviewees described activities such as one-on-one resourcing, including creating a recovery plan with recoverees using motivational interviewing; navigation such as helping those hospitalized find a place to live and reintegrate into the community; and group work such as leading support and education groups as well as some wellness coaching. PRSs also led support and recovery education classes. In one organization that did bill an MCO for peer support, PRSs were also responsible for billing documentation. While there is not an extensive career ladder, there are some supervisor and coordinator roles for PRSs in the organizations we visited.

PRSs were very well-versed in describing their roles and the boundaries of the coach role. As one explained, "I relate my own recovery experience. I don't try to counsel. I tell them, 'You might need to talk to someone with more experience and professional skill than I have'... We know that they are not just looking to us to help them and we will send them to (an external partner) if they need counseling."

### ***Acceptance by and Impact on Colleagues in the Organization***

Within both RCOs, the primary service provided by PRSs was recovery coaching. PRSs indicated that they were well accepted within the organization, but noted that

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<sup>vii</sup> 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).<sup>16</sup>

some licensed chemical dependency counselors (LCDCs) they encountered in other organizations felt threatened by them. They noted that they were trained to advocate for their role with collaborator organizations, explaining their role as a supplement rather than a replacement for clinical services. Treatment organizations reportedly have more difficulty starting their own peer-based programs due to the culture shift required.

Non-PRS staff noted that one of their own roles was to facilitate an environment in which the key service of recovery coaching could take place. One administrator noted, “It is like that metaphor where you put some big rocks in a jar—the groups and the coaching are the big rocks, but me and the staff, we are the water that fills in around them and touches everything.”

PRSs were encouraged to take care of themselves in what can be a stressful job. Supervision and group meetings to share concerns were part of support for the peer role. However, one interviewee noted that the low pay could undermine self-esteem and legitimacy as a role model for recovery.

### ***Training/Knowledge Gaps Identified***

PRS staff and administrators did not identify training gaps per se. All talked with enthusiasm about their training and anticipated doing more targeted training, including CPS training and CEU courses in WRAP and trauma-informed care. Some PRSs noted that the PRS experience could help them get into an academic program in counseling, but expressed trepidation about the different role expectations of licensed staff.

Many interviewees noted that MH and SUD advocates and trainers at the community and state level had collaborated to develop a co-occurring disorders curriculum for CPS and PRS taught by an instructor from each field. As one PRS who had taken the course noted, “What is hard is knowing how big the MH versus SUD parts are in their (consumers’) behavior. There are crisis calls, police calls...it is easier to work with just addiction rather than mental health AND addiction.”

### ***Professional Development and Career Aspirations***

The organizations that participated in this study were small and had few advancement opportunities for PRSs. Administrators noted that recoverees could become employed as PRSs, and that PRSs could become PRS supervisors, but there was not yet a defined career ladder. Some interviewees said that this experience

could help them with applications to social work programs and other educational opportunities.

### ***Implications for Integration with Primary Care***

We did not see much integration of peer support with primary care during this visit. However, one group had placed a PRS within a federally qualified health center and also employed a PRS who was cross-trained as a CHW who could assist with health education and monitoring.

### **Implications for Policy**

Texas has attempted to develop a statewide recovery-oriented system of care in both MH and SUD despite the geographic scale of the state, limited funding, and some political resistance from counseling groups. A statewide behavioral health workforce shortage and low rates of funding for behavioral health services have helped facilitate the interest in a peer workforce.

The fields of mental health and substance use disorders remain siloed in Texas. Some feel that this division is a strength because it allows each field to remain autonomous and retain its unique culture; others cite it as a failure to capitalize on the synergies of the 2 overlapping areas. Each has adopted best practices based on models in their respective fields, with MH adopting the Georgia model with a central training and certification body, and SUD the Connecticut model of ever widening rings of trainers and volunteers who create a community that continues beyond treatment and into recovery.

Public mental health has benefited from a strong partnership between individuals in DSHS, the Hogg Foundation, advocates, and the University of Texas, Austin. This partnership has allowed the coalition to develop a systematic, statewide approach to peer provider training and certification and conduct extensive evaluation on outcomes and conditions. This has helped bolster the case for MH peer support and resulted in greater political legitimacy and legislative support. ViaHope, the TTAC formed to develop and conduct CPS training and certification, has been able to build on this unitary vision by developing technical assistance for agencies to adopt a recovery-oriented framework that allows successful deployment of a peer support program.

Peer providers in SUD have benefited from strong advocacy by the RCOs, which were involved in developing training and certification standards for PRSs. SUD treatment in Texas has adopted a dispersed training structure. By putting

certification in the hands of the TCBAP, the SUD coalition has been able to achieve a level of accountability for the PRSs, statewide standards, and some reciprocity across state lines. The DSHS Substance Abuse Unit was also able to require that funded organizations in the Texas Recovery Initiative hire PRSs. The SUD coalition has also partnered with the University of Texas, Austin, for evaluation research that may help make the case for the efficacy of SUD peer support. However, this initiative is still in its pilot phase. A significant challenge for SUD organizations implementing peer support has been the fluctuating nature of grant funding.

Advocates from both fields intend to use evaluation data to support legislation to designate PRSs and CPSs as Medicaid-billable provider types in order to further legitimize and expand the role of peer support in behavioral health. Leaders in MH and SUD peer support also are actively engaged in facilitating the integration of peer providers into primary care and other settings, which will likely lead to greater utilization of peer providers in Texas.

## **Sites Visited**

- Association of Persons Affected by Addiction (APAA) – Dallas
- Communities for Recovery — Austin
- Division of Mental Health Services and Substance Use, Texas Department of State Health Services — Austin
- Division of Mental Health Services and Substance Use, Texas Department of State Health Services, Substance Abuse Program Services Unit, Austin
- ViaHope Texas Mental Health Resource — Austin
- Bluebonnet Trails Community Services – Round Rock and Bastrop
- Austin Mental Health Consumers Network (AAMHC) — Austin
- Austin State Hospital — Austin
- Texas Certification Board of Addiction Professionals — Houston (via phone)

## **Acronyms Used in this Report**

APAA – Association of Persons Affected by Addiction  
CCAR - Connecticut Community for Addiction Recovery  
CEU – Continuing Education Unit  
COSP – Consumer-Operated Service Program  
CPS – Certified Peer Specialist  
DSHS - Department of State Health Services  
IC&RC - International Certification and Reciprocity Consortium  
LMHA – Local Mental Health Authority  
LPHA - licensed practitioner of the healing arts  
MCO – Managed Care Organization  
MH – Mental Health  
MHBG – Mental Health Block Grant  
PRS - Peer Recovery Support Specialists  
RCO – Recovery Community Organization  
ROSC – Recovery-Oriented System of Care

SMI – serious mental illness  
SPA – State Plan Amendment  
SUD – substance use disorder  
TAY – Transition Age Youth  
TCBAP -Texas Certification Board of Addiction Professionals  
TTAC - Technical Assistance Center  
WRAP – Wellness Recovery Action Plan

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