Assessing Peer Specialist Integration in Texas

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Background

Peer specialists are individuals in the workforce who are in recovery from mental health issues and use their experiences to support people receiving services (Davidson, Chinman, Sells, & Rowe, 2006; Gates & Akabas, 2007). Recent research suggests that peer specialists improve outcomes for people with mental health issues by increasing engagement and activation in services (Craig, Doherty, Jamieson-Craig, Boocock, & Attafua, 2011; Druss et al., 2010), reducing hospitalizations (Clarke et al., 2000) and increasing socialization (Craig et al., 2011; Rivera, Sullivan, & Valenti, 2007). In a recent Texas Health and Human Services Commission (HHSC, 2016) survey of providers and people receiving services in the Texas state behavioral health system, respondents ranked the availability of peer services as one of the top strengths of the current behavioral health system; however, the survey also identified limited access to peer services as a service gap.

Peer specialists make significant contributions to recovery-oriented services, but these contributions are limited when they are not adequately integrated into the organizations where they work (Gates & Akabas, 2013). Effective workplace integration and job satisfaction are critical to the success of the peer provider workforce, particularly as the peer role requires balancing a supportive peer relationship with the clinical standards and boundaries of traditional providers (Davidson et al., 2006; Grant, Reinhart, Wituk, & Meissen, 2012; Kuhn, Bellinger, Stevens-Manser, & Kaufman, 2015).

Access to peer specialists is best assured when organizations engage in a process of strategic integration. Research suggests that the following facilitate peer specialist integration: educating non-peer staff about recovery and the benefits of peer support (Ahmed, Hunter, Mabe, Tucker, & Buckley, 2015), organizational policies guiding recruitment and hiring of peer specialists (Gates & Akabas, 2013), organizational guidelines about confidentiality and boundaries (Ahmed et al., 2015), a clearly defined role for peer specialists and appropriate supervision to that role (Ahmed et al., 2015; Cabral, Strother, Muhr, Selfton, & Savageau, 2014; Davis, 2013; Kuhn et al., 2015) and leadership support (Gates & Akabas, 2013).

The Texas Department of State Health Services (DSHS) contracted with the Texas Institute for Excellence in Mental Health (TIEMH) to evaluate peer specialist integration within the Texas state mental health system. To do this, TIEMH employed a qualitative and quantitative approach that:

- Administered a survey to employees of 39 local mental health authorities (LMHAs) and 9 psychiatric hospitals; and
- Conducted four focus groups with peer and non-peer employees from across Texas.

To provide insight into peer specialist integration in Texas, data collection efforts focused on examining six domains of peer specialist integration (the first five of which have been identified by Via Hope and the research literature). The six domains include:

1. organizational culture;
2. funding;
3. recruitment, hiring, and training;
4. role clarity;
5. supervision and career advancement; and
6. collaboration between peer specialists and other employees.

This report includes five sections: the statewide survey methods and results; the focus group methods and results; discussion; limitations; and recommendations.

Statewide Survey Methods

Distribution

In April and May 2016, TIEMH evaluators administered a survey to assess peer specialist integration within the state public mental health system. Evaluators developed the survey utilizing Qualtrics, a secure web-based survey platform (Qualtrics, LLC, 2016). DSHS distributed the survey in an email through DSHS' Broadcast Message system to all LMHA executive leadership and state hospital superintendents. The email described the purpose of the anonymous survey, provided a link to the survey, and requested that organizational leadership forward the survey to all staff (a snowball sampling technique). Survey distribution relied on the organization's leadership and as a result the total possible sample and exact response rate is unknown.

Measures

Based on their job role, the survey directed respondents to answer different questions as not all questions were appropriate for all job roles. Survey items measured demographics (age, gender, race, and ethnicity), organizational information (organizational type and whether peer specialists are employed at respondents' organization), employment characteristics (job role, employment duration, status as supervisor and job roles supervised, whether or not respondents work directly with people receiving services, number of people to whom services are provided on a weekly basis), and peer specialist integration in six domains: organizational culture; funding; recruitment, hiring, and staff training; job role clarity and job satisfaction; and, supervision of the peer specialist job role and career advancement (items by domain are described below). For a complete list of survey measures, please see Appendix A.

Organizational culture. Several items measured indicators of organizational culture: level of (dis)agreement that peer specialists are well integrated at the organizational level; level of (dis)agreement that services are recovery-oriented at the organizational level using a 13-item revised version of the Recovery Self-Assessment survey instrument (TIEMH, 2015); the frequency that boundary issues arise between peer specialists and people in services; the frequency that boundary issues arise between peer specialists and non-peer staff; the frequency that peer specialists are accepted at the organizational level; the frequency that policies at the organizational level create barriers to peer specialist integration; the frequency that peer specialists are included in organizational meetings; and the frequency that peer specialists serve on important organizational committees. All respondents, regardless of job role, were asked to respond to these organizational culture indicators.

Non-peer staff were also asked several questions that tap into the issue of staff buy-in: they were asked to indicate their level of (dis)agreement that they personally value the roles and activities of peer specialists; their level of (dis)agreement that their organization's staff value the roles and activities of peer specialists; their level (dis)agreement that they are concerned about the employment of peer specialists at their organization; their level of (dis)agreement that peer specialists are valuable members of the treatment teams; and their level of (dis)agreement that peer specialists increase the effectiveness of care.

Funding. Organizational leadership and human resources personnel were asked to respond to an open-ended question about what funding sources for peer specialists are currently being used at their organization.

Recruitment, hiring and staff training. Several items measured indicators of recruitment, hiring, and staff training. The following questions were administered to all survey respondents (regardless of job role): level of (dis)agreement that new staff training includes information about peer specialists and level of (dis)agreement that the organization would like to hire more peer specialists. Additionally, peer specialists, administrative staff, and human resources personnel responded to an item measuring whether or not newly hired peer specialists shadow current employees for a period of time. Administrative and human resources staff also responded to a question measuring what required qualifications exist for the peer specialist job role at their organization (respondents were able to select any of the following: must be recovering from a mental health condition, must be a certified peer specialist, must have a work history meeting minimum requirements [computer skills, communication skills], must have experience working in the mental health field, and must not be former utilizers of services at this organization) as well as a question about whether or not their organization has written policies regarding recruitment processes for peer specialists.

Job role clarity and job satisfaction. Data collected from peer specialists included employment status (full-time, part-time, contract or volunteer), duration working as a peer specialist at the organization, whether or not a job description exists for their position, what job duties they regularly perform, how frequently they understand what is expected of them in their job role, how frequently they are clear about how much authority they have, how frequently they receive requests incompatible with their job role, and how frequently they work on tasks not related to their job description. Peer specialists were also asked to indicate their level of (dis)agreement that they are able to work autonomously, level of (dis)agreement that their work is important and meaningful, level of (dis)agreement that they are confident in their ability to do their job. Additionally, peer specialists were ask to indicate how satisfied they are with their overall job experience and on a scale from one to ten indicate non-peer support staff's overall understanding of their job role and overall supportiveness of their job role.

Non-peer staff were asked to indicate their level of (dis)agreement that they personally understand the roles and activities of peer specialists and their level of (dis)agreement that their organization's staff understand the roles and activities of peer specialists. Administrative and human resources staff were also asked whether or not policies exist to distinguish the peer specialist role from non-peer specialist roles.

Supervision of the peer specialist job role and career advancement. Data collected from peer specialists measured whether or not they receive supervision specific to their job role, how frequently they receive supervision, their supervisor's job title, how supportive their supervisor is on a scale from one to ten, and their supervisor's overall understanding of their job role on a scale from one to ten. Peer specialists were also asked to indicate their level of (dis)agreement with the following: their supervisor helps them solve work-related challenges, their supervisor treats them like a colleague, and they feel comfortable approaching their supervisor about work-related challenges. Finally, peer specialists were asked to indicate whether their organization offers opportunities for career advancement in their job role.

Supervisors of peer specialists were asked to indicate their level of (dis)agreement with the following: they monitor whether peer specialists are integrated into treatment teams and they provide training and ongoing support in their role as a supervisor of peer specialists. Both peer specialists and supervisors responded to items that measured level of (dis)agreement in the following areas: that co-supervision occurs, the supervisor shows interest in the peer specialists' career goals, the supervisor supports the peer specialist obtaining additional training or education to further their careers, and the supervisor provides opportunities to develop and strengthen new skills.

Collaboration between peer specialists and non-peer staff. Peer specialists and non-peer staff who provide direct services to people in services were asked to indicate how frequently peer specialists and other direct care staff collaborate, how frequently peer specialists attend treatment planning meetings, how frequently peer specialists actively participate in treatment planning meetings, and how frequently direct care staff refer people in services to peer specialists. Administrative staff and human resources personnel were also asked to indicate whether policies exist to incorporate peer specialists into treatment processes and whether policies exist to mediate conflicts among staff. Non-peer staff were also asked to indicate their level of (dis)agreement that peer specialists are equal members of treatment teams.

Organizations that did not employ peer specialists. Data collected from respondents from organizations with no peer specialists asked all staff the following questions: an open-ended question assessing how they think peer specialists could benefit their organization; a question about whether or not survey respondents think that peer specialists could be integrated into the activities of their organization; an open-ended question about what barriers respondents think prevent peer specialists from being integrated into their organization; a multiple-response choice question about barriers to hiring peer specialists; and an open-ended question about what resources respondents think would help integrate peer specialists into their organization.

Analysis

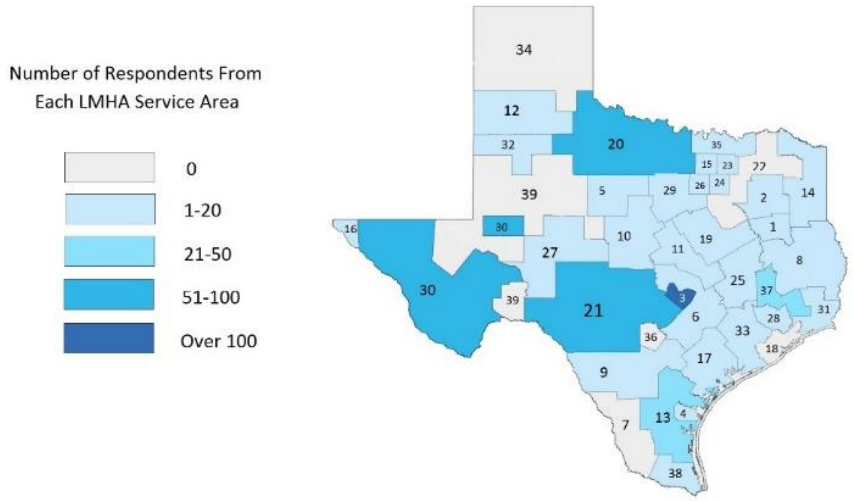
Survey data were exported directly from Qualtrics online survey software into SPSS data file format (.sav). Data were then cleaned and analyzed using IBM SPSS ver. 23. Duplicate respondents were excluded from analysis. Results of descriptive analysis are presented in this report.

Respondents

727 respondents from over 64 different organizations representing 32 LMHA service areas completed or partially completed the survey. The respondent organizations exceeded the initial organization sample as some recipients forwarded the survey to organizations that employ peer specialists but were not LMHAs or state hospitals (these are represented in the 6.5% other organizations). The actual response rate is unknown, as the number of people employed by the organizations and receiving the survey link is unknown. See Figure 1 for a map of respondents by LMHA service area. Most respondents worked at state hospitals (51%), followed by 42.6% at LMHAs and 6.5% at other types of organizations.

Figure 1. Number of respondents by LMHA service area

Job Roles. The most common job roles reported by survey respondents were 1) administrative support (17.6%), 2) executive leadership (12.8%), 3) other clinical or direct care staff (12.2%), 4) nurses (9.3%), and 5) peer specialists (8.8%). A slight majority (63%) of peer specialist staff respondents were full-time employees.



Note: See https://goo.gl/Rt88KB for service areas key

Emerging Workforce. Most (76%) peer specialist respondents had been employed at their current organization for less than three years at the time of the survey, whereas a majority (69%) of non-peer specialist respondents had been employed at their current organization for three years or more.

Respondent Characteristics. Survey respondents were primarily women (70.4%), over the age of 40 (70.4%), and White (76.8%). About one-fifth (21.4%) reported Hispanic ethnicity. See Table 1 for complete demographic information of survey respondents.

Table Respondent Characteristics (n=727)

Variable		Percentage
Gender	Female	70.4
	Male	29.3
	Not Listed	0.3
Age	18-25	3.2
	26-39	26.4
	40-55	41.5
	56 or older	28.9
Race	American Indian or Alaska Native	2.5
	Asian	1.4
	Black or African American	9.2
	Native Hawaiian or other Pacific Islander	0.4
	Other	5.9
	White	76.8
Ethnicity	Hispanic	21.4
	Non-Hispanic	78.6

Statewide Survey Results

Results of the survey that are presented below are organized by the peer specialist integration domains. See Appendix B for complete survey results presented in tabular format.

Organizational Culture

Recovery orientation / Readiness. Overall, survey respondents rated the recovery orientation of services at their organization highly (M(SD)=4.1(.65) on a 5-point scale). There was no difference in ratings between peer staff (M=4.1) and non-peer staff (M=4.1). Most (83%) reported that peer specialists were accepted at their organizations, though only 46% reported that peer specialists served on important organizational committees at their organizations. Peer specialist integration can only be successful at organizations which support recovery, in philosophy and in action.

Most (84%) respondents agreed or strongly agreed that they value the roles and activities of peer specialists, and 75% agreed or strongly agreed that peer specialists increase the effectiveness of care. These beliefs are important indicators of readiness for peer specialist integration.

Over half (59%) of respondents who were working at organizations that did not employ peer specialists reported that they thought peer specialists could be integrated into the activities of their organization. Among all respondents, only 41% had attended trainings or meetings that focused on the integration of peer specialists indicating a need to further disseminate integration trainings and implementation efforts.

Peer specialist job satisfaction. Peer specialists were asked how satisfied they were with their overall job experience. The majority (78%) were satisfied or very satisfied. Mean satisfaction for these 50 respondents was 4.08 (SD=1.0).

Integration. When asked whether they felt peer specialists were well integrated into their organizations, 58.7% of respondents agreed or strongly agreed. However, this indicates that 40% believe integration could be improved. Overall mean agreement with this statement was M=3.55 on a scale of 1 to 5 (SD=.99). The respondent subgroup in least agreement with this statement was nurses (n=40, M=3.2, SD=.96), while the respondent subgroup that agreed most with this statement was recovery coaches (n=10, M=4.1, SD=.57).

Recruitment and Hiring

Full-time versus part-time. A majority of peer specialist respondents were employed full time (≥32 hours per week; 63.9%), 33.3% were employed part-time, and 3.8% were working as contract employees (primarily peer specialists working in state hospital settings).

New-hires. While formal aspects of new-hire integration into the workplace such as having a job description or policy manual are essential, other aspects such as a mentoring/shadowing relationship with a seasoned staff member is necessary to introduce the new employee to the norms and rituals of the organization, as well as to reinforce learning of formal policies and procedures. Three quarters (75.9%) of respondents reported that their organizations demonstrated this type of integration indicator by having new employees shadow current employees for a period of time before working independently.

New employee orientation. Only about half (53.5%) of survey respondents reported that their organization had information about peer specialists included in their new employee orientation. Inclusion of this information might speed integration indicators such non-peer staff referral of people in services to peer specialist-provided services. However, even if every organization shared information about peer specialists in new employee orientation, on-the-job training may still be needed to link new employees to peer specialists and peer-provided services.

Barriers to hiring and training/technical assistance needs. The most commonly reported barriers to hiring peer specialists were: 1) funding, 2) lack of knowledge about peer specialists, and 3) knowing how to integrate the role within the organization. These barriers indicate opportunities for technical assistance to be provided to organizations in the areas of peer role integration, role clarity, collaboration, and untapped funding sources (e.g., technical assistance in

documentation and supervision requirements to receive Medicaid reimbursement for services provided by peer specialists).

Role Clarity

Job tasks. The five job tasks most frequently performed by peer specialists were 1) helping people advocate for themselves (100%), one-on-one support (98.1%), connecting people in services to resources/networking (96%), goal-setting (96%), and advocacy (92.3%).

About half (52%) of peer specialists reported that working on treatment teams was one of their job tasks. Forty percent of non-peer specialist survey respondents report that peers never or rarely attend treatment planning meetings. Further, when they do attend, 42.6% reported that peers never or rarely actively participate in the treatment planning meetings.

Job description. Most (92.6%) peer specialists reported that their employing organization had a job description for their role as a peer specialist, while 7.5% did not have a job description or were unsure whether they had one. Having a job description is an important aspect of integration by formalizing and professionalizing the role. However, ongoing on-the-job training is still necessary to translate the job description from paper to practice.

Understanding of the peer specialist role. Peer specialist respondents rated non-peer staff's understanding of the peer job role at 6.8 out of 10. From the non-peer perspective, about 83% of non-peer staff agreed or strongly agreed that they understand the roles and activities of peer specialists.

Nearly all respondents who were supervisors of peer staff (n=47) agreed or strongly agreed (98%) that they helped non-peer staff understand the role of peer specialists. Approximately 80% of peer specialist respondents agreed or strongly agreed that their supervisors helped non-peer staff understand the role of peer specialists. About 80% of peer supervisors reported they had attended trainings focused on the integration of peer specialists.

The average number of people served per week by staff that work directly with people in services was similar between peer specialists and non-peer staff (Table 2).

Table 2 Number of people served per week

Number served per week	Peer staff	Non-peer staff
1 to 9	31.5%	35.8%
10 to 19	24.1%	21.5%
20 to 29	22.2%	19.0%
30 or more	22.2%	23.7%

Supervision and Career Development

Supervision. Over one-third (34%) of peer specialist respondents reported that they were supervised either by other peer specialists or by staff whose job title was specific to peer support supervision. This is an important aspect of workplace integration because a supervisor should have a strong understanding of their employees' job roles. Ideally, that understanding would come from having been in that role. The practice of peer specialists being supervised by other (or former) peer specialists would also remedy the problem of inadequate supervision – a surprising 12% of peer specialist respondents reported that they did not receive supervision related to their role as a peer specialist.

Career advancement. Only 41.2% of peer specialist respondents reported that their organization offered opportunities for career advancement in their job role (21.6% were not certain), compared with 56.4% of all other employees (14% not certain). Further, about 30% of peer specialists disagreed or strongly disagreed that their supervisors asked them about their career goals and aspirations. Regardless of role, staff retention and satisfaction may be increased when an organization offers opportunities for career development (whether through mechanisms such as career ladders or lattices, new or advanced skill development, or salary increases).

Collaboration

Referrals. More than one quarter (28%) of non-peer specialist respondents report that they never or rarely refer people to peer specialists. This indicates opportunity for better workplace integration. Specifically, a greater degree of collaboration between peer specialists and other staff is likely to increase referral rates and the overall effectiveness of recovery-oriented services.

Collaboration. Survey respondents indicated that there is room for improvement regarding collaboration between peer specialists and other staff as 33.3% of direct care staff reported that they never or rarely collaborate with peer specialists, while only 16.5% reported collaborating daily with peer specialists. When peer specialist survey respondents were asked how often they collaborated with non-peer staff, 67.9% indicated that they did so on a daily basis while only 3.8% reported rarely or never doing so. Regarding the quality of these collaborative interactions, peer specialist respondents rated the supportiveness of non-peer staff as 7.4 out of 10. Opportunities for peer specialists to collaborate with other peer specialists could also be increased: 33.4% of peer survey respondents reported that they never or rarely collaborate with other peer specialists.

Although the number of peer specialists employed by mental health organizations has increased, collaboration and referral may also be impacted by the number of peer specialists who are employed by the organization. If there are few peer specialists working at an organization, this decreases opportunities for referral and collaboration.

Focus Group Methods

In March and April 2016, evaluators conducted four focus groups with N=51 staff members at public mental health organizations across Texas to assess peer specialist integration across the state. These focus groups coincided with Via Hope's Regional Recovery Immersion workshops which took place in Brownsville, Irving, Bryan/College Station, and Lubbock, Texas.

Recruitment

Via Hope provided evaluators with a list of registrants for their regional workshops. Evaluators then used stratified random sampling methods to select a representative number of individuals from community centers and hospitals with employed peer specialists as well as to select a representative number of individuals employed in leadership roles, peer specialist supervisory roles, peer specialist roles, and clinical roles. In an initial round, ten individuals were chosen for each focus group. These individuals were then contacted to determine if they would like to participate. Next, this process was repeated in a second round of invitations to participate (also consisting of ten invitations, except in the case of the Bryan/College Station focus group wherein only six individuals were invited to participate in the second round).

Table 3 below depicts the percentage of invitees who participated as well as the total number of participants in each focus group. In a few cases, individuals who were not invited to participate in the focus groups requested to do so and these participants are also denoted in the table below.

Table 3 Focus Group Participants

Focus Group	Round 1 (% participated)	Round 2 (% participated)	Additional Participants	Total N
Brownsville	60% (n=6)	70% (n=7)	0	13
Irving	30% (n=3)	60% (n=6)	2	11
Bryan/College Station	60% (n=6)	80% (n=5)	3	14
Lubbock	40% (n=4)	80% (n=8)	1	13

Table 4 lists the number of participants from each focus group whose primary organizational role is peer specialist; peer specialist supervisor; clinical; or leadership/administrative staff. At times these roles were overlapping (e.g., a peer specialist supervisor who also serves in a leadership capacity); in such cases participants were categorized by their primary role.

Table 4 Organizational Roles

Focus Group	Peer Specialist (n)	Peer Specialist Supervisor (n)	Clinical (n)	Leadership (n)	Total N
Brownsville	3	1	6	3	13
Irving	6	1	2	2	11
Bryan/College Station	4	3	2	5	14
Lubbock	6	0	5	2	13
Total	19 (37%)	5 (10%)	15 (29%)	12 (24%)	51 (100%)

Table 5 demonstrates the number of focus group participants from state hospitals, LMHAs, and other organizational-types (e.g., organizations serving homeless individuals, consumer-operated service providers). Eighty percent of participants were from LMHAs, limiting the ability to make comparisons across organizational-type.

Table 5 Organization Type

Focus Group	Hospital	LMHA	Other	Total N
Brownsville	5	7	1	13
Irving	0	9	2	11
Bryan/College Station	0	13	1	14
Lubbock	1	12	0	13
Total	6 (12%)	41 (80%)	4 (8%)	51(100%)

Data Collection

Focus groups were jointly moderated by two evaluators. Evaluators limited prompting unless discussions got off topic, one individual dominated the discussion, or clarifying questions were deemed necessary. Focus groups lasted approximately one and a half hours, and with participants' permission were recorded with a digital recorder and later transcribed. All participants were entered into a random drawing for eight $25 Amazon.com gift cards.

Focus group questions were developed by evaluators to gather data from participants on four key topics:

1. Indicators of peer specialist integration at participants' organizations;
2. Resources that have facilitated peer specialist integration at participants' organizations;
3. Needs and barriers to peer specialist integration at participants' organizations; and
4. Future plans related to peer specialist integration at participants' organizations.

Discussion of these broad issues were guided by the six domains of peer specialist integration: organizational culture; funding; recruitment, hiring, and staff training; role clarity; supervision and career advancement; and collaboration between peer specialists and other staff (Via Hope Texas Mental Health Resource, 2012). For a list of open-ended questions used to guide focus group data collection, please see Appendix C.

Analysis

Analysis was guided by a grounded theory approach whereby codes emerged from the data and were not predetermined prior to analysis (Charmaz, 2006) and was completed using NVIVO qualitative data analysis software (QSR International, 2012). Codes were developed iteratively and constantly refined – that is some codes were merged while others were disaggregated as more data were analyzed. To establish validity and inter-rater reliability, three researchers were involved in the coding process (Campbell, Quincy, Osserman, & Pederson, 2013). First, one researcher independently coded one focus group transcript and created a coding scheme that was recorded in a codebook with precise and concrete definitions. This codebook with shared with two other researchers who then independently coded the same transcript. All researchers then met to compare coding line-by-line, refining codes until consensus was met. All three researchers then independently coded a second focus group transcript and then met again to compare coding line-by-line and refine the coding scheme. One researcher then independently coded the remaining two transcripts. Finally, researchers met to refine the final coding scheme. Codes were categorized into six domains of peer specialist integration – organizational culture; funding; recruitment, hiring, and staff training; role clarity; supervision and career advancement; and collaborative working relationships. Finally, a final category included miscellaneous codes that could not be categorized into the existing domains. Results on indicators of peer specialist integration; indicators of a lack of peer specialist integration or barriers to integration; and resources that have facilitated integration are presented in relation to these domains. Results on future plans regarding peer specialist integration are presented on their own.

Focus Group Results

Focus group results are organized and presented in three main categories: 1) indicators of peer specialist integration; 2) resources that have facilitated peer specialist integration; and, 3) needs/barriers to peer specialist integration. Each of the category's findings is organized by the domains of peer specialist integration (i.e., organizational culture; funding; recruitment, hiring, and staff training; role clarity; supervision and career advancement; and collaboration). A listing of the categories with each domain of integration and the codes within each domain is presented in Appendix D. Finally, a fourth category on future plans regarding peer specialist integration is presented.

Indicators of Peer Specialist Integration

Forty-six unique codes that were indicators of peer specialist integration emerged from analysis of the focus groups. These codes are presented below in relation to the domains of peer specialist integration.

Organizational culture. Ten codes related to organizational culture emerged from analysis: administration buy-in/support; an embrace of values of recovery/recovery orientation; the use of language supportive of recovery; engagement in recovery-oriented activities; peers attendance at social gatherings; staff buy-in; peers on advisory board/positions of authority; empowerment of people in services; people in services talk about/reach out for peer specialists; and informal staff education on peer specialists.

Administration buy-in/support. Sixteen individuals reported administration buy-in or support from administration as an indicator of peer specialist integration. For example, one peer specialist from an LMHA said: "From my perspective, I feel like from directors and up, they're very supportive and I think that they think that everybody in between us and them, for example clinic managers, supervisors…are kind of on board."

Embrace values of recovery/recovery orientation. Ten individuals reported that their organization embraces the values of recovery or a recovery orientation – that is, that individuals can recover from mental health challenges and live meaningful lives in their communities. For example, an individual in a leadership position at an LMHA noted that: "We've implemented a recovery thinking or recovery model, recovery planning...you know, when you move towards a recovery model individuals are making choices, we're not dictating treatment, we're allowing people to live their lives."

Language. Eight individuals reported that their organization uses language that is supportive of recovery. For example, an individual in a clinical role at an organization noted that: "I think recently we had it changed…we used to call it a treatment plan and now it's called a recovery plan so, you know, it's like 'recovery: you're gonna get better.'"

Recovery-oriented activities. Three individuals reported that their organization engages in recovery-oriented activities. For example, an individual in a leadership role at a state hospital explained that: "We do a lot of recovery-oriented activities from our recovery radio to our newsletter to our…we have an AIM room…we do a recovery picnic every year which basically is the entire staff and all of the people that live there with us, we share a meal together out on the grounds."

Peer specialists attend social gatherings. Three individuals reported that peer specialists attend social gatherings at their organization as an indicator of peer specialist integration. For example, a peer specialist from an organization that serves homeless individuals explained: "Birthdays are observed…'Let's go out as a case management team to Botanical Gardens.'"

Staff buy-in. Ten individuals reported staff buy-in as an indicator of peer specialist integration. For example, a peer specialist supervisor at an LMHA said: "Our executive director and most of the recovery coaches, the clinic directors get it [peer support]. So fortunately I work at a great agency."

Peer specialists serve in positions of authority. Five individuals reported that peer specialists serve on advisory boards or in other positions of authority (e.g., management positions within the organization). For example, a peer specialist from an organization that serves homeless individuals said: "We've actually got a peer that's on our board of directors now for the first time so we feel good about that."

Empowerment of people in services. Six individuals reported that people in services are more empowered as an indicator of peer specialist integration. For example, a clinician from a state hospital said that: "It seems like since peer support has become more integrated, our clients have become more empowered. I'm seeing lots of volunteerism. We have volunteers in the art studio. We have people mentoring other artists in the studio…all over the hospital they're helping each other and it's really cool to see."

People in services talk about/reach out for peer specialists. Three individuals reported that people in services talk about and reach out for peer specialists as an indicator of peer specialist integration. For example, a clinician from a state hospital said: "I see a lot, a lot, a lot of the patients and when they come in they're talking about peer support."

Informal staff education on peer specialists. Eight individuals reported instances of informal staff education (as opposed to formal trainings) on peer specialists as an indicator of peer specialist integration. For example, a peer specialist from a LMHA explained efforts to educate case managers on peer specialists: "I think the caseworkers do [understand what peer specialists do] because we started going to caseworker staffings and telling them what we do, telling them about outside programs and…trying to bring energy of you know, "Here's what we can offer."

Recruitment, hiring, and staff training. Ten codes related to recruiting and hiring peer specialists and training staff emerged from analysis: internal training on peer specialists; more peer specialists in organizations; new employee orientation incorporates training on peer specialists; organizations are recruiting peer specialists from people in services; peer specialists are trained and certified; referrals for new peer specialist hires come from employed peer specialists; peer specialists are internally trained; peer specialists receive benefits; peer specialists are paid employees (versus independent contractors or volunteers); and peer specialists are full-time employees.

Internal training on peer specialists. Six individuals reported that their organization provides trainings on peer specialists. For example, a clinician from a state hospital said: "Our supervisor has me do trainings when we do department meetings based on the trainings we received from Via Hope so I can condense them and do short ones periodically."

More peer specialists. Five individuals reported that the fact that their organization employs more peer specialists is an indicator of peer specialist integration. For example, a leadership participant from an organization that serves individuals experiencing homelessness reported: "Our first peer support was in 2013 and it was someone who …was hired with not really any direction. Where right now is upper 20s [number of employed peers]. There's no department that doesn't have a peer and in addition, doesn't have a certified peer."

New employee orientation incorporates training on peer specialists. Seven individuals reported that new employee orientation at their organization incorporates some training on peer specialists. In some cases, this training is provided directly by peer specialists. For example, a leadership participant from a state hospital explained: "I do the introduction on the first day and right out of the bag…it's like 'We do peer specialists. They're on our organizational chart, where they report, on the PowerPoint slide that shows the disciplines and how the individuals are categorized. Peer specialists are their own discipline.' And then later on within the new employee orientation process, the actual peer specialists come in and talk to the new employees."

Organizations recruit peer specialists from people in services. Seven individuals reported that their organization recruits new peer specialists employees from their people in services base. For example, a peer specialist from an LMHA explained: "We try to recruit within the center…we try and get our individuals that we know are strong ones that are in LOC 3 getting ready to go to LOC 1, they've done WRAP, they know how to manage their illness, they're really in their recovery."

Peer specialists are trained and certified. Seven individuals reported that the fact that peer specialists at their organization are trained and certified is an indicator of peer specialist integration. For example, a leadership participant from an LMHA explained: "One of the things that we've tried to do is make sure that we make any kind of training opportunity available and we encourage participation, you know, on the state-level and Via Hope and other opportunities for all of our peer specialists…you know the WRAP programs and all that. So we really make sure that that's a priority."

Referrals for new peer specialist hires come from employed peer specialists. Four individuals reported that peer specialists at their organization make referrals for peer specialist hires. For example, a peer specialist supervisor from an LMHA explained: "Referrals…there are certain peers…if they tell me 'Oh, John Smith is amazing, you should take my word.' I trust them…I trust their judgement and I go with that."

Peer specialists are internally trained. Three individuals reported that an indicator of peer specialist integration is that peer specialists receive on-the-job internal training at their organization. For example, a peer specialist from an LMHA explained: "And we're currently getting trained every week…on moving towards person-centered recovery planning…you know, how to write a recovery, strength-based goal and objectives."

Peer specialists receive benefits. Two individuals reported that an indicator of peer specialist integration is that peer specialists now receive benefits (e.g., healthcare, paid vacation). For example, a peer specialist from an LMHA explained: "I'm really proud of the resources that my agency has. My director is amazing…I'm a full-time employee with full benefits."

Peer specialists are paid employees. Four individuals reported that an indicator of peer specialist integration is that peer specialists are now paid employees at their organization (as opposed to independent contractors or volunteers). For example, a leadership participant from an LMHA explained: "I think they're integrated because they're paid employees and they're treated like a regular employee like everybody else."

Peer specialists are full-time employees. Similarly, three individuals reported that an indicator of peer specialist integration is that peer specialists are now full-time employees. For example, a peer specialist from a LMHA explained: "I came on as a part-time employee. I made the request to move to full-time…members of the executive leadership team said 'Bill for hours. Lots of hours.' So that's what I did…And I work full-time now."

Role clarity. Four codes related to role clarity emerged from analysis: there is a formal job description for peer specialists; peer specialists are integrated into the operations manual; peer specialists are fully utilized (i.e., they perform various duties that fall within the peer specialist role); and staff know what peer specialists do.

Formal job description. Six individuals reported that there is a formal job description for peer specialists at their organization. For example, a peer specialist supervisor from an LMHA explained: "Developing like mission statements, vision statements, clarifying job duties, going back through rewriting those, explaining those to the peers, things like that. That's really helped us define the peer program because before it was more like case management support."

Peer specialists are integrated into the operations manual. Two individuals reported that peer specialists are integrated into their organization's operations manual. For example, a person in a leadership position at an organization that serves individuals experiencing homelessness explained: "We re-wrote our operations manual so it's [peer support] also integrated throughout every practice of the manual including to the foundation of how we practice services."

Peer specialists are fully utilized. Ten individuals reported that peer specialists are fully utilized – that is they perform various functions that fall within their job description. For example, an individual in a leadership position at an LMHA explained: "Our peers are very much integrated in the sense that they're being utilized for different things. Not only the groups, individual one-on-one sessions with clients, our welcome wagon welcoming our clients that come from let's say other MHMRs, hospital discharges, or newly diagnosed…we're utilizing them with our primary care providers…they're actually performing assessments."

Staff know what peer specialists do. Nine individuals reported that non-peer specialist staff know what the peer specialist role entails. For example, a peer specialist from an LMHA explained: "Actually it's gotten better. The role clarity…I started going to the case managers' meetings and talking about peer support and what we can do for them. And so we're getting better referrals, more referrals, less unrealistic expectations, you know, doing the case managers' job or things like that."

Supervision and career advancement. Eight codes related to supervision and career advancement emerged from analysis: co-supervision and support among peer specialists; peer specialist is a professional position; peer specialists receive regular feedback/communication from their supervisor; peer specialists are now salary instead of hourly; peer specialists are supervised by another peer specialist; there is a career ladder for peer specialists; peer specialists are held to the same accountability standards as other staff; and peer specialists receive mentorship.

Co-supervision and support. Three individuals reported that peer specialists at their organization provide co-supervision and support to one another. For example, a peer specialist from a homeless services organization explained: "There's two ways of being supervised: from top-down and from a collegial point of view. We're put together as a team usually…four or five peers to work as a team in different areas and different programs. And we help each other…some are technically, administratively strong…and we help each other grow that way."

Peer specialist is a professional position. Two individuals reported that an indicator of peer specialist integration is that the peer specialist position is now considered a professional position. For example, a leadership participant from an organization that serves individuals experiencing homelessness explained: "We moved far ahead when we moved members with shared lived experience in a peer role as part of our professional team."

Peer specialists receive regular feedback/communication from their supervisor. Ten individuals reported that peer specialists at their organization receive regular feedback or communication from their supervisor. For example, a peer specialist supervisor from a state hospital explained: "We will meet once a week. We'll talk about if they have any issues going on the units…if we would like to start something new because you want them all to be on the same page… I will sit in on groups that they're facilitating and just watch the flow of the group and then try to give them guidance…use that as a review on their annual evaluations. And I will talk with the treatment teams to see what their feedback is as to the participation…trying to give them guidance from that and help them engage."

Peer specialists are salaried instead of paid hourly. Two individuals reported that an indicator of peer specialist integration at their organization is that peer specialists are now on salary instead of paid hourly. For example, a leadership participant from a homeless services organization explained: "This fiscal year changed it…we were hourly before, now they are salary. They have the salary increase, making it more of a professional position."

Peer specialists are supervised by another peer specialist. Four individuals reported that an indicator of peer specialist integration is that peer specialists at their organization are supervised by another peer specialist. For example, a leadership participant from an LMHA explained: "We have a director of peer services that oversees our entire peer support staff so he's also a peer."

Career ladder for peer specialists. Three individuals reported that an indicator of peer specialist integration is that there is a career ladder for peer specialists at their organization. For example, a clinician from an LMHA explained: "In terms of career advancement, I will say that they do promote that because you can start off as what we call a peer advocate… once you progress and you get licensed, you can actually move up to a peer educator or a peer specialist or peer navigator…so they do encourage that."

Peer specialists are held to the same accountability standards as other staff. Two individuals reported that an indicator of peer specialist integration is that peer specialists are held to the same accountability standards as other staff. For example, an LMHA peer specialist supervisor explained: "They're held to the same accountability standards…as the clinicians …timeliness…face-to-face time, things like that. They have to have supervision as often as the others do."

Peer specialists receive mentorship. Three individuals reported that an indicator of peer specialist integration is that peer specialists receive mentorship at their organization. For example, an LMHA clinician explained: "I treat them [peer specialists] like clinicians. We do weekly supervision…they're advocates for their positions and….I have them set…goals and…kind of an objective like…plan and we work toward them."

Collaboration. Nine codes related to collaborative working relationships between peer specialists and other staff emerged from analysis: case managers and other clinical staff refer people in services to peer specialists; doctors value and include peer specialists; non-peer staff keep peer specialists "in the loop"/regularly communicate; peer specialists are on quality improvement/ implementation/advisory teams; peer specialists attend staff meetings; peer specialists are treated like equal colleagues; peer specialists are part of treatment teams; clinical staff and peer specialists collaborate; peer specialists participate in the new employee interview process; and there are open, honest relationships between peer specialists and other staff.

Case managers and other clinical staff refer people in services to peer specialists. Seven individuals reported that case managers and other clinical staff regularly refer people in services to peer specialists. For example, a peer specialist from an LMHA explained: "I started going to the case managers' meetings and just talking about peer support and what we can do for them. And so we're getting better referrals, more referrals, less unrealistic expectations."

Doctors value and include peer specialists. Six individuals reported that doctors value peer specialists and include them in the treatment planning process. For example, a peer specialist from a state hospital explained: "I am integrated into the team, I am integrated into the unit…I am a part of that team and I'm needed as one of the doctors said to be in that team because…it empowers the patients when they see me sitting there and I'm listening and then the doctors are having me participate in their conversations."

Non-peer staff keep peer specialists "in the loop"/regularly communicate. Nine individuals reported that non-peer staff regularly communicate with peer specialist staff at their organization. For example, a peer specialist from a state hospital explained: "The doctors will CC [carbon copy] me. I CC them everything…our social workers: 'So and so had a really bad day, this is what happened,' and they send me a copy of their progress notes...it's a heads-up that maybe this patient needs a little bit more of my time."

Peer specialists are on quality improvement/ implementation/advisory teams. Seven individuals reported that peer specialists are on quality improvement, implementation, and/or advisory teams within their organization. For example, a peer specialist supervisor from a state hospital explained: "Peer support is being used on many of the quality improvement teams. They're on the restraint/seclusion teams. They're all over."

Peer specialists attend staff meetings. Thirteen individuals reported that peer specialists attend staff meetings. For example, a peer specialist supervisor from an LMHA explained: "They [peer specialists] come to all of our staffings, staff meetings, trainings."

Peer specialists are treated like equal colleagues. Nine individuals reported that peer specialists are treated like equal colleagues at their organization. For example, a leadership participant from an LMHA explained: "They [peer specialists] are seen as equal team members. They…contribute to PCRP and to staffings like anyone else would on a treatment team."

Peer specialists are part of treatment teams. Eleven individuals reported that peer specialists are a regular, integral part of treatment teams at their organization. For example, a peer specialist supervisor from an LMHA explained: "The peers are invited to staffings and they're treated equally…I sat in these meetings and I've seen psychiatrists actually care and want to hear input from the actual peer when they're doing treatment plans."

Clinical staff and peer specialists collaborate. Twelve individuals reported that clinical staff and peer specialists collaborate in other capacities not captured by other codes (e.g., beyond attending staff meetings). For example, a leadership participant from an LMHA explained: "We do PCRP luncheons on Thursdays. So all our recovery coaches[1] and peer supports will come together and talk about treatment planning together…not only the concept of treatment planning but the language that's involved so that it meets the UM criteria and things like that."

Peer specialists participate in the new employee interview process. Five individuals reported that peer specialists

[1] Note: This organization uses the term "recovery coaches" to refer to case managers (rather than peer staff with lived experience of a substance use disorder).

participate in the new employee interview process at their organization. For example, a peer specialist from an LMHA explained: "I am incredibly lucky and privileged that my director includes me in the interview process and I have worked with her to develop the interview questions…I feel very, very valued…you know, we go through the applications together."

Miscellaneous indicators of peer specialist integration. Five additional codes emerged from analysis that did not fit into the existing domains of peer specialist integration: peer specialists are spread throughout the organization; peer specialists have their own offices; peer specialists meet people in services at intake; peer specialists have been employed for a long time; and peer specialists are involved in the continuity of care process.

Peer specialists are spread throughout the organization. Eight individuals reported that an indicator of peer specialist integration is that peer specialists are disseminated or spread throughout their organization. For example, a leadership participant from an LMHA explained: "We submitted as one of the projects under the 1115 [Medicaid Transformation] Waiver for a peer services project and expansion and with that we were able to hire a lot more peer specialists… and put them in all of the clinics because we're across 19 counties."

Peer specialists have their own offices. Four individuals reported that an indicator of peer specialist integration is that peer specialists have their own offices at their organization. For example, a peer specialist supervisor from an LMHA explained: "Some places have like a bullpen type structure…all of our clinicians have their own offices…they office just like…the others do."

Peer specialists meet people in services at intake. Seven individuals reported that peer specialists engage with people in services at intake. For example, a peer specialist supervisor from a state hospital explained: "Everybody that's admitted to our facility now meets peer specialists when they first get there."

Peer specialists have been employed for a long time. Two individuals reported that an indicator of peer specialist integration is that peer specialists have been employed for a long time at their organization. For example, a leadership participant from an LMHA explained: "We had one that we sponsored twelve years ago. So we've had that [peer specialists] a long time."

Peer specialists are involved in the continuity of care process. Four individuals reported that an indicator of peer specialist integration is that peer specialists are involved in the continuity of care process for people in services. For example, a peer specialist from an LMHA explained: "We chase them down a lot. I mean, we spend a lot of time on the phone, go get them, we transport them…we get them hooked up into this and hooked up into that."

Resources that have Facilitated Peer Specialist Integration

Fifteen unique codes related to resources that have facilitated peer specialist integration emerged from analysis of the focus groups. These codes are presented below in relation to the domains of peer specialist integration.

Organizational Culture. Three resources that fell within the domain of organizational culture emerged from analysis: a champion in leadership; administration buy-in; and recovery-oriented programs, structures or activities.

Champion. Eleven individuals reported that having a champion in a leadership capacity at their organization has facilitated peer specialist integration. For example, a clinician from a state hospital reported: "I think at our organization a lot of it is from our superintendent who was a real champion at getting peer support stuff up and running…it comes from the top down."

Administration buy-in. Five individuals reported that buy-in from administration was key to facilitating peer specialist integration. For example, a peer specialist supervisor from an LMHA reported: "From the beginning the upper management…especially the executive directors have been very on board."

Recovery-oriented programs, structures and/or activities. Eight individuals reported that recovery-oriented programs, structures, and/or activities have facilitated peer specialist integration at their organization. For example, several participants reported that using "Getting in the Driver's Seat of your Recovery Plan" was vital in integrating peer

specialists into their organization. A peer specialist supervisor from an LMHA explained: "Some of the things that we did that kind of helped us become more integrated was utilizing the "Getting in the Driver's Seat of Your Recovery Plan"…when they go in and sat down with the recovery coaches[2], they already had an idea of kind of what things they wanted to work on…so we're saving fifteen to thirty minutes on average per person on getting that recovery plan done. The clinic directors loved it. The recovery coaches loved it. All of a sudden we were a hit."

Funding. Two codes related to funding emerged from analysis: diverse funding streams and dedicated funding streams.

Diverse funding streams. Five individuals reported that obtaining funding from diverse sources has facilitated peer specialist integration at their organization. For example, a leadership participant from an organization that serves homeless individuals explained: "We've used diverse funding through Meadows Foundation specifically for peer support. And Kresge Foundation and DSHS. But also our county jail system."

Dedicated funding streams. Ten individuals reported that having funding dedicated specifically for peer specialists has facilitated peer specialist integration at their organization. For example, a leadership participant from an LMHA explained the importance of 1115 Medicaid Transformation Waiver funding for peer support: "We submitted as one of the projects under the 1115 [Medicaid Transformation] Waiver for a peer services project and expansion and with that we were able to hire a lot more peer specialists…certified peer specialists. And then afford to…send them off for certification and all the trainings they needed."

Recruitment, hiring, and staff training. Five codes related to recruitment, hiring, and staff training emerged from analysis: changing human resources' hiring policies; peer specialist integration as a contract mandate; Via Hope training, technical assistance, and coaching; raising peer specialists' wages; and networks of peer specialists.

Changing human resources' hiring policies. Two individuals reported the importance of modifying hiring policies at their organization to hire qualified peer specialists. For example, a peer specialist from an LMHA explained: "At one point they had to have their car [as a job requirement]. We changed that and I think they may have even changed the driver's license and allowed them to take the bus."

Peer specialist integration as a contract mandate. Two individuals reported that having peer specialist integration as a contract mandate facilitated peer specialist integration. For example, a leadership participant from an LMHA explained: "It wasn't really until it was integrated into our contracts that we were like 'Well now we have to do it…it's not a choice anymore. It's a mandate.'"

Via Hope training, technical assistance, and coaching. Two individuals reported that training, technical assistance, and/or coaching from Via Hope facilitated peer specialist integration at their organization. For example, a leadership participant from an organization that serves individuals experiencing homelessness explained: "Via Hope was also really important so we could learn how to deliver and how to train supervisors and peer supports who were doing multiple roles at the same time."

Raising peer specialists' wages. One individual reported that raising peer specialists' wages facilitated peer specialist integration at their organization by reducing turnover. A peer specialist supervisor at an LMHA explained: "We have competitive wages… at one point it was a barrier. And the former director had addressed that and so they raised the wages which has really helped with the turnover."

Networks of peer specialists. One individual reported that networks of peer specialists have facilitated recruiting qualified peer specialists at their organization. A peer specialist from an LMHA reported: "I think recruiting earlier on was a lot harder but now as all of us have been more out in the peer specialist world…we know a ton of people who are awesome that we've met at conferences and other places…you start making a lot of connections…so you're able to go, 'Oh yeah, I know he's been looking [for a job] for a while.'"

[2] Note: This organization uses the term "recovery coaches" to refer to case managers (rather than peer staff with lived experience of a substance use disorder).

Role clarity. Three codes related to role clarity emerged from analysis: peer specialists introduce themselves/self-advocate; internal trainings on recovery-oriented topics (including peer specialists); and having one peer specialist supervisor/a peer specialist unit.

Peer specialists introduce themselves/self-advocate. Eleven individuals reported the importance of peer specialists introducing themselves to other staff and people in services or advocating for their role in other ways. For example, a peer specialist supervisor from an LMHA explained self-advocating for the peer specialist role: "It was my job actually…the first two years I spent there trying just to educate people that 'Yes, I have something to contribute to this place.'"

Internal trainings on recovery-oriented topics (including peer specialists). Four individuals reported that internal trainings on recovery-oriented topics (including peer specialists) have facilitated peer specialist integration at their organization. For example, a peer specialist supervisor from an LMHA explained: "We've had the Demystifying the Peer [Workforce] staff trainings…a lot of stuff like that and it's been very helpful. And then just training on…me talking as a director what peer support is about, what can we offer, and how can that support what the recovery coach does…which is our case managers. And then also how does that contribute to helping the clinic out and then the agency as a whole."

Having one peer specialist supervisor/a peer specialist unit. Two individuals reported that having one peer support supervisor who supervises all peer specialists and a peer specialist unit has facilitated peer specialist integration. For example, a leadership participant from an LMHA explained: "We developed an outreach and recovery center…and we've relocated the peers to that location because I wanted to give the peer staff an identity… it has actually helped define the role by having a separate supervisor because when I came into my position I felt like the peers weren't being utilized the way should be…and so that was a way to kind of pull it apart, redefine…but we do meet together, we coordinate, and it's very cohesive."

Miscellaneous resources. Two additional resources emerged from analysis: time and seeing the power of peer support (e.g., evidence that peer support leads to better outcomes, decreased costs).

Time. Two individuals reported that the passage of time has facilitated peer specialist integration. For example, a peer specialist supervisor from an LMHA explained: "I think time. To me it was time."

Seeing the power of peer support. Three individuals reported a resource is evidence that peer support has the power to reduce costs and better outcomes for people in services. For example, a peer specialist supervisor from an LMHA explained: "As far as peers being effective…we want to see 'Is the patient's experience of care increased with peers? The population health of the people we're serving…is it increased? Is there a decrease in costs? Like a decrease in ER admissions.'…to get executive buy-in it has to be data driven."

Needs/Barriers to Peer Specialist Integration

Fifty-three unique codes related to needs or barriers to peer specialist integration emerged from analysis of the focus groups. Below these codes are presented in relation to the domains of peer specialist integration.

Organizational Culture. Eight needs or barriers within the domain of organizational culture emerged from analysis: agency doesn't support peer specialists; champion needed; incomplete staff buy-in; executive leadership do not value peer specialists; hiring peer specialists is not an agency priority; organization not recovery-oriented/ person-centered and/or medical model; peer specialists are not part of organizational decision-making processes; and fear and stigma.

Agency doesn't support peer specialists. Six individuals (all peer specialists) reported that their organization does not support peer specialists. For example, a peer specialist from an LMHA reported: "There's no support at all so it's a big issue. I think that's why there's a lot of turnover."

Champion needed. Three individuals (all leadership) reported that their organization needs a champion of peer support. For example, a leadership participant from an LMHA reported: "There hasn't been a real champion and you need a champion. So I'm kind of dipping my toe into that pond to see if that's something that I feel like I can take on or if it's something that I can go back and infect somebody with."

Incomplete staff buy-in. Fifteen individuals reported that while some staff value peer support, other staff at their organization do not. For example, a leadership participant from a state hospital explained: "At our facility we have 265 nurses and probably close to another 100 clinical staff…you're going to have folks that don't embrace it. So when you're working in a large organization like that, yeah the majority of the treatment teams are pretty open [to peer support] but then we've got those that are really closed."

Executive leadership do not value peer specialists. Eight individuals reported that leadership individuals at their organization do not value peer specialists. For example, a leadership participant from a homeless services organization explained: "One of the big barriers that we have is executive leadership…understanding the value…Because it means a lot to the folks in direct service and with shared lived experience but the folks making the decision, you know, what we hear is "Well no, the case manager can do that." …That's coming from folks that haven't worked in the field of recovery or direct service but they are the decision makers."

Hiring peer specialists is not an agency priority. Three individuals reported that hiring more peer specialists is not a priority at their organization (despite a need for more peer specialists). For example, a peer specialist from a state hospital explained: "It's not just shorthanded in peer support but they're shorthanded in other areas as well…and I understand that there's priorities and right now, unfortunately, we're not a big priority."

Organization not recovery-oriented/person-centered. Eight individuals reported that their organization is not recovery-oriented and/or person-centered and instead is based on a medical model. For example, a peer specialist from an LMHA explained: **"**We are integrated to a point but there is still very definitely a behavioral health/medical model sphere and then the peer support sphere and there's not a lot of overlap."

Peer specialists are not part of organizational decision-making processes. Seven individuals reported that peer specialists are not part of organizational decision-making processes at their organization. For example, a peer specialist from a LMHA explains how peer specialists attended management meetings at a previous job in another state: "They would have peers come to the management team meetings and make comment on the decisions that were being made in those meetings. That isn't happening that I see. Also, having peers come to the director meetings…I think that would be welcome. I would like to have the peer director come to our director meetings instead of it being all separate."

Fear and stigma. Three individuals reported that stigma and fear around employing individuals with lived experiences of mental health issues is a barrier to peer specialist integration. For example, a peer specialist supervisor from a LMHA explained: "There are certain people who might view peers as a liability. 'What if so-and-so relapses? What if so-and-so has a mental health breakdown?'…they always look at that one person who relapses…they don't see the other ten people that are doing great work in the workforce and they see that one bad example and they hold it against the whole peer movement. So it's just changing that culture."

Funding. Seven codes related to funding barriers emerged from analysis: a lack of funding for peer specialist positions; the need to hire more peers; hospitals are discouraged from pursuing diverse funding for hiring peer specialists; the need for funding to train and certify peer specialists; concern about sustainability once the 1115 Medicaid Transformation Waiver runs out; the need for funding for transportation; and the need for a peer-specific Medicaid billable code.

A lack of funding for peer specialist positions. Eight individuals reported that a lack of funding for peer specialist positions is a barrier to peer specialist integration. For example, a leadership participant from an LMHA explained: "Well it's unfunded positions…it's almost a luxury. It's an add-on. And as a result, you really have to rob from…there's just so much money."

The need to hire more peers. Nine individuals reported that there are not enough peer specialists at their organization. For example, a peer specialist at an LMHA explained: "Part of our problem is we don't have enough of them. There's only two of us at our work. Our agency has like seven counties and the only counties we have them at now is [name of county]…And I would like to see…where, you know, they greet them at the door and utilize us a lot more, but we don't have enough manpower and peer specialists there to actually do that."

Hospitals are discouraged from pursuing diverse funding for hiring peer specialists. One leadership participant reported that state hospitals are discouraged from pursuing outside funding to hire peer specialist: "They [HHSC] make it very difficult…when you go forward with it and say 'Well, I found this funding stream,' and they'll say 'Well, what are you going to do after five years when the funding dries up?'"

The need for funding to train and certify peer specialists. Three individuals discussed the lack of funding for training and certifying peer specialists. For example, a leadership participant from an LMHA explained: "We don't have the funding to send them to get certified. A lot of those individuals can't afford to get certified."

Concern about sustainability once the 1115 Medicaid Transformation Waiver runs out. Three individuals from organizations that received funding through the 1115 Medicaid Transformation Waiver to hire peer specialists discussed concern about sustaining a peer support program when the 1115 Medicaid Transformation Waiver expires. For example, a leadership participant from an LMHA explained: "I think it's very nice that we have the waiver...it's also concerning if the waiver goes away then what will happen to these programs…sustainability is an issue and we're all thinking about it."

Funding for transportation. Three individuals discussed the fact that funding for transportation for peer specialists is an issue at their organization. For example, a leadership participant from an LMHA explained: "My resource is very simple…a car…we have a six-county area and in order to get our peer specialists out of the central main office, he [peer specialist supervisor] needed to have access to a vehicle which he did not."

The need for a peer-specific Medicaid billable code. Three individuals discussed the need for a Medicaid billing code that is specific to peer support. For example, a leadership individual from an LMHA explained: "Having a billable code that's specific for the peer service would go very far… we can bill for skills trainings…but there's so many other components to the peer process that aren't billable. And what does that say? What's the message there? So I think having that would go far in statewide as far as valuing that service and having credibility…I think that would show commitment to have that fully billable code just like any other service in the system."

Recruitment, hiring, and staff training. Nine codes related to recruiting and hiring peer specialists and staff training emerged from analysis: bars to employment; the need to "grow our own" and get people in services certified to be peer specialists; the need for (ongoing) internal trainings (including new employee orientation [NEO]) on peer specialists; peer specialist positions are not attractive enough; the difficulty of finding qualified and certified peer specialists; hiring unqualified peer specialists; the need for peer specialists to participate in the new employee interview process; the difficulty of getting into Certified Peer Specialist (CPS) training; and the need for information on how to interview peer specialist applicants.

Bars to employment. Two individuals reported that bars to employment prevented hiring qualified peer specialists. For example, a peer specialist supervisor from a state hospital explained: "Somebody may come in with the exact skill sets you want but you can't hire them because there's a bar to employment."

The need to "grow our own" and get people certified to be peer specialists. Two individuals discussed the desire to certify current people in services as peer specialists but the difficulty of doing so. For example, a leadership participant from a state hospital explained:

> During their stays we identify people and people come to us and they want to be peer specialists… how can we get them maybe certified as a peer specialist while they're still with us and it not be a conflict of interest…because…people have affinity for this. They want to do this. So how can we across the board grow our own and be able to provide them with the assistance and the training while they're still in treatment with us?

The need for (ongoing) internal trainings (including NEO) on peer specialists. Thirteen individuals reported that there is a need for internal trainings (including NEO training) on peer specialists. For example, a leadership participant from an LMHA explained: "We train within the behavioral health program but as far as new employee orientation or center-wide, there isn't training there."

Peer specialist positions are not attractive enough. Fifteen individuals reported that peer specialist positions are not attractive enough to recruit qualified applicants. For example, a leadership participant from an LMHA explained: "I

think we're not making it attractive enough, we're not paying enough, we're not showing people that we value them enough."

The difficulty of finding qualified and certified peer specialists. Five individuals reported that a barrier to hiring is finding peer specialists who are qualified and certified. For example, a clinician from an LMHA explained: "It's just very rural, East Texas and they're just so hard to come by. We would have positions posted forever and HR just actively looking for them and encouraging the clinicians to 'If you have clients who you think would really like to do that and would be good at it, talk to them about it.' But that's not really been successful that way."

Hiring unqualified peer specialists. Three individuals reported that a barrier to peer specialist integration is hiring unqualified peer specialists. For example, a peer specialist supervisor from an LMHA explained: "I've been at places where they've just hired anyone who had lived experience and that was a disaster. You know, you have to have a certain skill set. You have to have certain core competencies."

The need for peer specialists to participate in the new employee interview process. Two individuals reported that a barrier to hiring qualified peer specialists is that employed peer specialists are not involved in the process of hiring new peer specialists. For example, a peer specialist supervisor from an LMHA explained: "I think during the process there has to be a peer during the interview…There should be input from peers."

The difficulty of getting into CPS training. Two individuals reported that it is difficult for peer specialists to be accepted into the CPS training – even for employed peer specialists For example, a peer specialist supervisor from an LMHA explained: "The first person I chose I thought was brilliant and she is a great example of recovery. She really is and it took me a year to get her into the Via Hope program. Actually, it took me a year and six months. And five rejections."

The need for information on how to interview peer specialist applicants. One leadership individual from an LMHA explained the need for information on how to interview peer specialist applicants: "I think for managers sometimes there's some confusion about…how to hire…is that different when you're hiring a peer, what do you ask, what do you not ask? I think training around that would be helpful, particularly for new managers. Is there a difference how to approach it."

Role clarity. Six codes within the domain of role clarity emerged from analysis: management do not understand what peer specialists do; peer specialists are performing job duties outside of their role; staff do not understand what peer specialists do; there is not a formal job description for peer specialists; peer specialists are not performing all the job functions that they could be; and peer specialists do not fully understand their value.

Management do not understand what peer specialists do. Seven individuals reported that management or leadership at their organization do not understand the peer specialist role. For example, a peer specialist from an LMHA explained: "We do the Health Risk Assessment…then we navigate…find them resources and any assistance that they need and then we have the ability to become a coach. But…there's only so much that we can do because the directors and not everyone else knows exactly what the capacity of our work…where it can take us. So they just see… 'She does a Health Risk Assessment and that's it.' I'm like, 'No, there's so much more out there'…I feel like I'm very limited."

Peer specialists are performing job duties outside of their role. Eight individuals reported that peer specialists at their organization are performing job duties that fall outside of the peer specialist role. For example, a peer specialist at an LMHA explained: "There's still a lot of lack of knowledge and education of what we do…they would have us like taxi drivers, transportation or drop off the meds and then we also are door greeters in the front…the receptionist has us doing copies and this and that…so we do things that it's nothing what we…well, what I wanted to do as a peer provider."

Staff do not understand what peer specialists do. Eighteen individuals reported that staff at their organization lack an understanding of what the peer specialist role entails. For example, a clinician from an LMHA explained: "I don't think the whole center…I don't know if each case manager, each counselor… secretaries…if every single person in the company knows exactly what they're doing. Not clearly."

There is not a formal job description for peer specialists. Two individuals reported that there is not a formal job description for peer specialists at their organization. For example, a leadership individual from an LMHA explained: "I've been going to meetings with our top VPs and that's something that we're working on right now is establishing…clear job descriptions for our peers and responsibilities."

Peer specialists are not performing all the job functions that they could be. Ten individuals (eight peer specialists) reported that peer specialists at their organization are not carrying out all the job duties that fall within the peer specialist role. For example, a peer specialist from an LMHA explained: "I think there's a lot of other ways in which we're not integrated which they can't see beyond this pole of what we're meant for. We are meant to run groups and we're integrated in that way and that's what we're good at but there's so many other ways that we can be used within the agency."

Peer specialists do not fully understand their value. Three individuals reported that peer specialists do not fully understand what they have to contribute to people in services. For example, a leadership participant from an LMHA explained: "Another barrier to collaboration…is insecurities of the certified peer specialist… understanding what they're able to contribute and what they have the ability to do. I think that they're shy sometimes and hesitant when they come on board and don't want to step on anybody's toes."

Supervision and career advancement. Seven codes related to supervision and career advancement emerged from analysis: the need for information on how to supervise peer specialists; inadequate supervision for peer specialists; peer specialists are not supervised by other peer specialists; supervisors are not trained on peer support; no career ladder; a confusing supervision structure; and the need for salary schedules to be adopted.

Need for information on how to supervise peer specialists. Three individuals reported that they need information on how to best supervise peer specialists. For example, a leadership participant from an LMHA explained: "We needed more information…like you have to know what somebody is supposed to do to be able to supervise them appropriately, right? And then we needed to formalize what we were gonna do."

Inadequate supervision for peer specialists. Nine individuals reported that peer specialists at their organization are not adequately supervised. For example, a peer specialist from an LMHA explained: "One thing with our two supervisors, neither one of them work in our building. So it's kinda weird to how they can supervise if they're never there."

Not supervised by other peer specialists. Ten individuals reported that peer specialists at their organization are not supervised by other peer specialists, despite the fact that many peer specialists expressed a desire to be supervised by another peer specialist. For example, a peer specialist at an LMHA explained: "My supervisor is the psychosocial rehab supervisor and they just kind of gave me to him."

Supervisors not trained on peer support. Seven individuals reported that individuals who supervise peer specialists are not trained on peer support. For example, a peer specialist from an LMHA explained: "I would like to see my supervisor go through some peer support training. And he hasn't done that. And I don't know if he's been told, no he can't or…if it's just something that he doesn't feel that he needs to do."

No career ladder. Twelve individuals reported that there is no career ladder for peer specialists at their organization. For example, a peer specialist at an LMHA said: "At our organization, there is no career ladder…we don't have a stratified CPS 1, CPS 2, CPS 3…and we don't have the different pay scale. After two years, you get a 30 cents an hour raise…And it leaves you feeling kinda stranded. It's like I want to make this my life's work and I want to continue to grow, but I need to have some incentive."

Confusing supervision structure. Three individuals reported that the supervision structure for peer specialists at their organization is confusing. For example, a leadership participant from an LMHA explained: "Our supervisor is based out of [name of clinic] so we have peer specialists in our clinics but they are answering to [director of peer services] and then we as center directors are their supervisor. So that's been really confusing and it's been a barrier for their integration and the way that they communicate."

Salary schedules need to be adopted. Ten individuals reported that there is a need for salary schedules for peer specialists. For example, a peer specialist from an LMHA explained: "I advocated for a raise and I was told that 'Well you know a case manager who has a Bachelor's degree only makes this much money. There's no way they're gonna pay you this much money.' And it put me…in that $12 an hour slot…there's no room."

Collaboration. Eight codes related to collaborative working relationships between peer specialists and other staff emerged from analysis: peer specialist and non-peer specialist staff do not collaborate/work together; stigma from non-peer specialist staff as a barrier to collaboration; case managers and other clinical staff do not regularly refer people in services to peer specialists; peer specialists are not involved in the treatment planning process; peer specialists are not allowed to access records; peer specialists are not listed as an intervention on person-centered recovery plans (PCRPs); doctors do not want peer specialists in planning meetings; and peer specialists cannot directly communicate with doctors.

Peer specialist and non-peer specialist staff do not collaborate/work together. Thirteen individuals reported a general lack of collaboration between peer specialist staff and non-peer specialist staff at their organization. For example, a peer specialist from an LMHA reported: "There's an 'us' and 'them' feeling and I feel very much like a 'them' not an 'us'"

Stigma from non-peer specialist staff. Six individuals reported that non-peer specialist staff stigmatized peer specialists and that this was a barrier to effective collaborative working relationships at their organization. For example, a peer specialist from a state hospital explained: "I was a patient there before I became a peer specialist, when I first started…there was a lot of [whispering sounds] behind my back."

Case managers and other clinical staff do not regularly refer people in services to peer specialists. Six individuals reported that case managers and other clinical staff fail to regularly refer people in services to peer specialists. For example, a peer specialist from an LMHA explained: "Case managers don't refer anybody to have a peer specialist. They don't tell them about what a peer specialist does and they don't inform them that…a peer specialist can be in the room and…can help them with their treatment plan…so all they get is the case management and the doctor."

Peer specialists are not involved in the treatment planning process. Three individuals reported that peer specialists are not actively involved in people in services' treatment planning process. For example, a peer specialist from an LMHA explained: "I think when it comes to treatment plans, the peer support people should be in the room. And we're not…When it comes to people being in crisis…treatment plans…we're not relevant."

Peer specialists are not allowed to access records. Three individuals reported that the fact that peer specialists are not allowed to access electronic health records is a barrier to collaboration. For example, a leadership participant from an LMHA explained: "There's some systems that they're not able to access and there's really no reason why they shouldn't… Why are we preventing them from accessing things that they need to do their…job duties."

Peer specialists are not listed as an intervention on PCRPs. Two individuals reported that an indicator of non-collaborative relationships is that people in services' PCRPs lack a peer specialist intervention. For example, a peer specialist supervisor from an LMHA explained: "We provide billable services. We write our own notes. But we can't when we're not on the intervention…you might have a group of eight and if one person's PCRP is expired or we're not on there as an intervention, then the whole group is non-billable now."

Doctors do not want peer specialists in treatment planning meetings. A peer specialist supervisor from an LMHA reported that doctors do not want peer specialists in treatment planning meetings: "They [doctors] don't always want a peer specialist…we've had a couple…not wanting peer specialists in there."

Peer specialists cannot directly communicate with doctors. Three individuals reported that peer specialists at their organization are not able to directly communicate with doctors. For example, a peer specialist from an LMHA explained: "I wish actually the certified peer specialists could talk and email the doctors directly…I think 90% of my clients talk about being dissatisfied with the doctors…if the certified peer specialists could talk to the doctors, I would at least email them."

Miscellaneous barriers to peer specialist integration. Eight additional codes emerged from analysis that did not fit into the existing domains of peer specialist integration: the state legislature does not value peer specialists; no accountability to integrate peer specialists; high turnover; organizational policies; a lack of collaboration across state agencies; peer specialists are not disseminated throughout the organization; state bureaucratic barriers; and people in services are not provided information on peer support.

State legislature does not understand the value of peer specialists. Two individuals reported that a barrier to peer specialist integration is that the state legislature does not value peer specialists. For example, a peer specialist explained: "We have a role to play and we need to play it but…it's gotta grow and in order to do that we need legislature to understand the importance."

No accountability to integrate peer specialists. One leadership individual from an LMHA discussed the issue of a lack of accountability to integrate peer specialists: "There's nobody breathing down your back to make sure that you do it… if it's not something that you're going to get evaluated on, chances are it's going to go to the side."

High turnover. Six individuals reported that high turnover rates in the public mental health system is a barrier to peer specialist integration. For example, a peer specialist from an LMHA reported: "We have four but one's leaving. There's a lot of turnover. A lot of people just don't stay so I think I've been the longest there."

Organizational policies. Four individuals reported that organizational policies pose a barrier to peer specialist integration. For example, a leadership individual from a state hospital explained: "Now that we have peers we have to change the policy and procedures. Well how long is that gonna take? Well about two more years so you stay stagnant in what you can do because of policy or procedures keeping you from doing it."

A lack of collaboration across state agencies. Three individuals reported that a lack of collaboration across mental health agencies in the state poses a barrier to peer specialist integration because agencies could learn from one another on how to integrate peer specialists. For example, a peer specialist from an LMHA explained: "I would like for the different organizations to be able to interconnect and learn from the different organizations that have the programs working successfully."

Peer specialists are not disseminated throughout the organization. One leadership participant from an LMHA discussed the fact that peer specialists are not disseminated throughout their organization: "They are…I don't want to say isolated, but what I want to say is that…their home base is what behavioral health is, not IDD, it's not with our veteran's services."

State bureaucratic barriers. One peer specialist from an LMHA discussed state bureaucratic barriers as a barrier to peer specialist integration: "Whenever peer services is requested by a consumer…it's an incredibly slow process…all of the bureaucracy has to be fed before…And then the recovery plan is generated by…others that legally have to have certain qualifications to sign off on the creation of that document. And then eventually the peer and the consumer begin working but it's quite a long time… whenever someone changes LOC, level of care…everything that was scheduled with the peer is now suddenly non-billable because that recovery plan has to be processed by the new case manager."

People in services are not provided information on peer services. Two individuals reported that a barrier to peer specialist integration is that people in services are not provided information on peer support services. For example, a peer specialist from an LMHA explained: "At no point in time does the consumer have the ability to look at their insurance plan and say 'I have available to me, this much service. I'm going to go to my provider and say 'I want this much service from a peer.'... There's not this nice little laundry list that they have of what's peer services, what would that do for me?"

Future Plans Related to Peer Specialist Integration

Of the 51 focus group participants, some described future plans to further integrating peer specialists into their organization. These plans are listed below with the number of individuals who reported each of the specific plans.

- Hire more peer specialists (n=8)
- Open a peer-run respite (n=3)
- Educate other staff on peer support, self-advocate (n=2)
- Create different peer support specializations (n=2)
- Integrate peer support into after-hours clinic (n=1)
- Integrate peer support into crisis clinic (n=1)
- Integrate peer support into criminal diversion program (n=1)
- Open a clubhouse (n=1)
- Diverse funding streams (n=1)
- Increase salaries/benefits (n=1)
- Monthly meetings with all recovery providers (n=1)
- Disseminate peer specialists across organization (n=1)

Discussion

In this section, key findings that emerged from both survey and focus group data are summarized and discussed. The discussion is organized by the six key domains of peer specialist integration: organizational culture; funding; recruitment, hiring, and staff training; role clarity; supervision and career advancement; and collaboration.

Organizational Culture

Three key themes related to organizational culture emerged from both survey and focus group data: recovery orientation (an important prerequisite of peer specialist integration), staff buy-in, and peer specialists serving in positions of authority.

Recovery orientation. Survey and focus group data both indicate that services across Texas are largely recovery-oriented – that is, they support the belief that individuals can recover from mental health challenges and live meaningful lives in their communities. Survey respondents rated the recovery orientation of services at their organization as 4.1 on a 5-point scale. Further, ten focus group participants reported that their organization embraces the values of recovery. There is, however, room for improvement – eight focus group participants reported that their organization is not recovery-oriented and/or person-centered and is instead based on a medical model, which is less supportive of peer specialist integration. Trainings, such as Via Hope's Recovery Institute Leadership Academy (RILA) training, are needed to further develop organizational cultures that support recovery. Other recommendations for developing recovery-oriented organizational cultures include adopting recovery-oriented language (e.g., mission statements that incorporate recovery-oriented language, renaming treatment plans to recovery plans, renaming caseworkers to recovery coaches, etc.) and engaging in recovery-oriented activities or programs (e.g., using "Getting in the Driver's Seat of your Recovery Plan," recovery-oriented social gatherings such as picnics, and recovery-oriented communications such as newsletters).

Buy-in. Data largely point to indicators of staff buy-in – that is staff believe in – and support – the effectiveness of peer specialists and peer specialist integration. For example, 83% of survey respondents reported that peer specialists are accepted at their organization. Further, 84% of survey respondents report that they value the roles and activities of peer specialists and 75% report that peer specialists increase the effectiveness of care. On the other hand, when survey respondents were asked to list barriers that their organization has experienced integrating peer specialists, the third most commonly reported barrier was a lack of staff buy-in (n=27). Buy-in emerged as a key topic of discussion in the focus groups as well. Sixteen focus group participants reported that buy-in from leadership or administrative staff is a key indicator of peer specialist integration, while another five participants reported that buy-in from leadership is a key resource that has facilitated peer specialist integration. Further, ten focus group participants reported that general staff buy-in is an indicator of peer specialist integration. On the other hand, fifteen participants reported that there was incomplete staff buy-in at their organization and another eight participants reported that a lack of buy-in from leadership is a key barrier to peer specialist integration. To facilitate buy-in from all staff, trainings on peer support (such as Via Hope's Demystifying the Peer Workforce), organizational champions, and data that show how peer support can reduce costs and improve outcomes are needed.

Peer specialists in positions of authority. Another key theme that emerged from survey and focus group data is whether peer specialists serve in positions of authority at their organization. Only 46% of survey respondents reported that peer specialists serve on important organizational committees. Seven focus group participants also reported that peer specialists are not part of organizational decision-making processes at their organization. On the other hand, five focus group participants reported that peer specialists serve on advisory boards or other positions of authority (e.g., management positions within the organization). Organizations should further work to incorporate peer specialists into organizational committees, advisory boards, and management positions (for example, by creating a position such as "Director of Peer Services"). Giving peer specialists a "seat at the table," and a voice in organizational decisions is vital for the full integration of peer specialists.

Funding

Across survey and focus group participants, the most commonly cited barrier to the integration of peer specialists was 'funding.' This catchall term refers to concrete resources needed to create positions and to retain, skilled and effective peer providers. The first step to addressing funding issues for peer specialist integration is for decision-makers at the organizational level to outline specific priorities, needs, and solutions. In other words, the following questions could be addressed by organizational administrators:

Is peer specialist integration an organizational priority and for what is funding needed? This question should be brought to the table at next opportunity (i.e., during strategic planning, organizational leadership meetings, staff meetings, etc.). Funding peer specialist positions should: consider attractive salaries, benefits and future raises; initial and ongoing training and professional development; and adequate supervision of peer support staff (see recruiting, hiring, and training in the next section).

What are sustainable sources of funding? The Texas Medicaid Mental Health Rehabilitation (Rehab) Option is available to eligible Medicaid providers statewide, includes peer specialists as eligible providers, and provides Medicaid coverage for many activities appropriate to the peer specialist role. If all requirements are met, peer providers may provide and bill for psychosocial rehabilitation services that are included in an approved treatment plan. However, only a portion of the activities appropriately assigned to peer specialists are included under Rehab, leaving the remaining peer-provided services without a federal funding source. Over the past five years, TIEMH evaluation of peer specialist integration initiatives in Texas have revealed that Medicaid Rehab option is underutilized, in-part, as a result of confusion about what activities are billable, how Rehab activities provided by a peer should be documented, and how Rehab services can be provided without comprising the peer role. Other sources of funding include, but are not limited to: state general revenue, block grant funding, some Medicaid waiver programs, local community funding, and other grant funding. All of these sources are generally finite. The sustainability of each of these should be considered on a case-by-case basis specific to the organization.

How can funding sources be accessed? Peer services in Texas are typically funded through state general revenue, mental health block grant, the 1115 Medicaid Transformation Waiver, and through the Medicaid Rehab option. Funding sources may be complex and complicated to access. For example, since Medicaid Rehab is largely used for reimbursement of traditional, non-peer provided services, confusion may be generated over when and how to bill for services that are uniquely 'peer' but could qualify as a Medicaid reimbursable service under the Rehab option. A Medicaid provision (i.e., State Plan Amendment) that covers all aspects of peer support services would address that confusion and simplify access to Medicaid for peer support. Until that provision is made, clear information from state agencies that fund peer services should be provided. In addition, the provision of training and technical assistance to organizations that employ peer providers would be needed. This specific training and technical assistance would assist in ensuring that organizations utilize appropriate documentation and supervision required to receive Medicaid reimbursement for peer services, while also maintaining the integrity of the peer role.

Recruitment, Hiring and Staff Training

This study revealed two key themes related to this domain: recruiting and hiring qualified peer specialists and the need to train non-peer staff about the role of peer specialists.

Recruiting and hiring qualified peer specialists. Five focus group participants reported that difficulty finding qualified peer specialists, particularly in rural areas, is a barrier to peer specialist integration. To address this, seven focus group participants reported that their organization recruits peer specialists from their people in services base. This practice is not recommended due to concerns about people transitioning from services to employment within the same organization; however, recruiting qualified candidates internally allows organizations to identify individuals who might obtain employment as peer specialists at another clinic within the same organization. Survey respondents and three focus group participants also reported that organizations hire peer specialists who lack training and certification. Two focus group participants spoke about the difficulty of being accepted to Via Hope's CPS training, stating that it often took repeated applications over the course of several years to be admitted. Therefore, there is a need to expand this program's capacity to accept more qualified applicants.

Inadequate compensation and a lack of benefits contribute to the difficulty finding qualified applicants: 15 focus group participants specified this as a barrier. A recent survey of peer specialists in Texas found the average rate of hourly pay is $14.02 (equivalent to about $29,000 full-time annual salary); this pay rate varied from $8.25 to $31.00 per hour, with more rural regions paying less (Earley et al., 2016). Organizations demonstrate the value of the peer specialists by providing commensurate compensation and full-time employment opportunities. Organizations also need funding to support job training and certification for peer specialists. Organizations will best manage the issue of under-qualified applicants by providing access to training and attracting qualified applicants with adequate compensation.

Internal training on peer specialists. Thirteen focus group participants described a lack of internal training on peer specialists as a barrier to integration. Further, only 53% of survey respondents reported that their organization includes information about peer specialists in new employee orientation, suggesting there is a need for more internal training of this nature. Knowledge of the unique role of peer specialists is best imparted through formal training: seven focus group participants reported that including information about peer specialists in new employee orientation is an indicator of peer specialist integration. Further, six focus group participants reported that the ongoing internal training of non-peer staff is also an indicator of peer specialist integration. Organizations should include introductory information about peer specialist staff during new employee orientation (including allowing peer specialists to introduce themselves and their role). Ongoing internal trainings to reinforce understanding about the role and how to better integrate the role into the daily activities of the organization would further enhance integration. Via Hope offers training for organizations and technical assistance specific to augmenting role clarity (i.e., Demystifying the Peer Workforce).

Role Clarity

Two key themes related to role clarity emerged from both survey and focus group data: whether organizations have a formal job description for peer specialists and whether staff understand the peer specialist role.

Formal job description. Formal job descriptions for peer specialists are an important aspect of integration. Nearly 93% of peer specialists who completed the survey reported that their organization has a job description for peer specialists, while 7% reported that their organization does not have a job description or they were unsure if their organization has a job description. This finding emerged in the focus groups as well: six focus group participants reported that their organization has a formal job description for peer specialists, while two focus group participants reported that their organization does not. However, despite the fact that most organizations in Texas appear to have a formal job description for peer specialists, as the next theme illustrates, there remains a lack of understanding about the peer specialist role.

Staff understand the peer specialist role. About 83% of non-peer staff reported that they understand the roles and activities of peer specialists while peer specialist survey respondents rated non-peer staff understanding of the peer job role fairly high at 6.8 out of 10. However, when survey respondents were asked to list barriers that their organization has experienced integrating peer specialists, the second most commonly reported barrier was that staff lack an understanding of the peer specialist role (n=28). This finding was echoed in the focus groups: eighteen participants reported that staff lack an understanding of what the peer specialist role entails at their organization (while nine participants reported that an indicator of peer specialist integration is that staff now understand the peer specialist role). To address this lack of understanding, formal and informal trainings on peer support are needed for all staff. Formal trainings could include Via Hope's Demystifying the Peer Workforce training or internal trainings facilitated by peer specialists or peer specialist supervisors. Informal training efforts could include peer specialists attending team meetings, social gatherings that include both peer and non-peer staff, organizational newsletters or other forms of communication, and collaborative working arrangements that facilitate communication between peer and non-peer staff. Survey data indicate that nearly all respondents who were supervisors of peer staff (n=47) agreed (77%) or strongly agreed (21%) that they engage in informal training efforts by helping non-peer staff understand the role of peer specialists. Further, focus group data indicate that peer specialists frequently engage in self-advocacy by introducing themselves to non-peer staff and educating them on the peer specialist role. However, it is important that organizations also take steps to address this lack of understanding, as the onus of staff education should not fall solely on peer specialists.

Supervision and Career Advancement

Research suggests that the single most important predictor of peer specialist job satisfaction, and thus employee retention, is the supervisor's understanding of the peer's job role (Kuhn, et al., 2015). Results from the statewide survey and focus groups indicate that inadequate training for supervisors presents a major barrier to this understanding. Fortunately, there are several practices that may offer solutions to this problem.

Peer specialists being supervised by other peer specialists. Approximately one third of peer specialist survey respondents reported that they were supervised either by other peer specialists or by staff whose job title was specific to peer support supervision. This practice should be implemented or expanded when possible because having worked in a particular role gives the supervisor insight into how to manage and mentor employees in that role. This type of supportive

and educational supervision that is specific to the peer role is needed in addition to the bare bones administrative clinical supervision that must be provided by LPHAs as a requirement for billing Medicaid.

Training needed for supervisors on peer specialists and how to supervise them. Focus group participants indicated that lack of training for supervisors of peer specialists presents a major barrier to peer specialist integration, and that more training is needed, especially for those supervisors that have no background in peer support. Only about one third of peer specialist survey respondents reported that they were supervised either by other peer specialists or by staff whose job title was specific to peer support supervision. Twelve percent of peer survey respondents reported that they did not receive any supervision related to their role as a peer specialist, which suggests that they were receiving only very general administrative or clinical supervision that is not applicable to their specific roles.

Results from the survey and focus groups also indicate a growing need for standardization of the role of peer supervisor. In the context of recent research suggesting that clear responsibilities and expectations set by a supervisor for peer specialists significantly impact satisfaction and retention (Kuhn et al., 2015), peer supervisors need formalized benchmarks for success and standards by which to set expectations for employees. Organizations should consider the following standards or best practices for supervisors of peer specialists:

- Provide formalized opportunities for co-supervision;
- Establish a formal career ladder/position classification system;
- Offer opportunities for career advancement and solicit feedback regarding their career goals and aspirations;
- Formalize opportunities for regular feedback and communication; and,
- Provide clinical oversight of and guidance on meeting documentation requirements specific to peer support services.

Collaboration

Peer specialist and non-peer staff working in collaboration to help people receiving services achieve their goals is a clear indicator of peer specialist integration. Two key themes emerged under this domain: clinical staff referrals to peer specialist staff and the frequency and nature of collaboration between peer specialists and other staff.

Clinical staff referrals to peer specialists. People receiving services may not always have direct access to peer specialists, but rather are referred by other non-peer direct care staff. Seven focus group participants reported that an indicator of peer specialist integration is that case managers regularly refer people in services to peer specialists. However, 28% of non-peer staff survey respondents reported *never or rarely* making referrals to peer specialists. Further, six focus group participants reported that clinical staff do not regularly refer people in services to peer specialists. Referrals to peer specialists can be built into organizational policies and practices: making peer specialists a part of recovery plans or intake processes integrates them into the work flow. Further, formal and informal social gatherings can build relationships between peer specialists and case managers or other direct care staff, which may lead to more referrals.

Frequency and nature of collaboration between peer specialists and other staff. Twelve focus group participants reported that collaboration between clinical staff and peer specialists is an indicator of peer specialist integration. Focus group participants also noted several different types of collaboration: six participants indicated that doctors value and include peer specialists, nine participants reported that peer specialists are kept "in the loop" by clinical staff, eleven participants reported that peer specialists are part of treatment teams, and nine participants noted that peer specialists are treated like colleagues.

Conversely, 13 focus group participants reported that a lack of collaboration between peer specialists and other staff is a barrier to peer specialist integration. Similar to the focus groups, 40% of non-peer staff survey respondents reported that they collaborate with peer specialists *once a month or less* while 39% of non-peer staff and 43% of peer specialists reported that peer specialists *rarely or never attend* treatment team planning meetings. Even when peer specialists do attend, 43% of clinical staff and 53% of peer specialists reported that peer specialists *rarely or never* actively participate. Six focus group participants indicated that stigma from non-peer staff is a barrier to collaboration while eight focus group participants noted that an "us versus them" mentality may prohibit collaborative work. Organizations can facilitate better collaborations with trainings describing the role of the peer specialist and providing guidance about best practices for collaboration. Additionally, organizations can create policies stipulating the involvement of peer specialists in

organizational practices, including treatment planning meetings. Supervisors and directors should encourage and support the inclusion of peer specialists in treatment team meetings.

Limitations

Several limitations of this mixed-methods evaluation should be considered in interpreting these findings. First, because the participants of this evaluation were limited to employees of the Texas public mental health system, the results may not be generalizable to peer specialist integration in the private mental health sphere, to other settings where peer specialists work, or beyond the state of Texas.

Second, respondents from organizations that had not previously participated in Via Hope recovery-oriented change initiatives were less likely to take part in the survey and the focus groups. The sample size for this group of survey respondents (n=107) was substantially smaller than for survey respondents from organizations that had previously participated in Via Hope recovery-oriented change initiatives (n=503). Similarly, only 10 out of 51 focus group participants were from organizations that had not participated in Via Hope initiatives. This response bias limited the ability to make comparisons between these groups.

Third, another potential response bias is that focus group dynamics may have limited the input of less extroverted participants and/or participants in positions of less authority (e.g., peer specialists) relative to other participants (e.g., those in leadership positions).

Fourth, several potential sampling biases may have affected findings including: staff who had limited access to computers would have been far less likely to, or unable to, complete the survey; only staff members who attended the Via Hope regional conferences were able to participate in the focus groups, and therefore, were probably more invested in the success of PSI than other staff from their organizations would have been; organizations not previously having participated in Via Hope recovery-oriented change initiatives were not as likely to be outreached to attend the regional conferences, and therefore less likely to attend the focus groups; and the survey methodology indicated that the invitation was sent first to organizational leadership of the LMHAs and state hospitals, and from there was to be forwarded throughout the organization. However, researchers learned that in some cases this did not occur.

Finally, although differences in focus group responses by organizational type (i.e., LMHA versus state hospital) and role (e.g., peer specialist, clinician) were examined, due to small sample sizes no definitive claims can be made regarding any differences.

Recommendations

Based on the findings of this evaluation, TIEMH offers the following recommendations:

Organizational Culture

- Organizations should provide regular internal and external trainings (e.g., Via Hope's Recovery Institute Leadership Academy [RILA]) on a recovery orientation to develop organizational cultures that are supportive of recovery and, thus, more prepared to integrate peer specialists.
- Organizations should adopt recovery-oriented language (e.g., mission statements that incorporate recovery-oriented language, providing recovery versus treatment plans, renaming case managers to recovery managers).
- Organizations should regularly engage in recovery-oriented activities or programs (e.g., using "Getting in the Driver's Seat of your Recovery Plan," recovery-oriented social gatherings such as picnics, and recovery-oriented communications such as newsletters) to develop a recovery-oriented culture.
- To facilitate buy-in from all staff, organizations should provide regular internal and external trainings (e.g., Via Hope's Demystifying the Peer Workforce) on peer support and the roles of the peer workforce.
- Organizations should identify and support organizational "champions" of peer specialist integration to increase staff buy-in.
- Organizations should incorporate peer specialists into organizational committees, advisory boards, and management positions (e.g., by creating a position such as "Director of Peer Services").
- To facilitate greater buy-in among stakeholders, continue to evaluate peer services to determine if (and if so, how) peer services improve outcomes at costs equal to or lower than usual services.

Funding

- Decision-makers at the organizational level should outline specific priorities, needs, and solutions to funding issues. The following questions should be addressed by organizational administrators:
    - *Does leadership consider peer specialist integration a priority deserving of funding?* This question should be brought to the table at next opportunity (i.e., during strategic planning, organizational leadership meetings, staff meetings, etc.).
    - *For what is funding needed?* For example: benefits, attractive salaries, future raises, initial and ongoing training and professional development, and supervision.
    - *Are available sources of funding adequate or sustainable to maintain existing peer support services?* Other sources of funding include state and local funding, general revenue, and grant funding. The sustainability of each of these should be considered on a case-by-case basis specific to the organization.
    - *Do local organizations understand how to access available funding sources? How can those sources be accessed*? If training and technical assistance is needed regarding the documentation and supervision requirements that must be fulfilled to receive Medicaid reimbursement for peer services, organizations may consult peer organizations, private consultants, or training and technical assistance resources like Via Hope. Processes for the assignment of the use of general revenue could also be initiated with the assistance of consultants. Applications for grant funding may be assigned to internal personnel or outsourced to contractors. Such decisions should be made on a case-by-case basis, considering the resources available to the organization.
- To expand the availability of peer support services, the state of Texas must ensure that funds are adequate and sustainable. This could be accomplished through at least two different approaches:
    - The state of Texas could dedicate state and/or Mental Health Block Grant funds to support the availability of peer specialists throughout the state. Unless additional funds were to become available, this approach would require redirecting funds from their current purpose.
    - Establishing a Medicaid provision for peer support. This approach could remove the confusion about what activities are Medicaid billable and what activities appropriate to the peer specialist role are not.

Training

- The state, through contract, should consider expanding the availability of Certified Peer Specialist training to meet demand.
- Organizations should have peer specialists introduce themselves and describe their work during new employee orientation.
- Organizations should conduct ongoing training on the role of peer specialists. Via Hope offers a 1-day training, Demystifying the Peer Workforce, which provides information about the role, job functions, skills that trained peer specialists have and the value of adding the peer specialist workforce to an organization.

Role Clarity

- Local provider organizations often set Medicaid billing performance standards that require focusing solely on billable activities, excluding those activities appropriate to the peer specialist role that are not Medicaid billable. Organizations should consider establishing performance standards for billing that are appropriate to the peer specialist role, that is, the proportion of peer services that are Medicaid billable and the proportion of peer services that are aligned with a peer role but are not Medicaid billable (Note: this concern would be addressed by establishing a Medicaid provision for peer support).
- To address the fact that many staff lack an understanding of the peer role, formal and informal trainings on peer support are needed for all staff. Formal trainings could include Via Hope's Demystifying the Peer Workforce training or internal trainings facilitated by peer specialists or peer specialist supervisors. Informal training efforts could include social gatherings that include both peer and non-peer staff, organizational newsletters or other forms of communication, and collaborative working arrangements that facilitate communication between peer and non-peer staff.

Supervision and Career Advancement

- To the extent possible, peer specialists should be supervised by other peer specialists.
- Training is needed for supervisors on the role of peer specialists and how to supervise them, especially for those supervisors that are not peers or have no background in peer support. To enhance effectiveness of the peer role, training should go beyond general administrative or clinical supervision not applicable to the specific peer role.
- The peer supervisor role lacks standardization. Organizations should consider the following standards or best practices for supervisors of peer specialists:
    - Provide formalized opportunities for co-supervision;
    - Establish a formal career ladder/position classification system;
    - Offer opportunities for career advancement and solicit feedback regarding career goals and aspirations;
    - Formalize opportunities for regular feedback and communication; and,
    - Provide clinical oversight of and guidance on meeting documentation requirements specific to peer support services.

Collaboration

- Facilitation of collaboration occurs best when organizational practices incorporate peer specialists into the service array and flow:
    - Have people new to services meet with peer specialists as a part of the intake processes;
    - Create avenues for non-peer staff to refer to peer specialists;
    - Include peer specialists as an intervention option on recovery plans; and,
    - Invite peer specialists to treatment team meetings.

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Appendix A: Peer Specialist Integration Survey

Note: Not every survey item was displayed to every respondent as question logic directed respondents to different items based on job role, supervisory status, peer employment status, etc.

DEMOGRAPHIC INFORMATION

What is your gender?
- ❍ Male
- ❍ Female
- ❍ Not Listed

What is your age range?
- ❍ 18 - 25
- ❍ 26 - 39
- ❍ 40 –- 55
- ❍ 56 or Older

Are you of Hispanic or Latino origin?
- ❍ Yes
- ❍ No

What race do you consider yourself to be? (Select all that apply)
- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ Black or African American
- ❑ Native Hawaiian or other Pacific Islander
- ❑ White
- ❑ Other (please specify below) _____

EMPLOYMENT INFORMATION

What is your specific job role at your organization?
- ❍ Administrative Support
- ❍ Case Manager
- ❍ Consumer Representative
- ❍ Doctor
- ❍ Education or Rehabilitation
- ❍ Executive Leadership
- ❍ Family Partner
- ❍ Human Resources
- ❍ Nurse
- ❍ Other Clinical or Direct Care Personnel
- ❍ Peer Specialist
- ❍ Psychiatrist
- ❍ Psychologist
- ❍ Quality Management
- ❍ Recovery Coach
- ❍ Social Worker
- ❍ Staff Training
- ❍ Other (please specify below) _____

How long have you worked at this organization?
- ❍ Less than 1 Year
- ❍ 1 Year to Less than 3 Years
- ❍ 3 Years to Less than 5 Years
- ❍ 5 Years or More

Do you supervise employees at your organization?
- ❍ No
- ❍ Yes

Which job roles do you supervise? (Select all that apply)
- ❑ Administrative
- ❑ Case Management
- ❑ Consumer Representative
- ❑ Doctor
- ❑ Education or Rehabilitation
- ❑ Family Partners
- ❑ Human Resources
- ❑ Leadership
- ❑ Nurse
- ❑ Other Clinical or Direct Care
- ❑ Peer Specialists
- ❑ Psychiatrist
- ❑ Psychologist
- ❑ Quality Management
- ❑ Recovery Coach
- ❑ Social Worker
- ❑ Trainer
- ❑ Other (specify below) _____

Do you work directly with people who receive services as a regular part of your duties?
- ❍ No
- ❍ Sometimes
- ❍ Yes

How many people receiving services do you work with during an average week?
- ❍ 1 to 9
- ❍ 10 to 19
- ❍ 20 to 29
- ❍ 30 or more

ORGANIZATION INFORMATION

At what type of organization are you currently employed?
- ❍ Local Mental Health Authority
- ❍ State Hospital
- ❍ Other (please specify below) _____

What is the name of the organization at which you are currently employed?

Have you attended any trainings or meetings that focused on the integration of peer specialists into the organization?
- ❍ No
- ❍ Yes

What trainings or meetings have you attended?

Are peer specialists employed at your organization? (Peer specialists are individuals with lived experience of mental illness who are willing to use their life experiences to assist others in earlier stages of recovery.)

- ❍ No
- ❍ Yes
- ❍ Unknown

PEER SPECIALIST JOB ROLE WITHIN THE ORGANIZATION

What is your employment status as a peer specialist at your organization?

- ❍ Employed – Full Time (32 or more hours per week)
- ❍ Employed – Part Time (31 or fewer hours per week)
- ❍ Contract Employee, Full Time (32 or more hours per week)
- ❍ Contact Employee, Part Time (31 or fewer hours per week)
- ❍ Volunteer, Full Time (32 or more hours per week)
- ❍ Volunteer, Part Time (31 or fewer hours per week)

Does your organization have a job description for your role as a peer specialist?

- ❍ No
- ❍ Yes
- ❍ I'm Not Sure

Do you perform any of the following job duties on a regular basis?

	Yes	No
Administrative tasks	❍	❍
Advocacy	❍	❍
Connecting consumers to resources/networking	❍	❍
Education (please specify what you teach and to whom)	❍	❍
Facilitating support groups (please specify the type of support group(s))	❍	❍
Goal-setting	❍	❍
Helping people advocate for themselves	❍	❍
Housing assistance	❍	❍
Medication monitoring	❍	❍
One-on-one support	❍	❍
Outreach or Engagement	❍	❍
Patient navigation	❍	❍
Provide supervision to other peer specialists	❍	❍
Serve on work groups and committees (please specify the type of work groups or committees)	❍	❍
Skill building (please specify the type of skills)	❍	❍
Support clients during transition from inpatient	❍	❍
Transportation assistance	❍	❍

Vocational assistance	❍	❍
Wellness Recovery Action Planning (WRAP)	❍	❍
Working on a treatment team	❍	❍
Other (please specify)	❍	❍

Thinking about your role as a peer specialist within this organization, please indicate how frequently the following occur:

	Never	Rarely	Sometimes	Often	Always
I know what is expected of me in my job role.	❍	❍	❍	❍	❍
I am clear about how much authority I have.	❍	❍	❍	❍	❍
I receive requests incompatible with my job role.	❍	❍	❍	❍	❍
I work on things not related to my job description.	❍	❍	❍	❍	❍

COLLABORATION WITH NON-PEER SPECIALIST STAFF

How frequently do you collaborate with non-peer specialist staff?

❍ Daily
❍ 2-3 Times a Week
❍ Once a Week
❍ 2-3 Times a Month
❍ Once a Month
❍ Less than Once a Month
❍ Never

Thinking about collaborating with non-peer specialist staff, please indicate how frequently the following occurs at your organization.

	Never	Rarely	Sometimes	Often	Always
I attend treatment planning meetings.	❍	❍	❍	❍	❍
I actively participate in treatment planning meetings.	❍	❍	❍	❍	❍
I receive referrals from non-peer specialists.	❍	❍	❍	❍	❍

PEER SPECIALIST PERSPECTIVES OF SUPERVISION

Do you receive supervision related to your job role as peer specialist?
- ❍ No
- ❍ Yes

How frequently do you receive this supervision?
- ❍ Daily
- ❍ 2-3 Times a Week
- ❍ Once a Week
- ❍ 2-3 Times a Month
- ❍ Once a Month
- ❍ Less than Once a Month
- ❍ Never

What is your supervisor's job title?

Thinking about your supervisor at this organization, please rate your level of agreement with each statement.

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
My supervisor helps non-peer specialist staff understand the role of peer specialists.	❍	❍	❍	❍	❍
My supervisor helps me solve work-related problems.	❍	❍	❍	❍	❍
My supervisor asks about my career goals and aspirations.	❍	❍	❍	❍	❍
My supervisor provides me with opportunities to develop and strengthen new skills.	❍	❍	❍	❍	❍
My supervisor supports my attempts to acquire additional training or education to further my career.	❍	❍	❍	❍	❍
When facing a work related challenge, I am	❍	❍	❍	❍	❍

comfortable talking to my supervisor.					
My supervisor treats me like a colleague in our supervisory sessions.	❍	❍	❍	❍	❍
I have opportunities to engage in co-supervision and support.	❍	❍	❍	❍	❍

On a scale of 1 to 10, 1 being the lowest and 10 being the highest, please rate your supervisor's overall understanding of your job role as a peer specialist.

❍ 1
❍ 2
❍ 3
❍ 4
❍ 5
❍ 6
❍ 7
❍ 8
❍ 9
❍ 10

On a scale of 1 to 10, 1 being the lowest and 10 being the highest, please rate the overall level of supportiveness of your supervisor for your job role as a peer specialist.

❍ 1
❍ 2
❍ 3
❍ 4
❍ 5
❍ 6
❍ 7
❍ 8
❍ 9
❍ 10

SUPERVISION OF PEER SPECIALISTS' ROLE

Thinking about your role as a supervisor of peer specialists at this organization, please rate your level of agreement with each statement.

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
I help non-peer specialists understand the role of peer specialists.	❍	❍	❍	❍	❍
I help peer specialists solve work-	❍	❍	❍	❍	❍

related problems.					
I ask peer specialists about their career goals and aspirations.	❍	❍	❍	❍	❍
I provide opportunities for peer specialists to develop and strengthen new skills.	❍	❍	❍	❍	❍
I support the peer specialists' attempts to acquire additional training or education to further their career.	❍	❍	❍	❍	❍
When peer specialists are facing a work related challenge, I am comfortable talking with them.	❍	❍	❍	❍	❍
I treat peer specialists like colleagues in our supervisory sessions.	❍	❍	❍	❍	❍
Peer specialists have opportunity to engage in co-supervision and support.	❍	❍	❍	❍	❍
I monitor whether peer specialists are integrated into treatment teams.	❍	❍	❍	❍	❍
I am provided training and ongoing support in my role as a	❍	❍	❍	❍	❍

supervisor of peer specialists.

PEER SPECIALISTS' PERCEPTION OF ORGANIZATIONAL ENVIRONMENT

Please rate your level of agreement with the following statements:

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
I can decide on my own how to go about doing my work.	❍	❍	❍	❍	❍
The work I do is very important to me.	❍	❍	❍	❍	❍
My job activities are personally meaningful to me.	❍	❍	❍	❍	❍
I am confident about my ability to do my job.	❍	❍	❍	❍	❍

How satisfied are you with your overall job experience?

❍ Very Dissatisfied
❍ Dissatisfied
❍ Neither Satisfied nor Dissatisfied
❍ Satisfied
❍ Very Satisfied

On a scale of 1 to 10, 1 being the lowest and 10 being the highest, please rate the supportiveness of non- peer specialist staff of your job role as a peer specialist.

❍ 1
❍ 2
❍ 3
❍ 4
❍ 5
❍ 6
❍ 7
❍ 8
❍ 9
❍ 10

On a scale of 1 to 10, 1 being the lowest and 10 being the highest, please rate non-peer support staff's overall understanding of your job role as a peer specialist.

❍ 1
❍ 2
❍ 3
❍ 4
❍ 5

- ❍ 6
- ❍ 7
- ❍ 8
- ❍ 9
- ❍ 10

ORGANIZATIONAL POLICIES AND PRACTICES

Does your organization offer opportunities for career advancement in your job role?
- ❍ No
- ❍ Yes
- ❍ I'm not certain

What funding sources for peer specialists are currently being used at your organization?

My organization's new employee orientation training includes information about peer specialists.
- ❍ No
- ❍ Yes
- ❍ I'm not certain.

My organization would like to hire more peer specialists.
- ❍ No
- ❍ Yes
- ❍ I'm not certain.

New peer specialists shadow a current employee for a period before working independently.
- ❍ No
- ❍ Yes
- ❍ I'm not certain.

To better integrate the peer specialist role, my organization has written policies that address the following: (Select all that apply)
- ❑ The incorporation of peer specialists into the treatment process
- ❑ Distinguishing peer specialist role from non-peer specialist role
- ❑ Mediating conflicts among staff
- ❑ Guiding recruitment processes for peer specialists

Select which of the following are required qualifications for a peer specialist at your organization. (Select all that apply)
- ❑ Must be recovering from a mental health condition
- ❑ Must be a certified peer specialist
- ❑ Must have work history meeting minimum requirements (computer skills, communication skills)
- ❑ Must have experience working in a mental health field
- ❑ Must NOT be former utilizers of services at this organization

ORGANIZATIONAL CULTURE AND RECOVERY ORIENTATION

I feel that peer specialists are well integrated in my organization.
- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neither Agree nor Disagree
- ❍ Agree
- ❍ Strongly Agree

At your organization, how frequently do the following occur?

	Never	Rarely	Sometimes	Often	Always
Boundary issues often arise between peer specialists and clients.	❍	❍	❍	❍	❍
Boundary issues often arise between peer specialists and other non-peer staff.	❍	❍	❍	❍	❍
Peer specialists are accepted at this organization.	❍	❍	❍	❍	❍
Policies utilized by my organization create barriers/challenges for integrating peer specialists.	❍	❍	❍	❍	❍
Peer specialists are included in organizational meetings.	❍	❍	❍	❍	❍
Peer specialists serve on important organizational committees.	❍	❍	❍	❍	❍

Please indicate your level of agreement with the following statements:

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
This organization provides options for clients to choose from to include in their recovery/treatment plan.	❍	❍	❍	❍	❍
Staff and clients partner to assess progress toward recovery goals.	❍	❍	❍	❍	❍
Staff offer clients opportunities to discuss their spiritual needs when they wish.	❍	❍	❍	❍	❍
Staff believe in the ability of clients to recover.	❍	❍	❍	❍	❍

Staff help clients include people who are important to them in their recovery/treatment planning	❍	❍	❍	❍	❍
Staff connect clients with self-help, peer support, or consumer advocacy groups.	❍	❍	❍	❍	❍
This organization offers services that align with individual interests, culture, or life experience.	❍	❍	❍	❍	❍
Staff and clients are encouraged to pursue challenges and try new things.	❍	❍	❍	❍	❍
The primary role of agency staff is to assist a person with fulfilling his/her recovery goals.	❍	❍	❍	❍	❍
Staff encourage clients to have hope and high expectations for their recovery.	❍	❍	❍	❍	❍
Staff ask clients about their interests or the things they would like to do in the community.	❍	❍	❍	❍	❍
Staff help clients to develop and plan for recovery goals.	❍	❍	❍	❍	❍
Staff respect the decisions that clients make about their care.	❍	❍	❍	❍	❍

Describe any barriers your organization has faced integrating peer specialists.

Is there anything else you would like to share?

UNDERSTANDING OF THE PEER SPECIALIST JOB ROLE BY NON PEER SPECIALIST STAFF

The following statements ask about your perceptions of the peer specialist job role within the organization. Please rate your level of agreement with the statements.

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
My organization's staff understands the roles and activities of peer specialists.	❍	❍	❍	❍	❍
My organization's staff values the roles and activities of peer specialists.	❍	❍	❍	❍	❍
I understand the roles and activities of peer specialists.	❍	❍	❍	❍	❍
I value the roles and activities of peer specialists.	❍	❍	❍	❍	❍
I have concerns about peer specialists being employed at this organization.	❍	❍	❍	❍	❍
Peer specialists increase the effectiveness of care.	❍	❍	❍	❍	❍
Peer specialists are valuable members of the treatment team.	❍	❍	❍	❍	❍
Peer specialists are equal members of the treatment team.	❍	❍	❍	❍	❍

COLLABORATION WITH PEER SPECIALISTS

How frequently do you collaborate with peer specialists?

- ❍ Daily
- ❍ 2-3 Times a Week
- ❍ Once a Week
- ❍ 2-3 Times a Month
- ❍ Once a Month
- ❍ Less than Once a Month
- ❍ Never

Thinking about collaborating with peer specialists, please indicate how frequently the following occur:

	Never	Rarely	Sometimes	Often	Always
Peer specialists attend treatment planning meeting.	❍	❍	❍	❍	❍
Peer specialists actively participate in treatment planning meeting.	❍	❍	❍	❍	❍
I refer people to peer specialists.	❍	❍	❍	❍	❍

ORGANIZATIONS WITH NO PEER SPECIALISTS

How could peer specialists benefit your organization?

Do you think peer specialists could be integrated into the activities of your organization?

- ❍ No
- ❍ Yes
- ❍ I am not certain

What barriers prevent peer specialists from being fully integrated in your organization?

What barriers currently prevent the hiring of peer specialists?

- ❑ Funding
- ❑ Knowing how to integrate the role within the organization
- ❑ Organizational Culture
- ❑ Hiring policies
- ❑ Supervision of the role
- ❑ Lack of knowledge about peer specialists
- ❑ Other _____

What resources would help integrate peer specialists into your organization?

Is there anything else you would like to share?

Appendix B: Survey Data

Survey Respondents

Type of organization of employment	N	% survey respondents
State Hospital	337	50.6
Local Mental Health Authority	286	42.9
Other	43	6.5

Demographic information

Variable		N	% survey respondents
Gender	Female	486	70.4
	Male	202	29.3
	Not Listed	2	00.3
Age	18-25	22	3.2
	26-39	182	26.4
	40-55	286	41.5
	56 or older	199	28.9
Race	American Indian or Alaska Native	18	2.5
	Asian	10	1.4
	Black or African American	67	9.2
	Native Hawaiian or other Pacific Islander	3	0.4
	Other	43	5.9
	White	557	76.8
Ethnicity	Hispanic	145	21.4
	Non-Hispanic	534	78.6

Job roles

Job Role	N	% survey respondents
Administrative support	120	17.6
Executive Leadership	87	12.8
Other Clinical or Direct Care Personnel	83	12.2
Nurse	63	9.3
Peer specialist	60	8.8
Education or Rehabilitation	42	6.2
Social Worker	42	6.2
Case Manager	41	6
Program Leadership	31	4.6
Other	29	4.3
Quality Management	22	3.2
Staff Training	13	1.9
Psychologist	11	1.6
Recovery coach	11	1.6
Consumer Representative	7	1
Family Partner	7	1
Doctor	6	0.9
Human Resources	4	0.6
Psychiatrist	2	0.3

Employment Status

What is your employment status as a peer specialist at your organization?	N	% peer staff survey respondents

Full-time	34	63.0
Part-time	18	33.3
Full-time – Contract	1	1.9
Part-time – Contract	1	1.9

Emerging workforce

How long have you worked at this organization?	N	% peer staff survey respondents	N	% non-peer staff respondents
Less than 1 year	16	29.1	64	10.3
1 year to less than 3 years	26	47.3	128	20.6
3 years to less than 5 years	9	16.4	69	11.1
5 years or more	4	7.3	361	58.0

Organizational Culture

Recovery orientation / Readiness

	N	**Mean (Std. Dev.)** peer staff respondents	N	**Mean (Std. Dev.)** non-peer staff respondents
This organization provides options for clients to choose from to include in their recovery/treatment plan.	48	4.10 (1.06)	438	3.95 (0.84)
Staff and clients partner to assess progress toward recovery goals.	48	4.19 (0.94)	439	4.09 (0.75)
Staff offer clients opportunities to discuss their spiritual needs when they wish.	47	3.81 (0.97)	437	3.95 (0.76)
Staff believe in the ability of clients to recover.	47	4.09 (1.08)	440	4.22 (0.78)
Staff help clients include people who are important to them in their recovery/treatment planning	48	4.23 (0.88)	435	4.08 (0.81)
Staff connect clients with self-help, peer support, or consumer advocacy groups.	47	4.15 (1.12)	439	4.11 (0.79)
This organization offers services that align with individual interests, culture, or life experience.	48	3.88 (1.08)	436	3.93 (0.83)
Staff and clients are encouraged to pursue challenges and try new things.	48	4.06 (1.08)	434	3.91 (0.88)
The primary role of agency staff is to assist a person with fulfilling his/her recovery goals.	46	4.07 (1.02)	437	4.18 (0.82)
Staff encourage clients to have hope and high expectations for their recovery.	46	4.00 (0.99)	436	4.12 (0.77)
Staff ask clients about their interests or the things they would like to do in the community.	48	4.17 (0.86)	436	4.12 (0.78)
Staff help clients to develop and plan for recovery goals.	48	4.29 (0.85)	436	4.17 (0.77)
Staff respect the decisions that clients make about their care.	48	3.94 (1.10)	434	4.00 (0.82)
RSA Total	48	4.07 (0.84)	438	4.06 (0.63)

Peer specialists are accepted at this organization	N	% survey respondents
Never	7	1.5
Rarely	2	.4
Sometimes	75	15.6
Often	205	42.5
Always	193	40.0

Peer specialists serve on important organizational committees.	N	% survey respondents
Never	28	6.2
Rarely	58	12.8
Sometimes	158	35.0
Often	142	31.4
Always	66	14.6

I value the roles and activities of peer specialists.	N	% survey respondents
Strongly Disagree	11	2.3
Disagree	13	2.7
Neither Agree nor Disagree	51	10.6
Agree	168	35.0
Strongly Agree	237	49.4

Peer specialists increase the effectiveness of care.	N	% survey respondents
Strongly Disagree	13	2.7
Disagree	23	4.8
Neither Agree nor Disagree	84	17.5
Agree	165	34.4
Strongly Agree	194	40.5

Do you think peer specialists could be integrated into the activities of your organization?	N	% survey respondents
No	4	4.6
Yes	51	58.6
I'm not certain	32	36.8

Have you attended any trainings or meetings that focused on the integration of peer specialists into organizations?	N	% survey respondents
No	394	59.4
Yes	269	40.6

Peer specialist job satisfaction

How satisfied are you with your overall job experience?	N	% peer staff survey respondents
Very Dissatisfied	0	0
Dissatisfied	7	14.0
Neither Satisfied nor Dissatisfied	4	8.0
Satisfied	17	34.0
Very Satisfied	22	44.0

Integration

I feel that peer specialists are well integrated in my organization.	N	% survey respondents
Strongly Disagree	17	3.3
Disagree	59	11.5
Neither Agree nor Disagree	136	26.5
Agree	225	43.9
Strongly Agree	76	14.8

Role Clarity

Job tasks

Do you perform any of the following job duties on a regular basis?	N (Yes)	% peer staff survey respondents
Helping people advocate for themselves	53	100
One-on-one support	52	98.1
Connecting consumers to resources/networking	48	96
Goal-setting	48	96
Advocacy	48	92.3
Facilitating support groups	46	90.2
Outreach or Engagement	40	80
Skill building	32	66.7
Support clients during transition from inpatient	31	64.6
Transportation assistance	32	61.5
Patient navigation	27	57.4
Wellness Recovery Action Planning (WRAP)	28	57.1
Administrative Tasks	26	54.2
Education	24	52.2
Working on a treatment team	26	52
Other	8	36.4
Serve on work groups and committees	17	36.2
Housing assistance	16	32.7
Vocational Assistance	13	30.4
Provide supervision to other peer specialists	11	22.9
Medication monitoring	4	8.7

Peer specialists attend treatment planning meeting.	N	% survey respondents
Never	72	22.0
Rarely	57	17.4
Sometimes	96	29.4
Often	69	21.1
Always	33	10.1

Peer specialists actively participate in treatment planning meeting.	N	% survey respondents
Never	74	22.7
Rarely	65	19.9
Sometimes	92	28.2
Often	69	21.2
Always	26	8.0

Job description

Do you perform any of the following job duties Does your organization have a job description for your role as a peer specialist?	N	% peer staff survey respondents
No	1	1.9
Yes	50	92.6
I'm not sure	3	5.6

Understanding of the peer specialist role

I understand the roles and activities of peer specialists.	N	% survey respondents
Strongly Disagree	11	2.3
Disagree	23	4.8
Neither Agree nor Disagree	50	10.4
Agree	212	44.2
Strongly Agree	184	38.3

I help non-peer specialists understand the role of peer specialists.	N	% peer supervisor survey respondents
Strongly Disagree	0	0
Disagree	0	0
Neither Agree nor Disagree	1	2.1
Agree	36	76.6
Strongly Agree	10	21.3

My supervisor helps non-peer specialist staff understand the role of peer specialists.	N	% peer staff survey respondents
Strongly Disagree	0	0
Disagree	3	6.8
Neither Agree nor Disagree	6	13.6
Agree	16	36.4
Strongly Agree	19	43.2

Have you attended any trainings or meetings that focused on the integration of peer specialists into organizations?	N	% peer supervisor survey respondents
No	10	20.4
Yes	39	79.6

Supervision and Career Development

Supervision

What is your supervisor's job title?	N peer staff survey respondents
Assistant Coordinator of patient relations and peer support	1
assistant manager	1
Assistant mental health Director/backed up by the Lampasas clinic coordinator	1
Assistant Program Manager	1
chief programs officer	1
Clinic Director	2
Director	1
Director of client rights	1
Director of Peer Specialist	1
Director of Peer Support	3
Division Director	1
I have two supervisor. A Mental Health Director and a Peer Support Coordinator	1
Integrated Care Administrator	1
LPHA	1
National Program Manager	1
Patient Program Director	1
peer service coordinator	1

What is your supervisor's job title?	N peer staff survey respondents
Peer Specialist Manager	1
Peer supervisor	1
Peer support administrator	1
Peer Support Coordinator	2
peer support supervisor	1
Peer Support Supervisor	1
Practice Manager	1
program manager	1
Program manager	1
Program Manager	3
Program Manager Mid Cities Clinic	1
Project Manager	1
Recovery Manager	1
Supervisor of Peer Support	1
team lead	1
Team Lead	1
team lead	1
Veterans Services Director West	1

Do you receive supervision related to your job role as peer specialist?	N	% peer staff survey respondents
No	6	12.0
Yes	44	88.0

Career advancement

Does your organization offer opportunities for career advancement in your job role?	N	% peer staff survey respondents	N	% non-peer staff respondents
No	19	37.3	140	29.6
Yes	21	41.2	267	56.4
I'm not certain	11	21.6	66	14.0

My supervisor asks about my career goals and aspirations.	N	% peer staff survey respondents
Strongly Disagree	2	4.5
Disagree	11	25.0
Neither Agree nor Disagree	9	20.5
Agree	12	27.3
Strongly Agree	10	22.7

Recruitment and Hiring

New-hires

New peer specialists shadow a current employee for a period before working independently.	N	% survey respondents
No	8	5.8
Yes	104	75.9
I'm not certain	25	18.2

New employee orientation

My organization's new employee orientation training includes information about peer specialists.	N	% survey respondents
No	57	10.8
Yes	283	53.5
I'm not certain	189	35.7

Barriers to hiring and training/technical assistance needs

What barriers currently prevent the hiring of peer specialists?	N	% survey respondents at organizations that do not employ peer specialists
Funding	32	60.4
Lack of knowledge about peer specialists	31	58.5
Knowing how to integrate the role within the organization	18	34.0
Other	16	30.2
Organizational Culture	11	20.8
Hiring policies	10	18.9
Supervision of the role	10	18.9

Collaboration

I refer people to peer specialists.	N	% non-peer staff respondents
Never	67	19.5
Rarely	29	8.5
Sometimes	96	28.0
Often	103	30.0
Always	48	14.0

How frequently do you collaborate with peer specialists?	N	% non-peer staff respondents
Daily	59	16.5
2-3 Times a Week	70	19.6
Once a Week	41	11.5
2-3 Times a Month	42	11.8
Once a Month	26	7.3
Less than Once a Month	54	15.1
Never	65	18.2

How frequently do you collaborate with non-peer specialist staff?	N	% peer staff survey respondents
Daily	36	67.9
2-3 Times a Week	9	17.0
Once a Week	5	9.4
2-3 Times a Month	0	0
Once a Month	1	1.9
Less than Once a Month	1	1.9
Never	1	1.9

Appendix C: Focus Group Schedule

I. Overall

- Are peer specialists integrated in your organization? How do you know? (IF YES: (How) is it better than it was?
- What resources have helped your organization successfully integrate peer specialists (probe for individual, organizational, and state-level resources)?
    - What resources do you need (probe for individual, organizational, and state-level resources)?
- What barriers has your organization faced in integrating peer specialists (probe for individual, organizational, and state-level barriers)?
    - If those barriers are in the past, how did your organization overcome?

II. Organizational culture

- Does your organizational culture (language, values, norms) support a recovery orientation? How do you know?
- Does your organizational culture (language, values, norms) support peer specialists? How?

III. Funding

- Have you experienced any issues with funding for peer specialists?

IV. Role Clarity

- Do you think staff at your organization have a clear understanding of the roles and activities of peer specialists? Why/why not? Vary by discipline/position?

V. Recruitment, Hiring, and New Staff Training

- Please describe the recruitment and hiring practices of peer specialists at your organization
    - Barriers to recruiting and hiring peer specialists?
- Please describe your organization's efforts to educate staff about peer specialists.
    - NEO? Internal trainings? External trainings?

VI. Supervision and career advancement

- Please describe how peer specialists are supervised at your organization – probe for challenges, specific supervisory tasks
    - How could supervisors better support peer specialists?
- Is there a career ladder for peer specialists at your organization? Describe.

VII. Collaboration

- Do peer and non-peer staff have effective collaborative working relationships at your organization?
    - If yes, what do you think contributes to the effectiveness of those relationships?
    - If no, what barriers do you see to effective collaborative relationships?

VIII. Future Plans

- What are the future plans for peer specialists at your organization? (probe for integration)

Appendix D: Integration Domains and Focus Group Codes

Integration Domains	Codes: Indicators of Integration
Organizational culture	*Administration buy-in/support* *Embrace values of recovery/recovery orientation* *Language* *Recovery-oriented activities* *Peer specialists attend social gatherings* *Staff buy-in* *Peer specialists serve in positions of authority* *Empowerment of people in services* *People in services talk about/reach out for peer specialists* *Informal staff education on peer specialists*
Recruitment, hiring, and staff training	*Internal training on peer specialists* *More peer specialists* *New employee orientation incorporates training on peer specialists* *Organizations recruit peer specialists from clients* *Peer specialists are trained and certified* *Referrals for new peer specialist hires come from employed peer specialists* *Peer specialists are internally trained* *Peer specialists receive benefits* *Peer specialists are paid employees* *Peer specialists are full-time employees*
Role clarity	*Formal job description* *Peer specialists are integrated into the operations manual* *Peer specialists are fully utilized* *Staff know what peer specialists do*
Supervision and career advancement	*Co-supervision and support* *Peer specialist is a professional position* *Peer specialists receive regular feedback/communication from their supervisor* *Peer specialists are salaried instead of paid hourly* *Peer specialists are supervised by another peer specialist* *Career ladder for peer specialists* *Peer specialists are held to the same accountability standards as other staff* *Peer specialists receive mentorship*
Collaboration	*Case managers and other clinical staff refer people in services to peer specialists* *Doctors value and include peer specialists* *Non-peer staff keep peer specialists "in the loop"/regularly communicate* *Peer specialists are on quality improvement/ implementation/advisory teams* *Peer specialists attend staff meetings* *Peer specialists are treated like equal colleagues* *Peer specialists are part of treatment teams* *Clinical staff and peer specialists collaborate* *Peer specialists participate in the new employee interview process*
Miscellaneous integration indicators	*Peer specialists are spread throughout the organization* *Peer specialists have their own offices* *Peer specialists meet consumers at intake* *Peer specialists have been employed for a long time* *Peer specialists are involved in the continuity of care process*

Integration Domains	Codes: Resources that have Facilitated Integration
Organizational Culture	*Champion* *Administration buy-in* *Recovery oriented programs, structures, activities*
Funding	*Diverse funding streams* *Dedicated funding streams*
Recruitment, Hiring, Staff Training	*Changing human resources' hiring policies* *Peer specialist integration as a contract mandate* *Via Hope training, technical assistance, and coaching* *Raising peer specialists' wages* *Networks of peer specialists*
Role Clarity	*Peer specialists introduce themselves/self-advocate* *Internal trainings on recovery-oriented topics (including peer specialists)* *Having one peer specialist supervisor/a peer specialist unit*
Miscellaneous Resources	*Time* *Seeing the power of peer support*

Integration Domains	Codes: Needs/Barriers to Peer Specialist Integration
Organizational Culture	*Agency doesn't support peer specialists* *Champion needed* *Incomplete staff buy-in* *Executive leadership do not value peer specialists* *Hiring peer specialists is not an agency priority* *Organization not recovery-oriented/person-centered* *Peer specialists are not part of organizational decision-making processes* *Fear and stigma*
Funding	*A lack of funding for peer specialist positions* *The need to hire more peers* *Hospitals are discouraged from pursuing diverse funding for hiring peer specialists* *The need for funding to train and certify peer specialists* *Concern about sustainability once the 1115 Medicaid Transformation Waiver runs out* *Funding for transportation* *The need for a peer-specific Medicaid billable code*
Recruitment, hiring, and staff training	*Bars to employment* *The need to "grow our own" and get consumers certified to be peer specialists* *The need for (ongoing) internal trainings (including NEO) on peer specialists* *Peer specialist positions are not attractive enough* *The difficulty of finding qualified and certified peer specialists* *Hiring unqualified peer specialists* *The need for peer specialists to participate in the new employee interview process* *The difficulty of getting into CPS training* *The need for information on how to interview peer specialist applicants*
Role clarity	*Management do not understand what peer specialists do* *Peer specialists are performing job duties outside of their role* *Staff do not understand what peer specialists do* *There is not a formal job description for peer specialists* *Peer specialists are not performing all the job functions that they could be* *Peer specialists do not fully understand their value*
Supervision and career advancement	*Need for information on how to supervise peer specialists* *Inadequate supervision for peer specialists*

	Not supervised by other peer specialists *Supervisors not trained on peer support* *No career ladder* *Confusing supervision structure* *Salary schedules need to be adopted*
Collaboration	*Peer specialist and non-peer specialist staff do not collaborate/work together* *Stigma from non-peer specialist staff* *Case managers and other clinical staff do not regularly refer people in services to peer specialists* *Peer specialists are not involved in the treatment planning process* *Peer specialists are not allowed to access records* *Peer specialists are not listed as an intervention on PCRPs* *Doctors do not want peer specialists in treatment planning meetings* *Peer specialists cannot directly communicate with doctors*
Miscellaneous Barriers	*State legislature does not understand the value of peer specialists* *No accountability to integrate peer specialists* *High turnover* *Organizational policies* *A lack of collaboration across state agencies* *Peer specialists are not disseminated throughout the organization* *State bureaucratic barriers* *People in services are not provided information on peer services*