



REPORT / TEXAS PEER PROVIDERS: TRAINING NEEDS AND CHALLENGES
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Texas Peer Providers: Training Needs and Challenges

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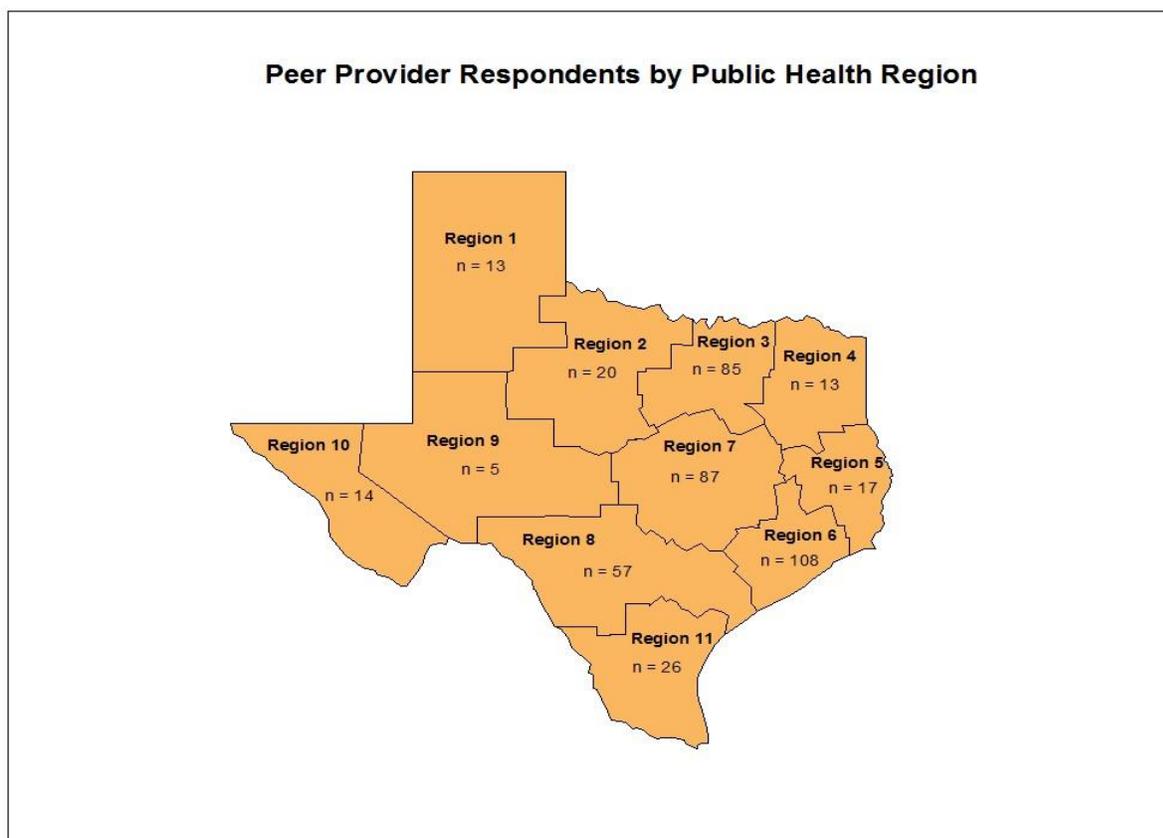
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Executive Summary

This report provides an overview of Texas peer providers' training needs and challenges with a focus on how these needs and challenges vary by Public Health Region (PHR). PHR differences were examined to inform the provision of peer training and technical assistance to support regional needs. The results in this report are based on secondary data analysis of the FY2019 Texas Peer Provider Work Settings and Practices survey and include data from peer provider respondents who are currently or have ever been employed in a peer role (n=470). Figure 1 displays the number of peer provider respondents from each PHR.

Figure 1: Number of peer provider respondents by Public Health Region (PHR)*



*Figure 1 (and subsequent figures) includes respondents who are currently or ever worked as a peer provider.

Training Needs

Among survey respondents, 209 respondents who were currently or had ever worked as a peer provider reported having unmet training needs. These respondents most commonly reported the following training needs:

- Trauma-Informed Peer Support (n=36);
- Community Re-entry Peer Support (n=19);
- Peer Supervision (n=19);
- Co-occurring Challenges (n=19);

- WRAP (n=19);
- Intentional Peer Support (n=15);
- Crisis Intervention (n=13);
- Whole Health Action Management (WHAM (n=11); and,
- Mental Health First Aid (n=11).

Among respondents who reported any training need, respondents from PHRs 1 and 8 were more likely to report Trauma-Informed Peer Support as a training need compared to respondents from other PHRs¹. In contrast, a higher percentage of respondents from PHRs 4 and 10 reported Community Re-Entry as a training need. A higher percentage of respondents from PHRs 2 and 10 reported Peer Supervision as a training need compared to respondents from other PHRs, whereas respondents from PHRs 4, 5, and 8 were most likely to report Co-Occurring Challenges as a training need. Finally, a higher percentage of respondents from PHRs 4 and 10 reported WRAP as a training need. There were some differences in the percentage of respondents that reported each training need by PHR, although these should not be interpreted as definitive differences because sample sizes are small and vary by PHR.

Training Challenges

Among survey respondents, 123 respondents who were currently or had ever worked as a peer provider reported experiencing training challenges. These respondents most commonly reported the following training challenges:

- the cost of training/financial barriers (n=51);
- a lack of availability (n=23);
- distance to trainings or a lack of local trainings (n=19); and,
- organizational barriers (e.g., getting time off from work, employer does not allow it; n=14).

A higher percentage of respondents from PHRs 1, 2, and 5 reported cost as a training challenge compared to respondents from other PHRs. Similarly, only respondents from PHRs 2, 6, 7, and 8 reported a lack of availability as a training challenge. A higher percentage of respondents from PHRs 1, 4, 10, and 11 reported distance as a training challenge, whereas a higher percentage of respondents from PHR 5 reported experiencing organizational barriers to training compared to respondents from other PHRs. Although there were some differences in the percentage of respondents that reported each training challenge by PHR, these differences should be interpreted with caution.

¹ Percentages are based on the number of respondents from a PHR who reported a code divided by the number of respondents from a PHR who responded to the survey item.

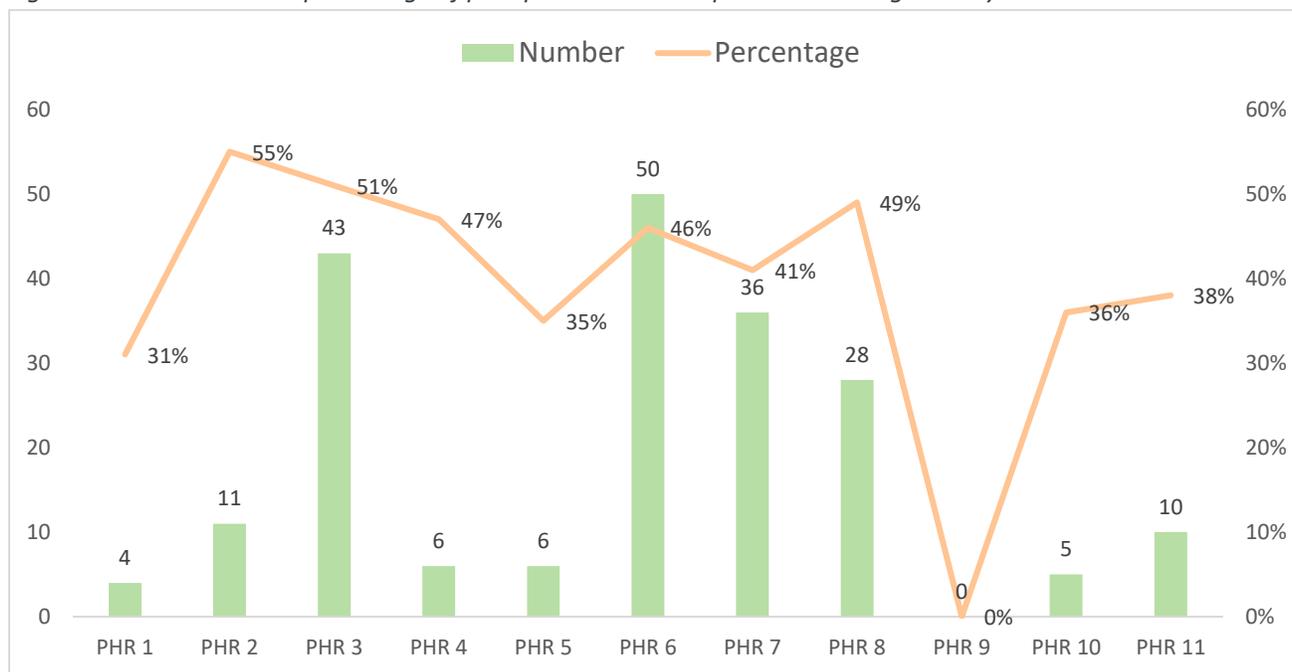
Training Needs

Peer providers who responded to the FY2019 Texas Peer Provider Work Settings and Practices survey were asked to qualitatively describe trainings they would like to receive. Among respondents who were currently or had ever worked as a peer provider (i.e., the analytic sample, n=470), 45% (n=209) provided qualitative responses to this question. These qualitative responses were reanalyzed to develop qualitative codes and these codes were then summed to determine if particular needs varied by public health region.

Figure 2 displays the number and percentage of respondents who reported a training need by public health region (note that Figure 2 excludes 10 respondents with missing PHR data whose qualitative responses were included in the analytic sample).

The regions with the highest *number* of respondents reporting that they experienced a training need were PHR 6 (n=50) and PHR 3 (n=43) while the regions with the highest *percentage* of respondents reporting that they experienced a training need were PHR 2 (55%) and PHR 3 (51%).

Figure 2: The number and percentage of peer providers who reported a training need by PHR

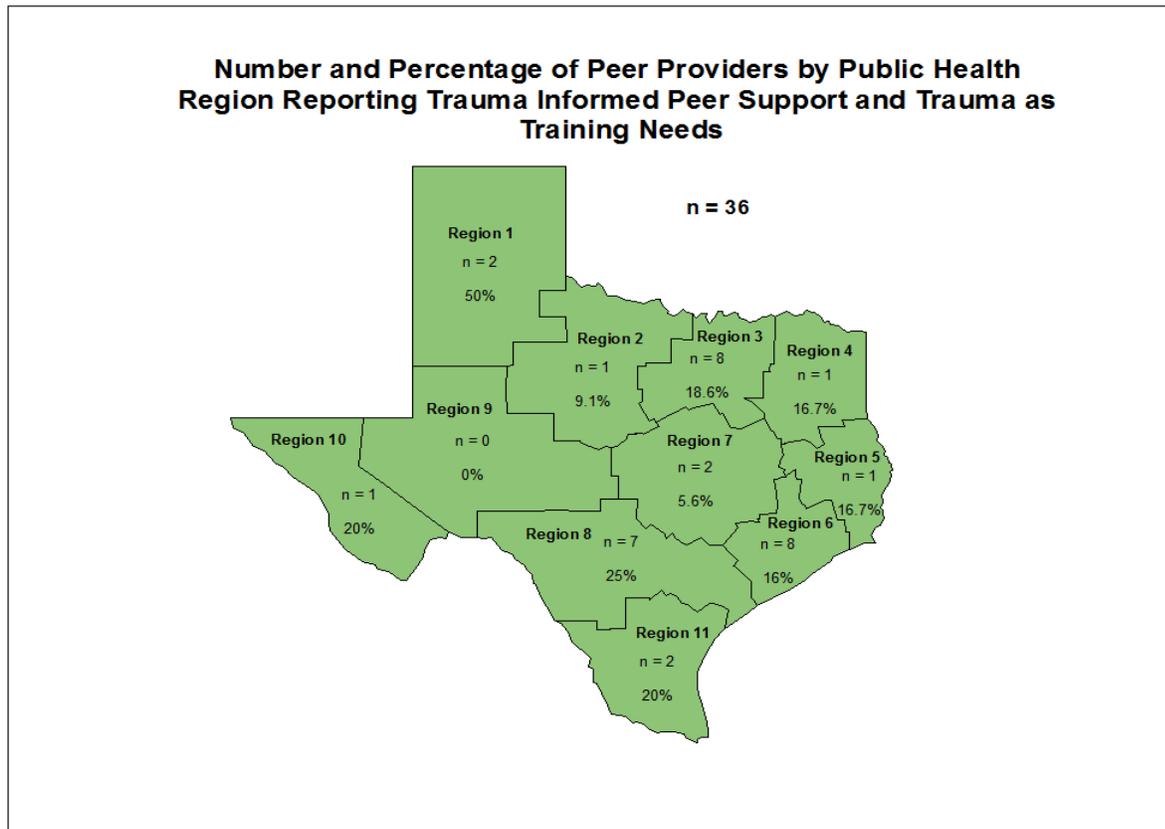


Trauma-Informed Peer Support Training

The most frequently reported training need was Trauma-Informed Peer Support or trauma training (n=36; 17% of respondents who reported any training need). Figure 3 shows the number of respondents from each region who reported Trauma-Informed Peer Support as a training need (note three respondents with missing PHR data also reported this training need).

Figure 3 also displays the percentage of respondents from each region who reported Trauma-Informed Peer Support as a training need relative to the number of respondents from each region who reported any training need. A higher percentage of respondents from PHRs 1 and 8 reported Trauma-Informed Peer Support as a training need compared to respondents from other PHRs. For example, 50% of respondents from PHR 1 who reported a training need reported Trauma-Informed Peer Support as a training need. Note that because the sample sizes are small and vary by PHR, PHR differences should not be interpreted as definitive differences, but rather as raising the possibility that these differences may exist.

Figure 3: Peer provider respondents who reported needing Trauma-Informed Peer Support training by PHR

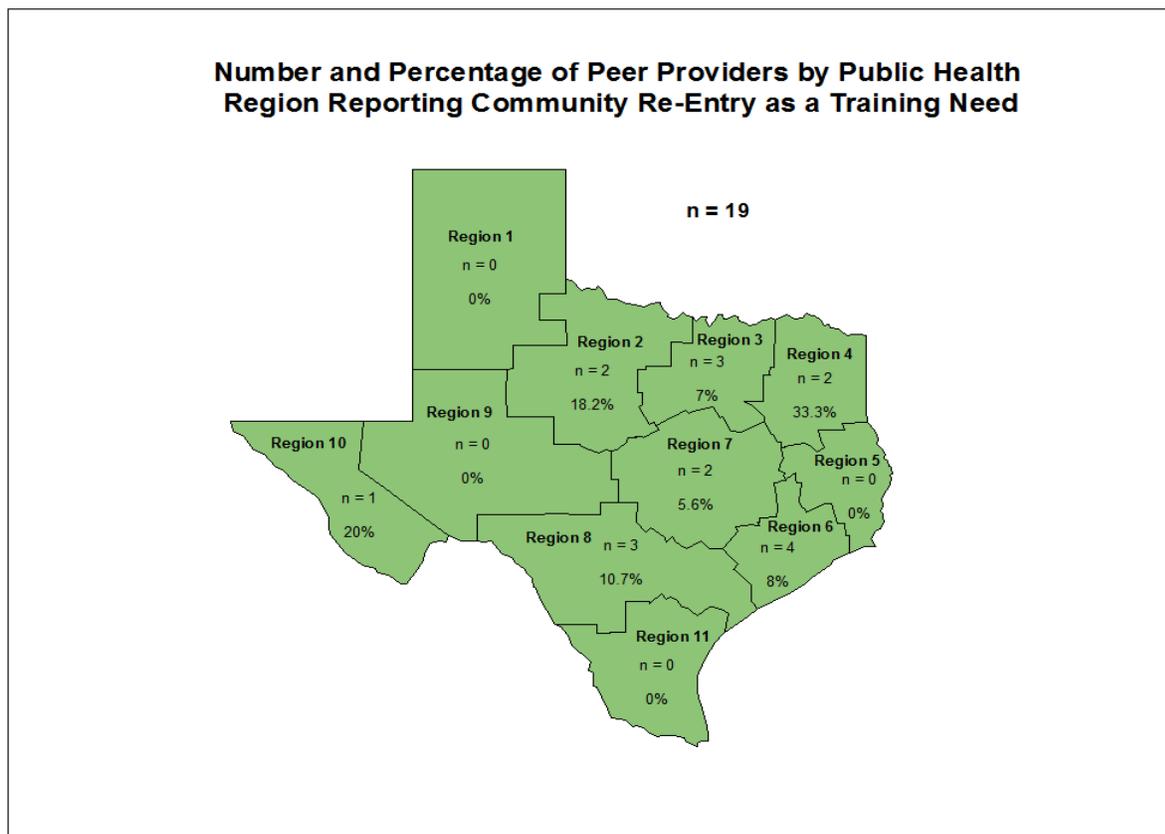


Community Re-Entry Training

Community Re-Entry training was identified as a training need by 19 peer provider respondents (9% of respondents who reported any training need). Figure 4 shows the number of respondents from each region who reported Community Re-Entry as a training need (note two respondents with missing PHR data also reported this training need).

A higher percentage of respondents from PHRs 4 and 10 reported Community Re-Entry as a training need compared to respondents from other PHRs. For example, 33% of respondents from PHR 4 who reported a training need reported Community Re-Entry as a training need.

Figure 4: Peer provider respondents who reported needing Community Re-Entry training by PHR

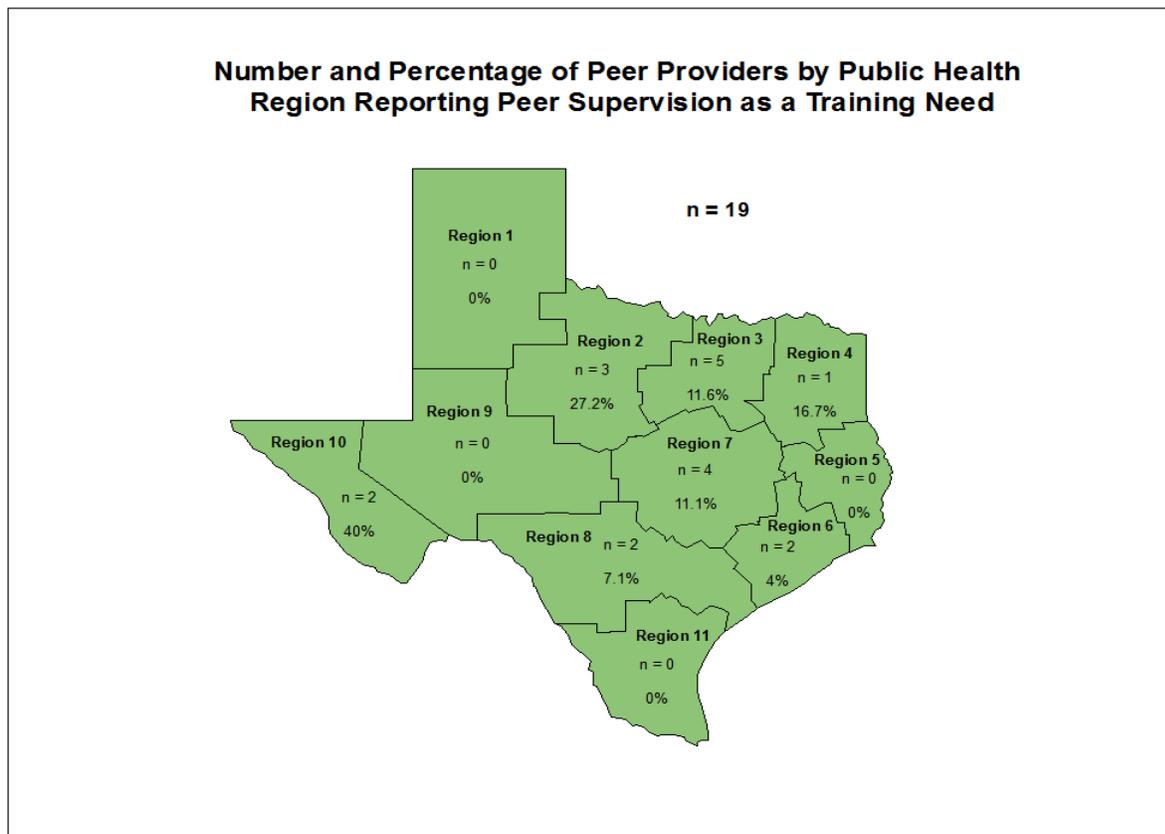


Peer Supervision Training

Peer Supervision training was identified as a training need by 19 peer provider respondents (9% of respondents who reported any training need). Figure 5 shows the number of respondents from each region who reported Peer Supervision as a training need (note two respondents with missing PHR data also reported this training need).

A higher percentage of respondents from PHRs 2 and 10 reported Peer Supervision as a training need compared to respondents from other PHRs. For example, 40% of respondents from PHR 10 who reported any training need reported Peer Supervision as a training need.

Figure 5: Peer provider respondents who reported needing Peer Supervision training by PHR

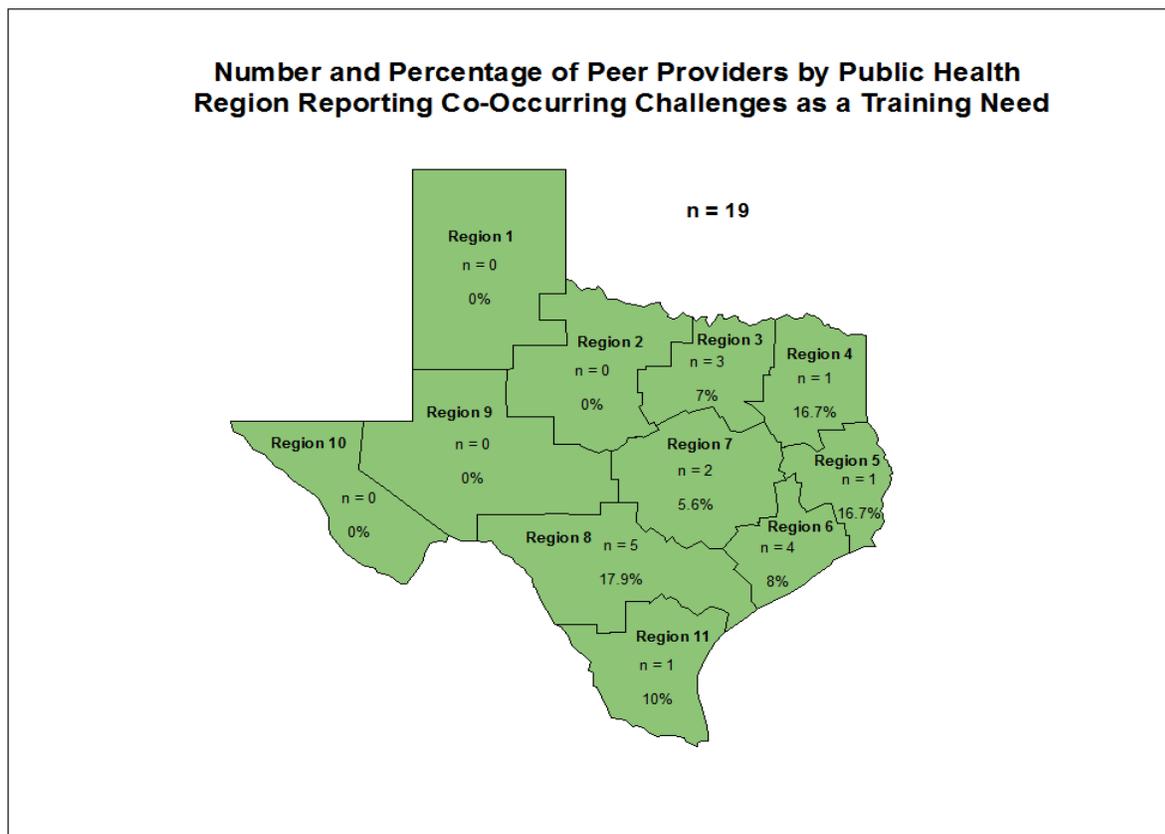


Co-Occurring Challenges Training

Co-Occurring Challenges training was identified as a training need by 19 peer provider respondents (9% of respondents who reported any training need). Figure 6 shows the number of respondents from each region who reported Co-Occurring Challenges as a training need (note two respondents with missing PHR data also reported this training need).

A higher percentage of respondents from PHRs 4, 5, and 8 reported Co-Occurring Challenges as a training need compared to respondents from other PHRs. For example, 18% of respondents from PHR 8 who reported any training need reported Co-Occurring Challenges as a training need.

Figure 6: Peer provider respondents who reported needing Co-Occurring Challenges training by PHR

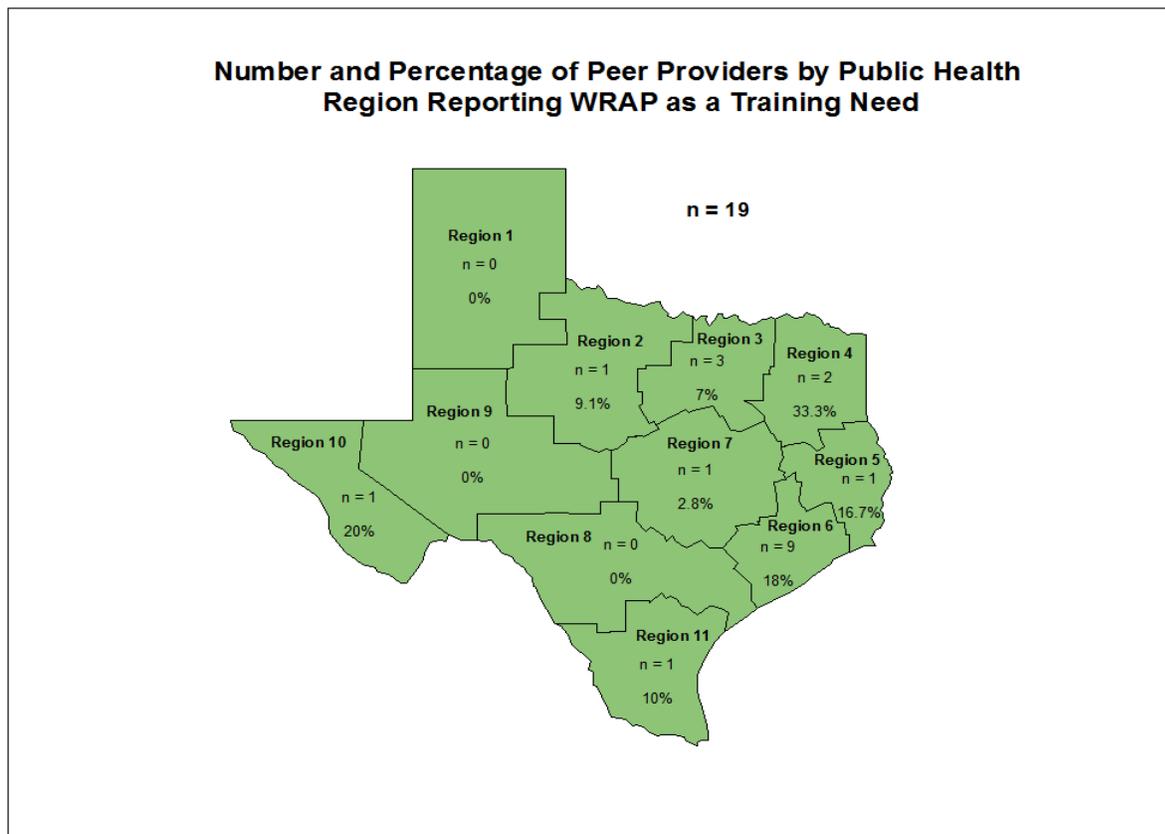


WRAP Training

Wellness Recovery Action Plan (WRAP) training was identified as a training need by 19 peer provider respondents (9% of respondents who reported any training need). Figure 7 shows the number of respondents from each region who reported WRAP as a training need.

A higher percentage of respondents from PHRs 4 and 10 reported WRAP as a training need compared to respondents from other PHRs. For example, 33% of respondents from PHR 4 who reported any training need reported WRAP as a training need.

Figure 7: Peer provider respondents who reported needing WRAP training by PHR



Additional Training Needs

Peer providers reported additional training needs. In addition to the above-discussed training needs, other commonly reported training needs included: Crisis Intervention (n=13), Intentional Peer Support (n=13), Mental Health First Aid (n=11), Whole Health Action Management (WHAM; n=11), Mental Health Peer Support (n=10), mental health trainings (n=9), Recovery Advocacy (n=9), and group facilitation training (n=8). An exhaustive list of all reported training needs is available in the Texas Peer Provider Work Settings and Practices, Fiscal Year 2019 report (Stevens Manser, Earley, Lodge, & Parkin, 2019).

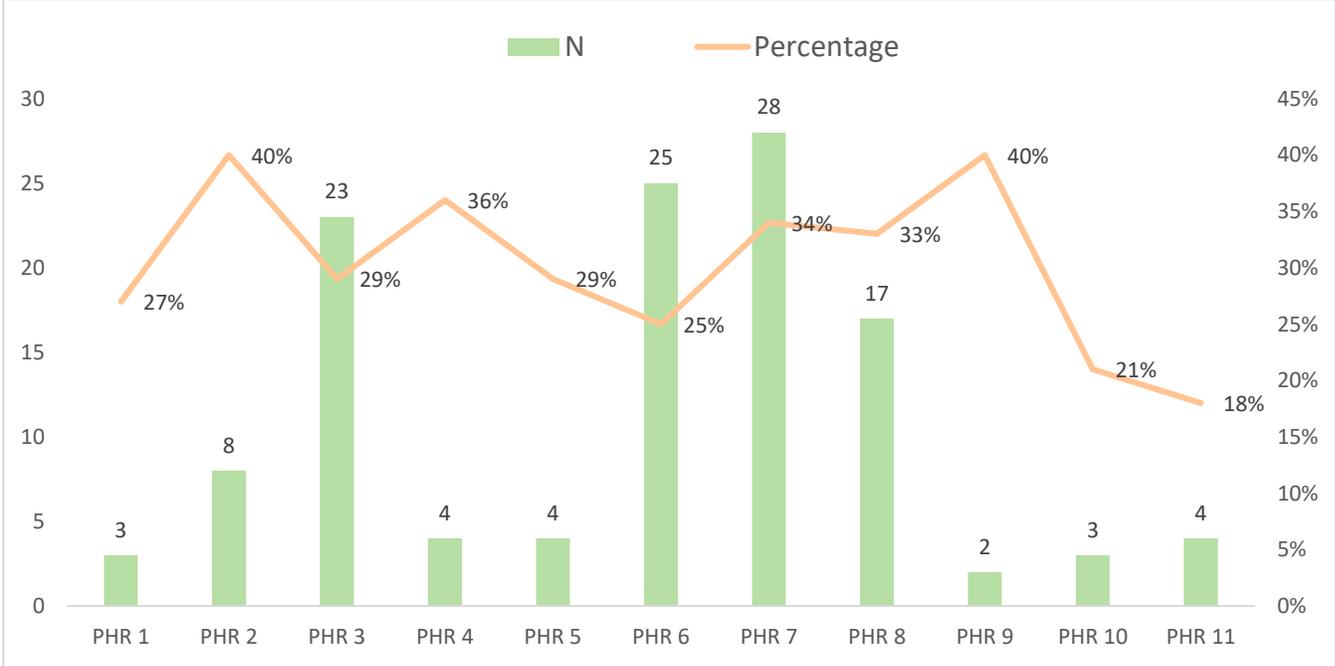
Training Challenges

Peer providers who responded to the FY2019 Texas Peer Provider Work Settings and Practices survey were asked to report whether or not they had experienced any challenges receiving training in peer practices. The majority (72%; n=313) of peer providers who responded to this question and were included in the analytic sample (n=436) reported that they have not experienced any challenges receiving training. However, 28% (n=123) reported that they have experienced a challenge receiving training in peer practices and these respondents were asked to qualitatively describe the challenges they have experienced. These responses were reanalyzed to develop qualitative codes and these codes were then summed to determine if particular challenges varied by public health region.

Figure 8 displays the number and percentage of respondents who reported experiencing a training challenge by public health region (note that Figure 8 excludes two respondents with missing PHR data whose qualitative responses were included in the analytic sample).

The regions with the highest *number* of respondents reporting that they experienced a training challenge were PHR 6 (n=25) and PHR 7 (n=28) while the regions with the highest *percentage* of respondents reporting that they experienced a training challenge were PHR 2 (40%) and PHR 9 (40%).

Figure 8: The number and percentage of peer providers who reported experiencing a training challenge by PHR



“The program I work for does not have the funding [for training]. My salary alone does not allow me to meet my basic needs therefore I cannot pay for them myself.”

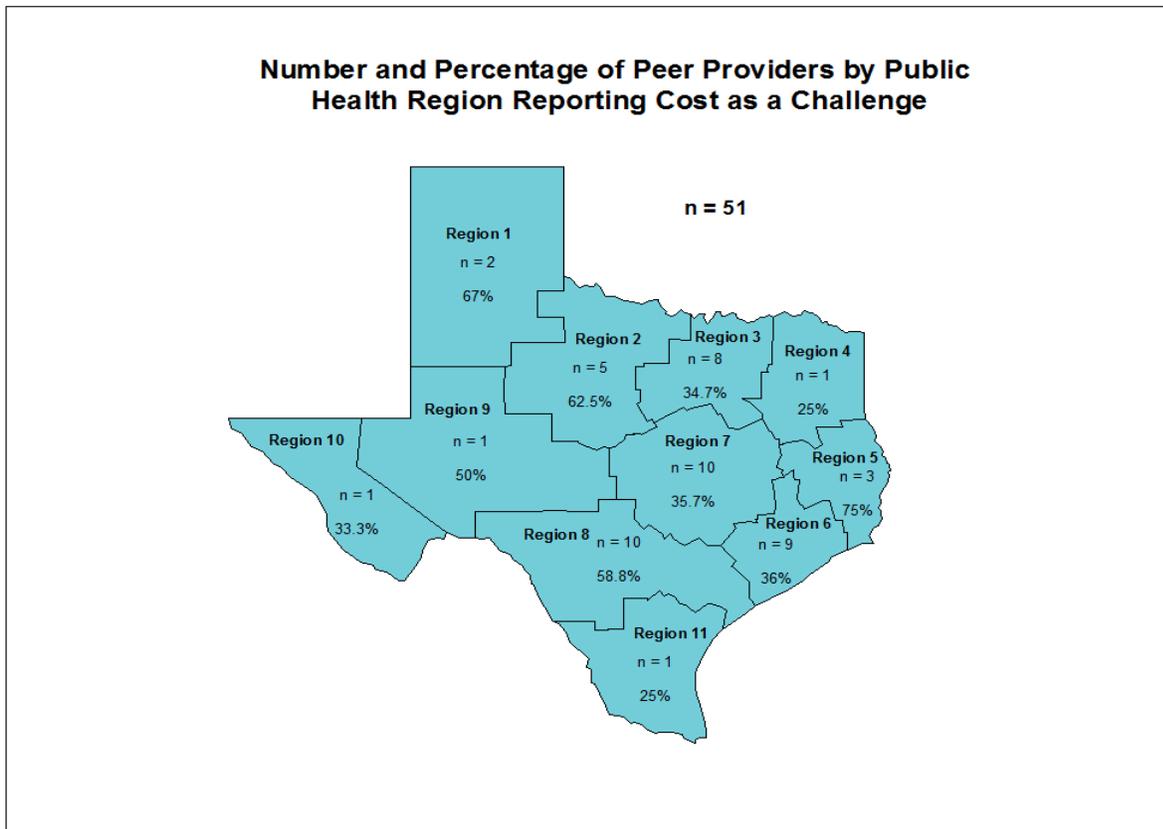
Cost

The most commonly reported training challenge was the cost of training or financial barriers (n=51; 41% of respondents who reported any training challenge). Specific financial barriers reported by respondents include the fact that employers are not willing to pay for training, a lack of scholarships, and the high cost of training relative to peer provider salaries. For example, one respondent reported: “The program I work for does not have the funding. My salary alone does not allow me to meet my basic needs therefore I cannot pay for them myself.”

For unemployed respondents, the cost of attending trainings was particularly prohibitive. For example, one respondent explained: “The training is very expensive. Employers can certainly afford to pay for their Peer Specialist employees’ training. However, if you are a Peer Specialist who is unemployed but are trying to beef up your endorsements, the cost is prohibitive.”

Figure 9 shows the number of respondents from each region who reported cost as a training challenge. Additionally, Figure 9 displays the percentage of respondents from each region who reported cost as a training challenge relative to the number of respondents from each region who reported any training challenge. A higher percentage of respondents from PHRs 1, 2, and 5 reported cost as a training challenge compared to respondents from other PHRs. For example, 75% of respondents from PHR 5 who reported experiencing a training challenge reported cost as a training challenge, compared to only 25% of respondents from PHRs 4 and 11. Note that because the sample sizes from are small and vary by PHR, PHR differences should not be interpreted as definitive differences, but rather as raising the possibility that these differences may exist.

Figure 9: Peer provider respondents who reported cost as a training challenge by PHR



Lack of Availability

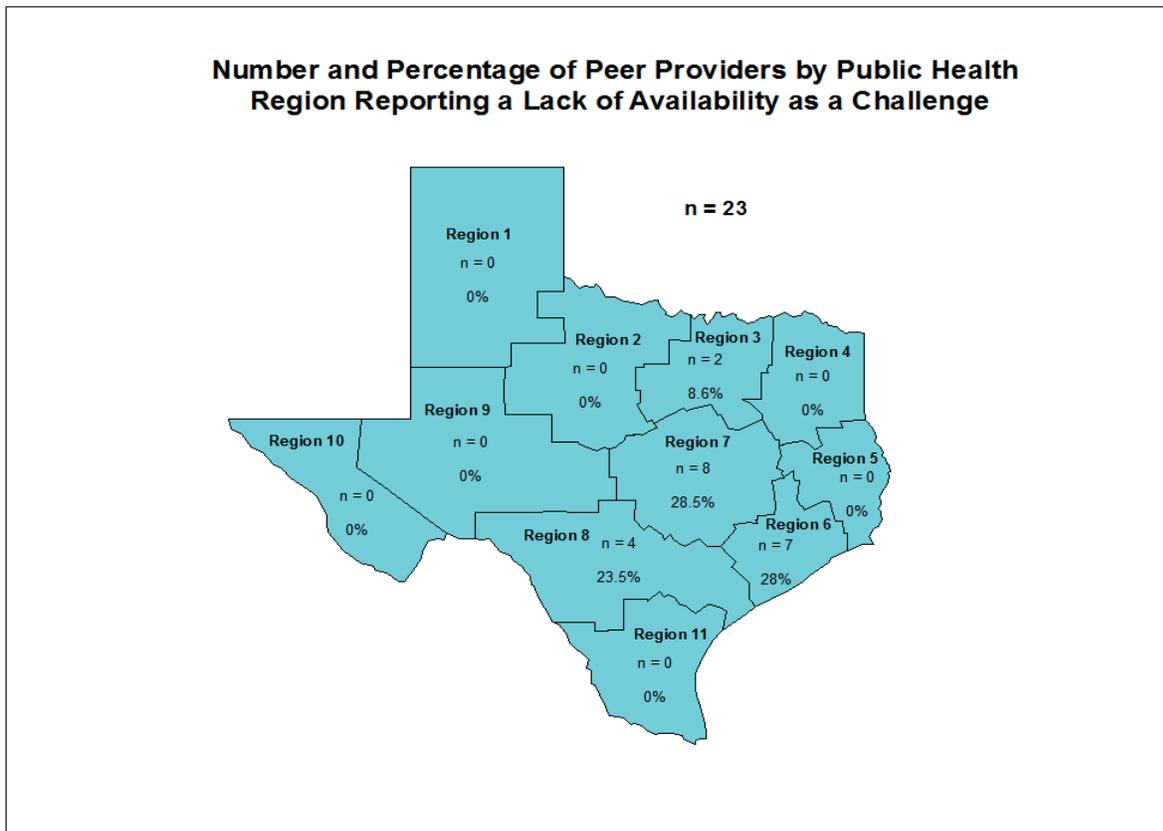
The second most commonly reported training challenge was a lack of availability (n=23; 19% of respondents who reported any training challenge). Specific availability barriers reported by respondents included difficulty finding trainings, not being accepted into trainings (or long wait times), a lack of good quality trainings, difficulty discerning appropriate trainings without a state-endorsed curriculum, and a lack of online CEUs. For example, one respondent explained: “There are not enough peer-specific trainings available that are good quality.” Similarly, another respondent reported: “You get turned down a lot because the classes are full.” Another respondent wrote:

“There are not enough peer-specific trainings available that are good quality.”

Training opportunities are available but they must be relevant to the scope of peer support (not for treatment or counseling), credible in theory and source, and useful in practice. This is sometimes hard to discern and it would be helpful to have a state endorsement of sound curricula specific for PRS.

Figure 10 shows the number of respondents from each region who reported a lack of availability as a training challenge (note two respondents with missing PHR data also reported this challenge). Only respondents from PHRs 3, 6, 7, and 8 reported a lack of availability as a training challenge. Additionally, Figure 10 displays the percentage of respondents from each region who reported a lack of availability as a training challenge relative to the number of respondents from each region who reported any training challenge.

Figure 10: Peer provider respondents who reported lack of availability as a training challenge by PHR

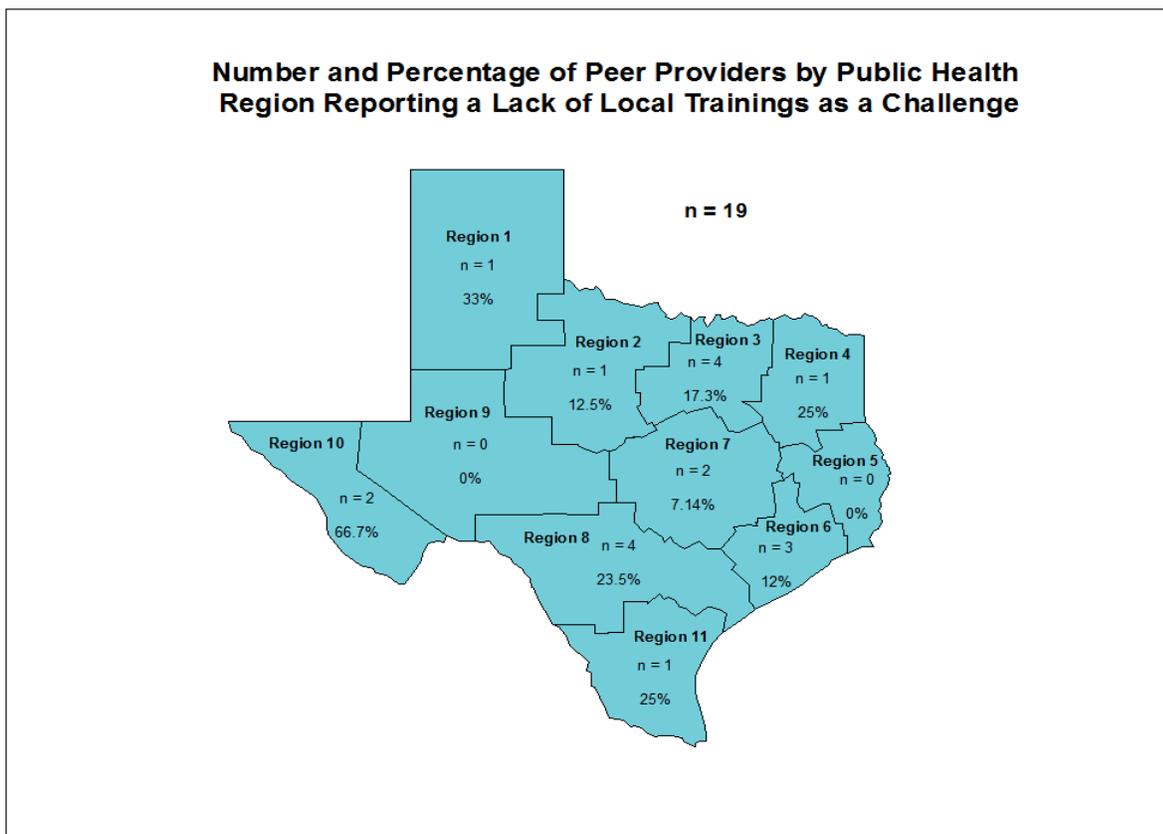


Distance to Trainings

The third most commonly reported training challenge was distance to trainings and a lack of local trainings (n=19; 15% of respondents who reported any training challenge). For example, one respondent wrote: “Distance. I live hundreds of miles from most all offered trainings.” Similarly, another respondent explained: “Geographically (far west Texas), [it is] very hard to find trainings nearby.” A third respondent echoed this theme: “Trainings are infrequently held locally. I cannot travel to other areas.”

Figure 11 shows the number of respondents from each region who reported distance as a training challenge. Additionally, Figure 11 displays the percentage of respondents from each region who reported distance as a training challenge relative to the number of respondents from each region who reported any training challenge. A higher percentage of respondents from PHRs 1, 4, 10, and 11 reported distance as a training challenge compared to respondents from other PHRs. For example, 67% of respondents from PHR 10 who reported experiencing a training challenge reported distance as a training challenge.

Figure 11: Peer provider respondents who reported distance as a training challenge by PHR



“Geographically (far west Texas), [it is] very hard to find trainings nearby.”

Organizational Barriers

The fourth most commonly reported training challenge was organizational barriers to training (n=14; 11% of respondents who reported any training challenge). Organizational barriers include several specific barriers such as difficulty getting time off from work due to high workloads, employer won't allow peers to attend trainings during work hours requiring the peers to use PTO, and employer won't allow peers to use PTO to attend trainings. For example, one respondent explained: "I have to take personal time off to attend training that is in person. Also any trainings online are during the day and that can take away from productivity that is expected of me and [I am] written up for not performing."

Additional organizational barriers were also identified including employers not allowing peers to attend trainings, a lack of support or organizational priority to send peers to training, and a lack of training support for volunteers. For example, one respondent reported: "I earned two scholarships through Via Hope while working for [name of organization redacted] to attend two trainings and was repeatedly denied the opportunity to attend."

Organizational barriers to training were reported by respondents from the following PHRs: 3, 5, 6, 7, and 10. A high percentage of respondents from PHR 5 reported that they experienced organizational barriers; 75% of respondents from PHR 5 who reported that they experienced a training challenge reported experiencing an organizational barrier to training.

"I have to take personal time off to attend training that is in person."

Additional Challenges

Respondents also reported challenges with obtaining and retaining peer provider certification (n=17) as well as challenges experienced while attending trainings (n=5).

In terms of challenges with obtaining and retaining certification, respondents reported challenges related to CEUs, supervised hours, HHSC rules, and additional process issues.

Regarding CEUs, respondents reported the need for more opportunities to earn CEUs online, more free CEU courses, more ethics CEU courses, and the need for clarity regarding what trainings count towards CEUs.

In terms of supervised hours, respondents reported that it was difficult to complete the required number of supervised hours for certification and that it was particularly challenging to receive supervised hours without being employed in a peer role or without at least a year of experience working as a peer.

Regarding HHSC rules, respondents reported that new certification requirements and the process of grandfathering after the new certification rules went into effect were challenging. Additionally, one respondent reported the challenge of not being able to be certified in both substance use and mental health.

Several additional process issues related to certification and recertification were reported including: finding someone to certify hours, difficulty signing up for the state test, organizations marketing certification dishonestly, challenges retaining certification, and trainers not preparing trainees for the certification exam.

Specific challenges that respondents experienced while attending training included: trainers who are biased, intense, and only knowledgeable in one tradition of peer support; trainings are triggering; trainings do not make disability accommodations; and trainings are overrated and over-regimented.

References

Environmental Systems Research Institute. ArcGIS. (2016). Version 10.6. Redlands, CA: Environmental Systems Research Institute, Inc.

Stevens Manser, S., Earley, J., Lodge, A., & Parkin, S. (2019). Texas Peer Provider Work Settings and Practices. Texas Institute for Excellence in Mental Health, Steve Hicks School of Social Work, University of Texas at Austin.