Peers in Texas:

Workforce Outcomes

The University of Texas at Austin
Texas Institute for Excellence in Mental Health
Steve Hicks School of Social Work

AUTHORS

Amy C. Lodge, Ph.D.
Juli Earley, LMSW
Stacey Stevens Manser, Ph.D.

CONTRIBUTORS

Jill E. Jendrzey, MHPS, JOY Journey Peer Connection
Susannah Parkin, MSW

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Introduction

Peer specialists are individuals who are in recovery from mental health or substance use issues and are employed to support people receiving behavioral health services (Davidson et al., 2006; Gates & Akabas, 2007). Research suggests that peer specialist services decrease substance use (Bernstein et al., 2005; Davidson et al., 2012; Mangrum et al., 2017; Smelson et al., 2013), increase patient activation and engagement in care (Chinman et al., 2015; Druss et al., 2010), reduce utilization of inpatient and emergency care (Clarke et al., 2000; Davidson et al., 2006; Goldberg et al., 2013; Jonikas et al., 2013; Sledge et al., 2011), reduce mental health symptoms and increase recovery and wellbeing (Cook, Copeland, et al., 2012; Cook, Steigman, et al., 2012; Rogers et al., 2016), and improve physical health and health behaviors (Druss et al., 2010; Kelly et al., 2014; Lorig et al., 2014).

It has been estimated that peer specialists will soon make up 25% of the behavioral health workforce (Manderscheid, n.d.). Yet a recent report on the behavioral health workforce also indicates that the number of peer specialists are not enough to meet the service need (SAMHSA, 2021). Workplace integration and job satisfaction are critical to the success and retention of the growing peer provider workforce (Cronise et al., 2016; Davidson et al., 2006; Grant et al., 2012; Kuhn et al., 2015). Research has identified several domains that are crucial to peer specialist integration and job satisfaction for peers, including collaborative and supportive relationships with colleagues, career advancement and development opportunities, adequate funding and compensation, supportive organizational cultures, role clarity, and appropriate supervision (Cronise et al., 2016; Earley et al., 2016; Kuhn et al., 2015; Mancini, 2018; Myrick & del Vecchio, 2016). For example, several studies have found that peer specialists experience issues with role clarity (Cabral et al., 2014; Cronise et al., 2016; Lodge et al., 2017; Mancini, 2018; Myrick & del Vecchio, 2016; Ostrow & Pelot, 2021). Role clarity issues may be particularly difficult for peers who work in organizations that adhere to a traditional medical model where peers may drift away from the peer role and become assimilated into clinical culture (Deegan, 2021). This research on role clarity also suggests that peer specialists whose job duties more closely align to peer work have higher rates of job satisfaction compared to peers whose job duties involve more administrative and clinical work tasks (Cronise et al., 2016).

Texas has been a leader in promoting self-directed care via peer-delivered services (HHSC, 2016). In a recent Texas Health and Human Services Commission (HHSC, 2016) survey of providers and people receiving services in the Texas 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. The use of peer services was listed as *Gap 8* in the *Texas Statewide Behavioral Health Strategic Plan* (HHSC, 2016), with increasing access to peer services identified as a cost-effective strategy to expand the behavioral health workforce and reduce reliance on crisis, inpatient, and other restrictive levels of care. In an effort to address this service gap, it is important to understand peer specialists' experiences working in the Texas behavioral health system in order to make recommendations to increase workforce satisfaction and retention.

Purpose of Project

The Texas Institute for Excellence in Mental Health (TIEMH) is contracted by Texas Health and Human Services (HHS) to evaluate employment outcomes for individuals who have been trained and certified as mental health and/or substance use peer specialists in Texas. Towards that end, in Fiscal Year 2021 TIEMH researchers administered a survey measuring peer specialist employment outcomes as well as conducted 30 in-depth interviews with a subset of peer specialists. The survey data collection focused on peer specialists' experiences with certification and employment, including topics such as:

- COVID-19,
- Medicaid billing,
- supervision,
- collaboration with other staff,
- role clarity,
- funding and compensation,
- CEUs, and
- work tasks.

The in-depth interviews provided an opportunity to examine the following topics in greater depth:

- how the COVID-19 pandemic has impacted the ways in which peer specialists do their jobs,
- peer specialists' experiences with the 2019 HHS peer certification grandfathering process, and
- peer specialists' experiences with billing Medicaid for their services.

Method

Survey

Survey development

A team of researchers familiar with the peer specialist workforce in Texas convened to discuss the purpose of the survey and to review the survey that was administered in FY2017 (the most recent year an extensive peer workforce survey was administered). Each survey item was reviewed and either revised or removed. Further, new items were added based on knowledge acquired and policy changes since the last survey administration. The survey was also reviewed by several members of the HHS Peer and Recovery Services Programs, Planning, and Policy Unit, who provided feedback on individual items. In response to this feedback, the survey was further revised.

The final survey examined the following areas: demographic characteristics, employment characteristics, career development and advancement (including training and certification), collaboration, funding and Medicaid billing, organizational culture, role and role clarity (including the impact of COVID-19 on peer roles), and supervision. See Appendix A for a complete list of survey questions.

Recruitment

Recruitment efforts targeted individuals certified as peer specialists by the Texas Certification Board (TCB) or Wales Education Services (WES). These certifications included: Mental Health Peer Specialist (MHPS) certification, Peer Recovery Support Specialist (PRSS) certification, and Recovery Support Peer Specialist (RSPS) certification. Both of these certifying agencies were asked to provide a list with email addresses for peers with these certifications. TCB provided a list of 791 peers (which excludes 12 peers who opted out of being included in this list) and WES provided a list of 91 peers (which excludes 45 peers who did not have email addresses on file). These peers (n=882) were emailed an invitation to participate in the survey through Constant Contact, a platform that can be used to launch and monitor email marketing efforts. For example, Constant Contact is able to determine if an individual did or did not open an email. Therefore, peers who did not open the first invitation to participate were sent a second reminder email one week later. Constant Contact also provides information on how many emails bounced or were undeliverable. Among the 791 TCB peers, 8.7% (n=69) had email addresses that were undeliverable. Among the 91 WES peers, 20.9% (n=19) had email addresses that were undeliverable. Due to low response rates, approximately one month into survey administration TIEMH requested that members of the HHS Peer and Recovery Services Programs, Planning, and Policy Unit assist with recruitment efforts by including invitations to participate in the survey in emails to their peer listservs. Finally, for peers who did not open the first or second Constant Contact email invitations, two email invitations (an initial invitation and a reminder invitation) were sent from the first author's personal email address rather than a TIEMH email address used in Constant Contact mailings. In total, 199 valid survey responses were recorded with 186 responses retained for analysis. An exact response rate cannot be determined due to the multiple methods used to distribute the survey. However, a response rate of 25% was estimated based on deliverable email addresses from the certification bodies.

Survey Administration

Survey administration took place over a period of two and a half months (early March to mid May 2021). The email invitation included information about the purpose of the survey and a link that redirected the individual to

the survey, which was administered through the web-based system, Qualtrics. To protect anonymity, Qualtrics settings were enabled so that no names, email addresses, or IP addresses were stored with the data. Upon clicking the survey link, participants were directed to an introductory consent page describing the survey, any risks or benefits to completing the survey, and the ability to discontinue survey participation at any time without incurring negative consequences. Upon completion of the survey, participants were eligible to enter into a drawing for one of 30 $25 gift cards. If interested in entering the drawing, participants were redirected to a separate form at the end of the survey to provide their name and email address to be contacted with if selected as a winner. This information was not linked to the survey data. Upon survey completion, participants were also provided the option of participating in an in-depth interview to share more about their experiences working as a peer specialist and to receive a $50 gift card. The process of signing up for an interview was similar to entering into the gift card drawing (i.e., a link at the end of the survey redirected participants to a separate form to sign up to participate in the interview). This study was determined not research by the University of Texas at Austin IRB and the Health and Human Services IRB2.

Analysis

Survey data were downloaded from Qualtrics and cleaned and analyzed with SPSS v27. First, duplicate cases (n=11) were identified based on participants' linking code. Of these 11 duplicate cases, in two cases one response was more complete than the other in which the more complete response was retained. For the remaining 9 cases, one response was randomly selected for retainment while the other response was deleted. The qualitative survey responses for these duplicate cases were combined into one response when each response contained unique information that provided greater context and information. Next, two cases were excluded from analysis due to the fact that these respondents reported never being certified or employed in a peer specialist capacity. After identifying duplicates and removing these two cases, the total N for the sample was 186. Additional cleaning included recoding some qualitative responses into existing survey response categories; this occurred when respondents selected "other" and wrote in responses for which survey response categories existed. Finally, some variables were recoded into new variables for analysis: a Public Health Region variable was created from respondents' zip code responses, a continuous variable based on total number of job tenure months was created from respondents' job tenure months and years responses, and a composite Recovery Oriented Services Assessment (ROSA; Lodge et al., 2018) variable was created by combining the responses to the 15 items on the ROSA. Basic descriptive statistics were run for all variables using SPSS v27 and are presented in this report. Additional statistical analyses were also conducted to explore relationships between variables and are also presented in this report. Qualitative survey data were analyzed using NVIVO qualitative data analysis software (QSR International, 2018).

In-depth Interviews

Recruitment

Upon completion of the survey, respondents were invited to sign up to participate in a phone or video conferencing interview. A total of 88 individuals signed up to participate in an interview. The initial sampling strategy was to target individuals from a variety of Public Health Regions (PHRs) in order to obtain geographic diversity, while prioritizing individuals who had obtained their certification prior to the HHS peer certification grandfathering process. However, as interviews were ongoing and it became clear that many interviewees lacked experience with using the Medicaid Peer Specialist Services billing code, researchers began targeting individuals who worked at organizations that bill Medicaid for peer services in order to learn more about peers' experiences with billing. A total of 30 individuals were interviewed.

Procedure

The interviews were conducted by an individual who is trained and certified as a Mental Health Peer Specialist (MHPS) and who has participated in various TIEMH trainings and workgroups on research methods. Interviews were conducted via a secure video conferencing platform and with interviewees' permission were audio recorded for professional transcription. See Appendix B for a list of the interview questions. Interviewees were assigned numerical codes as pseudonyms for the purposes of confidentiality. Upon completion of the interview, all interviewees received a $50 electronic gift card. The interviews lasted between 6 and 45 minutes (mean: 18 minutes) and explored the following topics:

1) how the COVID-19 pandemic has impacted the way that they do their work as a peer specialist,
2) experiences with the 2019 HHS grandfathering process (or experiences with the certification process in general) and how that has impacted their work as a peer specialist,
3) experiences billing Medicaid for their services, including if they use the Medicaid Peer Specialist Services billing code (also referred to as the peer code or the peer billing code), and if so, for what services, how having the peer code has impacted their work, and how the billing rate for the peer code has impacted their work, and
4) any other information they wanted to share about their experiences as a peer specialist.

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, 2018). Codes were developed iteratively and constantly refined – that is some codes were merged while others were disaggregated as more data were analyzed. Major codes, or themes, from the interviews are presented in this report.

Results

Peer Demographic Characteristics

For both the survey and the interviews, the majority of respondents reported being women, non-Hispanic, and white. Survey respondents were most likely to report being in their 50s and 60s while most interviewees were most likely to report being in their 40s or 50s. In terms of educational attainment, both survey respondents and interviewees most commonly reported having completed some college or post-high school training. See Table 1 for a description of the demographic characteristics of the survey respondents and interviewees.

Table 1: Demographic Data

	Survey Respondents (n=186)	Interviewees (n=30)
Gender[1]		
Agender	2 (1.1%)	--
Gender queer, gender fluid, or non-binary	1 (0.5%)	--
Man	50 (26.9%)	9 (30.0%)
Woman	111 (59.7%)	20 (66.7%)
Prefer not to disclose/missing	22 (11.8%)	1 (3.3%)
Ethnicity		
Hispanic or Latino	33 (17.7%)	5 (16.7%)
Non-Hispanic or Latino	131 (70.4%)	24 (80.0%)
Prefer not to disclose/missing	22 (11.8%)	1 (3.3%)
Race		
American Indian or Alaskan Native	2 (1.1%)	1 (3.3%)
Asian or Asian American	--	--
Black or African American	36 (19.4%)	3 (10.0%)
Hawaiian or Pacific Islander	1 (0.5%)	--
Other	3 (1.6%)	2 (6.7%)
Two or more races	4 (2.2%)	1 (3.3%)
White	118 (63.4%)	22 (73.3%)
Prefer not to disclose/missing	22 (11.8%)	1 (3.3%)
Age		
18-24	3 (1.6%)	--
25-30	11 (5.9%)	5 (16.7%)
31-35	6 (3.2%)	--
36-40	23 (12.4%)	2 (6.7%)
41-45	12 (6.5%)	6 (20.0%)
46-50	22 (11.8%)	4 (13.3%)
51-55	25 (13.4%)	5 (16.7%)
56-60	23 (12.4%)	4 (13.3%)
61-65	27 (14.5%)	4 (13.3%)
66 or older	14 (7.5%)	--
Prefer not to disclose/missing	20 (10.8%)	--
Education		
Less than 12th grade	--	--
High school diploma/GED	30 (16.1%)	6 (20.0%)

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[1] Additional response options that were provided in the survey but not selected by any respondents: questioning or unsure, trans man, trans woman, and an additional gender identity with an option to specify.

Some college or post-high school training	63 (33.9%)	10 (33.3%)
2-year associate degree	26 (14.0%)	4 (13.3%)
4-year college degree	29 (15.6%)	8 (26.7%)
Post-college graduate training	18 (9.7%)	2 (6.7%)
Prefer not to disclose/missing	20 (10.8%)	--

Geographic Representation

The survey and interview samples were regionally diverse. The survey sample included respondents from all public health regions (PHRs) in Texas, while the interview sample included respondents from most PHRs. While efforts were made to recruit a geographically diverse interview sample, we were unable to interview anyone from PHRs 4, 5, or 9. Both the survey and interview samples mirror the population distribution of Texas, however, with a greater number of individuals being from the major metro areas of Austin, Dallas/Fort Worth, Houston, and San Antonio than from South Texas, the Panhandle region, the Piney Woods region of East Texas, and West Texas. Figure 1 displays the number of survey respondents from each PHR, while Figure 2 displays the number of interviewees from each PHR. Additional analyses were conducted to examine how age ranges differ by PHR among survey respondents. See Table A1 in Appendix C for these results.

Figure 1: Survey respondents by public health region (PHR; n=162)
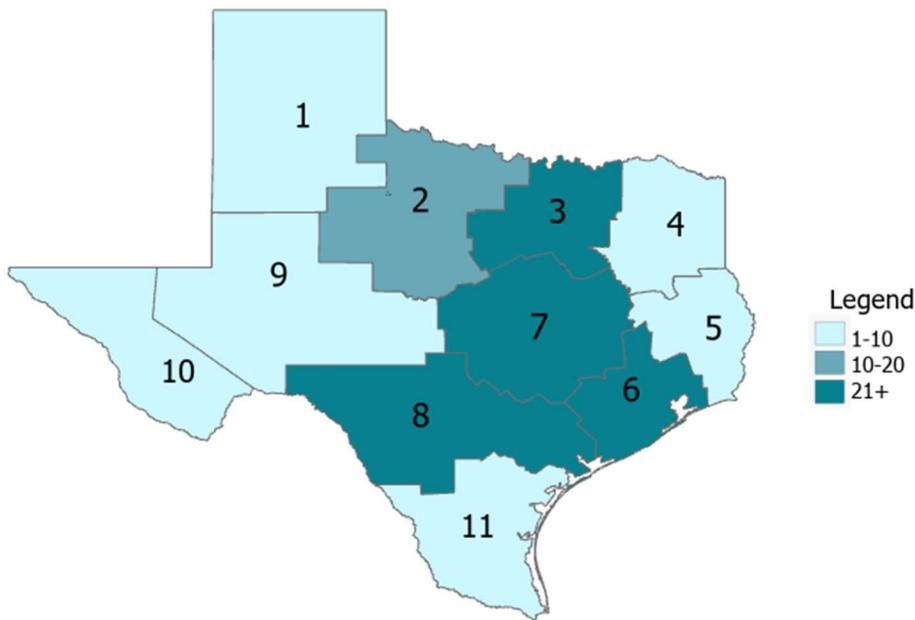
Figure 2: Interviewees by public health region (PHR; n=30)
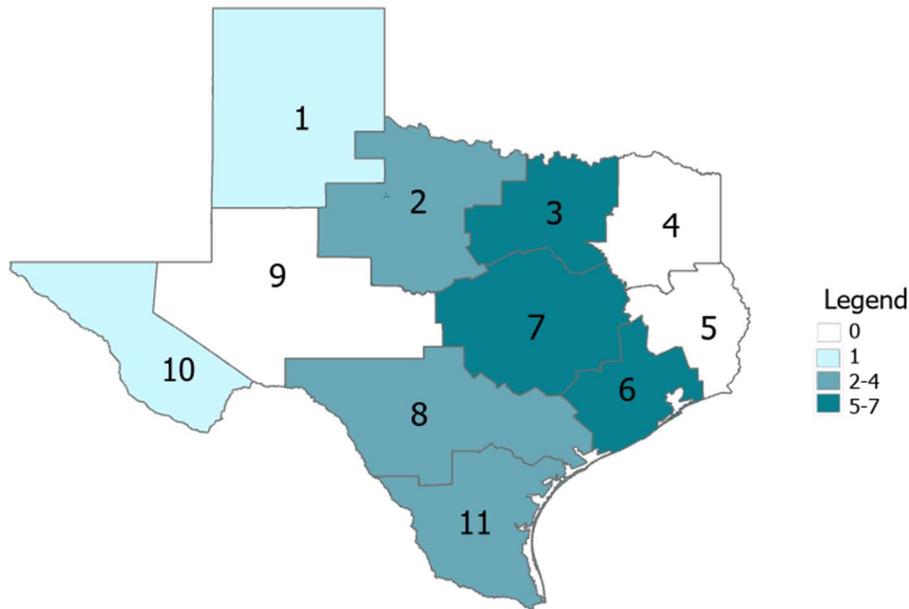
Employment

Employment Status

Survey respondents were asked if they are currently employed in a peer specialist position. The majority of respondents (n=155; 85%) reported that they are currently employed as a peer specialist (Figure 3). The remaining 27 respondents included 15 (8%) individuals who had previously been employed as a peer specialist and 12 (7%) individuals who had never been employed as a peer specialist. The 12 individuals who had never been employed as a peer specialist were not asked any further questions related to peer specialist employment experiences.

Figure 3: Currently or ever employed as a peer specialist (n=182)
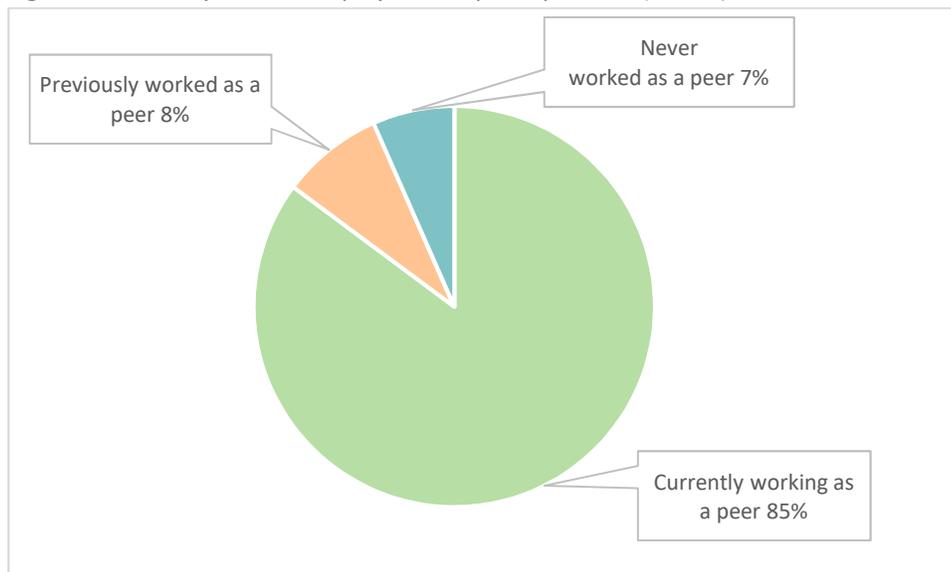
Survey respondents who reported that they are currently working as a peer specialist were asked about their type of employment. The majority (n=127; 82%) reported that they work in an hourly or salary full-time position. An additional 10% (n=15) reported working in an hourly or salary part-time position (see Figure 4). Peers working in contract positions were less common with only 4% (n=6) reporting working in a full-time contract position and 2% (n=3) reporting working in a part-time contract position. Finally, 2% (n=3) of survey respondents reported working in an "other" type of employment. Two of these individuals reported working in a volunteer position and a third individual reported working two part-time jobs.

Figure 4: Type of employment among currently employed peer specialists (n=154)
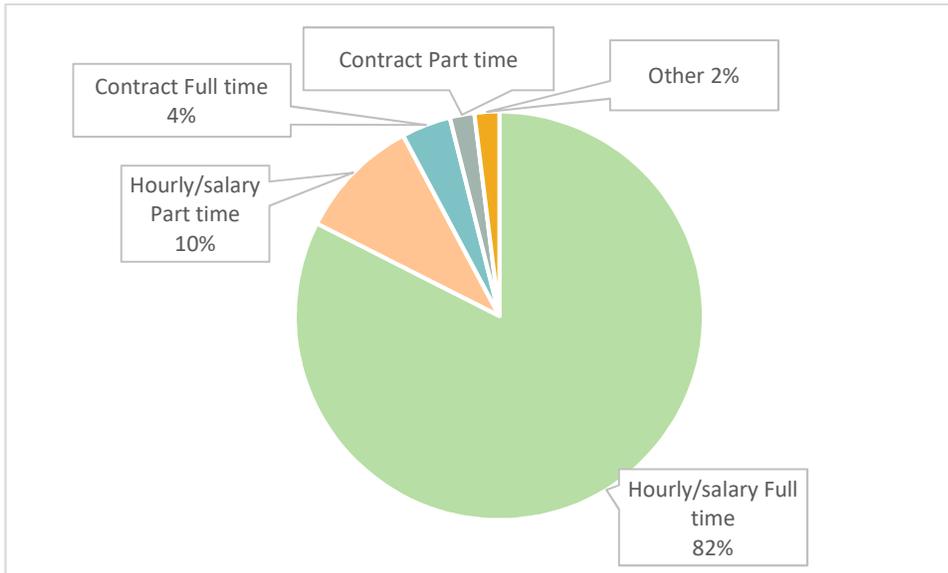
Survey respondents who reported currently or ever working as a peer specialist were asked to describe how many hours they work or worked per week. The majority (n=111; 68%) reported working 40 hours per week (Figure 5).

Figure 5: Average hours work(ed) per week (n=163)
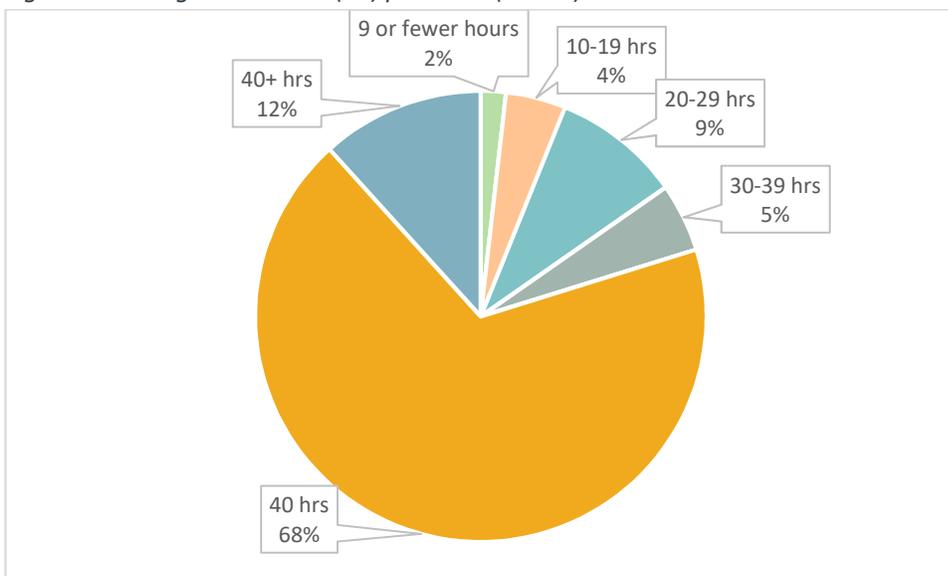
Survey respondents who reported that they are not currently working as a peer specialist (n=27) were asked to qualitatively explain why they are not employed as a peer. Most commonly, respondents reported that they are not employed as a peer specialist because they are working in a different role (although often still in the recovery,

substance use, or mental health field; n=12). Other explanations for not working as a peer specialist included an inability to find a job as a peer specialist (particularly a full-time job with benefits; n=5), dissatisfaction with an aspect of the position (e.g., pay, lack of benefits; n=4), and COVID-19 (n=3).

Survey respondents who reported that they are not currently working as a peer specialist were also asked if they had experienced any barriers to finding a job as a peer specialist. Of the 24 individuals that responded to this question, only one-third (n=8) reported that they experienced any barriers (Figure 6). These respondents were asked to explain what barriers they have experienced and these included a lack of full-time peer specialist positions (n=2), a lack of funding for peer positions (n=2), low pay (n=2), a lack of experience working as a peer (n=1), not having a degree (n=1), and not being able to speak Spanish (n=1).

Figure 6: Experience barriers to finding a job as a peer specialist among non-employed peers (n=24)
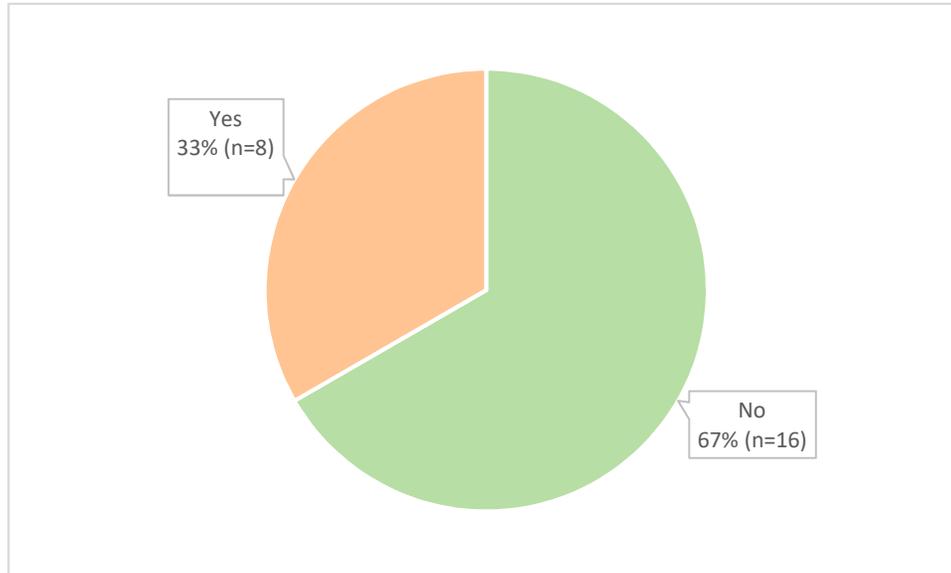

Job Titles

Survey respondents who reported that they currently or ever worked as a peer specialist were asked to qualitatively describe their job title. Figure 7 displays the many job titles that were reported, with more commonly reported job titles appearing in larger font. The most commonly reported job titles were: Mental Health Peer Specialist (n=21), Peer Support Specialist (n=17), Peer Recovery Support Specialist (n=14), Peer Specialist (n=11), and Recovery Coach (n=11).

Figure 7: Job titles (n=158)

Employer Organization

Survey respondents who reported that they currently or ever worked as a peer specialist were asked to report the type of organization(s) in which they were most recently employed. See Table 2 for a list of the employer organizations. Most commonly, respondents reported working at Community Mental Health Centers (CMHCs) or Local Mental Health Authorities (LMHAs; n=51), Recovery Community Organizations (RCOs; n=34), and community substance use treatment centers (n=25). Respondents who selected "other" (n=15) were asked to qualitatively describe at what type of organization they were most recently employed. Six of these individuals reported currently or previously working at a non-profit agency. Additional employer organizations included: integrated treatment services (n=2), clinic (n=1), Federally Qualified Health Center (n=1), substance abuse treatment facility (n=1), Alternative Peer Group (APG; n=1), public defender's office (n=1), sober living home (n=1), and a transitional house (n=1).

Table 2: Type of employer organization (n=163)

	N	%
Community mental health center (CMHC)	51	31.3%
Recovery community organization (RCO)	34	20.9%
Community substance use treatment center	25	15.3%
Organization serving people experiencing homelessness	16	9.8%
Other	15	9.2%
Consumer-operated service provider (COSP)	14	8.6%
Peer advocacy or training organization	14	8.6%
Inpatient mental health hospital	12	7.7%
Psychiatric crisis facility, unit, or respite program	11	6.7%
Jail, prison, or probation	8	4.9%
Clubhouse	6	3.7%
Drug court, family court, mental health court or veterans' court	6	3.7%
Department of Veterans Affairs or other veteran organization	5	3.1%
High school or collegiate recovery program	5	3.1%
Managed care organization (MCO)	5	3.1%
Hospital or emergency room	3	1.8%

Survey respondents were asked how long they have worked (or did work) at their employer organization. The mean employment tenure was 63.9 months (or 5.3 years) with a standard deviation (SD) of 51.1 months (or 4.3 years) and a range of 3 months to 392 months (or 32.7 years). The median employment tenure was 52 months (or 4.3 years) with an interquartile range of Q1=30.8 months (or 2.6 years) to Q3=93.0 months (or 7.8 years). Figure 8 displays the distribution of employment tenure among survey respondents. Most respondents reported working between 1 and 4.9 years (n=67; 41.4%) or between 5 and 9.9 years (n=58; 35.8%). Further analyses were conducted to examine how employment tenure differs by organizational type. See Table A2 in Appendix C for these results.

Figure 8: Tenure at employer organization (n=162)
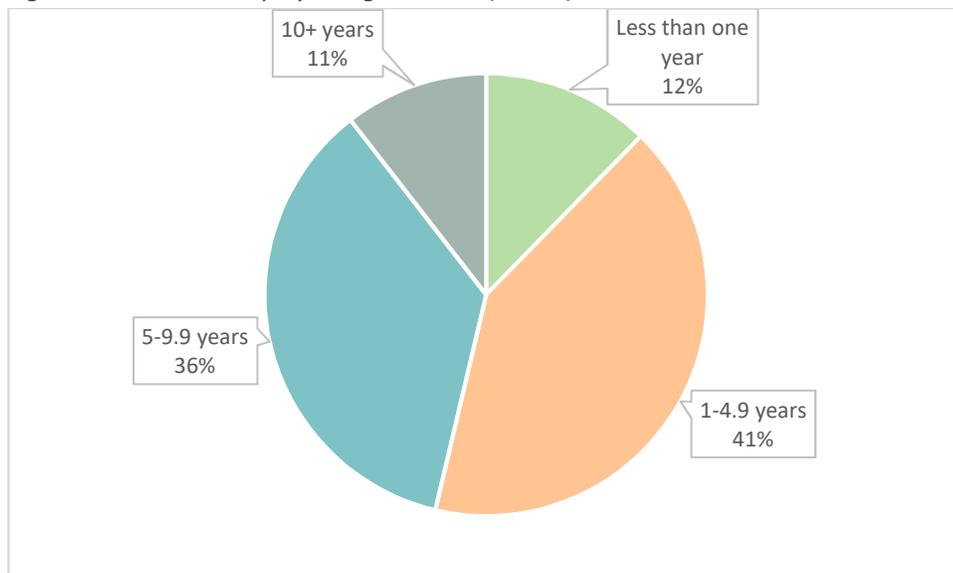
Employee Benefits

Survey respondents were asked about the benefits they receive or received from their employer as a peer specialist (see Figure 9). The most commonly reported benefits were paid vacation (n=127; 78.9% of individuals who responded to this question), paid sick leave (n=115; 71.4%), and medical insurance for self (n=109; 67.7%). Nineteen respondents reported receiving "other" additional benefits (not captured by the survey categories). These additional benefits included vision insurance (n=6), personal time off (PTO; n=4), life insurance (n=3), floating holiday (n=3), 401K (n=1), COVID sick leave (n=1), housing (n=1), paid training (n=1), and tuition reimbursement (n=1).

Figure 9: Job benefits (n=161)
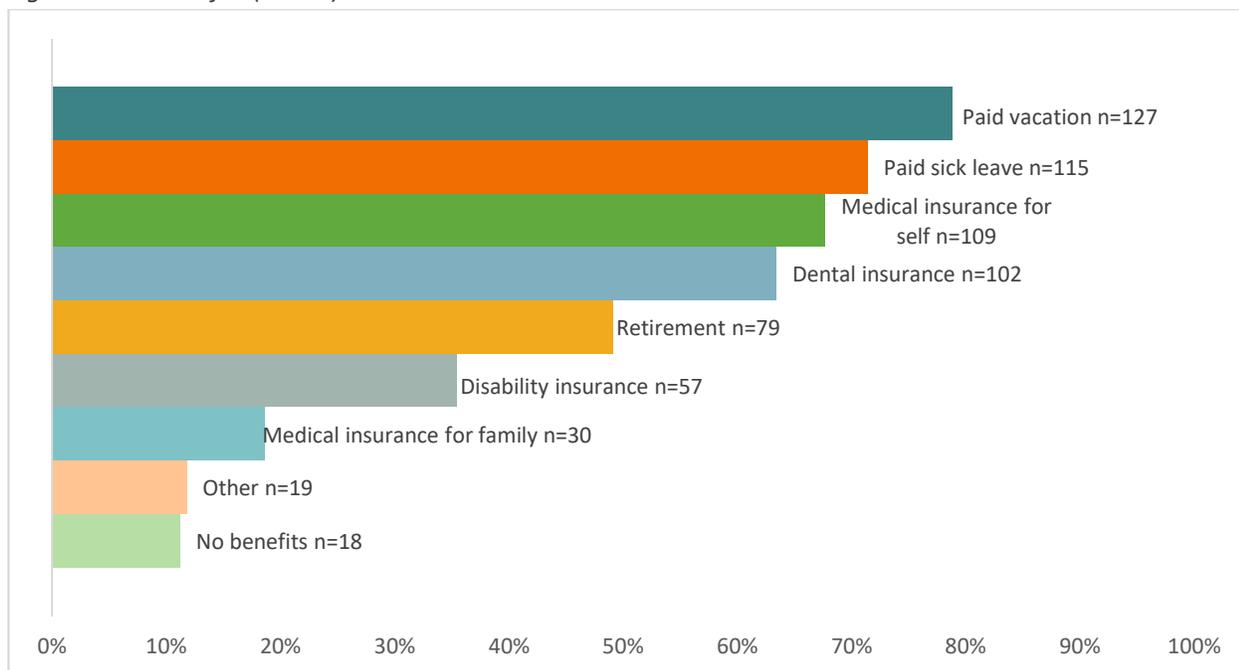
Career Advancement and Development

Survey and interview results in this and subsequent sections are organized by domains that have been identified in previous research as critical to the integration, success, and satisfaction of the peer provider workforce. These domains include: career advancement and career development; collaboration with colleagues; funding and compensation; organizational culture; role clarity, and supervision (Davidson et al., 2006; Earley et al., 2016; Grant et al., 2012; Kuhn et al., 2015; Lodge et al., 2017; Mancini, 2018).

Certification and Grandfathering

Survey respondents were asked to indicate which of the following peer specialist trainings they have attended: mental health peer specialist training, peer recovery support specialist training, and recovery support peer specialist training. As indicated in Figure 10 respondents most commonly reported attending the mental health peer specialist training (n=104; 55.9%), followed by the recovery support peer specialist training (n=89; 47.8%) and the peer recovery support specialist training (n=87; 46.8%).

Figure 10: Trainings attended (n=186)
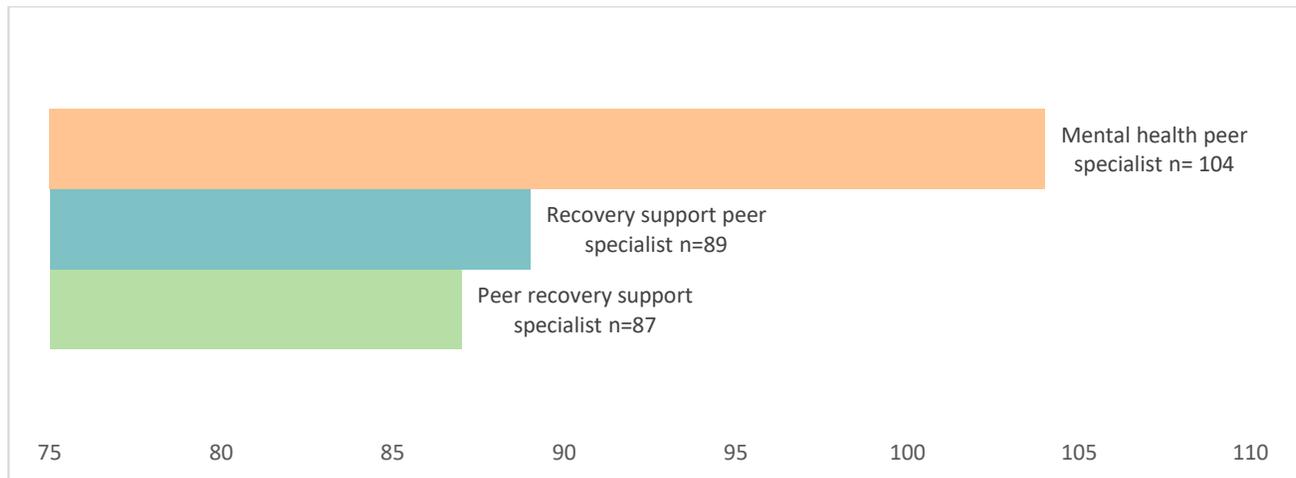
Survey respondents were also asked to indicate if they have active or lapsed certifications for the following peer specialist certifications: Mental Health Peer Specialist (MHPS), Peer Recovery Support Specialist (PRSS), and Recovery Support Peer Specialist (RSPS). As indicated in Figure 11, most commonly respondents reported having an active MHPS certification (n=87; 46.8%), followed by an active RSPS certification (n=75; 40.3%) and an active PRSS certification (n=72; 38.7%). Many respondents were dually or triply certified (n=53; 28.5%). Thirty respondents (16.1%) reported being dually certified as RSPS and PRSS; 10 respondents (5.4%) reported being triply certified as MHPS, RSPS, and PRSS; 7 respondents (3.8%) reported being dually certified as MHPS and PRSS; and 6 respondents (3.2%) reported being dually certified as MHPS and RSPS. Lapsed certifications were not common in this sample – perhaps due to the recent grandfathering process and recent certifications – eight respondents (4.3%) indicated having a lapsed PRSS certification, seven (3.7%) reported a lapsed MHPS certification, and four (2.2%) reported a lapsed RSPS certification.

Figure 11: Certification statuses, survey sample (n=186)
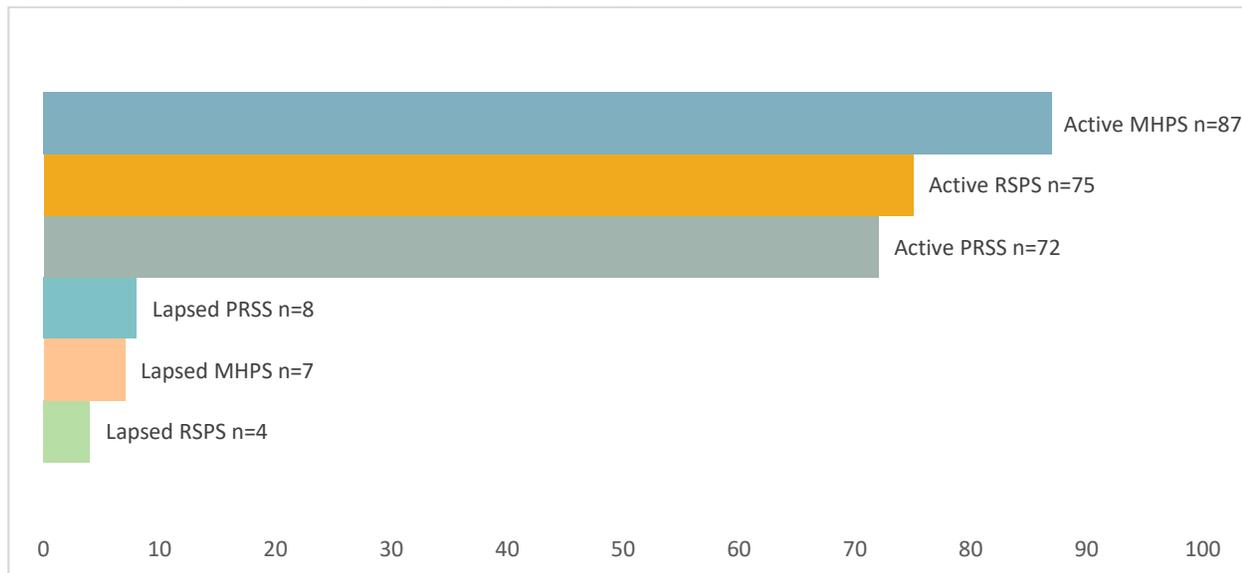
Survey respondents who reported one or more lapsed certifications (n=16) were asked to qualitatively explain why they had not renewed their certification. Survey respondents described several reasons for not maintaining certification including: certification is not required for their job (n=2), retirement or no longer working as a peer (n=2), the financial cost of renewal (n=2), limited time to complete renewal (n=2), forgetting to renew due to not

receiving a renewal notice (n=2), a lack of leadership support (n=1), a lack of access to training (n=1), and deciding to retain another certification type instead (n=1).

Survey respondents were asked to indicate in what year they were first certified as a peer, regardless if their certification is active or lapsed. Table 3 displays what year peers were first certified. Most commonly, survey respondents indicated that they were first certified in 2020 (23.5%) or 2019 (14.5%).

Table 3: Year first certified (n=179)

Year	N	%
Prior to 2009	4	2.2%
2010	5	2.8%
2011	6	3.4%
2012	12	6.7%
2013	15	8.4%
2014	9	5.0%
2015	14	7.8%
2016	10	5.6%
2017	16	8.9%
2018	19	10.6%
2019	26	14.5%
2020	42	23.5%
2021	1	0.6%
Total	**179**	**100%**

Survey respondents were asked if they completed the Texas Health and Human Services' peer support certification grandfathering process for the new peer support benefit that went into effect January 1, 2019. The grandfathering process provided the opportunity to peers who were certified as mental health or recovery peers prior to January 1, 2019 to apply to be newly certified in one or both of the two new Medicaid-endorsed peer certifications: Mental Health Peer Specialist (MHPS) and Recovery Support Peer Specialist (RSPS). The grandfathering process involved completing an application, submitting proof of 250 work hours as a peer specialist, completing a background check, and paying a $50 fee.

As depicted in Figure 12, about half of survey respondents indicated they completed the grandfathering process (n=92; 51.1%), while 41.1% (n=74) reported being certified after the grandfathering process and 7.8% (n=14) reported that they did not participate in the grandfathering process. Survey respondents who did not participate in the grandfathering process were asked to qualitatively explain why they did not. Responses included: submitting a late grandfathering application (n=2), not being aware of the grandfathering process (n=2), certification had already lapsed when the grandfathering process was occurring (n=2), and not being qualified to participate (n=1).

Figure 12: Participation in peer grandfathering process, survey sample (n=180)
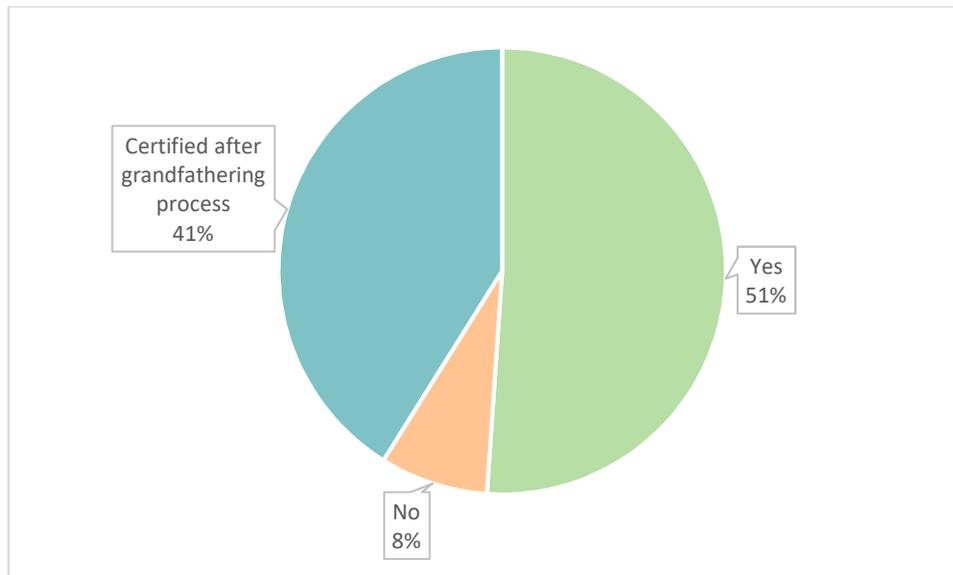
Survey respondents who reported participating in the grandfathering process were asked to indicate how satisfied they were with the process. Most respondents reported being very satisfied (n=33; 36.3%) or satisfied (n=33; 36.3%) as shown in Figure 13.

Figure 13: Satisfaction with grandfathering process (n=91)
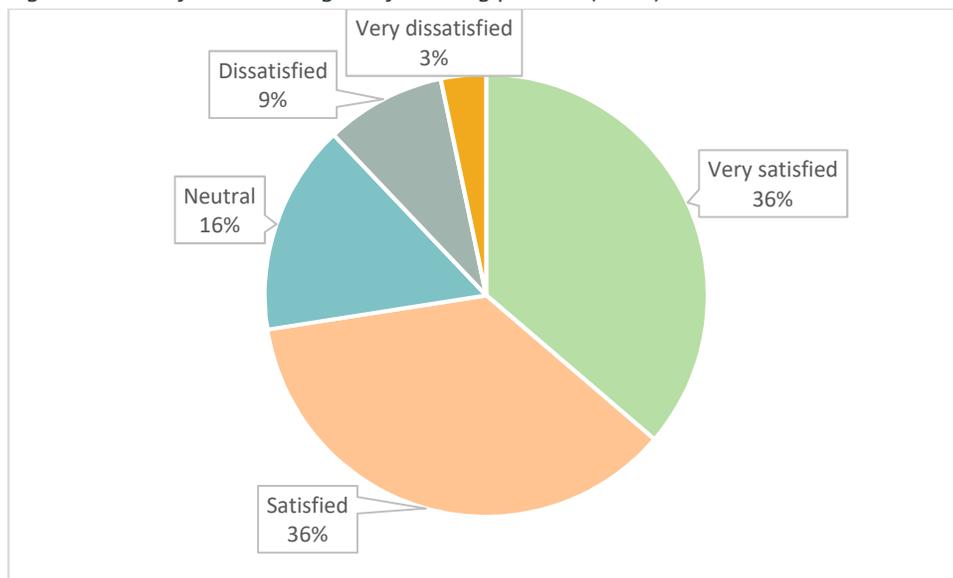
Survey respondents who responded to this question were also asked to qualitatively explain why they chose the satisfaction response that they did. Among respondents who were satisfied with the grandfathering process, the most commonly cited reasons were that the process was "simple," "easy," "straightforward," and "clear" (n=24). However, respondents also commonly reported that the grandfathering process was confusing, overly complicated, and lacked clarity (n=18). Respondents also indicated being dissatisfied due to the financial cost (n=9) and extra work (n=9) that the grandfathering process entailed.

Interviewees (n=30) were also asked several questions about their experiences with peer certification and the 2019 peer certification grandfathering process. To contextualize these findings, interviewees were asked if they have active or lapsed certifications for the following peer specialist certifications: Mental Health Peer Specialist

(MHPS), Peer Recovery Support Specialist (PRSS), and Recovery Support Peer Specialist (RSPS). As indicated in Figure 14, 19 interviewees reported being currently certified as an MHPS, while 9 reported being certified as a PRSS and 8 reported being certified as an RSPS. One interviewee reported a lapsed MHPS certification and one reported a lapsed RSPS certification.

Figure 14: Certification statuses, interview sample (n=30)
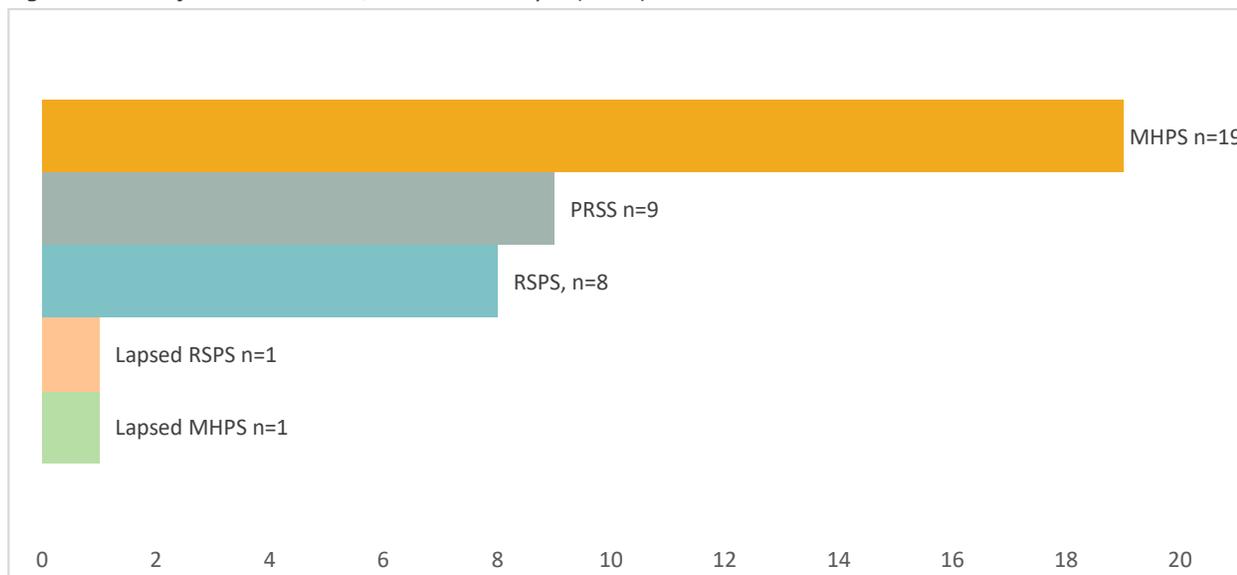
Interviewees were also asked if they participated in the 2019 peer certification grandfathering process. As indicated in Figure 15, the majority of interviewees (n=17; 56.7%) reported that they participated in the grandfathering process, while 5 (16.6%) reported that they did not participate in the grandfathering process, and 8 (26.7%) reported that they were certified after the grandfathering process.

Figure 15: Participation in the peer grandfathering process, interview sample (n=30)
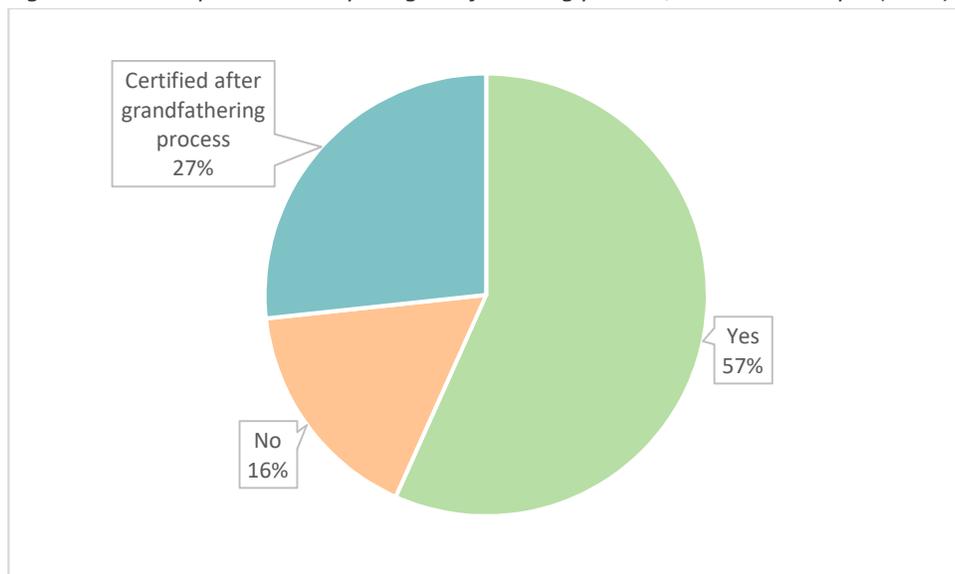
Interviewees who did not participate in the grandfathering process were asked about their experiences with the peer certification process. Many of these interviewees described the certification process as "easy" and "smooth."

> *It's been wonderful. I was able to get connected with a wonderful organization that did my training. We did that virtually. And then I was able to do the certification with the Texas Certification Board. That has been super easy, and I haven't had any problems. I don't know how it was before the pandemic, but I'd say they're handling the pandemic well.*

On the other hand, other interviewees described experiencing issues with obtaining certification. In particular, interviewees reported experiencing the following issues: difficulty obtaining a background check, an unresponsive certification agency that did not send their certificate, and a lack of clarity regarding the certification process. Several of these issues were also raised when interviewees discussed the grandfathering process and will be discussed in more depth in that section.

Interviewees who participated in the grandfathering process described their experiences. For a little over one-third of the interviewees who completed the grandfathering process (n=6), the process was described as "easy." For example, one interviewee said: "It was just paperwork, you know, go get the background check, process your paperwork, write them a check, move on."

Interviewees also described several factors that helped with the grandfathering process including: support from connections with other peers around the state, organizational support to complete the grandfathering process (i.e., time off as well as financial and procedural support), and support from certification agencies. For example, one interviewee described relying on connections with peers and other colleagues around the state to navigate the grandfathering process:

> *I participate on a lot of different committees and stuff across the state so I heard a lot of things from a lot of different places. And I knew the ins and outs of it and heard experiences from other people. It helped, which helped me to help my team.*

However, another group of interviewees (n=7; 41% of those that participated in the grandfathering process) described the grandfathering process as "confusing" and unclear. This experience may have been particularly the case for peers who didn't have support from their organization or other peers. For example, one interviewee explained:

> *It was a lot to take in. I just felt like we could have had a little bit of training on it. Maybe do groups to say 'Okay this is the process. If you want to be grandfathered in you need to do such and such.' Instead it was just thrown in an email and there was really nobody to talk to about it and I felt that disconnect feeling. There was just no one to turn to when you had issues.*

Interviewees also described experiencing challenges completing the necessary background check for the grandfathering process. Specifically, interviewees described problems scheduling background checks through IdentoGO (the required background checking vendor) as well as difficulties accessing an IdentoGO office, particularly in rural areas of the state. For example, one interviewee described trying to schedule background checks through IdentoGO as "the biggest hurdle and the biggest thing to get over with." They further elaborated on this experience: "Nobody was answering the phone, and there wasn't a clear way on how to get the appointments through the website."

Interviewees also described having to drive up to 200 miles round trip to complete a background check at an IdentoGO. For one interviewee this was a key reason that they chose not to renew their certification:

> *"I would have had to drive to another town to get the background check and it would have been half a day off, the extra gas expense, and you had to pay for the background check."*

When it came time to be re-certified, because of the expense I let it go. Actually, part of that was because we didn't have an IdentoGO in town. I would have had to drive to another town to get the background check done and it would have been a half a day off, the extra gas expense, and then you had to pay for the background check.

Indeed, other peers described the financial burden of the grandfathering process. For example, one interviewee said:

It took a bit of financial sacrifice because I had just gotten both of my certifications and then I had to pay fees for the grandfathering process. And I still was not yet working in the field. And it was like 'Well after you get this then you'll be able to work somewhere where they can bill Medicaid so you want to have it because it'll increase your opportunity to work.' But I just paid all of these hundreds of dollars to do this part of it, so I had to save my pennies and nickels.

Despite these challenges, some interviewees noted that the certification and recertification process has improved over time, particularly with the adoption of an online system (Certemy) that automates the process.

Finally, interviewees were asked how being certified as a peer or how participating in the grandfathering process impacted their work as a peer specialist. For some interviewees, being certified or participating in the grandfathering process was simply a requirement that had no impact on their work. However, other interviewees described benefits to being certified or participating in the grandfathering process including: enhanced legitimacy and respect from others, greater employability, and more career opportunities including supervisory opportunities.

Career Advancement and Development Opportunities

Survey respondents who were currently or ever employed as a peer were asked if their employer provides or provided them with a career ladder or career advancement opportunities. As indicated in Figure 16, less than half of the peers who responded to this question (n=67, 41.9%) indicated that their employer provides or provided them with a career ladder or career advancement opportunities. Another 41.9% (n=67) indicated that their employer does not provide these opportunities, while 16.3% (n=26) were unsure if their employer provides these opportunities.

Figure 16: Employer provides or provided career ladder or career advancement opportunities (n=160)
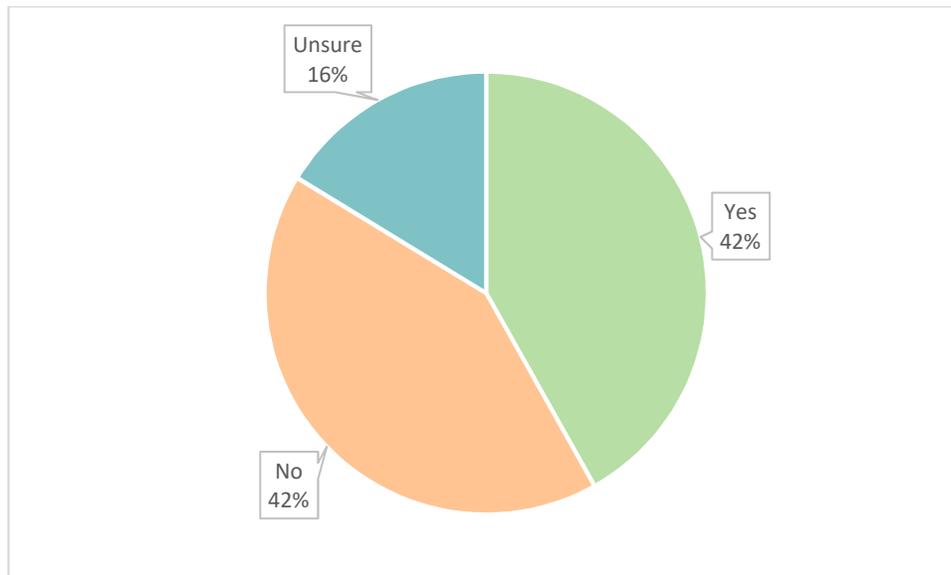
Some interviewees also discussed the topic of career advancement or a career ladder. Most commonly, they described taking the peer specialist supervisor endorsement training and supervising other peers as an avenue for career advancement. For example, one interviewee said: "As our peer force grows, we will need more peer specialist supervisors…I got the door open, took the training, and I have been [supervising other peers]." Similarly, another interviewee described working as a manager whose duties include training, coaching, and supervising other peers. However, as reflected in the survey data, some interviewees reported not having career advancement opportunities as some organizations do not support developing supervisory or managerial positions for peers. For example, one interviewee described a lack of organizational support for career advancement:

> *Clinicians just keep getting the promotions. And the peers don't. I've been advocating for that and I was told about a promotion for me for the past two years. And it's not happening… I'll look at the peer supervisor [training]. It's always going to be good to have that under my belt, but they [employer] said they cannot do the title of [peer supervisor].*

To facilitate greater career advancement and development opportunities for peers, one interviewee suggested the need for a peer ombudsman at the state level to advocate for peers.

"We need [an] advocate with our employers so that whenever peers have an issue they don't know how to solve, there's a method for it and there's support for it."

> *We need something like a peer ombudsman… so whenever you have questions of, 'I'm having problems on my worksite… who do I need to talk to about this problem?' Having someone…that is our go-to person. They have the ability to reach out and be our advocate with our employers so that whenever peers have an issue they don't know how to solve, there's a method for it and there's support for it.*

Survey respondents who were currently or ever employed as a peer were asked if their employer provides or provided them with career development opportunities, such as time off and/or reimbursement for training, in-house training, and skill development opportunities. As indicated in Figure 17, the majority of respondents (n=123, 76.9%) reported that their employer provides or provided them with career development opportunities. An additional 17 respondents (10.6%) reported that their employer does not or did not provide career development opportunities while 20 respondents (12.5%) were unsure. Respondents who reported that their employer does or did provide career

development opportunities were asked to qualitatively describe those opportunities. Most commonly, respondents reported receiving financial assistance to attend trainings (n=50), in-house training opportunities (n=35), time off to attend continuing education or other trainings (n=26), and skill development opportunities (n=21).

Figure 17: Employer provides or provided career development opportunities (n=160)
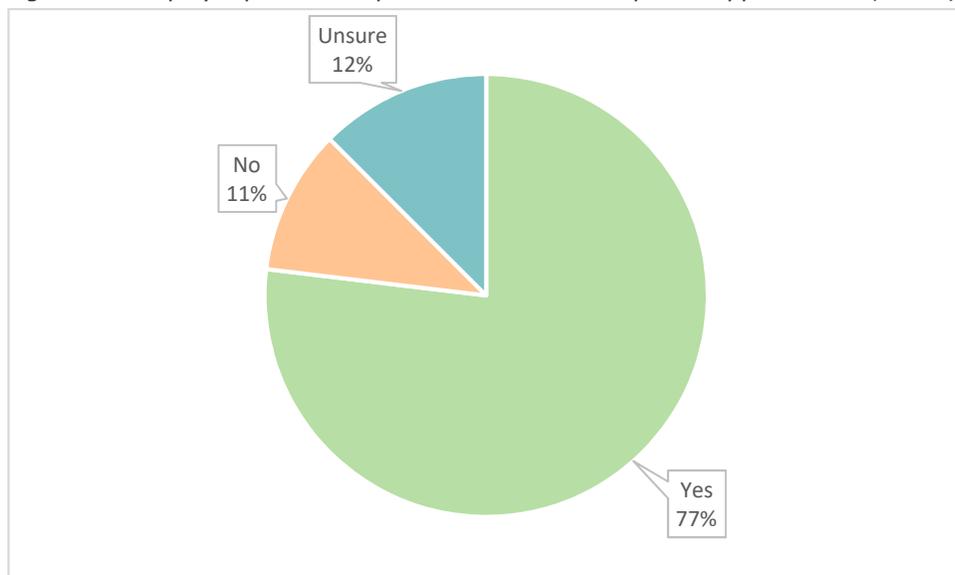
Survey respondents who were currently or ever employed as a peer specialist were asked to indicate the peer-related trainings or other educational opportunities that they have attended. Table 4 indicates how many respondents reported attending these trainings. Most commonly, respondents reported that they had attended Trauma Informed Peer Support training (n=86; 49.4%), Co-occurring Disorders training (n=81; 46.6%), and WRAP basic training (n=69; 40.0%).

Table 4: Trainings attended (n=174)

Training	N	%
Trauma Informed Peer Support	86	49.4%
Co-occurring Disorders	81	46.6%
WRAP basic training	69	40.0%
Intentional Peer Support	59	33.9%
ASIST (Applied Suicide Intervention Skills Training)	58	33.3%
Peer Support for Individuals with Co-occurring Disorders	53	30.5%
Emotional CPR	42	24.1%
Peer Support Whole Health and Resiliency	41	23.6%
NAMI's Peer to Peer	40	23.0%
Community Re-entry	36	20.7%
Alternatives Conference	33	19.0%
WRAP facilitator training	31	17.8%
Focus for Life	28	16.1%
Peerfest Conference	25	14.4%
WHAM (Whole Health Action Management)	16	9.2%
International Association of Peer Supporters Conference	13	7.5%
Next Steps	13	7.5%
Other	11	6.3%

Survey respondents who were currently or ever employed as a peer specialist were also asked what training areas would enhance their peer support practice (by selecting as many topics as they wanted). Table 5 indicates how many respondents reported that each of these training areas would enhance their practice as peer specialists. Most commonly, respondents reported that Co-occurring Disorders training (n=92; 52.9%), Trauma Informed Peer Support training (n=92; 52.9%), and Next Steps training (n=91; 52.3%) would enhance their peer support practice. Eleven respondents indicated additional training areas that would enhance their peer support practice that were not captured by the existing response categories. These training areas included: Certified Personal Medicine Coach training (n=1), Focus for Life training (n=1), RESPECT Institute training (n=1), harm reduction (n=1), APL[2] (n=1), being a peer in an outpatient setting (n=1), collaboration (n=1), billing Medicaid (n=1), person centeredness (n=1), workplace bullying training (n=1), and trainer of coaches training (n=1). Some interviewees also described wanting motivational interviewing training as well as training on self-care and training on compassion- or rapport-building techniques.

Table 5: Areas of training wanted (n=174)

Training	N	%
Co-occurring Disorders	92	52.9%
Trauma Informed Peer Support	92	52.9%
Next Steps	91	52.3%
Peer Support Whole Health and Resiliency	89	51.1%
Peer Support for Individuals with Co-occurring Disorders	87	50.0%
ASIST (Applied Suicide Intervention Skills Training)	85	48.9%
Emotional CPR	82	47.1%
Wellness Coaching	80	46.0%
Social Justice	78	44.8%
Boundaries	76	43.7%
Intentional Peer Support	75	43.1%
Self-advocacy	75	43.1%
Cultural Competency	74	42.5%
Community Re-entry	72	41.4%
Ethics	71	40.8%
Leading/facilitating support groups	69	39.7%
WHAM (Whole Health Action Management)	66	37.9%
WRAP Basic Training	66	37.9%
WRAP Facilitator Training	63	36.2%
Computer/Technology	62	35.6%
Time Management	60	34.5%
Other	13	7.5%

CEUs

Survey respondents were asked several questions about Continuing Education Units (CEUs). First, survey respondents who reported currently or ever working as a peer specialist were asked to indicate how many CEUs they had obtained since their last certification. About one-third (n=55; 35.5%) of individuals who responded to this question indicated they had obtained 20 or more CEUs. Figure 18 displays the reported distribution of CEUs obtained since last certification.

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[2] Appears as reported. TIEMH researchers were unable to determine what the acronym APL stands for.

*Figure 18: Number of CEUs obtained since last certification (n=155)*
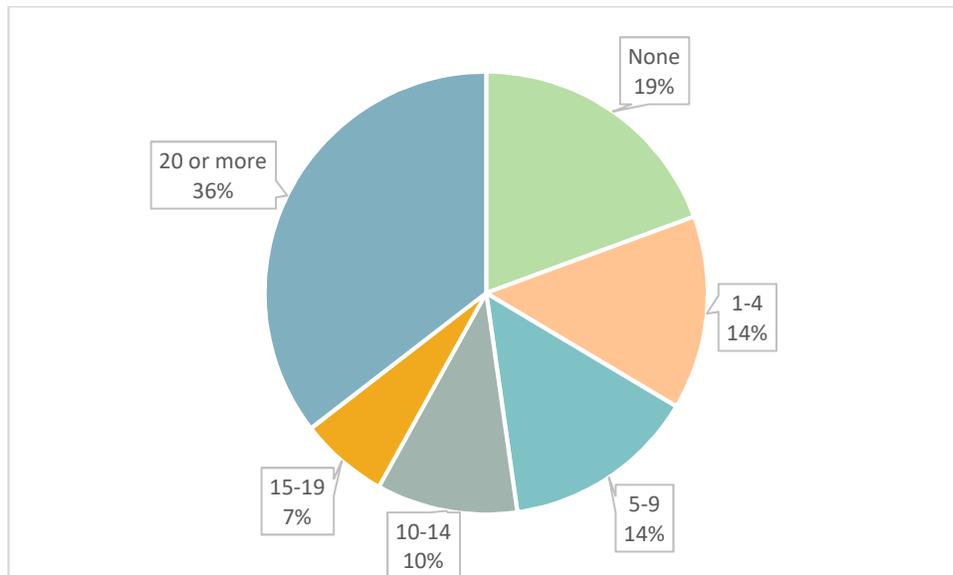
Second, survey respondents who reported currently or ever working as a peer specialist were asked to indicate their level of agreement with the statement: "I have access to CEUs." Most respondents indicated they either strongly agreed (n=71; 46.4%) or agreed (n=48; 31.4%) with this statement. See Figure 19 for the distribution of agreement with this statement.

Figure 19: Access to CEUs (n=153)
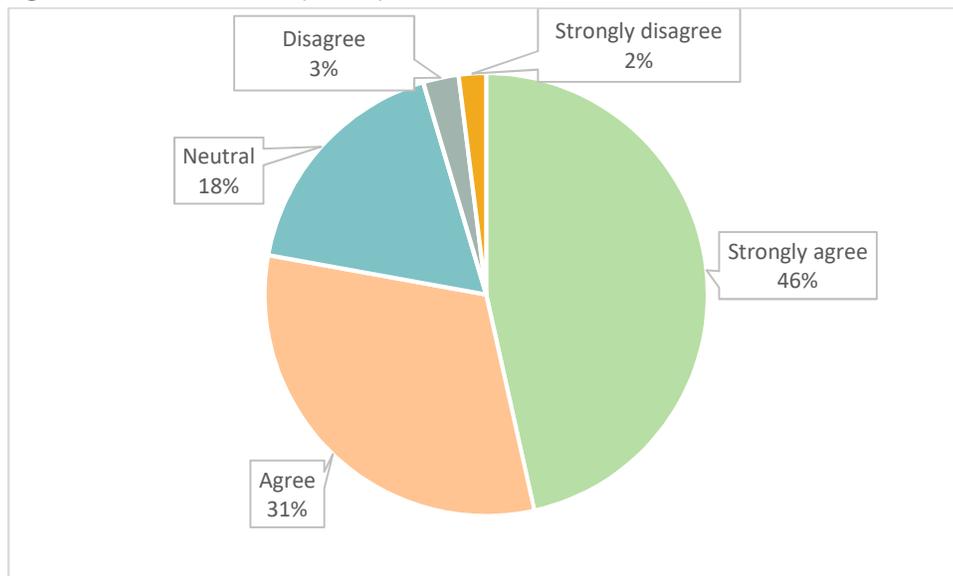
Third, survey respondents who reported currently or ever working as a peer specialist were asked to indicate their level of agreement with the statement: "I have access to funds to obtain CEUs." Most respondents indicated they either strongly agreed with (n=44; 28.4%) or were neutral about this statement (n=40; 25.8%). See Figure 20 for the distribution of agreement with this statement.

Figure 20: Access to funds to obtain CEUs (n=155)
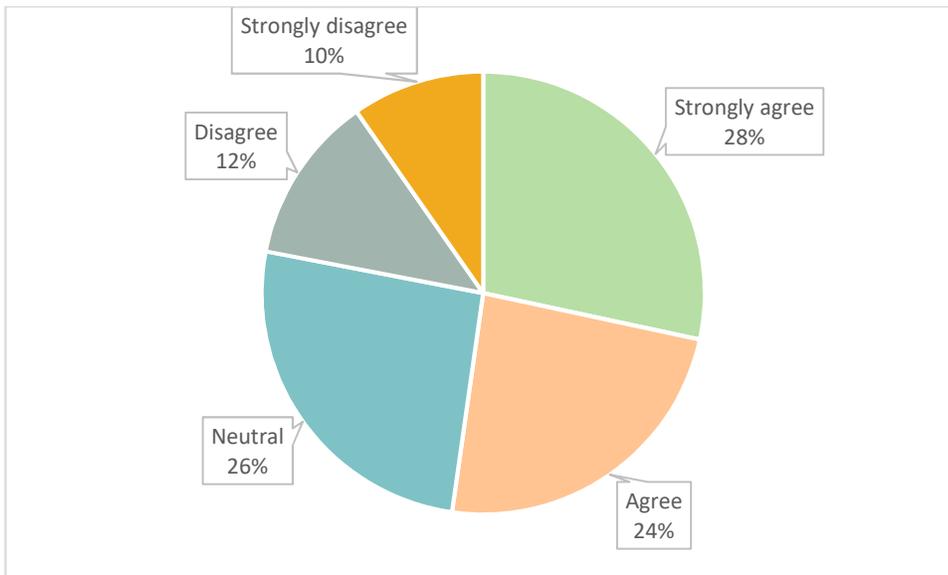
Strongly disagree 10%
Disagree 12%
Neutral 26%
Agree 24%
Strongly agree 28%

Next, survey respondents who reported currently or ever working as a peer specialist were asked to indicate their level of agreement with the statement: "My organization believes (or believed) it is important for me to obtain CEUs." Most respondents indicated they either strongly agreed (n=92; 59.4%) or agreed (n=34; 21.9%) with this statement. See Figure 21 for the distribution of agreement with this statement.

Figure 21: Organizational support for obtaining CEUs (n=155)

Disagree 4%
Strongly disagree 2%
Neutral 13%
Agree 22%
Strongly agree 59%
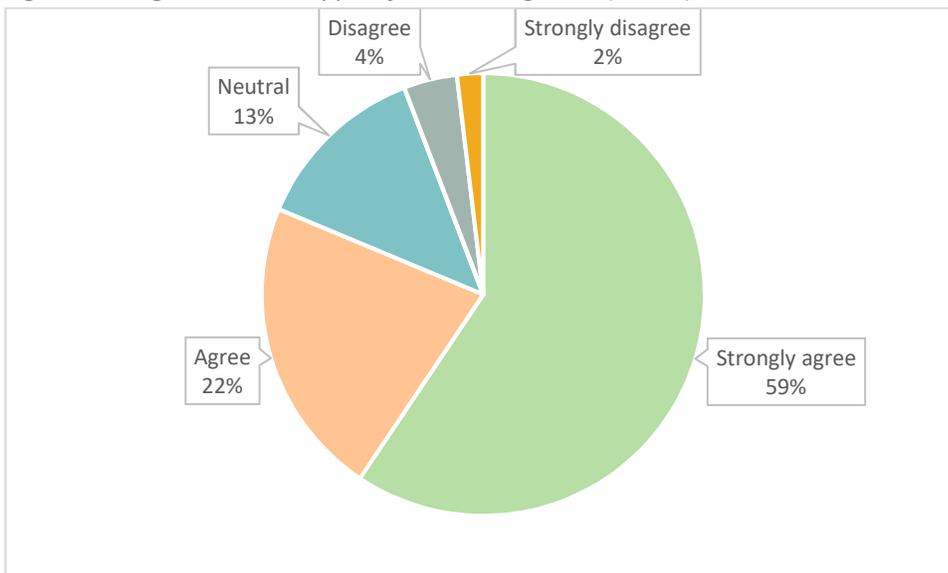
Finally, survey respondents who reported currently or ever working as a peer specialist were asked if they had encountered any barriers to obtaining CEUs. About two-thirds (n=99; 66.0%) indicated they had not experienced any barriers to obtaining CEUs while about one-third (n=51; 34%) indicated they had experienced a barrier (see Figure 22). The latter were asked to qualitatively describe what those barriers were. Most commonly, these respondents indicated that finances were a barrier to obtaining CEUs (n=23). For example, one respondent wrote: "Places are starting to charge for what used to be free. Our organization has very limited funds for CEU's." Respondents also commonly reported that certain CEUs were difficult to obtain, most notably CEUs for Ethics (n=9), that trainings conflict with work hours (n=9), and that COVID-19 has resulted in fewer CEU opportunities (n=7).

*Figure 22: Experience barriers to obtaining CEUs (n=150)*
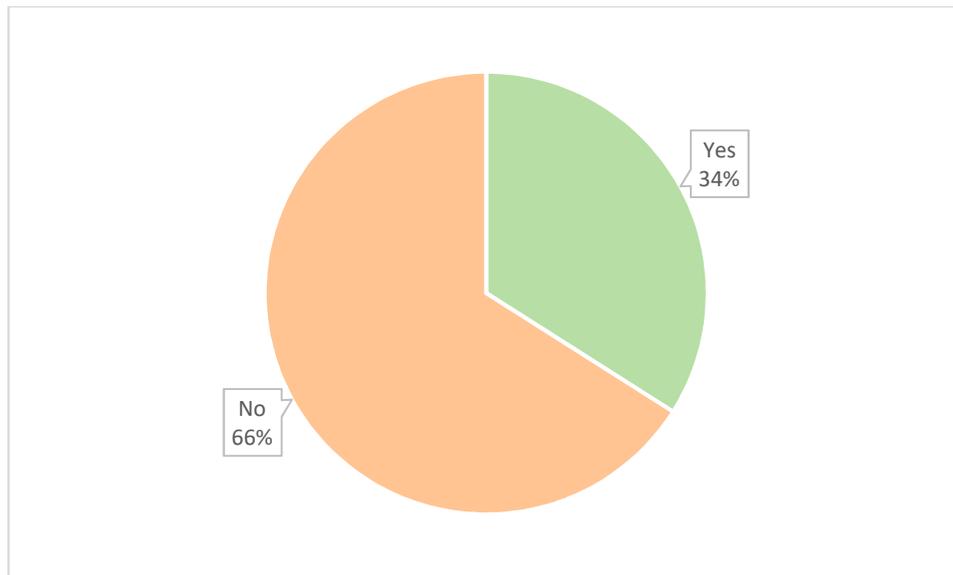
Collaboration

Collaboration between Peers

Survey respondents who reported currently or ever working as a peer specialist were asked how many other peer specialists are (or were) employed at their organization (including the respondent). Respondents reported that the mean number of peer specialists employed at their organization is 12.5 while the median number is 6 (range 1-100+; SD 16.4). See Figure 23 for a distribution of the number of peers employed at respondents' organizations.

Figure 23: Number of peers employed at organization (n=142)
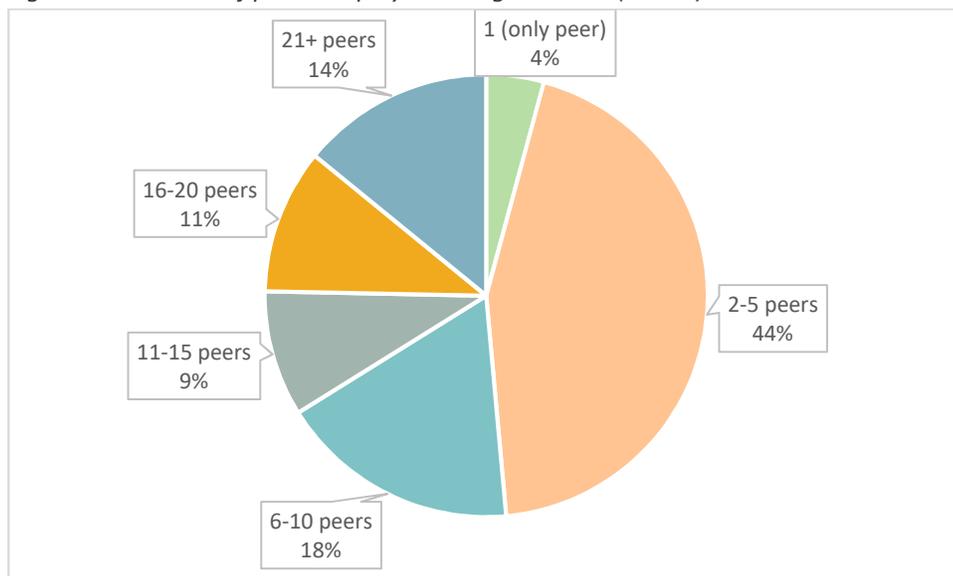
Survey respondents who reported currently or ever working as a peer specialist were asked how frequently they work (or worked) with other peer specialists at their organization. As indicated in Figure 24, respondents most commonly reported that they work(ed) with other peer specialists on a daily basis (n=79; 55.2%), followed by weekly collaboration (n=34; 23.8%).

Figure 24: Frequency of collaboration with other peer specialists (n=143)
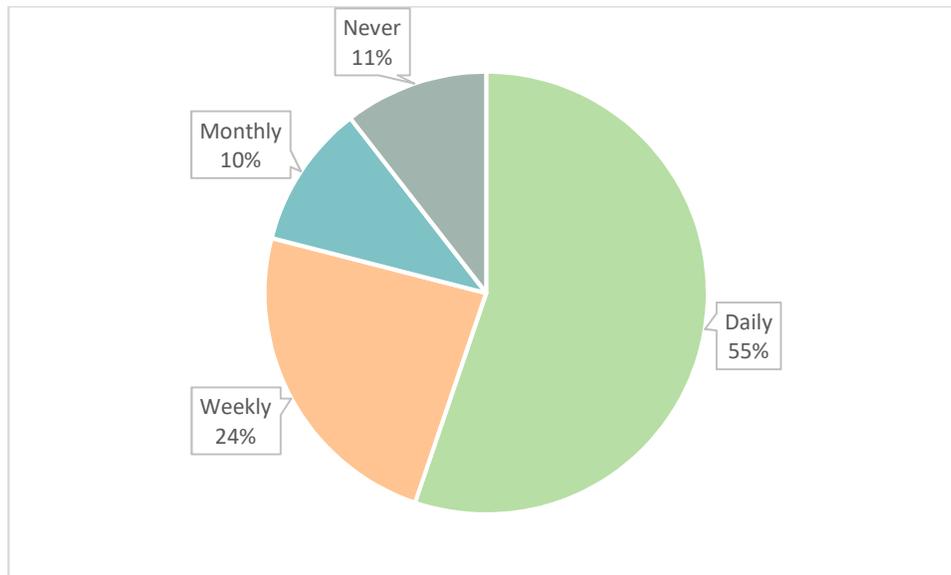
Some interviewees described supportive and collaborative relationships between peers at their organizations. For example, one interviewee said:

> We're a good team. We work together and we keep each other informed. The clients are comfortable working with, talking to any of us. If somebody comes in and their coach isn't here, there's somebody here. We're all real comfortable, and the majority of that's because of that coffee with the coaches. We've all sat around and we've all talked to each other.

Interviewees also described challenges related to the need for greater collaboration between peers. For example, one interviewee reported the need for a statewide database of peers in order to connect and refer across different types of peer certifications: "I want to know like, 'Oh, someone needs a mental health peer specialist. Call so and so there'…for [people in services] to have the smoothest transition of support services."

In addition to the need for greater connection and communication across different types of peer certifications, interviewees also described the need for greater integration between different types of peers. For example, one interviewee said:

"So much of the work that we do as peer staff across the state is siloed … we don't come together often enough."

> So much of the work that we do as peer staff across the state is siloed. It's substance use and child and adolescent over here and mental health over here. We're all under one umbrella, but we don't come together often enough.

Similarly, another interviewee described the need to address cultural differences between different types of peer specialists in order to facilitate greater collaboration and encourage more peers to become dually certified as both mental health and recovery support peer specialists. Specifically, cultural differences regarding the nature of recovery, privacy, and anonymity need to be addressed:

> The ones who did most of their work through the substance abuse system are not as private about their diagnoses and challenges…they've been trained, 'Callout your stuff so you can get help and you're as sick as your secrets.' People who have only dealt with the mental health hospitals and therapists are much

more secretive about their stuff. So, there's a little culture shock whenever the two meet. The substance abuse ones have to learn an expanded understanding of anonymity.

Collaboration with non-peer staff and community partners

Survey respondents who reported currently or ever working as a peer specialist were asked how frequently they work (or worked) with non-peer specialist staff at their organization. As indicated in Figure 25, respondents most commonly reported that they work(ed) with non-peer specialist staff on a daily basis (n=104; 65.4%), followed by weekly collaboration (n=36; 22.6%).

Figure 25: Frequency of collaboration with non-peer staff (n=159)
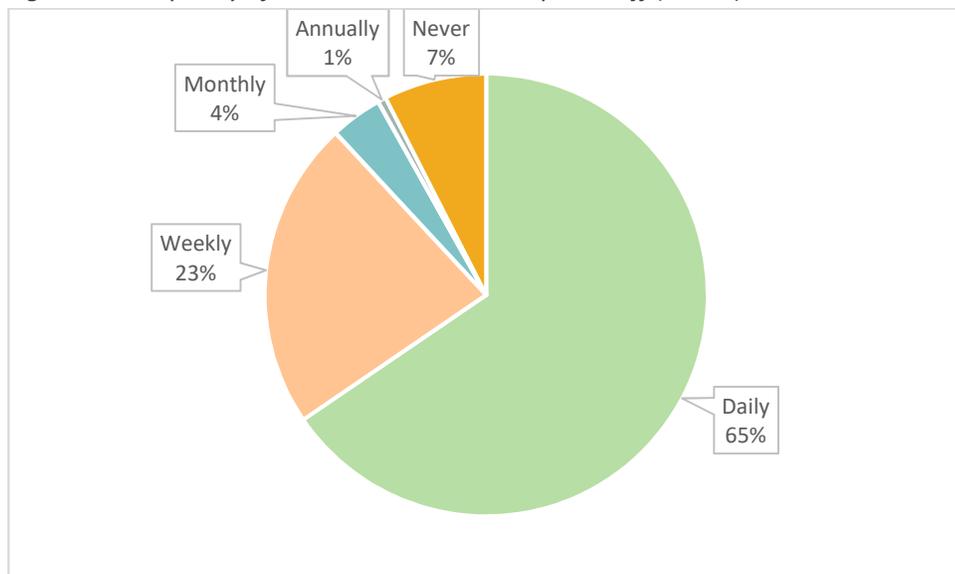
Some themes related to collaboration between peers and non-peer staff and community partners came up in the interviews. For example, interviewees described examples of both supportive and collaborative relationships with colleagues as well as challenges to successful collaboration. For example, one interviewee described having successful collaborative relationships with non-peer staff, while also acknowledging that for many peers this was not the case:

> *They're actually very inviting for us. What I hear is that not a lot of the clinical team leads invite the peers aboard. Versus ours had done the research, they wanted the role and so it really starts there. And if that clinical team lead doesn't invite you, then it creates that ripple of them versus us.*

The theme of building successful and collaborative community partnerships also emerged in the interviews. For example, one interviewee described building relationships with local law enforcement, the local substance use treatment facility, the local housing first community, the local family violence shelter, and others: "Through the ROSC, through the local Mental Health Task Force meetings, and these collaborations that I've been describing, we've seen a lot of silos breaking down and there is a lot more interactive collaboration, communication has a better flow."

Funding

Billing

Survey respondents who reported currently or ever working as a peer were asked if their employer organization bills (or billed) Medicaid for any of the services they provide. As indicated in Figure 26 over half (n=84; 52.5%) of those who responded to this question reported that their organization does not (or did not) bill Medicaid for their services. Another 28% of respondents (n=45) reported that their organization does (or did) bill Medicaid for their services, while 19% (n=31) reported that they were unsure if their organization does (or did) bill Medicaid for their services.

Figure 26: Organization bills/billed for Medicaid for peer services (n=160)
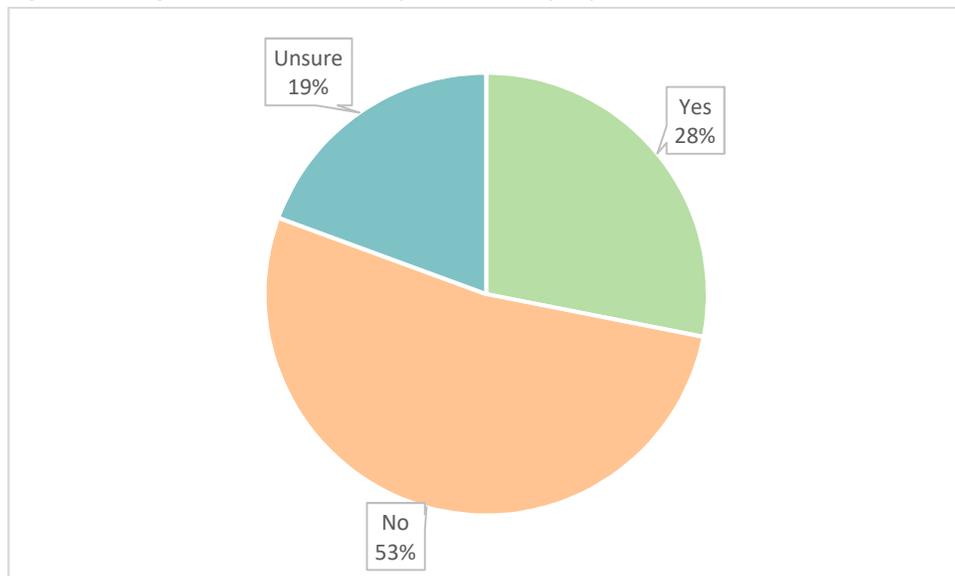
Survey respondents who reported that their organization does (or did) bill Medicaid for their services were asked to indicate what billing code(s) their organization uses (or used). Most commonly, respondents reported that their organization uses (or used) the Medicaid Peer Specialist Services billing code (n=25). Fifteen respondents indicated that they did not know what code is (or was) used, while 11 respondents reported their organization uses (or used) the Psychosocial Rehabilitation Services code. Finally, five respondents reported that their organization uses (or used) a code not captured by the response categories: three of these respondents reported that their organization uses (or used) the Skill Training code while one respondent reported that their organization uses (or used) the Whole Health code.

Figure 27: Code(s) used to bill for peer services (n=45)
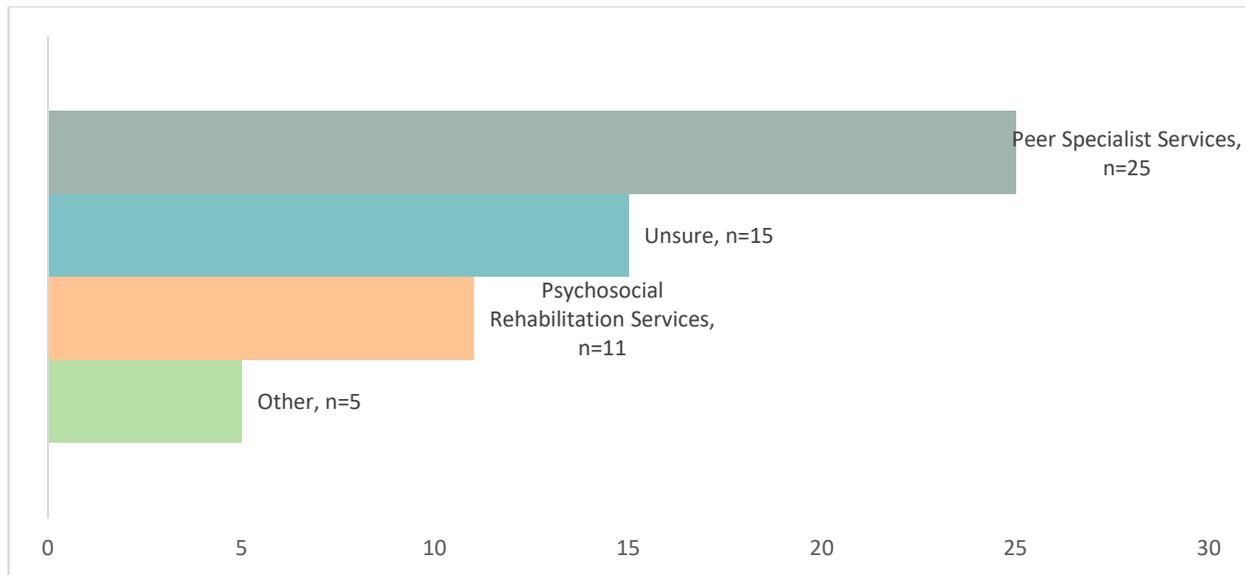
Billing was a large focus of the interviews. Specifically, interviewees were asked if their organization bills Medicaid for the services they provide and if so, if they use the Medicaid Peer Specialist Services billing code (hereafter also referred to as the peer billing code). Interviewees were also asked if the new Medicaid peer billing code as well as the billing rate for the peer code have impacted their work.

The peer billing code was adopted by Texas in 2019 for use by peer specialists who are certified as either MHPS or RSPS. Prior to the creation of the peer billing code, peers who billed Medicaid typically billed for their services using the Psychosocial Rehabilitation Services or Skills Training codes. The adoption of a Medicaid-billable peer code was met with mixed reactions, as interviewees reported both advantages and disadvantages of peers in Texas billing Medicaid. For example, some peers saw the creation of the peer billing code as a reflection of increased recognition of peer support:

> *This is a really giant step forward in the recognition of the value of peer support. Look how many years it took from when things were really beginning to be formalized in peer services in the state of Texas, and now it's becoming a billable service recognized by the federal government, that's a really big deal.*

Interviewees described additional benefits of the peer billing code including enhanced legitimacy of the peer role and therefore greater buy-in from non-peer colleagues as well as more revenue, which can in turn be used to hire more peers.

For other peers, however, the creation and use of the peer billing code is a threat to authentic peer support and a recovery-oriented approach. In particular, documentation requirements, 15-minute time increment requirements, and requirements regarding number of individuals served are seen as impediments to true peer support. For example, one interviewee explained how they enjoyed the flexibility of not having to bill for their services:

> *The purity of it, the freedom of it, of just being there and being able to jump in and be with that person in that moment, and for the length of time it goes through…because I know the peer support specialists at the local mental health authority they have to find something that's billable that they can write down that are in 15-minute increments.*

The interview data were similar to the survey data in that many interviewees reported that their organization does not bill Medicaid for their services. Interviewees provided several explanations for why their organization does not bill Medicaid for their services. These included working at a grant funded organization, working at a cash-only organization that does not accept insurance, working as an independent contractor, working at an organization subcontracted through the local mental health authority, working at a nonprofit organization, working with populations who are not Medicaid eligible (e.g., youth), and because the reimbursement rate for peer services is so low. For example, one interviewee said of the peer reimbursement rate: "I think we just felt like it wasn't worth all the extra effort and red tape for such a low amount."

Some interviewees reported working at organizations that do bill Medicaid for peer services but that the unit or program they work in does not bill Medicaid for peer services. Furthermore, some interviewees reported that their organization or program plans to bill Medicaid for peer services in the future and because of this they document for their services as if they were billing Medicaid. For example, one interviewee said: "We don't bill Medicaid, but it is coded like that. The big picture plan is to be able to accept insurance and use insurance in the hospital there. And it's a slow push."

Another subset of interviewees reported that their organization does bill Medicaid for their services. Some of these interviewees reported using the peer billing code, some reported billing for their services under Skills Training or Psychosocial Rehabilitation billing codes, and some reported that their organization uses both peer and non-peer billing codes depending on the situation. Finally, a fourth group was unsure what, if any, code(s) their organization uses to bill for their services, as billing is handled separately by the billing department at their organization.

Interviewees who use the peer billing code reported using the code for individual services, groups, and telehealth or phone sessions. Interviewees noted, however, that a disadvantage of using the peer billing code is that the reimbursement rate is low. The peer billing rate is less than one-third the rate for Skills Training or Psychosocial Rehabilitation per 15-minute increment. For example, one interviewee said:

> It's very concerning that it's such a small amount. My company is taking a loss on the amount that they're paying me and how much they're receiving. They're going out on a limb to help their patients achieve a different type of recovery and they're taking a loss money wise.

For some peers, this rate had an impact on how their organization bills for their services, with many organizations choosing not to use the peer billing code or only using it in particular situations. For example, one interviewee said of the peer billing code: "It's the stepchild of billing. We use it whenever there isn't another choice." Similarly, an interviewee reported that their organization only uses the peer billing code with new peers who need to accumulate 250 hours of peer support for certification requirements, while using Psychosocial Rehabilitation or Skills Training codes to bill for established peers' services:

> After the required 250 hours…you have a really big day with somebody and go with them to do a lot of stuff, like you're in the clinic and the labs and such, we'll do the four hours of the highest billing code, and then put to a pause and then will start billing Peer Services, just to try to cover the hourly for the peer that's present.

Due to the much lower reimbursement rate for the peer billing code, some interviewees described working at organizations that require or heavily encourage them to bill for their services using the Psychosocial Rehabilitation or Skills Training codes. For example, one interviewee reported:

> *They would prefer that we do Skills or Psychosocial Rehab. We're really, really pushed to use that code 100% of the time. The only time that they want us to use or allow us to use the [peer billing] code is if we absolutely, positively can't put a spin on it where it can be skills or PSR.*

However, many interviewees saw providing Skills Training or Psychosocial Rehabilitation as antithetical to authentic peer work based in mutuality. In particular, interviewees viewed teaching skills, focusing on a predetermined topic (rather than following the needs of the person in services), and delivering clinical services as opposed to true peer support. For example, one interviewee explained: "We have a situation that is pushing peers into non-peers, delivering non-peer services, simply because of the bottom line."

> *"We have a situation that is pushing peers into non-peers, delivering non-peer services, simply because of the bottom line."*

Thus, for some peers using the peer billing code (despite organizational requirements to bill using Skills Training or Psychosocial Rehabilitation codes) was viewed as "going rogue," as one interviewee explained:

> *We've gone rogue this year. We've been using [the peer billing code] a lot because we feel like that's what we should be doing. It's really just being present with people and letting them lead the whole session. Letting them say, 'Hey, this is something I'm struggling with. And let me tell you about it.' Really letting them open up and be themselves and being so much more mutual. It's hard to be really mutual when you're trying to teach somebody something off of a worksheet.*

Finally, other peer specialists reported not knowing what, if any, billing code(s) is used to bill for their services due to the fact that billing is handled separately by the billing department at their organization. "The documentation goes to somebody else that may do that. I don't know what goes on on the next floor."

Compensation, Funding, and Financial Assistance

Survey respondents who reported currently or ever working as a peer specialist were asked to indicate their hourly wage. Among individuals who responded to this question (n=156), the mean hourly wage reported was $16.30 (SD 3.87) while the median hourly wage was slightly lower at $15.81 (see Figure 28). Reported hourly wages ranged from $7.75 to $34.13 an hour. Further analyses were conducted to examine how hourly wages differ by organizational type and PHR. See Tables A3 and A4 in Appendix C for these results.

> *"State or funding agencies and employers should consider pay increases for Peer Support Specialists."*

The topic of compensation was also raised in some of the qualitative data. In particular, the need to increase peer specialist wages was raised by both survey respondents and interviewees. For example, one survey respondent wrote: "State or funding agencies and employers should consider pay increases for Peer Support Specialists." Related to low pay, some survey respondents and interviewees also indicated the need for financial assistance for peer certification fees, the need for peers to unionize, and the need for more funding for peer positions as well as peer-run organizations, such as Consumer Operated Service Providers (COSPs).

Figure 28: Peer wages (n=156)

Mean Hourly Wage: $16.30

Median Hourly Wage: $15.81

Hourly Wage Range: $7.75-$34.13
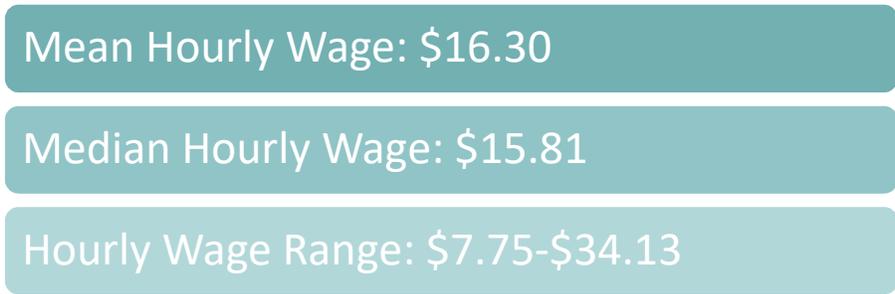
## Organizational and Statewide Culture

Organizational Support

Survey respondents who reported currently or ever working as a peer specialist were asked to rate how supportive their supervisor is or was on a scale from one to ten with one being not at all supportive and ten being very supportive. They were also asked to rate how supportive non-peer specialist staff were at their organization. Survey respondents rated their supervisors as particularly supportive. Among those that responded to this question (n=158) 62% (n=98) rated their supervisor as a ten or very supportive. The mean supervisor supportiveness rating was 8.5 (SD=2.5). For non-peer specialist staff, among those that responded to this question (n=156), 44% (n=68) rated non-peer specialist staff at their organization as a ten or very supportive. The mean non-peer specialist staff supportiveness rating was 7.8 (SD=2.6).

Figure 29: Support from supervisor (n=158) and non-peer specialist staff (n=156) ratings

8.5
- mean **supervisor support** rating on a 10-point scale
- (10 = very supportive)

7.8
- mean **non-peer specialist staff support** rating on a 10-point scale
- (10 = very supportive)
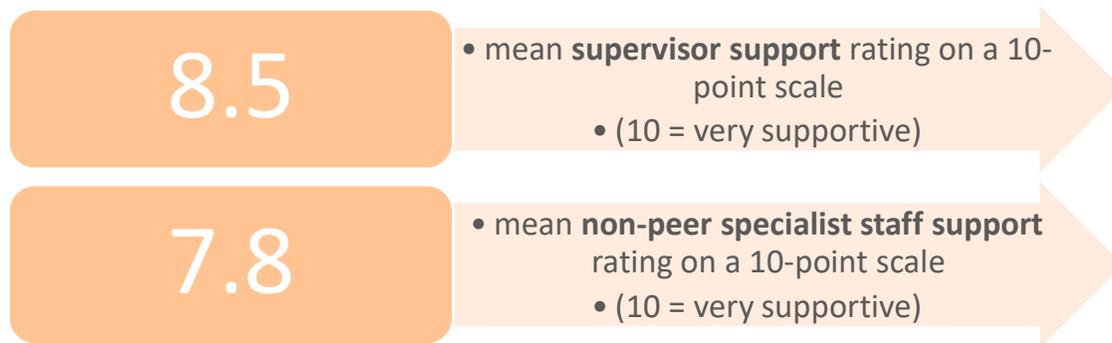
As additional indicators of organizational support, survey respondents were asked to indicate the degree to which they feel accepted and respected by colleagues as well as the degree to which they feel marginalized as a result of the actions or words of their coworkers. A 5-point Likert-type scale was utilized for these two questions with 1 being "Strongly Disagree" and 5 being "Strongly Agree." As indicated in Figure 30, respondents were most likely to report that they either strongly agreed (n=76; 49.4%) or agreed (n=48; 31.2%) with the statement that they feel accepted and respected by colleagues (mean 4.16; n=154).

Figure 30: Feel accepted and respected by colleagues (n=154)
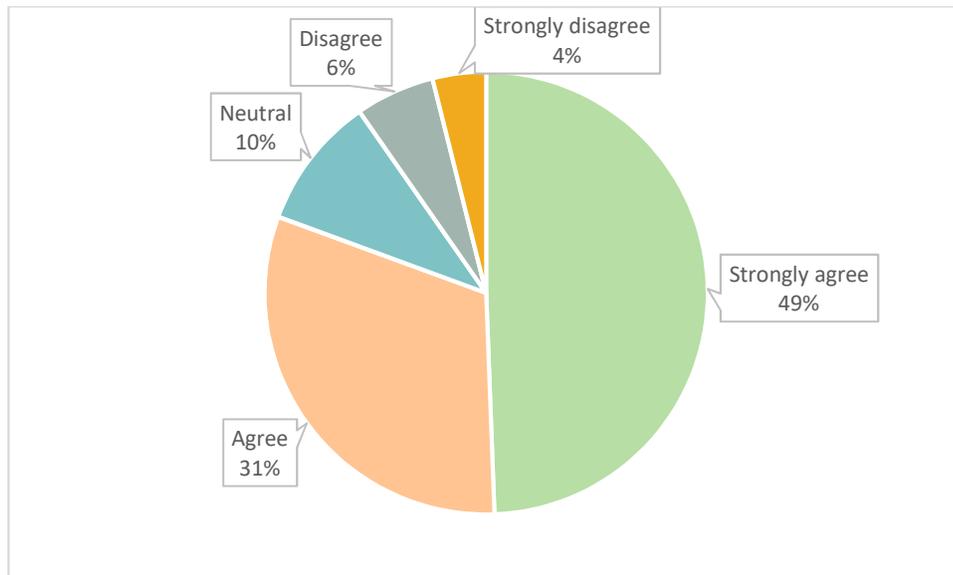
As indicated in Figure 31, respondents were most likely to report that they either strongly disagreed (n=44; 28.4%) or are neutral (n=41; 26.5%) with the statement that they feel marginalized as a result of the actions or words of their coworkers (mean=2.7; n=155). However, taken together over a quarter of respondents either agreed or strongly agreed with this statement.

Figure 31: Feel marginalized by coworkers (n=155)
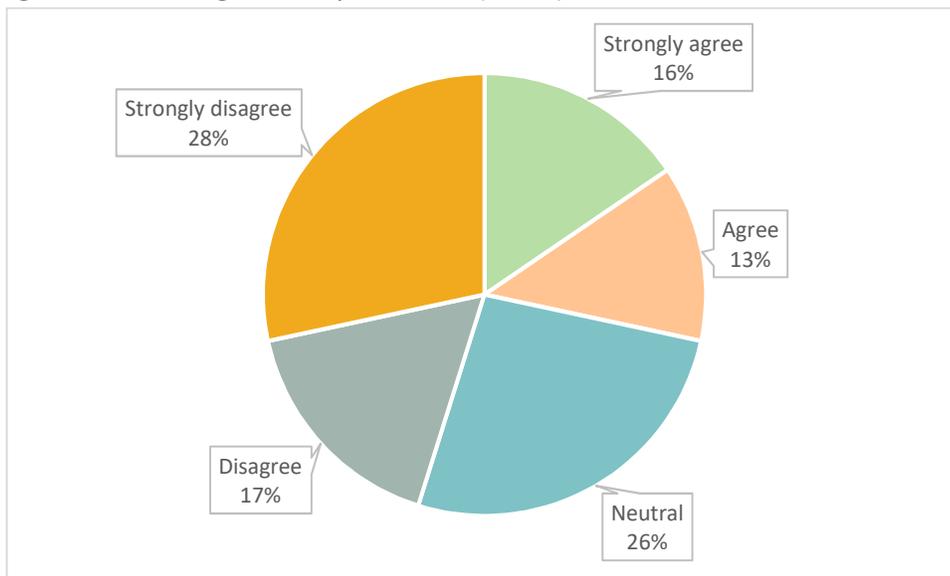
Qualitative survey and interview data further suggest that peers in Texas experience both supportive and unsupportive organizational cultures and climates. For example, several interviewees described working at organizations that were supportive and valued peer specialists. As one interviewee said:

> *It has been a great experience of working at a very awesome place. I have never felt discriminated, I have never felt different. They really care about what we do as a peer specialist. They see the power of when a person who we are serving here is like 'I've have been there. You know what I'm going through.'*

Unfortunately, other survey respondents and interviewees described working at organizations that were not supportive and did not value peer specialists. Peers described a lack of organizational support as demonstrated by low pay, stigma, and a lack of recognition, respect, or empathy. For example, one survey respondent wrote: "I don't understand why my agency has peers here because they are treated horribly and most run out the door from being retraumatized." Similarly, one interviewee explained:

> We're left towards the back and forgotten about. And that's something we were recently talking about with pay…we're just not appreciated as much as other positions like a therapist…I'm not asking to be on the same paycheck as them…but just showing us appreciation in compensation or in some other way like letting us know 'We're here for you. We understand that your job can be difficult at times. How can we help you?'

Recovery Oriented Culture and Cultural Change

To examine the recovery orientation of the employer organizations of survey respondents, the 15-item ROSA (Lodge et al., 2018) was included on the survey. Survey respondents who reported currently or ever working in a peer specialist capacity were asked to rate their current or former employer on a 5-point Likert scale with 1 being "Never" and 5 being "Always." Table 6 presents the mean score for each item on the ROSA.

Table 6: Recovery Oriented Services Assessment (ROSA) scale (n=156)

Our organization…	Mean (SD)
…asks people about their interests.	3.99 (1.03)
…supports people to develop plans for their future.	4.10 (1.05)
…invites people to include those who are important to them in their planning.	3.92 (1.14)
…offers services that support people's culture or life experience.	3.98 (1.12)
…introduces people to peer support or advocacy.	4.13 (1.02)
…encourages people to take risks to try new things.	3.81 (1.13)
…models hope.	4.29 (1.01)
…focuses on partnering with people to meet their goals.	4.21 (0.94)
…respects people's decisions about their lives.	4.26 (1.00)
…partners with people to discuss progress towards their goals.	4.18 (1.01)
…offers people a choice of services to support their goals.	4.19 (1.01)
…offers people opportunities to discuss their spiritual needs when they wish.	3.93 (1.16)
…believes people can grow and recover.	4.44 (0.88)
…is open with people about all matters regarding their services.	4.29 (0.97)
…provides trauma-specific services.	3.81 (1.21)
Total Mean	**4.10 (0.84)**

The ROSA scale had excellent internal reliability as indicated by a Cronbach's alpha of .966. ROSA items that were rated most highly, in terms of frequency of delivery, included believing that people can grow and recover, modeling hope, being open with people about all matters regarding their services, and respecting people's decisions about their lives. Lower scored items, in terms of frequency of delivery, included providing trauma-specific services, encouraging people to take risks to try new things, inviting people to include those who are important to them in their planning, and offering people opportunities to discuss their spiritual needs when they wish. Additional analyses were conducted to examine how ROSA scores differ by organizational type and PHR. See Tables A5 and A6 in Appendix C for these results.

Themes related to cultural change regarding a recovery orientation and peer support also emerged in the interview data. Notably, interviewees described how being a peer often provides an opportunity to be a cultural change agent working towards a more recovery-oriented system. For example, one interviewee said:

> We consistently promoted a recovery-oriented approach, multiple pathways, all the principles of peer support. Just helping people be a little bit more open minded and receptive to what real recovery really can look like and that there are multiple pathways. That's been encouraging.

Interviewees also described several indicators of a shift towards a more recovery-oriented system in Texas, including the use of more recovery-oriented language at the organizational and state levels, the representation of people with lived experience of recovery in state offices, and the fact that in many ways Texas is at the forefront regarding peer support services.

Role Tasks, COVID-19, and Role Clarity

Survey respondents who reported currently or ever working as a peer specialist were asked to indicate their level of agreement with the statement: "I am satisfied with my overall job experience." A 5-point Likert-type scale was utilized for this question with 1 being "Strongly Disagree" and 5 being "Strongly Agree." The mean satisfaction score was 4.25 (n=155). As indicated in Figure 32, the majority of respondents strongly agreed (n=79; 51.0%) or agreed (n=54; 34.8%) with this statement.

Qualitative survey and interview data provide further evidence that peers are satisfied with their job overall. Several interviewees and survey respondents expressed how much they enjoyed their job and described obtaining a great deal of satisfaction, fulfillment, and reward from their job. For example, one interviewee said: "I love this job. I would do it for free if I were rich. This job means the world to me and I feel like it's my calling." Similarly, another interviewee said "I've never been this fulfilled in any job I've ever done. I absolutely love it." Interviewees and survey respondents also emphasized that the peer role could at times be an emotionally difficult or taxing job and that self-care was important to counterbalance that.

Figure 32: Overall satisfaction with job (n=155)
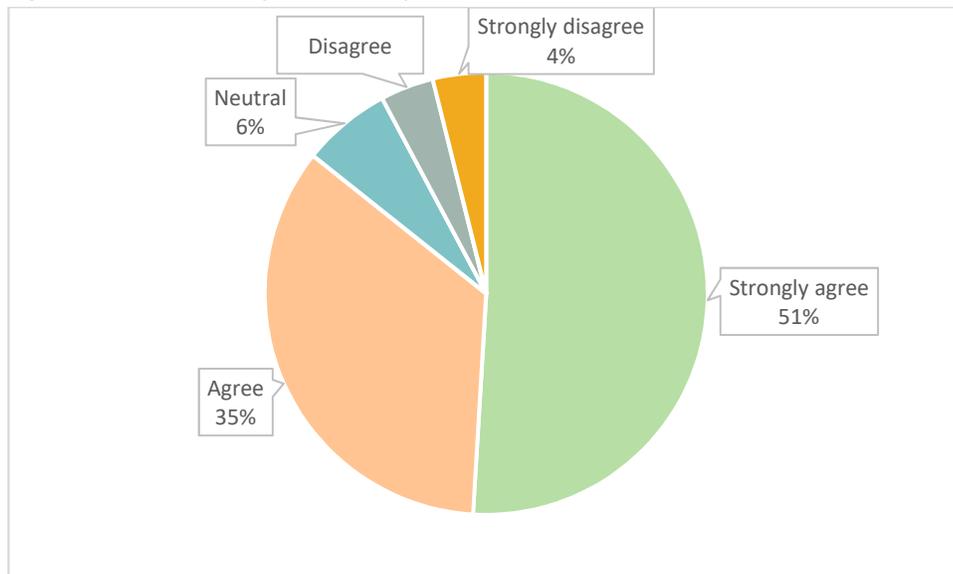
Role Tasks

Survey respondents who were currently or ever worked as a peer specialist were asked to select various job tasks that they performed in their work from a list of 20 common peer specialist job tasks. As displayed in Table 7 and Figure 33, the most commonly reported tasks were one-on-one support (n=152; 87.4%), connecting people to resources (n=148, 85.1%), and helping people advocate for themselves (n=147; 84.5%). The least commonly reported tasks were psychosocial rehabilitation (n=29; 16.7%), medication management and monitoring (n=30; 17.2%), and vocational assistance (n=38; 21.8%). Respondents were also provided an "other" option to specify any job tasks not captured by the list. These other job tasks included: facilitating trainings and classes (n=3); budgeting (n=1); serving as a subject matter expert for panels and pilot studies (n=1); completing surveys (n=1); facilitating staff and coaching meetings (n=1); peer workforce development (n=1); recovery planning (n=1); research (n=1); serving on subcommittees (n=1); suicide prevention (n=1); and working as a warmline operator (n=1).

Table 7: Peer role tasks (n=174)

	N	%
One-on-one support	152	87.4%
Connecting people to resources	148	85.1%
Helping people advocate for themselves	147	84.5%
Administrative tasks	130	74.7%
Facilitating support groups	127	73.0%
Goal-setting	124	71.3%
Education	110	63.2%
Outreach/Engagement	104	59.8%
Housing assistance	91	52.3%
Skill building	91	52.3%
Transportation assistance	84	48.3%
Support clients during transition from inpatient	77	44.3%
Wellness Recovery Action Planning (WRAP)	76	43.7%
Working on a treatment team	62	35.6%
Serve on work groups and committees	61	35.1%
Patient navigation	50	28.7%
Provide supervision to other peer specialists	47	27.0%
Vocational assistance	38	21.8%
Medication management and monitoring	30	17.2%
Psychosocial rehabilitation	29	16.7%
Other	12	6.9%

Figure 33: Most commonly reported peer job tasks (n=174)

One-on-one support (87%)

Connecting people to resources (85%)

Helping people advocate for themselves (85%)

Survey respondents who reported currently or ever working as a peer specialist were also asked to indicate what percentage of their time (in increments of five) that they spend on administrative tasks as well as what percentage of their time they spend on providing peer support. As displayed in Figure 34, respondents reported on average spending 37.7% of their time on administrative tasks and 56.5% of their time providing peer support.

Figure 34: Percent time spent on administrative and peer support tasks (n=156)

37.7%
- average % time spent on **administrative tasks**

56.6%
- average % time spent on **providing peer support**
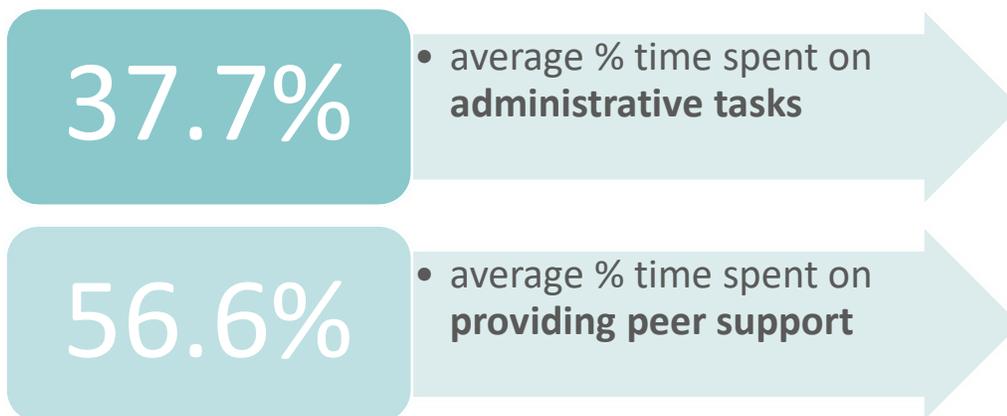
Survey respondents were asked to briefly describe how they document for peer services. Respondents provided information on what software or program that they use to document their services, what types of forms they use to document their services, and what details they include in their documentation. Of note, only three respondents reported here that they do not (or did not) document for their services.

First, regarding documentation software or programs, survey respondents most commonly reported using Clinical Management for Behavioral Health Services (CMBHS; n=24) to document services. Survey respondents also commonly reported using Salesforce (n=12), Avatar (n=8), EPIC (n=4) and SmartCare (n=3). Additional programs used by at least two survey respondents included: Anasazi, Client Track, Columbus Network, Homeless Management Information System (HMIS), RADplus, Recovery Data Platform, RedCAP, and Streamline. In contrast to the use of software, three respondents reported hand-writing their notes and one reported that their documentation process involved "verbal communication with supervisor."

Second, some survey respondents provided information about what types of forms or notes they use to document their services. Respondents commonly reported using the following types of forms for documentation: wellness, treatment, or recovery plans (n=5), progress notes (n=4), SOAP notes (Subjective, Objective, Assessment, and Plan;

n=4), CAN notes (Current, Action, and Next Steps; n=4), status notes (n=3), DAP notes (Data, Assessment, and Plan; n=3), and SWOT notes (Strengths, Weaknesses, Opportunities, and Threats; n=3).

Third, some survey respondents provided information about what details they include in their documentation notes. Most commonly, respondents reported detailing the type of contact or the purpose of the session (n=25). Other note details that were reported by at least two survey respondents include: a summary of the discussion with the person in services (n=10), observation of the person receiving services (including their behavior, level of engagement, and level of understanding; n=5), date and time of session (n=3), intervention (n=2), outcome or solution (n=2), attendance (n=2), and provider and individual served (n=2).

Survey respondents who were currently or ever worked as a peer specialist were asked to indicate how many individuals that they provide or provided peer services to in an average week. As displayed in Figure 35, respondents reported that they provide(d) services to a mean number of 20.7 people in an average week (median 16 individuals; range 0 to 100+; n=161).

*Figure 35: Number of individuals peers serve in an average week (n=161)*

Mean number of individuals served in a week = 20.7

Median number of individuals served in a week = 16

Survey respondents who reported currently or ever working as a peer specialist were asked to indicate which population(s) they work(ed) with: adults (ages 19 and older), youth or adolescents (ages 18 or younger), or other. Most respondents (n=151; 86.8%) reported working with adults, while 25 respondents (14.4%) reported working with youth or adolescents. All other responses fell into one of these two categories and were recoded as such.

Survey respondents who reported currently or ever working as a peer specialist were asked to what extent they feel they are able to do their job well. A 5-point Likert-type scale was utilized with 1 being "Strongly Disagree" and 5 being "Strongly Agree." As indicated in Figure 36, nearly all respondents either strongly agreed (n=96; 61.5%) or agreed (n=49; 31.4%) with this statement (mean=4.51; n=156).

Figure 36: Feel able to do job well (n=156)
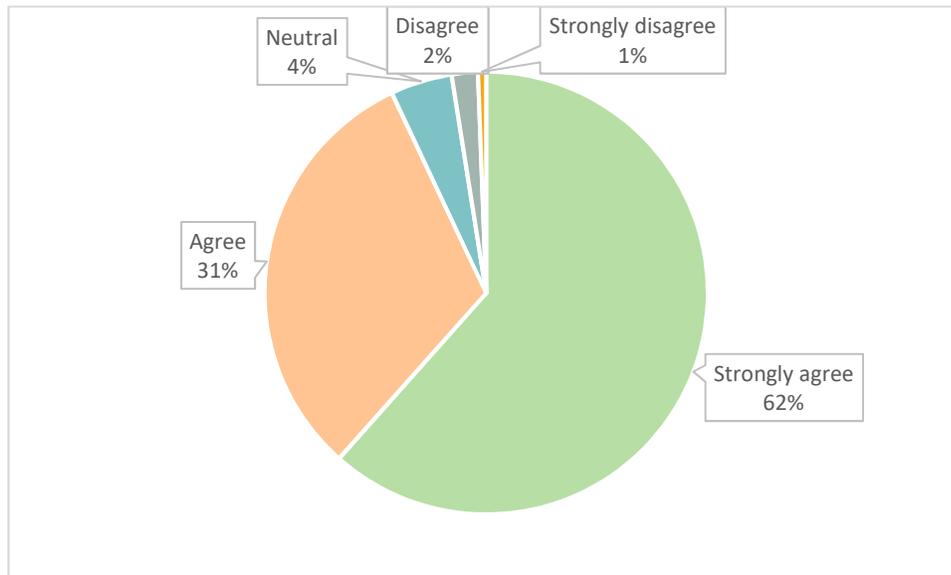
Job Role during the COVID-19 Pandemic

Survey respondents and interviewees were asked several questions about how the coronavirus (COVID-19) pandemic has impacted their work as a peer. First, survey respondents were asked to indicate if they had engaged in any new tasks in their peer specialist role since the COVID-19 pandemic began. As indicated in Figure 37, a little over half of individuals who responded to this question (n=85; 54.8%) reported that they had not engaged in any new tasks, while a little less than half (n=70; 45.2%) indicated that they had engaged in new tasks. Respondents who reported engaging in new tasks since the pandemic began were asked to qualitatively specify what those new tasks are. Most commonly, respondents reported providing virtual peer support or telehealth (n=47), attending virtual trainings and meetings (n=7), providing additional outreach to people in services (e.g., making more outreach phone calls; n=4), and finding new, additional, or alternative resources for people in services (n=3). Respondents also reported providing education on COVID-19 to people in services (n=2), consoling people in services who contracted COVID-19 or lost loved ones to COVID-19 (n=2), and adhering to and encouraging others to adhere to social distancing protocols, mask wearing, and hand washing (n=2).

Figure 37: Engaged in new tasks since COVID-19 pandemic began (n=155)
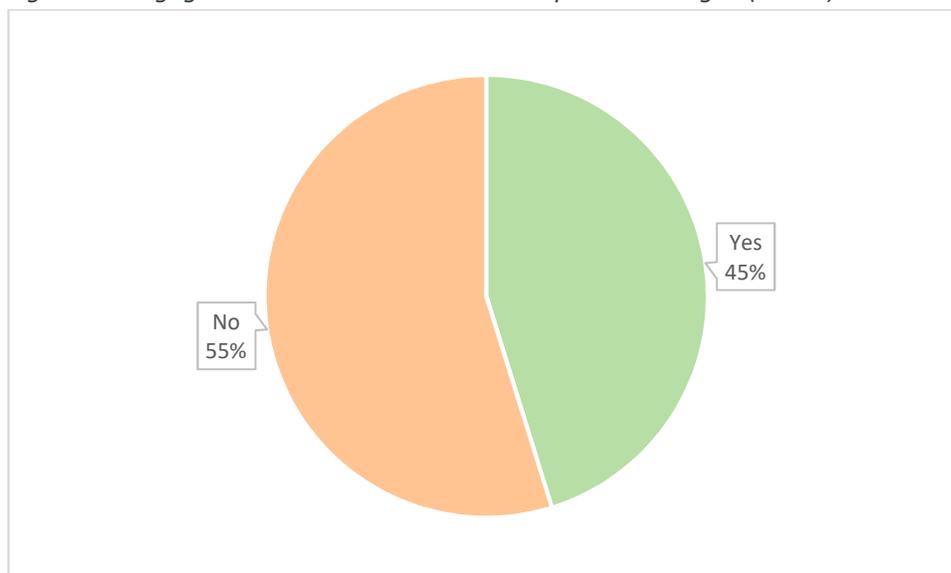
Survey respondents were also asked if they had experienced a number of challenges related to their job as a peer specialist since the COVID-19 pandemic began. As indicated in Table 8, the most commonly reported challenges included a lack of training for providing virtual peer support (n=35; 20.1%), difficulty obtaining CEUs (n=31; 17.8%), and a lack of technological resources for providing virtual peer support (n=20; 11.5%). Additional challenges not captured by these response categories include: difficulty finding virtual peer support trainings (n=1), reduced mileage reimbursement (n=1), having to supply own personal protective equipment (n=1), not being able to provide peer support to individuals in services who tested positive for COVID-19 (n=1), and being short staffed, and therefore overworked (n=1).

Table 8: Challenges related to the COVID-19 pandemic (n=174)

	N	%
Lack of training for providing virtual peer support	35	20.1%
Difficulty obtaining CEUs	31	17.8%
Lack of technological resources for providing virtual peer support	20	11.5%
Lack of personal protective equipment	13	7.5%
Laid off or lost job	12	6.9%
Took a pay cut due to reduced hours or demand for work	8	4.6%
Other	6	3.4%
Lost some or all job benefits	5	2.9%

Interviewees were also asked about how the COVID-19 pandemic has impacted the ways in which they do their work as a peer specialist. Interviewees described several ways in which the COVID-19 pandemic has changed how they deliver peer services. For example, interviewees commonly described providing peer support over the phone or over video conferencing platforms. As one interviewee described: "We're meeting online, we're meeting on the telephone, we're doing video groups, we're doing all that stuff." Many peers also continued to provide in-person services, although with various modifications. For example, some peers provided one-on-one peer support in-person but did not provide groups, some provided in-office services but not home visits, some worked at organizations that limited who could attend groups or how many individuals could enter a building, and others worked at organizations that simply enforced or encouraged social distancing protocols, meeting outside, wearing masks, and washing hands.

Delivering services in new or different ways presented challenges for both peer specialists as well as people receiving services. Peers commonly reported the following challenges associated with COVID-19 service delivery: fewer options for how peer support is provided; decreased ability to regularly engage with people in services; virtual peer support as less effective than in-person services; and issues with access to reliable technology.

A key challenge the pandemic presented is fewer options for how peer support is provided. Specifically, many of the ways that peer support had previously been delivered in-person (e.g., in-person groups, games, social activities, community outreach) were unavailable to many. For example, one interviewee reported: "It completely halted our harm reduction outreach, being able to do that. And then obviously the ability to do in-person sober social activities and stuff like that we normally would have."

A second challenge was that the pandemic sometimes decreased peers' ability to regularly engage with people in services. For peers who continued to provide services in person (and did not provide virtual services), spikes in COVID-19 cases and social distancing protocols limited how frequently they could engage with individuals in services, how many people in services they could serve, and how much time they could spend with individuals in services. Peers also commonly reported that providing virtual or phone-based peer support negatively impacted

engagement (compared to in-person services) among people receiving services. For example, one interviewee explained: "It did impact the engagement I had with individuals. Some didn't want peer services, or some just didn't feel comfortable meeting for the first time over the computer."

> "[COVID-19] did impact the engagement I had with individuals. Some didn't want peer services or some just didn't feel comfortable meeting for the first time over the computer."

A third challenge that COVID-19 service delivery presented is that virtual or phone-based services were characterized by many peers as less effective than in-person services in that virtual services were viewed as less personal, less comfortable, and less effective in fostering a sense of connection. For example, one interviewee said of virtual services: "It doesn't have that personal touch to me as much as what it did when I see people in person. So I feel disconnected at times with people." Similarly, another interviewee explained how virtual services were less effective for people in services, which in turn negatively impacted engagement:

> We couldn't do it in person so it was not as touching or not as beneficial to the client, because it's very hard to reach out to them and they're going through stuff too and all of this just made it worse for them. It was very, very closed off. Not much engagement.

> "A lot of the clients don't understand technology or just don't have the means to get online."

A fourth barrier that COVID-19 service delivery presented is that virtual peer support requires access to reliable and affordable technology, which not all peers or people in services have. Peers described personally experiencing issues with internet reliability due to overwhelmed bandwidths, internet affordability issues, and a lack of access to technology that could support virtual support groups. Similarly, many people in services lack access to technological resources that would allow them to access virtual peer services. Some peers were able to provide hybrid in-person, phone, and virtual services depending on individuals' needs and preferences, but undoubtably some individuals are unable to access services due to technological access barriers. For example, one interviewee explained:

> A lot of the clients don't understand technology or just don't have the means to get online. They have either a home phone or just a basic cell phone. So we just talk on the phone. And there's probably been a handful that I've met and talked in person, but we're at least six feet away, we wore our masks, and we were sitting outside. It's just unfortunate that a lot of people don't have that technology these days.

> "[COVID-19 has] upped the intensity of the work…It's not like you can say 'Well, they'll be back,' because a lot of them aren't coming back."

In addition to challenges related to COVID-19 service delivery, interviewees also described experiencing challenges related to adapting to changes to the peer role during the pandemic. For example, interviewees commonly described their work as more "serious" due to the numerous challenges that people in services experienced during the COVID-19 pandemic. These pandemic-related challenges included higher rates of suicide, overdose, domestic violence, deaths from domestic violence, social isolation, substance use, health anxiety due to fears of contracting COVID-19, job loss, housing loss, depression, hopelessness, distrust, and grief as they lose friends and family members to COVID-19. For example, one interviewee said: "[People in services are] now dealing with a lot of loss, loss of jobs, loss of family members, loss of places to live. Just a lot of loss." As a result, interviewees described a change in the peer role. For example, one said: "The effect that it's had on us is it's upped the intensity of the work. You can't be passive anymore. It's not like you can say 'Well they'll be back,' because a lot of them aren't coming back."

Interviewees also commonly described challenges supporting people in services' community resource needs during COVID-19. Challenges arose due to a number of issues, including overwhelmed community organizations, the closing of some community organizations, and difficulty supporting individuals' needs virtually. For example, one interviewee explained:

> It's a lot harder to support people with things that they need in the community. We have resource packets. We've always had that. But as peers we've always done it differently, like, go along with them. Or at least take them and introduce them. Or meet them somewhere.

Another peer-role related challenge was that some peers struggled to build rapport with people in services virtually or over the phone. For example, one interviewee explained:

> If somebody is able to sit there and look at you in person and read your body language and there's an actual live person that they see who has lived experience versus a voice on the phone… I've had experiences with that. They're not very trustworthy at first. They're not trusting me. Whenever we start going back in person, it will be a dramatic change.

A fourth peer-role related challenge that interviewees described was figuring out how to navigate and adapt to new situations and protocols associated with providing services during the COVID-19 pandemic. For example, one interviewee explained:

> We were all adapting. There have been so many unknowns with this. What the processes were going to look like? …Some of the group homes were like, 'We don't want to accept them until they come up negative [for COVID-19]. It doesn't matter how long it's been, because we have other people to protect.' So, you're also trying to figure out where can this person go in the meantime, until they're allowed to go back to their known living situation. That was very hard.

Another peer-role related challenge for some interviewees who continued to provide in-person services was the fear of contracting COVID-19. For example, one interviewee said: "It added stress on each person as we're fearful we're going to come into contact with someone that had COVID." One interviewee even described working at an organization in which some providers had peers take laptops for telehealth sessions to individuals on units that may have been exposed to COVID: "Sometimes certain disciplines didn't feel comfortable going on to a unit and they might have the peer specialists take the laptop with the camera."

Interviewees also described a number of other role-related challenges they experienced during the COVID-19 pandemic, although these were not as frequently reported as those described above. These challenges included: difficulty educating non-peer staff on the peer role, difficulty obtaining approval to work remotely, financial challenges, being understaffed, repetitive work, having less connection with people in services negatively impacting personal recovery, and a lack of organizational flexibility (particularly regarding documentation time limits) to account for the "new normal."

Despite the challenges associated with providing peer support during the COVID-19 pandemic, interviewees also described several ways in which the pandemic has afforded peers with new opportunities. These include opportunities to provide enhanced peer services, new career development opportunities, and new opportunities related to increased job flexibility. Regarding opportunities to provide enhanced peer services, interviewees most commonly described the opportunity to connect with more individuals in services or to connect more often with

individuals in services due to the fact that geography is less of a barrier to providing services to people. For example, one interviewee explained:

> "We're able to contact people in the outlying counties a lot more often...our ability to stay in contact has actually increased."

We're able to contact people in the outlying counties a lot more often. Because in the past, it would be drive out there, hope that they're home. So our ability to stay in contact with our people has really actually increased.

Interviewees also described the opportunity to expand telehealth peer services for individuals who experience transportation barriers or who are unable or would prefer not to have in-person services for other reasons. For example, one interviewee said: "There are a lot of people that prefer a telepresence delivery of service, because they're sitting in their own home, in their comfort zone." Some peers described working at organizations that plan to continue offering telehealth peer services in addition to in-person peer services and therefore are making efforts to expand access to technology for people in services as well as peer staff.

> "A lot of people prefer a telepresence delivery of service because they're sitting in their own home, in their comfort zone."

Interviewees described additional ways in which the pandemic has afforded peers with opportunities to provide enhanced peer services. These opportunities include: virtual services as providing the opportunity to spend more one-on-one time with people in services, virtual services as providing greater confidentiality for people in services, the opportunity to create new online groups and other new ways to connect virtually with people in services, and working virtually provides an opportunity to more efficiently perform job tasks.

Interviewees also described new career development opportunities that they have had since the COVID-19 pandemic began. Most commonly, interviewees described the opportunity to "get creative" and explore new strategies to engage and work with people in services. For example, one interviewee described:

> "[COVID-19] helped me to be better at engaging my clients and definitely become a better listener."

I had to be creative…It's really easy for people to talk to you when it's in person, but on the phone they just want to say 'Yeah, okay. I'm fine. Great.' So, I had to learn how to engage with them and ask them questions and probe them to find out 'What's going on with you today? What can I do to help you? Are there any other resources that will help you get out of this slump that you're in?'

This same interviewee explained that in exploring new strategies in their work with individuals in services: "It helped me to be better at engaging my clients and definitely become a better listener."

> "We had time to participate in oodles and oodles of webinars and Zoom conferences. And all of us have increased our skills."

Another interviewee described being able to better explore their role as a peer due to having a lighter caseload during COVID-19: "I was able to have a lighter caseload and that gave me a chance to really get my feet wet. Gave me a chance to really explore my new role."

Peers also described enhanced training and learning opportunities as a result of more virtual training offerings as well as having more time to attend trainings, webinars, and conferences. For example, one interviewee explained:

> *Because all the working peers were at home for so many months, we had time to participate in oodles and oodles of webinars and Zoom conferences. And all of us have increased our skills. It's like, 'Well, I'm not out in the community running 90 to nothing. I do have time for that one-hour little piece of education.'*

Virtual trainings also had the benefit of eliminating travel costs, which in turn made training more accessible to peers. For example, one interviewee said: "Us not having to pay for travel and pay for hotel rooms is a huge break." Another benefit of virtual trainings and webinars described by one interviewee is more opportunities for networking among peers:

> *Because we weren't pushed for time during quarantine, we would all go to the same videoconferences together. And then we would get together and talk about them. We ended up sharing some details of our recovery stories with each other…peers up here have developed contacts and relationships with peers in other centers because we had time to be in the same meetings together, the same conferences, the same webinars.*

Finally, some interviewees described new opportunities related to increased job flexibility and in particular the opportunity to work from home. For example, some peers described benefits to working from home including not having a commute, less stress and exhaustion from driving around town for work, and enhanced opportunities for self-care. As one interviewee explained: "The driving around the whole town like from east to the west side, from the north to the south. All over pretty much. It gets tiring and so the pandemic has impacted that in a positive light."

"The agency has recognized that there's a whole lot of meetings that can be videoconferencing."

Interviewees also described benefits to virtual meetings, including greater flexibility and convenience. For example, one interviewee explained:

> *The agency has recognized that there's a whole lot of meetings that can be videoconferencing. Which means that people don't so much drop what they're doing all to go to the central office. Everybody just pauses and gets still somewhere so they can join the meeting.*

Virtual meetings and trainings may also have the benefit of enhancing diversity among attendees, by making attendance more accessible. For example, one interviewee explained:

> *Being able to do those virtual meetings, has actually increased the diversity because more people were able to access that. When logistically maybe it just wasn't feasible for them to come to a lunch meeting so we've seen an increase in our Recovery Oriented System of Care (ROSC).*

Role Clarity

Survey respondents who were currently or ever worked as a peer specialist were asked if their organization has (or had) a peer specialist-specific job description for their position. As indicated in Figure 38, the majority of respondents (n=134; 83.8%) indicated that they have or had a peer specialist-specific job description for their position. Another 9.4% (n=15) indicated that they did not have a peer specialist-specific job description for their position while 6.9% (n=11) indicated that they did not know if they had a peer specialist-specific job description.

Figure 38: Peer specialist-specific job description
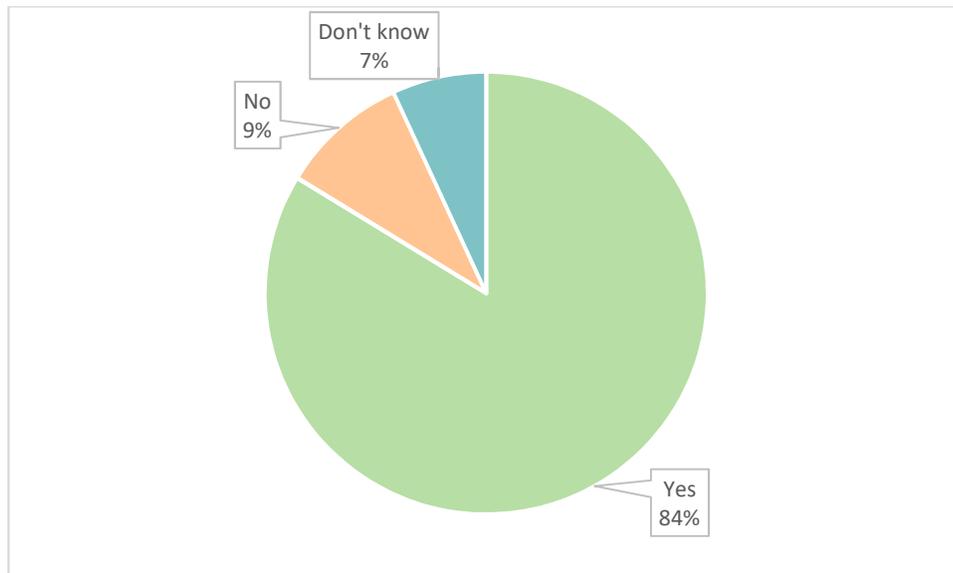
As an additional indicator of role clarity, survey respondents were also asked to what extent they agreed (on a 5-point Likert scale where 1 is strongly disagree and 5 is strongly agree) with the statement: "My job description is peer-based and reflects the actual work that I do." As indicated in Figure 39, the overwhelming majority of respondents strongly agreed (n=75; 48.4%) or agreed (n=47; 30.3%) with this statement (mean=4.15).

Figure 39: Job description is peer-based and reflects actual work (n=155)
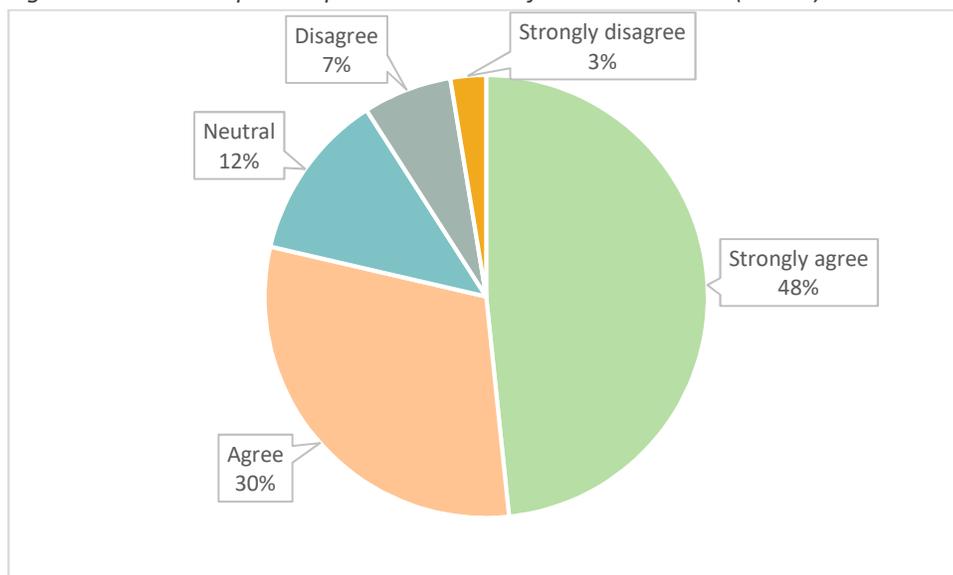
Survey respondents who reported currently or ever working as a peer were asked to indicate how well (on a scale from 1 being very poor to 10 being excellent) their job role is understood by the following individuals or groups: their supervisor, administrative staff, clinical staff, human resources (HR) staff, and executive leadership. Survey respondents rated their supervisors as having the highest mean understanding of their job role as a peer (mean=8.3; SD=2.6; n=159), while they rated HR staff as having the lowest mean understanding of their job role (mean=7.1; SD=2.9; n=153). Clinical staff had a mean peer role clarity rating of 7.3 (SD=2.7; n=148), administrative staff had a mean peer role clarity rating of 7.5 (SD=2.7; n=158), and executive leadership had a mean peer role clarity rating of 7.8 (SD=2.9; n=158). See Figure 40 for a visualization of the mean rating for each of these staff groups.

Figure 40: Mean understanding of peer job role by staff group
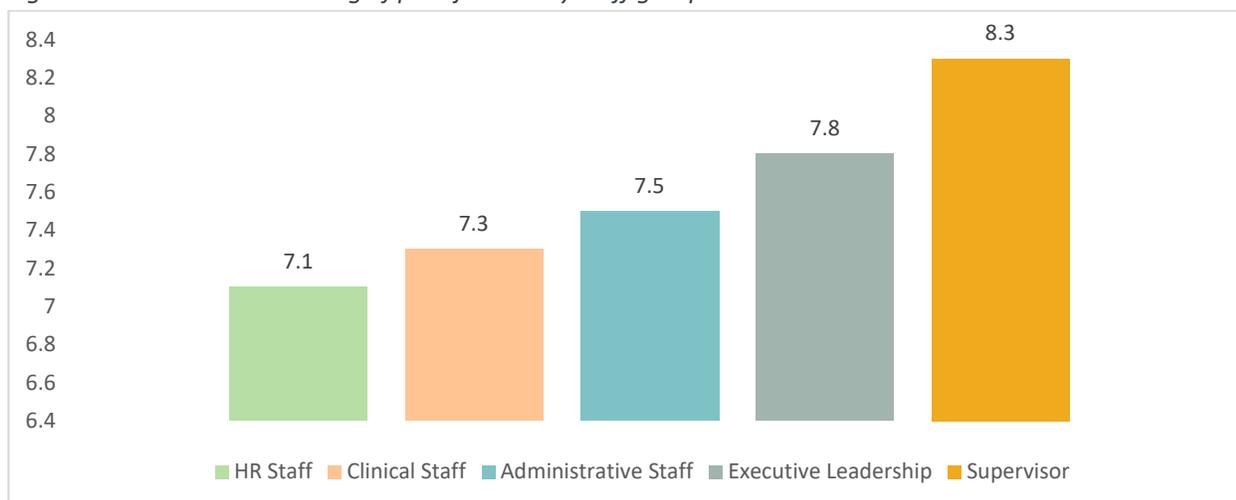
Qualitative survey and interview data provide evidence that the peer role is understood by many behavioral health care providers in Texas and that peer role clarity has increased over time in large part due to the efforts of peers to educate their colleagues as well as for supervisors to educate themselves on the peer role. For example, one interviewee described how their supervisors understand the peer role: "I've been really supported by my supervisors. Whenever they hired for this role, they did a lot of research on what a peer was and they knew the expectations." Another interviewee explained how role clarity has increased over time in Texas:

"We're finally becoming a lot more known for what we do. Seven years ago, nobody knew who we were or what we did."

We're finally becoming a lot more known for what we do. Seven years ago, nobody knew who we were or what we did. There was anger. In the beginning, it was rough but now people know that we're not out trying to steal their jobs. A lot of those fears are gone.

Much of the education and training on the peer role has been done by peers, as indicated by one interviewee who described their considerable efforts to educate colleagues on the peer role (prior to the COVID-19 pandemic which interrupted these efforts):

I used to get an opportunity to speak at the mental health staffing every Monday morning. I would share something about peer services. Every time that we got a new case manager, they would come and spend a whole day with me. We've always done the educating. And I made sure that it was on a day that I was doing group so that they got to see everything: individual services, group services, going out into the community. But this past year has shut all of that down.

However, the qualitative data indicate that there remains room for improvement regarding peer role clarity in Texas and in particular, the need for organizations to implement organizational or system-wide training on the peer role. For example, one survey respondent wrote:

I think that it starts at the top with various organizations to have a lengthy education process for the concept of the peer role, beginning with early history. This needs to be offered to various disciplines to ensure that they have a full understanding of what is considered peer role versus non-peer role in [an] effort to avoid confusion or incredulity.

Supervision

Survey respondents were asked several questions about the supervision they receive (or received) as a peer. First, they were asked how frequently they receive supervision: daily, weekly, monthly, annually, or never. As indicated in Figure 41, most commonly respondents reported receiving weekly supervision (n=70; 44.0%), followed by monthly supervision (n=45; 28.3%).

Figure 41: Supervision frequency (n=159)
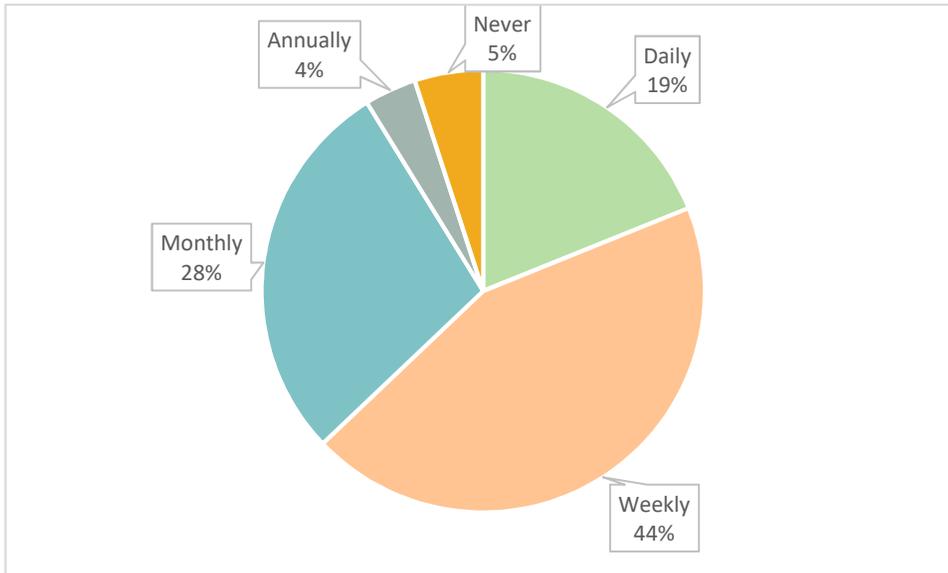
Survey respondents were also asked to what extent they agree with the following statement: "My supervisor explains the skills or procedures I am expected to perform." A 5-point Likert-type scale was utilized with 1 being "Strongly Disagree" and 5 being "Strongly Agree." As indicated in Figure 42, most commonly respondents reported that they strongly agree (n=63; 41.2%) or agree with this statement (n=48; 31.4%). The mean score for this item was 3.9 (n=153; SD=1.2).

Figure 42: Supervisor explains skills or procedures of peer role (n=153)
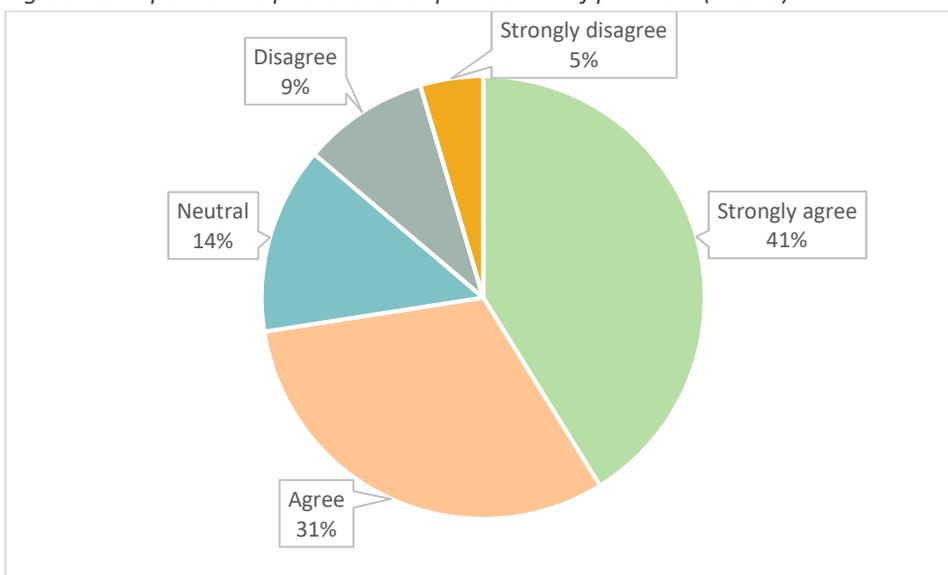
Next, survey respondents were asked to what extent they agree with the statement: "My supervisor acts upon my suggestions, ideas, and opinions." A 5-point Likert-type scale was utilized with 1 being "Strongly Disagree" and 5 being "Strongly Agree." As indicated in Figure 43, most commonly respondents reported that they strongly agree (n=77; 49.7%) or agree (n=42; 27.1%) with this statement. The mean score for this item was 4.1 (n=155; SD=1.1).

Figure 43: Supervisor acts upon peers' suggestions, ideas, and opinions (n=155)
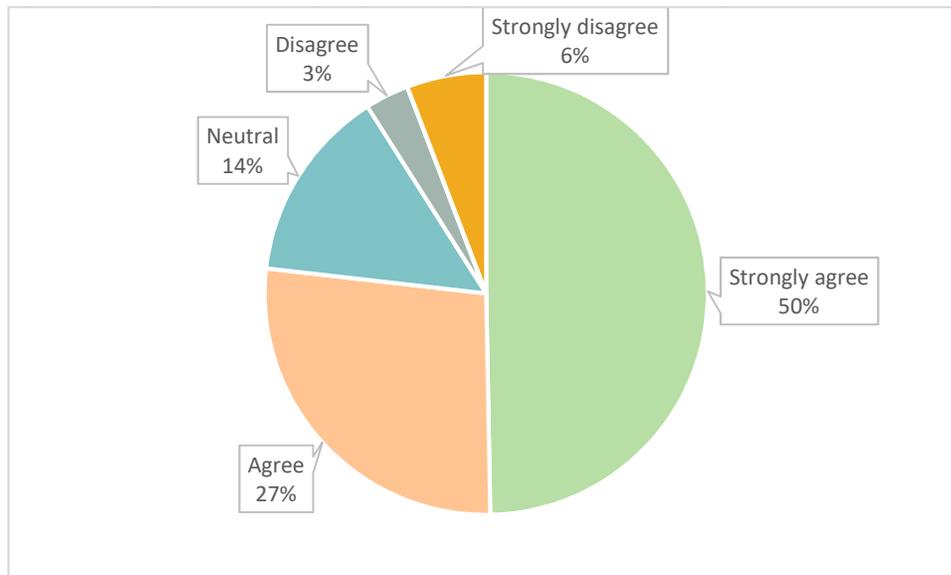
Survey respondents were also asked to indicate what supervision looks (or looked) like for them. Response categories included: one-on-one supervision, team meetings, shadowing, supervisor observation, administrative supervision, clinical supervision, supervision for special issues or circumstances, and other, with respondents asked to select all of the choices that apply to them. As indicated in Figure 44, the most commonly reported types of supervision were: one-on-one supervision (n=119), team meetings (n=109), and supervision for special issues or circumstances (n=70). The least commonly reported types of supervision were clinical supervision (n=28) and shadowing (n=39). Additionally, nine respondents reported receiving an "other" type of supervision and were asked to qualitatively specify what that supervision looks like. The following types of supervision were reported: groups (n=1); Via Hope trainings (n=1), new employee supervision (n=1), phone supervision (n=1), and supportive supervision (n=1). Two respondents reported receiving limited to no supervision due to 1) being the director of an organization and 2) needing to connect more with their supervisor. Respondents also reported receiving supervision from a board of directors (n=2), a professor (n=1), and two supervisors (n=1).

Figure 44: Types of supervision (n=174)

One-on-one supervision n=119
Team meetings n=109
Supervision for special issues n=70
Supervisor observation n=48
Administrative supervision n=47
Shadowing n=39
Clinical supervision n=28
Other n=9
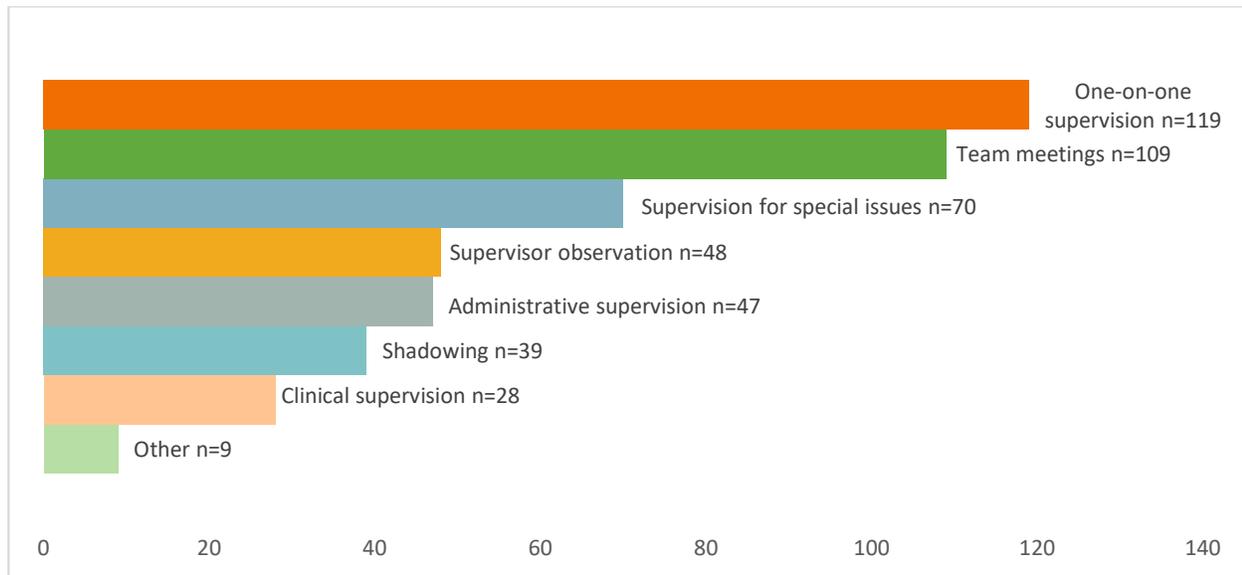
Survey respondents were also asked if their supervisor is (or was) a peer specialist. As indicated in Figure 45 almost half (n=77; 48.1%) reported that their supervisor is a peer specialist, while about 46% (n=73) reported that their supervisor is not a peer specialist and about 6% (n=10) reported that they do not know if their supervisor is a peer specialist.

Figure 45: Supervisor is a peer specialist (n=160)

Don't know 6%
Yes 48%
No 46%
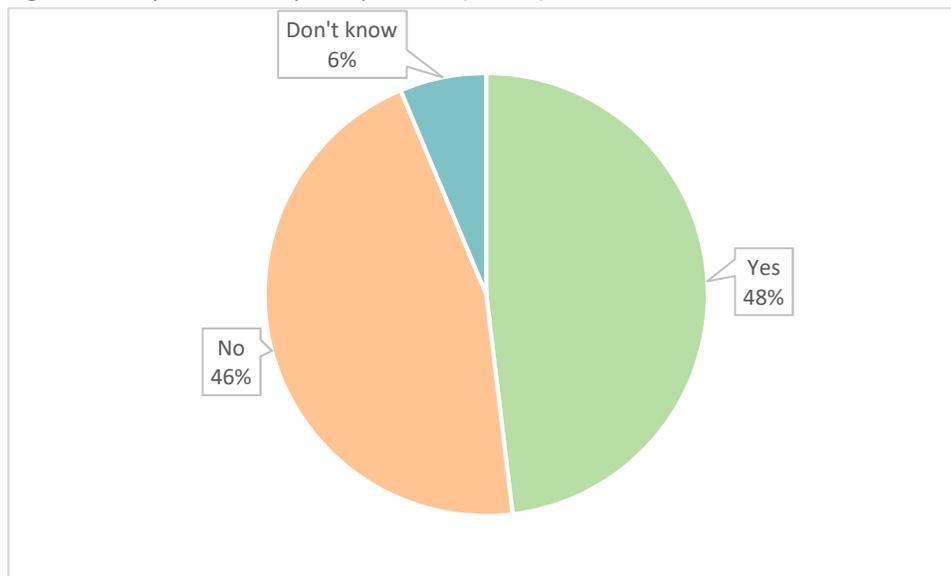
Peer versus Non-peer Supervisor Analyses

Additional analyses were conducted to examine how having a peer supervisor versus having a non-peer supervisor matters for other survey outcomes. These analyses indicate that survey respondents with a peer supervisor reported higher ratings of their organization's recovery orientation, as indicated by statistically significant higher mean ROSA scores (Table 9); significantly higher ratings of their supervisor's overall understanding of the peer specialist role (Table 10); and higher, but not statistically significantly higher, ratings of their supervisor's overall level of supportiveness (Table 11) compared to survey respondents with a non-peer supervisor.

Table 9: Supervisor type by ROSA scores

	N	M	SD
Peer Supervisor	75	4.30*	0.69
Non-Peer Supervisor	71	3.93	1.00
I don't know	10	3.84	1.05

*p=.023

Table 10: Supervisor type by supervisor's overall understanding of the peer specialist role

	N	M	SD
Peer Supervisor	77	9.27*	1.67
Non-Peer Supervisor	72	7.42	3.02
I don't know	10	7.70	2.91

*p=.001

Table 11: Supervisor type by supervisor's overall level of supportiveness

	N	M	SD
Peer Supervisor	77	8.91	2.07
Non-Peer Supervisor	71	7.99	2.89
I don't know	10	8.30	2.87

Summary and Recommendations

Peer services have been recognized as one of the top strengths in the current behavioral health system and have also been identified as a service gap due to limited access (HHSC, 2016). Additionally, estimates suggest that peer providers will soon make up 25% of the behavioral health workforce (Manderscheid, n.d.), but a recent SAMHSA report projects a shortage in the number of peer providers needed in the workforce (SAMHSA, 2021). It is therefore imperative to examine the factors that contribute to the success and sustainability of the peer provider workforce. By examining quantitative survey data in conjunction with qualitative interview data, we gain a fuller picture of peer workforce outcomes in Texas. In this section, key findings that emerged from this mixed-methods approach are summarized and recommendations based on these findings are provided.

Peer Demographic Characteristics

For both the survey and the interviews, the majority of respondents reported being women, non-Hispanic, and white. Survey respondents were most likely to report being in their 50s and 60s while most interviewees were most likely to report being in their 40s or 50s. In terms of educational attainment, both survey respondents and interviewees most commonly reported having completed some college or post-high school training.

The survey and interview samples were regionally diverse. The survey sample included respondents from all PHRs in Texas, while the interview sample included respondents from most PHRs. Both the survey and interview samples mirrored the population distribution of Texas with a greater number of individuals being from the major metro areas of Austin, Dallas/Fort Worth, Houston, and San Antonio than from South Texas, the Panhandle region, the Piney Woods region of East Texas, and West Texas.

Recommendations

- Peer training and certification agencies should collect demographic and geographic data on peer specialists. These data can be used to measure the extent to which different demographic groups are underrepresented among peer specialists, as well as to identify regions of Texas with peer workforce shortages.
- Based on the demographic characteristics of the survey and interview samples, greater efforts should be taken to train, certify, and retain a more diverse peer workforce. In particular, based on these samples there appears to be an extreme underrepresentation of Hispanic or Latino peers in Texas. Peer workforce diversity needs could be better understood if demographic information was collected during the training and certification process.

Employment

The majority of survey respondents in this study reported that they currently work in a full-time peer specialist position. Among respondents who were currently working or ever worked as a peer specialist, the most common employers included CMHCs or LMHAs, RCOs, and community substance use treatment centers. Survey respondents reported working on average 5.3 years at their employer, which is higher than the average of 4.5 years reported among employed mental health peer specialists in 2017 (Lodge et al., 2017). The majority of respondents also reported that they receive (or received) paid vacation time off, paid sick leave, and medical insurance for themselves. However, less than half of respondents reported receiving retirement benefits, disability insurance, or medical insurance for their family and nearly 12% of peers who responded to this question reported receiving no employee benefits.

About 15% of the survey sample were not currently working as a peer specialist; reasons given for not working as a peer included working in a different role, inability to find a job (particularly a full-time job with benefits), dissatisfaction with some aspect of the peer role (e.g., low pay, lack of benefits), and COVID-19. Only one-third of these respondents reported experiencing barriers to finding a job as a peer specialist. However, those that did experience barriers reported a lack of full-time peer positions, a lack of funding for peer positions, low pay, and barriers related to personal characteristics (e.g., lack of experience, not having a degree, not speaking Spanish).

Recommendations

- Expand employee benefits for peer specialists. At a minimum, all peers should have access to paid time off and health insurance.
- Offering more robust benefit packages that also include retirement and disability benefits as well as health insurance for family members may help to attract and retain qualified peer specialists.
- Allocate funding to create more full-time positions for peer specialists that offer living wages.

Career Advancement and Development

Regarding peer certification, survey respondents most commonly reported having an active MHPS certification, followed by an active RSPS certification and an active PRSS certification. Lapsed certifications were not common in this sample, perhaps due to the recent grandfathering and certification within the last two years. However, respondents who did have one or more lapsed certifications described several reasons for not maintaining certification including: certification is not required for their job, retirement or no longer working as a peer, the financial cost of renewal, limited time to complete renewal, forgetting to renew due to not receiving a renewal notice, a lack of leadership support, a lack of access to training, and deciding to retain another certification type instead.

About half of survey respondents reported participating in the HHS peer certification grandfathering process and the majority were satisfied or very satisfied with this process. Interviewees were also asked about their experiences with the grandfathering process. While some interviewees described finding the grandfathering process to be simple and easy, others found the process to be confusing and unclear. Some interviewees also described experiencing challenges with the required background check (e.g., challenges with scheduling, a lack of access to an IdentoGO in local area) as well as financial challenges regarding the grandfathering process. Interviewees who had access to financial and procedural support from their supervisors and colleagues were less likely to describe experiencing challenges with the grandfathering process compared to those who lacked support.

Recommendations

- The financial cost of certification and recertification is prohibitive to some peer specialists, especially given average hourly salaries. Peers need more financial support from the state and employer organizations to obtain and maintain their certification(s), including financial support for the background check.
- The state and peer certification agencies should consider expanding vendor options for peers to obtain a background check. IdentoGO offices are not located in many rural areas of the state and not all peer specialists are able to travel long distances to an IdentoGo.
- Peer employer organizations should support peers in their efforts to obtain and maintain their certifications, including providing paid time off as needed to attend trainings and complete certification requirements and offering financial assistance for certification and recertification.

Less than half of survey respondents reported that their employer provides or provided them with a career ladder or career advancement opportunities. For some peers, the peer specialist supervisor endorsement and supervising other peers is an avenue for career advancement. However, some interviewees reported not having career advancement opportunities as some organizations do not support developing supervisory or managerial positions for peers.

The majority of survey respondents reported that their employer provides or provided them with career development opportunities. Most commonly, respondents reported receiving financial assistance to attend trainings, in-house training opportunities, time off to attend continuing education or other trainings, and skill development opportunities. Many more virtual trainings were available during the pandemic, increasing opportunities to participate in career development.

Survey respondents who were currently or ever employed as a peer specialist were asked to indicate the peer-related trainings or other educational opportunities that they had attended. Most commonly, respondents reported that they had attended Trauma Informed Peer Support training, Co-occurring Disorders training, and WRAP basic training. Respondents were also asked what training areas would enhance their peer support practice. Most commonly, respondents reported that Co-occurring Disorders training, Trauma Informed Peer Support training, and Next Steps training would enhance their peer support practice.

Regarding CEUs, the majority of survey respondents indicated they had access to CEUs, had access to funds to obtain CEUs, and that their organization believes it is important for them to obtain CEUs. However, about one-third of respondents indicated they had experienced a barrier to obtaining CEUs. These barriers included financial barriers, difficulty obtaining certain CEUs (most notably Ethics), and difficulty attending trainings due to a scheduling conflict with work hours.

Recommendations

- Peer specialists need access to career advancement opportunities. Organizations that employ peers should support and provide opportunities for peer specialists to advance in their careers. Towards these ends, the state might consider developing a position to serve as an advocate for peers as they navigate issues related to their careers.
- Survey respondents most commonly reported wanting to take Co-occurring Disorders training, Trauma Informed Peer Support training, and Next Steps training. Peer training entities should take this into consideration for future training offerings.
- Organizational and state-level efforts to increase CEU access for peer specialists should focus on expanding financial support for CEUs, providing more paid time off to obtain CEUs, expanding offerings for particular CEUs that are in high demand (e.g., Ethics training), and continuing to offer virtual training opportunities that include CEUs.

Collaboration

The majority of survey respondents reported working with other peer specialists on a daily basis. Respondents reported that the mean number of peer specialists employed at their organization was 12.5 while the median number was 6. Interviewees provided examples of supportive and collaborative relationships between peers as well as suggested strategies for increasing collaboration between peers. These strategies included developing a statewide database of peers in order to connect and refer across different types of peer certifications as well as

addressing cultural differences to facilitate greater collaboration between different types of peer specialists and to encourage more peers to become dually certified as both mental health and recovery support peer specialists.

The majority of survey respondents also reported working with non-peer colleagues on a daily basis. Interviewees further described examples of both supportive and collaborative relationships with non-peer colleagues as well as challenges to successful collaboration, such as not being included in treatment team meetings. The theme of building successful and collaborative community partnerships also emerged in the interviews.

Recommendations

- Peer specialists need more opportunities to communicate, connect, and collaborate across different types of certifications.
- Build a statewide database or network of peers so that peers can connect and refer people in services to different types of peer services and facilitate warm hand-offs.
- Employer organizations should make efforts to support collaboration between peers and non-peers as well as support efforts by peers to build community partnerships.

Funding

Regarding Medicaid billing, more than half of survey respondents (53%) reported that their organization does not bill Medicaid for their services, while 28% reported that their organization does bill Medicaid for their services and about 19% were unsure. This is supported by recent research on utilization of the Texas peer support Medicaid benefit, which found that 50% of LMHAs/LBHAs utilized the benefit (Peterson et al., 2021). Among respondents who work at organizations that do bill Medicaid for their services, respondents most commonly reported that their organization uses the Peer Specialist Services code.

The interview data were similar to the survey data in that many interviewees reported that their organization does not bill Medicaid for their services. Interviewees provided several explanations for why their organization does not bill Medicaid for their services. These included working at a grant-funded organization, working at a cash-only organization that does not accept insurance, working as an independent contractor, working at an organization subcontracted through the LMHA, working at a nonprofit organization, working with populations who are not Medicaid eligible (e.g., youth), and because the reimbursement rate for peer services is so low. Some interviewees reported working at organizations that do bill Medicaid for peer services, but the unit or program they work in does not bill Medicaid for peer services.

Another subset of interviewees reported that their organization does bill Medicaid for their services. Some of these interviewees reported using the Peer Specialist Services billing code, some reported billing for their services under Skills Training or Psychosocial Rehabilitation billing codes, and some reported that their organization uses both peer and non-peer billing codes depending on the situation. Finally, a fourth group was unsure what, if any, code(s) their organization uses to bill for their services, as billing is handled separately by the billing department at their organization.

Interviewees noted that a disadvantage of using the Peer Specialist Services billing code is that the reimbursement rate is low. The peer billing rate is less than one-third the rate for Skills Training or Psychosocial Rehabilitation per 15-minute increment. At $7.58 it is also considerably less than the national average Medicaid reimbursement rate for peer services which stands at $13.08 and less than one-third of the reimbursement rate in Georgia which is $24.36 (Videka et al., 2019). For some peers, this rate had an impact on how their organization bills for their services, with many organizations choosing not to use the peer billing code or only using it in particular situations.

Due to the much lower reimbursement rate for the peer billing code, some interviewees described working at organizations that required or heavily encouraged them to bill for their services using the Psychosocial Rehabilitation or Skills Training codes (despite many peers viewing these services as antithetical to authentic peer work based in mutuality). Thus, for some peers using the peer billing code ran counter to organizational mandate and was viewed as "going rogue."

Regarding compensation, survey respondents reported a mean hourly wage of $16.30, while the median hourly wage was slightly lower at $15.81. Although inflation must be considered, this wage was slightly up from 2017 in which currently employed mental health peers reported a mean hourly wage of $15.20 and previously employed mental health peers reported a mean hourly wage of $13.07 (Lodge et al., 2017). The topic of compensation was also raised in some of the qualitative data. Echoing findings from national peer surveys regarding dissatisfaction with compensation and that peers in Texas have some of the lowest wages in the country (Cronise et al., 2016), the need to increase peer specialist wages was raised by both survey respondents and interviewees. Related to low pay, some survey respondents and interviewees also indicated the need for financial assistance for peer certification fees, the need for peers to unionize, and the need for more funding for peer positions as well as peer-run organizations, such as Consumer Operated Service Providers (COSPs).

Recommendations

- Raise the rate for Medicaid Peer Support Services to reflect the value and cost of the service and incentivize organizations to provide appropriate levels of peer support services (SAMHSA, 2021; Videka, 2019).
- Employer organizations should consider raising the wages for peer specialists to retain a qualified peer workforce. Wage increases may be facilitated by the state increasing the Medicaid reimbursement rate for peer services.
- Increase statewide funding for peer-run organizations and peer provider positions to support peer specialist sustainability in the workforce.
- Further examine reasons why the peer support Medicaid benefit is not more widely utilized and provide support to increase its use among eligible organizations.

Organizational and Statewide Culture

Previous research indicates that peer job satisfaction is contingent on acceptance by and respect from non-peer colleagues (Cronise et al., 2016; Mancini, 2018). In general, survey respondents reported that their supervisors and non-peer colleagues are supportive and that they feel accepted and respected by their colleagues. However, over a quarter of survey respondents reported that they feel marginalized as a result of the actions or words of their coworkers. Qualitative survey and interview data support the idea that peers in Texas experience both supportive and unsupportive organizational cultures and climates. While several interviewees described working at organizations that were supportive and valued peer specialists, other survey respondents and interviewees described working at organizations that were not supportive and did not value peer specialists. Peers described a lack of organizational support as demonstrated by low pay, stigma, and a lack of recognition, autonomy, respect, or empathy.

To examine the recovery orientation of their employer organizations survey respondents responded to the 15-item ROSA (Lodge et al., 2018). ROSA items that were rated most highly, in terms of frequency of delivery, included believing that people can grow and recover, modeling hope, being open with people about all matters regarding their services, and respecting people's decisions about their lives. Lower scored items, in terms of

frequency of delivery, included providing trauma-specific services, encouraging people to take risks to try new things, inviting people to include those who are important to them in their planning, and offering people opportunities to discuss their spiritual needs when they wish. These results are similar to results found in previous TIEMH administrations of the ROSA including a workforce survey of mental health peer specialists (Lodge et al., 2017) and a survey of COSP member outcomes (Peterson et al., 2020), both of which found that trauma-specific services and spiritual opportunities were among the least frequently delivered while modeling hope, being open about services, and believing that people can grow and recover were among the most frequently delivered.

In comparing the overall ROSA mean to previous administrations of the ROSA, results indicate a higher mean ROSA score of 4.1 compared to the 2017 workforce survey of mental health peer specialists which had an overall mean ROSA score of 3.85 for currently employed peer specialists and 3.36 for previously employed peer specialists. This may reflect a shift towards a more recovery-oriented system. Interviewees also described several indicators of a shift towards a more recovery-oriented system in Texas, including the use of more recovery-oriented language at the organizational and state levels, the representation of people with lived experience of recovery in state offices, and the fact that in many ways Texas is at the forefront regarding employing peers. However, the mean ROSA score was lower than the mean ROSA score of 4.27 found in the 2020 COSP member outcomes survey (Peterson et al., 2020). This may reflect the fact that COSPs, which are peer-run organizations, more frequently provide recovery-oriented services compared to peer employer organizations in general.

Recommendations

- Employer organizations should take steps to ensure the organizational culture is supportive of peers and peer specialist integration. Specific steps organizations can take include staff training on the peer support role to reduce stigma (and increase role clarity), incorporating peer specialists into organizational committees, advisory boards, and management positions, and providing peer specialists with workplace autonomy (i.e., the ability to provide genuine peer services with supervision but without micro-management).
- Employer organizations should take steps to more frequently provide trauma-specific services, encourage people in services to take risks to try new things, invite people in services to include those who are important to them in their planning, and offer people in services opportunities to discuss their spiritual needs when they wish.

Role Tasks, COVID-19, and Role Clarity

Survey respondents generally reported being satisfied with their job. Several interviewees and survey respondents also expressed how much they enjoy their job and described obtaining a great deal of satisfaction, fulfillment, and reward from their work. Survey respondents reported that the tasks they most commonly provide are one-on-one support, connecting people to resources, and helping people advocate for themselves. The least commonly reported tasks were psychosocial rehabilitation, medication management and monitoring, and vocational assistance. These most commonly and least commonly reported tasks are similar to job tasks reported in previous peer surveys (Lodge et al., 2017; Stevens Manser et al., 2019). Respondents reported on average spending 37.7% of their time on administrative tasks and 56.5% of their time providing peer support. Most respondents reported providing services to adults and, on average, respondents reported that they provide services to 20.7 people in an average week. Nearly all survey respondents reported that they feel they are able to do their job well.

Survey respondents and interviewees were asked several questions about how the COVID-19 pandemic has impacted their work. A little less than half of survey respondents indicated they have engaged in new tasks since the COVID-19 pandemic began. Most commonly, survey respondents reported providing virtual peer support or

telehealth peer services, attending virtual trainings and meetings, providing additional outreach to people in services (e.g., making more outreach phone calls), and finding new, additional, or alternative resources for people in services. Survey respondents also reported experiencing challenges related to providing peer services. The most commonly reported challenges included a lack of training for providing virtual peer support, difficulty obtaining CEUs, and a lack of technological resources for providing virtual peer support.

Interviewees also described several ways in which the COVID-19 pandemic has changed how they deliver peer services. For example, interviewees commonly described providing peer support over the phone or over video conferencing platforms. Many also continued to provide in-person services, although with various modifications. For example, some peers provided in-person one-on-one services but did not provide groups, some provided in-office services but not home visits, some worked at organizations that limited who could attend groups or how many individuals could enter a building, and others worked at organizations that simply enforced or encouraged social distancing protocols, meeting outside, wearing masks, and washing hands.

Interviewees commonly reported the following challenges associated with COVID-19 service delivery: fewer options for how peer support is provided; decreased ability to regularly engage with people in services; virtual peer support as less effective than in-person services; and issues with access to reliable technology. In addition to challenges related to COVID-19 service delivery, interviewees also described experiencing challenges related to adapting to changes to the peer role during the COVID-19 pandemic. Interviewees commonly described their work as more "serious" due to the numerous challenges that people in services experienced during the COVID-19 pandemic (e.g., higher rates of suicide, overdose, domestic violence, social isolation, substance use, job loss, housing loss, depression, and grief). Additional role-related challenges that interviewees described experiencing during the pandemic included: supporting people in services' community resource needs, building rapport with people in services virtually or over the phone, figuring out how to navigate and adapt to new situations and protocols associated with providing services during the COVID-19 pandemic, and fear of contracting COVID-19.

Despite the challenges associated with providing peer support during the COVID-19 pandemic, interviewees also described several ways in which the pandemic has afforded peers with new opportunities. These opportunities included the ability to provide enhanced peer services by, for example, connecting with more individuals in services or connecting more often with individuals in services due to the fact that geography is less of a barrier to providing services as well as expanding peer telehealth services for individuals who experience transportation barriers or who are unable or would prefer not to have in-person services for other reasons.

Interviewees also described career development opportunities that they have had since the COVID-19 pandemic began such as the opportunity to "get creative" and explore new strategies to engage and work with people in services, being able to better explore their role as a peer due to having a lighter caseload during COVID-19, and enhanced training and learning opportunities as a result of more virtual training offerings as well as having more time to attend trainings, webinars, and conferences. Interviewees also described benefits to virtual meetings and trainings, including greater flexibility, convenience, and accessibility. Some interviewees also described opportunities related to increased job flexibility and the opportunity to work from home, such as not having a commute, less stress and exhaustion from driving around town for work, and enhanced opportunities for self-care.

Regarding role clarity, the majority of survey respondents indicated that they have a peer specialist-specific job description for their position and that their job description is peer-based and reflects the actual work that they do. This is important because research on role clarity suggests that peer specialists whose job duties more closely align to peer work have higher rates of job satisfaction compared to peers whose job duties involve more administrative and clinical work tasks (Cronise et al., 2016). As additional indicators of role clarity, survey

respondents reported how well their job role is understood by their supervisor, administrative staff, clinical staff, human resources (HR) staff, and executive leadership. Although they rated all of these groups as having an above average understanding of their job, they rated their supervisors as having the highest mean understanding of their job role as a peer, while they rated HR staff as having the lowest mean understanding of their job role. Supervisor job role understanding is particularly important for job satisfaction among peers (Kuhn et al., 2015). Qualitative survey and interview data also provide evidence that the peer role is understood by many behavioral health care providers in Texas and that peer role clarity has increased over time in large part due to the efforts of peers to educate their colleagues. However, the qualitative data indicate that there remains room for improvement regarding peer role clarity in Texas and in particular, the need for organizations to implement organizational or system-wide training on the peer role.

Recommendations

- Peers need access to training on providing peer support virtually, including training on how to virtually build rapport with individuals receiving services.
- Employer organizations and the state should work towards increasing technological access for peers and individuals in services, including reliable internet access, access to internet-enabled devices, digital literacy training, and access to secure virtual software systems.
- Employer organizations should continue to provide peers with flexible job options, including options to work from home, provide telehealth services, and attend meetings virtually.
- Peer training organizations should continue to offer virtual training opportunities to enhance accessibility for peers who are unable to travel to attend trainings.
- Peer employer organizations should implement system-wide training on the peer role.

Supervision

Most survey respondents reported receiving weekly or monthly supervision and nearly half reported that their supervisor is a certified peer specialist. This is up from data collected in 2017 with mental health peer specialists that indicated only about one-quarter of peers were supervised by peer specialists (Lodge et al., 2017). Additionally, survey respondents with a peer supervisor reported higher ratings of their organization's recovery orientation as indicated by significantly higher mean ROSA scores, significantly higher ratings of their supervisor's understanding of the peer specialist role, and higher ratings of their supervisor's level of supportiveness compared to survey respondents with a non-peer supervisor. Most survey respondents indicated that their supervisor explains the skills or procedures they are expected to perform as well as acts on their ideas, suggestions, and opinions. Survey respondents also indicated what supervision looks like for them and the most commonly reported types of supervision were: one-on-one supervision, team meetings, and supervision for special issues or circumstances, while respondents were less likely to receive clinical supervision and shadowing.

Recommendations

- Employer organizations should (continue to) employ peer specialists in supervisory positions, particularly given findings that peers who are supervised by other peers rate their organizational culture as more recovery oriented and rate their supervisor as more supportive and having a better understanding of their job role compared to peers who are supervised by non-peers.
- Employer organizations should (continue to) provide support (e.g., paid time off, financial assistance) for all peer supervisors to attend the Texas Medicaid-endorsed Peer Specialist Supervisor Training, including peer specialists who may wish to advance into a supervisory position.

- Training entities may consider prioritizing training peers who wish to attend the Texas Medicaid-endorsed Peer Specialist Supervisor Training, for example, by offering financial assistance or waiving registration fees for peers.

Conclusion

Texas faces a considerable behavioral health workforce shortage which has been further exacerbated by the COVID-19 pandemic (HHS, 2020). Increasing access to peer support services has been identified as an effective and cost-effective strategy to address this workforce shortage (HHS, 2020; HHSC, 2016). The data in this report provide information on steps that can be taken to increase access to peer support services in Texas by attracting and retaining a diverse peer workforce. Some of the most significant recommendations made in this report include creating full-time peer support positions that pay living wages and offer robust employee benefit packages, providing financial and procedural support for obtaining and maintaining peer certification including paid time off to attend CEU trainings, raising the rate for Medicaid Peer Support Services to ensure peers are adequately compensated for providing authentic peer services, and creating more career advancement opportunities for peers. Considerable evidence suggests that peer support improves the lives of individuals who receive peer services, which in turn reduces health care costs. Therefore, investment in the peer support workforce promises not only to improve the lives of Texans who receive behavioral health services but to also improve community well-being and save the state of Texas money.

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Appendix A: Survey Questions

Consent Form

The purpose of this form is to provide you information that may affect your decision to participate in this research survey. If you choose to participate, this form will also be used to record your consent.

The Texas Institute for Excellence in Mental Health at the University of Texas at Austin is evaluating peer specialist workforce outcomes. You were selected to participate in this evaluation because you are a certified peer specialist in Texas. Participation in the evaluation entails completing this survey.

- You are being asked to complete an online survey that will take approximately 20 minutes or less to complete.

- Your participation is voluntary. You do not have to participate in this survey if you choose not to, and you can stop the survey at any time. If you choose to participate, you do not need to answer every question. Your name, email address, and IP address will not be included or connected with responses you provide. Your decision to participate or not will not have any effect on your employment or your relationship with the State, peer specialist certification or training entities, or the University of Texas at Austin.

- This survey is confidential and the records of the survey will be kept private. You will be asked to provide a linking code to ensure your anonymity. No identifiers linking you to this survey will be included in any sort of report that might be published. Data will be reported such that no identifying information will be revealed.

- If it becomes necessary for the Institutional Review Board to review the study records, information that can be linked to you will be protected to the extent permitted by law. Your research records will not be released without your consent unless required by law or a court order. The data resulting from your participation may be made available to other researchers in the future for research purposes not detailed within this consent form. In these cases, the data will contain no identifying information that could be associated it with you, or with your participation in any study.

- After participating in this survey, you may register for a drawing to win [insert number] of [insert number] $50 gift cards. Although you will receive no other direct benefit from participating in this survey, the information from this survey will contribute to a better understanding of how to support peer specialist workforces in Texas.

- The risks associated with this survey are minimal, and are no greater than risks ordinarily encountered in daily life.

If you have any questions about this survey you may contact Amy Lodge, at the Texas Institute for Excellence in Mental Health at the University of Texas, by phone: (843) 817-8255 or email: amylodge@austin.utexas.edu.

This study has been reviewed and approved by The University of Texas at Austin Institutional Review Board (UT-IRB) and the HHSC Institutional Review Board #2 (IRB#2). If you have questions about your rights as a study participant, or are dissatisfied at any time with any aspect of this study, you may contact – anonymously, if you wish – the UT-IRB by phone at (512) 471-8871 or email at orsc@uts.cc.utexas.edu or the HHSC-IRB#2 by email at IRB2@hhsc.state.tx.us

- o Yes, I have read the information above and I would like to complete the survey
- o No, I will not complete the survey

[START OF SURVEY BLOCK 2: TRAINING AND CERTIFICATION]

1. An anonymous linkage code will be used to match your responses from this survey with all previous surveys and any future surveys you complete related to this evaluation. Please create your anonymous code from the following information.

    First letter in mother's first name: [drop down menu A-Z]
    First letter in mother's maiden name: [drop down menu A-Z]
    Last digit in your social security number: [drop down menu 0-9]
    Last digit in your phone number: [drop down menu 0-9]

2. **The questions below ask you to share your experiences related to training and certification as a peer specialist.**

3. Which peer specialist training(s) have you attended? (Select all that apply)
    - o Mental health peer specialist training
    - o Peer recovery support specialist training
    - o Recovery support peer specialist training

4. Regarding certification as a peer specialist: (Select all that apply)

    - o I am currently certified as a Mental Health Peer Specialist (MHPS)
    - o I am currently certified as a Peer Recovery Support Specialist (PRSS)
    - o I am currently certified as a Recovery Support Peer Specialist (RSPS)
    - o My certification as a Mental Health Peer Specialist (MHPS) is lapsed
    - o My certification as a Peer Recovery Support Specialist (PRSS) is lapsed
    - o My certification as a Recovery Support Peer Specialist (RSPS) is lapsed

5. Why did you not renew your peer specialist certification?

   _____
   _____

6. During what year were you first certified, whether your certification is current or has lapsed?

   o Prior to 2009
   o 2009
   o 2010
   o 2011
   o 2012
   o 2013
   o 2014
   o 2015
   o 2016
   o 2017
   o 2018
   o 2019
   o 2020

7. Did you complete the Texas HHSC peer support certification grandfathering process for the new peer support benefit that went into effect January 1, 2019?
   o Yes
   o No
   o I was certified after the grandfathering period

8. How satisfied were you with the HHSC peer support certification grandfathering process?
   o Very satisfied
   o Satisfied
   o Neutral
   o Dissatisfied
   o Very dissatisfied

9. Please describe why you chose the satisfaction response you did regarding the HHSC grandfathering process.

_____
_____

10. Why did you not complete the HHSC peer support certification grandfathering process?

_____

[START OF SURVEY BLOCK 3: CURRENTLY WORKING or EVER WORKED A PEER SPECIALIST]

11. Are you currently employed as a peer specialist?
    o   Yes
    o   No

12. What is your current employment status?
    o   Hourly/Salary, Full-time (32 or more hours a week)
    o   Hourly/Salary, Part-time (31 or fewer hours a week)
    o   Contract, Full-time (32 or more hours a week)
    o   Contract, Part-time (31 or fewer hours a week)
    o   Other (specify:) _____

13. Why are you not currently working as a peer specialist?

_____
_____

14. Have you encountered any barriers related to obtaining a job as a peer specialist?
    o   Yes (please explain:) _____
    o   No

15. Have you ever been employed as a peer specialist?
    o   Yes
    o   No *[SKIP TO BLOCK 4]*

16. **Please respond to the following items with your current employment in mind or if you are not currently working as a peer specialist role, with your last peer specialist employment in mind.**

17. Which of the following benefits do (or did) you receive from your employer? (Select all that apply):
    o   I do not receive any benefits

- o Medical insurance for myself
- o Medical insurance for my family
- o Dental insurance
- o Retirement
- o Disability insurance
- o Paid vacation
- o Paid sick leave
- o Other (specify:) _____

18. How much are (or were) you paid per hour of work? (Enter a number with 2 decimal places. Do not use the $ sign. For example, 11.00. To calculate hourly wage from a full time, 40-hour per week annual salary, divide annual salary by 2,080 hours. For example, $30,000 / 2080 = 14.42

_____

19. At what type of organization are (or were) you most recently employed? (Select all that apply)
- o Clubhouse
- o Community mental health center (CMHC)
- o Community substance use treatment center
- o Consumer-operated service provider (COSP)
- o Department of Veterans Affairs (VA) or other veterans' organization
- o Drug court, family court, mental health court or veterans' court
- o High school or collegiate recovery program
- o Hospital or emergency room
- o Inpatient mental health hospital
- o Jail, prison, or probation
- o Managed care organization (MCO)
- o Organization serving people experiencing homelessness
- o Peer advocacy or training organization
- o Psychiatric crisis facility, unit, or respite program
- o Recovery community organization (RCO)
- o Other (specify:) _____

20. How long have you worked (or did you work) at this organization?
- o Years: [drop down menu 0 to more than 50]
- o Months: [0 to 11]

21. What is (or was) your specific job title?

_____

22. On average, how many hours per week do (or did) you work in the position listed above?
- o [drop down menu 1 to more than 40]

23. On average, how many people do (or did) you provide a peer service to in one week?
    o [drop down menu 0 to more than 100]

24. Which of the following best describes the population(s) that you work(ed) with? (Select all that apply)
    o Adults (19 and older)
    o Youth or Adolescents (18 and under)
    o Other (specify:) _____

25. What percentage of your time as a peer specialist is (or was) spent on administrative tasks (including documentation) versus what percentage of your time is (or was) spent on providing peer support?
    o Administrative tasks: [drop down menu 0 to 100 in increments of 5]
    o Peer support: [drop down menu 0 to 100 in increments of 5]

26. What tasks do you (or did) you perform in your work? (Select all that apply)
    o Administrative tasks
    o Connecting people to resources
    o Education
    o Facilitating support groups
    o Goal-setting
    o Helping people advocate for themselves
    o Housing assistance
    o Medication management and monitoring
    o One-on-one support
    o Outreach / Engagement
    o Patient navigation
    o Provide supervision to other peer specialists
    o Psychosocial rehabilitation
    o Serve on work groups and committees
    o Skill Building
    o Support clients during transition from inpatient
    o Transportation assistance
    o Vocational assistance
    o Wellness Recovery Action Planning (WRAP)
    o Working on a treatment team
    o Other (specify): _____

27. Since the coronavirus (COVID-19) pandemic began, have you engaged in any new tasks in your peer specialist role?
    o Yes (specify):_____
    o No

28. Briefly describe how you document for peer services (e.g., the SWOT note).
     [open-ended text box]

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29. Does (or did) your organization have a peer specialist-specific job description for your position?
     o Yes
     o No
     o I don't know

30. Does (or did) your organization have a career ladder or provide career advancement opportunities for peer specialists?
     o Yes
     o No
     o I don't know

31. Does (or did) your organization provide opportunities for career development (e.g., time off and/or reimbursement for training, in-house training, skill development, etc.)?
     o Yes (please describe): _____
     o No
     o I don't know

32. How frequently do (or did) you receive supervision? (Select the option that most closely aligns with how often you receive or received supervision).
     o Daily
     o Weekly
     o Monthly
     o Annually
     o Never

33. Is (or was) your supervisor a certified peer specialist?
     o No
     o Yes
     o I don't know

34. What does (or did) supervision look like for you? (Select all that apply)
     o One-on-one meetings with supervisor
     o Team meetings
     o Shadowing
     o Supervisor observation
     o Administrative supervision
     o Clinical supervision

- Supervision for special issues or circumstances
- Other (specify): _____

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35. Since the coronavirus (COVID-19) pandemic, have you experienced any of the following challenges related to your job as a peer specialist? (Select all that apply)
    - Been laid off or lost your job
    - Lost some or all of your job benefits
    - Had to take a pay cut due to reduced hours or demand for your work
    - Difficulty obtaining Continuing Education Units (CEUs)
    - Lack of training for providing virtual peer support
    - Lack of technological resources for providing virtual peer support
    - Lack of personal protective equipment
    - Other (specify):_____

36. Does (or did) your organization bill Medicaid for any of the services you provide?
    - No
    - Yes
    - I don't know

[Display question if "Yes" is selected on "Does your organization bill Medicaid for any of the services you provide?"]
37. What Medicaid code(s) does (or did) your organization use to bill for the services you provide? (Select all that apply)
    - Peer specialist services code
    - Psychosocial rehabilitation services
    - Other (please specify): _____
    - I don't know

38. Are there (or were there) other individuals employed in a peer specialist role at your organization?
    - Yes
    - No
    - I don't know

[Display question if "Yes" is selected on "Are there other individuals employed in a peer specialist role at your organization?"]
39. Please select the number of peer specialists employed at your organization (including yourself):
    - [drop down menu 1 to more than 100]

40. How frequently do you (or did) you work with other peer specialists at your organization? (Select the option that most closely aligns with how often you work(ed) with other peer specialists).
    - o Daily
    - o Weekly
    - o Monthly
    - o Annually
    - o Never

41. How frequently do you (or did) you work with non-peer specialist staff at your organization? (Select the option that most closely aligns with how often you work(ed) with non-peer specialist staff).
    - o Daily
    - o Weekly
    - o Monthly
    - o Annually
    - o Never

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42. How would you rate your supervisor's overall level of supportiveness? (Supportive supervision may include supervision that promotes mentorship, joint problem-solving, and communication between supervisors and supervisees).
    - o 1 Not at all supportive
    - o 2
    - o 3
    - o 4
    - o 5
    - o 6
    - o 7
    - o 8
    - o 9
    - o 10 Very supportive

43. How would you rate non-peer specialist staff's overall level of supportiveness?
    - o 1 Not at all supportive
    - o 2
    - o 3
    - o 4
    - o 5
    - o 6
    - o 7

- 8
- 9
- 10 Very supportive

44. How would you rate your supervisor's overall understanding of your job role as a peer specialist?
    - 1 Very poor
    - 2
    - 3
    - 4
    - 5
    - 6
    - 7
    - 8
    - 9
    - 10 Excellent

45. How would you rate administrative staff's overall understanding of your job role as a peer specialist?
    - 1 Very poor
    - 2
    - 3
    - 4
    - 5
    - 6
    - 7
    - 8
    - 9
    - 10 Excellent

46. How would you rate clinical staff's overall understanding of your job role as a peer specialist?
    - 1 Very poor
    - 2
    - 3
    - 4
    - 5
    - 6
    - 7
    - 8
    - 9
    - 10 Excellent

47. How would you rate Human Resources (HR) staff's overall understanding of your job role as a peer specialist?
    o   1 Very poor
    o   2
    o   3
    o   4
    o   5
    o   6
    o   7
    o   8
    o   9
    o   10 Excellent

48. How would you rate executive leadership's overall understanding of your job role as a peer specialist?
    o   1 Very poor
    o   2
    o   3
    o   4
    o   5
    o   6
    o   7
    o   8
    o   9
    o   10 Excellent

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49. Please indicate your level of agreement with the following statements (based on your current or most recent employment as a peer specialist):

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I am satisfied with my overall job experience.	1	2	3	4	5
I feel accepted and respected by my colleagues.	1	2	3	4	5
My job description is peer-based and reflects the actual work that I do.	1	2	3	4	5
My supervisor explains the skills or procedures I am expected to perform.	1	2	3	4	5
I feel I am able to do my current job well.	1	2	3	4	5

My supervisor acts upon my suggestions, ideas, and opinions.	1	2	3	4	5
I feel marginalized as a result of the actions or words of my co-workers.	1	2	3	4	5

50. Please respond how often (from "never" to "always") you believe your organization provides recovery-oriented services. Please answer the following questions based on your perspective of the organization as a whole and based on your current or most recent employer.

Our organization...	Never	Rarely	Sometimes	Often	Always
...asks people about their interests.	1	2	3	4	5
...supports people to develop plans for their future.	1	2	3	4	5
...invites people to include those who are important to them in their planning.	1	2	3	4	5
...offers services that support people's culture or life experience.	1	2	3	4	5
...introduces people to peer support or advocacy.	1	2	3	4	5
...encourages people to take risks to try new things.	1	2	3	4	5
...models hope.	1	2	3	4	5
...focuses on partnering with people to meet their goals.	1	2	3	4	5
...respects people's decisions about their lives.	1	2	3	4	5
...partners with people to discuss progress towards their goals.	1	2	3	4	5
...offers people a choice of services to support their goals.	1	2	3	4	5
...offers people opportunities to discuss their spiritual needs when they wish.	1	2	3	4	5
...believes people can grow and recover.	1	2	3	4	5
...is open with people about all matters regarding their services.	1	2	3	4	5
...provides trauma-specific services.	1	2	3	4	5

51. Which of the following areas would enhance your peer support practice? (Select all that apply)
   o ASIST (Applied Suicide Intervention Skills Training)
   o Boundaries
   o Community Reentry

- Computer/Technology
- Co-Occurring Disorders
- Cultural Competency
- Emotional CPR
- Ethics
- Intentional Peer Support
- Leading/facilitating support groups
- Next Steps (for experienced Certified Peer Specialists)
- Peer Support for Individuals with Co-Occurring Disorders
- Peer Support Whole Health and Resilience
- Self-advocacy
- Social Justice
- Time Management
- Trauma Informed Peer Support
- Wellness Coaching
- WHAM (Whole Health Action Management)
- WRAP Basic Training
- WRAP Facilitator Training
- Other (specify): _____

52. Which of the following peer-related trainings or other educational opportunities have you attended? (Select all that apply)
    - Alternatives Conference
    - ASIST (Applied Suicide Intervention Skills Training)
    - Co-Occurring Disorders
    - Community Reentry
    - Emotional CPR
    - Focus for Life
    - Intentional Peer Support
    - International Association of Peer Supporters Conference
    - NAMI's Peer to Peer
    - Next Steps
    - Peerfest Conference
    - Peer Support for Individuals with Co-Occurring Disorders
    - Peer Support Whole Health and Resiliency
    - Trauma Informed Peer Support
    - WRAP Basic Training
    - WRAP Facilitator Training
    - WHAM (Whole Health Action Management)
    - Other (specify): _____

53. Indicate your level of agreement with the following statement: I have access to Continuing Education Units (CEUs).

- o Strongly agree
- o Agree
- o Neutral
- o Disagree
- o Strongly disagree

54. Indicate your level of agreement with the following statement: I have access to funds to obtain Continuing Education Units (CEUs).
    - o Strongly agree
    - o Agree
    - o Neutral
    - o Disagree
    - o Strongly disagree

55. Indicate your level of agreement with the following statement: my organization believes (or believed) it is important for me to obtain Continuing Education Units (CEUs).
    - o Strongly agree
    - o Agree
    - o Neutral
    - o Disagree
    - o Strongly disagree

56. How many (if any) Continuing Education Units (CEUs) have you obtained since your most recent certification?
    - o None
    - o 1 to 4
    - o 5 to 9
    - o 10 to 14
    - o 15 to 19
    - o 20 or more

57. Have you encountered any barriers related to obtaining your Continuing Education Units (CEUs)?
    - o Yes (please explain): _____
    - o No

58. Is there any additional information you would like to share with us?

_____
_____
_____

[START OF SURVEY BLOCK 4: DEMOGRAPHIC DATA]

60. What is your home zip code?

61. What is your gender identity (Select all that apply):
    o Agender
    o Genderqueer, gender fluid, or non-binary
    o Man
    o Questioning or unsure
    o Trans man
    o Trans woman
    o Woman
    o Additional gender category/identity (specify): _____
    o Prefer not to disclose

62. What is your age range?
    o 18 – 24
    o 25 – 30
    o 31 – 35
    o 36 – 40
    o 41 – 45
    o 46 – 50
    o 51 – 55
    o 56 – 60
    o 61 – 65
    o 66 or older

63. Are you of Hispanic or Latino origin?
    o No
    o Yes

64. What race do you consider yourself to be? (Select all that apply)
    o American Indian or Alaska Native
    o Asian or Asian American
    o Black or African American
    o Native Hawaiian or other Pacific Islander
    o White
    o Other (specify): _____

65. What is the highest level of education you have obtained?
    o Less than 12th grade
    o High school diploma / GED
    o Some college or post-high school training
    o 2-year Associate degree

- o 4-year college degree
- o Post-college graduate training

[START OF SURVEY BLOCK 5: INDIVIDUALS WHO COMPLETED THE SURVEY]

Thank you for your participation! This concludes the survey. As a peer specialist, your feedback is critical to evaluating peer specialist workforce outcomes. Your time and input are greatly appreciated.

You are now eligible to be entered into a drawing for a chance to win one of 30 $25 gift cards. Your responses to the survey will remain anonymous and will not be linked to your contact information if you choose to be entered into the gift card drawing.

We are also conducting virtual interviews to learn more about peer specialists' employment experiences. Each interviewee will receive a $50 gift card.

If you would like to enter the drawing for the $25 gift card AND sign up for an interview, please click here: Enter Gift Card Drawing and Sign Up for Interview

If you would ONLY like to enter the drawing for the $25 gift card, please click here: Enter to Win Gift Card.

If you are ONLY interested in participating in an interview, please click here: Interview Sign Up.

If you have any questions or would like to be contacted regarding this survey, please contact Amy Lodge at the Texas Institute for Excellence in Mental Health at the University of Texas at Austin by phone: (843) 817-8255 or by e-mail: amylodge@austin.utexas.edu.

Appendix B: Interview Questions

1. How has the coronavirus pandemic (COVID-19) impacted the ways that you do your work as a peer specialist?

2. Did you participate in the HHSC peer certification grandfathering process for the new peer support benefit that went in to effect back in Jan 1, 2019?
    a. What was your experience?
    b. How is impacted your work as a peer specialist?
    c. If you did not participate, what was your experience with the peer training and certification process?

3. Does your organization bill Medicaid for your services as a peer?
    a. Do you use the peer code?
    b. For what type of services?
    c. How has having the new code impacted your work?
    d. How has the billing rate impacted your work?

4. Is there any other information you would like to share about your experiences as a peer specialist?

Appendix C: Additional Analyses

Age Range by Public Health Region

Survey respondents' age ranges were examined by public health region (PHR). Because of the variation in the number of peers in each PHR and age range category, these data should only be viewed descriptively and generalizations should not be made.

Table A1: Survey respondent age range by public health region (PHR)

Age Range

PHR	18-24	25-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66 or older	Total
1	0	0	0	0	1	1	0	1	0	1	4
2	0	1	0	1	0	5	1	2	2	2	14
3	0	3	0	6	2	4	7	7	7	1	37
4	0	0	0	0	0	0	0	0	0	1	1
5	0	0	0	1	0	0	1	0	0	0	2
6	1	2	1	6	4	5	4	5	5	2	35
7	0	1	1	3	1	3	4	4	8	0	25
8	2	1	2	2	3	2	6	3	1	3	25
9	0	1	1	1	0	0	0	0	0	0	3
10	0	1	0	2	0	1	0	0	1	2	7
11	0	1	1	1	0	0	2	1	2	1	9
Total	**3**	**11**	**6**	**23**	**11**	**21**	**25**	**23**	**26**	**13**	**162**

Employment Tenure by Organizational Type

Of the 162 survey respondents who reported the organization where they were most recently employed, 133 selected one organization. Employment tenure was then examined by organization type. Because of the variation in the number of peers in each organization type, tenure should only be viewed descriptively and generalizations should not be made.

Table A2. Employment tenure by organization type (when only one organization was selected)

Organization Employed	N	Mean (Months)	Median (Months)	Mean (Years)	SD
Community Mental Health Center	37	57.30	48.00	4.77	39.88
Recovery Community Organization	22	66.09	48.00	5.51	76.43
Community Substance Use Treatment Center	17	73.82	72.00	6.15	40.95
Inpatient Hospital	10	91.10	99.00	7.59	55.20
COSP	8	93.38	69.50	7.78	75.12
Justice Setting (Court, Jail, Probation)	5	63.60	52.00	5.30	31.48
Non-Profit Organization	5	40.20	49.00	3.35	28.01
Veterans Administration or Veteran Program	4	135.75	134.50	11.31	34.97
MCO	4	65.75	65.50	5.48	38.86
High School / Collegiate Recovery Program	3	41.33	39.00	3.44	22.59

Homeless Organization	3	37.67	7.00	3.14	56.62
Psychiatric Crisis	3	33.33	25.00	2.78	34.27
Hospital / ER	2	94.50	94.50	7.88	86.97
Clubhouse	2	17.50	17.50	1.46	19.09
Sober Living / Transitional Housing	2	12.50	12.50	1.04	6.36
Peer Advocacy or Training Organization	2	9.50	9.50	0.79	9.19
Prevention Program	1	114.00	114.00	9.50	...
Federally Qualified Health Center	1	74.00	74.00	6.17	...
Alternative Peer Group	1	52.00	52.00	4.33	...
Integrated Treatment Services	1	12.00	12.00	1.00	...
Total	**133**	**65.18**	**52.00**	**5.43**	**53.45**

Hourly Wages by Organizational Type

Hourly wage was examined by organization type. Because of the variation in the number of peers in each organization type, hourly wages should only be viewed descriptively and generalizations should not be made.

Table A3: Hourly wage by organization type

Organization Type	N	Mean	SD	Min	Max
Community Mental Health Center	37	14.90	2.91	10.00	23.00
Recovery Community Organization	20	17.83	5.12	12.00	34.13
Community Substance Use Treatment Center	16	16.90	3.77	13.50	28.84
Inpatient Hospital	10	15.66	4.26	10.00	22.68
Consumer Operated Service Provider	7	14.82	4.71	7.75	20.00
Justice Program (Court, Prison, Jail, Probation)	5	18.88	1.78	17.70	21.99
Nonprofit Organization	5	17.83	2.52	14.00	20.19
Managed Care Organization	4	19.66	3.27	15.00	22.50
Homeless Organization	3	15.46	0.91	14.88	16.50
Psychiatric Crisis Services	3	14.59	0.57	14.00	15.14
Veterans Administration or Veteran Program	3	23.37	9.91	12.00	30.12
Clubhouse	2	13.50	2.12	12.00	15.00
High School or Collegiate Recovery Program	2	15.00	0.00	15.00	15.00
Hospital / Emergency Room	2	17.55	7.96	11.92	23.18
Peer Advocacy or Training Organization	2	14.44	2.21	12.88	16.00
Sober Living/Transitional Housing	2	16.00	5.66	12.00	20.00
Alternative Peer Group	1	17.00	...	17.00	17.00
Federally Qualified Health Center	1	11.00	...	11.00	11.00
Integrated Treatment Services	1	20.19	...	20.19	20.19
Prevention Program	1	20.19	...	20.19	20.19
Total	**127**	**16.40**	**4.15**	**7.75**	**34.13**

Hourly Wage by Public Health Region

Hourly wage was examined by public health region (PHR). Because of the variation in the number of peers in each PHR, hourly wages should only be viewed descriptively and generalizations should not be made.

Table A4: Hourly wages by public health region (PHR)

PHR	N	Mean	SD	Min	Max
1	2	11.73	1.61	10.59	12.86
2	14	14.99	6.24	7.75	34.13
3	34	16.59	2.64	12.00	23.18
4	1	15.20	…	15.20	15.20
5	1	13.75	…	13.75	13.75
6	33	16.80	3.54	12.00	30.12
7	21	17.13	4.46	10.31	28.84
8	23	16.51	3.10	10.50	25.00
9	2	17.25	5.30	13.50	21.00
10	7	15.70	5.94	11.00	28.00
11	8	16.06	4.97	10.00	23.00
Total	**146**	**16.39**	**3.95**	**7.75**	**34.13**

ROSA Scores by Organizational Type

Mean ROSA scores were examined by organizational type. Because of the variation in the number of peers in each organization type, ROSA mean scores should only be viewed descriptively and generalizations should not be made.

Table A5: ROSA mean scores by organizational type

Organization Employed	N	Mean	SD
Community Mental Health Center	35	4.04	0.96
Recovery Community Organization	22	4.19	0.80
Community Substance Use Treatment Center	17	4.02	0.91
Inpatient Hospital	10	3.89	0.94
Consumer Operated Service Provider	8	4.36	0.57
Justice Setting (Court, Prison, Jail Probation)	5	4.35	0.84
Non-Profit Organization	5	4.25	0.96
Managed Care Organization	4	3.98	0.90
High School or Collegiate Recovery	3	4.29	0.34
Homeless Organization	3	4.27	1.10
Psychiatric Crisis Services	3	3.84	0.62
Veterans Administration	3	3.02	1.80
Peer Advocacy or Training Organization	2	3.57	0.05
Sober Living/Transitional Housing	2	4.60	0.19
Alternative Peer Group	1	4.93	…
Clubhouse	1	4.60	…
Federally Qualified Health Center	1	5.00	…
Hospital / Emergency Room	1	2.80	…
Integrated Treatment Services	1	4.60	…
Prevention Program	1	4.00	…
Total	**128**	**4.09**	**0.88**

ROSA Scores by Public Health Region

Mean ROSA scores were examined by PHR. Because of the variation in the number of peers in each PHR, ROSA mean scores should only be viewed descriptively and generalizations should not be made.

Table A6: ROSA mean scores by public health region (PHR)

PHR	N	Mean	SD
1	2	4.30	0.80
2	14	4.26	0.71
3	34	4.15	0.90
4	1	4.00	...
5	1	4.67	...
6	35	4.27	0.75
7	21	4.20	0.57
8	25	4.12	1.00
9	2	3.73	1.04
10	7	3.68	1.27
11	9	3.46	1.38
Total	**151**	**4.13**	**0.88**