Peer Specialist Training and Certification Program

Outcomes Evaluation Report: September 2011

CENTER FOR SOCIAL WORK RESEARCH

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Executive Summary

Background Information

As part of the state's mental health transformation efforts, the Texas Department of State Health Services (DSHS) aimed to augment the trained peer specialist workforce as well as expand peer support services. Toward this end, DSHS contracted with Via Hope Texas Mental Health Resource in 2009 to establish a peer specialist training and certification (PSTC) program to educate consumers about recovery and prepare them to deliver recovery-oriented mental health services – especially peer support. Based on the "Georgia model" developed by the Appalachian Consulting Group (ACG), the Texas training and Certified Peer Specialist (CPS) credentialing process is currently in its infancy and requires ongoing evaluation in order to inform a successful evolution.

Researchers at the University of Texas at Austin Center for Social Work Research (UT-CSWR) conduct the evaluation to inform program improvements and sustainability. Evaluation results of participants' training and vocational outcomes are discussed in this report.

Evaluation focused on outcomes in three areas including:

- pre-training eligibility and screening,
- training curriculum and certification components, and
- post-training and employment outcomes.

Two sequential post-training online surveys were completed by program participants to assess factors related to each of these areas.

Training & Certification Outcomes

Trainees' demographic characteristics as well as their reported satisfaction with the training highlight potential issues with pre-training and training implementation; needed changes are discussed. Respondents from the first survey were representative of the training participants overall based on demographic information obtained via daily satisfaction surveys. Most attendees were non-Hispanic Caucasian females over 40 years of age. Although they were located all across the state of Texas, there were several regions where peer specialists were concentrated, such as in the Central Texas area. This signals potential issues with underrepresentation of other groups in terms of geographic location, gender, age, and especially ethnicity, pointing to the need for attention to and/or adjustment in applicant screening methods and acceptance patterns. Efforts should be given to recruiting and accepting diverse cohorts so that the peer workforce represents the diversity of the consumers whom it serves. Toward this end, outreach and education are needed to

overcome mental health stigmas in minority ethnocultural communities.

Related to this, trainees reported the desire for a more culturally aware training – a concern also reported in the FY2010 evaluation of this PSTC program (Steinley-Bumgarner, Kaufman, Stevens-Manser, & Murphy-Smith, 2010) with Hispanic respondents demonstrating less satisfaction with training modules but greater job satisfaction in diverse work environments. These findings point to the need for the training to incorporate tailored cultural competency into its curriculum. Increasing respondent interest also indicates the need to offer Continuing Education Units (CEUs) in cultural competency.

Most trainees in the first four cohorts of the PSTC program reported that they were currently employed (Figure 7). This is because priority acceptance was given to those applicants who were already working as peer specialists in the field. As more become certified, the number of trainees who are already employed will decrease in future training classes, indicating the need for post-training connection to employment resources.

Respondents' exam and certification outcomes point to the need for changes to the curriculum and to course implementation. While the overall pass rate for respondents was high for the first survey (93.9%) and for the second (100%), certification exam results revealed that scores were generally lower for skill area competencies (M=81.19) when compared to knowledge area competencies (M=87.36). A likely explanation is that the training program lacks emphasis on skill-building; in other words, there was more focus on increasing conceptual knowledge versus hands-on job skills. This ongoing issue was previously recognized by trainees in the 2010 evaluation of this program (Steinley-Bumgarner et al., 2010). This finding combined with the increase seen in the number of CPSs facilitating support groups at the time of the second survey suggests that the PSTC program could enhance skills training, either during training or through post-training continuing education, to better prepare CPSs for the tasks they are increasingly performing at work.

Post-Training & Vocational Outcomes

Changes in the services which peer specialists are providing as well as in their level of involvement and integration at work and with consumer advocacy organizations highlight the evolving role of peer specialists, both within the organizations at which they work and within the broader mental health system. Respondents reported being employed in a variety of settings, and many reported having job descriptions for their position, a subtle but robust indicator of standardization and integration of CPSs within the mental health field. An increase in the average number of hours worked by CPSs as well as in the proportion of salaried and full time employees could indicate an increased value given to the role of trained peer specialists within organizations.

A shift was seen toward more regular provision of direct mental health services by CPSs, representing a paradigm shift in which peer specialists are regarded as professionals in a recovery-oriented system of care. Regarding services provided, peer specialists are increasingly performing the task of facilitating support groups, however they still lack training in this skill. One of the tasks performed least by respondents is medication monitoring. Medication training and support is one of three Medicaid billable services of CPSs, however it is the least billed for across the state of Texas (Kaufman, Brooks, & Stevens-Manser, 2011). This indicates the need for Medicaid billable skills training, which, like support group facilitation, could be incorporated into either the PSTC program, post-training CEU classes, or offered by employers as part of in-house training.

As the number of certified peer specialists continues to grow, fewer applicants will have previous work experience making the PSTC program a more critical window in which to provide CPSs with skills training before they begin providing services. Both the frequency of using CPS skills and confidence in using them increased for every skill. This highlights the benefit of practice in using these skills and suggests that even a short three month window can make a noticeable difference in the quality of peer-provided services.

Findings also show that more peer specialists are becoming involved in consumer advocacy organizations over time, which empower consumers, strengthen their social support networks, and have reach in mental health policy planning (Swarbrick, 2009). Because of the benefits of membership in such organizations, post-training support is needed to promote awareness and encourage membership. More peer specialists are also attending additional peer-related trainings (e.g., Prosumers Focus for Life, NAMI's In Our Own Voice) strengthening their support networks and increasing their recovery knowledge. Allowing the completion of such trainings to fulfill CEU requirements would encourage this type of involvement within the behavioral health system.

All but one respondent from both surveys was employed or seeking employment in the field of peer support/mental health. Results showing the great diversity in the jobs of CPSs are evidence that PSTC training provides a foundation for a wide array of work opportunities. This is indicative of labor force security for this group, such that, even if certain types of programs are defunded, individuals who receive certification will remain a stable presence in the workforce in a number of other areas. The job security of peer specialists was also evidenced by the increase seen in average hours worked, average caseload, and full-time employment of peer specialists.

Job satisfaction of peer specialists is multidimensional as it relates to a number of intrapersonal, interpersonal, and organizational factors. Overall, job satisfaction was high. Findings suggest that supervision, support, and opportunity for advancement at work may affect peers' job satisfaction. Suggested ways to move this knowledge into action include encouraging the training of supervisors in supporting peer specialists and establishing

standards for an optimal level of supervision. The Recovery Self-Assessment (RSA; O'Connell et al., 2005) was found to be associated with job satisfaction at both survey times, suggesting that a recovery-orientation sustains more positive outcomes through the use of recovery-oriented CPS skills. This highlights a notion from a previous evaluation of the PSTC that a shift in the recovery orientation at the level of organizational culture is required to successfully integrate peer specialists into a recovery oriented system of care (Steinley-Bumgarner et al., 2010). Like the PSTC program itself, what occurs following training and certification is important to the satisfaction and wellbeing of CPSs and to the advancement toward a recovery-oriented system of care.

The findings of this evaluation are important because the use of knowledge and skills gained from training, involvement in consumer advocacy and trainings, and job satisfaction all affects the recovery of peer specialists and the consumers they serve. Respondents to this evaluation reported that both training and work greatly strengthened their recovery.

Recommendations

Specific recommendations for program improvement are cited throughout the report and at the conclusion; however, the following address broader needs for training and post-training change in Texas' peer specialist workforce transformation efforts:

- Efforts should be given to recruiting and accepting diverse cohorts so that the peer workforce represents the diversity of the consumers whom it serves. Toward this end, outreach and education are needed to overcome mental health stigmas in minority ethnocultural communities.
- Cultural competency should be incorporated into the PSTC curriculum as well as offered as Continuing Education Units (CEUs).
- The PSTC should offer CPSs post-training connection to employment resources.
- Changes to the curriculum and to course implementation are needed to minimize performance differences between cohorts and increase CPS job readiness and satisfaction.
- The PSTC program should enhance skills training, either during training or through post-training continuing education, to better prepare CPSs for the tasks they are increasingly performing at work.
- Medicaid billable skills training should be incorporated into either the PSTC program, post-training CEU classes, or offered by employers as part of in-house training to increase rates of reimbursement for CPSs.
- Post-training support is needed to promote awareness and encourage membership in consumer advocacy organizations and additional peer-related trainings. Allowing the completion of such trainings to fulfill CEU requirements would encourage this type of involvement with the behavioral health system.

- The PSTC should encourage the training of supervisors in supporting peer specialists and establishing standards for an optimal level of supervision.
- Shift in the recovery orientation at the level of organizational culture is required to successfully integrate peer specialists (Steinley-Bumgarner et al., 2010). Organizational level recovery education is a step in the right direction.

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Introduction

The growth of the consumer/survivor movement in mental healthcare over the past 60 years has led to an upsurge in the number of peers providing critical services and supports to other mental health consumers (Swarbrick, 2009). The number of states providing training and certification programs for peer providers is increasing (University of Texas at Austin Center for Social Work Research [UT-CSWR], 2011b), but limited research has been conducted to understand the outcomes and effectiveness of these programs and the extent to which they meet the goals of states working to develop a recovery-oriented system of care.

Via Hope, Texas Mental Health Resource was established in 2009 as an integral part of the state's Mental Health Transformation State Incentive Grant initiatives funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). Via Hope, a collaborative effort of the Texas Department of State Health Services (DSHS), Mental Health America of Texas, and National Alliance on Mental Illness Texas, was established as a training and technical assistance resource for adult and youth mental health consumers, their family members, and mental healthcare professionals. One of Via Hope's primary goals was the creation of a Peer Specialist Training and Certification (PSTC) program. To this end, Via Hope consulted with Appalachian Consulting Group (ACG) to adapt their peer training and certification model to meet the needs of Texas. This report will present and compare the initial findings of two post-training evaluations of the PSTC program including outcomes related to participants' recovery experience, exam performance, competency attainment, involvement in the behavioral health system, and employment. Relationships between these variables are explored. Insights into the potential contributions of program structure and implementation to these outcomes are also explored. Recommendations for program improvement and future evaluation are made based on these findings.

Methods

This study was approved by the University of Texas at Austin and the Texas DSHS Institutional Review Boards. The primary data sources analyzed in this report are two sequential online surveys pertaining to outcomes associated with attending the PSTC program and working as a peer specialist. The first survey was opened in February 2011 and closed in March 2011; the identical follow up survey was opened exactly three months later in June 2011 and closed in July 2011.

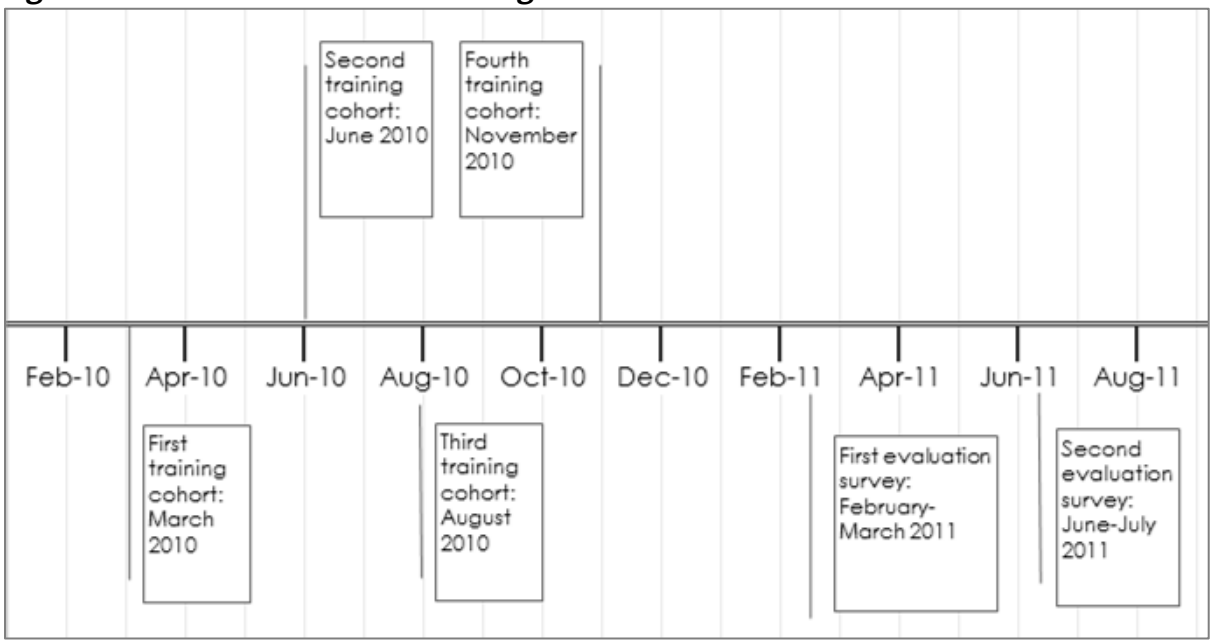
Participants

A total of 102 individuals participated in four Certified Peer Specialist (CPS) training sessions offered in March, June, August, and November 2010. Eight of those individuals were grandfathered in. Individuals are eligible to become certified via grandfathering if they have taken the Depression and Bipolar Support Alliance's (DBSA) peer specialist training and certification exam within the previous two years; then, Via Hope certification is contingent upon successful completion of the one-day Whole Health training, which is not part of the DBSA curriculum.

The first survey, administered from February to March 2011, was sent to 101 of the 102 total participants (1 did not provide an email address). Three of these were returned as undeliverable, leaving a total of 98 individuals who received the survey. Of these, 42 completed the survey, resulting in a 42.9% response rate. Four of those individuals were grandfathered in.

The second follow-up survey, administered from June to July 2011, was sent to the 98 individuals who received the initial survey. Of these, 32 completed the survey, resulting in a 32.7% response rate. None of these individuals were grandfathered in. An anonymous linking code and demographic data was used to determine that 20 respondents completed both follow-up surveys. A timeline of the implementation of training classes and the administration of evaluation surveys is represented in Figure 1.

Figure 1. Timeline of 2010 - 2011 training and evaluation activities



Measurement and Analysis

The primary data sources were identical online surveys assessing participant experiences with the PSTC training and current employment. Participants received a hyperlink to the survey in an e-mail sent at each time period. These surveys were administered using SurveyMonkey™ web-based software. Items were Likert-type, open-ended, or dichotomous yes-no questions. The first survey was open for a period of five weeks from February to March 2011, and the second survey was open for a period of four weeks from June to July 2011. The data presented throughout the report was analyzed for all survey respondents, including those who completed both surveys.

Secondary data sources were participant certification exam scores obtained from Via Hope as well as daily satisfaction surveys completed at the end of each training day. Respondents were informed on the survey's introductory consent page that individual responses would be matched to satisfaction surveys and examination scores using an anonymous linking code that respondents were asked to provide.

Results

Participant Characteristics

Respondents from the first survey were demographically representative of the training participants overall based on demographic information obtained via daily satisfaction surveys. Most respondents were female and at least 40 years of age (Table 1). The majority of respondents were White; racial/ethnic minority groups included Hispanic/Latino and African American. Three participants reported more than one race/ethnicity. Respondents from the second survey were demographically similar to respondents from the first survey. Most were female and at least 40 years of age (Table 1). The majority of respondents were White; racial/ethnic minority groups including Hispanic/Latino, African American, and American Indian/Alaska Native. One participant reported more than one race/ethnicity. No respondents reported their ethnicity as Asian for either survey. The somewhat homogenous racioethnic composition of respondents signals that future efforts should focus on recruiting and accepting more diverse cohorts to ensure culturally competent services are available to the diverse population of Texas. Outreach and education surrounding stigma reduction may be necessary for successful recruitment in minority communities.

When asked about their living situation (Table 1), many respondents reported living alone or with family. Others lived with a spouse or significant other, or with a roommate. No participants reported living in a facility, boarding, or assisted living situation.

Table 1. Demographic characteristics of respondents

		February-March	June-July
Gender	Male	31%	25%
	Female	69%	75%
Age	26 - 39	21.4%	25%
	40 – 55	57.1%	62.5%
	56 or older	21.4%	12.5%
Race/ethnicity	African American	23.8%	19.4%
	Asian	--	--
	White	61.9%	64.5%
	American Indian or Alaska Native	--	3.2%
	Hispanic/Latino	20.5%	26.7%
	Other	9.5%	6.5%
Living Situation	Living alone	38.1%	26.7%
	Living with spouse or significant other	21.4%	20%
	Living with family	31%	40%
	Other	9.5%	13.3%

Note: Respondents were able to select more than one race/ethnicity.

Education

When asked about educational attainment, all but one respondent from the first survey reported that they had completed high school or received a GED equivalent and most reported completing at least some post-high school education (Table 2). According to the Texas Administrative Code (TAC) Title 25, Part 1, Chapter 419, Subchapter L, Rule §419.453, a peer provider is required to have received either a high school diploma or GED. If this criterion is not met, peer specialists are not eligible to be reimbursed by Medicaid for providing services. A high school diploma or GED equivalent is also one of Via Hope's requirements for admission into the PSTC program, regardless of whether peer specialists intend to provide billable services or not. The finding that one respondent did not meet this requirement indicates the need for greater oversight of the admission process. Respondents from the second survey all reported completing at least a high school education or receiving a GED equivalent and most had completed at least some post-high school education.

A majority of respondents from both survey times indicated completing *at least* some college or post-high school education (83.2% at Time 1 and 90.7% at Time 2). Respondents indicated a wide range of educational pursuits. For example, various individuals reported having received degrees in journalism, Russian language, art, psychology, photography, business, music education, English literature, sociology, and other disciplines.

Table 2. Educational attainment of respondents

		February-March	June-July
What is the highest level of education you have obtained?	No formal schooling	2.4%	--
	High school diploma/GED	14.3%	9.4%
	Some college or post-high school training	45.2%	46.9%
	2-year Associate degree	7.1%	9.4%
	4-year College degree	21.4%	18.8%
	Post-college graduate training	9.5%	15.6%

Income

The majority of annual household incomes were below $30,000 for respondents of the first survey (70%) and the second survey (71%; Table 3). This figure is well below the estimated median income for a family of four in Texas, which is $62,358, as well as below the estimated median income for a family of one, which is $32,426 (Department of Health and Human Services & Administration for Children and Families, 2009). Household income was not significantly correlated with any measure of job satisfaction or work-based strengthening of recovery on either survey, suggesting that it has little to no bearing on the career success of peer specialists.

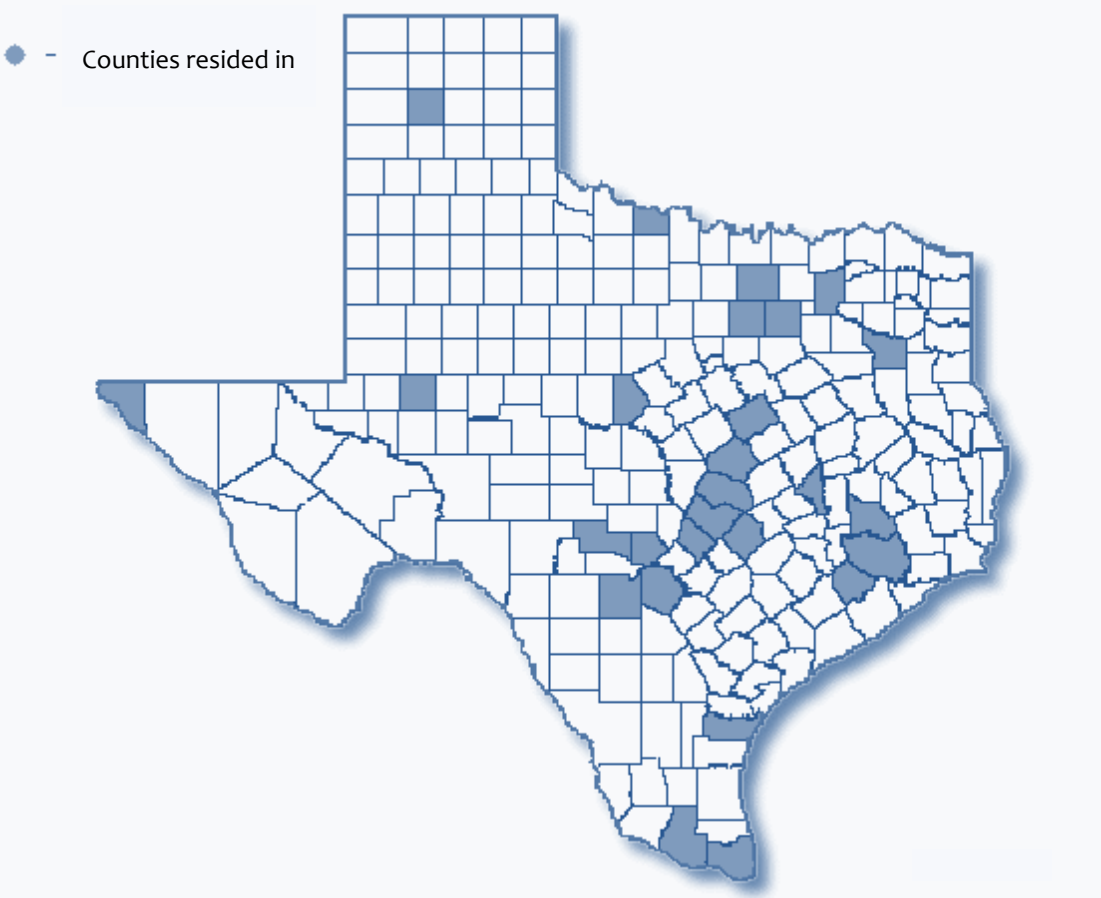
Table 3. Annual household income of respondents

		February-March	June-July
What is your annual household income?	Less than $15,000	25%	19.4%
	$15,000 - $29,000	45%	51.6%
	$30,000 - $44,999	22.5%	16.1%
	$45,000 - $59,999	7.5%	3.2%
	$60,000 - $74,999	--	3.2%
	$75,000 - more	--	6.5%

Geographic Diversity

Respondents were located all across the state of Texas, although there were several regions where peer specialists were concentrated, such as in the Central Texas area (Figure 2). Respondents from both surveys were located in rural and urban areas, and along the Texas-Mexico border. This geographic diversity represents a variety of regional cultural experiences, local mental health systems, and employment opportunities that affected participant experiences with the training and post-training vocational outcomes. Results of this evaluation should be considered in the context of such situational factors. Future consideration should be given to the geographic diversity of PSTC applicants to ensure that trainees represent a variety of experiences.

Figure 2. Geographic location of respondents attending PSTC program



Financial Support

The most commonly reported sources of financial support for respondents of both surveys were earned income and Social Security Disability Income (SSDI) (Table 4). Other reported forms of assistance not listed in the survey included disability retirement, annuity payments, food benefits, PLANCTX (a non-profit service agency for people with mental health needs), church donations, section 8 housing, medical leave, retirement pensions, and unemployment benefits.

Table 4. Sources of financial support for respondents

		February-March	June-July
In the past 30 days, have you had any financial support from the following sources?	Earned Income	33.3%	25%
	Social Security Benefits (SSA)	7.1%	3.1%
	Social Security Disability Income (SSDI)	33.3%	28.1%
	Supplemental Security Income (SSI)	4.8%	6.3%
	Veteran's benefits	4.8%	6.3%
	General assistance	2.4%	3.1%
	Assistance from family members	11.9%	18.8%
	Other sources	21.4%	18.8%

Professional Certifications and Licensures

Other than Certified Peer Specialist (CPS), 22% of respondents of the first survey reported that they held professional certification/licensure in a number of specialized areas. For example, AAS in Radiology; Certified Heating, Venting, and Air Conditioning (HVAC) Technician; cosmetologist; licensed paramedic; and teaching certificate were among the licensures/certifications that respondents held. Only two respondents were licensed in the mental health field; these certifications included Qualified Mental Health Professional (QMHP) and Licensed Professional Counselor (LPC). Of respondents from the second survey, 25% reported professional certifications/licensures other than CPS. Titles held in other areas of specialization included Ph.D., LPC, Certified Hepatitis C (HCV) educator, licensed Texas Real Estate Broker, Computer Accounting Specialist, Certified Nursing Assistant (CNA), and Emergency Medical Technician (EMT).

Involvement in Behavioral Health System

Consumer Advocacy Organizations

Most respondents (66.7%) from the first survey reported being a member of a consumer advocacy organization. Some organizations of membership included National Alliance on Mental Illness (NAMI; 33.3%), Alcoholics Anonymous (AA; 11.9%), Narcotics Anonymous (NA;

7.1%), Depression-Bipolar Support Alliance (DBSA; 11.9%), Prosumers International (11.9%), Consumer Advisory Councils (CACs; 7.1%), and others. Participation in these types of organizations is important for consumers and family members because it enhances social support networks and empowers members, and it may foster an increased sense of responsibility through members taking more active roles in mental health policy planning (Swarbrick, 2009).

Slightly more (71%) respondents from the second survey reported belonging to a consumer advocacy organization compared to respondents of the first survey. Some organizations of membership included NAMI (29%), consumer-operated service providers (COSPs; 3.2%), DBSA (12.9%), Prosumers (19.4%), MHMRAs (6.5%), AA (6.5%), NA (6.5%), and CACs (9.7%). The slight increase in respondents' membership with consumer advocacy organizations may indicate that more trainees from all 2010 cohorts are becoming actively involved with the behavioral health system as their recovery is strengthened. Post-training support should be established which connect peer specialists with these organizations and encourage membership.

Consumer Meetings

Respondents were asked whether they were aware of meetings occurring in their local areas that bring together employed consumers to support one another (Table 5). Meetings included AA/NA, NAMI, DBSA, Prosumers, Peer Navigator staff meetings, peer support group meetings for peer providers, and Winner's Circle. The increase between the first and second survey in the proportion of respondents reporting that there were regular meetings may reflect that more consumer meetings are occurring and / or that awareness of these meetings is increasing.

Table 5. Percentage of respondents aware of local consumer meetings

		Survey	%
Are there regular meetings in your area specifically to bring together consumers who are employed to support one another?	No	1	42.9%
		2	32.3%
	Yes	1	28.6%
		2	45.2%
	I don't know	1	28.6%
		2	22.6%

Those who were aware of consumer meetings were asked whether they attended the meetings (Table 6). Although the proportion of respondents reporting that they attended

on a regular basis increased, so did the proportion of those who attended sometimes as well as those who did not attend. This indicates that increased awareness does not necessarily lead to increased attendance. Post-training efforts should be applied to not only increasing awareness of local consumer meetings, but also promoting participation through various methods (e.g., periodic announcements).

Table 6. Percentage of respondents attending local consumer meetings

		Survey	%
Do you attend these [local consumer meetings]?	No	1	4.8%
		2	12.5%
	Sometimes	1	11.9%
		2	15.6%
	On a regular basis	1	9.5%
		2	12.5%

Almost all respondents who attended these meetings found them helpful, with many explaining that attendance strengthens one's recovery and allows one to help others through the recovery process, in addition to teaching advocacy skills and providing a sense of empathy. Respondents reported that, "these meetings help me socialize, network, and collect useful information which will allow individuals to use in their personal recovery," and that the meetings, "have a host of topics that really engage the consumer to be a part of the process." Others reported that, "I like feeling like a functioning member of our team and like the connection I feel with them," and that attending meetings, "lets me know that I am not alone in my recovery." Respondents claimed that meetings helped them not only to share life experiences and support, but also to learn coping skills, to learn about their medications, and to receive support for legal issues. Local consumer meetings may also aid in strengthening support networks and providing an additional mechanism of support that fosters long-term job tenure while preventing burnout.

Use of Mental Health Services

Regarding the use of mental health services in general, 75.6% of respondents from the first survey reported that they were currently using services while 92.5% reported having received services for a total of at least one year during their lifetime. Note that the "one year" benchmark is not arbitrary. Peer support services are not billable to Medicaid in Texas unless the peer provider meets the requirement of "at least one cumulative year of receiving mental health services for a disorder that is treated in the target population for Texas" (Texas Administrative Code (TAC) Title 25, Part 2, Chapter 419, Subchapter L, Rule §419.453).

The proportion of respondents from the second survey reporting that they were currently using mental health services increased to 86.7%, while 100% reported having received services for a total of at least one year during their lifetime. These increases may reflect that more respondents began using services in the months following CPS training. Ideally, 100% of trainees would be using mental health services throughout their recovery journeys, even if these services consisted only of peer support. This is important because of the benefits that utilization of recovery-oriented services such as peer support brings to the consumer, the provider, and the mental health service delivery system (Solomon, 2004). It is possible that the language of this survey question was not successful at designating peer support as a "mental health service," and discouraged some from answering "yes" despite the fact that they were receiving peer support services. Nonetheless, this finding highlights the need for the PSTC to encourage the ongoing use of mental health services throughout a lifetime.

Training and Certification

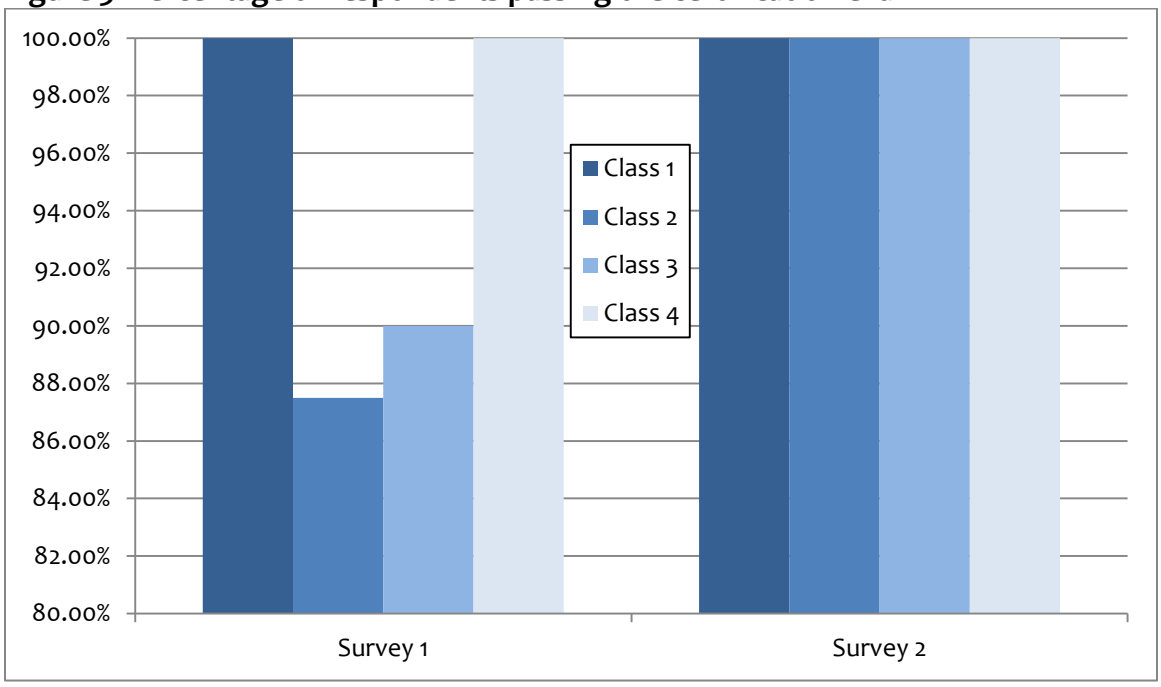
Cohorts

Of the 42 participants completing the first survey, 9 attended the March class, 9 attended the June class, 11 attended the August class, 7 attended the November class, 2 did not report, and 4 were grandfathered in by Via Hope. Of those respondents who took the CPS certification exam, 93.9% had received a passing score of 70 or higher. This pass rate is higher than that of all individuals who took the exam and passed (84.5%), indicating that those who were certified were more likely to complete the survey than those who were not. Passing rates differed slightly between classes (Figure 3). Differences between training classes may reflect differences in how the curriculum materials were taught by the different instructors or participant differences. For instance, the August class went through a less rigorous application process because the MHMR Authority of Harris County requested a training class be held on-site. Most applicants were employed or volunteered at this LMHA and were accepted in order to fill the class to capacity, regardless of qualifications. This also highlights the issue of trainee motivation, which should be sufficiently high in order for training to be optimally effective. If participants were admitted with less effort on their parts, then perhaps less effort was given to class participation. If the differences were actually the result of instructor differences, Via Hope should work with the trainers to develop the skills to effectively teach the class; otherwise, trainees may be differentially prepared to provide services in the field.

Of the 32 participants completing the second survey, 8 attended the March class, 6 attended the June class, 8 attended the August class, 9 attended the November class, and 1 did not report. The percentage of certified respondents increased slightly in the second survey (Figure 3). Of those who took the CPS certification exam, 100% received a passing score.

Differences in pass rates between classes highlight the need to more closely examine the factors that led to performance discrepancies and to standardize training such that these differences are minimized and the number of re-takes is reduced.

Figure 3. Percentage of respondents passing the certification exam



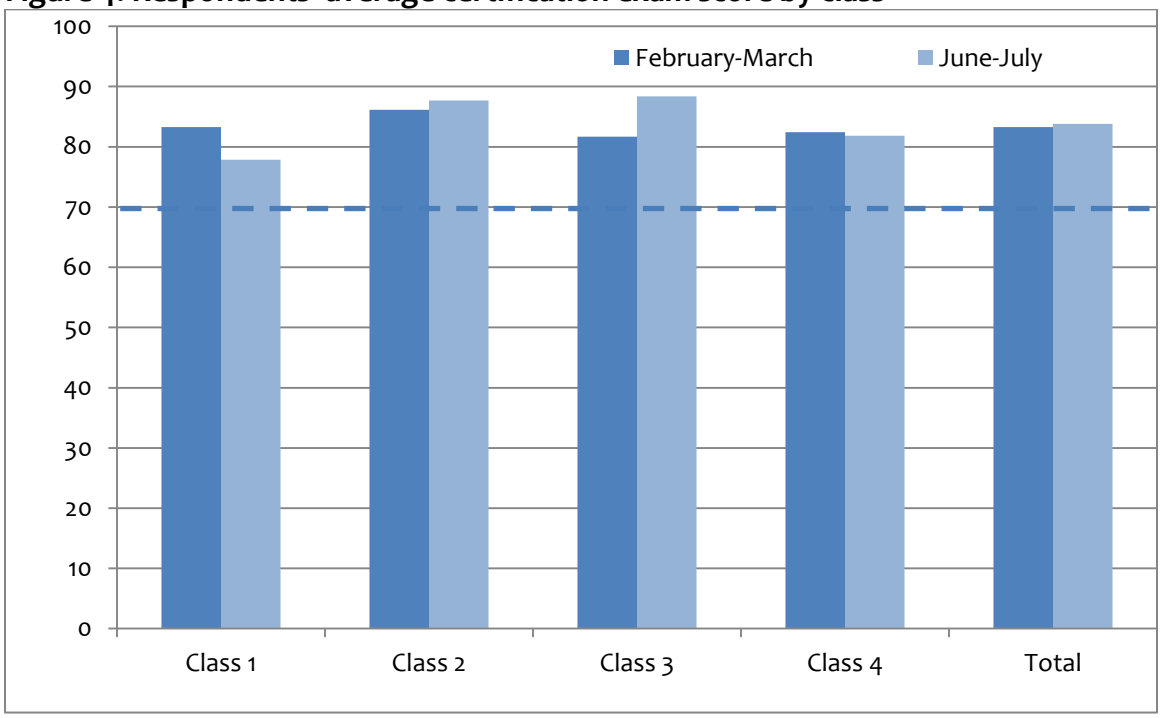
Note: Two examinees included in these data (1 from Class 2 and 1 from Class 3) initially failed the certification exam and then passed upon retaking it; one of these respondents completed both surveys. Only these examinees' passing scores are included in these data.

Exam Performance

Certification exams were made available online within four weeks of completion of the PSTC program. Examinees were allowed to begin the exam at any time during the five to seven day exam administration period. Although it was not proctored, examinees were asked not to receive any assistance or reference materials during the exam period.

The 36-item exam is divided into two sections. The first section consists of 24 multiple choice/short answer items worth 3 points each; examinees are only required to answer 20 of these questions (i.e., they may elect to skip up to four questions). If all 24 questions are answered, only the first 20 will be calculated in the final score. The second section consists of 12 essay items worth five points each; examinees are only required to answer eight of these. Exam total scores are on a scale out of 100 points; a minimum score of 70 is required to become certified. Differences in respondents' average exam scores by class are represented in Figure 4.

Figure 4. Respondents' average certification exam score by class



Note: Dotted line represents minimum passing score of 70. Two examinees included in these data (1 from Class 2 and 1 from Class 3) initially failed the certification exam and then passed upon retaking it; one of these respondents completed both surveys. Only these examinees' passing scores are included in these data.

Modules and Competency Attainment

The PSTC program is based on three overarching competencies (Appendix A), which have been outlined by ACG as core competencies for peer specialists. Competencies include:

1) the peer provider role and skills needed to perform the job;
2) the recovery process and how to use one's own recovery story to help others; and
3) gaining knowledge and skills to establish healing relationships.

These three overarching competencies encompass 23 specific skill and knowledge areas. All but two areas, both of which relate to cultural competence, were addressed by Via Hope's 30 curriculum modules (Appendix B; see Table 7 for average module scores). Examinees were tested on 20 of these areas; average scores in each area are summarized in Table 8. It is important to note that the exam does not assess all competency areas; however, in order to ensure that peer specialists are qualified professionals, examinees should be tested in *all* areas. Skill area competencies pertain to job skills that CPSs should possess; these constitute the peer specialist skills listed in Table 9 (p. 19). The broader knowledge area competencies pertain to having an understanding of concepts or systems related to mental health services, peer support, and recovery.

Table 7. Average scores on curriculum modules

Module		Survey 1 Mean	Survey 2 Mean
1	Welcome and Introductions	100.00	100.00
2	Overview of the Training	90.00	92.86
3	State System and the Role of the Training	--	--
4	Five Stages in the Recovery Process: Overview	95.59	91.15
5	The Role of Peer Support in the Recovery Process	84.52	85.00
6	Using Your Recovery Story as a Recovery Tool	89.06	89.58
7	Creating Program Environments That Promote Recovery	88.06	85.24
8	Exploring Beliefs That Promote Recovery	83.84	84.00
9	The Dynamics of Change	78.13	78.79
10	Facilitating Recovery Dialogues	77.78	79.86
11	Effective Listening and the Art of Asking Questions, Part 1	66.36	70.00
12	Dissatisfaction as an Avenue for Change	77.42	84.72
13	Facing One's Fears	57.97	57.41
14	Combating Negative Self-Talk	85.51	82.03
15	Problem Solving with Individuals	92.71	97.22
16, 17	Effective Listening and the Art of Asking Questions, Part 2, Part 3	--	--
18	Peer Specialist Ethics and Professional Boundaries	87.50	92.00
19, 20, 21	Power, Conflict and Integrity in the Workplace, Part 1, Part 2, Part 3	85.81	83.75
22	Creating the Life One Wants	93.04	91.25
23	The Pillars of Peer Support Services	87.72	78.43
24	Check-in and Transition to Peer Support Whole Health	--	--
25	Introduction to Peer Support Whole Health	80.00	82.05
26, 27, 28	Person-Centered Planning for Peer Support Whole Health, Part 1 , Part 2, Part 3	78.21	78.03
29	Implementing the Five Keys to Success	--	--
30	Final Reflections and Next Steps	--	--

Note: Scores are ratios out of 100%. Higher averages indicate greater mastery. Examinees were not tested on modules 3, 16, 17, 24, 29, or 30.

Table 8. Average scores on exam competency areas

Competency area	Associated Module(s)	Survey 1 Mean	Survey 2 Mean	Skill or Knowledge
An understanding of the job and the skills needed to perform that job				
1. Understand the basic structure of the state's mental health system and how it works	3	--	--	Knowledge
2. Understand the Certified Peer Specialist (CPS) job description and Code of Ethics within the state's mental health system	3, 18, 23	92.33	88.75	Knowledge
3. Understand the meaning and role of peer support	5	84.52	85.00	Knowledge
4. Understand the difference between treatment goals and recovery goals, and be able to create and facilitate a variety of group activities that support and strengthen recovery	10, 22	84.57	86.77	Knowledge
5. Be able to help other consumers to combat negative self-talk, overcome fears, and solve problems	13, 14, 15	76.21	76.24	Skill
6. Be able to help a consumer articulate, set and accomplish his/her goals, including whole health and wellness goals	22, 25, 26/27/28, 29	79.17	87.96	Skill
7. Be able to teach other consumers to advocate for the services that they want	19/20/21	85.81	83.75	Skill
8. Be able to help a consumer create a Person Centered Plan	25, 26/27/28, 29	77.98	76.28	Skill
An understanding of the recovery process and how to use their own recovery story to help others				
9. Understand the five stages in the recovery process and what is helpful and not helpful at each stage	4	95.59	91.15	Knowledge
10. Understand the role of peer support at each stage of the recovery process	4, 5	90.13	87.84	Knowledge
11. Understand the power of beliefs / values and how they support or work	7, 8	85.95	84.62	Knowledge
12. Understand the basic philosophy and principles of psychosocial rehabilitation	7, 10	82.92	82.25	Knowledge
13. Understand the basic definition and dynamics of recovery	2, 4	92.45	91.29	Knowledge
14. Be able to articulate what has been helpful and not helpful in his / her own recovery	6	89.06	89.58	Skill
15. Be able to discern when and how much recovery story to share, and with whom	6, 11, 16/17	77.50	80.83	Skill
16. Be able to identify the beliefs and values a consumer holds that works against his/her own recovery	8, 9, 11, 16/17	74.60	80.83	Skill

An understanding of, and the ability to establish healing relationships				
17. Understand the dynamics of power, conflict, and integrity in the workplace	19/20/21	85.81	83.75	Knowledge
18. Understand the concept of 'seeking out common ground'	19/20/21	85.81	83.75	Knowledge
19. Understand the meaning and importance of cultural competency	--	--	--	Knowledge
20. Be able to ask open ended questions that relate a person to his/her inner wisdom	11, 12, 16/17	74.13	79.05	Skill
21. Be able to personally deal with conflict and difficult interpersonal relations in the workplace	18, 19/20/21	90.00	88.89	Skill
22. Be able to demonstrate an ability to participate in 'healing communication'	11, 12, 16/17 19/20/21	78.89	81.71	Skill
23. Be able to interact sensitively and effectively with people of other cultures	--	--	--	Skill
Total		84.17	84.52	

Note: Scores are ratios out of 100%. Higher averages indicate greater mastery. Scores for competency 1 "Understand the basic structure of the state's mental health system and how it works," could not be calculated because examinees were not tested on any of the associated modules for that area. Competencies 19 and 23 relating to cultural competency were not addressed by the training material.

Based on Table 8, the average score for skill area competencies was lower (*M*=81.19) than the average score for knowledge area competencies (*M*=87.36). Differences are potentially due to the ways in which exam responses were graded (e.g., if generalizations regarding broader knowledge was not evaluated as rigorously as specific content regarding skills), or to differences in how well trainees were able to understand the two types of content. A more likely explanation is the training program's lack of emphasis on skill-building; in other words, there was a focus on teaching conceptual knowledge over hands-on job skills. This ongoing issue was previously recognized by trainees in the Fiscal Year (FY) 2010 evaluation of this program (Steinley-Bumgarner et al., 2010), highlighting the need for Via Hope to enhance skills training in the curriculum, or given time limitations of the training, offer more in-depth skills training through continuing education.

Certified Peer Specialist (CPS) Knowledge and Skills

One focus of the PSTC program was to develop and enhance skills which the participants would likely use while working as peer specialists. These skills are adapted directly from Via Hope's required competencies for CPSs and respondents were asked to indicate on a 10-point scale (1 being "never" or "not at all confident" and 10 being "every day" or "very confident") their frequency and confidence associated with the skill. For both surveys, means, standard deviations, and correlations for reported frequency and confidence of skill

use are displayed in Table 9. For both time points, respondents reported a higher degree of confidence in using all skills compared to the frequency with which they use their skills. However, between the time of the first survey and the time of the second, both frequency of using the skills and confidence in using them increased for every skill. This highlights the benefit of practice in using these skills and suggests that even a short three month window can make a noticeable difference in the quality of peer-provided services.

Across both surveys, the highest ranked skill on both frequency and confidence of use is, "discern when and how much of your recovery story to share, and with whom," while the lowest ranked is, "help a consumer create a Person Centered Plan." Discerning when and how much of one's recovery story to share is an interpersonal skill which peers will be able to refine throughout their lifetime, usually without any instruction. This is also a skill area that the PSTC curriculum focuses on, allowing training participants to practice telling their recovery stories to a small group during class time. It is therefore not surprising that peers reported using this skill often and with great confidence. On the other hand, Person Centered Planning (PCP) is a specialized skill that requires both conceptual and manifest instruction. Without proper training, peers are unlikely to understand or conduct this skilled activity. PCP requires intensive training and ongoing coaching. Responses to the survey support the need for additional training and technical assistance to develop this skill rather than a failure of the recovery model or PSTC program. As part of Via Hope's FY2012 multilevel Recovery Institute, training and technical assistance on PCP will be provided to a group of interested CMHCs/state hospitals. This will provide an opportunity for CPSs to apply their acquired PCP skills/knowledge and also to help others at their organizations understand and use it.

Table 9. Relationship of frequency and confidence of use of peer specialist skills at work

Skill	Survey Time	Frequency *M*(*SD*)	Confidence *M*(*SD*)	Spearman's Rho correlation
1. help consumers combat negative self-talk, overcome fears and solve problems	1	7.86(2.35)	8.34(1.91)	.50**
	2	8.16(1.97)	8.94(1.39)	.45*
2. help a consumer articulate, set and accomplish his/her goals, including whole health and wellness goals	1	6.31(2.70)	7.85(2.21)	.41**
	2	6.87(2.68)	8.16(2.37)	.59**
3. teach consumers to advocate for the services that they want	1	6.67(2.49)	8.05(2.09)	.54**
	2	7.84(2.40)	8.90(1.45)	.56**
4. help a consumer create a Person Centered Plan	**1**	**5.02(3.53)**	**6.85(2.74)**	**.56****
	2	**5.19(3.44)**	**7.00(2.90)**	**.56****
5. create and facilitate a variety of group activities that support and strengthen recovery	1	5.34(3.53)	7.37(2.75)	.55**
	2	6.61(3.23)	8.03(2.48)	.62**
6. articulate what has been helpful and what has not been helpful in your own recovery	1	7.83(2.48)	8.88(1.74)	.46**
	2	8.77(1.91)	9.44(.80)	.55**
7. identify the beliefs and values a consumer holds that work against his/her own recovery	1	6.95(2.52)	7.93(2.15)	.42**
	2	7.33(2.43)	8.59(1.50)	.19
8. discern when and how much of your recovery story to share, and with whom	**1**	**8.24(2.26)**	**8.95(1.83)**	**.45****
	2	**8.77(1.52)**	**9.56(.76)**	**.37***
9. ask open ended questions that relate a person to his/her inner wisdom	1	7.53(2.25)	8.22(1.82)	.66**
	2	7.84(2.28)	8.34(1.91)	.71**
10. personally deal with conflict and difficult interpersonal relations in the workplace	1	6.02(3.06)	7.80(2.12)	.34*
	2	6.87(3.20)	7.81(2.29)	.48**
11. demonstrate an ability to participate in 'healing communication'	1	6.98(2.95)	7.95(2.21)	.68**
	2	7.42(2.80)	8.22(2.11)	.64**
12. interact sensitively and effectively with people of other cultures	1	7.88(2.71)	8.68(2.02)	.70**
	2	9.00(1.65)	9.13(2.24)	.59**

Note: Respondents used a 10-point scale where 1 indicated "never" or "not at all confident" and 10 indicated "every day" or "very confident." Higher averages indicate greater frequency or confidence.
*=significant at $p<.05$ level; **=significant at $p<.01$ level

Continuing Education Units (CEUs)

In Texas, peer specialists are required to obtain 20 CEUs every two years in order to maintain certification. When asked about CEUs received, 51.3% of respondents of the first survey indicated that they had not obtained any CEUs. Respondents from the second survey demonstrated an increase in the number of CEUs obtained, with only 25.8% reporting that they had not obtained any (Table 10). The increase in CEUs obtained since the first survey was most likely seen in part because of the 3 month window in which CPSs had the opportunity to obtain more units.

Table 10. Number of Continuing Education Units (CEUs) obtained since certification

		February-March	June-July
How many CEUs have you obtained since certification?	None	51.3%	25.8%
	1-4 units	10.3%	9.7%
	5-9 units	7.7%	19.4%
	10-14 units	7.7%	6.5%
	15-19 units	10.3%	12.9%
	20 or more units	10.3%	25.8%

When respondents from the first survey were asked to identify CEU classes that they had interest in attending (Figure 5), the leading interests were Wellness Recovery Action Planning (WRAP) (73.8%) and leading/facilitating support groups (59.5%). The high interest in WRAP aligns with Via Hope's *WRAP Across Texas Initiative* which aims to increase the program's availability throughout Texas by training consumers to be WRAP facilitators and by providing them technical support including meeting space, supplies, supervision, and access to interested populations. Respondents' interest in obtaining skills related to support group facilitation was reported during the evaluation conducted in FY2010 (Steinley-Bumgarner, Kaufman, Stevens-Manser, & Murphy-Smith, 2010), where peer specialists shared that skill-building was not adequately incorporated into the training. This is also supported by exam scores on particular curriculum modules, which indicate less mastery of skills (Table 8).

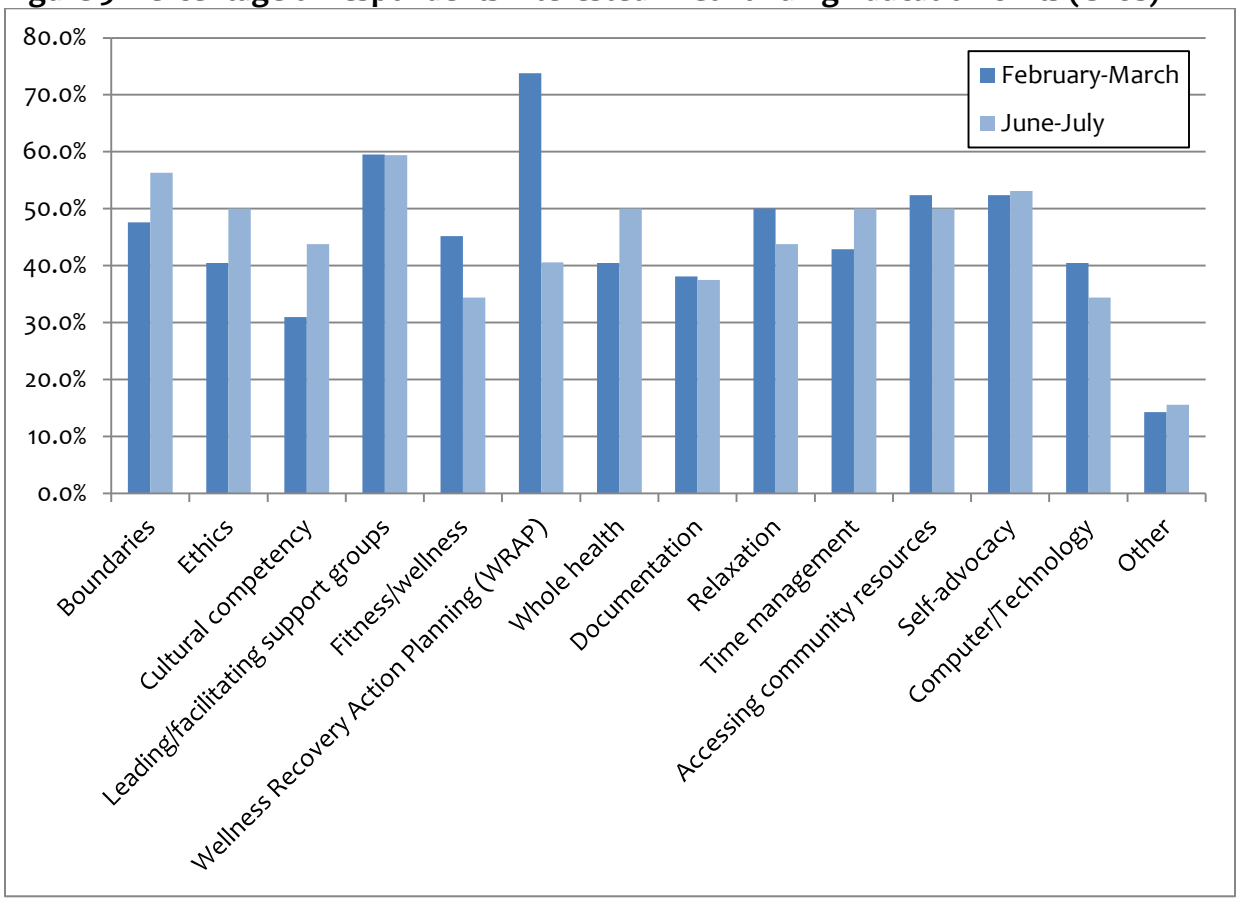
The CEU of least interest in the first survey was cultural competency (31%). Interestingly, of the 20 CEU's required every two years, the state mandates that three of these be in ethics and three in cultural competency. A study by Brooks, Kaufman, Steinley-Bumgarner, and Stevens-Manser (2011) revealed ethnic differences in satisfaction with PSTC training and employment. Results of analyses showed that Hispanic/Latino participants were less satisfied with nearly all of the training modules. Additionally, job satisfaction for

Hispanic/Latinos was tied to racioethnic workplace diversity. All of these findings seem to suggest that cultural competency should be addressed as an ongoing need in PSTC training as well as in post-training education and employment settings. Respondents' interest in culturally-competent training was also expressed during the FY2010 evaluation (Steinley-Bumgarner et al., 2010).

When respondents from the second survey identified CEU classes which they were interested in attending (Figure 5), leading/facilitating support groups (59.4%) and boundaries (56.3%) were reported as leading interests. Interest in WRAP dropped significantly (to 40.6%) between the first and second surveys; this was the greatest decrease in interest, which may have resulted from more respondents attending this class between survey times. The greatest gain in interest was seen in cultural competency which increased to 43.8%; this increase lends further support to the recommendation that cultural competency be better integrated into post-training continuing education. Interest levels remained steady in the areas of leading/facilitating support groups, documentation, accessing community resources, and self-advocacy; the call for skill-building in the PSTC education trajectory is ongoing.

Other reported areas of interest that were not listed as choices include eradicating the stigma of mental illness in the workplace and community, motivational interviewing, program development, spirituality, trauma, and yoga/meditation (first survey). In the second survey, other reported areas of interest included spirituality, trauma, and as one respondent reported, "anything that would help us tell our story to congress." The latter comment approaches the topic of policy change, suggesting that some PSTC participants are ready move beyond intrapersonal/interpersonal dialogue toward system-level discourse. This demonstrated interest in the tailoring of ongoing education points to the need for CEUs that align with the interests of peer specialists, empowering them to choose the knowledge and skills needed to strengthen recovery for themselves and others.

Figure 5. Percentage of respondents interested in Continuing Education Units (CEUs)



Additional Peer-Related Trainings

Half (50%) of respondents from the first survey had attended additional peer-related trainings. Examples of trainings attended include Advanced Peer Practices, Intentional Peer Support training, DBSA facilitator training, Prosumers Focus for Life training, NAMI's In Our Own Voice and Peer-to-Peer, and many others; all of these classes/endorsements (except DBSA facilitator training) are pre-approved for CEU credit through Via Hope. It is not known if these trainings increase skills or knowledge, but such additional training programs promote involvement in the behavioral health system and interaction with other peers as well as knowledge of recovery principles, resulting in more informed and empowered consumers with the skills needed to provide effective peer support to other consumers.

The percentage of respondents from the second survey who had attended additional peer-related trainings increased to 56.3%. In addition to NAMI, DBSA, and Prosumers trainings, examples of other trainings attended included Joel Slack's Respect Institute, Mental Health First Aid, Medicaid Billing, Art as Therapy, Pet Care, and Whole Health/Wellness. Beyond promoting involvement in the behavioral health system, trainings of this nature promote

skills and knowledge that can be used in self-care as well as in the provision of peer support in clinical or other settings.

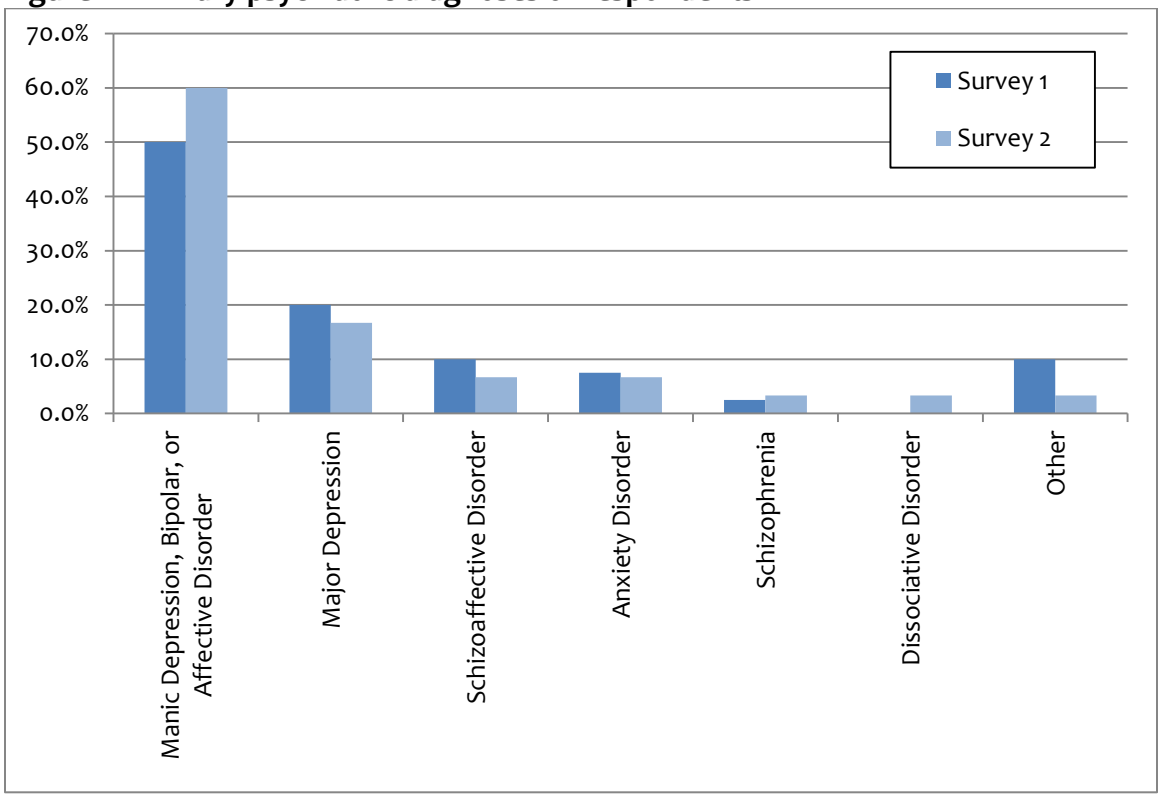
Recovery Experience

Respondents reported on several aspects of their recovery experiences including their diagnosis, impetus for recovery, training-driven recovery gains, and work-driven recovery gains. The group revealed a wide range of diverse experiences, which may have differentially affected training and subsequent employment outcomes for individuals.

Diagnosis

Respondents reported primary psychiatric diagnoses of "manic depression, bipolar, or affective disorder," "major depression," "schizoaffective disorder," "anxiety disorder," "schizophrenia," "dissociative disorder," and "other" (Figure 6). Substance abuse disorder was listed as a diagnosis in the "other" category. Via Hope requires that peer specialists have a primary diagnosis related to mental health, and that substance use issues may be co-occurring but not primary. The finding that some respondents indicated substance abuse as a primary diagnosis could indicate that some individuals consider themselves in recovery from their mental health disorder and no longer consider this as their primary diagnosis. Regardless, this is an area Via Hope may wish to explore given the current peer specialist training admission requirement of a primary diagnosis related to mental health.

Figure 6. Primary psychiatric diagnoses of respondents



Recovery Journey

As an eligibility requirement, Via Hope includes on the application that the applicant should have "at least one year of experience working on recovery…" According to survey responses, some reported having been in recovery for over 30 years, but some had just begun their recovery journeys within the last year. The application process could be more closely monitored, however, time since recovery began was not significantly correlated with job efficacy for respondents of either survey, indicating that even those peer specialists who have only been in recovery for a short time report that they can perform their jobs effectively. Currently, Via Hope requires a telephone interview and two letters of reference as part of the application process. However, the relative weight placed on various application components may need to be examined to ensure accuracy establishing an applicant's readiness for the peer specialist training.

When asked the highly subjective question of what started him/her on the road to recovery, some recounted a series of events in-detail while others reported simply that they did not know. Responses were qualitatively coded based on how elements fit into six thematic categories pertaining to the impetus for recovery: medical/psychiatric support, empowerment, social support, traumatic event/crisis, rising to meet increased responsibility,

spiritual/religious experience; some responses did not have aspects relating to any of these categories (Table 11). Many responses had elements relating to more than one theme (48%). For example, one respondent indicated, "Support Groups; Gainful Employment within a Mental Health Non-Profit and being able to disclose my disorder; Family Support; Great Doctor," as being the geneses of his/her recovery journey. This response was coded as medical/psychiatric support, social support, and empowerment. Another response, "being in a clinical drug study and having to commit to becoming drug free to participate in it," was coded as rising to meet increased responsibility. "I attempted to kill myself and my child," was coded as traumatic event/crisis.

Significant increases were seen in the second survey in the percentage of respondents who recalled an empowering experience, rising to meet increased responsibilities, and social support. These themes are also mechanisms of peer support. Decreases were seen in those reporting medical/psychiatric support, traumatic events/crises, and spiritual/religious experiences. These changes could be associated with respondents having greater CPS knowledge and experience, which may have affected the salience of certain contributing factors in their memories. Most responses in this survey (62.1%) had elements relating to more than one theme supporting the fact that there are many paths to recovery. The importance of the *recovery story* to recovery itself is underscored by a notion taken from narrative psychologist Jerome Bruner (1986) that people make meaning in their lives by constructing stories (as cited in Richert, 2006, p. 84). For the narrator, these stories become a constructed reality and, depending on their form, can lead either to disempowerment and distress or to empowerment and adaptive functioning (Richert, 2006).

Table 11. Thematic content of respondents' recovery impetus

		February-March	June-July
What started you on your road to recovery?	Medical/psychiatric support	**50%**	41.4%
	Empowerment	33.3%	**58.6%**
	Social support	23.8%	31.0%
	Traumatic event/crisis	23.8%	13.8%
	Rising to meet increased responsibility	14.3%	31.0%
	Spiritual/religious experience	9.5%	3.5%
	Other	7.1%	10.4%

Note: Many responses included content relating to more than one theme; categories are overlapping. Bolded items are highest percentages for each survey.

Strengthening of Recovery

Respondents from the first survey reported that their recovery was strengthened through participating in the PSTC program and through working as a peer specialist. When asked to what extent the training had strengthened their recovery on a 10-point semantic differential (i.e., Likert) response scale (10 being "every aspect of my personal recovery," and 1 being "no aspect of my personal recovery"), trainees reported a high degree of impact of both training and work on their recovery journeys (Table 12). Over half (52.5%) of respondents from the first survey reported that work strengthened every aspect of their recovery and almost half (48.8%) selected that training strengthened every aspect of their recovery. The percentage of respondents reporting that work strengthened every aspect of their recovery increased to 58.1% in the second survey, while the percentage of those reporting that training strengthened every aspect remained about the same (48.4%). The increase in work-based strengthening of recovery is probably due to continued experience working as a CPS during the three months following the first survey. Training-based recovery gains probably developed alongside work-based gains because the PSTC's effect on personal recovery was continuously reiterated as peer specialists integrated learned concepts and skills at with work.

Table 12. Average impact of training and work on recovery

On a scale of 1 to 10 …	Survey 1 Mean	Survey 2 Mean
Participating in the peer specialist training sponsored by Via Hope helped strengthen my recovery…	8.15	8.61
Working as a peer specialist has helped strengthen my recovery…	8.53	8.87

While the purpose of delivering peer support is primarily to aid in the recovery of others, these findings suggest the importance of the training and of the work itself to peer-providers' personal recovery. This bolsters a growing body of research showing that peer support benefits not only the consumer but also the provider (Solomon, 2004). These findings also offer insight into the relative effectiveness of some of the mechanisms (i.e., training and work) underlying this reciprocity.

Employment

Respondents reported paid employment, volunteer employment, contract employment, and unemployment (Figure 7). All but one respondent from both surveys was employed or seeking employment in the consumer/peer support/mental health field. A large majority of respondents of the first (82.9%) and second (70%) surveys reported that their organization had a job description for their position, an indicator of standardization and integration of peer support services within the mental health field. The decrease seen between the first and second surveys may reflect that more respondents of the latter were employed as volunteers who would probably be less likely to have a job description. The increase in full-time employment and accompanying decrease in part-time employment suggests that peers are transitioning into more stable and influential roles within their organizations. The other numbers represent opportunities for organizations to develop meaningful positions for peer specialists seeking employment.

The types of organizations at which the peer specialists were employed included state hospitals, local mental health authorities (LMHAs), and other settings (Table 13). Overall, a majority of peer specialists were employed by LMHAs.

Figure 7. Employment status of respondents

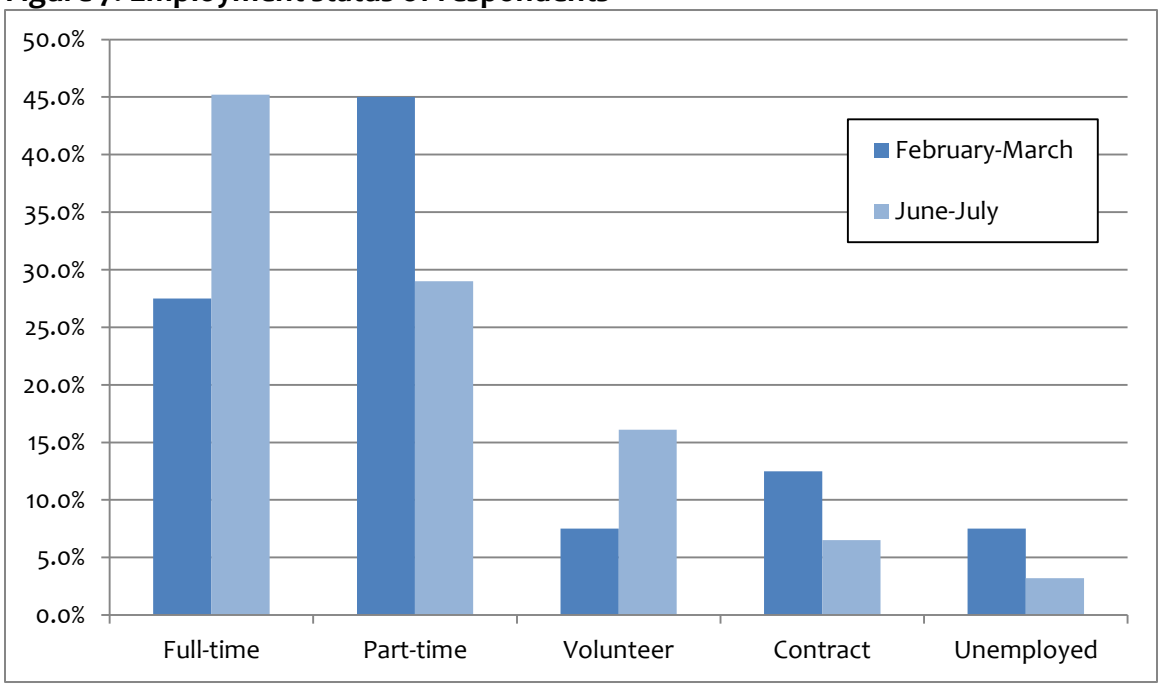


Table 13. Type of organization at which respondents were employed

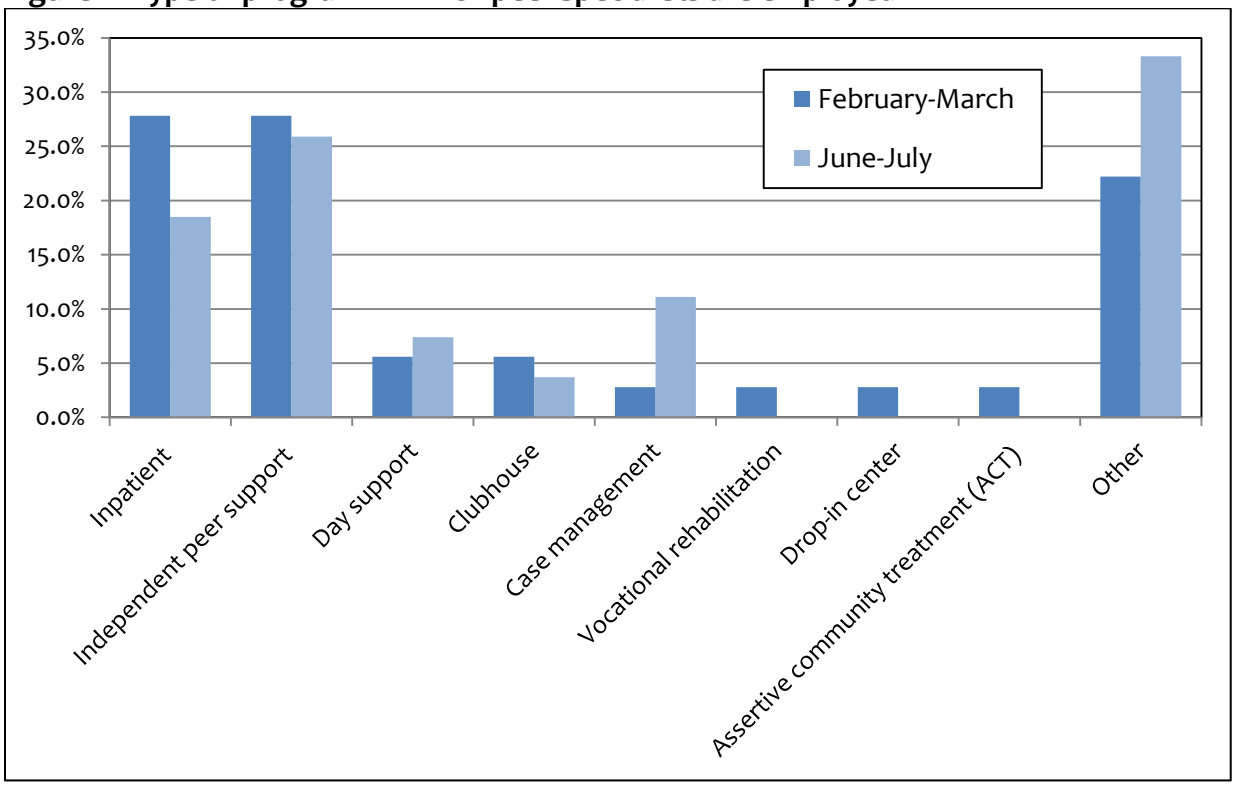
		February-March	June-July
What type of organization are you currently employed at?	Local Mental Health Authority (LMHA) / Community Mental Health Center (CMHC)	73%	63%
	State Hospital	13.5%	18.5%
	Other	13.5%	18.5%

Program of Employment

When asked to best describe the program in which they worked (Figure 8), the most common programs of employment for respondents of both surveys combined were inpatient programs (23.8%) and independent peer support programs (27%). Those who reported "other" programs of employment (27%) worked in capacities such as crisis support and psychiatric emergency services (7.9%), HIV/STD education and risk reduction, in-home peer support, homeless programs, and substance abuse programs. It would be helpful to have a better understanding of the "other" categories - including conversations with these employers – as they represent opportunities to expand the employment of peer specialists beyond the traditional mental health system.

Results showing this great diversity in the jobs of CPSs are evidence that PSTC training provides a foundation for a wide array of work opportunities. This is indicative of labor force security for this group, such that, even if certain types of programs are defunded, individuals who receive certification will remain a stable presence in the workforce in a number of other areas.

Figure 8. Type of program in which peer specialists are employed



Duration of Employment

Respondents' duration of employment at their current job ranged from less than 1 month to 16 years. Average length of employment was greater for the first training class (March 2010) than for all other classes (Table 14). Because those that were already employed received priority acceptance into the training, the first training class was unique in that most participants were already working in a peer specialist capacity. As the number of state-certified peer specialists in the workforce continues to grow, fewer training applicants will have previous work experience and thus average length of employment as a peer specialist at the time of training will diminish.

Table 14. Average length of employment by training class

		Survey 1 Mean Years	Survey 2 Mean Years	Total Mean Years
Length of employment	Class 1 (March 2010)	4.85	1.99	3.42
	Class 2 (June 2010)	1.39	2.08	1.60
	Class 3 (August 2010)	2.33	2.63	2.44
	Class 4 (November 2010)	1.86	2.85	2.43
	All Classes	**2.60**	**2.34**	**2.52**

Provision of Mental Health Services

Only direct mental health services are reimbursed by Medicaid. The time between the first and second follow-up surveys ushered a shift toward more regular provision of direct mental health services by CPSs (Table 15). One potential explanation for this change is that, as CPSs gained greater experience at work, their job duties increased. Alternatively, there may have been latent effects of PSTC that improved skill level and confidence in providing such services, and therefore increased the frequency of provision among CPSs.

Table 15. Percentage of respondents providing direct mental health services to consumers

		February-March	June-July
Do you provide direct mental health services to consumers?	No	17.1%	14.3%
	Sometimes, as an occasional part of my job	22%	21.4%
	Yes, as a regular part of my job	61%	64.3%

Number of Consumers Served

Respondents reported the number of consumers they served per week as part of their jobs (Table 16), although many indicated that this figure was highly variable. In fact, some respondents reported only that the number was variable and did not provide an estimate. The average number of consumers served increased significantly from survey 1 to survey 2, representing what could be a typical "caseload."

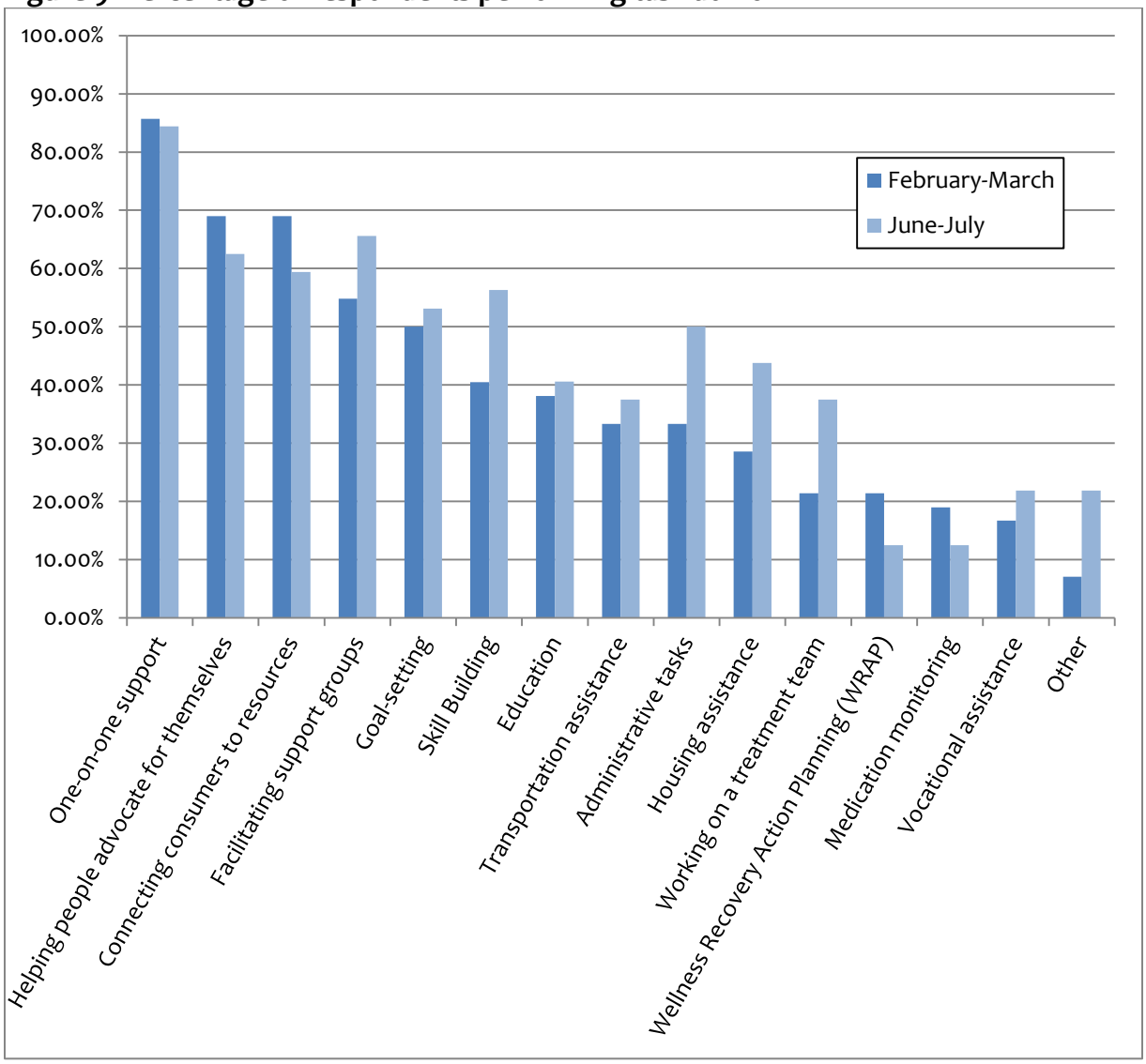
Table 16. Number of consumers served per week by Certified Peer Specialists (CPSs)

		February-March	June-July
Consumers served per week	Range	1 - 81	4 - 300
	Mean	21.53	39.79
	Median	19	25

Job Tasks

Respondents were asked to identify from a list the job tasks they performed as peer specialists (Figure 9). The tasks performed most by respondents from the first survey were one-on-one support (85.7%), helping people advocate for themselves (69%), and connecting consumers to resources/networking (69%). The tasks performed least, but still constituting a significant portion of time, included vocational assistance (16.7%), medication monitoring (19%), working on a treatment team (21.4%), and Wellness Recovery Action Planning (WRAP) (21.4%). The tasks performed most by respondents of the second survey were one-on-one support (84.4%), facilitating support groups (65.6%), and helping people advocate for themselves (62.5%). The least performed tasks by the same respondents were WRAP (12.5%) and medication monitoring (12.5%). Results from a survey of LMHA Mental Health Directors indicated that "clinical" staff, such as nurses, are more likely than peer specialists to provide medication training and support services (Kaufman, Brooks, & Stevens-Manser, 2011), although Texas DSHS does offer billing codes for peers to provide these services.

Figure 9. Percentage of respondents performing task at work



The finding that only a limited number of peer-providers are performing some of these fundamental tasks (e.g., working on a treatment team) may indicate a number of barriers to integration such as poorly defined job roles, lack of resources (i.e., funding), prejudices held by mental health professionals, or the limitations of what a peer specialist can do. Because of such challenges, job strain may be greater for those who work alone as the sole peer specialist at their organization or in isolation from their peer co-workers (Independent Living Research Utilization [ILRU] Community Living Partnership, 2008). Additionally, peers may not possess the qualifications required to perform more clinically oriented tasks such as medication monitoring or require additional training to do so. In the FY2010 evaluation, some peers revealed that they were not allowed to perform activities that were key to their

role as a CPS, highlighting the need for a system-wide culture shift toward integration and acceptance of peers as providers of mental health services (Steinley-Bumgarner et al., 2010).

Hours Worked

An increase was seen between the first and second survey in the average number of hours worked per week by respondents (Table 17). Two possible explanations for the increase in average hours worked per week by CPSs are (a) increased recognition of their value by employers, and (b) increased rates of reimbursement or other funding for peer provided services. Data exists to support both explanations. Unpublished data from Texas DSHS (2011) shows that total client hours billed to Medicaid by all peers working at LMHAs in Texas for peer provided services increased from 5,401.29 hours in FY2010 to 7,440.00 hours FY2011. Additionally, in surveys administered by UT-CSWR, providers in the mental health system report increasing awareness of the important role peer specialists play in their service systems (Kaufman, Stevens-Manser, Espinosa, & Brooks, 2011; Kaufman, Brooks, & Stevens-Manser, 2011).

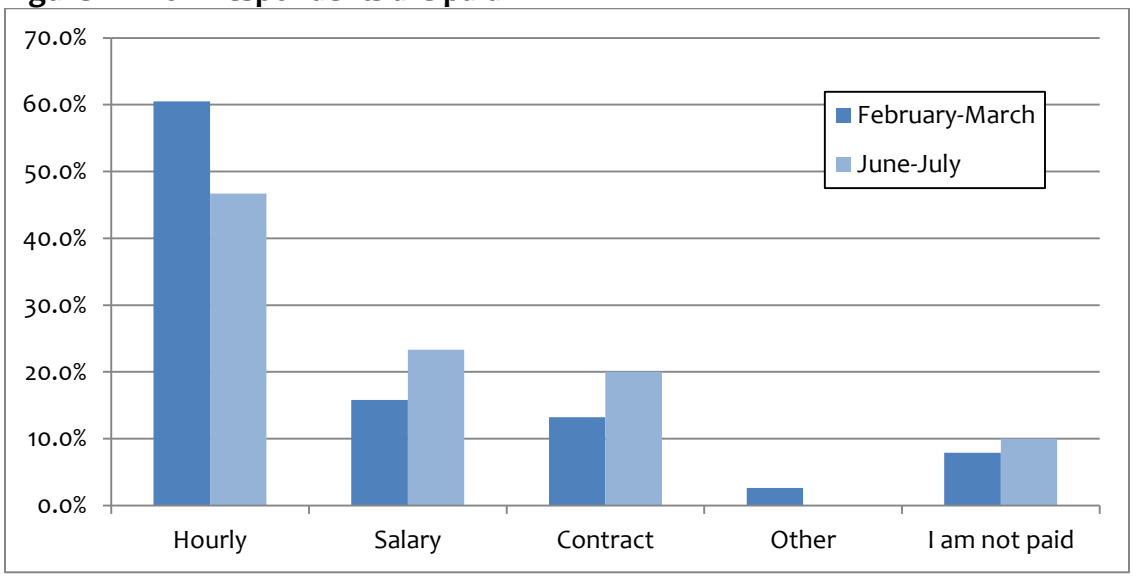
Table 17. Average hours worked per week by Certified Peer Specialists (CPSs)

		February-March	June-July
Hours worked per week	Range	2 – 40	2 - 50
	Mean	22.83	29.04
	Median	20	35

Salary

Figure 10 below shows the various ways in which respondents are paid. Across both surveys, most were paid by the hour; however, a significant decrease in the percentage of hourly wage earners in the second survey was accompanied by increases in the proportion of salary, contract, and volunteer payees.

Figure 10. How respondents are paid



All respondents were asked to report their salary, contract, or hourly pay. For salary and contract earners, an average hourly rate was calculated based on how many hours were worked per week for the purpose of comparison with hourly wage earners (Table 18). A slight increase in average hourly pay was seen between the first survey and the second survey.

Table 18. Average hourly pay for all respondents

		February-March	June-July
Hourly pay	Mean	$12.09 per hour	$12.38 per hour
	Median	$11.95 per hour	$12.00 per hour

Note: Unpaid volunteers are not represented in these averages. One respondent reported hourly earnings of less than minimum wage (<$7.25/hour).

Analysis of the first survey revealed that hourly pay was negatively associated with the supportiveness of respondents' supervisors (r_s=-.50, p=.008) such that those with lower pay indicated receiving greater supervisor support and vice versa. The negative association may indicate that smaller organizations that can only afford to pay employees a limited salary (e.g., a consumer operated service provider) foster a more intimate, supportive working environment. The correlation was reversed in the second survey becoming positive (r_s=.24) but not reaching statistical significance (p=.258).

This pattern of reversal was also seen in the relationship between hourly pay and job satisfaction (Table 19). At the time of the first survey, lower pay generally correlated with

higher measures of satisfaction, and the opposite was found in the second survey. In other words, overall job satisfaction was moderately associated with higher earnings at the second post-training evaluation. One potential explanation is that peer specialists who were initially being paid at a lower rate at the time of the first survey, and were nonetheless satisfied with their job experience, had increased pay at the time of the second survey while maintaining job satisfaction. Alternatively, because work-based e-mail addresses were used to send the survey invitations to participants, it may be the case that some who were dissatisfied with their jobs and received higher relative pay during the first survey were no longer employed during the second survey. These findings should be interpreted with caution because many of the correlations were non-significant. As the number of peer specialists increases, continued evaluation could shed light on this relationship.

Table 19. Association of hourly pay with job satisfaction

Measure of job satisfaction	February-March	June-July
	Spearman's Rho correlation	
I am satisfied with my overall job experience.	-.06	.55*
Working in my current position has positively impacted my recovery.	-.11	.39
I feel accepted and respected by my colleagues.	-.20	.14
My job description realistically reflects my actual job duties.	.12	.21
My supervisor explains the skills or procedures I am expected to perform.	-.16.	.24
I feel I am able to do my current job well.	-.44*	-.02
My supervisor listens to my suggestions, ideas, and opinions.	-.37	-.04
I have experienced stigma as a result of the actions or words of my co-workers.	.38*	.09

Note: Respondents used a 5-point scale where 1 indicated "strongly disagree" and 5 indicated "strongly agree."

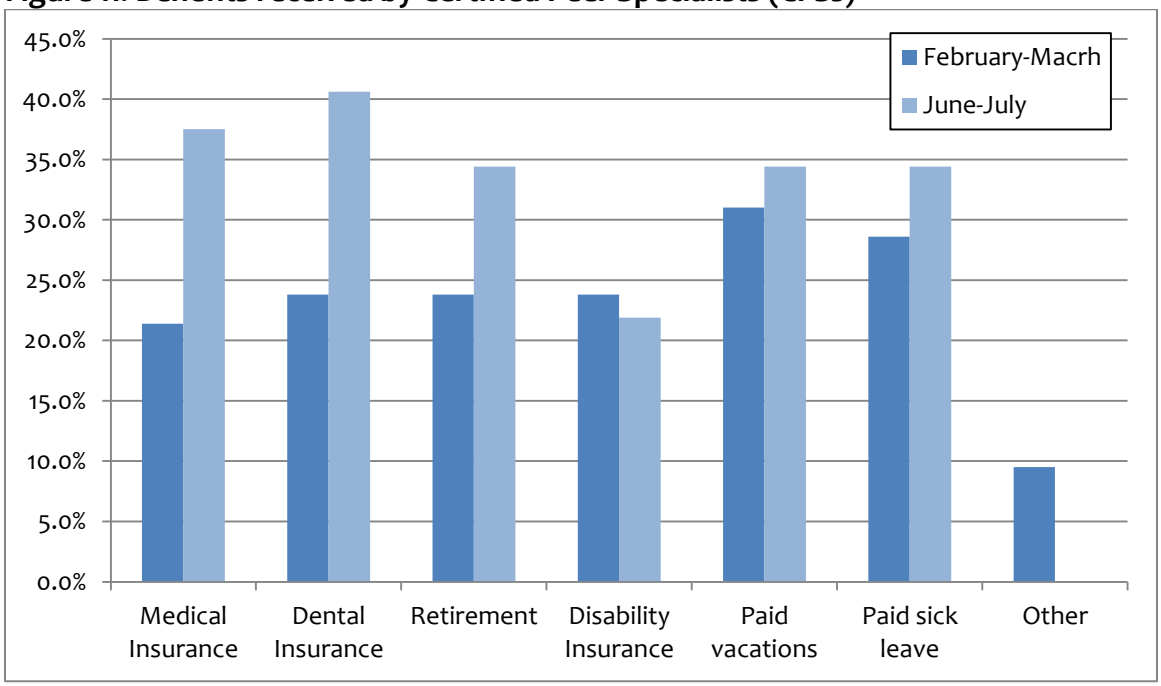
Benefits

Respondents were asked whether or not they received benefits from their employers (Table 20). A slight increase between the first survey and the second in the number of CPSs receiving benefits mirrors the increase in the number of respondents reporting full-time employment, often a condition for receiving benefits from any employer. The most commonly received benefits were dental and medical insurance in the first survey, and paid vacations and paid sick leave in the second survey (Figure 11).

Table 20. Percentage of Certified Peer Specialists (CPSs) receiving benefits

		February-March	June-July
Do you receive benefits from your employer?	No	55.26%	46.7%
	Yes	44.74%	53.3%

Figure 11. Benefits received by Certified Peer Specialists (CPSs)



Job Satisfaction

Respondents were asked eight questions pertaining to job satisfaction, rating how satisfied they were with each aspect on a Likert scale from 1 to 5 (with 1 being "Strongly disagree" and 5 being "Strongly agree"). Overall, satisfaction was high (Table 21). The first survey

revealed a significant association of six of these items with the extent to which working as a peer specialist helped to strengthen respondents' personal recovery; in the second survey, the association was only found with three items (Table 21). One possible explanation for this change is that the strengthening of personal recovery becomes less dependent on positive experiences at work over time. As job responsibilities increase and job stress becomes greater, peers may feel that they are nonetheless stronger in recovery because practice and experience have strengthened their ability to manage and cope with such stressors.

Table 21. Job satisfaction: Association with strengthening of personal recovery

Measure of job satisfaction	Survey 1		Survey 2	
	Mean	Spearman's Rho correlation	Mean	Spearman's Rho correlation
I am satisfied with my overall job experience.	4.30	.59**	4.43	.26
Working in my current position has positively impacted my recovery.	4.65	.61**	4.57	.54**
I feel accepted and respected by my colleagues.	4.17	.29	4.43	.13
My job description realistically reflects my actual job duties.	4.16	.59**	4.26	.51**
My supervisor explains the skills or procedures I am expected to perform.	4.31	.80**	4.33	.48*
I feel I am able to do my current job well.	4.62	.44**	4.78	.30
My supervisor listens to my suggestions, ideas, and opinions.	4.69	.43*	4.67	.22
I have experienced stigma as a result of the actions or words of my co-workers.	2.59	.11	2.73	-.06

Note: Strengthening of personal recovery is assessed by the item (on a scale of 1 to 10) "working as a peer specialist has helped strengthen my recovery…" Job satisfaction was measured on a 5-point scale where 1 indicated "strongly disagree" and 5 indicated "strongly agree." Higher averages indicate stronger agreement. *=significance level is $p<.05$; **=significance level is $p<.01$

Medicaid Billing

Respondents reported whether their organizations billed Medicaid for peer provided services rendered (Table 22). The majority in both surveys did not bill Medicaid for services. There was an increase in the proportion of respondents who did not know whether or not their organization billed Medicaid. This is likely due to the fact that this group had been employed for a shorter period of time on average (Survey 1 *M*=1.01 years; Survey 2 *M*=1.60 years) when compared to those who did know (Survey 1 *M*=2.56 years; Survey 2 *M*=2.50 years). Regardless of length of employment, it is not surprising that many peer specialists lack clarity on this subject because many Local Mental Health Authorities (LMHAs) in Texas do not bill Medicaid for the peer support services they provide despite the fact that many of these services are billable (Kaufman, Brooks, & Stevens-Manser, 2011). LMHA-reported barriers include: (a) lack of clarity around billable services or billing codes, (b) difficulties with supervision, (c) training and credentialing issues, (d) issues with documentation, (e) attendance at groups, (f) lack of computer skills, and (g) exclusion of certain service packages (Kaufman, Brooks, & Stevens-Manser, 2011).

Table 22. Percentage of respondents billing Medicaid for peer support services

		February-March	June-July
Does your organization bill Medicaid for the services you provide?	No	43.2%	39.3%
	Yes	35.1%	32.1%
	I don't know	21.6%	28.6%

Another reason why a significant proportion of respondents' organizations do not bill Medicaid for peer provided services may be simply that peer specialists are providing only non-billable services. Such services include administrative duties; transportation duties; and any service that does not fall under the billable categories of Medication Training and Support, Skills Training, and Psychosocial Rehabilitation. Barriers to having peer specialists provide billable services include: (a) peer specialists are providing other services, (b) additional training is needed, (c) peer specialists are employed as volunteers, (d) there is a lack of supervision required to bill, (e) billing code systems are not yet established, and (f) exclusion of certain service package populations (Kaufman, Brooks, & Stevens-Manser, 2011). Based on these findings, Kaufman and colleagues recommended providing organizations with training and technical assistance regarding documentation of services, identification of billable services, and clarification of billing codes/rules. In the context of the PSTC program, additional skills training could feasibly be provided to CPSs as a CEU and / or LMHAs could open training provided locally to peer specialists.

Although it is critical to an organization's sustainability to bill for services where possible, it is important to note that some non-billable services such as support and outreach/engagement are precisely the mechanisms by which peer support is complementary to traditional care, which generally consists only of billable services. Systems should caution against making peer support services something which may only be indexed by billing codes. The interpersonal connection and intrinsic reward that come with peers providing mutual support may be undermined by a strictly fee-for-service model.

Supervision

Peer specialists must be supervised by a Licensed Professional of the Healing Arts (LPHA) in order to bill Medicaid for the allowable services they provide (TAC Title 25, Part 1, Chapter 419, Subchapter L). The percentage of respondents receiving supervision increased between the first and second surveys (Table 23).

Table 23. Percentage of respondents receiving supervision at their jobs

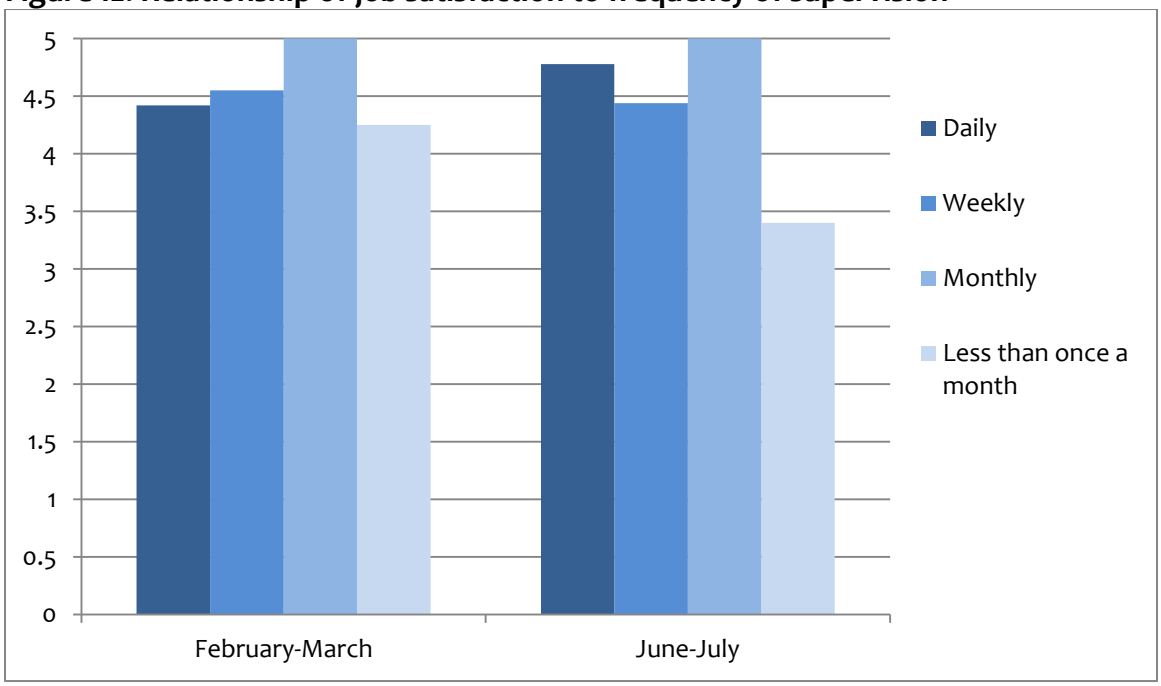
		Frequency of Supervision	February-March	June-July
Do you receive supervision?	No	--	16.2%	10.7%
	Yes	Total	83.8%	89.3%
		Daily	38.7%	38.5%
		Weekly	35.5%	34.6%
		Monthly	9.7%	7.7%
		Less than once a month	12.9%	19.2%
		Never	3.2%	--

Although those in the first survey who did receive supervision were more satisfied (*M*=4.50) than those who did not (*M*=3.33), this difference dissipated in the second survey (*M*=4.38 v. *M*=4.67). However, of those who did receive supervision, the frequency of supervision had a slight bearing on overall job satisfaction such that those who received only monthly supervision were more satisfied with their jobs overall (Figure 12). All of the employees receiving monthly supervision (*n*=5) were employed across different types of organizations (i.e., state hospitals, LMHAs/CMHCs, and other organizations), and therefore it is unlikely that differences were due to type of organizational employment. The finding that those respondents who were supervised monthly were all maximally (5 out of 5) satisfied and those who were supervised less than once per month were the least satisfied may indicate

that there is an optimal level of supervision. This provides support for the TAC rule that peer providers are only required to be supervised monthly.

While existing literature recommends that supervision of peer specialists occur weekly (Sinclair, 2009), this heuristic should be reevaluated based on the evolving role of peer specialists both within their own organizations and within the mental health system as a whole. In a study of a Pennsylvania Certified Peer Specialist Initiative, Salzer and colleagues (2009) found that even infrequent supervision was perceived positively by peer specialists. In addition to frequency, the quality and scope of supervision are also important to the satisfaction of CPSs; these factors will vary according to the needs of states' mental health systems (Centers for Medicare & Medicaid Services [CMS], 2007).

Figure 12. Relationship of job satisfaction to frequency of supervision



Note: Respondents used a 5-point scale where 1 indicated "strongly disagree" and 5 indicated "strongly agree." Higher averages indicate stronger agreement.

The element of supervisor supportiveness may be a critical factor in how supervision affects peer specialist job satisfaction. Respondents from both surveys reported that their supervisor's overall level of supportiveness was very high (Table 24). Correlation analysis revealed that reported supervisor's level of supportiveness was associated with greater job satisfaction at both survey times (Table 24). This provides evidence for the value of the training Via Hope offers for supervisors of peer specialists. The training is a 2-day course which clarifies the role, job functions, and skills that CPSs learn in the PSTC program. The purpose is to give supervisors a greater appreciation of the value of CPSs and to

demonstrate how they can be directed to work in the most effective manner possible in their organizations. Because these findings suggest that their support increases job satisfaction for peer specialists, supervisors should be encouraged to attend the training.

Table 24. Association of supervisor supportiveness with job satisfaction

	February-March	June-July
Mean (out of 10)	9.09	8.96
Median (out of 10)	10	10
Spearman's Rho correlation with job satisfaction	.36*	.42*

Note: Respondents used a 10-point scale where 1 indicated "not at all supportive" and 10 indicated "very supportive." Higher averages indicate greater support.
*=significant at the $p<.05$ level.

Support and Collaboration

The persistent stigma against peers held by some non-peer staff often breeds negative attitudes about these individuals accompanied by a devaluing of their role within an organization (Gates & Akabas, 2007). At the other end of the spectrum, it follows that the support of other non-peer staff at an organization plays a role in job satisfaction and efficacy for peer providers. On average, respondents reported the overall supportiveness of other non-peer staff as high. Average reported level of supportiveness of other staff increased between the first and second surveys (Table 25), which may be the result of increased acceptance of peer staff occurring over time or increased sense of confidence as the peer specialist acclimated to their role within the organization.

Table 25. Average reported supportiveness of non-peer staff

		February-March	June-July
How would you rate the overall level of supportiveness of other non-peer staff?	Mean	7.75	8.43
	Median	8.00	8.50

Note: Respondents used a 10-point scale where 1 indicated "not at all supportive" and 10 indicated "very supportive." Higher averages indicate greater support.

Other staff's level of supportiveness was associated significantly with several outcomes important to vocational wellbeing including nearly all measures of job satisfaction and the extent to which working as a peer specialist strengthened respondents' recovery at the time of the first survey, but many of these associations dissipated in the second survey (Table 26). One potential explanation for this change is that the factors which are most important to

job satisfaction are dynamic such that the relative importance of different factors fluctuates over time. For example, social support at work may be of great importance at the beginning of one's assignment as a peer specialist, during the time when group acceptance is being established. However, after a peer specialist has established him/herself as a viable part of the working group, other factors such as salary or access to resources may come to be of greater importance.

Table 26. Relationship of supportiveness of non-peer staff with measures of vocational wellbeing

Measure of vocational wellbeing	February-March	June-July
	Spearman's Rho correlation	
I am satisfied with my overall job experience.	.61**	.24
Working in my current position has positively impacted my recovery.	.46**	.29
I feel accepted and respected by my colleagues.	.67**	.22
My job description realistically reflects my actual job duties.	.56**	.35
My supervisor explains the skills or procedures I am expected to perform.	.59**	.48*
I feel I am able to do my current job well.	.40*	-.071
My supervisor listens to my suggestions, ideas, and opinions.	.38*	.17
I have experienced stigma as a result of the actions or words of my co-workers.	.00	-.04
Working as a peer specialist has helped strengthen my recovery... (on a scale of 1 to 10)	.41*	.25

Respondents were asked whether there were other consumers on staff at their organization. An increase was seen in the percentage of respondents who said that there were other consumers on staff between the first and second survey (Table 27). Of those who did work with other peers, the number of other consumer staff ranged from 1 to 14, although some were uncertain of this number and therefore the maximum could be higher. Most respondents who had other consumers on staff reported that they collaborated with other peer specialists on a regular basis (68.2% Survey 1; 84.2% Survey 2), while those who were the only consumer on staff generally did not collaborate with other peer specialists (88.9% Survey 1; 75% Survey 2). This can be explained simply by the notion that those who did

not work with other peers had fewer opportunities to collaborate. It seems likely that as the proportion of peer specialists working together continues to increase, so will the proportion that regularly collaborate with one another, strengthening the larger network of CPSs.

Table 27. Percentage of respondents with other consumers on staff at their organization

		February-March	June-July
Are there other consumers on staff at your organization?	No	23.7%	13.8%
	Yes	57.9%	69%
	I don't know	18.4%	17.2%

On-the-job collaboration with other peer specialists is an aspect which is important to working and communicating effectively as well as maintaining employment (ILRU, 2008); indeed, collaboration is of key importance in most jobs. An increase was seen between the first and second survey in the percentage of peer specialists who reported collaborating regularly with other peer specialists (Table 28). Respondents reported that the number of peer specialists that they collaborated with on a regular basis ranged from 1 to 10. Regular collaboration with other peer specialists may be an indication of the recovery orientation of the organization, and it may decrease risk for peer provider burnout that can occur as a result of over-reliance on one individual to render all peer support services. Additionally, this may be a marker for the organization's resource capacity for employing multiple peer providers.

Table 28. Percentage of respondents collaborating with other peer specialists on a regular basis

		February-March	June-July
Do you collaborate with other peer specialists on a regular basis?	No	48.7%	36.7%
	Yes	51.3%	63.3%

Career Ladder

Most respondents' organizations of employment did not have a "career ladder" for peer specialists (Table 29), in other words they did not perceive opportunity for advancement at their jobs. A career ladder was significantly associated with overall job satisfaction at the time of the first survey (r=.47, p=.006), but not at the time of the second survey.

Table 29. Percentage of respondents whose organizations had a "career ladder"

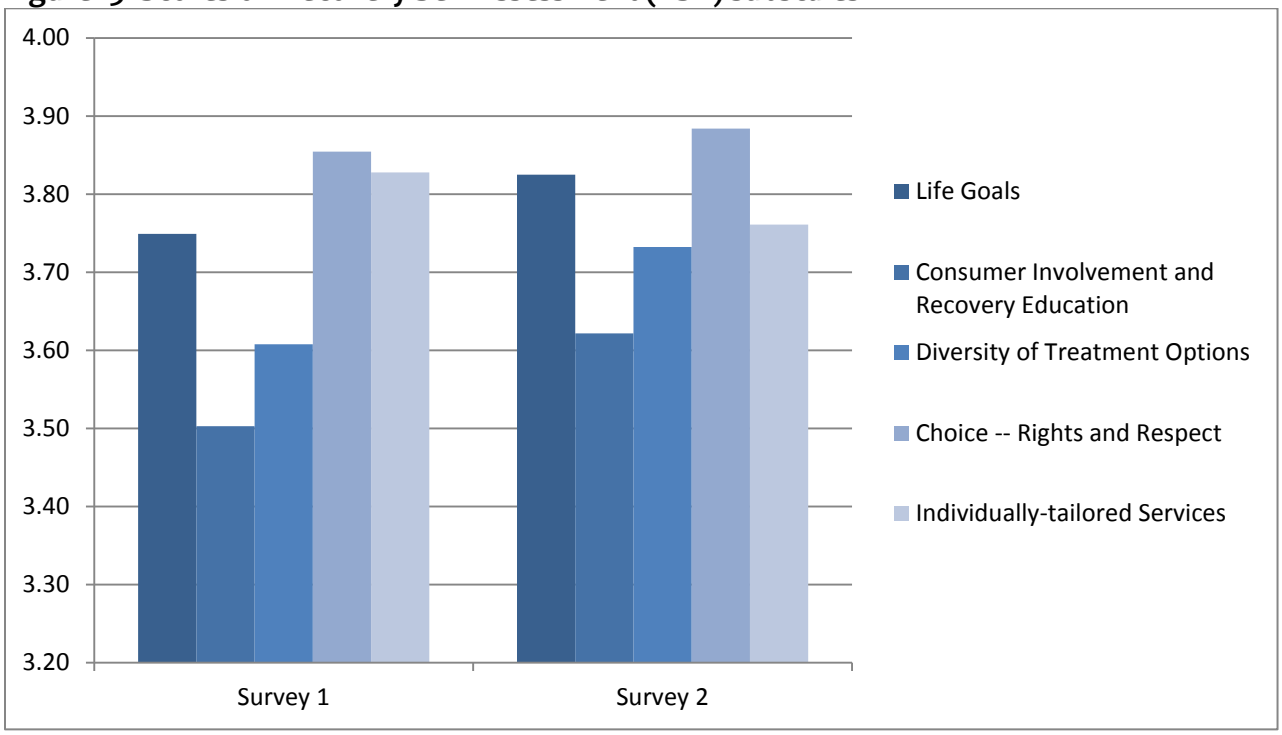
		February-March	June-July
Does your organization have a "career ladder" or opportunities for advancement for peer specialists?	No	75.8%	76.9%
	Yes	24.2%	23.1%

Organizational Recovery Orientation

The degree to which a peer specialist's organization of employment is recovery oriented indicates its strength in providing services which promote consumer recovery. As part of the online surveys, respondents completed the Recovery Self-Assessment (RSA; O'Connell, Tondora, Croog, Evans, & Davidson, 2005), which measures the degree to which recovery oriented practices are implemented in mental health program settings. Average total score on the RSA was moderately high and remained relatively stable between the first (*M*=3.73 out of 5) and second surveys (*M*=3.78 out of 5).

The instrument is also divided into five distinct subscales, scores on which provide insight into how the organization is performing in five domains that relate to recovery orientation (Figure 13). Average score (also on a 5-point scale) increased for all but one subscale, indicating that organizations were generally seen as improving in these areas. Across both survey times, the highest rated subscale was Choice – Rights and Respect (Survey 1 *M*=3.85; Survey 2 *M*=3.88), which relates to respectful treatment of consumers, access to treatment records, and assistance with referrals to external resources. Across both survey times, the lowest rated subscale was Consumer Involvement and Recovery Education (Survey 1 *M*=3.50; Survey 2 *M*=3.62), which relates to consumers being involved in the development and provision of programs/services, staff trainings, advisory functions, and community education.

Figure 13. Scores on Recovery Self-Assessment (RSA) subscales



Recovery orientation as assessed by the total RSA score was significantly associated with several components of job satisfaction, and these associations grew stronger in the second survey (Table 30). This continuity probably reflects that recovery-orientation increases the sustainability of improved outcomes for not only the organization but also its staff.

Table 30. Association of the Recovery Self-Assessment (RSA) with measures of job satisfaction

Measure of job satisfaction	February-March	June-July
	Spearman's Rho correlation	
I am satisfied with my overall job experience.	.28	.39*
Working in my current position has positively impacted my recovery.	.20	.66**
I feel accepted and respected by my colleagues.	.53**	.65*
My job description realistically reflects my actual job duties.	.43*	.53*
My supervisor explains the skills or procedures I am expected to perform.	.59**	.53**
I feel I am able to do my current job well.	.42*	.38
My supervisor listens to my suggestions, ideas, and opinions.	.34	.37
I have experienced stigma as a result of the actions or words of my co-workers.	-.20	-.22

Note: Respondents used a 5-point scale where 1 indicated "strongly disagree" and 5 indicated "strongly agree." Higher averages indicate stronger agreement.
*=significant at the $p<.05$ level; **=significant at the $p<.01$ level.

Total RSA is also associated with the confidence with which respondents reported using many of these skills in both surveys. This association was significant for five skills in the first survey, and increased to eight in the second survey (Table 31). This highlights a potential benefit of recovery-orientation that it promotes the effective use of essential CPS skills. Otherwise, increases in the effective use of CPS skills foster a recovery orientation within an organization.

Table 31. Respondents' confidence of use of peer specialist skills associated with organizational recovery orientation (Recovery Self-Assessment - RSA)

Skill	Survey Time	Confidence *M*(*SD*)	Spearman's Rho correlation with RSA
1. help consumers combat negative self-talk, overcome fears and solve problems	1	8.34(1.91)	.29
	2	8.94(1.39)	.44*
2. help a consumer articulate, set and accomplish his/her goals, including whole health and wellness goals	1	7.85(2.21)	.46*
	2	8.16(2.37)	.24
3. teach consumers to advocate for the services that they want	1	8.05(2.09)	.19
	2	8.90(1.45)	.27
4. help a consumer create a Person Centered Plan	1	6.85(2.74)	.36
	2	7.00(2.90)	.45*
5. create and facilitate a variety of group activities that support and strengthen recovery	1	7.37(2.75)	.14
	2	8.03(2.48)	.40*
6. articulate what has been helpful and what has not been helpful in your own recovery	1	8.88(1.74)	.27
	2	9.44(.80)	.20
7. identify the beliefs and values a consumer holds that work against his/her own recovery	1	7.93(2.15)	.42*
	2	8.59(1.50)	.46*
8. discern when and how much of your recovery story to share, and with whom	1	8.95(1.83)	.21
	2	9.56(.76)	.17
9. ask open ended questions that relate a person to his/her inner wisdom	1	8.22(1.82)	.37*
	2	8.34(1.91)	.43*
10. personally deal with conflict and difficult interpersonal relations in the workplace	1	7.80(2.12)	.41*
	2	7.81(2.29)	.57**
11. demonstrate an ability to participate in 'healing communication'	1	7.95(2.21)	.26
	2	8.22(2.11)	.45*
12. interact sensitively and effectively with people of other cultures	1	8.68(2.02)	.44*
	2	9.13(2.24)	.54**

Note: Respondents used a 10-point scale where 1 indicated "never" or "not at all confident" and 10 indicated "every day" or "very confident." Higher averages indicate greater frequency or confidence.

*=significant at $p<.05$ level; **=significant at $p<.01$ level

Conclusions

Nationally, many states are in the process of building their peer mental health workforce and peer-provided service infrastructure (Kaufman, Brooks, Steinley-Bumgarner, & Stevens-Manser, 2011) – Texas is keeping pace with this movement. One critical component of this growth is the training and certification of CPSs. There is an ongoing need for PSTC programs to cultivate peer specialists with improved mental health and vocational outcomes not only for themselves but also for the target populations they serve. Ultimately, training and certification programs should be cost-effective for the system which implements them as well as producing the greatest possible returns in the lives of the providers and the consumers whom they serve. In order to make evidence-based recommendations to expand and improve Texas' PSTC program, this evaluation links the structure and implementation of current program elements to trainee outcomes.

UT-CSWR evaluated personal and vocational outcomes for four cohorts of trainees in a new Texas PSTC program begun in FY2010. Evaluation surveys were administered at two follow-up time points (11 months and again at 14 months) post-training. Any changes that occurred in the outcomes between surveys were highlighted in this report. On some variables, outcomes remained relatively steady across survey times. When outcomes changed, whether in expected or unexpected directions, possible reasons for these fluctuations were explored.

Findings regarding the characteristics of the 2010 training cohorts of the PSTC program signal some issues that may exist before, during, and after this type of training. Consideration should be given to geographic diversity in screening applications for acceptance into the program. In a large state such as Texas, a multitude of regional cultural experiences, local mental health systems, and employment opportunities for peer specialists exist. Such an array of factors likely affects participant experiences with training and post-training vocational outcomes. Consideration should also be given to the racioethnic composition of trainees as a lack of diversity may result in issues with the culturally-competent delivery of peer support services. Outreach and education is needed to overcome mental health stigma in minority ethnocultural communities in order to increase the diversity of program applicants. The most commonly reported sources of financial support for respondents were earned income and SSDI. Many of the 2010 training cohorts were employed, but as more individuals currently working as peer specialists are trained, the number of trainees with previous work experience will dwindle. In order to tip the balance toward earned income and potentially away from SSDI, there is a need for a post-training focus on connecting peer specialists to employment opportunities.

Findings revealed that PSTC trainees are increasing their involvement in the behavioral health system through greater participation in consumer advocacy organizations as well as

greater use of mental health services for themselves. Participation in consumer advocacy organizations strengthens recovery by enhancing social support networks, empowering members, and fostering an increased sense of responsibility through members taking more active roles in mental health policy planning (Swarbrick, 2009). Additionally, evidence that long-term utilization of (and greater involvement in) peer support services facilitates greater recovery (Solomon, 2004) highlights the need for the PSTC to encourage the use of such services as needed for the CPSs themselves.

Outcomes of the training and certification process point to the need for changes to the curriculum itself as well as to the course implementation. Performance discrepancies between cohorts indicate the need to standardize training such that these differences are minimized or investigate the application process to determine if readiness affects training outcomes. Findings of Brooks and colleagues (2011) revealed ethnic differences in PSTC training and job satisfaction. The need for culturally-competent training was also recognized in the 2010 evaluation of this program (Steinley-Bumgarner et al., 2010). Furthermore, interest in cultural competency CEUs increased. All of this taken together suggests that cultural competency should be addressed both in PSTC training as well as in post-training education and should be assessed by the certification examination.

Via Hope should tailor curriculum content to the trainee population as well as offer CEUs aligned with trainee interests. Scores on skill area competencies were generally lower than on knowledge area competencies. A likely explanation is that the training program lacks emphasis on skill-building; in other words, there was more focus on increasing conceptual knowledge versus hands-on job skills. This ongoing issue was previously recognized by trainees in the 2010 evaluation of this program (Steinley-Bumgarner et al., 2010). This finding combined with the increase seen in the number of CPSs facilitating support groups at the time of the second survey suggests that the PSTC program could enhance skills training, either during training or through post-training continuing education, to better prepare CPSs for the tasks they are increasingly performing at work.

Trainees reported a variety of experiences with their recovery journeys, informing a better understanding of how PSTC training and employment affect recovery. The finding that substance abuse was reported as a primary diagnosis indicates an area to explore in the application process as policy states that a mental health diagnosis must be primary for program eligibility. An increase between surveys in respondents' strengthening of recovery through working as a peer specialist is probably due to continued experience working as a CPS. Also, the finding that respondents of both surveys thought that working as a peer specialist strengthened their personal recovery to a greater extent than did training may indicate the relative effectiveness of these mechanisms in reinforcing recovery. In other words, learning recovery concepts is not as effective at reinforcing recovery as is the application of this knowledge.

Employment outcomes found in these surveys offer insights into the work experience of trained CPSs in Texas as well as the factors related to their job satisfaction. As evidenced by the great diversity of jobs which CPSs held, this group has found employment in a variety of settings. Furthermore, many reported having job descriptions for their position, a subtle but robust indicator of standardization and integration of CPSs within the mental health field. An increase in the average number of hours worked by CPSs could indicate an increased value given to the role of trained peer specialists within organizations. Also, an increase in the proportion of salaried workers accompanied by a decrease in hourly pay workers parallels the increase seen in full time employees and decrease in part time employees.

Regarding services rendered, a shift was seen toward more regular provision of direct mental health services by CPSs, representing a paradigm shift in which peer specialists are regarded as professionals in a recovery-oriented system of care. Peer specialists are increasingly performing the task of facilitating support groups, however they still lack training in this skill both in the PSTC program and in continuing education. Like support group facilitation, training related to skills that are billable to Medicaid could also be incorporated into either the PSTC program, post-training CEU classes, or offered by employers as part of in-house training. One of tasks performed least by respondents is medication monitoring; medication training and support is one of three Medicaid billable services of CPSs, however it is the least billed for across the state of Texas (Kaufman, Brooks, & Stevens-Manser, 2011). As the number of certified peer specialists continues to grow, fewer applicants will have previous work experience making the PSTC program a more critical window in which to provide CPSs with skills training before they begin providing services.

Job satisfaction of peer specialists seems to be related to a number of intrapersonal, interpersonal, and organizational factors. Findings suggest that the frequency of supervision and the supportiveness of one's supervisor may affect the satisfaction of peer specialists with their jobs. Potential ways to approach such issues include encouraging the training of supervisors in being supportive of peer specialists and establishing an optimal level of supervision. Furthermore, the supportiveness of other non-peer staff affects how comfortable peer specialists feel at their jobs. If PSTC training extended beyond peers themselves and also facilitated non-peer staff in playing a more collegial role for CPSs, it could increase the acceptance of peer staff on the front end - where it may be most important. The finding that the supportiveness of other non-peer staff became less important to peers' satisfaction in the second survey suggests that factors contributing to job satisfaction are dynamic over time. Finally, recovery orientation was found to be associated with job satisfaction at both survey times, suggesting that a recovery-orientation sustains more positive outcomes through the use of recovery-oriented CPS skills. Like the PSTC program itself, what occurs following training and certification is important to the satisfaction and wellbeing of CPSs and to the advancement toward a recovery-oriented system of care.

Because participant characteristics between the two samples of survey respondents were generally consistent, it is likely that differences in outcomes were due to external variables and not to preexisting differences. Thus, it is concluded that there are real and continuing effects resulting from the Texas PSTC program and from subsequent employment as a CPS. This evaluation has demonstrated that the PSTC and associated vocational outcomes have great potential to make a meaningful impact on the lives of individuals in recovery, which will impact the mental healthcare system as a whole. Great care should be taken in implementing program improvements and performing ongoing evaluation of the PSTC program which will improve outcomes for trainees, the consumers they serve, and the public mental health system. Recommendations based on the findings are outlined in the following section.

Recommendations

SCREENING

- Implement greater oversight of the screening and admission process to ensure that trainees who intend to provide billable services meet all of the requirements of a peer provider set forth by Via Hope and the TAC. Specifically, the following requirements should be verified before accepting these applicants into the training program:
    - Primary diagnosis is mental health
    - High school diploma or GED
    - Received mental health services for a total of one year
        - *Note:* Discrepancies between Via Hope's applicant eligibility checklist and the requirements set forth in the policy and procedure manual should be reconciled to eliminate confusion and standardize the admissions process. For example, the application checklist indicates that candidates should have at least one year of recovery experience while the policy and procedure manual indicates only that candidates should be "far enough along" in recovery to cope with CPS job stress.

- Consideration should be given to the need for peer specialists in geographically underrepresented areas. Efforts should be applied toward recruitment from underrepresented areas so that CPS trainees represent a wide diversity of regional cultural experiences.

- Related to increasing geographic diversity, future efforts should focus on recruiting/accepting more racially/ethnically diverse cohorts in order to promote a more culturally-competent delivery of peer support services to the diverse populations of Texas. This may require outreach and education to under-represented groups.

TRAINING

- The factors that led to exam performance discrepancies between cohorts should be closely examined and training (as well as the application process) should be standardized accordingly in order to minimize those differences. If differences were the result of instructor differences, Via Hope should work with the trainers to develop the skills to effectively teach the class; otherwise, trainees may be differentially prepared to provide services in the field.

- Skill-building could be better incorporated into and emphasized throughout the training curriculum so that peer specialists are prepared to perform essential job tasks such as facilitating support groups. As skill building occurs over time and is more successful with coaching, continuing education and / or ongoing coaching should be considered.

- Cultural competency should be addressed as an ongoing need throughout the training, post-training, employment trajectory so that both training in provision of peer support services and the services themselves are equally effective for diverse populations. Incorporating cultural competency into training and CEUs was also a recommendation cited in the 2010 evaluation (Steinley-Bumgarner et al., 2010).

- Findings suggest that supervisor support increases job satisfaction for peer specialists. For this reason, supervisors should be encouraged to attend Via Hope's training for supervisors of peer specialists, which is designed to give supervisors a greater appreciation of CPSs' value within the organization.

- Develop a training program for non-peer staff to educate them about recovery and peer specialists in order to reduce stigma and increase job satisfaction.

EXAM

- There is a need to ensure, via exam questions, that all curriculum competencies have been attained. In order for this to occur, the option to skip questions would need to be revoked and exam questions should assess all competencies. This need was also cited in the FY2010 evaluation.

- To ensure that the exam itself does not have unintended effects on the pass/fail rate, a review of item analyses (item difficulty, item discrimination) after each exam and across exams is needed to identify items which should be revised or excluded. This was also a recommendation cited in the 2010 evaluation (Steinley-Bumgarner et al., 2010).

- Exam scores, particularly deficiencies in specific competency areas, should be used to bolster the curriculum and identify opportunities for continuing education.

CONTINUING EDUCATION

- CEU classes should be offered that align with trainee interests and needs to ensure that peer specialists are empowered to direct their own mental health education while simultaneously tailoring it to align with the needs of the consumer population.
    - Interests may continuously change, so it's important to communicate with CPSs periodically to ensure their needs are met.

- The finding that interest levels in CEUs remained steady in the areas of leading/facilitating support groups, documentation, accessing community resources, and self-advocacy indicates that skill-building should be better incorporated into the post-training education trajectory.

- There is a need to increase awareness surrounding pre-approved activities, such as conferences and trainings, in order to enhance CEU attainment.

- Allowing completion of other peer related trainings to fulfill CEU requirements would enhance CEU attainment.

POST-TRAINING SUPPORT

- Post-training supports should be established which connect peer specialists to one another and with consumer advocacy organizations through membership to promote increased involvement in the mental health system and allow peers to network with one another.

- Post-training efforts should be applied to not only increasing awareness of local consumer meetings, but also promoting participation through various methods (e.g., periodic announcements). This is important because peers who regularly attended these meetings claimed that attendance helped them to strengthen their own recovery and helped them act as advocates in the recovery of others whom they served.

- The PSTC should encourage the use of mental health services as needed throughout a lifetime, even after becoming a CPS. The recovery journey of the provider does not end with certification and receiving services should not be stigmatized.

- To connect CPSs to employment opportunities, Via Hope should consider implementing a job bank or database of available peer specialist jobs in Texas on the Via Hope website so that peers are made aware of employment opportunities.

- Post-training support of CPSs includes support and education for their employers. The supervision training was received positively and should be continued.

References

Brooks, W., Kaufman, L., Steinley-Bumgarner, M., & Stevens-Manser, S. (2011). *Assessing cultural competency in a peer specialist training and certification program*. Manuscript submitted for publication, University of Texas at Austin Center for Social Work Research.

Centers for Medicare & Medicaid Services. (2007). *State Medicaid Director Letter #07-011*. Retrieved August 23, 2011 from http://www.cms.gov/SMDL/downloads/SMD081507A.pdf

Department of Health and Human Services & Administration for Children and Families. (2009, March 13). State median income estimate for a four-person family: Notice of the federal fiscal year (FFY) 2010 state median income estimates for use under the low income home energy assistance program (LIHEAP). Retrieved from http://federalregister.gov/a/E9-5412

Gates, L. & Akabas, S. (2007). Developing strategies to integrate peer providers into the staff of mental health agencies. *Administration and Policy in Mental Health & Mental Health Services Research, 34*, 293-306. doi:10.1007/s10488-006-0109-4

Independent Living Research Utilization Community Living Partnership. (2008). *Policy issue #2: Introducing and supporting peer providers in traditional mental health provider networks.* Houston, TX: O'Brien, J., Tiegreen, W.W., & Campbell, J.

Kaufman, L., Brooks, W., Steinley-Bumgarner, M., & Stevens-Manser, S. (2011). *Overview of peer specialist training and certification programs in the United States.* Manuscript submitted for publication, University of Texas at Austin Center for Social Work Research.

Kaufman, L., Brooks, W., & Stevens-Manser, S. (2011). *Peer-Provided Services and Medicaid Billing at the Local Mental Health Authorities in Texas.* Austin, TX: University of Texas at Austin Center for Social Work Research.

Kaufman, L., Stevens-Manser, S., Espinosa, E., & Brooks, W. (2011). *Consumer Operated Service Providers and Local Mental Health Authorities: Assessment of Current Models, Training, and Technical Assistance Needs.* Austin, TX: University of Texas at Austin Center for Social Work Research.

Mental Health Rehabilitative Services, Tex. Admin. Code. 31 TexReg 6343 (2006).

O'Connell, M., Tondora, J., Croog, G., Evans, A., & Davidson, L. (2005). From rhetoric to routine: Assessing perceptions of recovery-oriented practices in a state mental health and addiction system. *Psychiatric Rehabilitation Journal*, *28* (4), 378-386. doi:10.2975/28.2005.378.386

Richert, A. J. (2006). Narrative psychology and psychotherapy integration. *Journal of Psychotherapy Integration, 16* (1), 84-110. doi:10.1037/1053-0479.16.1.84

Salzer, M., Katz, J., Kidwell, B., Federici, M., & Ward-Colasante, C. (2009). Pennsylvania certified peer specialist initiative: Training, employment, and work satisfaction outcomes. *Psychiatric Rehabilitation Journal, 32* (4), 301-305.

Sinclair, C. (2009). The implementation of a consumer-provider program: The launching of a peer health worker program at Pathways to Housing, Inc., Washington, DC. (Unpublished master's thesis). University of Calgary, Canada.

Solomon, P. (2004). Peer support/peer provided services underlying processes, benefits, and critical ingredients. *Psychiatric Rehabilitation Journal, 27* (4), 392-401. Retrieved from EBSCO*host*.

Steinley-Bumgarner, M., Kaufman, L., Stevens-Manser, S., & Murphy-Smith, M. (2010). *Peer Specialist Training and Certification Program Evaluation Report: October 2010*. Austin, TX: University of Texas at Austin Center for Social Work Research.

Swarbrick, M. (2009). Historical perspective -- from institution to community. *Occupational Therapy in Mental Health*, *25* (3-4), 201-223. Retrieved from EBSCO*host*.

Texas Department of State Health Services. (2011). [Billing Codes Utilized by Local Mental Health Authority Centers for Peer Services]. Unpublished raw data.

Appendix A
PSTC Curriculum Competencies

Competency	Module	
An understanding of the job and the skills needed to perform that job		
Understand the basic structure of the state's mental health system and how it works	3	State System and the Role of the Training
Understand the Certified Peer Specialist (CPS) job description and Code of Ethics within the state's mental health system	3 18 23	State System and the Role of the Training Peer Specialist Ethics and Professional Boundaries The Pillars of Peer Support Services
Understand the meaning and role of peer support	5	The Role of Peer Support in the Recovery Process
Understand the difference between treatment goals and recovery goals, and be able to create and facilitate a variety of group activities that support and strengthen recovery	10 22	Facilitating Recovery Dialogues Creating the Life One Wants
Be able to help other consumers to combat negative self-talk, overcome fears, and solve problems	13 14 15	Facing One's Fears Combating Negative Self-Talk Problem Solving with Individuals
Be able to help a consumer articulate, set and accomplish his/her goals, including whole health and wellness goals	22 25 26, 27, 28 29	Creating the Life One Wants Introduction to Peer Support Whole Health Person-Centered Planning for Peer Support Whole Health, Parts 1, 2, 3 Implementing the 5 Keys to Success
Be able to teach other consumers to advocate for the services that they want	19, 20, 21	Power, Conflict and Integrity in the Workplace, Parts 1, 2, 3
Be able to help a consumer create a Person Centered Plan	25 26, 27, 28 29	Introduction to Peer Support Whole Health Person-Centered Planning for Peer Support Whole Health, Parts 1, 2, 3 Implementing the 5 Keys to Success

Competency	Module	
An understanding of the recovery process and how to use their own recovery story to help others		
Understand the five stages in the recovery process and what is helpful and not helpful at each stage	4	Five Stages in the Recovery Process: Overview
Understand the role of peer support at each stage of the recovery process	4 5	Five Stages in the Recovery Process: Overview The Role of Peer Support in the Recovery Process
Understand the power of beliefs / values and how they support or work	7 8	Creating Program Environments That Promote Recovery Exploring Beliefs That Promote Recovery
Understand the basic philosophy and principles of psychosocial rehabilitation	7 10	Creating Program Environments That Promote Recovery Facilitating Recovery Dialogues
Understand the basic definition and dynamics of recovery	2 4	Overview of the Training Five Stages in the Recovery Process: Overview
Be able to articulate what has been helpful and not helpful in his / her own recovery	6	Using Your Recovery Story as a Recovery Tool
Be able to identify the beliefs and values a consumer holds that works against his/her own recovery	8 9 11, 16/17	Exploring Beliefs That Promote Recovery The Dynamics of Change Effective Listening and the Art of Asking Questions, Parts 1, 2, 3
Be able to discern when and how much recovery story to share, and with whom	6 11, 16,17	Using Your Recovery Story as a Recovery Tool Effective Listening and the Art of Asking Questions, Parts 1, 2, 3

Competency	Module	
An understanding of, and the ability to establish healing relationships		
Understand the dynamics of power, conflict, and integrity in the workplace	19, 20, 21	Power, Conflict and Integrity in the Workplace, Parts 1, 2, 3
Understand the concept of 'seeking out common ground'	19, 20, 21	Power, Conflict and Integrity in the Workplace, Parts 1, 2, 3
Understand the meaning and importance of cultural competency	*	*Not addressed by Via Hope curriculum.*
Be able to ask open ended questions that relate a person to his/her inner wisdom	11 12 16, 17	Effective Listening and the Art of Asking Questions, Part 1 Dissatisfaction as an Avenue for Change Effective Listening and the Art of Asking Questions, Parts 2 and 3
Be able to personally deal with conflict and difficult interpersonal relations in the workplace	18 19, 20, 21	Peer Specialist Ethics and Professional Boundaries Power, Conflict and Integrity in the Workplace, Parts 1, 2, 3
Be able to demonstrate an ability to participate in 'healing communication'	11 12 16, 17 19, 20, 21	Effective Listening and the Art of Asking Questions, Part 1 Dissatisfaction as an Avenue for Change Effective Listening and the Art of Asking Questions, Parts 2 and 3 Power, Conflict and Integrity in the Workplace, Parts 1, 2, 3
Be able to interact sensitively and effectively with people of other cultures	*	*Not addressed by Via Hope curriculum.*

Source: Adapted from Steinley-Bumgarner et al.'s (2010) *Peer Specialist Training and Certification Program Summary Report: October 2010.*

Appendix B
PSTC Modules

Modules		Description
1	Welcome and Introductions	People with psychiatric diagnoses are coming together across the country as major players in system transformation. Session 1: Welcome and Introductions provides an opportunity for the group to create a common understanding and guidelines for an effective training experience.
2	Overview of the Training	Over the past 10-15 years, there have been major shifts in mental health systems to support recovery. Session 2: Overview of the Training gets out the major concepts, beliefs and images that will be explored and explained throughout the training.
3	State System and the Role of the Training	The Texas mental health system is making a shift toward recovery, and consumers have a key role to play in supporting this shift. Session 3: The State System, Peer Specialists and the Role of Training explains why participants are attending this training course, and how it fits into what is happening in the state.
4	Five Stages in the Recovery Process: Overview	Creating a common understanding for the term "recovery" and common language to talk about recovery is very important in the transformation of the mental health system. Session 4: Five Stages in the Recovery Process presents some common images and language for discussing recovery and introduces five basic stages in the recovery process that seem to speak to most people with recovery experience.
5	The Role of Peer Support in the Recovery Process	Consumers have a special and unique role to play in promoting and supporting the recovery process. Session 5: The Role of Peer Support in the Recovery Process helps the participants think and share in a systematic way the unique role of the Peer Specialist and how that role differs from the role of traditional staff - or non-consumer providers.

Modules		Description
6	Using Your Recovery Story as a Recovery Tool	One of the major "recovery tools" that consumers bring to a mental health service is their own experience and recovery story. Session 6: Using Your Recovery Story as a Recovery Tool explores the difference between an "illness story" and a "recovery story" and helps participants experience the power and potential of their own story as a recovery tool to be used to educate and inspire peers and non-peer staff.
7	Creating Program Environments That Promote Recovery	Staff do not have control over community and home environments of the people they serve, but they do have control over program environments. It is very important that program environments become environments that promote recovery. Session 7: Creating Program Environments That Promote Recovery explains how negative messages keep people from moving forward with their lives, and what it means to surround people with the possibility of recovery.
8	Exploring Beliefs That Promote Recovery	The beliefs of the mental health system need to be seriously examined to determine whether or not they promote and support the recovery process and agreement needs to be reached on those that do. Session 8: Exploring Beliefs that Promote Recovery shares some of the emerging beliefs of the mental health system that promote and support the recovery process.
9	The Dynamics of Change	Recovery – or moving on with one's life – always involves changing our thinking and acting. Session 9: The Dynamics of Change explains the how and why people change and why change is so difficult to sustain.
10	Facilitating Recovery Dialogues	Many Peer Specialists have opportunities to lead groups, but good, recovery-focused group discussion material is not always readily available. Session 10: Facilitating Recovery Dialogues presents guidelines and procedures for facilitating Recovery Dialogues that can be used in mental health programs.

Modules		Description
11	Effective Listening and the Art of Asking Questions, Part 1	It is important that we learn to listen and help people who have been "disabled" by the old system to get in touch with their passion and potential for creating the life they want. Session 11: Effective Listening and the Art of Asking Questions: Part 1 demonstrates effective listening and the art of asking questions and the kinds of questions that are helpful and not helpful in putting a person in touch with his or her own inner wisdom.
12	Dissatisfaction as an Avenue for Change	It is important that we find ways to help people get in touch with their passion and potential for creating the future that they want. Session 12: Dissatisfaction as an Avenue for Change shares a process of asking questions that help people reflect on their lives and make their own decisions about what they want to work on in their lives.
13	Facing One's Fears	Even though a person may be in touch with what he wants, there are many things that keep him from believing that he can create the life he wants. One block to creating the life that a person wants is his fears. Session 13: Facing One's Fears provides a safe environment for discussing uncomfortable feelings and thoughts and explores what is involved in learning to handle them.
14	Combating Negative Self-Talk	Another major block to creating the life that one wants is one's negative self-talk. Session 14: Combating Negative Self-Talk explores a variety of ways to catch, check and change negative self-talk in order to prevent the spiral into frustration, depression and/or despair.
15	Problem Solving with Individuals	Another block to creating the life that a person wants is the belief that a person needs to be "fixed" by someone else, because she does not have the ability to solve her own problems. Session15: Problem Solving with Individuals shares a problem solving process that can be very helpful in finding solutions to many problems.

Modules		Description
16, 17	Effective Listening and the Art of Asking Questions, Part 2, Part 3	There are certain kinds of questions that are more helpful than others in helping a person get in touch with his or her own inner wisdom. Sessions 16 & 17: Effective Listening and the Art of Asking Questions: Parts 2 & 3 examine the sessions on Dissatisfaction as an Avenue for Change, Facing One's Fears, Combating Negative Self-talk, and Problem Solving in order to identify the kinds of questions that are most helpful.
18	Peer Specialist Ethics and Professional Boundaries	Peer Specialists are not clinical professionals, but they must do their jobs professionally and ethically. Session 18: Peer Specialist Ethics and Professional Boundaries presents a model Code of Ethics to help guide peer specialist service delivery.
19, 20, 21	Power, Conflict and Integrity in the Workplace, Part 1, Part 2, Part 3	Peers working in the system as providers, and the shift to recovery, bring a dynamic to the workplace that can cause interpersonal conflict. Sessions 19, 20 & 21: Power, Conflict and Integrity in the Workplace: Parts 1, 2 & 3 explore a variety of potential areas of conflict in the workplace, presents some of the basic techniques of mediation and conflict resolution and offers an opportunity to practice these in group role-play and small group settings.
22	Creating the Life One Wants	Once people are in touch with their passion and potential for creating the life they want and have set a goal, they need to know how to create an action plan for accomplishing that goal. Session 22: Creating the Life that One Wants: Accomplishing Recovery Goals discusses the difficulty of sustaining change in one's life and shares basic steps for accomplishing a goal.
23	The Pillars of Peer Support Services	Peer support services are emerging as an important addition to the array of services available in the mental health system. Session 23: The Pillars of Peer Support Services describes the 25 Pillars of Support that are helpful in creating and sustaining a peer support specialist workforce.
24	Check-in and Transition to Peer Support Whole Health	*No description provided.*

Modules		Description
25	Introduction to Peer Support Whole Health	Peer Support Whole Health is a person-centered planning process that: 1) looks comprehensively at a person's health life-style; 2) is a strength-based and focuses on a person's strengths, interests and natural supports; 3) stresses creating new health life-style habits and disciplines; and 4) provides peer support delivered by peer specialists to promote self-directed whole health.
26	Person-Centered Planning for Peer Support Whole Health, Part 1	This session introduces the Five Keys to Success and The Importance of a Goal in Creating the Life that One Wants. The following lifestyle areas are reviewed: healthy eating, physical activity, and restful sleep.
27	Person-Centered Planning for Peer Support Whole Health, Part 2	The following lifestyle areas are reviewed: stress management, service to others, and social network.
28	Person-Centered Planning for Peer Support Whole Health, Part 3	This session introduces the SMART process for setting and clarifying a whole health goal.
29	Implementing the Five Keys to Success	This session covers the following Five Keys to Success 1) A Person-Centered Goal 2) A Weekly Action Plan 3) Daily/Weekly Personal Log 4) Peer Accountability 5) Peer Support Group

Modules		Description
30	Final Reflections and Next Steps	It is important that we take a look back at the training course and look at next steps. Session 30: Final Reflections and Next Steps gives the group the opportunity to evaluate the overall training experience and to discuss the next steps in each individual's journey and the journey of the group as a whole.

Source: Adopted from Steinley-Bumgarner et al.'s (2010) *Peer Specialist Training and Certification Program Summary Report: October 2010.*