REPORT / THE PEER SPECIALIST WORKFORCE IN TEXAS

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The Peer Specialist Workforce in Texas:

Training and Certification, Workforce Outcomes, and Workforce Integration

Submitted to the Texas Health and Human Services Commission

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Introduction

Peer Specialist Workforce

Peer specialists are individuals who are in recovery from mental health issues and are employed to support people receiving mental health services (Davidson, Chinman, Sells, & Rowe, 2006; Gates & Akabas, 2007). Recent research suggests that peer specialists improve outcomes for people with mental health issues by increasing engagement and activation in services (Craig, Doherty, Jamieson-Craig, Boocock, & Attafua, 2011; Druss et al., 2010), reducing hospitalizations (Clarke et al., 2000) and increasing socialization (Craig et al., 2011; Rivera, Sullivan, & Valenti, 2007).

In a recent Texas Health and Human Services Commission (HHSC, 2016) survey of providers and people receiving services in the Texas state behavioral health system, respondents ranked the availability of peer services as one of the top strengths of the current behavioral health system; however, the survey also identified limited access to peer services as a service gap. The use of peer services was listed as *Gap 8* in the *Texas Statewide Behavioral Health Strategic Plan* (HHSC, 2016), with increasing access to peer services identified as a cost-effective strategy to expand the behavioral health workforce and reduce reliance on crisis, inpatient, and other restrictive levels of care. In an effort to address this service gap, it is important to better understand peer specialists' experiences working in the Texas mental health system.

National and Texas research has found that effective workplace integration and job satisfaction are critical to the success of the peer provider workforce (Davidson et al., 2006; Grant, Reinhart, Wituk, & Meissen, 2012; Kuhn, Bellinger, Stevens-Manser, & Kaufman, 2015). Previous research on Texas peer providers has identified several domains that are critical to peer specialist integration (PSI), including collaborative working relationships, career advancement and development, funding, organizational culture, recruitment and hiring, role clarity, supervision, and training (Earley, Lodge, Kuhn, Daggett, & Stevens Manser, 2016). This research also suggests that there are several ways that peer specialists are not integrated into Texas mental health organizations (Earley et al., 2016) and what limited longitudinal data exists on this workforce suggests low employee retention rates (Via Hope, 2016a).

Purpose of Project

Via Hope has trained and certified 827 peer specialists (current as of the end of 2016) since 2010 (Via Hope, 2016a). The Texas Institute for Excellence in Mental Health (TIEMH) is contracted by the Texas Health and Human Services Commission (HHSC) to evaluate employment outcomes for peer specialists who have completed the state-recognized Via Hope Peer Specialist Training and Certification program. Towards that end, in fiscal year 2017 TIEMH researchers administered a survey measuring peer specialist employment outcomes as well as conducted 25 in-depth interviews with a subset of peer specialists. Data collection efforts focused on the following topics: 1) the Via Hope training and certification program, 2) working as a peer specialist in Texas, and 3) peer specialist integration (PSI) in Texas. TIEMH researchers were also interested in examining the perspectives of individuals who are currently working as a peer specialist in comparison to individuals who previously worked as a peer specialist to gain insight into peer workforce retention issues. Thus, when possible, the data are presented by these two categories.

Methods

Survey

Survey development. A team of researchers familiar with the peer specialist workforce in Texas convened to discuss the purpose of the survey and to review the survey administered the previous year. Each survey item was reviewed and either revised or removed. Further, some new items were added based on knowledge acquired since the last survey administration. The final survey, which contained a maximum of 80 items for each respondent, examined the following areas: participant characteristics/demographics, training and certification, personal recovery, vocational status, and the recovery orientation of employer organizations. See Appendix A for a full list of survey questions.

Recruitment. Recruitment efforts targeted individuals who are currently or have previously worked as a peer specialist in addition to individuals who have an active or inactive peer specialist certification status. Survey respondents were primarily recruited through email. Researchers obtained a list from Via Hope staff, which included the email addresses of most individuals who have ever attended a peer specialist training offered by Via Hope, regardless of current certification status. Of the 718 individuals with email addresses, 221 (30.8%) had an inactive certification status at the time of survey recruitment. In addition to email, respondents were recruited through flyers. Electronic versions of the flyers were distributed through peer specialist-related email distribution lists maintained by Via Hope, while paper versions of the flyers were distributed at in-person trainings and conferences hosted by Via Hope.

Survey administration. Survey administration took place over a period of three weeks between November and December 2016. Potential participants were sent an initial email invitation at the beginning of survey administration and a follow-up reminder email invitation one week before the end of survey administration. The email invitation included information about the purpose of the survey, the estimated time to complete (20 minutes), and a link that redirected the individual to the survey, which was administered through the web-based system, Qualtrics. To protect anonymity, Qualtrics settings were enabled so that no names, email addresses, or IP addresses were stored with the data. Upon clicking the survey link, participants were directed to an introductory consent page describing the survey, any risks, and the ability to discontinue participation at any time without incurring negative consequences. Upon completion of the survey, participants were eligible to enter into a drawing for one of five $50 gift cards. If interested in entering the drawing, participants were redirected to a separate form at the end of the survey to provide their first name, email address, and phone number in which to be contacted if they were selected as a winner. This information was not linked to the survey data. Upon survey completion, participants were also provided the option of participating in an interview to share their experiences in a more qualitative manner. The process of signing up for an interview was similar to entering into the gift card drawing (i.e., a link at the end of the survey redirected participants to a separate form to sign up to participate in the interview).

Analysis. Survey data were downloaded from Qualtrics and analyzed with SPSS v24. Descriptive results are presented in this report.

Interviews

Recruitment. To gain a more complete understanding of the diversity of experiences of individuals who have completed Via Hope's training and certification program, TIEMH researchers sought to interview four specific groups: 1) individuals currently certified by Via Hope and currently employed as a peer specialist, 2) individuals currently certified by Via Hope and previously employed as a peer specialist, 3) individuals previously certified by Via Hope and currently employed as a peer specialist, and 4) individuals previously certified by Via Hope and previously employed as a peer specialist. These four groups were selected to more fully understand individuals' motivations related to maintaining their certification as well as working as a peer specialist.

Survey. Upon completion of the survey, respondents were invited to sign up to participate in a phone interview. Forty-eight eligible individuals signed up for an interview in this round of recruitment, the overwhelming majority (n=37) of whom were currently employed and currently certified (Group 1). In order to select individuals within Group 1 to interview, researchers first stratified the group by region in Texas and then within those regions selected individuals who worked at diverse types of organizations. Individuals selected to participate were emailed or called to schedule an interview. If these individuals did not respond to schedule requests, an alternate individual from the same region was contacted. Because there were very few individuals from the other three groups, researchers attempted to interview all individuals in these groups who signed up (although not all individuals who signed up for interviews responded to schedule requests).

Targeted email. In a second round of recruitment, TIEMH researchers sent emails to individuals on Via Hope's list of individuals who have completed the training and certification program but who have not maintained their certification. This recruitment method yielded five interview sign-ups.

Snowball sampling. In a third recruitment round, TIEMH researchers reached out to peer specialists who had completed the interviews and/or who had participated in prior workgroups or research activities with TIEMH to ask for their help in recruiting participants – particularly participants who have not maintained their certification. Researchers also drew on other informal networks in this round. This recruitment method yielded three sign-ups.

Social media. In a final recruitment round, researchers posted on the TIEMH Facebook and twitter pages inviting participants to sign up for interviews. This round yielded four interview sign-ups, but all four were from Group 1.

Table 1: Interview Recruitment Groups

Sign-Ups	Survey	Targeted Email	Snowball	Social Media	Interviewed
Active, Employed (Group 1)	37	2	2	4	12
Active, Previously Employed (Group 2)	8	1	1	0	8
Inactive, Employed (Group 3)	0	2	0	0	2
Inactive, Previously Employed (Group 4)	3	0	0	0	3
Total	48	5	3	4	25

Interview Schedule. Interview questions differed for each group (see Appendix B for all four interview schedules), but generally focused on experiences with the Via Hope training and certification process (including things participants did and did not like about the process), motivations for maintaining or not maintaining certification, challenges maintaining certification, likes/dislikes about providing peer services, and peer specialist integration (PSI) at the organization they provide/provided peer services. Interviewees were also asked about several PSI domains: career advancement and development, collaboration, funding, organizational culture, recruitment and hiring, role clarity, and supervision. All interviews were conducted via phone at a time convenient for participants.

Three researchers conducted interviews, which lasted between 19 and 93 minutes (average: 43 minutes). With interviewees' permission, interviews were recorded and professionally transcribed. Interviewees were assigned pseudonyms and received a $25 Amazon.com gift card for their participation.

Analysis. Analysis was guided by a grounded theory approach whereby codes emerged from the data and were not predetermined prior to analysis (Charmaz, 2006) and was completed using NVIVO qualitative data analysis software (QSR International, 2012). Codes were developed iteratively and constantly refined – that is some codes were merged while others were disaggregated as more data were analyzed. To establish validity and inter-coder reliability, two researchers were involved in the coding process (Campbell, Quincy, Osserman, & Pederson, 2013). In the first step towards establishing inter-coder reliability, two researchers independently coded one interview transcript line-by-line. Codes that emerged from this process were recorded in a codebook with precise and concrete definitions. The two researchers then met to compare coding decisions line-by-line, refining and revising codes until consensus was achieved. This process was then repeated three more times, such that inter-coder consensus was established for one transcript from each of the four interview groups. The remaining 21 transcripts were then coded line-by-line by one researcher. Finally, five members of the research team met to discuss and refine the final coding scheme.

Table 2 provides a visual representation of the categories that emerged within the topics of: 1) Training and Certification, 2) Working as a Peer Specialist, and 3) Peer Specialist Integration. Within each of the categories listed below, numerous codes emerged which will be presented in the results.

Table 2: Interview Topics and Categories

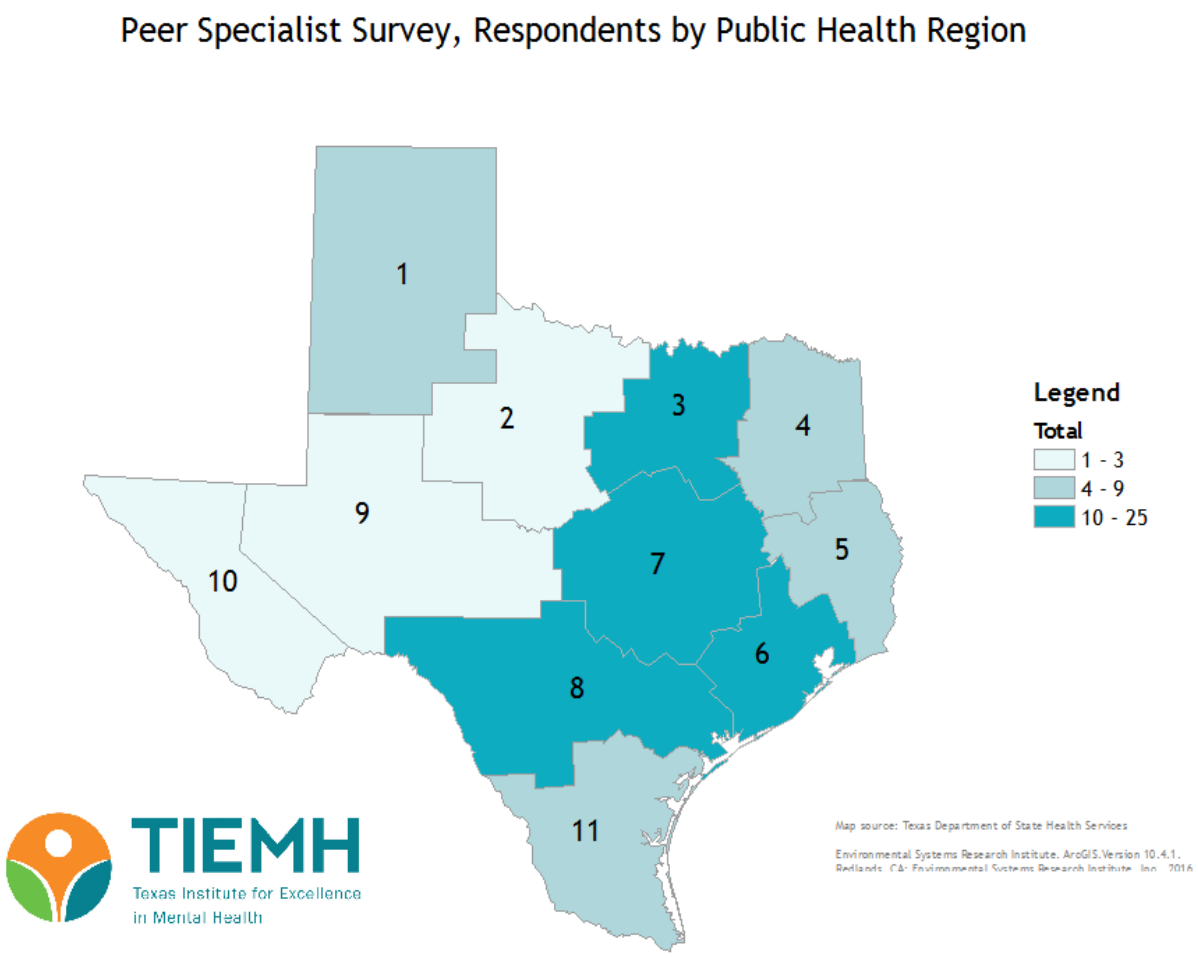
Training and Certification	Likes about Training
	Challenges/Dislikes about Training
	Benefits Obtaining and Maintaining Certification
	Recertification Process
	Reasons Why No Longer Certified
Working as a Peer Specialist	Likes about Working as a Peer Specialist
	Dislikes about Working as a Peer Specialist
	Reasons Why No Longer Working as a Peer Specialist
	Plans to Return to Working as a Peer Specialist
Peer Specialist Integration	Career Advancement and Development
	Collaboration
	Funding
	Organizational Culture
	Recruitment and Hiring
	Role Clarity
	Supervision
	Training Staff on Peer Support

Results

Survey invitations were delivered to 721 peer specialists who had email addresses on file with Via Hope. Seventy-three emails were returned as undeliverable, for a final distribution sample of 648. The final number of survey responses was 115 (response rate of 17.7%) despite additional methods to recruit more peer specialists to complete the survey. Results also include analysis of information collected from 25 interviewees.

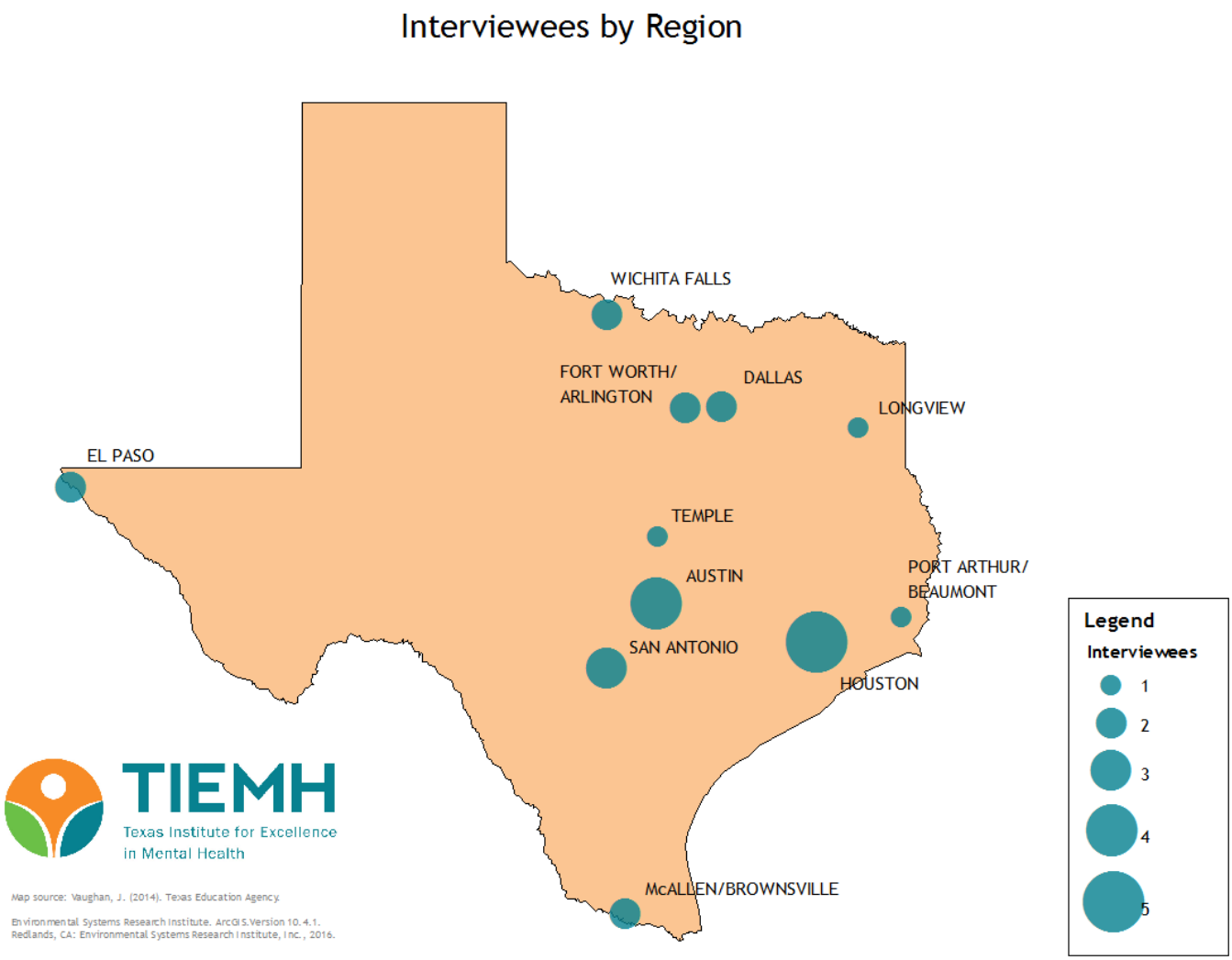
The survey and interview samples were both regionally diverse, including respondents from all major areas of Texas. Figure 1 displays the number of survey respondents by public health region in Texas. Figure 2 displays the number of interviewees by region of Texas. Mirroring the population distribution of Texas, a greater number of survey respondents and interviewees were from the major metro areas of Austin, Dallas/Fort Worth, Houston, and San Antonio than from South Texas, the Panhandle region of Texas, and West Texas.

Figure 1: Survey Respondents by Public Health Region



In addition to mirroring the population distribution of Texas, both survey respondents and interviewees reflected the distribution of certified peer specialists across Texas, with larger numbers of peer specialists living along the I-35 corridor and in the highly populated areas comprising and surrounding Harris County.

Figure 2: Interviewees by Region



Demographics

For both the survey and the interviews, the majority of the respondents were female (58.3% for the survey, 64.0% for the interviews) and non-Hispanic white (62.5% for the survey, 56.0% for the interviews). Recruitment efforts to train and certify a more diverse peer specialist workforce that is more representative of the population should continue. Peer specialists also reflect a general behavioral health workforce issue, with a higher percentage of peer specialists at or approaching retirement eligibility. See Table 3 for a description of the demographic characteristics of the survey respondents and interviewees.

Table 3: Demographic Data

	Survey Respondents	Interviewees
Gender		
Male	47 (40.9%)	9 (36.0%)
Female	67 (58.3%)	16 (64.0%)
Not listed	1 (0.9%)	--
Ethnicity/Race		
Hispanic	16 (14.3%)	3 (12.0%)
Non-Hispanic, American Indian or Alaska Native	1 (0.9%)	--
Non-Hispanic, Black or African American	1 (0.9%)	7 (28.0%)
Non-Hispanic, White	70 (62.5%)	14 (56.0%)
Non-Hispanic, other race	1 (0.9%)	--
Non-Hispanic, two or more races	2 (1.8%)	1 (4.0%)
Age		
18 to 25	2 (1.7%)	
26 to 39	20 (17.4%)	
40 to 55	55 (47.8%)	
56 or older	38 (33.0%)	
Age		
25 to 34		4 (16%)
35 to 44		4 (16%)
45 to 54		5 (20%)
55 to 64		6 (24%)
65+		2 (8%)
Missing		3 (12%)
Education		
Less than 12th grade	1 (0.9%)	
High school diploma/GED	17 (14.8%)	
Some college or post-high school training	36 (31.3%)	
2-year Associate degree	19 (16.5%)	
4-year college degree	23 (20.0%)	
Post-college graduate training	19 (16.5%)	
Total	115 (100%)	25 (100%)

Survey respondents were asked to indicate how many people were currently living in their household, annual household income, and sources of financial support in the past 30 days. More than half of the respondents reported living with either 1 or 2 other people; 28.1% of respondents reported living alone.

Table 4: Number of People Living in Household

	N (%)
None, I live alone	32 (28.1%)
1	29 (25.4%)
2	30 (26.3%)
3	11 (9.6%)
4	8 (7.0%)
5 or more	4 (3.5%)
Total	114 (100.0%)

Approximately one-third of survey respondents (31%) reported a total annual household income from $30,000 to $44,999, with another 27.4% reporting a total annual household income from $15,000 to $29,000. According to the American Community Survey, the median annual household income in Texas is $53,207 (U.S. Census Bureau, 2016); thus, more than two-thirds of the survey respondents are living below Texas median income levels.

More than two-thirds (67.8%) of the survey respondents reported earned income as their primary source of financial support. Other sources of financial support in the past 30 days include Social Security Disability Income (19.1%), Veterans benefits (15.7%), assistance from family members (10.4%), Social Security Benefits (6.1%), and Supplemental Security Income (3.5%), and other sources (7.8%) (e.g., child support, property, or a second job).

Table 5: Annual Household Income

	N (%)
Less than $15,000	13 (11.5%)
$15,000 to $29,000	31 (27.4%)
$30,000 to $44,999	35 (31.0%)
$45,000 to $59,999	6 (5.3%)
$60,000 to $74,999	12 (10.6%)
$75,000 or more	16 (14.2%)
Total	113 (100.0%)

Table 6: Sources of Financial Support in the Past 30 Days

	n (%)
Earned income	78 (67.8%)
Social Security Benefits (SSA)	7 (6.1%)
Social Security Disability Income (SSDA)	22 (19.1%)
Supplemental Security Income (SSI)	4 (3.5%)
Veterans Benefits	18 (15.7%)
Assistance from family members	12 (10.4%)
Other (please specify)	
Child support	
Employment	
Father lives with me and shares expenses	
Married	
N/A	9 (7.8%)
None	
OPM	
Property	
Second job	
State pension; royalties	
Total	113 (100.0%)

Training and Certification

Via Hope training and certification process. Via Hope is authorized by the Texas Health and Human Services Commission (HHSC) to provide a standardized peer specialist training and certification program in Texas. Individuals who wish to attend the training and complete the certification process must meet Via Hope's eligibility requirements, which include self-identifying as a person with lived experience of being in recovery from mental health challenges and having a desire to use those experiences to help others in recovery. Prospective applicants must complete a written application and provide two letters of recommendation. Accepted applicants are required to attend a 43-hour intensive course and successfully pass an exam to receive their certification. Peer specialists may also be certified in another state and receive certification through reciprocity in Texas. The full cost of the training and certification program is $750 (which includes all training supplies, lodging, breakfasts, and lunches). Via Hope encourages employers to cover these costs, although a limited number of Via Hope scholarships are available (Via Hope, 2016b).

Nearly all survey respondents (97.4%) became certified peer specialists in Texas by attending the Via Hope training and passing the certification exam. Two survey respondents (1.7%) were certified in another state and received reciprocity; one survey respondent did not answer this survey item. Of the 112 respondents who completed the peer specialist training in Texas, more than half had attended the training within the last three years but there was representation of peer specialists from each year since the training and certification program began in 2010.

Table 7: Peer Specialist Training Year

	n (%)
2010	12 (10.7%)
2011	11 (9.8%)
2012	12 (10.7%)
2013	13 (11.6%)
2014	17 (15.2%)
2015	26 (23.2%)
2016	21 (18.8%)
Total	112 (100%)

Certification status. The majority of respondents were currently certified (93.8% of survey respondents and 80.0% of interviewees). The survey and interview samples may not be representative of all peer specialists in Texas with regard to certification status, as only 70.7% (510 out of 721 peer specialists with a current email address) had an active certification status at the time of survey administration (Via Hope, 2016a).

Table 8: Certification Status

	Survey Respondents	Interviewees
Active	106 (93.8%)	20 (80.0%)
Inactive	7 (6.2%)	5 (20.0%)
Total	113 (100%)	25 (100%)

To better understand perspectives about the Via Hope training and certification process, interviewees were asked to describe what they did and did not like about the process, benefits to obtaining and maintaining certification, experiences with the recertification process (certification must be renewed every two years in Texas), and, if applicable, why they are no longer certified as a peer specialist. These results are presented below.

Likes about training. Thirty-five unique codes emerged from the interviews regarding things about the Via Hope training process that interviewees liked. These codes were organized into two major categories: content and process. Further within these major categories, codes were organized into sub-categories, when applicable. For a list of all codes related to likes about training, see Table 9.

Table 9: Interview Codes – Likes about Training

Content	Informative (n=9)	
	Curriculum empowering (n=3)	
	Appalachian consulting material (n=1)	
	Learning about insurance and billing (n=1)	
	Curriculum alignment, training matched book (n=1)	
	Peer Role Content	Gave hands-on knowledge and skills to apply to work (n=8)
		Learning about the difference in being clinical versus peer provider (n=6)
		Sharing story (n=5)
		Ethics/professional boundaries (n=3)
		Learning about the value of lived experience (n=2)
		Learning about the history of peer support (n=2)
		Values of peer support (n=1)
		Introduction to the role (n=1)
	Recovery Content	Learned recovery movement versus traditional mental health (n=4)
		Learned about own mental health (n=1)
		Learned about person-first language (n=1)
		Learned recovery is a journey (n=1)
Process	**Trainers**	Trainers knowledgeable (n=6)
		Trainers engaged (n=1)
		Trainers/developers have lived experience of mental health challenges (n=1)
	Relationships	Other trainees supportive (n=3)
		Everyone on the same level (n=3)
		Connecting with other peers (n=2)
		Accommodations for self-care (n=2)
		Accommodations for learning disability (n=1)
	Format	Hands on/interactive (n=5)
		Testing system (n=5)
		Five-day format (n=2)
		Felt free to ask questions (n=1)
		Organized/focused (n=1)
	Logistics	Aesthetically-pleasing environment (n=3)
		Via Hope funding for training (n=3)
		Via Hope came to organization/region (n=2)
		Accepted to training first time applied (n=1)
		Small group, more direct time with trainers (n=1)

Content. Within the content category, nine interviewees noted that the training was informative, while three interviewees said that the curriculum was empowering. For example, one interviewee said: “They share hope and strength with you and encourage you to be educated.”

Several codes within the content category were specific to peer role content. For example, eight interviewees said that the training provided hands-on knowledge and skills that they could apply to their job as a peer specialist. As

one interviewee noted: “Like giving me listening skills, learning how important it was to listen to a person and then learning new ways to approach a person and not be more clinical, but be more of a peer.”

Additionally, six interviewees noted that the training usefully covered how the peer role differs from a clinical role. For example, one interviewee said: “I learned a lot about the difference in being clinical and being a peer provider and how having a diagnosis, I could help other people just by sharing my own lived experience.”

Five interviewees described that they liked that the training involved learning how to share one’s recovery story or journey, as illustrated by one interviewee who said: “I especially liked the part where we got to work on how to tell our story in a way that was both helpful for us and helpful for all users.”

Other peer role content noted by interviewees included ethics/professional boundaries for peers, learning about the value of lived experience, learning about the history of peer support, learning about the values of peer support, and a general introduction to the peer support role.

Several codes within the content category were specific to recovery content. For example, four interviewees noted that they liked that the training covered the difference between the recovery movement and a traditional approach to mental health. As described by one interviewee:

> During the '50s, '60s, and '70s, they explained that mental health, it was in a totally different mindset as far as people receiving services. They weren't in a position to really make many decisions on their own and they didn't have an opportunity to participate in their own treatment. They were kind of just warehoused and they didn't have any means of participating in their own recovery…I was very fascinated by that.

Interviewees also described enjoying learning that recovery is a journey, learning about person-first language, and learning about their own mental health.

Process. Within the process category, four sub-categories of codes emerged: 1) codes related to *trainers*, 2) codes related to interviewees’ *relationships* with other peers and the trainers, 3) codes related to training *format*, and 4) codes related to training *logistics*.

Six interviewees noted that trainers were knowledgeable. For example, one interviewee said: “The three trainers that I had were well-versed in the material.” One interviewee also said that the trainers were engaged while another interviewee noted that they liked that the trainers and developers of the training had lived experience of mental health issues.

Three interviewees reported that the other trainees were supportive. Similarly, three interviewees reported that the other trainees were on the same “level” or similar to them. For example, one interviewee explained: “What I liked about the training is one, they had people that are like me, that went through the experiences that I had. So they understood.” Similarly, two interviewees noted that they enjoyed connecting with and being around other peer specialists. Finally, three interviewees reported that they liked that the trainers made accommodations for self-care and accommodations for a learning disability. For example, one interviewee explained:

> I really liked in the training how we were able to, if we had any diagnosis or if we had anything that probably we needed to do for self-care that was really important that we could do it, as long as we weren’t interrupting others. So I really liked that. It made me more comfortable.

In terms of format, five interviewees noted that they liked that the training was hands-on and interactive. For example, one interviewee explained: “I liked it because it was done as a group and it was interactive. We participated, we listened; we participated, we listened.” Five interviewees also noted that the test that they took at the end of the training to obtain their certification was fair and worked well. For example, one interviewee explained: “The test is based on you listening and learning and engaging in the training and if you engage and you listen and pay attention to what’s going on, the testing is not hard at all.” Interviewees also reported enjoying the five-day format of the training, that the training was organized and focused, and that they felt free to ask questions.

In terms of logistics, three interviewees noted that they liked that they received Via Hope funding for the training. Three interviewees also noted that they liked that the training was held in an aesthetically-pleasing environment. For example, one interviewee explained: “We were in an amazing hotel, served lovely food. I felt very, very special.” Two interviewees reported that they liked that Via Hope came to their organization or region to conduct the training, rather than have to travel to Austin for the training. For example, one interviewee explained: “The procedure was easy, convenient. I think it was done here in Houston.” Interviewees also reported enjoying being in a small training group and having more direct one-on-one time with the trainers as well as being accepted to the training the first time that they applied for it.

Challenges/dislikes about training. Twenty-four unique codes emerged from the interviews regarding things about the Via Hope training process that interviewees disliked or found challenging. These codes were organized into two major categories: content and process. Further within these major categories, codes were organized into sub-categories, when applicable. For a list of all codes related to dislikes about training, see Table 10.

Table 10: Interview Codes -- Challenges/Dislikes about Training

Content	Difficult to share story (n=3)	
	Curriculum does not align with test (n=2)	
	Training does not cover documentation (n=2)	
	Emphasis on problem solving and goal setting (n=1)	
	It's not Intentional Peer Support (n=1)	
	Definition of peer support is limited (n=1)	
	Test badly written (n=1)	
	Didn't prepare interviewee for job stressors (n=1)	
	Training needs greater emphasis on the peer role (n=1)	
	No discussion of how peers can plug into local resources (n=1)	
Process	**Trainers**	Sometimes trainers are unprofessional (n=1)
	Relationships	Other trainees demonstrate a lack of readiness/competence (n=2)
		Pressure to perform in front of other trainees (n=1)
		Pressure to form study groups (n=1)
	Format	Testing stressful (n=4)
		Not long enough (n=3)
		Not enough breaks after traumatic story telling (n=1)
		Need pre-trainings (n=1)
		Manual didn't match structure of training (n=1)
	Logistics	A lack of geographical diversity in training location (n=1)
		Need different caterers (n=1)
		Need to have a large enough, trauma-informed, space (n=1)
		Applied multiple times to training program (n=1)
		Need to modify application process (n=1)

Content. While some interviewees enjoyed sharing their recovery story in the training, three interviewees also noted that they found it challenging or difficult. For example, one interviewee explained: “It was hard for me to stand up in front of a group of people and share my story.”

Two interviewees described being frustrated that the training curriculum did not match or align with the material covered in the certification test. For example, one interviewee explained: “When I was going through it, it was under reconstruction of some sort and the tests didn’t match my training and it actually triggered test anxiety.”

Two interviewees also described frustration that the training curriculum did not include anything on documentation. For example, one interviewee explained: “There was nothing in the training at that time about preparing us for documentation of our encounters and the possible tools that we would be using.”

Interviewees also described what they saw as a limited definition of peer support presented in the training, particularly in comparison to the one presented in Intentional Peer Support training. As one interviewee explained:

> Well, I don't think that they had a very good understanding of the role of the peer specialist. Even my understanding of the role of a peer specialist grew as I got more training, and in particular the Intentional Peer Support training.

Specifically, this interviewee reported that the Via Hope training was focused on problem solving and goal setting with individuals in services, a focus they did not see as true peer support:

> Exercises that we learned how to do in the certified peer specialist training seemed to definitely have a problem-solving focus, kind of goal setting. I guess myself, I came to think less favorably of that as a primary objective of the peer support person and that kind of thinking more in line with mainstream mental health. I came to think of peer support more along the lines of learning together, growing together, relating to each other rather than, 'I'm here to help you solve your problems' kind of thing.

Similarly, another interviewee reported that they left the training without a good understanding of what the peer role is and is not, noting that the training focuses too heavily on recovery rather than the peer specialist role:

> There needs to be something in the curriculum like, 'This is what a peer specialist is not' because what's happening is we're setting a precedent now instead of a separate discipline. I think people need to go empowered leaving not as to, 'What is recovery and connection' but 'How do you do your job?'

Another interviewee had a similar complaint, noting that the training did not prepare them for the stressors of the job:

> I certainly didn't feel prepared by my one week of certification training. If it wasn't for my own life experience and counseling that I was getting every week privately…I couldn't have done it. I could not have coped with the responsibilities that I felt for my job.

Additionally, one interviewee reported frustration with the fact that the training lacked any discussion of how geography affects how peer specialists deliver services and in particular which local resources they plug into:

> One of the things I think that kind of didn't work was building a network where – there were 30ish people in the room from all over the state, and there really wasn't any time or context in which people sort of talked a little bit about how their particular location affected the way that services are delivered...your go-to resources, what website do you find curriculum off of, what partner agencies are good at helping.

Finally, one interviewee noted that the certification test was badly written:

> It was very upsetting for me and it was a trigger for me to have a poorly worded test, a test that did not match, multiple choice answers where the difference between one answer and another was subtle and the language was not very clear. Communication and clear writing and clear language, especially in a test, is critical to me.

Process. Within the process category, four sub-categories of codes emerged: 1) codes related to *trainers*, 2) codes related to interviewees' *relationships* with other peers and the trainers, 3) codes related to training *format*, and 4) codes related to training *logistics*.

One interviewee noted that sometimes the trainers were unprofessional: "But to sit there and struggle while you're training and be distracted and snippy with people and short and not even say why, those are things where I think that something should have been mentioned."

Within the relationship sub-category, two interviewees noted that other trainees demonstrated a lack of readiness and/or competence. For example, one interviewee explained: "I felt like I was being certified along with people who weren't nearly as capable as I am, which was a little bit disconcerting for me, as I want the field to be represented as well as possible."

Additionally, interviewees described feeling pressure to perform well in front of other trainees and pressure to form study groups with other trainees.

Within the format sub-category, four interviewees said the certification testing process was stressful. For example, one interviewee noted: "I got to the testing and I became anxious that I was not going to pass. I had to actually leave the room because it made me tear up."

Three interviewees noted that the training was not long enough. For example, one interviewee explained: "I think it's not a long enough training. I think one week of training is not enough to get someone prepared for the field." Similarly, one interviewee noted that pre-trainings would be useful. One interviewee also noted that the trainers did not allow for enough breaks during the section of the training in which trainees share their recovery stories, given that these stories often involve traumatic memories. Finally, one interviewee felt frustrated that the training manual did not match the structure of the training.

Within the logistics sub-category, interviewees reported challenges related to a lack of geographical diversity in training locations (with most trainings located in Austin), the need for different caterers, the need for a training space that is trauma-informed and large enough to comfortably accommodate all trainees, difficulty getting into the training (applying multiple times to the training before being accepted), and the need to modify the application process to incorporate different media (e.g., phone interviews, videos) rather than base the application solely on essays.

Benefits obtaining (and maintaining) certification. Interviewees were also asked about what they saw as the benefits to obtaining (and maintaining) their peer specialist certification. See Table 11 for a list of these codes.

Table 11: Interview Codes – Benefits Obtaining (and Maintaining) Certification

To feel more professional and qualified (n=5)
Job requirement to be certified (n=3)
Just in case an employment opportunity arises (n=3)
Benefit of continuing education (n=3)
Will always be the field interviewee wants to work in (n=2)
Benefit within the context of employment (n=2)
Getting hired (n=2)
Need certification to attend some trainings (n=1)
Good for consulting business (n=1)

Five interviewees reported that having their peer specialist certification made them feel more professional and qualified. For example, one interviewee explained: "It's like anything. If you don't have the certificate, you're not qualified. Yeah, it gives you that street cred. It legitimizes you in your position and what you're trying to do."

Three interviewees reported that they have to obtain and maintain their certification as a condition of their employment as a peer specialist. For example, one interviewee said: "Part of our job is to get certified, so I have to make the effort."

Similarly, three interviewees who are not currently working as peer specialists reported that they maintain their certification in case a peer specialist job opportunity arose. For example, one interviewee explained: "I guess because I honestly believe that being a mentor is becoming more popular and that the whole peer mentoring thing will grow and if I maintain my certification, there may be opportunities that aren't there now."

Three interviewees also reported that a benefit of maintaining their certification is the value of continuing education. For example, one interviewee explained:

> All of the requisites for maintaining [certification] provide us with opportunities to continue to learn and progress in our field. So, I really like that aspect of it. I don't see anything wrong with, you know, the continuing education hours that we need in order to re-apply and to continue our certification.

Two interviewees who are not currently working as a peer specialist reported that they maintain their certification because they will always want to work as a peer specialist if given the opportunity. For example, one interviewee explained:

> Well, because it's my passion it's exactly what I – I'm not working right now. I lost my job in 2013 under some very horrible circumstances. But I've utilized this time mainly for personal growth...so, it's always been and always will be as far as I know the field where I want to work.

Two interviewees reported that they saw benefits to maintaining certification in the context of employment. For example, one interviewee explained that there were benefits to being certified within the context of employment: "Benefits, definitely. Especially with employment. But I don't quite know too much about the volunteer part of being certified." More specifically, two interviewees reported that obtaining their certification meant that they were hired as peer specialists. For example, one interviewee explained: "That's what gets you in the door. My interest in getting it was so that I could get in the door and say, 'Okay, I've had the training and now I want to do the work.'"

Recertification process. Survey respondents and interviewees were also asked – if applicable – about their experiences with the recertification process. The peer specialist certification is valid for 24 months. Certified peer specialists are required to obtain at least 20 Continuing Education Units (CEUs) during the 24-month period in order to maintain an active certification status. To recertify, peer specialists are also required to pay a nominal processing fee (Via Hope, 2016b).

Survey respondents with an active certification were asked how many CEUs they had obtained since their most recent certification; slightly more than half of the respondents have earned at least the required number of CEUs to be recertified.

Table 12: Number of CEUs Obtained since Most Recent Certification

CEUs	n (%)
None	17 (16.2%)
1 to 4	9 (8.6%)
5 to 9	9 (8.6%)
10 to 14	10 (9.5%)
15 to 19	7 (6.7%)
20 or more	53 (50.5%)
Total	105 (100.0%)

To learn about interest in various content areas for CEUs, survey respondents were asked to select areas in which they are interested in developing additional knowledge and skills. The areas that garnered the most interest include: Next Steps (52.3%), WRAP facilitator training (36.7%), trauma-informed peer support (34.9%), social justice (33.3%), and leading/facilitating support groups (32.1%). Via Hope should consider offering or expanding on CEU opportunities in these areas.

Table 13: Interest Areas for Knowledge and Skill Development

Interest Areas	n (%)
Next Steps (for experienced Certified Peer Specialists)	57 (52.3%)
WRAP facilitator training	40 (36.7%)
Trauma-informed peer support	38 (34.9%)
Social justice	36 (33.0%)
Leading/facilitating support groups	35 (32.1%)
ASIST (Applied Suicide Intervention Skills Training)	32 (29.4%)
Wellness coaching	31 (28.4%)
Basic WRAP training	31 (28.4%)
Intentional Peer Support	31 (28.4%)
Peer support for individuals with co-occurring disorders	30 (27.5%)
Co-occurring disorders	29 (26.6%)
Boundaries	28 (25.7%)
Emotional CPR	27 (24.8%)
Community re-entry	24 (22.0%)
Self-advocacy	23 (21.1%)
Peer Support Whole Health and Resilience	21 (19.3%)
Cultural competency	21 (19.3%)
Ethics	21 (19.3%)
Time management	20 (18.3%)
WHAM (Whole Health Action Management)	19 (17.4%)
Computer/technology	15 (13.8%)
Other	12 (11.0%)
Total	109 (100.0%)

Interviewees were also asked about their experiences with the recertification process. Most of the codes that emerged in this section were related to challenges interviewees faced with the recertification process, although a few more general codes also emerged (see Table 14 for a list of codes related to the recertification process).

Table 14: Interview Codes -- Recertification Process

Required CEUs easy to obtain (n=11)	
Plans to recertify (n=2)	
CEUs should not be done online (n=1)	
Challenges maintaining certification	Access to trainings for CEUs (n=6)
	Paying for training for CEUs (n=6)
	Getting time off to go to CEU trainings (n=3)
	Getting CEUs is more difficult when not employed as a certified peer specialist (CPS) (n=2)
	Requirements to maintain certification unclear (n=2)
	Via Hope unresponsive (n=2)
	Need to train that people can self-advocate for what counts for CEUs (n=2)
	Cost to renew certification (n=1)
	Not notified if passed test to earn CEUs (n=1)
	Badly written tests to earn CEUs (n=1)
	CEUs not documented and distributed (n=1)
	Not knowing how to ask for time off for CEUs (n=1)
	CEUs are mostly Via Hope trainings (n=1)

For example, eleven interviewees reported that maintaining the required number of CEUs to recertify (20 hours every two years) was easy. One interviewee explained: "I mean I wouldn't be surprised if I have 100 [CEUs]. So yeah, it was very easy." Two interviewees whose certification was currently expired reported that they planned to recertify in the future. One interviewee voiced concern with the fact that CEUs can now be completed online:

> The advisory council has approved that all continuing education hours, which there's 20 in two years, can be done online. Peer support to me is about bringing people together and building that peer network as we depend upon each other.

Challenges with the recertification process. Interviewees also voiced several challenges with the recertification process, particularly challenges related to access to trainings and choice of trainings to as well as challenges related to a lack of clarity and responsiveness from Via Hope related to requirements to maintain certification.

For example, six interviewees reported that access to trainings (due to geographical or other constraints) to earn CEUs was a challenge. For example, one interviewee explained:

> I get emails all the time about different classes and courses and I can pick and choose which one I want. I mean, well, I guess there are challenges because some of them are not in Austin. Some of them are in other cities. That is a challenge.

The financial cost of attending trainings to earn CEUs was also mentioned as a common challenge, as one interviewee explained: "Sometimes your employer will sponsor and pay for it but our employers, not. They're kind of like, 'On your own time. You take the time off, you pay for it.'" Similarly, getting time off from work to attend CEU trainings was mentioned by three interviewees as a challenge.

At the same time, two unemployed peer specialists mentioned that it was easier to earn CEUs when they were employed. For example, one interviewee explained:

> There's something coming up in May or June…that's here in [name of city] and I'll beg and plead to get in. When I worked at [name of organization], it was very easy because they held seminars and referred me places where I could get CEUs.

Another issue mentioned by two interviewees was that the Via Hope requirements to maintain certification are not clear. For example, one interviewee explained that there needs to be a discussion of CEUs in the training class: "So in the training...there needs to be a section talking about the CEUs, what options are provided to them."

Two interviewees also mentioned the need for knowledge and training on the fact that peer specialists can advocate to Via Hope about what could count as CEUs. As one interviewee explained:

> There's a couple of places that they can get their CEUs, but additionally what they need to know is if they can't come to the endorsement training, Via Hope can still approve. So if they maybe go to a conference that's on mental health, they have the option to self-advocate to say: "I went to this. Could it be approved?"

Other challenges to maintaining certification mentioned by respondents included: the renewal fee, not being notified if they passed a test to earn CEUs, badly written tests to earn CEUs, CEUs not being documented and distributed by Via Hope in any standardized manner, not knowing how to ask an employer for time off from work to earn CEUs, and that most CEU opportunities are Via Hope trainings.

Time since lapsed certification. Survey respondents who were no longer certified were asked how long it had been since their peer specialist certification had been inactive. Of the seven survey respondents who had let their certification lapse, six responded to this item; of these, two (33.3%) had let their certification lapse within the last year. The remaining respondents let their certification become inactive within the previous one to four years.

Table 15: Time since Lapsed Certification

	n (%)
Less than 1 year	2 (33.3%)
1 year	1 (16.7%)
2 years	1 (16.7%)
3 years	1 (16.7%)
4 years	1 (16.7%)
Total	6 (100.0%)

Reasons why no longer certified. While researchers had initially hoped to interview 20 individuals whose peer specialist certification had lapsed, researchers were only able to successfully recruit five interviewees with lapsed certification into the interview study. Thus, what we know about reasons for not recertifying are limited. Nonetheless, results suggest a variety of internal and external reasons for not recertifying. See Table 16 for a list of these codes.

Table 16: Interview Codes -- Reasons Why No Longer Certified

External Reasons	Via Hope misplaced paperwork (n=1)
	Via Hope did not reimburse (n=1)
	TAC does not require certification (n=1)
	Unemployed (n=1)
	Organization has not noticed lapsed certification (n=1)
Internal Reasons	Career change (n=1)
	Pending interviewee renewal (n=1)
	Focused on higher education and let certification lapse (n=1)

External reasons. Two interviewees reported that they were no longer certified because of Via Hope process issues. For example, one interviewee reported that Via Hope misplaced their recertification paperwork: "I sent the paperwork in and Via Hope was moving their offices and somewhere along the way my paperwork got misplaced or whatever…They said that they hadn't received it." Another interviewee reported that they were never reimbursed for lodging during an out-of-town training and therefore did not want to pay Via Hope the renewal fee.

Other external reasons interviewees mentioned for not renewing their certification included: being unemployed, the fact that their employer has not noticed that they are no longer certified, and that the Texas Administrative Code (TAC) does not require that peer specialists be certified to work as peer specialists in Texas.

Survey respondents who were not currently certified (but had been certified in the past) were also asked to describe why they have not renewed their peer specialist certification. Seven respondents replied to this question and external reasons for not renewing included: Via Hope unresponsive (n=1), termination (n=1), and peer specialist program closed (n=1).

Internal reasons. Interviewees also mentioned three internal, or personal, reasons for no longer being certified, including: a career change, focusing on school/higher education, and a need for the interviewee to renew. Survey respondents who were not currently certified (but had been certified) in the past were also asked to describe why they have not renewed their peer specialist certification and internal reasons for not renewing included: career change (n=3) and respondent completed other similar certification (n=1).

Working as a Peer Specialist

More than 75% of the survey respondents and more than 50% of the interviewees were working or volunteering as a peer specialist at the time they participated in the survey and/or interview. Eighteen percent of survey respondents and 44% of interviewees previously worked or volunteered as a peer specialist. Six of the 115 survey respondents (5.2%) had never worked or volunteered as a peer specialist, despite having an active certification status.

Table 17: Working or Volunteering as a Peer Specialist

	Survey Respondents	Interviewees
Currently works or volunteers as a peer specialist	88 (76.5%)	14 (56.0%)
Previously worked or volunteered as a peer specialist	21 (18.3%)	11 (44.0%)
Never worked or volunteered as a peer specialist	6 (5.2%)	…
Total	115 (100.0%)	25 (100.0%)

Survey respondents and interviewees were working/volunteering (or had worked/volunteered) as a peer specialist in a variety of settings. See Table 18 for a list of the types of employer organizations.

Table 18: Type of Employer Organization

	Survey Respondents	Interviewees
Community Mental Health Center/Local Mental Health Authority	53 (51.5%)	15 (60%)
Consumer Operated Service Provider	3 (2.9%)	--
Department of Veterans Affairs or other Veterans organization	10 (9.7%)	1 (4%)
Managed Care Organization	5 (4.9%)	1 (4%)
Organization that serves people experiencing homelessness	10 (9.7%)	3 (12%)
State Hospital	7 (6.8%)	3 (12%)
Other	15 (14.6%)	2 (8%)
Total	103 (100.0%)	25 (100.0%)

Survey respondents were asked how long they have been employed at their organization. Those who were currently working as a peer specialist at the time of the survey had been employed slightly longer than those who had previously been employed as a peer specialist (e.g., 4.5 years and 4.1 years, respectively).

Table 19: Tenure at Organization

	Mean	Median	Standard Deviation
Currently a peer specialist (n=85)	4.5	3.8	3.6
Previously a peer specialist (n=20)	4.1	4.0	2.0

Survey respondents were asked about their type of employment and the hours they work each week. Individuals who were currently working as a peer specialist were more likely to report working full-time in hourly/salary employment compared to those who previously worked as a peer specialist (67.0% and 52.4%, respectively). Previously employed peer specialists were more likely to report working in part-time hourly/salary employment compared to those who were currently working as a peer specialist (38.1% and 15.8%, respectively). It is unknown if part-time employment, which likely did not include benefits, contributed to individuals no longer working as a peer specialist.

Table 20: Type of Employment

	Currently a peer specialist	Previously a peer specialist
Hourly/salary, full-time (at least 80% time)	59 (67.0%)	11 (52.4%)
Hourly/salary, part-time (less than 80% time)	13 (15.8%)	8 (38.1%)
Contract, full-time (at least 80% time)	3 (3.4%)	…
Contract, part-time (less than 80% time)	3 (3.4%)	1 (4.8%)
Volunteer, full-time (at least 80% time)	3 (3.4%)	…
Volunteer, part-time (less than 80% time)	13 (14.8%)	3 (14.3%)
Other (please specify) *Contract, part-time – 30 hours per week* *I have 2 jobs. I do peer support 20 hours a week and I'm also a part-time hairstylist doing 20-25 hours a week.* *I would volunteer on Thursday evenings to run the small groups. On Saturday to do the music and the large discussion groups.* *Started out on contract then put me on hourly wage.*	2 (2.2%)	2 (9.6%)
Total	88 (100.0%)	21 (100.0%)

Approximately 70% of the currently employed peer specialists reported working at least 31 hours each week. Slightly more than half (52.3%) of the previously employed peer specialists reported working at least 31 hours each week.

Table 21: Hours Worked Per Week

	Currently a peer specialist	Previously a peer specialist
1 to 10 hours	7 (8.1%)	2 (10.0%)
11 to 20 hours	9 (10.5%)	5 (25.0%)
21 to 30 hours	8 (9.3%)	2 (10.0%)
31 to 40 hours	50 (58.1%)	7 (35.0%)
More than 40 hours	12 (14.0%)	4 (20.0%)
Total	86 (100.0%)	20 (100.0%)

Survey respondents were asked how much they are paid per hour of work. Individuals currently employed as a peer specialist reported getting paid an average of $15.20 per hour of work, while individuals who were previously employed as a peer specialist were paid slightly less, with a reported average of $13.07 per hour of work.

Table 22: Hourly Pay

	Mean	Standard Deviation	Minimum	Maximum
Currently a peer specialist (n=74)	15.20	5.13	8.50	40.00
Previously a peer specialist (n=17)	13.07	1.93	9.47	16.00

Survey respondents were asked about the benefits they receive from their employer. The top three benefits reported by both currently and previously employed peer specialists were paid vacation, medical insurance for the individual employed, and paid sick leave.

Table 23: Benefits Received from Employer

	Currently a peer specialist	Previously a peer specialist
I do not receive benefits	22 (25.0%)	7 (33.0%)
Medical insurance for myself	48 (54.5%)	10 (47.6%)
Medical insurance for my family	11 (12.5%)	3 (14.3%)
Dental insurance	39 (44.3%)	8 (38.1%)
Retirement	43 (48.9%)	7 (33.3%)
Disability insurance	29 (33.0%)	3 (14.3%)
Paid vacation	58 (65.9%)	11 (52.4%)
Paid sick leave	48 (54.5%)	9 (42.9%)
Other (please specify) *Education leave (without pay)* *Eye care* *FMLA* *Life insurance* *Paid education leave* *PTO (n=2)* *Texflex spending account* *Vision insurance*	9 (10.2%)	
Other (please specify) *I receive spiritual benefits* *Paid holidays*		2 (9.6%)
Total	88 (100.0%)	21 (100.0%)

Survey respondents were asked to indicate to what degree working in their position has positively impacted their recovery. A 5-point Likert-type scale was utilized with 1 being “Strongly Disagree” and 5 being “Strongly Agree.” Individuals currently employed as peer specialists were more likely to agree or strongly agree and less likely to disagree or strongly disagree that currently working as a peer specialist has positively impacted their recovery compared to those who were previously employed as peer specialists.

Table 24: Degree to which Working in Current Position has Positively Impacted Recovery

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Currently a peer specialist (n=79)	2 (2.5%)	1 (1.3%)	4 (5.1%)	19 (24.1%)	53 (67.1%)
Previously a peer specialist (n=20)	3 (15.0%)	1 (5.0%)	1 (5.0%)	3 (15.0%)	12 (60.0%)

Survey respondents were also asked to indicate the degree to which they are satisfied with their overall job experience and the ability to do their current job well. A 5-point Likert-type scale was utilized with 1 being “Strongly Disagree” and 5 being “Strongly Agree.” For survey respondents who were currently employed as a peer specialist, 83.8% reported that they agree or strongly agree that they are satisfied with their overall job experience. Seventy percent of survey respondents who were previously employed as a peer specialist reported that they agree or strongly agree that they are satisfied with their overall job experience. The majority of survey respondents agreed or strongly agreed that they felt they are able to do their job well, regardless if they are currently or were previously working as a peer specialist.

Table 25: Degree to which Individual is Satisfied with their Overall Job Experience

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Currently a peer specialist (n=80)	1 (1.3%)	4 (5.0%)	8 (10.0%)	30 (37.5%)	37 (46.3%)
Previously a peer specialist (n=20)	1 (5.0%)	1 (5.0%)	4 (20.0%)	4 (20.0%)	10 (50.0%)

Table 26: Degree to which Individual is Able to do their Job Well

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Currently a peer specialist (n=80)	1 (1.3%)	2 (2.5%)	5 (6.3%)	26 (32.5%)	46 (57.5%)
Previously a peer specialist (n=20)	1 (5.0%)	1 (5.0%)	1 (5.0%)	5 (25.0%)	12 (60.0%)

To better understand individuals' experiences working as a peer specialist in Texas, interviewees were asked about what they liked and did not like about working as a peer specialist. Additionally, interviewees who were not currently working or volunteering as a peer specialist at the time of their interview were asked about why they no longer work or volunteer as a peer specialist and about their plans for returning to work as a peer specialist in the future. These results are presented below.

Likes about working as a peer specialist. Interviewees described eleven unique things that they liked about working as a peer specialist (see Table 27 for a list of these codes).

Table 27: Interview Codes -- Likes about Working as a Peer Specialist

Mutuality with people in services (n=15)
Sharing story with people in services (n=10)
Strengthens own recovery/provides a sense of fulfillment (n=9)
Being an advocate/helping people (n=7)
When people in services see their self-efficacy (n=7)
Community outreach (n=4)
Providing information on community resources (n=3)
Collegial camaraderie (n=3)
Learning about the mental health system in trainings (n=2)
Working as a peer in different capacities (n=2)
When staff buy into peer support and recovery (n=1)

Fifteen interviewees described enjoying a sense of mutuality (i.e., a sense of shared experience, mutual connection, and rapport) with people in services. For example, one interviewee explained: "I loved that part of getting to know someone and finding the connect part. Finding that 'Ah-hah' moment between two people where you really connect."

Part of building mutuality occurs when peer specialists share their own recovery stories with people in services and ten interviewees specifically mentioned liking that aspect of working as a peer specialist. For example, one respondent explained: "I really, in my heart of hearts, I want to be a peer support specialist because I want to be able to interface with others and connect with others using empathy and my recovery story to help others."

Nine interviewees reported that working as a peer specialist strengthens their own recovery and provides a sense of fulfillment. For example, one interviewee explained:

> It actually helps me improve myself because the longer that I'm doing this, the stronger I feel that I'm getting in my own recovery and the more that I do my own self-care and the more tools that I have to help myself. Then it's just a big circle. I learn how to help myself better and then I learn how to help other people better and I learn something every time I talk to someone new.

Seven interviewees described enjoying helping people and being an advocate for people in services. For example, one interviewee explained:

> I just felt it was like this little link in a chain that I was able to help connect them to – sometimes, I would go with them to their doctor's appointments and advocate for them. We'd work on their goals. And I would just be a huge cheer coach for them and let them know that they can do everything they want to do.

Seven interviewees also described enjoying when people in services come to see their self-efficacy -- that is, when they believe they can change their lives for the better. For example, one interviewee explained:

> I liked to see the light bulb go on. I liked to interact with clients that – they would come into my program, sometimes, hesitant, unsure, and I liked to be able to provide that comfort and help them get the resources that they need so they can get back on their feet and maybe discover some goals that they might not have even thought were possible.

Four interviewees described enjoying doing community outreach. For example, one interviewee explained: "Then also I connect with other resources and connect with other agencies and even schools. We went to one of our high schools so that we could promote about mental health awareness."

Similarly, three interviewees said that they enjoyed providing information on community resources to people in services. For example, one interviewee explained: "I also provided resources, community resources, and I did like that, gathering that stuff up."

Three interviewees also reported that they enjoyed the camaraderie that they had with other employees. For example, one interviewee explained: "It was truly fun for all of us and our team because we would always joke that we felt like we weren't working."

Interviewees also reported the following likes about working as a peer specialist: learning about the mental health system in trainings, working as a peer specialist in different capacities, and when non-peer staff believe in and support the idea of recovery and peer specialists.

Dislikes about working as a peer specialist. Interviewees were asked if there was anything that they did not like about working as a peer specialist at their organization. Most responses focused on organizational characteristics (e.g., a lack of career development opportunities, a lack of collaboration with other staff), rather than things inherent to the job itself. In terms of the latter, however, two codes did emerge. First, two interviewees said that they did not like it when they could not help people in services. For example, one interviewee explained:

> Coming to that realization was rough for me. One of the caseworkers used to say, "Keith[1], you got to stop wearing your heartstrings on your sleeve. You have to remember this is a business. We can't save everyone that has an issue and some people just don't get saved or don't get help."

Another interviewee explained that they did not like to approach people in services that they did not know:

> I didn't like the – I had to go up to people in the lobby and just cold...talk to them and make sure everything's okay. That was the part I did not like because I'm not good at that, cold, going up to somebody that I don't know and start talking.

Reasons why no longer working as a peer specialist. Interviewees who were no longer working as a peer specialist were asked why they no longer work as a peer specialist. Codes were categorized into external and internal sub-categories. External reasons refer to factors outside of the person's control or non-personal reasons while internal reasons refer to personal issues or decisions. For a list of all codes see Table 28.

Table 28: Interview Codes -- Reasons Why No Longer Working as a Peer Specialist

External Reasons	A lack of opportunities in area (n=5)
	Asked to resign/fired (n=2)
	Contract was not renewed (n=1)
	Organization no longer allowed peers to run groups (n=1)
	Job involved too much administrative work and not enough peer support (n=1)
	Documentation requirements conflicted with peer role (n=1)
	Organization ran out of funding (n=1)
	Eliminated interviewee's position (n=1)
Internal Reasons	Physical Illness (n=3)
	Career change (n=2)
	Burn out (n=1)
	Caretaking responsibilities (n=1)
	Does not want to work at a CMHC (n=1)
	Can make a bigger difference on the outside than inside (n=1)
	Passionate about being a trainer (n=1)
	Graduate school (n=1)
	Earning LCDC (n=1)

External reasons. The most commonly described reason (n=5) for no longer working as a peer specialist was that there are a lack of peer specialist job opportunities where they live. For example, one interviewee said: "There's not a lot of opportunities where I live. They're too far from my house."

Two interviewees reported they no longer work as a peer specialist because they were fired or forced to resign. Similarly one interviewee reported that their contract was not renewed.

Other interviewees described not working as a peer specialist because their job role changed in ways they did not like. For example, one interviewee reported that the organization they worked at decided to no longer allow peer specialist to run groups:

[1] Pseudonym

> They stopped letting us help out in groups, in the peer-led groups, and I would go back if that would improve. I had the opportunity to get my job back, but because they no longer allow the peer advocate to sit in on peer groups and help with peer groups, I decided not to try and get it back, because that was my favorite part of the job.

Another interviewee described moving up into a position that required too much administrative work and not enough peer support work. A third interviewee explained that documentation requirements conflicted with the peer role:

> I decided to leave my peer specialist job primarily – I kind of see it as a values conflict sort of thing and it was a variety of things, but one of the real sticking points for me was this requirement for documentation of conversations I was having with people that I considered to be vulnerable, confidential conversations.

Finally, one interviewee reported that the organization they worked for ran out of funding for their position, whereas another interviewee reported that the organization they worked at eliminated their position:

> They made some positions for me what were never there before, which was actually my demise. Because they created a position and after studying in it for, I don't know, eight months, seven months, or maybe a year, they realized that the program could run without me...They did away with the position and just let itself run.

Internal reasons. The most commonly reported internal or personal reason for no longer working as a peer specialist was physical illness. For example, one interviewee explained: "I had very, very serious back surgery and that is the reason I left is I was on recovery."

Two interviewees reported that they no longer work as a peer specialist due to a career change. For example, one interviewee explained: "Now I'm a full-fledged social worker."

One interviewee described being burned out from working as a peer: "I took a break because being a peer mentor and being the type of person I am, it's emotionally and mentally taxing. You're always thinking about how you can help people and blah-blah, blah-blah, blah. I took a break."

One interviewee reported that they no longer work as a peer specialist because they are currently taking a "sabbatical" to care for their elderly mother.

Another interviewee reported that they no longer work as a peer specialist because they do not want to work in a community mental health center which is the only option for peer support employment in their area: "I kind of don't want to be in a community mental health agency and so I don't know that I'll really be using the certification, honestly, unless some opportunities arise that aren't available right now."

Similarly, one interviewee reported that they no longer work as a peer specialist because they feel like they can make a bigger impact on the mental health field outside of mental health agencies: "I think I can make more change on the outside than I can on the inside." This same interviewee explained that they were more passionate about training other peer specialists than directly providing peer support: "It's the training that fed my soul."

Other interviewees reported no longer working as a peer specialist because they have returned to school, with one interviewee reporting that they now attend graduate school and another reporting that they are currently earning their LCDC license.

Qualitative survey results. Survey respondents who were no longer employed or volunteering as a peer specialist were also asked to describe why they no longer work/volunteer as a peer specialist. Twenty-one respondents replied and their responses represent a mixture of internal and external factors. See Table 29 for a list of these reasons.

Table 29: Survey Results -- Reasons Why No Longer Work as a Peer Specialist

External Reasons	Employer not supportive (n=2)
	Unable to find a peer specialist job (n=2)
	Terminated (n=1)
	Quit because agency was not recovery-oriented (n=1)
	Hours cut due to funding (n=1)
	Program closed (n=1)
	Job did not have benefits (e.g., health insurance) (n=1)
Internal Reasons	Now work as a case manager/QMHP (n=5)
	Family health issues (n=2)
	Returned to school (n=2)
	Burn out (n=2)
	Career change -- now provide peer role consultation (n=1)
	Documentation requirements conflict with personal values (n=1)

Plans to return to working as a peer specialist. Interviewees who were no longer working as a peer specialist were asked about their future plans to return to work as a peer specialist. Seven interviewees said that they wished to work as a peer specialist in the future. For example, one interviewee explained: "I intend to stay certified so that I can do this again in the future. I loved that work."

Other interviewees explained how they want to return to work as a peer specialist but in a different way than they were in the past. For example, one interviewee explained that in the future they want to open a private counseling practice that incorporates peer support groups: "After I finish and I get my license, I thought it would be so awesome to open up a practice and provide counseling and therapy. But also have 'x' amount of groups per week that are led by peers."

Another interviewee reported that they would like to work at a peer-run organization that does not require a diagnosis for services:

> I think that just in terms of the direction of peer support in Texas, I really think the development of these peer-run or at least independently-run organizations that aren't linked to insurance, that aren't requiring people to have a mental health label, I think there is a lack of that in Texas.

Similarly, one interviewee explained that they would like to return to work as a peer specialist but that ideally it would be outside of the current mental health system: "I think that peer support needs to be outside the system...like a social media website where they can look at different people's backgrounds and say, 'Hey, I really can relate to Sally. Could she be my peer specialist?'"

One interviewee noted that they would like to find a position where their peer specialist and LCDC skills could complement one another: “I started with, initially, wanting to be a peer support and, now, I'm standing on the cusp of getting my Associate's Degree for LCDC and I'm trying to make some type of weird hybrid between the two.”

Finally, one interviewee reported that they would like to return to working part-time as a peer specialist, rather than as their full-time employment:

> I’m looking about doing some...connecting one-on-one or in small groups with individuals because that still feeds my experience. In my training, I can use examples of people that I’ve worked with. I don’t want to do it too much...but I don’t want to miss that component of still having some connection with people that are fresh in recovery.

Peer Specialist Integration: Career Advancement and Development

Previous research suggests that effective workplace integration is critical to the success of the peer provider workforce (Davidson et al., 2006; Grant et al., 2012; Kuhn et al., 2015). Therefore, survey and interview data collection efforts focused on several integration domains that have previously been identified including: career advancement and career development; collaboration; funding; organizational culture; recruitment and hiring; role clarity, supervision; and training staff on peer support (Earley et al., 2016). Results in this section are organized by these peer specialist integration domains.

Survey respondents, those who were currently working or volunteering as a peer specialist (or had previously worked or volunteered), were asked if their organization had a career ladder for peer specialists. Approximately half of the respondents in each group (currently or previously a peer specialist) indicated that their employer organization did not have a career ladder for their position.

Table 30: Career Ladder

	Currently a peer specialist	Previously a peer specialist
Yes	19 (22.1%)	4 (20.0%)
No	42 (48.8%)	11 (55.0%)
I don’t know	25 (29.1%)	5 (25.0%)
Total	86 (100.0%)	20 (100.0%)

Survey respondents were also asked if their organization provides opportunities for career development. Slightly more than two-thirds of the respondents in each group indicated that their employer organization provided opportunities for career development; these individuals were asked to describe these opportunities, which are listed in Table 32 and Table 33.

Table 31: Career Development

	Currently a peer specialist	Previously a peer specialist
Yes	58 (67.4%)	14 (70.0%)
No	13 (15.1%)	3 (15.0%)
I don’t know	15 (17.4%)	3 (15.0%)
Total	86 (100.0%)	20 (100.0%)

Table 32: Qualitative Survey Results -- Career Development Opportunities (Current Peer Specialists)

Training Costs (n=14)	Peer Fest Costs (n=2)
Travel Expenses for Training (n=6)	Authorized Absence (n=1)
Paid Time off for Training (n=4)	Once Per Year (n=1)
Conference Costs (n=3)	Paid Vacation/Sick Leave (n=1)
Education Benefits (n=3)	Training Money ($400/year) (n=1)
CPS Training Costs (n=2)	Volunteer Opportunities (n=1)

Table 33: Qualitative Survey Results -- Career Development Opportunities (Previous Peer Specialists)

Training Costs (n=8)	Travel Expenses (n=2)
Time off to Attend Training/Classes (n=3)	Conference Costs (n=1)
Authorized Absence (n=2)	Paid Time off for Training/Classes (n=1)

Interviewees were asked if they have received opportunities for career advancement and development as a peer specialist. Several codes related to career advancement and development emerged and were categorized as: 1) opportunities for/indicators of career advancement and development, 2) resources supporting career advancement and development, and 3) barriers to career advancement and development. Further, within these categories, codes were divided into the subcategories of 1) raises and career ladder and 2) training and continuing education. For a list of all codes related to career advancement and development see Table 34.

Table 34: Interview Codes -- Career Advancement and Development

Opportunities	**Raises & Career Ladder**	Career advancement to management (n=5)
		Career ladder for peers (n=3)
		Career advancement to a combined clinical & peer role (n=1)
		Career advancement to team lead (n=1)
		Career advancement to health manager (n=1)
		Regular merit raises (n=1)
		Raise after a year (n=1)
		Raise after two years (n=1)
		Raise with certification (n=1)
		Peers receive better raises (n=1)
		Raise because doing the job of two peer specialists (n=1)
	Training & Continuing Education	Organization pays for training (n=11)
		Organization pays for Via Hope certification (n=8)
		Time off to attend trainings (n=7)
		Paid to attend trainings (n=6)
		Organization encourages peers to attend trainings (n=4)
		Organization encourages peers to continue their education (n=2)
		Organization requires certification within one year of hire (n=1)
		New peers are trained by experienced peers (n=1)
		Internal training on documentation (n=1)
		Accepted to PIR voice project and able to start own program (n=1)
Resource	Self-advocating by peers (n=5)	
Barriers	**Raises & Career Ladder**	No career ladder (n=12)
		No raises (n=5)
		No set pay scale for peers (n=4)
		Minimal raise after 2 years (n=2)
		Nowhere to move up because only peer at the organization (n=2)
		Organization won't put a peer in a supervisory position (n=1)
	Training & Continuing Education	Organization provides no funding for training (n=9)
		Peers unable to attend trainings during work hours (n=4)
		Access to training limited by geography (n=2)
		Organization provides no funding for conferences (n=1)
		Organization does not provide training on documentation (n=1)

Opportunities for/indicators of career advancement and development. Within the raises and career ladder sub-category, five interviewees reported that they had experienced career advancement to management. For example, one interviewee explained: "I mean the idea that a peer support is in a management position, and I'm not the only one, I think that shows good vision on party agencies."

Three interviewees said that there was a formal career ladder for peer specialists at their organization. For example, one interviewee explained: “We have peer specialists. We have peer assistants. And then, there’s Peer Specialists 1, 2, and 3. And we have a formalized career ladder thing going on for sure.”

Interviewees described other forms of career advancement within their organization, including career advancement to team lead, career advancement to a health manager position, and career advancement to a combined clinical and peer role.

Interviewees also described receiving raises, including raises based on merit, automatic raises after one or two years of employment, raises upon receiving Via Hope certification, better raises, and raises for performing the job duties of two peer specialists.

Within the training and continuing education sub-category, eleven interviewees reported that their employer organization pays for training while eight interviewees reported that their employer organization paid for their Via Hope certification training. Seven interviewees reported that they receive time off from their employer to attend trainings and six interviewees reported that they received their regular pay when attending trainings. Four interviewees reported that their organization encourages peers to attend trainings while two interviewees reported that their organization encourages peers to continue their education via higher education.

Other indicators of career advancement and development reported included: employer requires peers to complete the Via Hope certification within one year of hire date, new peer specialists are provided on-the-job training by experienced peer specialists, peer specialists receive internal training on documentation, and being able to start their own program after completing Via Hope’s Person-in-Recovery (PIR) Voice project.

Resource supporting career advancement and development. Five interviewees reported that the reason that their organization provides opportunities for career advancement and development to peer specialists is that they advocated for these opportunities. For example, one interviewee explained self-advocating for career development opportunities:

> The agency pays for the basic [Via Hope] certified peer specialist training completely. And then when I did Next Steps, because they were equivocating about saying yes. I said, “Well, I’ll pay the registration fee if you just pay me for my time that week.” And so that’s how we did that.

Barriers to career advancement and development. Within the raises and career ladder sub-category, twelve interviewees reported that there is no career ladder at their organization. For example, one interviewee explained:

> Technically, my boss has me under a peer specialist two, but we all make the same amount of money and, as far as I know right now, there’s no room for potential raises or being promoted. There’s not really a career ladder.

Similarly, five interviewees reported that peer specialists do not receive raises at their organization and four interviewees reported that there is no set pay scale for peers at their organization. Two interviewees reported that while they received raises after two years of employment, they were very minimal. For example, one interviewee explained: “My organization – once you’ve been with them for two years, you get a minimal raise. I got 24 cents, which that sounds like a lot, but it’s not.”

Two interviewees reported that there were no opportunities for career advancement because they are the only peer employed at their organization. An interviewee explained: "It's a one-stop position. I'm not going to go any higher than this. There is no place."

Finally, one interviewee explained that career advancement opportunities are hindered by the fact that their organization refuses to put a peer specialist into a supervisory position:

> I was considering getting my LPHA so that I could move into a supervisory position and maybe supervise the peer program but I was told that that will not happen. Even if I get my master's they won't put me in that position because they won't have a peer in a supervisory position.

Within the training and continuing education sub-category, nine interviewees reported that their employer provides no funding for training. For example, one interviewee explained:

> Right now, if I had to go to a training, I would be pretty much out of luck because my employer is on a real tight budget constraint. So, I can't attend any trainings that are not fully funded unless I'm going to do it myself.

Similarly, four interviewees indicated that they were unable to attend trainings during their regular work hours (i.e., had to take time off to attend trainings). One interviewee explained:

> There was one training I wanted to do and I was told I could do it on my own time and that they wouldn't pay for it. So I did. I took vacation time and I went to a training and I got a scholarship to do it.

Two interviewees reported that due to their geographical location in Texas, trainings were sometimes difficult to access. For example, one interviewee noted: "Because I live in El Paso, it's really difficult to get over there and do more of the training."

Other barriers mentioned by interviewees included a lack of funding to attend conferences and a lack of internal training on documentation.

Peer Specialist Integration: Collaboration

Survey respondents were asked to indicate if there were other individuals employed as peer specialists at their organization. Approximately 85% of both current and previous peer specialists reported working at an organization in which other individuals were employed as peer specialists. Individuals currently working as a peer specialist reported an average of 10.5 other peer specialists working at their organization. Individuals previously working as a peer specialist reported an average of 5.8 other peer specialists working at their organization.

Table 35: Other Peer Specialists Employed at Organization

	Currently a peer specialist	Previously a peer specialist
No	13 (15.1%)	1 (5.0%)
Yes	73 (84.9%)	17 (85.0%)
I don't know	--	2 (10.0%)
Total	86 (100.0%)	20 (100.0%)

Table 36: Number of Peer Specialists Employed at Organization

	Mean	Median	Standard Deviation
Currently a peer specialist (n=65)	10.5	7.00	9.5
Previously a peer specialist (n=16)	5.8	4.00	4.7

Interviewees were asked about their experiences collaborating with other peers at their organization as well as their experiences collaborating with non-peer staff at their organization. Several codes emerged and were categorized as: 1) Indicators of effective collaborative relationships, 2) Resources supporting effective collaborative relationships, 3) Indicators of ineffective collaborative relationships, and 4) Barriers to collaboration. For a list of all codes related to collaboration between peers see Table 37 and for a full list of codes related to collaboration between peers and non-peer staff see Table 38.

Table 37: Interview Codes -- Collaboration between Peers

Indicators of Effective Collaborative Relationships	Cooperative problem solving (n=12)
	Regular opportunities to meet (n=10)
	Open Communication (n=3)
	Shared purpose (n=2)
	Capitalize on individual strengths (n=1)
Barriers to Collaboration	Peers work in different units/clinics (n=3)
	No other peers at the organization (n=1)
	Peer meetings censored by supervisor (n=1)
	Peers getting power (n=1)
	No place for peers to meet (n=1)
	Management (n=1)

Indicators of effective collaborative relationships between peers. Twelve interviewees described engaging in cooperative problem-solving (or co-supervision/co-reflection) with other peers at their organization. For example, one interviewee explained: "We collaborate together very well. It's effective. We come to each other for suggestions on how to engage someone for resources out in the community. We have great relationships as peers."

Ten interviewees indicated that they have regular opportunities to meet with other peers at their organization. For example, one interviewee explained: "We were all at different clinics, so we would meet once a week for staff meetings."

Three interviewees emphasized the importance of open communication with other peers at their organization. For example, one interviewee explained:

> Peer supports tend to communicate pretty readily here. Because we see people who are right coming off the street and follow them if they choose, all the way into their own independent living. So, all of that requires a lot of communication.

Two interviewees indicated the importance of having a shared purpose with other peer specialists at their organization. For example, one interviewee explained how peers share a common purpose of communicating about and working with other staff who are recovery-oriented:

> We'll say, "Oh, you know, I talked to Dr. so-and-so and they were really awesome the other day. They're somebody you can go to." So we "out" the allies and then let each other know who they are when we need to get something done or get something approved.

Finally, one interviewee described how peers work together effectively by capitalizing on each other's individual strengths: "Everybody has a different skill set. Everybody's good at different things. We're all not good at this and we're not all good at that."

Barriers to collaboration between peers. Three interviewees noted that a barrier to collaboration is that peers are spread out across different units or clinics in an organization, limiting the amount of contact they have with one another. For example, one interviewee explained:

> We didn't get to work together all in one setting. We were all dispersed all through the community and then we would all come together once a week. So, we never even got to see each other as teams. So you had to be a very independent worker.

Another interviewee noted that a barrier to collaboration with other peers is that they were the only peer at their organization: "That was probably the biggest challenge in my job, in where I worked because I was alone. I was the only one. And it was more times than not really hard."

One interviewee noted that while peers at their organization met regularly, they did so only with their supervisor present who censored peers' ideas, thus limiting collaboration:

> Well, we do have a monthly meeting. Unfortunately, our supervisor requires that we allow her to be present at that meeting. So, we're not allowed to discuss things or do like a support group type setting or anything anymore during that meeting because she just wants to hit specific points, such as budget constraints, how many client hours we're doing.

Another interviewee described peers obtaining power as a barrier to collaboration:

> It seems like if we do get a little bit of power, we aren't real sure of what to do with it. And we start eating each other and biting each other's heads off and consuming our children. So sometimes, you can foster an environment where peer providers are able to work with each other in harmony and under appropriate situations. And sometimes, it's the World Wrestling Federation.

One interviewee explained that there was nowhere for peers to meet or gather at their organization:

> I wish the peer mentor department was a little bit bigger because there were only three or four people and then we spread out so far that we didn't really have a main office to gather and talk about stuff. We met in hallways or somebody else's office.

Finally, one interviewee noted management as a barrier to effective collaboration between peers:

> The peers as a group could be more collaborative if management would get out of the way. It's like we come up with ideas of doing stuff together, like free clinics with a clinic van, and take people to an activity. "Oh, well that's gonna take too much coordination." "Oh, we can't do it on a Saturday morning because we're not gonna pay overtime." Everything is "we can't." The managers say "we can't."

Table 38: Interview Codes -- Collaboration between Peers and Non-Peer Staff

Indicators of Effective Collaborative Relationships	Shared purpose (n=14)
	Capitalize on individual strengths (n=8)
	Cooperative problem solving (n=8)
	More referrals (n=8)
	Peers attend staff meetings (n=5)
	Peers part of treatment team (n=4)
Resources Supporting Effective Collaborative Relationships	Seeing the power of peer support (in terms of client outcomes) (n=4)
	Communication (n=3)
	Non-peer staff buy-in (n=2)
	Team-building trainings (n=1)
	Via Hope opportunities to collaborate (n=1)
	Training non-peer staff on peer support (n=1)
	Leadership support (n=1)
Indicators of Ineffective Collaborative Relationships	Peers are not part of treatment team (n=5)
	Peers do not get enough referrals (n=4)
	Peers have to ask caseworkers for referrals (n=1)
Barriers to Effective Collaboration	Non-peer staff do not want to collaborate with peers (n=4)
	Caseworkers resent peers (n=2)
	Non-peer staff dump unwanted tasks on peers (n=2)
	Peers averse to sharing client information with other staff (n=1)
	Disagreement over clients' goals (n=1)
	Peers are not kept in communication loop (n=1)
	A lack of relationship building (n=1)
	Some peers are not open to feedback (n=1)

Indicators of effective collaborative relationships between peers and non-peer staff. Fourteen interviewees described effectively collaborating with non-peer staff toward a shared purpose – namely, helping people in services. For example, one interviewee explained this shared purpose: "We're all in this about helping people and…we all have a heart and all of us have a mindset that we're here to help and serve other people."

Eight interviewees described capitalizing on individual strengths -- that is, non-peer and peer staff collaborate together effectively by recognizing and valuing the unique strengths and perspectives that each brings to the table. For example, one interviewee explained:

> The doctor values us in what we do and our work more than anything…because he feels that when we provide our services and we have sessions, that he gets a lot more details. He gets a lot more of who the person is and how he can better treat that person because they've opened up more to us. They're honest with us.

Eight interviewees also described engaging in cooperative problem-solving with non-peer staff -- that is, working together with non-peer staff to improve the lives of people in services. As one interviewee explained:

> I would be called in to assist. It was almost like it was a consult. If you need assistance, you say what the problem is. You could shoot me an email or send me a phone call, and then I will either follow up with the veteran, if they're engaged, or I would go with the social worker to meet the client if they were ambivalent.

Another indicator of effective collaborative relationships between peers and non-peer staff mentioned by eight interviewees is that peers receive more referrals from other staff than they did in the past, as explained by one interviewee: "We started noticing more referrals, and that's how we felt our integration. When we received more referrals we felt that we were being more respected."

Five interviewees reported that an indicator of effective collaborative relationships between peers and other staff is that peers attend staffing meetings. For example, one interviewee said: "We would occasionally go to the caseworker meetings like I said. That was some collaboration."

Finally, four interviewees reported being an active part of the treatment team. As one interviewee explained:

> I would get a new referral and then I would work with the case manager that was assigned to them. And also, the psychiatrist that was assigned to them. We would meet and discuss progress regularly, challenges, and the case manager would solicit my help with finding housing or finding community support, food. Stuff like that.

Resources supporting effective collaborative relationships between peers and non-peer staff. Four interviewees reported that peers and non-peer staff have effective collaborative relationships because non-peer staff have seen the power of or the positive impact that peer support has made in terms of client outcomes. For example, one interviewee explained:

> They're working with clients every day and they see the difference that we make and they're willing to listen to us. So, I think that's really why we have a good working relationship with them. They're like, "Wow, things are so different since we've had peers and it's gotten so much better" and our clients are asking, "Hey, can I meet with a peer about this?"

Interviewees described several other resources that have contributed to effective collaborative relationships between peers and non-peer staff including communication, non-peer staff buy-in and open-mindedness, staff trainings on peer support, Via Hope opportunities to collaborate (e.g., Via Hope workshops, trainings), and leadership support.

Indicators of ineffective collaborative relationships between peers and non-peer staff. Five interviewees reported that peers are not an active part of treatment team meetings and decision-making. For example, one interviewee explained:

> If there's anything of a greater magnitude, it's like – "Okay. Get out. It's time to get off the field" kind of thing. Whereas, the people in recovery [clients] are like, "I need her. I want her here with me through this process and you're pretty much kicking her to the sideline and taking over and you're not the person that I want to really deal with right now."

Four interviewees reported that they are not receiving "enough" referrals from other staff. For example, one interviewee explained: "There were a lot of people that just weren't willing to refer any clients to me because

there's…a little bit of prejudice towards peer support specialists." Similarly, one interviewee reported that peers have to ask case managers for client referrals.

Barriers to collaboration between peers and non-peer staff. Four interviewees reported that a barrier to collaboration between peers and non-peer staff is that non-peer staff do not want to work with peer specialists. For example, one interviewee explained:

> I've been able to engage a few non-peers but it's sometimes tough because I don't think we have the respect that we deserve as peers. I think that sometimes they look at us as not needed. They avoid some engagements, some collaborations. As far as other peers and them getting good relationships with non-peers, they have complained about it being tough to get engaged with non-peer staff.

Similarly, two interviewees reported that a barrier to collaboration is that case managers resent peer specialists. For example, one interviewee explained:

> We're in debt up to our elbows, and here you come making a dollar less than what we're making and it's an icy feeling. You can tell. Not all but I guarantee 80 percent of all caseworkers, peer mentors rub them the wrong way. The policy is for them to get along with us. You can see them trying but as soon as they turn that corner – as soon as their head turns, you can see the expression leave or sometimes you hear conversations.

Two interviewees also reported that a barrier to collaboration is that case managers sometimes "dump" unwanted tasks on peer specialists. For example, one interviewee explained:

> Case management, "Oh, we can get Sarah[2] to do it" or "Why can't Sarah do that as part of her job?" And I carried a heavy caseload for just one person. I was assigned tasks that they felt they didn't have time for.

Interviewees reported several other barriers to collaboration, including peer specialists being averse to sharing confidential client information with other staff, disagreement between peer specialists and non-peer staff over client recovery goals (e.g., life goals versus symptom management), peer specialists not being included in the communication loop, a lack of relationship building between peer specialists and non-peer staff, and peer specialists not being open to critical feedback from other staff.

Peer Specialist Integration: Funding

Interviewees were asked about any funding issues they have experienced at their organization. Several codes emerged and were categorized as: 1) Funding resources, 2) Indicators of funding resources, 3) Funding issues, and 4) Billing. For a list of all codes related to funding and billing see Table 39.

[2] Pseudonym

Table 39: Interview Codes – Funding

Funding Resources	Grants (n=7)
	1115 waiver (n=3)
	Allocated funds (n=1)
	Multiple sources (n=1)
	Shifts in funding sources over time(n=1)
Indicators of Funding Resources	No funding issues (n=6)
	Organization provides vehicles for peers (n=1)
Funding Issues	Low pay for peers (n=3)
	Hiring freeze for peers (n=2)
	No space for private offices for peers (n=2)
	Need more peer support staff (n=2)
	Need more money (n=1)
	Dilapidated facility (n=1)
	Peers low on budget priorities (n=1)
	Receive no benefits as a contract employee (n=1)
	Unlike other departments, peer support department does not have an automatic budget (n=1)
	Funding is always a concern (n=1)
	Receiving peer support is only a 30-day program (n=1)
	Lack basic supplies (n=1)
	No paid positions for peer specialists (n=1)
	Peers cannot work full time (n=1)
	Cannot afford to hire peers for every clinic (n=1)
Billing	Peers bill (n=5)
	Peers have quotas for client interactions (n=3)
	Productivity standards for peers are too high (n=3)
	No quotas for client interactions (n=2)
	Peers are not allowed to bill Medicaid (n=2)
	Peers unable to bill is a barrier to integration (n=1)
	Not having to bill allows for better relationships with clients (n=1)
	Organization created a combined clinical and peer role so that peers could bill Medicaid (n=1)

Funding resources. Seven interviewees reported that peer specialists are funded by grant money while three interviewees reported that 1115 waiver money helps to fund peer specialists at their organization. One interviewee reported that allocated funds are used to fund peer specialists, while another interviewee reported that funding for peer specialists relies on multiple funding sources. Finally, one interviewee explained that the funding sources for peer specialists have shifted over time.

Indicators of funding resources. Six interviewees indicated that there are no funding issues related to peer specialists at their organization. Additionally, one interviewee reported that an indicator of funding resources is that their organization provides vehicles and gas allowances for peer specialists.

Funding issues. Three interviewees reported that peer specialists received low pay at their organization. For example, one interviewee explained:

> I was trying to get us a pay raise at my job, I was telling them "We are paid less than a lot of other places. You guys don't understand -- $8.00 an hour is nothing." So, I told them and they said "Those places are in big towns and this and that." I said "Not all of them."

Two interviewees reported that there was a hiring freeze for peer specialists at their organization. One interviewee explained: "For the last year, when I've had open positions for peer providers, I have not had the opportunity to hire folks in the open positions. It's been locked up." Similarly two interviewees explained that there is a need for more peer support staff at their organization.

Two interviewees reported that peer specialists at their organization are allocated very little space for group or private meetings. As one interviewee explained:

> We have to use other people's offices when we have groups or we have to use the conference room if we have a group or sometimes, they don't want to come see the counselors or the doctors. They want to just come see the peer support. So I have to go find space for it to be private.

Several other funding issues were identified by interviewees including the need for more money, working in a dilapidated facility, peer specialists as being low on the list of budget priorities, working as a contract employee and receiving no benefits, funding always being a concern, the peer support department not having an automatic budget (unlike other departments at the organization), peer support only being a 30-day program for clients, lacking basic supplies, not having any paid positions for peer specialists, peer specialists being able to only work part-time, and not having enough money to hire peers for every clinic in an organization.

Billing. Survey respondents were asked if their organization bills Medicaid for any of the services they provide. Slightly more respondents who were currently employed as a peer specialist reported that their organization bills Medicaid for their services compared to those who were previously employed as peer specialists (41.9% vs. 35.0% respectively).

Table 40: Medicaid Billing for Peer Specialist Services

	Currently a peer specialist	Previously a peer specialist
Organization bills Medicaid	36 (41.9%)	7 (35.0%)
Organization does not bill Medicaid	38 (44.2%)	9 (45.0%)
I don't know	12 (14.0%)	4 (20.0%)
Total	86 (100.0%)	20 (100.0%)

Interviewees were not directly asked about billing for Medicaid; however, several interviewees spoke about billing concerns. Opinions were mixed in terms of how interviewees felt about billing for Medicaid. Five interviewees reported that peer specialists bill for their services. For example, one interviewee explained: "Yeah, we do bill for Medicaid. Rehabilitative services is how we bill." Another two interviewees reported, however, that peers were not allowed to bill for services at their organization. One explained:

> Seventeen other LMHAs [local mental health authorities] in Texas bill peer support as psychosocial rehab at the same rate as the caseworker. Here the people in management are not on board with the idea that what we're doing is the same thing as what the caseworker is doing in that respect.

One interviewee reported that the fact that peers were unable to bill at their organization was a barrier to peer specialist integration:

> The organization that I worked at, we were very, very – as far as our president and our CEO and all the VP's, everyone was very big on billing and making money. And peers do not bill. And because of that, we kind of got slanted to the side...Because there was a stigma. We definitely dealt with stigma every day.

This same interviewee, however, reported that to address this issue, leadership at the organization created a combined clinical and peer role so that peers could bill:

> My supervisor and her supervisor created a position and I was able to be the peer QMHP-CS, so I was able to do clinical and peer work, and that was really successful for an organization to be able to have a peer also be a case manager…once that position was made, where we were able to incorporate someone who could bill, but then could also turn off and do another code and provide peer services, we started really gaining more credibility and finding ourselves in clinics more…And that really helped us integrate because they saw us as completely equal…once they started seeing, "Oh, they can also provide the same job that I'm doing and be a peer?"

In contrast, one interviewee reported that not billing allowed for better and more authentic relationships with clients:

> There was an advantage in not doing billable hours in that my time was focused totally on the residents there, not on paperwork, on anything else. Just focused on them. And it made me able to say to them, "I am a staff member here, but I'm closer to where you are than staff."

Three interviewees reported that peer specialists have quotas in terms of how many hours or client interactions they must meet. For example, one interviewee explained:

> This will be the last year that we get funding under that waiver. So, at the last meeting that we had with our supervisor we were told that we needed to bring in at least 30 hours of client time every month to pay our wages and it would probably be going up and if we couldn't do that, this might not be the place for us.

Similarly, three interviewees reported that their productivity standards or number of client interactions they must meet is too high. For example, one interviewee explained: "Seeing 100 clients in a month for an hour each is a lot for me." Two interviewees, however, reported that they did not have any quotas for client interactions which they saw as facilitating more authentic relationships with people in services. For example, one interviewee explained meeting with their supervisor:

> We'll discuss who I'm meeting with, how it's going, how my interactions have been with staff, but he's not counting how many people I meet with or how many interactions I'm having, which helps. It allows my work to be more authentic and mutual. So it's not about numbers. It's not about quantity. It's more about the quality of the relationships I'm building.

Peer Specialist Integration: Organizational Culture

To examine the recovery orientation of the employer organizations of survey respondents, the 15-item Recovery Self-Assessment adapted by TIEMH staff (RSA-TIEMH; Lodge et al., 2016) from the original Recovery Self-

Assessment (O'Connell, Tondora, Croog, Evans, & Davidson, 2005) was included on the survey. Individuals who were currently working or volunteering or had previously worked or volunteered in a peer specialist capacity were asked to rate their current or former organization of employment on a 5-point Likert scale with 1 being "Never" and 5 being "Always." The findings in Table 41 present the average score for each item on the RSA-TIEMH.

Survey respondents who were currently working or volunteering as a peer specialist rated their employer organization higher on all 15 items of the RSA-TIEMH compared to survey respondents who previously worked or volunteer in a peer specialist capacity. For both groups, the three items that were ranked the highest were: "our organization believes people can grow and recover," "our organization models hope," and "our organization is open with people about all matters regarding their services." The following two items were ranked in the lowest 3 by both groups: "our organization encourages people to take risks and try new things," and "our organization offers people opportunities to discuss their spiritual needs when they wish." Those currently employed also ranked "our organization provides trauma-specific services" in their lowest 3; those previously employed ranked "our organization offers services that support people's culture or life experiences" in their lowest 3.

Table 41: Recovery Orientation

Our organization...	**Currently a peer specialist**	**Previously a peer specialist**
...asks people about their interests.	3.81	3.15
...supports people to develop plans for their future.	3.90	3.40
...invites people to include those who are important to them in their planning.	3.89	3.30
...offers services that support people's culture or life experience.	3.74	3.00
...introduces people to peer support or advocacy.	3.96	3.10
...encourages people to take risks to try new things.	3.57	3.00
...models hope.	4.05	3.65
...focuses on partnering with people to meet their goals.	3.97	3.50
...respects people's decisions about their lives.	3.91	3.55
...partners with people to discuss progress toward their goals.	3.94	3.55
...offers people a choice of services to support their goals.	3.89	3.50
...offers people opportunities to discuss their spiritual needs when they wish.	3.60	3.00
...believes people can grow and recover.	4.06	4.05
...is open with people about all matters regarding their services.	4.00	3.55
...provides trauma-specific services.	3.58	3.05
Total Mean	3.85	3.36

Survey respondents were asked about non-peer specialist staff's overall level of supportiveness. For this item, a 10-point response scale was utilized. Individuals currently employed as peer specialists rated non-peer specialist staff's overall level of supportiveness higher than those who were previously employed as peer specialists.

Table 42: Non-peer Specialist Staff's Level of Supportiveness

	Currently a peer specialist Mean (SD) n=77	Previously a peer specialist Mean (SD) n=20
How would you rate non-peer specialist staff's overall level of supportiveness? *1 – Not at all supportive; 10 – Very supportive*	7.3 (2.5)	5.5 (3.2)

Survey respondents were asked to indicate the degree to which they feel accepted and respected by colleagues as well as the degree to which they feel stigmatized as a result of the actions or words of their coworkers. A 5-point Likert-type scale was utilized with 1 being "Strongly Disagree" and 5 being "Strongly Agree." Individuals currently working as a peer specialist were more likely to agree or strongly agree that they feel accepted and respected by colleagues compared to individuals previously working as a peer specialist. Additionally, individuals previously working as a peer specialist were more likely to disagree or strongly disagree that they feel stigmatized as a result of the actions or words of coworkers compared to individuals currently working as a peer specialist.

Table 43: Degree to which Individual Feels Accepted and Respected by Colleagues

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Currently a peer specialist (n=80)	4 (5.0%)	1 (1.3%)	11 (13.8%)	25 (31.3%)	39 (48.8%)
Previously a peer specialist (n=20)	4 (20.0%)	2 (10.0%)	3 (15.0%)	6 (30.0%)	5 (25.0%)

Table 44: Degree to which Individual Feels Stigmatized as a Result of the Actions or Words of Coworkers

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Currently a peer specialist (n=78)	30 (38.5%)	20 (25.6%)	14 (17.9%)	7 (9.0%)	7 (9.0%)
Previously a peer specialist (n=20)	4 (20.0%)	4 (20.0%)	7 (35.0%)	4 (20.0%)	1 (5.0%)

Interviewees were asked to describe if their organization supports recovery and peer specialists (in terms of language, values, and norms) and what the indicators of that support or lack thereof were. Several codes related to organizational culture emerged and were categorized as either 1) indicators of a supportive organizational culture or 2) indicators of an unsupportive organizational culture. For a full list of codes related to organizational culture, see Table 45 and Table 46.

Table 45: Interview Codes -- Indicators of a Supportive Organizational Culture

Revolutionary spirit among peer specialists (n=16)
Staff buy-in (n=13)
Leadership support/buy-in (n=12)
Peers get a lot of input into organizational operations (n=8)
Peers set up programs/groups (n=7)
Peers are on organizational committees/coalitions (n=6)
Recovery-oriented culture (n=6)
Organization has adopted more recovery-oriented and person-centered language (n=5)
Peers are represented across the organization (n=5)
Peers are built into the formal intake and service-provision process (n=4)
Person-centered culture (n=4)
People in services can walk into the organization and meet with peers at any time (n=2)
Buy-in from people in services (n=2)

Indicators of a supportive organizational culture. Sixteen interviewees reported that peer specialists at their organization have what TIEMH researchers are calling a "revolutionary spirit" -- that is to say that peer specialists work to affect change at their organization. For example, one interviewee exemplified this revolutionary spirit:

> I am serving on a committee for…community trauma-informed care for an organizational change…I was told the only reason I'm on it is because I'm a consumer and they had to have a consumer voice. I was like, actually, "I'm a client and I'm a staff member and I'm a peer." But, anyway, so I have been included on that and I am speaking out vehemently…when we got the surveys back, one of the lowest scores...was *being consumer-driven*. So, fortunately, I was able to argue that fact with the committee and they have agreed with me to take on being more consumer-driven.

Thirteen interviewees reported that staff at their organization buy in to peer support. For example, one interviewee said of staff at their organization: "They're all very big on the idea that peer services can be a key component in someone's long-term recovery." Similarly, twelve interviewees indicated that leadership at their organization support peer support. For example, one interviewee explained:

> I like the fact that the upper people above me that had the vision to see that peer support could work, and now that I'm doing it – I'm the only person right now – they're trying to expand it and they're allowing me to break ground in different areas.

Eight interviewees reported that peer specialists get a lot of input into organizational operations and processes. For example, one interviewee explained: "If I come up with an idea, I can pitch it to them and they run it through and then they'll give me the green sign to go." Similarly, seven interviewees described peer specialists setting up programs or groups. For example, one interviewee explained:

> They allowed us to come up with startup groups and start it up. "You wanna have a group for this? You wanna have a group for that? Alright. Get it going. What do you need? How can we help? You need a room? You need a set time for a certain room? Let us know."

Six interviewees reported that peer specialists serve on organizational committees or coalitions at their organization. For example, one interviewee explained:

> My supervisor's done a really good job of making sure we have a peer support specialist on every committee there. So we have a diversity committee. We have a leadership committee. We have a community relations and planning committee…So peer support is always welcomed, invited, and they prefer to have one of us on those teams.

Six interviewees reported that their organization has a recovery-oriented culture. For example, one interviewee explained:

> We have a recovery team of people…there's a recovery department. They worked really hard to get person-centered treatment plans as a new thing. Person-centered recovery plans they call them now. That kind of feels like the crux and the philosophy of where everyone works from; the clinical team, the education rehab teams.

Similarly, five interviewees reported that their organization has adopted the use of more recovery-oriented and person-centered language. For example, one interviewee explained:

> I think that our language has gradually changed over the last four years or so just because we use the word recovery a lot…and we say mental health. We don't say mental illness…We have encouraged the case managers to do that since we work so closely with them. They have started saying mental health instead of mental illness. We tell people a lot that they're not their diagnosis.

Five interviewees also reported that peer specialists are represented across the organization (i.e., across different units, clinics, or departments). For example, one interviewee explained:

> We've got peer specialists in behavioral health, we've got them in addiction services, we've got them in housing. We even have a telephonic peer that's part of the emergency screening system. We call it iCare. It's a 24-hour intake point for non-emergency mental health. And we have peers in supported employment. So really across all areas of behavioral health we've got peers.

Four interviewees reported that peer specialists are built into the formal intake and service-provision process at their organization. For example, one interviewee explained:

> We also were always meeting with people immediately after intake. So anybody coming into the agency, who qualified for peer services…would meet with one of us. So we were able to meet almost everyone starting and let them know about peer support.

Four interviewees also described their organization as having a person-centered or client-driven culture. For example, one interviewee described how people in services have a voice in organizational processes:

> We've started patient voice meetings…that's where the patients and administration meet together and they talk about the different issues and challenges that are going on…things that are working well, groups and classes that are working well, employees that are doing a good job, and some of the things that could be changed or issues they're having trouble with that have not been solved.

Two interviewees also reported that an indicator of a supportive organizational culture is that people in services can walk into the clinic at any time and meet with peer specialists. For example, one interviewee explained:

> The people that we see, they don't need to be clients of the clinic, they can just walk in and they can just show up, they don't need an appointment – we are in the front of the clinic, we have an open door policy – they can come in any time of day even.

Finally, two interviewees mentioned that people in services have bought into the idea of peer support. For example, one interviewee explained: "Some people [in services] have come up to me, after they got to know me, and said, 'I appreciate what you're doing. I would love to do what you're doing.'"

Table 46: Interview Codes -- Indicators of an Unsupportive Organizational Culture

Lack of staff buy-in (n=13)
Stigma (n=10)
Staff resistant to change (n=8)
Organization is slow to understand peer support and its value (n=7)
Lack of leadership buy-in (n=5)
Organization is not recovery-oriented (n=5)
Organization is not person-centered/client-driven (n=4)
Peers are not disseminated across organizational departments/clinics (n=3)
Organization is just learning about recovery and thus, is in the pre-PSI stage (n=2)
Lost identity as mental health peers due to a merger with addiction services (n=1)
Human Resources staff ignore abuses against peer specialists (n=1)
Peers' sessions with clients are not confidential (n=1)
Peers are not on organizational committees (n=1)
Peers are tokens (n=1)
Peers are not included in staff meetings (n=1)
Staff do not care about clients, they are just there for a paycheck (n=1)
Leadership ignore violations of clients' rights (n=1)
Leadership do not know how to support peers (n=1)
Organization is slow to expand the peer support program (n=1)
Backsliding due to the loss of a champion (n=1)
Being a change agent/advocate causes retaliation (n=1)

Indicators of an unsupportive organizational culture. Thirteen interviewees reported that staff at their organization do not support/buy in to the notion of peer support. For example, one interviewee explained:

> The therapists and the doctors and some of the caseworkers really didn't take advantage of what we had to offer. I was able to work with some of the caseworkers because they were on board with the idea of peer specialists, but other people were not.

In addition to a lack of staff buy-in, ten interviewees specifically mentioned that staff stigmatized peer specialists at their organization. As one interviewee said "We definitely dealt with stigma every day." Another interviewee further elaborated:

> They probably weren't quite ready to accept a peer specialist as a peer – as an equal on their treatment team. "Who is this person? This person doesn't have any type of degrees or anything like this. He's a patient, himself – a former patient or whatever."

Eight interviewees reported that staff at their organization were resistant to change -- specifically in terms of buying in to peer support and the notion of recovery. For example, one interviewee explained: "When I came in, fresh and jolly and was like, 'How about this? How about this?' It was 'Change is hard.' Change is really hard to think about, even the smallest things."

Similarly, seven interviewees reported that their organization was slow to understand peer support and its value. For example, one interviewee explained: "I just wish that we could move a little faster with getting people to understand peer services and how it can help."

Five interviewees reported that there was a lack of leadership buy-in for peer support at their organization. For example, one interviewee said of leadership at their organization:

> [I was] presenting information on how it is very possible to have peers and have a peer program that's sustainable and successful…And then feeling like they're slamming the door saying, "You know what? We don't care enough about this to even hear you out."

Five interviewees also reported that their organization was not recovery-oriented. For example, one interviewee explained:

> I don't like the system. I don't like forced medication. I don't like that we're teaching people that that's the only solution...and then the attitude of staff it's – "They want a free meal. They want a place to live."

Similarly, four interviewees reported that their organization was not person-centered or client-driven. As one interviewee explained:

> I'd like to see the mental health professionals at [name of organization] treating people as people, as individuals, embracing them on a level at which folks would begin to feel like they were valued. And I don't see any of that.

Three interviewees reported that peer specialists at their organization were not disseminated across different departments or clinics. As one interviewee explained:

> We don't have peers in our substance abuse department, in our children and adolescent department, in our IDD department, in supported employment for housing or benefits. So, there are no peers involved in any of those different departments of our organization, only in adult behavioral health.

Two interviewees reported that their organization is just learning about recovery and, therefore, is in the pre-PSI phase. This notion -- that an understanding of recovery must precede PSI likely reflects the structure of Via Hope program planning. As one interviewee explained:

> They got the grant for their Recovery Institute, the Leadership Academy. So…there were small changes. I think the next step would have been peer support integration…that's just where they were with the level of, "What is recovery?" and so…I don't think there was really an integration process.

Interviewees reported several other ways that the organizational culture at their organization was not supportive, including: peer specialists at their organization lost their identities as mental health peers due to a merger with addiction services, Human Resources staff ignore abuses against peer specialists, peer specialists' sessions with clients are not considered confidential (and must be documented), peer specialists are not on organizational committees, peer specialists are considered tokens and not taken seriously, peer specialists are not included in staff meetings, staff do not care about people in services and are only working to collect a paycheck, leadership ignore violations of clients' rights, leadership do not know how to support peer specialists, the organization is slow to expand the peer support program, the loss of a peer support champion resulted in cultural regression or backsliding, and being a change agent or advocating for people in services results in retaliation from other staff.

Peer Specialist Integration: Recruitment and Hiring

Interviewees were asked to describe how they were recruited to be a peer specialist. Several codes related to recruiting and hiring peer specialists emerged and were categorized as either 1) personal recruitment stories, 2) indicators of successful recruitment and hiring methods, or 3) recruitment and hiring issues. For a full list of codes related to recruitment and hiring peer specialists, see Table 47.

Table 47: Interview Codes -- Recruitment and Hiring

Personal Recruitment Stories	Recruited by case manager (n=6)
	Started as a volunteer (n=6)
	Learned that lived experience was a job requirement (n=4)
	Recruited at a training (n=4)
	Had a personal relationship with someone providing peer services (n=3)
	Searching mental health jobs (n=2)
	NAMI internship in college (n=2)
	Referral from a contact made volunteering (n=1)
	Becoming a peer specialist required to maintain employment (n=1)
	Recruited through VA (n=1)
	Recruited by supported employment officer (n=1)
	Learned about peer support work through work as a peer recovery coach (n=1)
	Self-advocacy (n=1)
Indicators of Successful Hiring and Recruitment Methods	Peers represent a sizable proportion of the staff at the organization (n=2)
	Organization is hiring more peers (n=1)
	Organization recruits from clients (n=1)
	Organization provides training for prospective peer specialists on how to get hired (n=1)
Recruitment and Hiring Issues	Too many peers, not enough jobs (n=2)
	Unable to get hired at volunteer organization (n=2)
	Need better recruitment methods for peer specialists (n=1)
	Need an employment hub for unemployed peer specialists (n=1)
	Hiring decisions made on the basis of personality (n=1)
	Unable to find peer specialists in the area to hire (n=1)

Personal recruitment stories. Six interviewees reported that they were recruited by their caseworker. For example, one interviewee explained:

> I was a client at the center and when the peer program was starting, my case manager talked to me and said “They are starting this new program and they’re looking for people who are clients here and that are interested in working here and working with other people to help them overcome some of the obstacles and barriers and understand their diagnosis and things like that. Would you be interested?”

Six interviewees reported that they began as volunteers before becoming employed as a peer specialist. For example, one interviewee explained: “I volunteered there almost two years doing some peer groups because I wasn’t secure in my abilities at that time after seven years of doing nothing, so volunteer work.”

Four interviewees described the importance of learning that lived experience of mental health issues was a job requirement of the peer specialist role. For example, one interviewee explained:

> When I first found out that there was such a thing as peer support that I could use the things that I had been struggling with in the past – like my mental health issues, and my substance abuse, my recovery – I could use that as a means to actually help myself and help others, it’s very exciting. So, it's like, as people, I guess, individually in their own experiences find out about that, they want to be a part of it.

Four interviewees reported that they were recruited to be a peer specialist at a training they attended. For example, one interviewee explained:

> Well, I had taken Mental Health First Aid training and it ended up being at the agency where I then worked. I just independently decided to take this training. I didn’t even know that peer specialists existed, but there were a couple at the training. Then the person who ended up being my supervisor was actually leading the training.

Three interviewees reported that they became a peer specialist because they had a personal relationship with someone employed as a peer specialist. For example, one interviewee explained: “I had a friend that was a peer specialist and she actually kind of told me about the job when it was opening up, when the program was just being revved up, and I applied for the position.”

Two interviewees reported that they were searching mental health jobs when they saw job postings for peer specialists. Another two interviewees reported that they learned about peer support through college internships at the National Alliance on Mental Illness (NAMI).

Interviewees also reported being recruited through the Department of Veteran’s Affairs (VA), through a supported employment officer, through work as a peer recovery coach, and through a referral from a contact made while volunteering.

Another interviewee reported that they became a peer specialist because it was a requirement to maintain their employment:

> Well, actually the job was contingent on it. I started in the intake department here. And they wanted to make sure that the first point of contact [for people in services] were gonna be certified peer support specialists…So my job was actually contingent on taking the training.

Finally, one interviewee emphasized the role of self-advocacy in their recruitment story:

> How was I recruited? Self-advocacy. Once I went to a conference and Dan Fisher spoke about recovery. That was the first time I’d ever heard about that, it empowered me. I got involved in the community. Anything with mental health, I would go to one of the universities and listen to a lecture.

Indicators of successful hiring and recruitment methods. Although interviewees were not specifically asked about indicators of successful hiring and recruitment methods, a few indicators emerged organically. Two interviewees indicated that peer specialists represented a sizable or significant proportion of the staff at their organization. For example, one interviewee explained: "About 25 percent of the workforce here are peer specialists."

Another interviewee indicated that their organization is currently in the process of hiring more peer specialists: "They've been trying to open up two new positions, one on each campus, for the last two years and they finally got it approved last year and we're in the hiring process right now. So peer support is finally gonna be expanded."

Another interviewee reported that their organization recruits from clients:

> They come out different individuals with a different energy, and they come out knowing the only way they can stay that way is to help other veterans. So, it is a recruiting tool, but that's not the reason we do it.

Finally, one interviewee indicated that the organization that they volunteer for provides training for prospective peer specialists on how to get hired:

> I would attend the classes that they would have for the peer supports...if you wanted to seek employment, they would give you that necessary information and explain the process that you would have to go through in order to try to get a position there.

Recruitment and hiring issues. Two interviewees indicated that there were not enough peer specialist jobs in proportion to the size of the workforce. For example, one interviewee who is underemployed (that is, unable to find full-time work as a peer specialist) explained that people in services often ask about the peer specialist job market:

> I have met several people who have expressed interest in getting their peer specialist certification, but are asking the question, "Well, if I get it, and I go through it, there's still no work for me." And so, that discourages them, and that's a little bit frustrating.

Similarly, two interviewees reported that they were unable to obtain employment at the organization they were volunteering for. For example, one interviewee explained: "I was volunteering at [name of organization] and I had applied for an opening there and didn't get hired. I believe I applied two or three times."

One interviewee reported that there should be better recruitment methods for peer specialists – and specifically mentioned the need for peer specialist recruiters:

> I think recruitment could be a big asset to people that take the training. I wish there was a recruitment role out there like there is for Army, Navy, Air Force, Marines. I think if we had a better process of recruitment, interviews, application process, it would really strengthen our field.

Similarly, another interviewee mentioned the need for an employment hub where unemployed peer specialists could go to for job resources: "I wish there was a peer mentor hub…there should be someplace where out-of-work peer mentors can go for support and direction and help. It's recognized by all of the companies that hire peer mentors."

Another interviewee reported that hiring decisions for new peer specialists were made on the basis of personality, rather than on the basis of job qualifications: "The peer had to be a good fit for the clinic…And our supervisor had to choose a personality type that she thought would fit with this clinic. That was a huge barrier for us."

Finally, one interviewee reported that their organization had a peer specialist job opening that they were unable to fill:

> There came a point when the insurance company that we were contracting with wanted us to have another CPS, but we couldn't find anybody. It startles me about the numbers of people that've been trained, even from this area, that seemed like nobody wanted to work.

Survey results: barriers to obtaining a job as a peer specialist. Survey respondents who were not currently working as a peer specialist were asked if they had encountered any barriers related to obtaining a job as a peer specialist. Slightly less than half of the respondents indicated that they have encountered barriers related to obtaining a job as a peer specialist.

Table 48: Barriers Encountered Related to Obtaining a Job as a Peer Specialist

	n (%)
Yes	12 (48.0%)
No	13 (52.0%)
Total	25 (100.0%)

Survey respondents who indicated that they have experienced barriers related to obtaining a job as a peer specialist were asked to indicate what those barriers were. Twelve individuals responded to this open-ended question (note: this question was only asked of individuals who were not currently working or volunteering as a peer specialist). Barriers listed included: not qualified due to a lack of job experience (n=2), a lack of job opportunities (n=2), age (n=1), a lack of understanding by other mental health staff about the benefit of peer support (n=1), criminal charges (n=1), no full-time jobs for peers at agency (n=1), discrimination (n=1), have not sought a peer specialist job (n=1), red tape (n=1), and pay is too low (n=1).

Peer Specialist Integration: Roles and Role Clarity

Survey respondents were asked about non-peer specialist staff's understanding of their job role as a peer specialist. For this item a 10-point response scale was utilized. Individuals currently employed as peer specialists rated non-peer specialist staff's understanding of their job role higher than those who were previously employed as peer specialists.

Table 49. Non-peer Specialist Staff's Understanding of Job Role

	Currently a peer specialist Mean (SD) n=77	**Previously a peer specialist Mean (SD) n=20**
How would you rate non-peer specialist staff's overall understanding of your job role as a peer specialist? *1 – Very poor; 10 – Excellent*	6.7 (2.7)	5.2 (3.0)

Interviewees were asked about whether staff at their organization have a clear understanding of the job roles and activities of peer specialists. Several codes related to role clarity emerged and were categorized as either 1) indicators of role clarity, 2) resources supporting role clarity, or 3) indicators of a lack of role clarity. For a full list of codes related to role clarity, see Table 50.

Table 50: Interview Codes -- Role Clarity

Indicators of Role Clarity	Staff know what peers do (n=6)
	Staff who interviewee works closely with know what peers do (n=5)
	Allies know what peers do (n=1)
	Staff with longer tenure know what peers do (n=1)
Resources Supporting Role Clarity	Self-advocating by peers (n=16)
	Training on peer support (n=2)
	Employees are considered family (n=1)
Indicators of a Lack of Role Clarity	Staff do not know what peers do (n=15)
	Peers are not providing peer support (n=5)
	Peers providing clinical services (n=5)
	Peers are reprimanded for advocating for clients (n=2)
	Staff have a superficial understanding of peer support (n=2)
	Job description is long and convoluted (n=1)
	Job description does not match evaluation criteria (n=1)
	Boundary issues related to working and receiving services at the same organization (n=1)
	Peers reprimanded for sharing too much of their story (n=1)

Indicators of role clarity. Six interviewees indicated that staff at their organization know what peer specialists do. For example, one interviewee explained: "I think everybody understands the role of peer support within the [name of organization] system. Like management on down." Five interviewees reported that staff who they work closely with know what peer specialists do. For example, one interviewee explained:

> I think the four staff that I work with, they understand what I do, and they understand…all the underpinnings of recovery…But, as an organization as a whole, usually it's kind of on an individual basis to go in and talk to them and say, "Hey, I'm a peer support specialist. This is what I do."

Other interviewees also indicated that only particular staff understand the peer specialist role. For example, one interviewee reported that allies of peer specialists and the recovery movement know what peer specialists do:

> I want to say it varies by discipline, but more or less people. We used to have a superintendent that was a peer himself and he got it. So he did a lot of advocating. There are definitely just random people littered throughout the hospital that I think of as allies. They've got a family member or they've been through some things themselves.

Similarly, another interviewee reported that staff with longer tenure at the organization understand what peer specialists do, whereas newer employees do not:

> There were quite a few that were understanding. I think people that had been there longer at the organization were more understanding. But I think if I can generalize, it would be the newer people felt or may have felt like we didn't have a place there.

Resources supporting role clarity. Sixteen interviewees reported that peer specialists have to advocate for themselves by telling other staff and people in services what peer specialists do. For example, one interviewee explained educating other staff on the peer support role: "They didn't have an idea. I needed to explain that we have roles... it's not just like being a friend."

Two interviewees indicated that training other staff on peer support has resulted in greater role clarity. For example, one interviewee when asked if staff know what peer support does reported: "They do now. We've had a lot of education. We've had in-services. We've had training."

Finally, one interviewee when asked about role clarity reported that staff know what peer specialists do because employees at their organization are considered family: "I would say partially because of training, but also, a big part of it is most of the people that work at [name of organization] are considered family. And I think that's broke down a lot of barriers."

Indicators of a lack of role clarity. Fifteen interviewees reported that staff at their organization do not know what peer specialists do. For example, one interviewee explained: "I don't think that they had a very good understanding of the role of the peer specialist…and, in particular, I think my supervisor, who was a great guy in many ways, did not have a very good understanding."

Five interviewees indicated that peer specialists employed at their organization are not actually providing peer support. For example, one interviewee explained: "So many people are going back and not really doing peer support. They're doing a role with lived experience -- as a caseworker with lived experience or an intake specialist with lived experience, getting people to appointments, driving a van."

Similarly, five interviewees indicated that peer specialists at their organization are providing clinical services. For example, one interviewee explained:

> [My supervisor] doesn't understand peer services and a lot of times we are asked to do things that are clinical and we're told that when we come to our job, we are staff. We are no longer clients and we're no longer peers. That we are to do the services that we provide.

Two interviewees reported being reprimanded by supervisors or management for advocating for people in services – a defined peer specialist role. For example, one interviewee explained:

> You want to…be that voice and…say, "Hey. This isn't right and y'all need to change this…And they have rights." I'm a big advocate on client rights and I'm currently dealing with an issue right now where definitely, lines were crossed; boundaries were crossed. And so, my organization – or I guess you'd say just my supervisors [said] "You're a representative of [name of organization], right?" And I'm, like, "No. Yeah, I represent them but I'm a peer. I'm an advocate for people."

Similarly, two interviewees reported that staff only have a superficial understanding of peer support. For example, one interviewee explained: "I think they perceive us as just another level of support that comes from a little bit closer, shared experience and understanding."

Another issue related to role clarity is peer specialist job descriptions. While the majority of survey respondents (both currently working as a peer specialist and previously working as a peer specialist) indicated that their organization has a job description for their position and that they have a copy of the job description (Table 51 and Table 52), interviewees described specific issues related to the job description for their position.

Table 51: Job Description

	Currently a peer specialist	Previously a peer specialist
Yes	76 (88.4%)	14 (70.0%)
No	6 (7.0%)	2 (10.0%)
I don't know	4 (4.7%)	4 (20.0%)
Total	86 (100.0%)	20 (100.0%)

Table 52: Copy of Job Description

	Currently a peer specialist	Previously a peer specialist
Yes	54 (71.1%)	12 (85.7%)
No	22 (28.9%)	2 (14.3%)
Total	76 (100.0%)	14 (100.0%)

Survey respondents were asked to indicate the degree to which they feel their job description realistically reflects actual job duties. A 5-point Likert-type scale was utilized with 1 being "Strongly Disagree" and 5 being "Strongly Agree." Individuals currently working as a peer specialist were more likely to agree or strongly agree that the job description realistically reflects actual job duties compared to individuals who previously worked as a peer specialist.

Table 53: Degree to which Job Description Realistically Reflects Actual Job Duties

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Currently a peer specialist (n=79)	2 (2.5%)	8 (10.1%)	14 (17.7%)	25 (31.6%)	30 (38.0%)
Previously a peer specialist (n=20)	2 (10.0%)	3 (15.0%)	5 (25.0%)	6 (30.0%)	4 (20.0%)

One interviewee explained that their job description is long and convoluted: "I have a six page job description...I think somewhere back there when they were trying to justify paying consumers anything, they just wanted to make it as long as possible." Similarly, they explained that their job description does not match the criteria upon which they are evaluated: "The criterion on which I am evaluated annually doesn't really tie into it much…it just never occurred to them that those two things should be congruent."

Another interviewee described peer specialists at their organization experiencing boundary issues related to receiving services at the same organization that they are employed at:

> I think the problem is that they're trying to treat them like patients and not staff. I think that's confusing because, for myself, when you come to work, you leave that stuff at the door. But some peer supports actually get their care here. I used to tell the people that I worked with or that I helped supervise in a non-official capacity "If you have the ability to get care out in town, go out in town and get it so you don't mix that, you don't cross that boundary." For some people it's a difficult transition but not for everyone.

Finally, one interviewee reported that peer specialists at their organization have been reprimanded by their supervisor for sharing too much of their recovery story with people in services:

> [Our supervisor] does let us share our recovery story minimally but she would rather that we don't share anything outside of just how we originally started our recovery. She wants us to be very careful about what we share and a few of my peers have been reprimanded. They've been told that they overshare.

Job tasks. Survey respondents were asked to select various job tasks that they performed in their work as a peer specialist from a list of 20 common peer specialist job tasks. Respondents were also provided an "other" option to specify any job tasks not presented in the list. Overall, respondents performed a wide variety of tasks in their role as a peer specialist. Regardless if the respondent was currently working or had formerly worked as a peer specialist, the four most commonly performed job tasks included: helping people advocate for themselves, goal setting, one-on-one support, and connecting people with resources. Current and former peer specialists were also similar with regard to the job tasks performed least commonly, which included: medication management and monitoring, vocational assistance, serving on work groups and committees, and psychosocial rehabilitation. Providing supervision to other peer specialists was an additional job task that was not commonly performed amongst current peer specialists.

Table 54: Job Tasks

	Currently a peer specialist	Previously a peer specialist
Administrative tasks	54 (61.4%)	15 (71.4%)
Connecting people to resources/networking	79 (89.8%)	16 (76.2%)
Education*	48 (54.5%)	7 (33.3%)
Facilitating support groups*	65 (73.9%)	14 (66.7%)
Goal-setting	76 (86.4%)	18 (85.7%)
Helping people advocate for themselves	83 (94.3%)	19 (80.5%)
Housing assistance	41 (46.6%)	10 (47.6%)
Medication management and monitoring	24 (27.3%)	5 (23.8%)
One-on-one support*	73 (83.0%)	17 (81.0%)
Outreach/engagement	53 (60.2%)	16 (76.2%)
Patient navigation	39 (44.3%)	11 (52.4%)
Provide supervision to other peer specialists	24 (27.3%)	10 (47.6%)
Psychosocial rehabilitation	32 (36.4%)	7 (33.3%)
Serve on work groups and committees*	31 (35.2%)	7 (33.3%)
Skill building*	47 (53.4%)	9 (42.9%)
Support clients during transition from inpatient	45 (51.1%)	9 (42.9%)
Transportation assistance	37 (42.0%)	13 (61.9%)
Vocational assistance	26 (29.5%)	5 (23.8%)
Wellness Recovery Action Planning (WRAP)	37 (42.0%)	11 (52.4%)
Working on a treatment team	42 (47.7%)	13 (61.9%)
Other*	8 (9.1%)	3 (14.3%)
Total	88 (100.0%)	21 (100.0%)

*Participants were asked to provide additional information if this job task was selected. This information was qualitatively coded and is presented in Appendix C.

Survey respondents were asked how many people they provide services to each week. On average, individuals who were currently employed as peer specialists served approximately 24 people each week, while those who were previously employed as peer specialists served approximately 25 people each week.

Table 55: Number of People Served per Week

	Mean	Standard Deviation	Minimum	Maximum
Currently a peer specialist (n=84)	24.1	18.9	3.0	102.0
Previously a peer specialist (n=20)	24.8	16.8	3.0	76.0

Survey respondents were asked to describe the population(s) they provide services to. The majority of respondents indicated that they provide services to adult populations, regardless if they were currently or previously employed as peer specialists.

Table 56: Population Served

	Currently a peer specialist	Previously a peer specialist
Adults	82 (93.2%)	20 (95.2%)
Adolescents	13 (14.8%)	1 (4.8%)
Other (please specify) *Child welfare – mental health – substance use* *Ages 15-30 only* *Both* *IDD, geriatric, and other special needs* *Veterans* *Veterans and civilians*	6 (6.8%)	
Other (please specify) *Homeless families* *Veterans*		3 (14.3%)
Total	88 (100.0%)	21 (100.0%)

Peer Specialist Integration: Supervision

Survey respondents were inquired about supervision received, frequency of supervision, and whether their supervisor is also a certified peer specialist. Additionally, they were asked to describe what the supervision they receive looks like. While 84.9% of current peer specialists reported receiving supervision related to their work as a peer specialist, only 55.0% of former peer specialists reported receiving supervision. Of those who do (or did) receive supervision, more than half received supervision on at least a weekly basis.

Table 57: Receive Supervision

	Currently a peer specialist	Previously a peer specialist
Yes	73 (84.9%)	11 (55.0%)
No	13 (15.1%)	9 (45.0%)
Total	86 (100.0%)	20 (100.0%)

Table 58: Frequency of Supervision

	Currently a peer specialist	Previously a peer specialist
Daily	10 (13.7%)	…
2-3 times a week	9 (12.3%)	5 (45.5%)
Once a week	20 (27.4%)	2 (18.2%)
2-3 times a month	12 (16.4%)	1 (9.1%)
Once a month	18 (24.7%)	2 (18.2%)
Less than once a month	4 (5.5%)	1 (9.1%)
Total	73 (100.0%)	11 (100.0%)

Current peer specialists were more likely to report that their supervisors were certified peer specialists compared to respondents who were previously peer specialists (26.4% vs. 9.1%, respectively).

Table 59: Is your Supervisor a Certified Peer Specialist?

	Currently a peer specialist	Previously a peer specialist
Yes	19 (26.4%)	1 (9.1%)
No	49 (68.1%)	9 (81.8%)
I don't know	4 (5.6%)	1 (9.1%)
Total	72 (100.0%)	11 (100.0%)

Survey respondents were asked about their supervisor's understanding of their job role as a peer specialist and their supervisor's overall level of supportiveness. For both items, a 10-point response scale was utilized. Individuals currently employed as peer specialists rated their supervisor's understanding of their job role and overall level of supportiveness higher than those who were previously employed as peer specialists.

Table 60: Supervisor's Understanding of Job Role and Level of Supportiveness

	Currently a peer specialist Mean (SD) n=79	Previously a peer specialist Mean (SD) n=20
How would you rate your supervisor's overall understanding of your job role as a peer specialist? *1 – Very poor; 10 – Excellent*	7.6 (2.7)	6.5 (3.8)
How would you rate your supervisor's overall level of supportiveness? *1 – Not at all supportive; 10 – Very supportive*	8.3 (2.5)	6.3 (3.8)

Survey respondents were asked to indicate the degree to which they feel their supervisor explains the skills or procedures they are expected to perform and the degree to which they feel their supervisor listens to their suggestions, ideas, and opinions. A 5-point Likert-type scale was utilized with 1 being "Strongly Disagree" and 5 being "Strongly Agree." Individuals currently working as a peer specialist were more likely to agree or strongly agree on both of these items compared to individuals previously working as a peer specialist.

Table 61: Degree to which Individual Feels that Supervisor Explains the Skills or Procedures Expected

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Currently a peer specialist (n=78)	2 (2.6%)	6 (7.7%)	18 (23.1%)	25 (28.4%)	27 (34.6%)
Previously a peer specialist (n=20)	2 (10.0%)	1 (5.0%)	7 (35.0%)	8 (40.0%)	2 (10.0%)

Table 62: Degree to which Individual Feels that Supervisor Listens to Suggestions, Ideas, and Opinions

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Currently a peer specialist (n=79)	5 (6.3%)	2 (2.5%)	8 (10.1%)	23 (29.1%)	41 (51.9%)
Previously a peer specialist (n=20)	3 (15.0%)	5 (25.0%)	2 (10.0%)	4 (20.0%)	6 (30.0%)

Table 63: Qualitative Survey Results -- What Does Supervision Look Like (Current Peer Specialists)

Supervisory structure	Supervised by LPHA (n=2)
	Supervised by peer specialist (n=1)
Supervisory methods	Provides Feedback (n=18)
	Monthly Check-in (n=3)
	Provides Training (n=3)
	All Peers Meeting (n=2)
	Clinical Supervision (n=2)
	Discuss Desired Organizational Changes (n=2)
	Daily Supervision (n=1)
	Ensuring Clients are being Helped (n=1)
	Hands-off Supervision (n=1)
	No Supervision (n=1)
	Ten-minute Check-in (n=1)
	Weekly Meeting (n=1)
	Weekly Peer Meeting (Co-Supervision) (n=1)
	Weekly Peer Recovery Coaching Supervision (n=1)
Supervisory Culture	Support/Mentorship (n=20)
	Active Involvement (n=5)
	Advocating for Peers (n=4)
	Autonomy (n=1)
	Open-minded (n=1)
	Supervisor Does Not Know What My Job Is (n=1)

Table 64: Qualitative Survey Results -- What Does Supervision Look Like (Previous Peer Specialists)

Supervisory Methods	Ask Supervisor Questions (n=4)
	Provided Feedback (n=3)
	Daily Meetings (n=2)
	Open-door Policy (n=2)
	Shadowing (n=1)
	Weekly Meetings (n=1)
	Weekly Meeting with Peers & Supervisor (n=1)
	Worked Together Daily (n=1)
Supervisory Culture	Provided Support/Mentorship (n=2)

Interviewees were asked to describe who they were supervised by, what supervision looked like for them (and how they felt about that supervision), and about ways that their supervisor could better support them. Several codes related to supervision emerged and were categorized as: 1) indicators of effective supervision or 2) indicators of ineffective supervision. Further, within these categories, codes were divided into the subcategories of 1) supervisory structure, 2) supervisory methods, or 3) supervisory culture. For a list of all codes related to supervision see Table 65 and Table 66.

Table 65: Interview Codes -- Indicators of Effective Supervision

Supervisory structure	Supervised by a peer specialist (n=3)
Supervisory methods	Open-door supervision (n=11)
	Supervisor provides knowledge and feedback (n=8)
	Weekly meetings with supervisor (n=7)
	Monthly meetings with supervisor (n=2)
	Supervisor created career ladder for peer specialists (n=1)
Supervisory culture	Supervisor provides support and encouragement (n=8)
	Supervisor trusts peers (n=6)
	Supervisor open to peers' ideas (n=6)
	Supervisor advocates for peers (n=5)
	Supervisor invested in learning about peer support (n=4)
	Supervisor is flexible with time off (n=2)
	Supervisor generous with their time (n=1)

Indicators of effective supervision. Three interviewees reported that they are supervised by another peer specialist. For example, one interviewee explained: "My direct supervisor was at every training I think she could possibly go to, along with her supervisor. They're both peer specialists, advanced in the field."

In terms of supervisory methods, eleven interviewees reported that their supervisor has an open-door style of supervision (that is, they can go to their supervisor whenever they need anything). For example, one interviewee explained: "If we're having a certain problem or we need some help or whatever. Yes, she's got an open-door policy. We can definitely go in and talk to her."

Eight interviewees reported that their supervisor provides knowledge and feedback on their work. For example, one interviewee described their meetings with their supervisor:

> We would go through my client list, my caseload. I would just take two or three people and highlight them and spend time on them….And then she would give me feedback on areas that I needed to work on as far as administrative stuff or talk about new projects.

Seven interviewees reported that they had weekly meetings with their supervisor, while two reported that they met with their supervisor monthly.

One interviewee reported that their supervisor created a career ladder for them:

> Within six months, my supervisor and her supervisor created a position and I was able to be the peer QMHP-CS, so I was able to do clinical and peer work, and that was really successful … And then after that, I was able to do program manager after my supervisor left.

In terms of supervisory culture, eight interviewees reported that their supervisor provides support and encouragement. For example, one interviewee described their supervisor:

> She tells me, "You've got a lot to offer." She calls me a "star peer." I'm like, "I don't know about all that." But she's like, "But really, you are my star peer. I always want to use you." I've done a lot of community talks and I've shared my story throughout several community events and stuff like that. So, yes, there is a lot of support.

Six interviewees emphasized the fact that their supervisor trusts them. For example, one interviewee explained:

> She knew our schedules, when our groups were. She'd stay on us, but she also trusted us. Because it is a big trust job, and we're going to a clinic where our supervisor isn't there. Are we coming in on time? Because the program manager there isn't going to really notice.

Six interviewees also reported that their supervisor was open to ideas that peer specialists suggested. For example, one interviewee explained:

> If I want to try doing a music group or a group around music and peer support, he's been real supportive of that or if I want to try doing a group that's all about self-care and doing the nails and aromatherapy stuff. I mean just anything we want to try, he's very supportive. So I feel like I get to keep it fresh and try different things and hone in on what my special skill set is.

Five interviewees reported that their supervisor advocates for peer specialists to organization management when they are not included at the table. For example, one interviewee said: "She advocates every time they have a meeting. She's our voices."

Four interviewees reported that their supervisor is invested in learning about peer support. For example, one interviewee explained:

> We have watched the Via Hope modules together. We talk at length about recovery and what it looks like to me. I have a small YouTube channel, and so she actually took the time to watch all my videos and she had questions, "So, what did it mean? What does this mean in recovery?" And on my very first day of teaching WRAP, she sent me flowers to encourage me. And, on the little note, it said, "Now, I believe that recovery happens."

Two interviewees reported that their supervisor was flexible with taking time off from work, while one interviewee reported that their supervisor gave them plenty of their time.

Table 66: Interview Codes – Indicators of Ineffective Supervision

Supervisory structure	Supervised by non-peer (n=18)
	Peer has multiple supervisors (n=2)
	Peers do not have the same supervisor (n=2)
	Supervised by someone who does not work in mental health (n=1)
Supervisory method	Receives no formal, one-on-one supervision (n=2)
	Receives administrative supervision (n=2)
	Infrequent supervision sessions (n=2)
	Receives no supervision (n=2)
	Never receives any critical feedback (n=1)
	Peer has to fill in supervisory gap (n=1)
	Receives clinical supervision (n=1)
Supervisory culture	Supervisor is not trained or knowledgeable on peer support (n=7)
	Learning about peer services is not a priority for supervisor (n=2)
	Supervisor created hostile work environment (n=2)
	Supervisor does not value peer support (n=1)
	Supervisor "bought out" (n=1)
	Supervisor does not provide flexibility with time off (n=1)
	Supervisor only cares about billing for client hours (n=1)
	Supervisor takes advantage of peers' time (n=1)
	Supervisor interprets negative emotions as symptoms (n=1)
	Supervisor does not listen to peers' ideas (n=1)
	Supervisor may or may not buy in depending on the day (n=1)
	Supervisor does not support peers due to bureaucratic concerns (n=1)
	Supervisor treats peers like clients (n=1)

Indicators of ineffective supervision. Eighteen interviewees reported that they were supervised by someone who was not a peer, while one interviewee reported that they were supervised by someone who did not work in mental health (i.e., program director for the chemical dependency program). Two interviewees reported that peer specialists at their organization have multiple supervisors. For example, one interviewee explained: "I have several [supervisors]...I'm under two people right now, both Client Rights and Rehab programs." Similarly, two interviewees reported that peer specialists at their organization have different supervisors. One explained: "Each of us were assigned a different social worker on the different hall we worked at."

In terms of supervisory methods, two interviewees reported that they received no formal, one-on-one supervision. For example, one interviewee explained: "There wasn't any scheduled, regular, individual supervision." Similarly, two interviewees reported that they received no supervision at all. As one interviewee explained: "So right now, we kind of get pretty much ignored…so there's not really anybody in charge of us." Another two interviewees reported that although they received supervision, it was infrequent. As one interviewee explained:

> If we got it [supervision] twice a week, even if it was only for 40 minutes, half hour, I think that would've been better than once a week or once every other week. You asked me what would be better? If there was one thing, that's the thing that I would improve upon.

Similarly, one interviewee explained that because peer specialists at their organization receive very little supervision, they have filled in that supervisory gap: "If they're asking me for help, I'm going to help them. I do

some supervisory duties and she [supervisor] asks me to write supervisory notes even though I'm not the actual supervisor, so I don't know. It's confusing."

One interviewee explained that although they receive supervision, they are never given any critical feedback:

> I think that there's always room for growth or to better yourself. I think that there should always be a small inch of feedback or something that you can give me that I can work on…. I know there's somewhere where I can do better. I have not experienced that type of supervision, yet.

Finally, three interviewees reported that the type of supervision they receive is not related to their work as a peer specialist; two interviewees reported receiving administrative supervision whereas one interviewee reported receiving clinical supervision.

In terms of supervisory culture, seven interviewees reported that their supervisor is not trained or knowledgeable on peer support. For example, one interviewee explained: "He was not a peer and he had not received any training on how to supervise peer specialists and I think he didn't have a very good understanding of what the role was." Similarly, two interviewees reported that learning about peer support was not a priority for their supervisor. For example, one interviewee explained:

> I've tried to provide her some materials and I showed her where she can see the stuff on the Via Hope website and things like that to learn about peer services but it's not a priority for her right now.

Two interviewees reported that their supervisor has created a hostile (i.e., abusive, retaliatory) work environment. For example, one interviewee explained:

> She [supervisor] said that our old supervisor is not here anymore and we will do it her way. I mean, it's just pretty much "This is the way it's going to be." So, as a matter of fact, it has caused some relapse for some of my other peers and they feel like it's a hostile work environment and, well, they have been re-traumatized in some ways.

Interviewees described several other ways that their supervisors created an ineffective supervisory culture, including: not valuing peer support, no longer supporting peer support (i.e., they "bought out"), not providing flexibility with time off from work, only caring about billing for client hours, taking advantage of peer specialists' time, interpreting negative emotions as symptoms, not listening to peer specialists' ideas and suggestions, being fickle with supporting peer specialists (i.e., "buying in" some days while other days not "buying in"), not supporting peer specialists due to competing bureaucratic concerns, and treating peer specialists as if they are people in services.

Peer Specialist Integration: Training Staff on Peer Support

Interviewees were not asked directly about training other staff on peer support; however, some interviewees mentioned training needs and opportunities. These codes were categorized as either 1) internal training opportunities or 2) internal training needs/issues. For a full list of codes related to training non-peer staff on peer support, see Table 67.

Table 67: Interview Codes -- Training Staff on Peer Support

Internal Training Opportunities	Internal training on peer support (n=3)
Training Needs/Issues	No internal trainings on peer support (n=3)
	Peers need a bigger role in NEO (n=2)
	Awaiting supervisor approval to incorporate peer support into NEO (n=1)
	Peers introduce themselves at NEO, but staff need to be educated about peers more frequently (n=1)
	NEO training on peer support is outdated and clinical (n=1)

Internal training opportunities. Three interviewees reported that their organization provided training on peer support to non-peer staff. For example, one interviewee explained: "They do lunch and learn once a month. And we provide CEUs to the people that attend. So once a year we have a luncheon about peer support."

Training needs/issues. Three interviewees, however, also reported that their organization provides no internal training on peer support. For example, one interviewee explained that there is no training on peer support in new employee orientation (NEO) and that, therefore, most staff lack a clear understanding of the peer support role:

> A lot of them haven't had any formal training about what peer services are. They just hear from us but then they get a different story from the supervisor. So, it's kind of a jumbled deal but we always go, "No, no, that's not what we really do. What we're really supposed to do is…" – so, it's kind of a back and forth. It's difficult.

Two interviewees reported that although peer specialists have a role in NEO, their role is limited and should be expanded. As one interviewee explained:

> Well, the orientation is a two week orientation and as peer support, we have two slots in there, but it's really brief what we talk about. We go in and we answer some questions and we briefly talk about our stories… That was one of the first things I said to my supervisor. I said, "How can we get the orientation looked at or updated or how can peer support have a bigger role in that?"

One interviewee explained that although peer specialists are not currently involved in NEO, they are working to get approval from their supervisor to do so:

> That is one of the things that we're looking at implementing is having a peer at each of the new employee orientations to explain what peer services are. I have to get it approved by my supervisor first but that's what we're trying to get done.

Similarly, another interviewee explained that although peer specialists introduce themselves to staff at NEO, there is a need to expand training to educate staff more frequently and across programs: "They send us when they introduce the programs and they introduce the people. I think maybe they should have that a little bit more often so that each and every program gets it because we have satellite offices."

Finally, one interviewee explained that the information on peer support in NEO is outdated and clinical: "I was a bit surprised at the orientation that the information we got seemed very clinical and kind of dated. There's a lot of new research and new information out there that I thought needs to be shared."

Discussion

Peer services have been recognized as one of the top strengths in the current behavioral health system and have also been identified as a service gap due to limited access (HHSC, 2016). Moreover, Via Hope records (2016a) indicate that over 30% of all individuals who have been certified as peer specialists in Texas since 2010 no longer have an active peer specialist certification. It is therefore imperative to assess factors that contribute to the sustainability of the peer provider workforce. The results of this mixed-methods study indicate several key themes with regard to the Via Hope peer specialist training and certification program as well as peer specialists' experiences working in mental health settings in Texas. By examining quantitative survey data in conjunction with qualitative interview data, we gain a fuller picture of perceptions about the state training and certification program, peer specialist retention, and peer specialist integration. In this section, key findings that emerged from this mixed-methods approach are summarized and discussed.

Via Hope Training and Certification

Several key themes regarding the Via Hope peer specialist training emerged from the interview data. Interviewees described the trainers as knowledgeable and the training as informative, hands-on, and empowering. More specifically, they commonly described the training as providing: hands-on skills and knowledge they could apply on the job; an understanding of the difference between the peer specialist role and a clinical role; and knowledge on how to share their recovery story.

On the other hand, interviewees also reported that the training was too short to cover all of the information they needed to acquire, that the testing process was stressful, that the test did not always align with the training curriculum, and that they wanted the trainers to cover documentation and provide more breaks and support when sharing their recovery story.

Interviewees described many benefits to being a certified peer specialist -- including the fact that it affords them a greater sense of professionalism, that many agencies require certification for employment, and that the CEU requirements ensure that they gain the benefits of continued education and training.

Survey and interview data both suggest that the CEU requirements to maintain certification (20 hours every 24 months) are realistic. Over half of survey respondents reported that they had obtained 20 or more CEU hours since their most recent certification. Similarly, eleven interviewees reported that the CEU requirements were relatively easy to obtain. Conversely, some interviewees identified barriers to obtaining CEUs and maintaining their certification, including: a lack of access to trainings for CEUs due to geographical and financial barriers; employers not providing peer specialists time off from work to attend trainings; the increased difficulty of obtaining CEUs when unemployed (due to a reduction in financial, instrumental, and social support); a lack of clarity regarding certification requirements; and issues with Via Hope tracking and communicating with peer specialists regarding documenting CEUs and the recertification process.

Most survey respondents and interviewees had an active peer specialist certification. However, among individuals with inactive certifications, the most commonly reported reasons for not maintaining their certification were: career change, job layoff/termination, and Via Hope certification tracking and communication issues.

Working as a Peer Specialist

Overall, the data from this study suggest that peer specialists find providing peer support immensely rewarding. For example, fifteen interviewees reported enjoying a sense of mutuality (i.e., a sense of shared experience, mutual connection, and rapport) with people in services. Interviewees also reported enjoying the following aspects of being a peer specialist: sharing their recovery story with people in services, being an advocate/helping people, when people in services see themselves as self-efficacious, and that helping others provides a sense of fulfillment and positively impacts their own recovery. The survey data corroborates these findings; for example, 67% of respondents who were currently working as a peer specialist reported that they "strongly agreed" with the statement: "working in my current position has positively impacted my recovery."

Despite this positivity, 44% of interviewees and nearly 24% of survey respondents were not currently working or volunteering as peer specialists. Both interviewees and survey respondents who were not currently working (or volunteering) as peer specialists were asked to describe why they were not currently employed as peer specialists. Among interviewees and survey respondents the most common explanations were: a lack of peer specialist job opportunities in their area; career changes (including now working as a case manager/QMHP or working in peer support in a training/policy/advocacy position); being terminated, asked to resign, or laid off; personal or family health issues; burn out; returning to school; and a lack of support from their employer. Given the alleviation of these issues, most peer specialists not currently working or volunteering would like to return to providing peer support in the future. For example, of the 11 interviewees who were not currently working, seven reported that they would like to return to providing peer support in the future. These issues will be further elaborated on in the section of the discussion on recruitment and hiring.

Peer Specialist Integration: Career Advancement and Development

Survey data indicate that less than 21% of currently employed peer specialists have a career ladder at their organization. The interview data corroborate this: when asked about career advancement opportunities, twelve interviewees reported that their employer organization had no career ladder while only three interviewees reported that their employer organization had one. While some interviewees reported moving into higher-paid positions, these were most typically management positions that did not involve providing peer support. Therefore within the peer specialist role itself, there appears to be a lack of career advancement opportunities and differentiation. Adopting Peer Specialist I, II, and III designations with an established pay grade would help to address this, along with creating a peer specialist supervisory position (e.g., a "Peer Supervisor" or "Peer Services Manager/Director" position filled by a peer specialist who supervises other peer specialists or directs the peer services).

Data indicate that opportunities for career development are more common than opportunities for career advancement. Nearly 66% of survey respondents who were currently employed as a peer specialist reported that they receive opportunities for career development. When asked to describe what those opportunities are, survey respondents and interviewees most commonly reported that their organization pays for them and provides time off to attend trainings. However, there is room for improvement – nine interviewees reported that their organization provides no funding for training and four reported that their organization does not provide any time off to attend trainings. Further, five interviewees reported that they have had to advocate for career advancement and development opportunities. Organizations should therefore adopt policies that mandate the provision of career advancement and development opportunities for peer specialists, such that the onus of obtaining these opportunities is not solely on peer specialists.

Peer Specialist Integration: Collaboration

In general, peer specialists described having effective collaborative relationships with other peer specialists at their organization. Most commonly, interviewees reported that peer specialists at their organization met regularly and that peer specialists engage in cooperative problem-solving (or co-supervision or co-reflection) with one another. A few interviewees mentioned organizational or structural barriers to collaboration -- for example, peers being spread out across different units/clinics, being the only peer at the organization, or not having offices or a place to meet. Creating a peer specialist department (with a central hub and supervisor) and integrating peer specialists into existing teams would help to reduce these structural barriers.

Although interviewees described several indicators of effective collaborative relationships with non-peer staff – such as having a shared purpose (e.g., helping people in services), capitalizing on individual strengths, and engaging in cooperative problem-solving – they also frequently described not being a part of the treatment/recovery team and not receiving client referrals from non-peer staff. Further, interviewees mentioned several barriers to collaboration between peer and non-peer staff, with most of them related to resistance from non-peer staff. For example, four interviewees reported that non-peer staff simply do not want to work with peer specialists, while two interviewees reported that caseworkers resent peer specialists.

Addressing barriers to collaboration requires that organizations make both structural and cultural changes that are actively supported or directed by leadership. In terms of structural changes, organizations should set up policies that: incorporate referrals to peer specialists into the standard service array and flow (for example, all people meet peer specialists at intake), ensure peer specialists attend staff meetings, and ensure peer specialists are active and equal members of treatment/recovery teams. In terms of cultural changes, organizations should regularly conduct team-building exercises and trainings that emphasize the shared purpose of all staff as well as the benefits to all staff when they engage in cooperative problem-solving and capitalize on the unique strengths of different staff roles (including benefits such as better outcomes for people in services and reduced workload for staff).

Peer Specialist Integration: Funding and Billing

Six interviewees described their employer organization as experiencing no funding issues related to peer specialists. Most commonly, these interviewees worked at organizations receiving grant or 1115 waiver money specifically for peer support. Interviewees that worked at organizations that lacked these funding sources specifically for peer support or that failed to prioritize peer support in their budgets were more likely to report being plagued by issues such as: low pay for peer specialists, a lack of paid positions for peer support staff and hiring freezes, and a lack of benefits for peer specialists. This suggests that at the state level, more general revenue, waiver and grant money needs to be allocated towards funding specifically for peer specialists. This data also suggest that organizations must prioritize both obtaining grant and waiver money for peer support as well as allocating general funding to ensure that there are full-time peer specialist positions that pay a living wage and provide benefits and that there are an adequate number of peer specialists at every clinic/on every unit.

Another funding resource that organizations rely on is Medicaid billing. Nearly 41% of survey respondents who were currently working as a peer specialist reported that their organization bills Medicaid for services they provide. Peer specialists who bill Medicaid typically bill peer support as psychosocial rehabilitation because, at the time of this writing, there is not a Medicaid billing code specifically for peer support. However, the state recently passed HB 1486, which stipulates the inclusion of peer support services among services provided under the state Medicaid plan. The passage of this bill suggests that peer specialists will be billing much more frequently for their

services in the near future. This suggests that training on billing and documentation will need to be developed for peer specialists. This training should be provided as part of the Via Hope training and certification program as well as internally at the organizational-level. The interviewee data also suggest that billing for Medicaid can negatively impact peer support when peer specialists must meet high quotas for client interactions (when salaries are required to be 100% funded by Medicaid, services are driven by Medicaid-allowable services). Therefore, those organizations that do bill Medicaid for peer-provided services should adopt productivity standards that take into consideration the fact that peer support services encompass much more than what is defined and billable under psychosocial rehabilitation.

Peer Specialist Integration: Organizational Culture

The data from this study suggest several ways that organizations' cultures are both supportive and unsupportive of peer specialists and peer specialist integration. Among interviewees, the most commonly described organizational culture characteristics include a revolutionary spirit amongst peer specialists; staff buy-in or lack thereof; leadership support/buy-in or a lack thereof; stigma against peer specialists; resistance to change among staff; and peer specialists are able to provide input into organizational operations (including by serving on committees and setting up programs or groups).

The survey data also provide some indication of how prevalent some organizational culture characteristics are. For example, when asked to rate the supportiveness of non-peer specialist staff on a ten-point scale, currently employed peer specialists rated them at a 7.3. In contrast, previously employed peer specialists rated the supportiveness of non-peer specialist staff at a 5.5 -- suggesting that a lack of supportiveness may contribute to reduced workforce retention. On the other hand, it may indicate that over time organizations in Texas have become more supportive of peer specialists. This trend held true for two other organizational culture survey indicators. First, among currently employed peer specialists, 49% "strongly agreed" that they feel accepted and respected by colleagues whereas only 25% of previously employed peer specialists strongly agreed with this statement. Second, when asked if they felt stigmatized as a result of the actions or words of their co-workers, only 18% of currently employed peer specialists agreed or strongly agreed, compared to 25% of previously employed peer specialists. These findings might also point to the need to provide training, such as Via Hope's *Demystifying the Peer Workforce*, so that non-peer staff can better understand the peer role and how they are an integral part of recovery-oriented service delivery.

In order to improve workplace retention and job satisfaction among peer specialists in Texas, leadership at mental health organizations should continue to take steps to ensure the culture of their organizations are supportive of peer support and peer specialist integration. Included among the recommendations that TIEMH makes for addressing organizational culture issues are: identifying and supporting organizational "champions" of peer support to increase staff buy-in; evaluating peer services to determine if (and if so, how) peer services improve outcomes at costs equal to or lower than usual services to facilitate greater staff buy-in and reduce stigma; incorporating peer specialists into organizational committees, advisory boards, and management positions (e.g., by creating a position such as "Supervisor/Director of Peer Services"); providing peer specialists input and autonomy to set up support groups and other programs; and encouraging peer specialists to see themselves as change agents and seriously considering the changes that peer specialists advocate for.

Peer Specialist Integration: Recruitment and Hiring

Given the demographics of the survey and interview respondents, special or more focused recruitment efforts to train and certify a more diverse peer specialist workforce should be undertaken. Similar to other behavioral health

professions, a high number of peer specialist respondents are at or approaching eligibility for retirement. As the state considers strategies to recruit and retain a behavioral health workforce, peer specialists should be included in these approaches.

Among survey respondents who were not currently employed as peer specialists, 48% reported that they had encountered barriers related to obtaining a job as a peer specialist. When asked to describe what those barriers were, survey respondents reported the following barriers: a lack of qualifications due to a lack of job experience, a lack of peer specialist job opportunities, discrimination, a lack of full-time positions, and criminal charges, among others. Interviewees reported similar barriers including a lack of jobs, volunteering for organizations that are unable or unwilling to hire them, making hiring decisions on the basis of personality rather than role qualifications, and a lack of resources for unemployed peer specialists. Organizations with peer specialist volunteers should consider creating a formal process (and provide or link to training on this process) for individuals who wish to become employed as peer specialists at the organization. Additionally, creating an employment hub at the state level for unemployed peer specialists to access resources and connect to hiring organizations might ease barriers to hiring for both organizations and peer specialists.

The interview data also provide insight into how individuals become recruited to working as a peer specialist. The most commonly reported ways that individuals become peer specialists is by being recruited by a case manager, starting as a volunteer, learning that lived experience of mental health issues is a job requirement for a role, being recruited at a training, and having a personal relationship with someone working as a peer specialist. For organizations that are unable to find qualified peer specialists to hire (particularly those in rural areas of the state), creating a formal process for hiring people receiving services at the organization could be adopted -- although to the extent possible individuals should work at a different clinic or service area than the one in which they receive services. In addition, one interviewee suggested developing a peer specialist recruitment role at the state level.

Peer Specialist Integration: Role Clarity

Overall the data suggest several indicators of a lack of role clarity around the peer specialist role. For example, when survey respondents were asked to rate (on a scale from 1-10 with 10 being excellent) non-peer specialist staff's overall understanding of the respondent's job role as a peer specialist, currently employed peer specialists rated them at 6.7. Previously employed peer specialists rated non-peer specialists' staff's understanding even lower at 5.2. Interview data corroborate this finding – 15 interviewees reported that staff do not know what peer specialists do. A few interviewees, however, made some distinctions amongst non-peer staff -- reporting that staff they work closely with, are allies to peer support, and have worked at the organization longer were more likely to have an understanding of what peer specialists do and support them in their role.

Non-peer specialist staff's understanding of the peer specialist role is important, particularly given data indicating that many peer specialists are not actually providing peer support at the organizations that they are working at. For example, five interviewees reported that despite being employed as peer specialists, they were not actually providing peer support. Five interviewees also reported providing clinical services and one splits their time in a dual peer and clinician role. Interviewees also described being reprimanded for advocating for people in services and sharing their recovery story -- both of which SAMHSA has identified as core competencies for peer workers in behavioral health services (SAMHSA, 2015).

Given this lack of understanding and role fidelity, it is not surprising that 16 interviewees reported that they self-advocate by informing other staff and people in services what peer specialists do. These efforts would be greatly bolstered by organizational and state-level support. HB 1486 mandates that the state provides a clear definition of

the peer specialist role that defines the full scope of peer specialist services and how those services are distinguishable from other services. This state-level role definition should then be used at the organizational level to inform formal and informal training and education efforts directed to all staff on the peer support role as well as peer specialist job descriptions and evaluations.

Peer Specialist Integration: Supervision

Several issues related to supervisory structure, methods, and culture emerged from the data. In terms of supervisory structure, a clear theme emerged that peer specialists are generally supervised by someone who is not a peer specialist. Among survey respondents, only 26% of currently employed peer specialists and 9% of previously employed peer specialists reported that they were supervised by a certified peer specialist. This was corroborated by interview data in which three interviewees said they were supervised by a peer specialist, compared to 18 respondents who reported they were not supervised by a peer specialist. The lack of peer supervisors may also be due to organizations following the supervision requirements outlined in the Texas Administrative Code. Organizations should, however, consider placing advanced peer specialists in non-clinical supervisory roles over other peer specialists at the organization, which would both contribute to a peer specialist career ladder and provide newer peer specialists mentorship and support from someone with substantial knowledge and lived experience of the role.

In terms of supervisory methods, one clear issue that emerged from the data is that many peer specialists are not receiving adequate supervision. For example, survey data indicate that nearly 15% of currently employed peer specialists receive no supervision at all. This number is even higher for survey respondents who were previously employed as a peer specialist – nearly 43% reported that they received no supervision when they were employed as a peer specialist. Further, the survey data indicate that among currently employed peer specialists who reported that they do receive some form of supervision, over 30% reported that this supervision occurs once a month or less.

In terms of supervisory culture, the data suggest that a substantial number of peer specialists in Texas are supervised by individuals who have little knowledge or training in peer support. For example, seven interviewees reported that their supervisor is not trained in or knowledgeable about peer support. And, although survey respondents rated their supervisor's understanding of their job role as higher than non-peer specialist staff's understanding, there remains room for improvement. On a scale from 1-10 with 10 being excellent, currently employed peer specialists rated their supervisor's understanding of their job role at a 7.6. This number was again lower for previously employed peer specialists who rated their supervisor's understanding of their job role at 6.5.

Further, although the data indicate that many peer specialists have supervisors who are supportive, encouraging, open to peers' ideas, invested in learning about peer support, and advocate for peers, the data also indicate that many peer specialists do not. Therefore, TIEMH suggests that the state (in partnership with other organizations) develop a mandatory training for supervisors of peer specialists that includes information on: the peer specialist role (including scope of services), peer specialist integration domains (i.e., career advancement and development, collaboration, funding and billing, organizational culture, recruitment and hiring, role clarity, supervision, staff training), evidence on the effectiveness of peer support, and best practices for supervising peer specialists. Based on the data from this study, these best practices for supervising peer specialists should include: a supervisor who understands the peer role, regular one-on-one supervision meetings, advocating for peer specialists at the organizational level, creating a culture of effective supervision (e.g., providing support, developing trust, listening to peers' ideas), and to the extent possible, providing flexibility with time off from work.

Peer Specialist Integration: Staff Training

The data suggest two clear themes with respect to staff training. First, staff need frequent trainings on peer support. This training should begin with new employee orientation and continue with frequent refreshers, particularly given the high rates of turnover that plague the public mental health system. Further this should be codified in organizational policies that mandate NEO training include information on peer support and that staff should receive regular training on peer support (e.g., quarterly, biannually).

Second, organizational policies should mandate that peer specialists at the organization have the option to be involved in the development and delivery of these trainings. In terms of training development, organizations could for example, create a training development committee in which all peer specialists at the organization have the option to be part of. Similarly, peer specialists should be involved in the delivery of these trainings – to the extent that they wish to participate.

Recommendations

The recent passage of House Bill 1486 stipulates, among other provisions, the adoption of rules related to peer support services – particularly those related to training and certification requirements, supervision requirements, role clarity, and differentiation from clinical services. TIEMH offers the following recommendations based on the findings from this report, with the hope that they inform the development of these rules.

Via Hope Training

- Retain/expand content on the peer specialist role (including how it differs from a clinical role)
- Retain/expand hands-on knowledge and skills that peer specialists can directly apply on-the-job
- Retain/expand content on peer specialist ethics and professional boundaries
- Retain/expand aspects of the training that are interactive/hands-on
- Retain/expand aspects of the training that address billing and documentation (especially as HB 1486 rules are developed)
- Retain content on sharing recovery story (however, allow for more breaks or support in this section of the training)
- Include section on the recertification process and CEUs in the training (including how to advocate for time off from employer to attend trainings and how to advocate to Via Hope in terms of what can count as CEUs)
- Ensure individuals developing and delivering the training have lived experience of mental health challenges but do not discount the lived experience of substance use disorders
- Ensure that individuals delivering the training maintain fidelity to the curriculum
- Ensure that accommodations for self-care and disabilities are made for individuals attending the training
- Ensure that the training space is trauma-informed and aesthetically pleasing
- Ensure that the certification test aligns with training content
- Expand trainings to different regions of Texas for greater accessibility
- Expand training length
- Consider modifying application process beyond a written application (e.g., phone interview, video submission)

Via Hope Certification

- Retain current CEU requirements (i.e., 20 hours of CEUS every 24 months)
- Via Hope should consider offering or expanding on CEU opportunities in the following areas: Next Steps, WRAP facilitator training, trauma-informed peer support, social justice, and leading/facilitating support groups
- Expand access to CEUs -- expand geography of trainings, provide scholarships for unemployed peer specialists and peer specialists whose employer will not cover the cost of training
- Waive recertification fee for unemployed peer specialists
- Assign a point person to regularly communicate with all trained and certified peer specialists and update them on how many CEUs they have earned and their timeline for recertification
- Assign a point person to communicate with peer specialists with both active and lapsed certification to identify and overcome barriers to renewing their certification

- Provide a method for peer specialists to easily update their contact information on the Via Hope website

Peer Specialist Integration: Career Advancement and Development

- Organizations should adopt a formal peer specialist career ladder (e.g., Peer Specialist I, Peer Specialist II, Peer Specialist III, Director of Peer Services, Peer Supervisor) with established, living wage salary ranges
- Organizations should prioritize training by providing funding for peer specialists to attend the Via Hope training and certification program and by providing funding (including travel and lodging expenses) and paid time off for peer specialists to attend trainings to earn CEUs and other career development opportunities (e.g., conferences); particularly so if they support other staff in these ways
- New peer specialists should be trained by senior/more experienced peers

Peer Specialist Integration: Collaboration

- Regularly conduct team-building exercises and trainings that emphasize the shared purpose of all staff as well as the benefits to all staff when they engage in cooperative problem-solving and capitalize on the unique strengths of different roles (including benefits such as better outcomes for people in services and shared workload)
- Include peer specialists in staff meetings
- Set up policies that ensure that peer specialists are active and equal members of recovery teams
- Incorporate referrals to peer specialists into the standard service array and flow
- If there are multiple peer specialists in an organization, ensure that they have regular opportunities to meet to provide co-supervision and support to one another
- Organizations should have a peer specialist department (with a central hub and supervisor)
- A network to link peer providers across the state, or regular peer provider conferences (e.g., PeerFest), would provide an avenue for continuous learning and ongoing support, especially for peer specialists who work in organizations with few other peer providers

Peer Specialist Integration: Funding and Billing

- At the state level, dedicate funds that organizations must use for peer support
- Organizations should prioritize obtaining funding for peer specialists through allocating general funds to peer specialists as well as by seeking to obtain grant and other funding
- Organizations should prioritize funding in such a way that allows them to pay peer specialists a living wage
- Organizations should prioritize funding to ensure that there are full-time peer specialist positions with benefits
- Organizations should prioritize funding to ensure that there is an adequate number (at least one) of peer specialists at every clinic/unit
- With the passage of HB 1486, peer specialists will have the opportunity to bill for peer support services. Organizations should began to prepare for this by developing adequate internal training on billing and documentation
- Organizations should adopt realistic productivity standards for peer specialists that take into consideration the fact that not all peer support is currently an individual billable unit of service

Peer Specialist Integration: Organizational Culture

- Organizations should provide regular internal and external trainings (e.g., Via Hope's Recovery Institute Leadership Academy [RILA]) on a recovery orientation to develop organizational cultures that are supportive of recovery and, thus, more prepared to integrate peer specialists
- Organizations should seek ways to create a more client-driven culture (e.g., survey clients about the types of organizational changes they would like to see; take seriously and address client rights' violations)
- Organizations should adopt recovery-oriented and person-centered language (e.g., mission statements that incorporate recovery-oriented language; providing recovery versus treatment plans; "a person with lived experience of schizophrenia" versus "a schizophrenic")
- Organizations should identify and support organizational "champions" of peer support to increase staff buy-in
- Organizations should incorporate peer specialists into organizational committees, advisory boards, and management positions (e.g., by creating a position such as "Director/Supervisor of Peer Services")
- Organizations should give peer specialists input to set up support groups or other programs
- To facilitate greater buy-in and reduce stigma, continue to evaluate peer services to determine if (and if so, how) peer services improve outcomes at costs equal to or lower than usual services
- Peer specialists should be built into the formal intake/service provision process (e.g., people meet with peer specialists immediately following intake to learn about peer support)
- Organizations should encourage peer specialists to see themselves as change agents and should take seriously the changes that peer specialists advocate for

Peer Specialist Integration: Recruitment and Hiring

- State and community-level organizations should make targeted efforts to recruit a more diverse and representative peer specialist workforce
- Organizations with peer specialist volunteers should create a formal process (and training on this process) for individuals who wish to become employees
- At the state level, create an employment hub for unemployed peer specialists to access resources and connect to hiring organizations
- At the state level, create a role for peer specialist recruiters or coordinators
- At the organizational level, ensure that hiring decisions are made on the basis of role qualifications
- Particularly for organizations that are unable to find qualified peer specialists to hire, create a formal process for hiring people receiving services (although to the extent possible, individuals should work at a different clinic/service area than the one where they receive services)

Peer Specialist Integration: Role Clarity

- At the state level, clearly define the peer specialist role in such a way that defines the full scope of peer specialist services and how those services are distinguishable from other services, particularly clinical services (as mandated in HB 1486)
- At the organizational level, this state-level role definition should be used to inform peer specialist job descriptions and peer specialist performance evaluations
- At the organizational level, this state-level role definition should be used to inform formal and informal training and educational efforts directed at all staff on the peer support role

Peer Specialist Integration: Supervision

- To the extent possible, peer specialists should be supervised by other peer specialists
- At the state level, develop a mandatory training for supervisors of peer specialists. This training should include:
    - Information on the peer specialist role (scope of services and how peer services differ from other services)
    - Peer specialist integration domains
    - Evidence on the effectiveness of peer support and how to use the evidence to inform services
    - Best practices for supervising peer specialists (see next bullet for a list of suggested best practices)
- Establish best practices for supervising peer specialists such as:
    - Regular one-on-one supervision meetings that allow for the provision of feedback
    - The creation of a position within the organization that is responsible for supervising all peer specialists (e.g., "Director of Peer Services")
    - Advocating for peer specialists at the organizational level
    - Creating a culture of effective supervision (e.g., providing support, developing trust and openness, listening to peers' ideas)
    - To the extent possible, providing flexibility with respect to time off from work (i.e., Family Medical Leave) to increase workforce retention

Peer Specialist Integration: Staff Training

- At the organizational level, create policies that mandate organizations provide frequent trainings to all staff on peer support – starting with new employee orientation
- At the organizational level, create policies that mandate the active involvement of peer specialists in the development and delivery of trainings on peer support services

References

Campbell, J.L., Quincy, C., Osserman, J., & Pedersen, O.K. (2013). Coding in-depth semistructured interviews: Problems of unitization and intercoder reliability and agreement. Sociological Methods & Research, 42(3), 294-320.

Clarke, G.N., Herinckx, H.A., Kinney, R., Paulson, R.I., Cutler, D.L., Lewis, K., & Oxman, E. (2000). Psychiatric hospitalizations, arrests, emergency room visits and homelessness of clients with serious and persistent mental illness: Findings from a randomized trial of two ACT programs vs. usual care. Mental Health Services Research, 2(3), 155-164. doi:10.1023/A:1010141826867

Craig, T., Doherty, I., Jamieson-Craig, R., Boocock, A., & Attafua, G. (2011). The consumer employee as a member on a Mental Health Assertive Outreach Team: Clinical and social outcomes. Journal of Mental Health, 13(1), 59-69.doi:10.1080/09638230410001654567

Davidson, L., Chinman, M., Sells, D., & Rowe, M. (2006). Peer support among adults with serious mental illness: A report from the field. Schizophrenia Bulletin, 32(3), 443-450. doi:10.1093/schbul/sbj043

Druss, B., Zhao, L., von Esenwein, S., Bona, J., Fricks, L., Jenkins-Tucker, S., Sterling, E., DiClemente, R. & Lorig, K. (2010). The Health and Recovery Peer (HARP) Program: A peer-led intervention to improve medical self-management for persons with serious mental illness. Schizophrenia Research, 118(1), 264-270. doi:10.1016/ j.schres.2010.01.026

Earley, J., Lodge, A.C., Kuhn, W., Daggett, P., & Stevens Manser, S. (2016). Assessing Peer Specialist Integration in Texas. Texas Institute for Excellence in Mental Health, School of Social Work, University of Texas at Austin.

Gates, L.B., & Akabas, S.H. (2007). Developing strategies to integrate peer providers into the staff of mental health agencies. Administration and Policy in Mental Health and Mental Health Services Research, 34(3), 293-306. doi: 10.1007/ s10488-006-0109-4.

Grant, E., Reinhart, C., Wituk, S., & Meissen, G. (2012). An examination of the integration of certified peer specialists into community mental health centers. Community Mental Health Journal, 48(4), 477–481. doi:10.1007/s10597-012-9519-9.

Kuhn, W., Bellinger, J., Stevens-Manser, S., & Kaufman, L. (2015). Integration of peer specialists working in mental health service settings. Community Mental Health Journal, 51(4), 453-458.

Lodge, A., Earley, J., Kuhn, W., Daggett, P., Carney, C., Cruickshank, R., … Stevens Manser, S. (2016). Revising the Recovery Self-Assessment: A mixed methods approach. Texas Institute for Excellence in Mental Health, School of Social Work, University of Texas at Austin.

NVIVO qualitative data analysis software; QSR International Pty Ltd. Version 10, 2012.

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

Rivera, J.J., Sullivan, A.M., & Valenti, S.S. (2007). Adding consumer-providers to intensive case management: Does it improve outcome? Psychiatric Services, 58(6), 802-809.

Substance Abuse and Mental Health Services Administration. (2015). Core competencies for peer workers in behavioral health services. Bringing Recovery Supports to Scale – Technical Assistance Center Strategy (BRSS TACS). Retrieved from https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/core-competencies.pdf

Texas Health and Human Services Commission. (2016). Texas statewide behavioral health strategic plan: Fiscal years 2017-2021. Statewide Behavioral Health Coordinating Council, as required by 2016-17 General Appropriations Act, H.B. 1, 84th Legislature, Regular Session, 2015 (Article IX, Section 10.04). Retrieved from https://hhs.texas.gov/reports/2016/05/statewide-behavioral-health-strategic-plan

U.S. Census Bureau. (2016). *Selected economic characteristics, 2011-2015 American Community Survey 5-year estimates*. Retrieved from https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk.

Via Hope, Texas Mental Health Resource. (2016a). Certified peer specialist master list. Austin, TX.

Via Hope, Texas Mental Health Resource. (2016b). Texas certified peer specialist program policy and procedure manual. Austin, TX.

Appendix A: Survey Questions

[START OF SURVEY BLOCK 1: ALL PARTICIPANTS]

The questions below ask you to share demographic information about yourself.

1. An anonymous linkage code will be used to match your responses from this survey with all previous surveys and any future surveys you complete related to this evaluation. Please create your anonymous code from the following information.
   First letter in mother's first name: [drop down menu A-Z]
   First letter in mother's maiden name: [drop down menu A-Z]
   First digit in your social security number: [drop down menu 0-9]
   Last digit in your social security number: [drop down menu 0-9]

2. What is your home zip code?

3. What is your gender?
   - ○ Male
   - ○ Female
   - ○ Not listed

4. What is your age range?
   - ○ 18 – 25
   - ○ 26 – 39
   - ○ 40 – 55
   - ○ 56 or older

5. Are you of Hispanic or Latino origin?
   - ○ No
   - ○ Yes

6. What race do you consider yourself to be? (Please select all that apply)
   - ☐ American Indian or Alaska Native
   - ☐ Asian
   - ☐ Black or African American
   - ☐ Native Hawaiian or other Pacific Islander
   - ☐ White
   - ☐ Other (please specify): _____

7. What is the highest level of education you have obtained?
   - ○ Less than 12th grade
   - ○ High school diploma / GED
   - ○ Some college or post-high school training (please specify area of study): _____
   - ○ 2-year Associate degree (please specify area of study): _____
   - ○ 4-year college degree (please specify area of study): _____
   - ○ Post-college graduate training (please specify area of study): _____

8. How many people currently live with you in your household, *not including yourself*?

- None, I live alone
- 1
- 2
- 3
- 4
- 5 or more

9. What is your annual household income?
   - Less than $15,000
   - $15,000 to $29,000
   - $30,000 to $44,999
   - $45,000 to $59,999
   - $60,000 to $74,999
   - $75,000 or more

10. In the past 30 days, from which of the following sources have you had financial support? (Please select all that apply)
    - ☐ Earned income
    - ☐ Social Security Benefits (SSA)
    - ☐ Social Security Disability Income (SSDI)
    - ☐ Supplemental Security Income (SSI)
    - ☐ Veteran's benefits
    - ☐ Assistance from family members
    - ☐ Other sources (please specify): _____

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

11. How did you become a certified peer specialist in Texas?
    - I have never been certified
    - I attended the Via Hope Peer Specialist training
    - I was grandfathered in
    - I was certified in another state and received reciprocity in Texas

12. Did you take the Via Hope certification exam?
    - Yes, I passed the exam
    - Yes, but I did not pass the exam
    - No, I never took the exam

[Display question if "Yes, but I did not pass the exam" is selected on "Did you take the Via Hope-sponsored certification exam?"]

13. Do you plan to take the certification exam in the future?
    - No
    - Yes
    - Unsure

[Display question if "I attended the Via Hope Peer Specialist Training" is selected on "How did you become a certified peer specialist?"]

14. In what year did you attend the Via Hope Peer Specialist training?
    - 2010
    - 2011
    - 2012

- 2013
- 2014
- 2015
- 2016

[Display question if "I attended the Via Hope Peer Specialist Training," or "I was grandfathered in," or "I was certified in another state and received reciprocity" is selected on "How did you become a certified peer specialist?"]

15. What is the status of your peer specialist certification?
    - Current
    - Inactive

[Display question if "Inactive" is selected on "What is the status of your peer specialist certification?"]

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

_____

[Display question if "Inactive" is selected on "What is the status of your peer specialist certification?"]

17. How long has your peer specialist certification been inactive?
    - Less than 1 year
    - 1 year
    - 2 years
    - 3 years
    - 4 years
    - 5 years
    - More than 5 years

The questions below ask you to share your experiences related to employment as a peer specialist.

18. Do you currently work or volunteer in a peer specialist role?
    - No, I have never worked or volunteered as a peer specialist
    - No, but I have worked or volunteered as a peer specialist in the past
    - Yes, I currently work or volunteer as a peer specialist

*[Display question if "No, but I have worked or volunteered as a peer specialist in the past" is selected on "Do you currently work or volunteer in a peer specialist role**?"]***

19. Why do you no longer work or volunteer as a peer specialist?

_____

[Display question if "No, I have never worked as a peer specialist in the past," or "No, but I have worked or volunteered as a peer specialist in the past" is selected on "Do you currently work or volunteer in a peer specialist role?"]

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

The questions below ask you to share your experiences related to obtaining Continuing Education Units and training and educational opportunities related to peer specialists.

[Display question if "Active" is selected on "What is the status of your peer specialist certification?"]

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

[Display question if "Inactive" is selected on "What is the status of your peer specialist certification?"]

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

[Display question if "Active" is selected on "What is the status of your peer specialist certification?" or if "Yes, I currently work or volunteer as a peer specialist in the past" is selected on "Do you currently work or volunteer in a peer specialist role?"]

23. In which of the following areas would you like to develop additional knowledge or skills? (Please select all that apply)
    - ASIST (Applied Suicide Intervention Skills Training)
    - Basic WRAP Training
    - Boundaries
    - Community Reentry
    - Computer/Technology
    - Co-Occurring Disorders
    - Cultural Competency
    - Emotional CPR
    - Ethics
    - Intentional Peer Support
    - Leading/facilitating support groups
    - Next Steps (for experienced Certified Peer Specialists)
    - Peer Support for Individuals With Co-Occurring Disorders
    - Peer Support Whole Health and Resilience
    - Self-advocacy
    - Social Justice
    - Time Management
    - Trauma Informed Peer Support
    - Wellness Coaching
    - WHAM (Whole Health Action Management)
    - WRAP Facilitator Training
    - Other (please specify below) _____

[Display question if "Active" is selected on "What is the status of your peer specialist certification?" or if "Yes, I currently work or volunteer as a peer specialist in the past" or "No, but I have worked or volunteered as a peer specialist in the past" is selected on "Do you currently work or volunteer in a peer specialist role?"]

24. Which of the following peer-related trainings or other educational opportunities have you attended? (Please select all that apply)
    - Alternatives Conference
    - ASIST (Applied Suicide Intervention Skills Training)
    - Basic WRAP Training
    - Co-Occurring Disorders

- Community Reentry
- Emotional CPR
- Focus for Life
- Intentional Peer Support International Association of Peer Supporters Conference
- NAMI's Peer to Peer
- Next Steps
- Peerfest Conference
- Peer Support for Individuals With Co-Occurring Disorders
- Peer Support Whole Health and Resiliency
- Trauma Informed Peer Support
- WRAP Facilitator Training
- WHAM (Whole Health Action Management)
- Other (please specify:) _____

25. According to the Via Hope-sponsored peer specialist training, recovery is "the process of gaining control over one's life – and the direction one wants that life to go – on the other side of a psychiatric diagnosis and all of the losses usually associated with that diagnosis." Thinking about your lived experience, what started you on your road to recovery?

_____

[END OF SURVEY BLOCK 1: ALL PARTICIPANTS]

[SKIP TO END OF SURVEY if "No, I have never worked as a peer specialist in the past" is selected on "Do you currently work or volunteer in a peer specialist role?"]

[SKIP TO SURVEY BLOCK 3 if "No, but I have worked or volunteered as a peer specialist in the past" is selected on "Do you currently work or volunteer in a peer specialist role?"]

[START OF SURVEY BLOCK 2: INDIVIDUALS CURRENTLY WORKING OR VOLUNTEERING AS A PEER SPECIALIST REGARDLESS OF CERTIFICATION STATUS]

26. What is your current employment status? (please select all that apply)
    - Unemployed
    - Hourly/Salary, Full-time (at least 80% time)
    - Hourly/Salary, Part-time (less than 80% time)
    - Contract, Full-time (at least 80% time)
    - Contract, Part-time (less than 80% time)
    - Volunteer, Full-time (at least 80% time)
    - Volunteer, Part-time (less than 80% time)
    - Other (please specify:) _____

27. Which of the following benefits do you receive from your employer?
    - I do not receive benefits
    - Medical insurance for myself
    - Medical insurance for my family
    - Dental insurance
    - Retirement
    - Disability insurance
    - Paid vacation

- Paid sick leave
- Other (please specify:) _____

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

29. What is the name of the organization where you are currently employed?
    _____

30. At what type of organization are you currently employed?
    - Community Mental Health Center
    - Consumer Operated Service Provider
    - Department of Veterans Affairs or other Veterans organization
    - Managed Care Organization
    - Organization that serves people experiencing homelessness
    - State Hospital
    - Other (please specify:) _____

31. How long have you worked at this organization?
    - Years: [drop down menu 0 to more than 50]
    - Months: [0 to 11]

32. What is your specific job title?
    _____

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

34. On average, how many people do you serve in one week?
    - [drop down menu 0 to more than 100]

35. Which of the following best describes the population(s) you serve? (please select all that apply)
    - Adults
    - Adolescents
    - Other (please specify:) _____

36. What tasks do you perform in your work? (Select Yes or No for each)
    - Administrative tasks
    - Connecting people to resources/networking
    - Education (please specify what you teach and to whom)
    - Facilitating support groups (please specify the type of support group(s))
    - Goal-setting
    - Helping people advocate for themselves
    - Housing assistance
    - Medication management and monitoring
    - One-on-one support (please describe)
    - Outreach / Engagement
    - Patient navigation

- Provide supervision to other peer specialists
- Psychosocial rehabilitation
- Serve on work groups and committees (please specify the type of work groups or committees)
- Skill Building (please specify the type of skills)
- Support clients during transition from inpatient
- Transportation assistance
- Vocational assistance
- Wellness Recovery Action Planning (WRAP)
- Working on a treatment team
- Other (please specify:) _____

37. Does your organization have a job description for your position?
    - No
    - Yes
    - I don't know

[Display question if "Yes" is selected on "Does your organization have a job description for your position?"]

38. Do you have a copy of your job description?
    - No
    - Yes

39. Does your organization have a "career ladder" for peer specialists?
    - No
    - Yes
    - I don't know

40. Does your organization provide opportunities for career development (e.g., time off and/or reimbursement for trainings, skill development, etc.)?
    - No
    - Yes (please describe the opportunities for career development:)_____
    - I don't know

41. Do you receive supervision related to your work as a peer specialist?
    - No
    - Yes

[Display question if "Yes" is selected on "Do you receive supervision related to your work as a peer specialist?"]

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

[Display question if "Yes" is selected on "Do you receive supervision related to your work as a peer specialist?"]

43. Is your supervisor a certified peer specialist?
    - No
    - Yes

[Display question if "Yes" is selected on "Do you receive supervision related to your work as a peer specialist?"]

44. What does supervision look like for you?

_____

45. Does your organization bill Medicaid for any of the services you provide?
    - No
    - Yes
    - I don't know

46. Are there other individuals employed in a peer specialist role at your organization?
    - No
    - Yes
    - I don't know

[Display question if "Yes" is selected on "Are there other individuals employed in a peer specialist role at your organization?"]

47. Please specify the number of individuals employed in a peer specialist role at your organization (including yourself):
    - [drop down menu 1 to more than 100]

[Display question if "Yes" is selected on "Are there other individuals employed in a peer specialist role at your organization?"]

48. How frequently do you collaborate with other peer specialists at your organization?
    - Daily
    - 2-3 times a week
    - Once a week
    - 2-3 times a week
    - Once a month
    - Less than once a month
    - Never

49. How frequently do you collaborate with non-peer specialist staff at your organization?
    - Daily
    - 2-3 times a week
    - Once a week
    - 2-3 times a week
    - Once a month
    - Less than once a month
    - Never

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

- 10 Excellent

51. How would you rate your supervisor's overall level of supportiveness?
    - 1 Not at all supportive
    - 2
    - 3
    - 4
    - 5
    - 6
    - 7
    - 8
    - 9
    - 10 Very supportive

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

53. How would you rate non-peer specialist staff's overall level of supportiveness?
    - 1 Not at all supportive
    - 2
    - 3
    - 4
    - 5
    - 6
    - 7
    - 8
    - 9
    - 10 Very supportive

54. Please indicate your level of agreement with the following statements:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I am satisfied with my overall job experience.	1	2	3	4	5
Working in my current position has positively impacted my recovery.	1	2	3	4	5
I feel accepted and respected by my colleagues.	1	2	3	4	5

My job description realistically reflects my actual job duties.	1	2	3	4	5
My supervisor explains the skills or procedures I am expected to perform.	1	2	3	4	5
I feel I am able to do my current job well.	1	2	3	4	5
My supervisor listens to my suggestions, ideas, and opinions.	1	2	3	4	5
I feel stigmatized as a result of the actions or words of my co-workers.	1	2	3	4	5

55. For this final section of questions, please respond how often (from "never" to "always") your organization provides recovery-oriented practices to people in a recovery-supportive environment. Please answer the following questions based on your perspective of the organization.

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

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

_____

[END OF SURVEY BLOCK 2: INDIVIDUALS CURRENTLY WORKING OR VOLUNTEERING AS A PEER SPECIALIST REGARDLESS OF CERTIFICATION STATUS]

[START OF SURVEY BLOCK 3: INDIVIDUALS WHO PREVIOUSLY WORKED OR VOLUNTEERED AS A PEER SPECIALIST REGARDLESS OF CERTIFICATION STATUS]

57. What was your employment status when you worked or volunteered as a peer specialist? (please select all that apply)
    - Hourly/Salary, Full-time (at least 80% time)
    - Hourly/Salary, Part-time (less than 80% time)
    - Contract, Full-time (at least 80% time)
    - Contract, Part-time (less than 80% time)
    - Volunteer, Full-time (at least 80% time)
    - Volunteer, Part-time (less than 80% time)
    - Other (please specify:) _____

58. Which of the following benefits did you receive from your employer when you worked or volunteered as a peer specialist?
    - I did not receive benefits
    - Medical insurance for myself
    - Medical insurance for my family
    - Dental insurance
    - Retirement
    - Disability insurance
    - Paid vacation
    - Paid sick leave
    - Other (please specify:) _____

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

    _____

60. What is the name of the organization where you were employed when you worked or volunteered as a peer specialist?

    _____

61. At what type of organization did you work or volunteer at as a peer specialist**?**

    - Community Mental Health Center
    - Consumer Operated Service Provider
    - Department of Veterans Affairs or other Veterans organization
    - Managed Care Organization
    - Organization that serves people experiencing homelessness
    - State Hospital
    - Other (please specify:) _____

62. How long did you work or volunteer as a peer specialist at this organization?
    - Years: [drop down menu 0 to more than 50]

- Months: [0 to 11]

63. What was your specific job title when you worked or volunteered as a peer specialist?
    _____

64. On average, how many hours per week did you work when you worked or volunteered as a peer specialist?
    - [drop down menu 0 to more than 40]

65. On average, how many people did you serve in one week when you worked or volunteered as a peer specialist?
    - [drop down menu 1 to more than 100]

66. Which of the following best describes the population(s) you served when you worked or volunteered as a peer specialist? (please select all that apply)
    - Adults
    - Adolescents
    - Other (please specify:) _____

67. What tasks did you perform when you worked or volunteered as a peer specialist? (Select Yes or No for each)
    - Administrative tasks
    - Connecting people to resources/networking
    - Education (please specify what you teach and to whom)
    - Facilitating support groups (please specify the type of support group(s))
    - Goal-setting
    - Helping people advocate for themselves
    - Housing assistance
    - Medication management and monitoring
    - One-on-one support (please describe)
    - Outreach / Engagement
    - Patient navigation
    - Provide supervision to other peer specialists
    - Psychosocial rehabilitation
    - Serve on work groups and committees (please specify the type of work groups or committees)
    - Skill Building (please specify the type of skills)
    - Support clients during transition from inpatient
    - Transportation assistance
    - Vocational assistance
    - Wellness Recovery Action Planning (WRAP)
    - Working on a treatment team
    - Other (please specify:) _____

68. Did your organization have a job description for your position when you worked or volunteered as a peer specialist?
    - No
    - Yes
    - I don't know

[Display question if "Yes" is selected on "Did your organization have a job description for your position when you worked or volunteered as a peer specialist?"]

69. Did you have a copy of your job description when you worked or volunteered as a peer specialist?
    - No
    - Yes

70. Did your organization have a "career ladder" for peer specialists when you worked or volunteered as a peer specialist?
    - No
    - Yes
    - I don't know

71. Did your organization provide opportunities for career development (e.g., time off and/or reimbursement for trainings, skill development, etc.) when you worked or volunteered as a peer specialist?
    - No
    - Yes (please describe the opportunities for career development:)_____
    - I don't know

72. Did you receive supervision related to your work as a peer specialist when you worked or volunteered as a peer specialist?
    - No
    - Yes

[Display question if "Yes" is selected on "Did you receive supervision related to your work as a peer specialist when you worked or volunteered as a peer specialist?]

73. How frequently did you receive this supervision when you worked or volunteered as a peer specialist?
    - Daily
    - 2-3 Times a Week
    - Once a Week
    - 2-3 Times a Month
    - Once a Month
    - Less than Once a Month
    - Never

[Display question if "Yes" is selected on "Did you receive supervision related to your work as a peer specialist when you worked or volunteered as a peer specialist?]

74. Was your supervisor a peer specialist when you worked or volunteered as a peer specialist?
    - No
    - Yes

[Display question if "Yes" is selected on "Did you receive supervision related to your work as a peer specialist when you worked or volunteered as a peer specialist?]

75. What did supervision look like for you when you worked or volunteered as a peer specialist?

_____

76. Did your organization bill Medicaid for any of the services you provided when you worked or volunteered as a peer specialist?
    - No
    - Yes

- I don't know

77. Were there other individuals employed in a peer specialist role at your organization when you worked or volunteered as a peer specialist?
    - No
    - Yes
    - I don't know

[Display question if "Yes" is selected on "Were there other individuals employed in a peer specialist role at your organization when you worked or volunteered as a peer specialist?"]

78. Please specify the number of individuals employed in a peer specialist role at your organization (including yourself) when you worked or volunteered as a peer specialist:
    - [drop down menu 1 to more than 100]

[Display question if "Yes" is selected on "Were there other individuals employed in a peer specialist role at your organization when you worked or volunteered as a peer specialist?"]

79. How frequently did you collaborate with other peer specialists at your organization when you worked or volunteered as a peer specialist?
    - Daily
    - 2-3 times a week
    - Once a week
    - 2-3 times a week
    - Once a month
    - Less than once a month
    - Never

80. How frequently did you collaborate with non-peer specialist staff at your organization when you worked or volunteered as a peer specialist?
    - Daily
    - 2-3 times a week
    - Once a week
    - 2-3 times a week
    - Once a month
    - Less than once a month
    - Never

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

82. How would you rate your supervisor's overall level of supportiveness when you worked or volunteered as a peer specialist?

- 1 Not at all supportive
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10 Very supportive

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

84. How would you rate non-peer specialist staff's overall level of supportiveness when you worked or volunteered as a peer specialist?
    - 1 Not at all supportive
    - 2
    - 3
    - 4
    - 5
    - 6
    - 7
    - 8
    - 9
    - 10 Very supportive

85. Thinking about when you worked as a peer specialist, please indicate your level of agreement with the following statements:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I was satisfied with my overall job experience.	1	2	3	4	5
Working in my position positively impacted my recovery.	1	2	3	4	5
I felt accepted and respected by my colleagues.	1	2	3	4	5
My job description realistically reflected my actual job duties.	1	2	3	4	5

My supervisor explained the skills or procedures I was expected to perform.	1	2	3	4	5
I felt I was able to do my job well.	1	2	3	4	5
My supervisor listened to my suggestions, ideas, and opinions.	1	2	3	4	5
I felt stigmatized as a result of the actions or words of my co-workers.	1	2	3	4	5

86. Thinking about the organization where you used to work or volunteer as a peer specialist, please respond how often (from "never" to "always") your organization provided recovery-oriented practices to people in a recovery-supportive environment. Please answer the following questions based on your perspective of the organization.

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

87. Is there any additional information on peer specialist training, certification, and employment you would like to share with us?

_____

[END OF SURVEY BLOCK 3: INDIVIDUALS WHO PREVIOUSLY WORKED OR VOLUNTEERED AS A PEER SPECIALIST REGARDLESS OF CERTIFICATION STATUS]

[START OF SURVEY BLOCK 4: INDIVIDUALS WHO COMPLETED THE SURVEY]

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

If you have any questions or would like to be contacted regarding this survey, please contact Laura Kaufman at the Texas Institute for Excellence in Mental Health at the University of Texas at Austin by phone: (512) 232-8464 or by e-mail: laura.kaufman@austin.utexas.edu.

Because you completed this survey, you are eligible to be entered into a drawing for a chance to win a $50 gift card. In addition, we are conducting brief phone interviews with individuals who are or who were at one point certified as peer specialists to learn about their workforce experiences. Every person who participates in an interview will receive a $25 gift card.

- If you would like to enter the drawing for the $50 gift card, please click the following link: bit.do/psgiftcard
- If you are interested in being contacted to participate in an interview ONLY, please click the following link: bit.do/psinterview
- If you would like to enter the drawing AND participate in an interview, please click the following link: bit.do/psgiftcardinterview

Your responses to the above survey will remain anonymous and will not be linked to your contact information.
[END OF SURVEY BLOCK 4: INDIVIDUALS WHO COMPLETED THE SURVEY]

Appendix B: Interview Questions

Version A: Employed and Active Certification

Training/Certification Process:

1. Tell me about your experience with Via Hope's training and certification process. When did you become certified? What did you like about the training and certification process? Did you face any challenges with the training and certification process?
2. What are the benefits of maintaining your certification?
3. Do you face any challenges maintaining your certification?

Employment:

1. Tell me about your current employment situation. What type of organization do you work at and how long have you worked there? What do you like about your organization? What do you wish was different? (Probe for experience working with people in services, organizational characteristics, collegial experiences).
2. Does your organization support recovery and peer specialists (in terms of language, values, norms)? How do
3. you know?

Peer Specialist Integration: (defined as incorporating peer specialists into the fabric of an organization)

1. Do you feel like you (and other peer specialists at your organization, if applicable) are integrated into your organization? In what ways do you feel integrated? In what ways do you not feel integrated?
2. Have you experienced any issues with funding for peer specialists at your organization?
3. Do you think staff at your organization have a clear understanding of the roles and activities of peer specialists? Why/why not? Vary by discipline/position?
4. How were you recruited to be a peer specialist?
5. Who is your supervisor (i.e., what is their job title)? How do you feel about their supervision?
6. What does supervision look like for you? In what ways could your supervisor better support you (and other peer specialists at your organization, if applicable)?
7. Have you (and other peer specialists at your organization, if applicable) been given opportunities for career advancement or development at your organization? (Probe for time off/reimbursement for trainings, skill development, pay increases, and opportunities to move up in terms of job title).
8. Do you (and other peer specialists at your organization, if applicable) have effective collaborative working relationships with peer and non-peer staff at your organization? What do you think contributes to the effectiveness of those relationships? What barriers do you see to effective collaborative relationships? (Probe for if this varies by discipline)
9. Is there anything else you'd like to talk about?

Version B: Employed and Inactive Certification

Training/Certification Process:

1. Tell me about your experience with Via Hope's training and certification process. When did you become certified? What did you like about the training and certification process? Did you face any challenges with the training and certification process?
2. When did your certification expire and why have you not maintained your certification?

3. Do you face any challenges not being certified at your organization?
4. Would you like to renew your certification in the future?

Employment:

1. Tell me about your current employment situation. What type of organization do you work at and how long have you worked there? What do you like about your organization? What do you wish was different? (Probe for experience working with people in services, organizational characteristics, collegial experiences).
2. Does your organization support recovery and peer specialists (in terms of language, values, norms)? How do you know?

Peer Specialist Integration: (defined as incorporating peer specialists into the fabric of an organization)

1. Do you feel like you (and other peer specialists at your organization, if applicable) are integrated into your organization? In what ways do you feel integrated? In what ways do you not feel integrated?
2. Have you experienced any issues with funding for peer specialists at your organization?
3. Do you think staff at your organization have a clear understanding of the roles and activities of peer specialists? Why/why not? Vary by discipline/position?
4. How were you recruited to be a peer specialist?
5. Who is your supervisor (i.e., what is their job title)? How do you feel about their supervision?
6. What does supervision look like for you? In what ways could your supervisor better support you (and other peer specialists at your organization, if applicable)?
7. Have you (and other peer specialists at your organization, if applicable) been given opportunities for career advancement or development at your organization? (Probe for time off/reimbursement for trainings, skill development, pay increases, and opportunities to move up in terms of job title).
8. Do you (and other peer specialists at your organization, if applicable) have effective collaborative working relationships with peer and non-peer staff at your organization? What do you think contributes to the effectiveness of those relationships? What barriers do you see to effective collaborative relationships? (Probe for if this varies by discipline)
9. Is there anything else you'd like to talk about?

Version C: Not Employed and Active Certification

Training/Certification Process:

1. Tell me about your experience with Via Hope's training and certification process. When did you become certified? What did you like about the training and certification process? Did you face any challenges with the training and certification process?
2. What are the benefits of maintaining your certification?
3. Do you face any challenges maintaining your certification?

Employment:

1. What did you like about the organization where you worked? What did you wish was different? (Probe for experience working with people in services, organizational characteristics, collegial experiences).
2. Tell me about your current employment situation. Are you currently employed? (If yes, probe for details about current employment situation and why they are not employed as a peer specialist at a mental health organization).
3. What did you like about providing peer services to people receiving mental health services? What did you not like?
4. Do you want to provide peer services to people receiving mental health services in the future? Why or why

not?

Peer Specialist Integration: (defined as incorporating peer specialists into the fabric of an organization)

1. Did you feel like you (and other peer specialists at your organization, if applicable) were integrated into your organization? In what ways did you feel integrated? In what ways did you not feel integrated?
2. Did you experience any issues with funding for peer specialists at your organization?
3. Do you think staff at your organization had a clear understanding of the roles and activities of peer specialists? Why/why not? Vary by discipline/position?
4. How were you recruited to be a peer specialist?
5. Who was your supervisor (i.e., what was their job title)? How did you feel about their supervision?
6. What did supervision look like for you? In what ways could your supervisor have better supported you (and other peer specialists at your organization, if applicable)?
7. Were you (and other peer specialists at your organization, if applicable) given opportunities for career advancement or development at your organization? (Probe for time off/reimbursement for trainings, skill development, pay increases, and opportunities to move up in terms of job title).
8. Did you (and other peer specialists at your organization, if applicable) have effective collaborative working relationships with peer and non-peer staff at your organization? What do you think contributed to the effectiveness of those relationships? What barriers did you see to effective collaborative relationships? (Probe for if this varies by discipline).
9. Is there anything else you'd like to talk about?

Version D: Not Employed and Inactive Certification

Training/Certification Process:

1. Tell me about your experience with Via Hope's training and certification process. When did you become certified? What did you like about the training and certification process? Did you face any challenges with the training and certification process?
2. When did your certification expire and why have you not maintained your certification?
3. Would you like to renew your certification in the future?

Employment:

1. What did you like about the organization where you worked? What did you wish was different? (Probe for experience working with people in services, organizational characteristics, collegial experiences).
2. Tell me about your current employment situation. Are you currently employed? (If yes, probe for details about current employment situation and why they are not employed as a peer specialist at a mental health organization).
3. What did you like about providing peer services to people receiving mental health services? What did you not like?
4. Do you want to provide peer services to people receiving mental health services in the future? Why or why not?

Peer Specialist Integration: (defined as incorporating peer specialists into the fabric of an organization)

1. Did you feel like you (and other peer specialists at your organization, if applicable) were integrated into your organization? In what ways did you feel integrated? In what ways did you not feel integrated?
2. Did you experience any issues with funding for peer specialists at your organization?
3. Do you think staff at your organization had a clear understanding of the roles and activities of peer specialists? Why/why not? Vary by discipline/position?

4. How were you recruited to be a peer specialist?
5. Who was your supervisor (i.e., what was their job title)? How did you feel about their supervision?
6. What did supervision look like for you? In what ways could your supervisor have better supported you (and other peer specialists at your organization, if applicable)?
7. Were you (and other peer specialists at your organization, if applicable) given opportunities for career advancement or development at your organization? (Probe for time off/reimbursement for trainings, skill development, pay increases, and opportunities to move up in terms of job title).
8. Did you (and other peer specialists at your organization, if applicable) have effective collaborative working relationships with peer and non-peer staff at your organization? What do you think contributed to the effectiveness of those relationships? What barriers did you see to effective collaborative relationships? (Probe for if this varies by discipline).
9. Is there anything else you'd like to talk about?

Appendix C: Additional Qualitative Survey Results

Table A1: Support Groups (Current Peer Specialists)

Peer support (n=7)	CTSS (n=1)
Wellness and Recovery (n=6)	DIC (n=1)
WRAP (n=5)	Health Support (n=1)
Depression/Bipolar support (n=4)	IMR (n=1)
Whole Health (n=4)	Jail Re-entry (n=1)
Anger Management (n=3)	Meditation (n=1)
Coping Skills (n=3)	Mindfulness (n=1)
Life Skills (n=3)	Motivational (n=1)
PTSD (n=3)	Parent Group (n=1)
Stress and Anxiety Management (n=3)	Positive Affirmations (n=1)
Basic (n=2)	Seeking Safety (n=1)
Co-occurring (n=2)	Self-actualization (n=1)
NAMI connections (n=2)	Social Skills (n=1)
Relaxation (n=2)	Socialization Group (n=1)
Twelve-Step Recovery (n=2)	Substance Abuse (n=1)
AA (n=1)	Tobacco Cessation (n=1)
All (n=1)	Weight Loss (n=1)
Any Requested (n=1)	Women's Group (n=1)
Communications Skills (n=1)	Women's Survivor Group (n=1)

Table A2: Support Groups (Previous Peer Specialists)

Open -- All Levels (n=3)	WRAP (n=2)
Depression (n=2)	Art Classes (n=1)
Peer Support (n=2)	Discussion Groups (n=1)
Wellness and Recovery (n=2)	Grief Recovery (n=1)
Whole Health (n=2)	Vet-to-Vet (n=1)
Women's (n=2)	

Table A3: One-on-One Support (Current Peer Specialists)

What	Active Listening (n=8)	COPSD (n=2)
	One-on-One Talks (n=8)	Counseling (n=1)
	Emotional Support (n=6)	Intentional Peer Support (n=1)
	Goal Setting (n=5)	Job Referrals (n=1)
	Advocate (n=4)	Life Coach (n=1)
	Discuss Client Needs & Challenges (n=4)	Peer Mentoring (n=2)
	Tell about Recovery Journey (n=4)	Peer-to-Peer (n=1)
	Education (n=3)	Provide Resources (n=1)
	Encourage Recovery (n=3)	Self-actualization (n=1)
	Psychosocial (n=3)	Shared Experience (n=1)
	Referrals (n=3)	Spiritual (n=1)
	Coping Skills (n=2)	
Where	Out in the Field after Discharge (n=1)	

Who	Peers Unable to Engage in Social Settings (n=1)	Veterans and their Families (n=1)
When	Every Eight weeks (n=2)	Weekly Check-ins (n=1)
	By Appointment through Referrals (n=1)	When in Crisis (n=1)
	Daily at Random (n=1)	When Requested (n=1)

Table A4: One-on-One Support (Previous Peer Specialists)

What	Vet-to-Vet (n=2)	Listening (n=1)
	Daily Discussions (n=1)	Peer Support Sessions (n=1)
	Discuss Client Needs & Challenges (n=1)	Tell about Recovery Journey (n=1)
	Grocery Shopping and Meal Prep (n=1)	
Where	People's Homes (n=1)	
Who	For Individuals Requiring Specialized Care (n=1)	

Table A5: Types of Skill Building (Current Peer Specialists)

Coping Skills (n=11)	Self-Reliance (n=2)
Socialization and Social Skills (n=7)	Critical Thinking (n=1)
Anger Management (n=6)	Community Outreach (n=1)
Job Skills & Job-seeking Skills (n=6)	Diagnosis Skills Development (n=1)
Communication (n=5)	Hope (n=1)
Life Skills (n=5)	Housing Advocacy (n=1)
Advocacy (n=4)	IMR (n=1)
Budgeting and Financial Skills (n=4)	Journaling (n=1)
Goal Achievement (n=4)	Parenting (n=1)
Boundaries (n=3)	Photography as Mindfulness & Meditation
Confidence and Self-Esteem (n=3)	Public Speaking (n=1)
Recovery (n=3)	Reduce Hospital Stays (n=1)
Self-care (n=3)	Relationships (n=1)
Symptom Management (n=3)	Resilience (n=1)
Anxiety and Stress Management (n=2)	Resource Locator (n=1)
Assertiveness (n=2)	Smoking Cessation (n=1)
Combat Negative Thinking Patterns (n=2)	Staying-in-School Skills (n=1)
Computer Skills (n=2)	Storytelling (n=1)
Controlling Emotions (n=2)	WRAP (n=1)
Meditation (n=2)	Yoga (n=1)

Table A6: Types of Skill Building (Previous Peer Specialists)

Communication (n=2)	Coping Skills (n=1)
Interviewing and Job Skills (n=2)	Reading (n=1)
Anger Management (n=1)	Recovery (n=1)
Budgeting and Financial Skills (n=1)	Traveling and Exploration (n=1)
Computer Skills (n=1)	Whole Health (n=1)
Cooking (n=1)	

Table A7: Education/What do you Teach (Current Peer Specialists)

WRAP (n=7)	Intentional Peer Support (IPS) (n=1)
Recovery Steps & Facilitators (n=4)	Job & Career Skills (n=1)
WHAM (n=4)	Job Quest (n=1)
Coping Skills (n=3)	Medication (n=1)
Diagnosis (n=3)	Meditation (n=1)
Tobacco Cessation (n=3)	Mental Health First Aid (n=1)
Basic Life Skills (n=2)	Motivational Interviewing (n=1)
Depression and Bipolar (n=2)	NAMI Peer-to-Peer (n=1)
Educate Clients/Staff on Peer Support (n=2)	NCCER Core (n=1)
Emotional CPR (n=2)	Peer Support Group (n=1)
Health & Wellness (n=2)	Policy Stakeholders (n=1)
IMR (n=2)	Positive Thinking (n=1)
Social Skills (n=2)	Post-Traumatic Stress Disorder (n=1)
Substance Abuse (n=2)	Psychosocial Rehab (n=1)
Symptoms (n=2)	Reading to a Client (n=1)
Weight Loss (n=2)	Relapse (n=1)
Whole Health & Resiliency (n=2)	Seeking Safety (n=1)
Anger Management (n=1)	Self-esteem (n=1)
Contemplative Photography (n=1)	Share Recovery Experience (n=1)
COPSD (n=1)	Stress & Anxiety (n=1)
Counseling (n=1)	Symptom Management Skills (n=1)
Education about 1st Episode Psychosis (n=1)	Systems Software Training for Colleagues (n=1)
Five Stage of Recovery (n=1)	Teach about Military Culture to Community Stakeholders (n=1)
Goal Setting (n=1)	Transitional Age Youth (TAY) Classes (n=1)
Going Back to School (n=1)	Twelve Steps (n=1)
Hygiene & Grooming (n=1)	Wellness to Peers (n=1)
Illness (n=1)	

Table A8: Education/What do you Teach (Previous Peer Specialists)

WRAP (n=2)	Mental Disorders (n=1)
Breathing Techniques (n=1)	Mental Health Recovery (n=1)
Cognitive Behavioral Therapy (n=1)	Role Play (n=1)
Computer Skills (n=1)	Skills Training (n=1)
Dialectical Behavioral Therapy (n=1)	Stress Reduction (n=1)
Emotions (n=1)	Veterans (n=1)
Interns (n=1)	Women's Trauma (n=1)

Table A9: Workgroups/Committees Served On (Current Peer Specialists)

Veteran's (n=5)	NAMI (n=1)
Advisory (n=2)	Peer-led Voice Groups (n=1)
Decrease in Restraints & Seclusions (n=2)	Planning Network Advisory Community (n=1)
Hiring (n=2)	Project Teach (n=1)
Recovery (n=2)	Recovery (n=1)

Transition Age Youth (n=2)	Recovery-oriented systems of care (ROSC) (n=1)
Via Hope (n=2)	Soldier's Angels (n=1)
Accept Youth Move (n=1)	Summer CAMP (n=1)
Child Welfare (n=1)	Terrell State Hospital Mental Health Awareness Walk (n=1)
Community Health Worker (n=1)	Trauma-informed Care (n=1)
Community Re-entry (n=1)	Utilization Management Agency Meeting (n=1)
Conferences (n=1)	Veteran's Court (n=1)
Homeless (n=1)	Wellness Committee (n=1)
Integrated Health Care (n=1)	WHAM (n=1)
Juvenile Justice (n=1)	

Table A10: Workgroups/Committees Served On (Previous Peer Specialists)

Peer Support Group (n=2)	Christmas Hygiene Packs (n=1)
Behavioral Health Leadership Team (n=1)	Customer Service (n=1)