REPORT / PEER WORKFORCE OUTCOMES

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Peers in Texas:

Workforce Outcomes

Submitted to Texas Health and Human Services

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Executive Summary

Project Overview

This project examines the workforce needs and strengths of individuals certified as peer specialists in Texas. Researchers at the Texas Institute for Excellence in Mental Health (TIEMH) administered a survey (n=189) exploring the following topics: demographic characteristics, employment characteristics, training and certification, compensation and Medicaid billing, job satisfaction, organizational recovery culture, role tasks and role clarity, and supervision.

Results and Recommendations

Greater efforts should be made to attract, train, and retain a more diverse peer workforce. In particular, based on the survey sample, there is an underrepresentation of Hispanic or Latino peers (12% of sample) compared to the Hispanic population in Texas (40% of the population in 2022; U.S. Census Bureau, 2022).

Survey respondents reported working on average 3.7 years at their employer, which is lower than the average of 5.3 years reported by peer specialists in 2021 (Lodge et al., 2021). The majority of respondents reported that they receive (or received) personal time off (PTO), medical insurance for themselves, dental insurance, vision insurance, paid sick leave, paid vacation, and retirement. However, less than half reported receiving disability insurance or medical insurance for their family and 12% of peers who responded to this question reported receiving no employee benefits (which is unchanged from 2021). All peers should have access to paid time off and health insurance. Offering more robust benefit packages that also include disability benefits as well as health insurance for family members may help to attract and retain qualified peer specialists.

Respondents commonly reported wanting to take training on crisis work, motivational interviewing, mental health and recovery, group facilitation, trauma, peer ethics, and documentation. Respondents most commonly reported attending (and also preferring) online trainings. Peer training entities should take these preferences into consideration for future training offerings.

More than one-third (37%) of survey respondents reported that their organization bills Medicaid for their services, which is up from 2021 when only 28% of peers reported their organization was billing for their services (Lodge et al., 2021). Among respondents who work at organizations that bill Medicaid for their services, respondents most commonly reported that their organization uses the Peer Specialist Services code. Although more organizations may be using the Peer Support billing code (possibly reflecting the March 2022 increase in the reimbursement rate), further raising the reimbursement rate to reflect the value and cost of peer services may further incentivize organizations to utilize the code for peer support reimbursement.

Respondents reported a mean hourly wage of $19.04. This is up from 2021 when peer survey respondents reported a mean hourly wage of $16.30 (Lodge et al., 2021) and 2016 when employed mental health peers reported a mean hourly wage of $15.20 (Lodge et al., 2017). However, after adjusting for inflation, peer mean hourly wages have remained flat since 2016 (United States Bureau of Labor Statistics, 2023). Employer organizations should consider raising the wages for peer specialists to retain a qualified peer workforce.

In general, peers report being satisfied with their jobs, with some reporting that they love their job and that working as a peer is their purpose or calling in life. However, respondents also emphasized aspects of the peer role that they are dissatisfied with, including low pay, high levels of stress, long hours, emotional exhaustion, and (for

some) unsupportive supervisors. In addition to raising peer specialist wages, the adoption of a resiliency-focused supervision model (Mack, 2020) – whereby supervisors are responsive to stressors and attend to the health and wellness of supervisees as well as identify self-care practices to reduce work-related stress and burnout symptoms – may increase job satisfaction among peer specialists (Abraham et al., 2022; Forbes et al., 2022).

To examine the recovery orientation of their employer organizations survey respondents responded to the 15-item Recovery Oriented Services Assessment (ROSA; Lodge et al., 2018). ROSA items that were rated most highly, in terms of frequency of delivery, included believing that people can grow and recover, modeling hope, being open with people about all matters regarding their services, and respecting people's decisions about their lives. Lower scored items, in terms of frequency of delivery, included providing trauma-specific services, encouraging people to take risks to try new things, inviting people to include those who are important to them in their planning, and offering people opportunities to discuss their spiritual needs when they wish. Employer organizations should take steps to more frequently provide trauma-specific services, encourage people to take risks to try new things in support of their recovery, invite people to include those who are important to them in their planning, and offer opportunities to discuss spiritual needs.

Respondents reported that the tasks they most commonly provide are connecting people to resources (85%), one-on-one support (84%), and advocating for people in services (82%). The least commonly reported tasks were medication management and monitoring (14%), psychosocial rehabilitation (19%), and supervision (25%). These most commonly and least commonly reported tasks are similar to job tasks reported in previous peer surveys. Respondents reported on average spending 35% of their time on administrative tasks (down from 38% in 2021) and 60% of their time providing peer support (up from 57% in 2021; Lodge et al., 2021). Most respondents reported providing services to adults and, on average, respondents reported that they provide services to 18.8 people in an average week (down from 20.7 in 2021; Lodge et al., 2021).

To a question about how peer specialist service delivery has changed since the coronavirus (COVID-19) pandemic, more than half (52%) reported that the way they provide services has not changed or that this question is not applicable to them. Among those who did experience changes to the way they deliver services, the most common change was providing virtual and/or telephonic services, including both one-on-one and group services.

Most respondents reported receiving weekly or monthly supervision. The most commonly received types of supervision include: problem resolution (64%), professional growth (62%), and administration supervision (58%). The least common forms include peer competencies supervision (47%) and provision of peer services (43%). Peer supervisors may need more support to provide peer competencies supervision and supervision on providing peer services.

Sixty-four percent of respondents reported that their supervisor is a peer specialist; this is up from 2021 when 48% reported having a peer specialist supervisor (Lodge et al., 2021) and 2016 when only about a quarter of mental health peer specialists reported being supervised by a peer specialist (Lodge et al., 2017).

The three most frequently practiced supervisor competencies were: supporting peers' ongoing training and education, supporting meaningful peer roles, and promoting a recovery orientation. The three least frequently practiced competencies (although still frequently practiced) were: facilitating access to community resources, providing role clarity for peers, and providing quality peer services supervision rather than only administrative or clerical supervision. Peer supervisors may need more support (including more training and technical assistance as well as a lower administrative burden) to share community resource information with peers, provide role clarity for peers, and provide quality peer services supervision rather than only administrative or clerical supervision.

Introduction

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

It has been estimated that peer specialists will soon make up 25% of the behavioral health workforce (Manderscheid, n.d.). Yet a recent report on the behavioral health workforce also indicates that the number of peer specialists is not enough to meet the service need (SAMHSA, 2021). Workplace integration and job satisfaction are critical to the success and retention of the growing peer provider workforce (Cronise et al., 2016; Davidson et al., 2006; Grant et al., 2012; Kuhn et al., 2015). Research has identified several domains that are crucial to peer specialist integration and job satisfaction for peers, including collaborative and supportive relationships with colleagues, career advancement and development opportunities, adequate funding and compensation, supportive organizational cultures, role clarity, and appropriate supervision (Abraham et al., 2022; Cronise et al., 2016; Earley et al., 2016; Kuhn et al., 2015; Mancini, 2018; Myrick & del Vecchio, 2016). For example, several studies have found that peer specialists experience issues with role clarity (Cabral et al., 2014; Cronise et al., 2016; Lodge et al., 2017; Mancini, 2018; Myrick & del Vecchio, 2016; Ostrow & Pelot, 2021). Role clarity issues may be particularly difficult for peers who work in organizations that adhere to a traditional medical model where peers may drift away from the peer role and become assimilated into clinical culture (Deegan, 2021). This research on role clarity also suggests that peer specialists whose job duties more closely align to peer work have higher rates of job satisfaction compared to peers whose job duties involve more administrative and clinical work tasks (Cronise et al., 2016).

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

Purpose of Project

The Texas Institute for Excellence in Mental Health (TIEMH) is contracted by Texas Health and Human Services (HHS) to evaluate employment outcomes for individuals who have been trained and certified as mental health and/or substance use peer specialists in Texas. Towards that end, in Fiscal Year 2023 TIEMH researchers administered a survey measuring peer specialist employment outcomes. Data collection focused on peer specialists' experiences with certification and employment, including topics such as:

- demographic characteristics

- employment characteristics
- training and certification
- compensation and Medicaid billing
- job satisfaction
- organizational culture
- role tasks and role clarity, and
- supervision.

Method

Survey

Survey development

A team of researchers familiar with the peer specialist workforce in Texas convened to discuss the purpose of the survey and to review the peer workforce survey that was administered in FY2021. Each survey item was reviewed and either retained, revised, or removed. Further, new items were added based on knowledge acquired and policy changes since the last survey administration. The survey was also reviewed by members of the HHS Peer and Recovery Services Programs, Planning, and Policy Unit, who provided feedback on survey items. In response to this feedback, the survey was further revised.

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

Recruitment

Recruitment efforts targeted individuals certified (and initials who are in process to become certified) as Mental Health Peer Specialists (MHPSs) and Recovery Support Peer Specialists (RSPSs) by the Texas Certification Board (TCB). TCB was asked to provide a list with email addresses for peers with these designations (n=1,311). On March 8, 2023, peers were emailed an invitation to participate in the survey through Constant Contact, a platform used to launch and monitor email marketing efforts. Among these 1,311 PSS, 85 (7%) had emails that bounced or were undeliverable, resulting in a population size of 1,226. On April 3, 2023 PSS were emailed a reminder to participate in the survey before the survey closed on April 11, 2023.

Survey Administration

Survey administration took place over a period of one month (early March to early April 2023). The email invitation included information about the purpose of the survey and a link that redirected the individual to the survey, which was administered through the web-based system, Qualtrics. To protect anonymity, Qualtrics settings were enabled so that no names, email addresses, or IP addresses were stored with the data. Upon clicking the survey link, participants were directed to an introductory consent page describing the survey, any risks or benefits to completing the survey, and the ability to discontinue survey participation at any time without incurring negative consequences. Upon completion of the survey, participants were eligible to enter into a drawing for one of 25 $25 gift cards. If interested in entering the drawing, participants were redirected to a separate form at the end of the survey to provide their name and email address to be contacted with if selected as a winner. This information was not linked to the survey data. This study was reviewed and determined to not be research by the University of Texas at Austin IRB.

Analysis

Survey data were downloaded from Qualtrics and cleaned and analyzed with SPSS v29. First, duplicate cases (n=9) were identified. Of these 9 duplicate cases, if one response was more complete than the other the more complete

response was retained. If the responses were equally complete, one response was randomly selected for retainment while the other response was deleted. Next, two cases were excluded from analysis due to the fact that these respondents reported never being certified or employed in a peer specialist capacity. After identifying duplicates and removing these two cases, the total N for the sample was 189. Additional cleaning included recoding some qualitative responses into existing survey response categories; this occurred when respondents selected “other” and wrote in responses for which survey response categories existed. Finally, some variables were recoded into new variables for analysis: a Public Health Region variable was created from respondents’ zip code responses, a continuous variable based on total number of job tenure months was created from respondents’ job tenure months and years responses, and a composite Recovery Oriented Services Assessment (ROSA; Lodge et al., 2018) variable was created by combining the responses to the 15 items on the ROSA. Basic descriptive statistics were run for all variables using SPSS v29 and are presented in this report.

Results

Demographic Characteristics

The majority of respondents reported being women, white, and middle aged. In terms of educational attainment, respondents most commonly reported having completed some college or post-high school training. See Table 1 for a description of the demographic characteristics of the survey respondents.

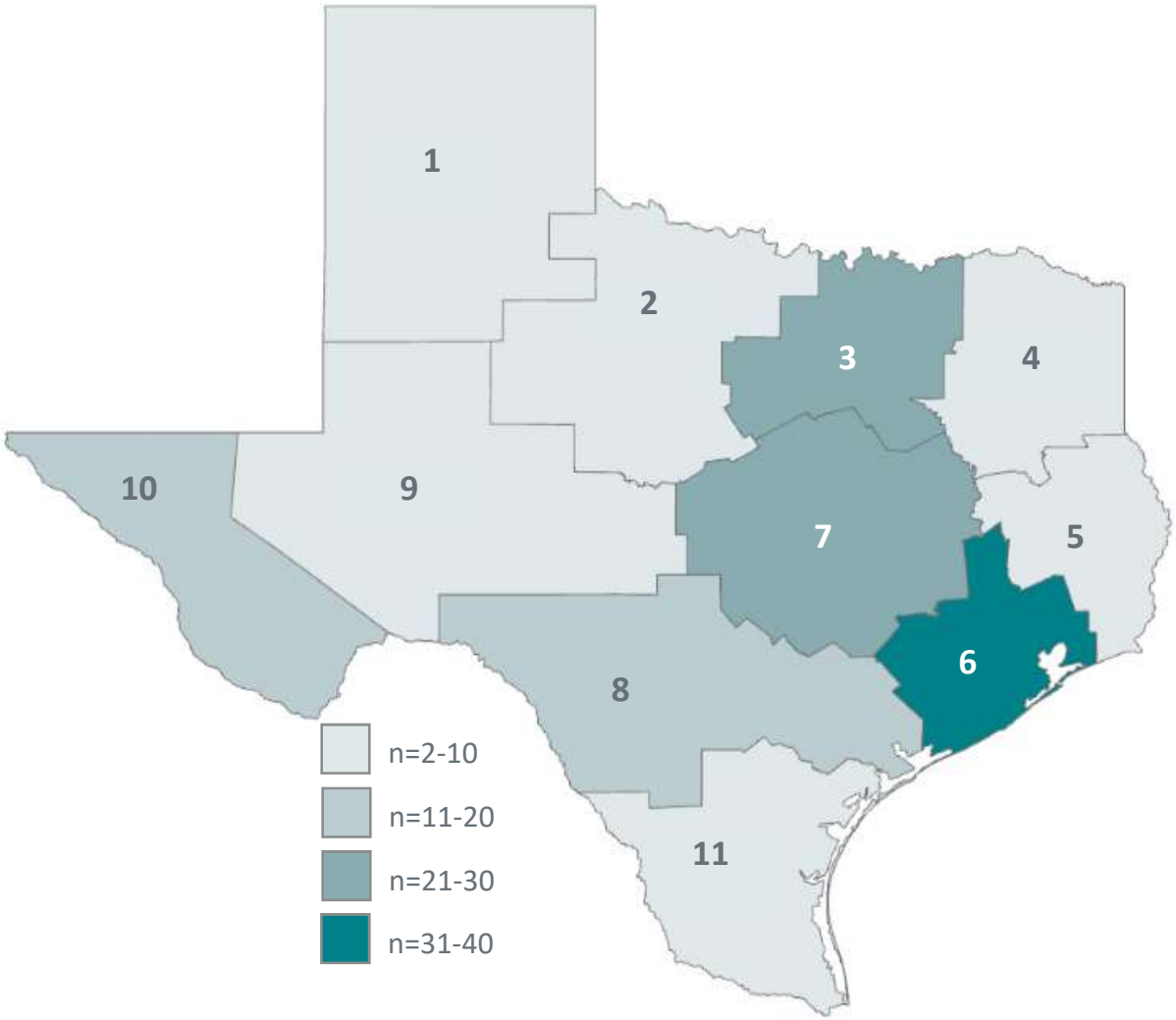
Table 1: Demographic Data

	Survey Respondents (n=189)
Gender	
Additional gender category/identity	1 (.5%)
Gender queer, gender fluid, or non-binary	3 (2%)
Man	42 (22%)
Transwoman	1 (.5%)
Two or more gender identities	3 (2%)
Woman	115 (61%)
Prefer not to disclose/missing	24 (13%)
Race/Ethnicity	
American Indian or Alaskan Native	1 (.5%)
Asian or Asian American	1 (.5%)
Black or African American	27 (14%)
Hispanic or Latino	22 (12%)
Other	1 (.5%)
Two or more races	19 (10%)
White	92 (49%)
Prefer not to disclose/missing	26 (14%)
Age	
18-24	2 (1%)
25-34	20 (11%)
35-44	36 (19%)
45-54	57 (30%)
55-64	36 (19%)
65 or older	14 (7%)
Prefer not to disclose/missing	24 (13%)
Education	
Less than 12th grade	2 (1%)
High school diploma/GED	26 (14%)
Some college or post-high school training	60 (32%)
2-year associate degree	28 (15%)
4-year college degree	33 (17%)
Post-college graduate training	15 (8%)
Prefer not to disclose/missing	25 (13%)

Geographic Representation

The survey sample was regionally diverse and included respondents from all public health regions (PHRs) in Texas. The sample also mirrors the population distribution of Texas, with a greater number of individuals being from the major metro areas of Austin, Dallas/Fort Worth, Houston, and San Antonio than from South Texas, the Panhandle region, the Piney Woods region of East Texas, and West Texas. Figure 1 displays the number of survey respondents from each PHR.

Figure 1: Survey respondents by public health region (PHR; n=151)



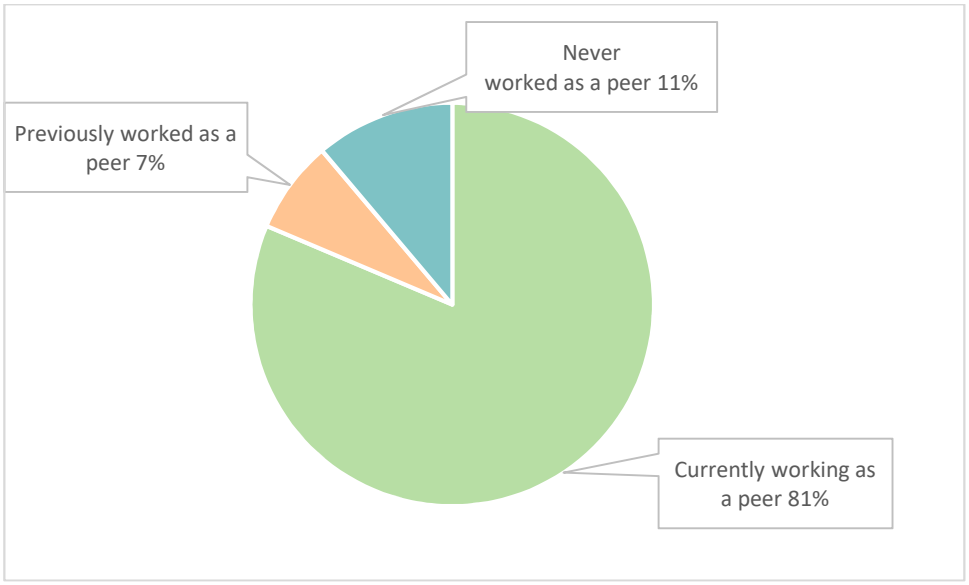
Employment

Employment Status

Survey respondents were asked if they are currently employed in a peer specialist position. The majority of respondents (n=153; 81%) reported that they are currently employed as a peer specialist (Figure 2). The remaining 35 respondents included 14 (7%) individuals who had previously been employed as a peer specialist and 21 (11%)

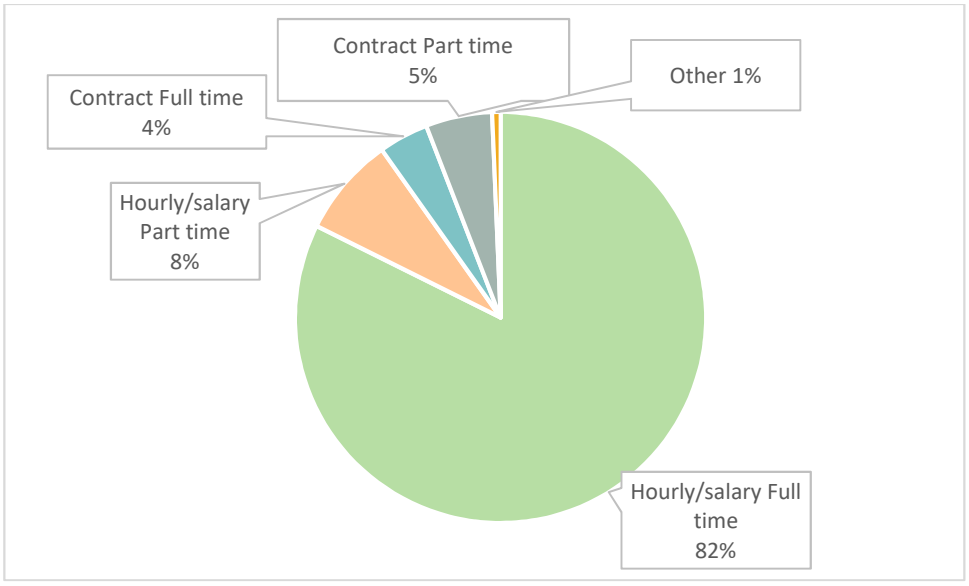
individuals who had never been employed as a peer specialist. The 21 individuals who had never been employed as a peer specialist were not asked any further questions related to peer specialist employment experiences.

Figure 2: Currently or ever employed as a peer specialist (n=188)



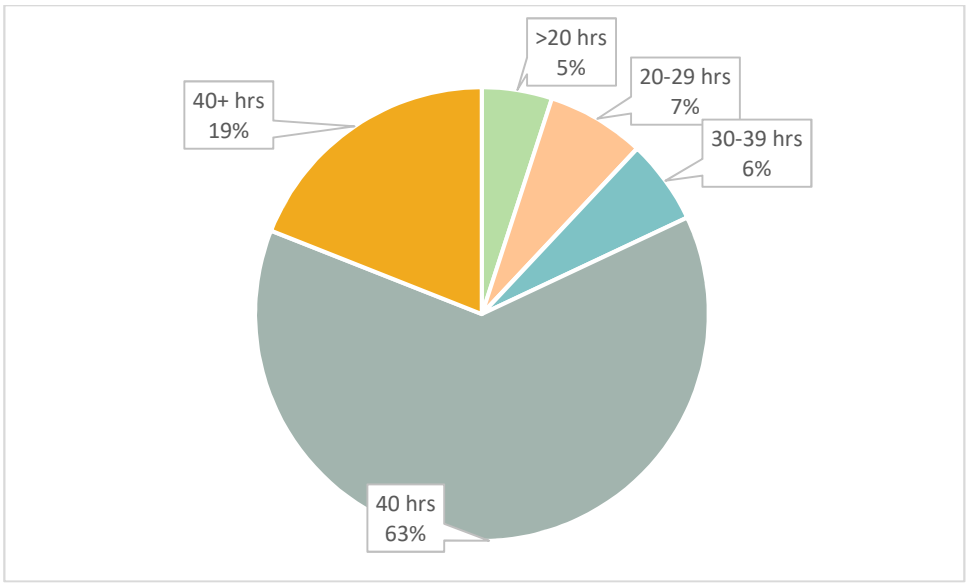
Survey respondents who reported that they are currently working as a peer specialist were asked about their type of employment. The majority (n=126; 82%) reported that they work in an hourly or salary full-time position. An additional 8% (n=12) reported working in an hourly or salary part-time position (see Figure 3). Peers working in contract positions were less common with only 4% (n=6) reporting working in a full-time contract position and 5% (n=8) reporting working in a part-time contract position. Finally, one survey respondent reported working in an "other" type of employment as an initial.

Figure 3: Type of employment among currently employed peer specialists (n=153)



Survey respondents were asked to describe how many hours they work or worked per week. The majority (n=106; 63%) reported working 40 hours per week (see Figure 4).

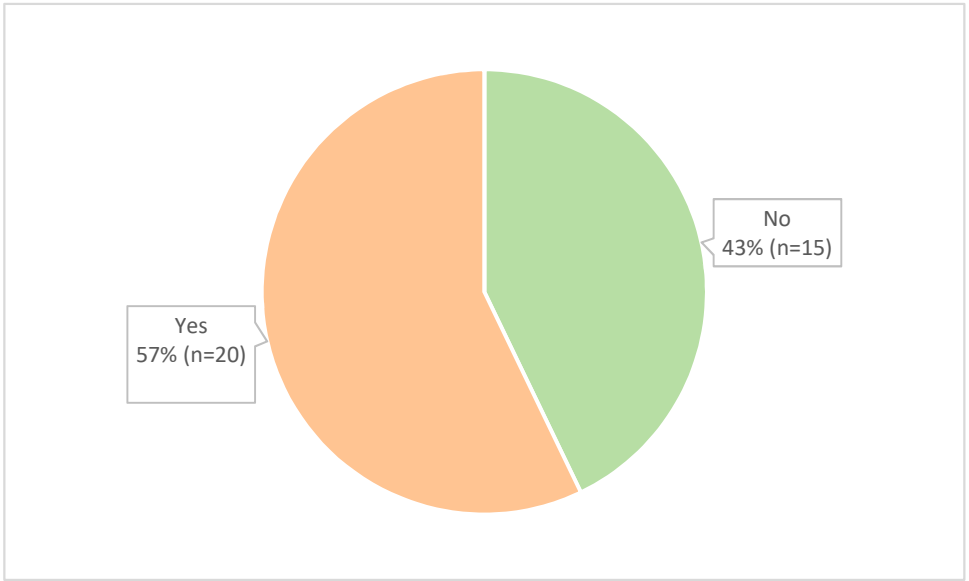
Figure 4: Average hours work(ed) per week (n=167)



Survey respondents who reported that they are not currently working as a peer specialist (n=35) were asked to qualitatively explain why they are not employed as a peer. Most commonly, respondents reported that they are not employed as a peer specialist because they are working in a different role (although all reported still working in the recovery, substance use, or mental health field; n=14). Other job roles included: Behavioral Health Advocate, Peer Specialist Supervisor, Peer Program Manager, LCDC, Youth Advocate, Recovery Advocate, Case Manager, and LCSW. Other reasons for not working as a peer specialist included an inability to find a job as a peer specialist (n=11), having an initial certification (n=5), low pay (n=3), and stress (n=2).

Survey respondents who reported that they are not currently working as a peer specialist were also asked if they had experienced any barriers to finding a job as a peer specialist. Of the 35 individuals that responded to this question, over half (n=20) reported that they experienced barriers (Figure 5). These respondents were asked to explain what barriers they have experienced and these included a lack of peer positions in their area (n=12), a lack of understanding of the peer role among employers (n=3), a lack of funding for peer positions among employers (n=2), low pay (n=2), and having criminal justice involvement (n=2).

Figure 5: Experience barriers to finding a job as a peer specialist among non-employed peers (n=35)



Employer Organization

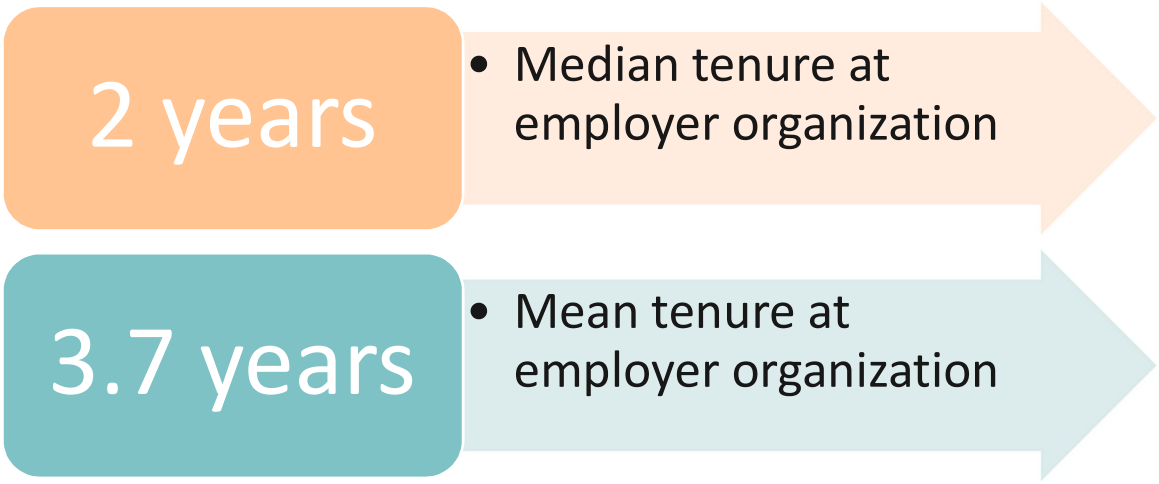
Survey respondents were asked to report the type of organization(s) in which they were most recently employed (note that respondents were able to choose more than one type of organization). See Table 2 for a list of the employer organizations. Most commonly, respondents reported working at Community Mental Health Centers (CMHCs) or Local Mental Health Authorities (LMHAs; n=54), Recovery Community Organizations (RCOs; n=34), and community substance use treatment centers (n=31). Respondents who selected "other" (n=26) were asked to qualitatively describe at what type of organization they were most recently employed. Four of these individuals reported currently or previously working at a non-profit agency. Additional employer organizations included: Federally Qualified Health Center (n=3), sober living home (n=3), inpatient treatment center for substance use disorder (n=2), and domestic violence agency (n=2).

Table 2: Type of employer organization (n=168)

	N	%
Community mental health center (CMHC)	53	31.5%
Recovery community organization (RCO)	34	20.2%
Community substance use treatment center	31	18.5%
Other	26	15.5%
Organization serving people experiencing homelessness	24	14.3%
Peer advocacy or training organization	13	7.7%
Psychiatric crisis facility, unit, or respite program	11	6.5%
Department of Veterans Affairs or other veteran organization	8	4.8%
Drug court, family court, mental health court or veterans' court	7	4.2%
Managed care organization (MCO)	7	4.2 %
Inpatient mental health hospital	5	3.0%
Non-profit agency	4	2.4%
Clubhouse	3	1.8%
Consumer-operated service provider (COSP)	3	1.8%
Jail, prison, or probation	3	1.8%
Federally qualified health center (FQHC)	3	1.8%
Inpatient treatment for substance use disorder	2	1.2%
Domestic violence agency	2	1.2%
High school or collegiate recovery program	2	1.2%
Hospital or emergency room	1	0.6%

Survey respondents were asked how long they have worked (or did work) at their employer organization. The mean employment tenure was 44.9 months (or 3.7 years) with a standard deviation (SD) of 45.9 months (or 3.8 years) and range of 1 month to 216 months (or 18 years). The median employment tenure was 24 months (or 2 years) with an interquartile range of Q1=12 months (or 1 year) to Q3=72 months (or 6 years). Figure 6 displays the mean and median employment tenure.

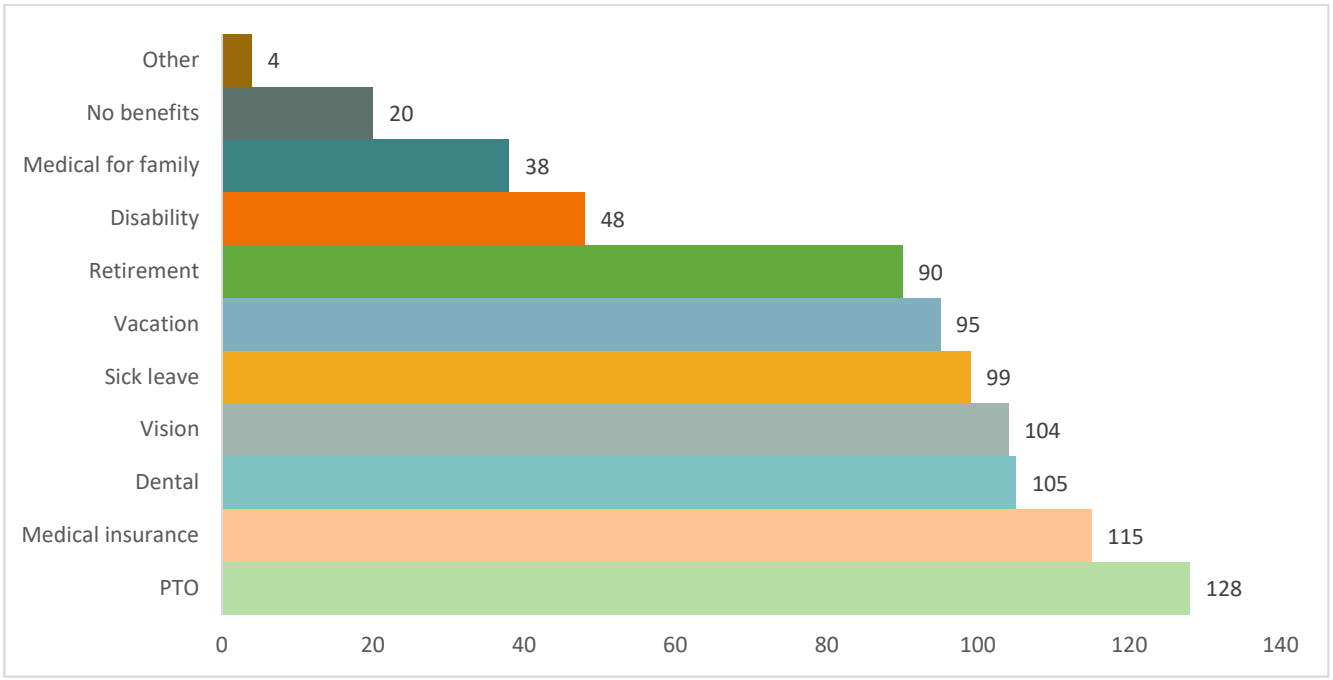
Figure 6: Tenure at employer organization (n=167)



Employee Benefits

Survey respondents were asked about the benefits they receive or received from their employer as a peer specialist (see Figure 7). The most commonly reported benefits were personal time off (PTO; n=129), medical insurance for self (n=115), dental insurance (n=105), and vision insurance (n=104. Twenty respondents reported receiving no benefits and five respondents reported receiving additional benefits. Among the 20 respondents reporting no benefits, 12 are employed in a part-time capacity, 6 are employed in a full-time capacity, and 1 identified as an intern. These additional benefits included life insurance (n=3), self-care days (n=1), supplemental insurance (n=1), voluntary insurance (n=1), discounts (n=1), and employee assistance program (n=1).

Figure 7: Number reporting receiving job benefits (n=168)



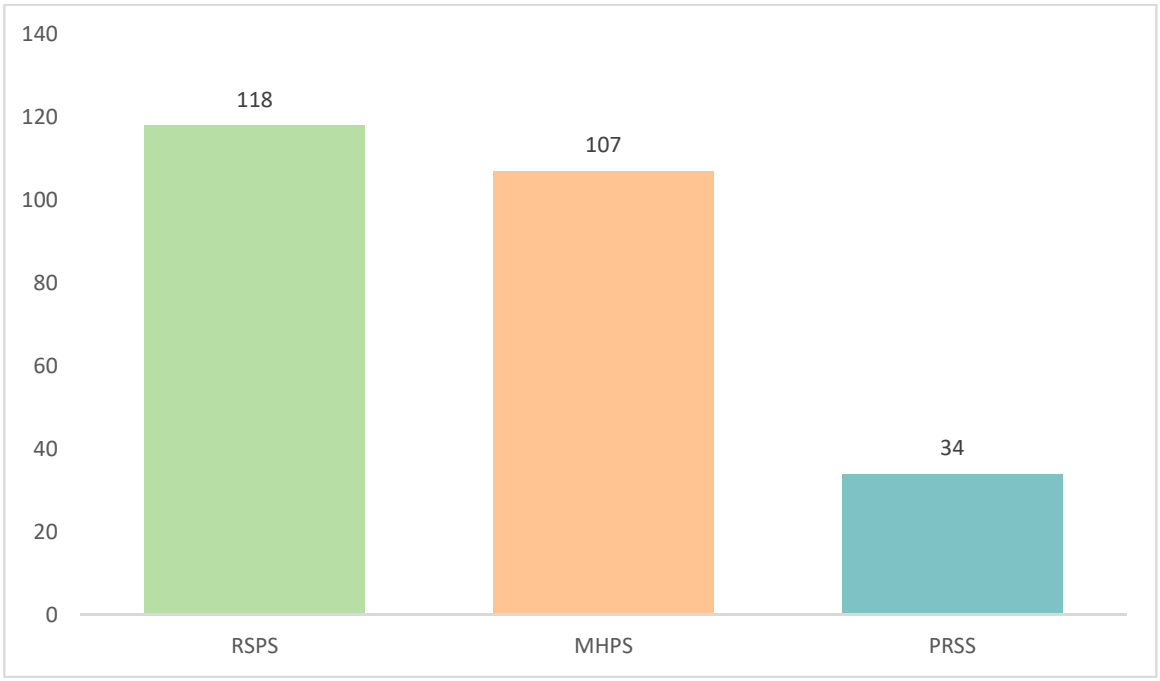
Career Advancement and Development

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

Certification

Survey respondents were asked to indicate which of the following peer specialist trainings they have attended: mental health peer specialist (MHPS) training, recovery support peer specialist (RSPS) training, and the legacy peer recovery support specialist (PRSS) training. As indicated in Figure 8, respondents most commonly reported attending the RSPS training (n=118), followed closely by the MHPS training (n=107) and less closely by the legacy PRSS training (n=34).

Figure 8: Trainings attended (n=189)



Survey respondents were also asked to indicate if they have the following peer specialist certifications: MHPS initial certification, MHPS active certification, MHPS lapsed certification, RSPS initial certification, RSPS active certification, RSPS lapsed certification, and PRSS lapsed certification.

As indicated in Figure 9, most commonly respondents reported having an active RSPS certification (n=104; 55%), followed by an active MHPS certification (n=85; 45%), an initial RSPS certification (n=17; 9%), and an initial MHPS certification (n=13; 7%). Some respondents were dually certified or in the process of becoming dually certified (n=35; 19%). Twenty-eight respondents (15%) reported being dually certified as an RSPS and an MHPS; 3 respondents (2%) reported being certified as an RSPS and an initial MHPS; 2 respondents (1%) reported being certified as an MHPS and an initial RSPS; and 2 respondents (1%) reported being certified as both an initial MHPS and an initial RSPS (see Figure 10). Lapsed certifications were not common in this sample: seven respondents (4%)

indicated having a lapsed PRSS certification, two (1%) reported a lapsed MHPS certification, and two (1%) reported a lapsed RSPS certification.

Figure 9: Certification statuses (n=189)

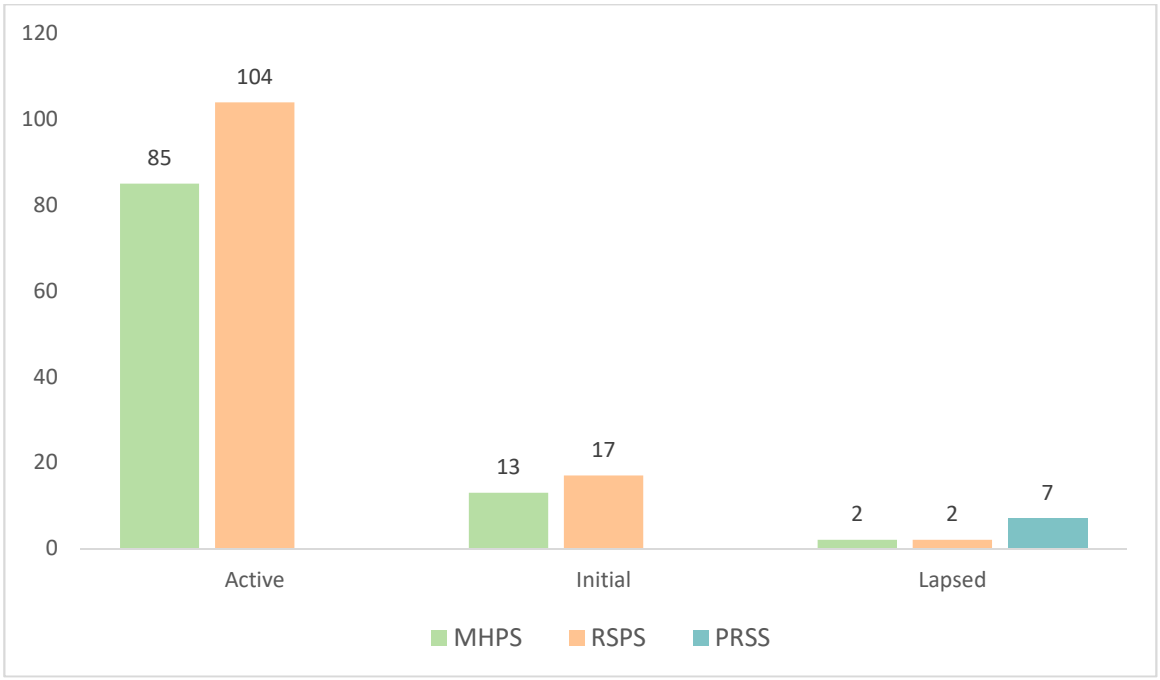
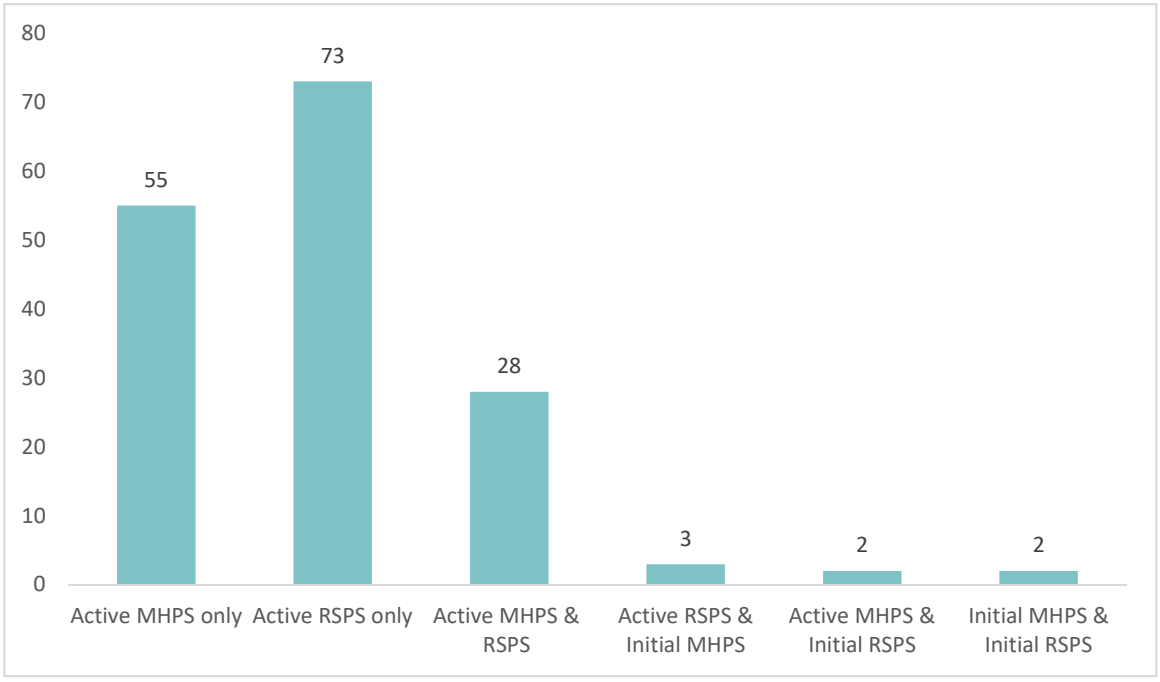


Figure 10: Certification statuses (n=189)



Survey respondents who reported one or more lapsed certifications (n=11) were asked to qualitatively explain why they had not renewed their certification. Respondents described several reasons for not maintaining certification including: PRSS certification no longer needed (as it was replaced by the RSPS certification), personal or family issues, difficulty finding training, moving to a new career or peer focus (e.g., from SUD to MH), never used the certification, and dissatisfaction with the career.

Survey respondents were asked to indicate in what year they were first certified as a peer, regardless of whether their certification is active or lapsed. Table 3 displays what year peers were first certified. Most commonly, survey respondents indicated that they were first certified in 2022 (54%) or 2021 (32%).

Table 3: Year first certified (n=167)

Year	N	%
2009	2	1%
2010	2	1%
2011	4	2%
2012	2	1%
2013	9	5%
2014	7	4%
2015	7	4%
2016	7	4%
2017	8	5%
2018	6	4%
2019	9	5%
2020	6	4%
2021	32	19%
2022	54	32%
2023	12	7%
Total	**167**	**100%**

Career Advancement and Development Opportunities

Survey respondents were asked how frequently their supervisor promotes (or promoted) professional development and advancement opportunities to them. On a five-point scale where 1 is never and 5 is always, on average survey respondents rated their supervisor frequency of promoting professional development and advancement opportunities as a 4.21. Survey respondents were also asked how frequently their supervisor supports (or supported) their ongoing training and education. On average, survey respondents rated their supervisor frequency of promoting training and education as a 4.58. See the section on Supervisor Competencies (on page 27) for more information.

Survey respondents were also asked to qualitatively describe the topics or trainings that would enhance their peer support practice (see Figure 11). The most commonly reported types of training that respondents want included: crisis work (n=12), motivational interviewing (MI; n=11), mental health and recovery (n=11), group facilitation (n=9), trauma (n=9), peer ethics (n=9), documentation (n=9), SUD and recovery (n=8), skills training (n=8), outreach and engagement (n=8), peer roles and role clarity (n=6), supervision or leadership training (n=6), and cultural awareness training (n=6). Overall, respondents reported wanting training on specific populations and lived experiences which included (in addition to the above-named topics) LGBTQ individuals (n=3), youth (n=3), and re-entry education (n=3); training on the peer profession or peer role such as peer professionalism and professionalization (n=5); and training for specific job skills and tasks which included (in addition to the above-named topics) housing support (n=5) and WRAP (n=5).

Figure 11: Most common training topics wanted

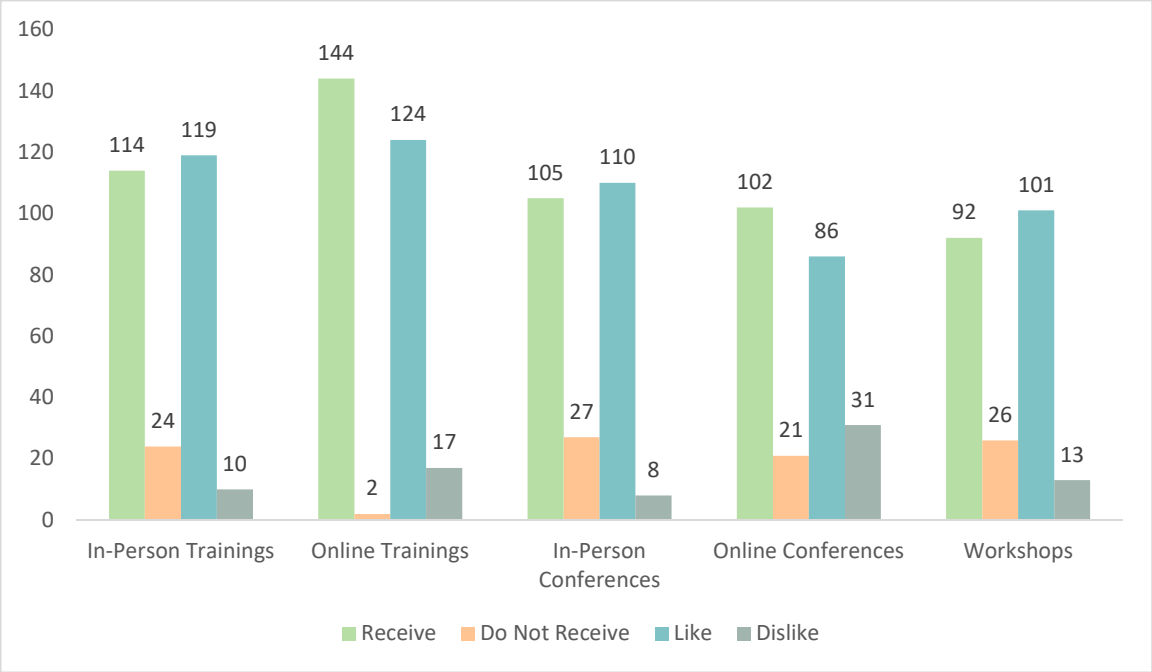
Survey respondents were also asked to qualitatively describe from whom they receive peer-related trainings or other continuing educational opportunities. Figure 12 displays the many training sources that were reported, with more commonly reported training sources appearing in larger font. The most commonly reported training sources were: Via Hope (n=43), online self-discovered trainings (n=16), internal trainings (n=16), and Texas Health and Human Services Commission (HHSC; n=11).

Figure 12: Training sources

Survey respondents were asked about the format(s) that they get their peer-related trainings or continuing educational opportunities as well as which format(s) they prefer (see Figure 13). Respondents most commonly reported attending online trainings (n=144) and also most commonly reported preferring online trainings (n=124).

Respondents were least likely to report attending workshops (n=92) compared to other training formats and were least likely to prefer attending online conferences.

Figure 13: Training formats (n=168)

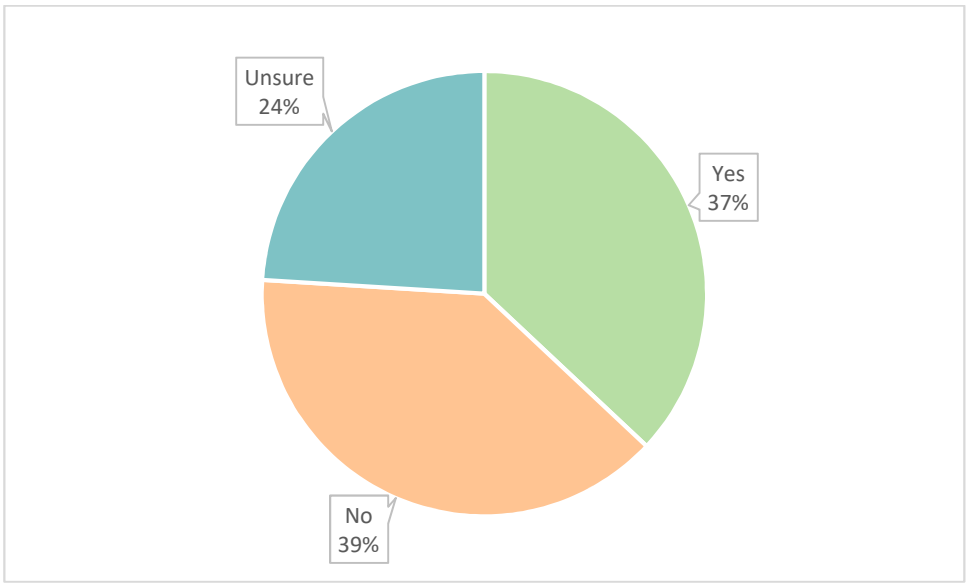


Compensation and Billing

Billing

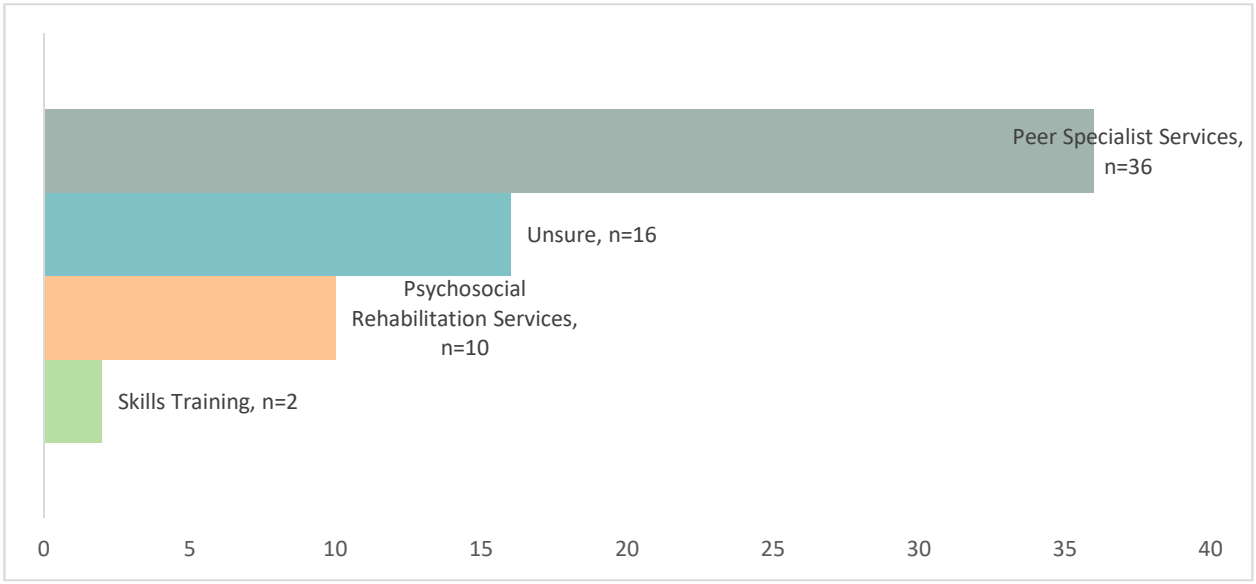
Survey respondents were asked if their employer organization bills (or billed) Medicaid for any of the services they provide. As indicated in Figure 14, 39% of individuals who responded to this question reported that their organization does not bill Medicaid for their services, while 37% reported that their organization bills Medicaid for their services. Another 24% were unsure if their organization bills Medicaid for their services.

Figure 14: Organization bills/billed for Medicaid for their services (n=158)



Survey respondents who reported that their organization does (or did) bill Medicaid for their services were asked to indicate what billing code(s) their organization uses (or used). Most commonly, respondents reported that their organization uses only the Medicaid Peer Specialist Services billing code (n=28; see Figure 15). Sixteen respondents indicated that they did not know what code is used, seven respondents reported their organization uses both the Peer Specialist Services and the Psychosocial Rehabilitation Services code, and two respondents reported only using the Psychosocial Rehabilitation Services code. Finally, two respondents reported using the Skills Training code (one reported using it in conjunction with the Peer code and one reported using it in conjunction with the Psychosocial Rehabilitation code).

Figure 15: Code(s) used to bill for peer services (n=55)



Compensation, Funding, and Financial Assistance

Survey respondents were asked to indicate their hourly wage. Among individuals who responded to this question (n=159), the mean hourly wage reported was $19.04 (SD 4.92) while the median hourly wage was slightly lower at $18.00 (see Figure 16). Reported hourly wages ranged from $11.00 to $35.62 an hour.

Figure 16: Peer wages (n=159)

Mean Hourly Wage: $19.04

Median Hourly Wage: $18.00

Hourly Wage Range: $11.00-$35.62

Job Satisfaction

Survey respondents were asked to indicate their level of agreement with several statements measuring job satisfaction. A 5-point Likert-type scale was utilized for these questions with 1 being “Strongly Disagree” and 5 being “Strongly Agree” for the first five items. The final two items indicate a negative sentiment and are therefore reverse coded with 1 being “Strongly Agree” and 5 being “Strongly Disagree.” Table 4 displays the mean score for each item. Overall, the results indicate that peer specialists are satisfied with their jobs with peers indicating

agreement that their work is personally rewarding, that they would still take their job if they were to decide again, and that they would recommend this job to a friend. Although still rated highly, peers were slightly less likely to agree that their job met the expectations that they had when they took it and were slightly more likely to indicate frequently thinking about quitting their job and that they plan to look for a new job in the next year.

Table 4: Job satisfaction measures (n=144)

Item	mean (sd)
My work is personally rewarding.	4.49 (0.78)
If I had to decide all over again, I would still take this job.	4.35 (0.89)
I would recommend this job to a friend.	4.18 (0.99)
All in all, I am satisfied with my job.	4.18 (1.04)
My job meets the expectations I had when I took it.	3.97 (1.11)
I frequently think about quitting this job.	3.74 (1.31)
I will probably look for a new job in the next year.	3.73 (1.31)

Qualitative survey data provide further evidence that peers are satisfied with their job overall. When asked if they had any additional information to share, survey respondents commonly reported that they love their job and that working as a peer is their purpose or calling in life. For example, one respondent wrote: "I am grateful to be a Peer Specialist…I believe I am living in my purpose." Similarly, another respondent wrote: "Being a RSPS is such a rewarding job not only for me professionally even more so on a personal level." However, respondents also emphasized aspects of the peer role that they are dissatisfied with, most notably the pay. They also commonly expressed that the peer role was a hard one due to stress, long hours, emotional exhaustion, and (for some) unsupportive supervisors. For example, one respondent wrote: "I love my actual job, working with my clients. However, the hours my company expects me to work, and the minimal pay that accompanies it, as well as the time I spend working off the clock, are emotionally exhausting and overwhelming."

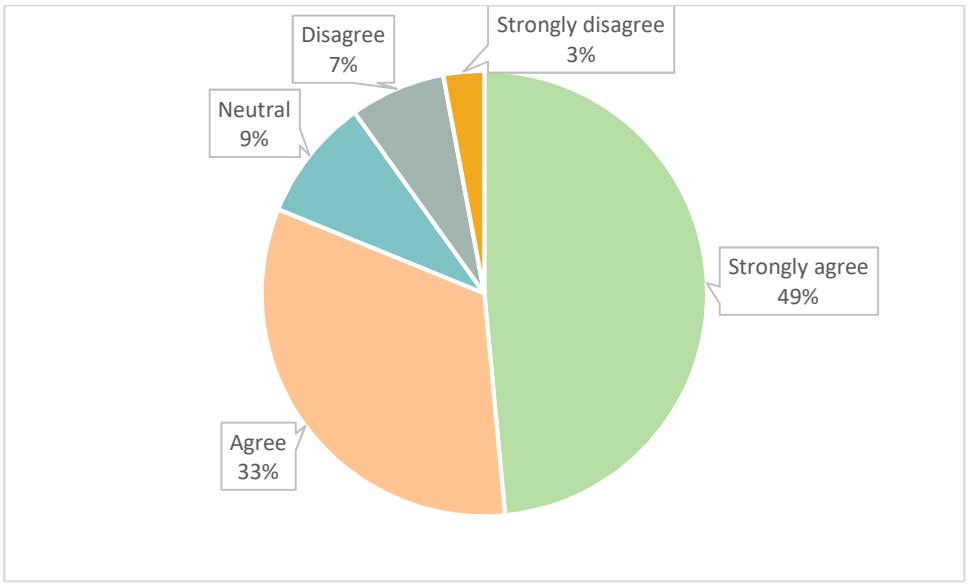
"I am grateful to be a Peer Specialist…I believe I am living in my purpose."

Organizational Culture

Organizational Support

As an indicator of organizational support, survey respondents were asked to indicate the degree to which they feel that their coworkers respect the work that they do. A 5-point Likert-type scale was utilized for this question with 1 being "Strongly Disagree" and 5 being "Strongly Agree." As indicated in Figure 17, respondents were most likely to report that they either strongly agreed (n=71; 49.3%) or agreed (n=48; 33.3%) with the statement that their coworkers respect the work they do (mean 4.25; n=144).

Figure 17: Coworkers respect the work I do (n=144)



Recovery Oriented Culture

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

Table 5: Recovery Oriented Services Assessment (ROSA) scale (n=143)

Our organization…	**Mean (SD)**
…believes people can grow and recover.	4.60 (0.73)
…is open with people about all matters regarding their services.	4.44 (0.83)
…models hope.	4.41 (0.87)
…respects people's decisions about their lives.	4.40 (0.84)
…offers people a choice of services to support their goals.	4.37 (0.88)
…focuses on partnering with people to meet their goals.	4.34 (0.91)
…partners with people to discuss progress towards their goals.	4.30 (0.82)
…supports people to develop plans for their future.	4.25 (0.93)
…introduces people to peer support or advocacy.	4.20 (0.89)
…asks people about their interests.	4.15 (0.90)
…offers services that support people's culture or life experience.	4.15 (0.89)
…provides trauma-specific services.	4.10 (1.12)
…invites people to include those who are important to them in their planning.	3.99 (1.07)
…offers people opportunities to discuss their spiritual needs when they wish.	3.96 (1.14)
…encourages people to take risks to try new things.	3.88 (0.98)
Total Mean	**4.24 (0.75)**

The ROSA scale had excellent internal reliability as indicated by a Cronbach's alpha of .965. ROSA items that were rated most highly, in terms of frequency of delivery, included believing that people can grow and recover, modeling hope, being open with people about all matters regarding their services, and respecting people's decisions about their lives. Lower scored items, in terms of frequency of delivery, included encouraging people to

take risks to try new things, inviting people to include those who are important to them in their planning, offering people opportunities to discuss their spiritual needs when they wish, and providing trauma-specific services.

Role Tasks and Role Clarity

Role Tasks

Survey respondents were asked to select various job tasks that they performed in their work from a list of 24 common peer specialist job tasks. As displayed in Table 6 and Figure 18, the most commonly reported tasks were connecting people to resources (n=143, 85%), one-on-one support (n=141; 84%), and advocating for people in services (n=138; 82%). The least commonly reported tasks were medication management and monitoring (n=24; 14%), psychosocial rehabilitation (n=32; 19%), and supervision (n=42; 25%). Respondents were also provided an "other" option to specify any job tasks not captured by the list. These other job tasks included: harm reduction/street outreach (n=1), obtain social security benefits (n=1), reinstating driver's licenses (n=1), speaking and legislation/bill support (n=1), care coordination (n=1), and crisis work (n=1).

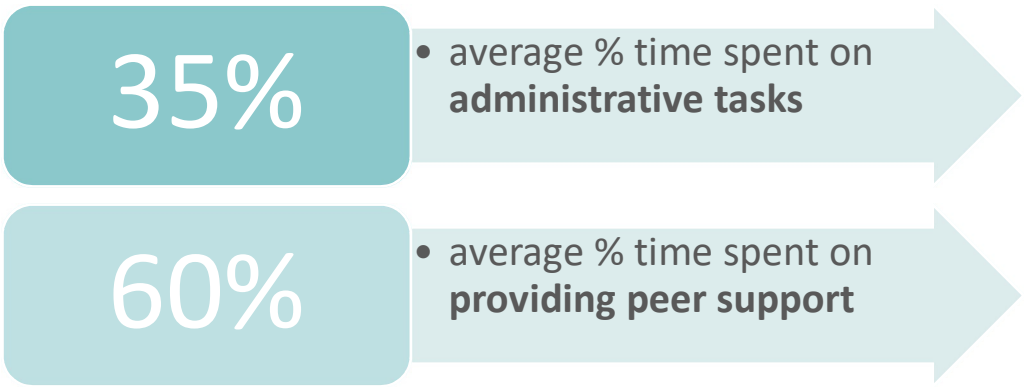
Table 6: Peer role tasks (n=168)

Task	N	%
Connect people to resources	143	85.1%
One-on-one support	141	83.9%
Advocate for people in services	138	82.1%
Recovery and wellness support	135	80.4%
Provide assistance in finding community resources and services	134	79.8%
Help people advocate for themselves	133	79.2%
Administrative tasks	131	78.0%
Goal-setting	128	76.2%
Facilitate support groups	127	75.6%
Outreach/Engagement	101	60.1%
Skill building	100	59.5%
Transportation assistance	98	58.3%
Housing supports	90	53.6%
Education	89	53.0%
Work on a treatment team	69	41.1%
Serve on work groups and committees	65	38.7%
Support clients during transition from inpatient	64	38.1%
Wellness Recovery Action Planning (WRAP)	57	33.9%
Patient navigation	44	26.2%
Vocational assistance	43	25.6%
Provide supervision to other peer specialists	42	25.0%
Psychosocial rehabilitation	32	19.0%
Medication management and monitoring	24	14.3%
Other	9	5.4%

Figure 18: Most commonly reported peer job tasks (n=168)

Survey respondents were also asked to indicate what percentage of their time (in increments of five) that they spend on administrative tasks as well as what percentage of their time they spend on providing peer support. As displayed in Figure 19, respondents reported on average spending 35.3% of their time on administrative tasks and 60.0% of their time providing peer support.

Figure 19: Percent time spent on administrative and peer support tasks (n=158)



Survey respondents were asked what they use to document for peer services from a list of commonly used documentation formats or programs. Survey respondents most commonly reported using progress notes (n=70, 42%), case notes (n=67; 40%), recovery wellness plans (n=41; 24%), and another (not listed) documentation program (n=43; 26%). These additional programs most commonly included: Recovery Data Platform (n=7; 4%), SmartCare (n=5; 3%), CPRS (n=3; 2%), EPIC (n=3; 2%), SalesForce (n=2; 2%), and Recovery Link (n=2; 2%). See Table 7 for a list of documentation formats or programs.

Table 7: Documentation formats/programs used (n=168)

Program	N (%)
Progress note	70 (42%)
Case note	67 (40%)
Other	43 (26%)
Recovery wellness plan	41 (24%)
CMBHS (Clinical Management for Behavioral Health Services)	40 (24%)
Collaborative documentation	33 (20%)
WRAP plan (Wellness Recovery Action Plan)	30 (18%)

Custom note	25 (15%)
SAMHSA GPRA	23 (14%)
In the Driver's Seat	10 (6%)
SOAP note (Subjective, Objective, Assessment, and Plan)	7 (4%)
DAP note (Data, Assessment, and Plan)	6 (4%)
SWOT note (Strengths, Weaknesses, Opportunities, and Threats)	2 (2%)
Consumer Operated Service Provider (COSP) Form N	1 (1%)

Survey respondents were asked to indicate how many individuals that they provide or provided peer services to in an average week. As displayed in Figure 20, respondents reported that they provide(d) services to a mean number of 18.8 people in an average week (median 15 individuals; range 0 to 90; n=166).

Figure 20: Number of individuals peers serve in an average week (n=166)

Survey respondents were asked to indicate which population(s) they work(ed) with: adults (ages 19 and older), youth or adolescents (ages 18 or younger), or other (n=159). Most respondents (n=143; 90%) reported working only with adults, while 13 respondents (8%) reported working with both adults and youth, and only 3 respondents reported working only with youth (2%). All other responses fell into one of these two categories and were recoded as such.

Changes to the Peer Role since the COVID-19 Pandemic

Survey respondents were asked to qualitatively describe if there have been any changes to the way they deliver services since the coronavirus (COVID-19) pandemic. More than half of those who responded to this question (n=63 of 121 responses, 52%) reported that the way they provide services have not changed or that this question is not applicable to them (including respondents who reported not having pre-COVID experience as a peer specialist). Among those that did experience changes to the way they deliver services, the most common change was providing virtual and/or telephonic services (n=26), including both one-on-one and group services. Other changes included attending virtual meetings (n=8), connecting individuals in services to resources (n=3), COVID-19 education (n=3), virtual trainings (n=3), and adhering to COVID-19 protocols (e.g., mask wearing; n=3).

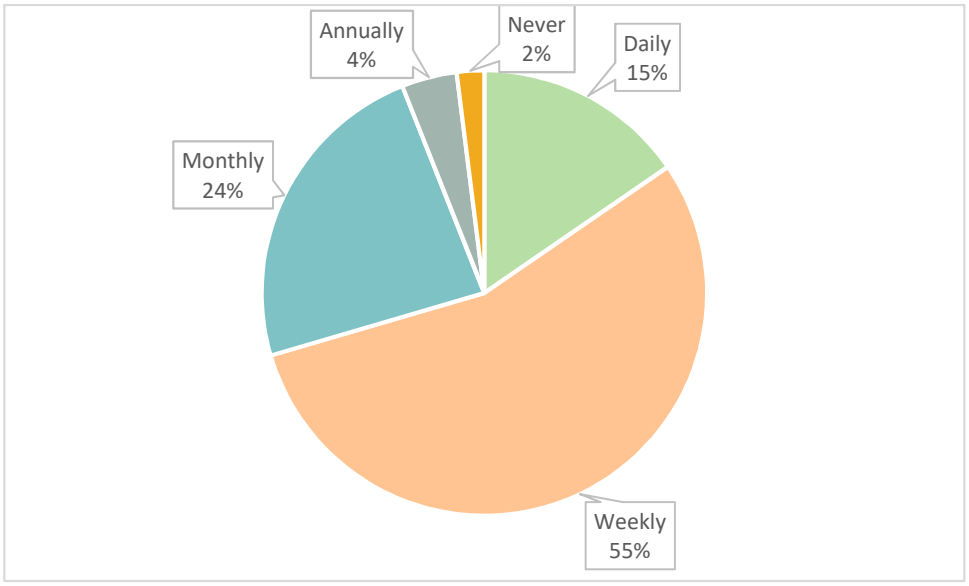
Role Clarity

Survey respondents were asked how frequently their supervisor provides role clarity for them through accurate job descriptions and advising them when role ambiguity or role confusion arises. On a five-point scale where 1 is never and 5 is always, on average survey respondents rated their supervisor frequency of providing role clarity as a 4.20. See the section on Supervisor Competencies (on page 27) for more information.

Supervision

Survey respondents were asked several questions about the supervision they receive (or received) as a peer. First, they were asked how frequently they receive supervision: daily, weekly, monthly, annually, or never. As indicated in Figure 21, most commonly respondents reported receiving weekly supervision (n=82; 55.0%), followed by monthly supervision (n=35; 23.5%).

Figure 21: Supervision frequency (n=149)



Next, survey respondents were asked to indicate on a scale from never to always how frequently they receive both in-person and online supervision. In terms of in-person supervision, peers most commonly reported always receiving in-person supervision (n=43, 30.0%). Only 6% of peers (n=9) reported never receiving in-person supervision (see Figure 22). In terms of online supervision, peers most commonly reported receiving online supervision often (n=44, 32.1%).

Figure 22: In-person (n=144) and online supervision frequency (n=137)

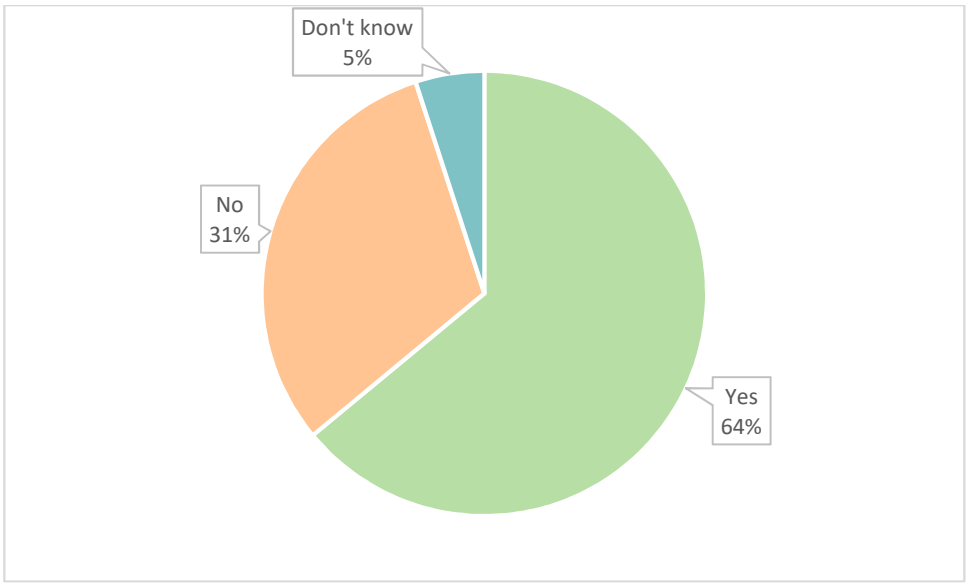
Survey respondents were also asked if they receive several types of supervision. Among the types of supervision respondents were asked about, the most commonly received include: problem resolution (n=108, 64%), professional growth (n=104, 62%), and administrative supervision (n=97, 58%). The least common forms include peer competencies supervision (n=79, 47%) and provision of peer services (n=72, 43%). Additionally, eight respondents (5%) reported receiving an "other" type of supervision and were asked to qualitatively specify what that supervision looks like. The following types of supervision were reported: light conversation, constructive criticism with corrective action, video call check-ins, email check-ins, email instructions on "how to" items, relating to clinicians, developmental and recovery messaging, helping peers deal with imposter syndrome, and trauma-informed and strength-based mutual time spent in supervision. See Table 8 to see how frequently peers receive each type of supervision.

Table 8: Types of supervision (168)

	n (%)
Problem resolution	108 (64.3%)
Professional growth	104 (61.9%)
Administrative supervision	97 (57.7%)
Review of cases and activities	92 (54.8%)
Peer ethics supervision	91 (54.2%)
Supervision for special issues and circumstances	86 (51.2%)
Skill building	83 (49.4%)
Peer competencies supervision	79 (47.0%)
Provision of peer services	72 (42.9%)
Other	8 (4.8%)

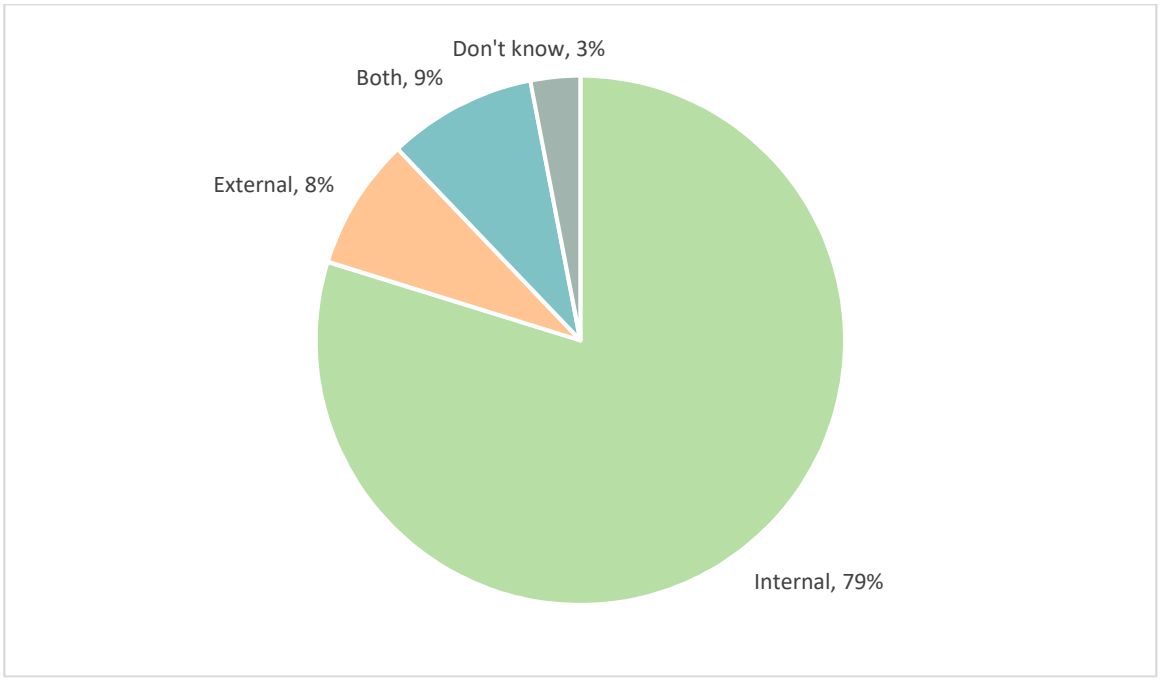
Survey respondents were also asked if their supervisor is (or was) a peer specialist. As indicated in Figure 23, 64% (n=96) reported that their supervisor is a peer specialist, while about 31% (n=46) reported that their supervisor is not a peer specialist and about 5% (n=7) reported that they do not know if their supervisor is a peer specialist.

Figure 23: Supervisor is a peer specialist (n=149)



Next, survey respondents were asked if they receive internal supervision (i.e., their supervisor works at their organization), external supervision (i.e., their supervisor works outside of their organization), both, or they do not know which type(s) of supervision they receive. As indicated in Figure 24, the majority of respondents (n=118, 79%) reported receiving internal supervision, while 9% (n=14) reported receiving both internal and external supervision, 8% (n=12) reported receiving only external supervision, and 3% (n=5) reported they do not know which type(s) of supervision they receive.

Figure 24: Internal and external supervision (n=149)



Supervisor Competencies

Peers were asked to indicate how frequently (on a scale from never=1 to always=5) their supervisor practices 19 peer supervisor core competencies. Table 9 displays the mean scores for each core competency from most frequently practiced to least frequently practice (with a mean closer to five indicating more frequent practice). The three most frequently practiced supervisor competencies included: supporting peers ongoing training and education, supporting meaningful peer roles, and promoting a recovery orientation. The three least frequently practiced competencies (although still frequently practiced) were: facilitating access to community resources by finding and sharing community resource information with peers, providing role clarity for peers through accurate job descriptions and advising peers when role ambiguity or role confusion arises, and providing quality peer services supervision rather than only administrative or clerical supervision.

Additionally, core competency means were compared for peers with supervisors who are peer specialists (n=96) and peers with supervisors who are not peer specialists (n=46). Independent sample t-tests for significance were run for all of the supervisor competencies to determine if there were any statistically significant differences between peers who are and who are not supervised by a peer specialist. There were significant differences in mean scores for nine supervisor competencies: peers with peer supervisors rated competencies higher than peers with non-peer supervisors in terms of supporting meaningful peer roles, promoting a recovery orientation, advocating for peer-delivered services, navigating workplace and community settings safely, understanding the peer role, practicing strengths-based, person-centered supervision, finding and sharing community resource information, providing role clarity, and providing quality peer services supervision rather than solely administrative or clerical supervision. However, due to small sample sizes, these results should be considered preliminary or tentative.

Table 9: Mean supervisor competencies (n=149)

Competency	All (n=149)	Peer Supervisor (n=96)	Non-Peer Supervisor (n=46)
My supervisor supports my ongoing training and education.	4.58 (0.85)	4.61 (0.78)	4.58 (0.94)
My supervisor supports meaningful peer roles (e.g., instilling hope, client advocacy, system navigation).	4.58 (0.89)	4.73 (0.72)	4.30 (1.13)*
My supervisor promotes a recovery orientation (e.g., hope, mutuality, person-first, strengths-based).	4.54 (0.87)	4.68 (0.69)	4.26 (1.10)*
My supervisor supports me engaging in self-care.	4.51 (0.89)	4.57 (0.77)	4.48 (0.93)
My supervisor advocates for peer-delivered services.	4.51 (0.88)	4.67 (0.72)	4.20 (1.09)*
My supervisor recognizes the importance of addressing trauma, social inequality, and health care disparity.	4.51 (0.91)	4.60 (0.72)	4.44 (1.08)
My supervisor engages in equitable hiring and employment practices (e.g., ADA accommodations, grievances, employee rights).	4.48 (0.92)	4.53 (0.81)	4.36 (1.12)
My supervisor guides me in adhering to relevant laws and regulations.	4.44 (1.00)	4.57 (0.90)	4.27 (1.12)
My supervisor supports me to navigate workplace and community settings safely.	4.43 (0.95)	4.57 (0.76)	4.25 (1.10)*
My supervisor is consistently available to me.	4.43 (0.87)	4.32 (0.87)	4.28 (0.91)
My supervisor understands the peer role.	4.42 (0.97)	4.65 (0.71)	3.93 (1.27)*
My supervisor guides me in navigating ethical dilemmas and boundary issues that arise in my work.	4.40 (0.99)	4.51 (0.93)	4.23 (1.12)

My supervisor practices strengths-based, person-centered supervision.	4.38 (1.07)	4.56 (0.87)	4.14 (1.25)*
My supervisor cultivates peer competencies (e.g., active listening, supporting self-efficacy).	4.36 (1.07)	4.50 (0.89)	4.16 (1.26)
My supervisor maintains regular supervision appointments with me.	4.30 (1.06)	4.43 (0.99)	4.16 (1.03)
My supervisor promotes professional development and advancement opportunities to me.	4.21 (1.12)	4.28 (1.03)	4.14 (1.21)
My supervisor facilitates access to community resources by finding and sharing community resource information with me.	4.20 (1.13)	4.38 (1.03)	3.93 (1.20)*
My supervisor provides role clarity for me through accurate job descriptions and advising me when role ambiguity or role confusion arises.	4.20 (1.20)	4.35 (1.09)	3.91 (1.35)*
My supervisor provides quality peer services supervision rather than only administrative/clerical supervision.	4.19 (1.20)	4.35 (1.03)	3.91 (1.43)*

**Indicates statistically significant difference at the 0.05 level or lower*

Summary and Recommendations

Peer services have been recognized as one of the top strengths in the current behavioral health system and have also been identified as a service gap due to limited access (HHSC, 2016). Additionally, estimates suggest that peer providers will soon make up 25% of the behavioral health workforce (Manderscheid, n.d.), but a recent SAMHSA report projects a shortage in the number of peer providers needed in the workforce (SAMHSA, 2021). It is therefore imperative to examine the factors that contribute to the success and sustainability of the peer provider workforce. In this section, key survey findings from a statewide survey of peers are summarized and recommendations are provided based on these findings.

Peer Demographic Characteristics

More respondents identified as a woman (61% of total respondents) than identified as a man (22%) or gender non-binary (2%) or an additional gender category (3%). The majority of respondents identified as White (49% of total respondents), Black/African American (14%), or Hispanic/Latino (12%). In terms of age, midlife respondents were well represented in the sample with the most common age group being 45-54 years old (30% of total respondents). In terms of educational attainment, respondents most commonly reported having completed some college or post-high school training (32%).

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

Recommendations

- Greater efforts should be made to attract, train, and retain a more diverse peer workforce. In particular, based on this sample, there is an underrepresentation of Hispanic or Latino peers (12% of sample) compared to the Hispanic population in Texas (40% of the population in 2022; U.S. Census Bureau, 2022).
- Peer workforce diversity needs could also be better understood if demographic information was collected during the training and certification process.

Employment

The majority of survey respondents in this study reported that they currently work in a full-time peer specialist position (82% of those currently working as a peer). The most common employers included CMHCs or LMHAs, RCOs, and community substance use treatment centers. Survey respondents reported working on average 3.7 years at their employer, which is lower than the average of 5.3 years reported by peer specialists in 2021 (Lodge et al., 2021).

The majority of respondents reported that they receive (or received) personal time off (PTO), medical insurance for themselves, dental insurance, vision insurance, paid sick leave, paid vacation, and retirement. However, less than half of respondents reported receiving disability insurance or medical insurance for their family and 12% of peers who responded to this question reported receiving no employee benefits (which is unchanged from 2021).

About 19% of the survey sample were not currently working as a peer specialist; reasons given for not working as a peer included working in a different role, inability to find a job as a peer specialist, having an initial certification,

low pay, and stress. Over half of these respondents (up from one-third in 2021) reported experiencing barriers to finding a job as a peer specialist. Barriers included a lack of peer positions in their area, a lack of understanding of the peer role among employers, a lack of funding for peer positions, low pay, and having criminal justice involvement.

Recommendations

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

Career Advancement and Development

Regarding peer certification, respondents most commonly reported having an active RSPS certification (55%), followed by an active MHPS certification (45%), initial RSPS (9%), and initial MHPS (7%). Nineteen percent of respondents were dually certified or in process of becoming dually certified. Most commonly, respondents indicated that they were first certified in 2022 (54%) or 2021 (32%). Lapsed certifications were not common in this sample. Respondents who reported one or more lapsed certifications (n=11) described several reasons for not maintaining certification including: PRSS certification no longer needed (as it was replaced by the RSPS certification), personal or family issues, difficulty finding training, moving to a new career or peer focus (e.g., from SUD to MH), never used the certification, and dissatisfaction with the career.

Respondents reported wanting training on crisis work, motivational interviewing, mental health and recovery, group facilitation, trauma, peer ethics, documentation, SUD and recovery, skills training, outreach and engagement, peer roles and role clarity, supervision or leadership, and cultural awareness. Respondents also reported wanting training on specific populations and lived experiences including LGBTQ individuals, youth, and re-entry education; training on the peer profession or peer role such as peer professionalism and professionalization; and training for specific job skills and tasks which included (in addition to the above-named topics) housing support and WRAP.

The most commonly reported training sources were: Via Hope trainings, online self-discovered trainings, internal trainings, and Texas Health and Human Services Commission trainings. Respondents most commonly reported attending online trainings and also most commonly reported preferring online trainings. Respondents were least likely to report attending workshops compared to other training formats and were least likely to prefer attending online conferences.

Recommendations

- Respondents most commonly reported wanting to take training on crisis work, motivational interviewing, mental health and recovery, group facilitation, trauma, peer ethics, and documentation. Peer training entities should take this into consideration for future training offerings.
- Respondents were most likely to report attending and preferring online trainings compared to other training formats. Peer training entities should take this into consideration for future training offerings.

Compensation and Billing

Regarding Medicaid billing, 39% of survey respondents reported that their organization does not bill Medicaid for their services, while 37% reported that their organization does bill Medicaid for their services and about 24% were unsure about billing status. The percentage of respondents billing for their services is up from 2021 survey data which found that only 28% of peers were billing for their services, while 53% reported not billing and 19% reported being unsure (Lodge et al., 2021). Among respondents who work at organizations that do bill Medicaid for their services, respondents most commonly reported that their organization uses the Peer Specialist Services code.

Regarding compensation, survey respondents reported a mean hourly wage of $19.04, while the median hourly wage was slightly lower at $18.00. Peer wages are up from 2021 when peer survey respondents reported a mean hourly wage of $16.30 (Lodge et al., 2021) and 2016 when employed mental health peers reported a mean hourly wage of $15.20 (Lodge et al., 2017). However, after adjusting for inflation, peer mean hourly wages have remained fairly consistent since 2016 when mean hourly wages were $18.99 for employed mental health peers and 2021 when they were $18.52 for mental health and substance use peers (United States Bureau of Labor Statistics, 2023). Echoing findings from national peer surveys regarding dissatisfaction with compensation and that peers in Texas have some of the lowest wages in the country (Cronise et al., 2016), the need to increase peer specialist wages was raised by survey respondents when they were asked about job satisfaction.

Recommendations

- Although data suggest that more organizations may be using the Peer Specialist Services billing code (possibly reflecting the March 2022 increase in the reimbursement rate), further raising the reimbursement rate to reflect the value and cost of peer services may further incentivize Medicaid provider organizations to utilize the code.
- Employer organizations should consider raising the wages for peer specialists to retain a qualified peer workforce. Simultaneously, there is a need to increase statewide funding for peer provider positions to support peer specialist sustainability in the workforce which may be supported in part by increasing the Medicaid reimbursement rate for peer services.

Job Satisfaction

Survey data indicate that overall peers are satisfied with their jobs with peers indicating agreement that their work is personally rewarding, that they would still take their job if they were to decide again, and that they would recommend the peer job to a friend. Although still rated highly, peers were slightly less likely to agree that their job met the expectations that they had when they took it and were slightly more likely to indicate frequently thinking about quitting and their job and that they plan to look for a new job in the next year. Qualitative survey data provide further evidence that peers are satisfied with their job overall. When asked if they had any additional information to share, survey respondents commonly reported that they love their job and that working as a peer is their purpose or calling in life. However, respondents also emphasized aspects of the peer role that they are dissatisfied with, including low pay, high levels of stress, long hours, emotional exhaustion, and (for some) unsupportive supervisors.

Recommendations

- In addition to raising peer specialist wages, the adoption of a resiliency-focused supervision model (Mack, 2020), whereby supervisors are responsive to stressors and attend to the health and wellness of supervisees and identify self-care practices to reduce work-related stress and burnout symptoms may increase job satisfaction among peer specialists (Abraham et al., 2022; Forbes et al., 2022).

Organizational and Statewide Culture

As an indicator of organizational support, respondents were asked to indicate the degree to which they feel that their coworkers respect the work that they do. Respondents generally strongly agreed (49%) or agreed (33%), with the statement that their coworkers respect the work they do.

To examine the recovery orientation of their employer organizations, survey respondents responded to the 15-item ROSA (Lodge et al., 2018). ROSA items that were rated most highly, in terms of frequency of delivery, included believing that people can grow and recover, modeling hope, being open with people about all matters regarding their services, and respecting people's decisions about their lives. Lower scored items, in terms of frequency of delivery, included providing trauma-specific services, encouraging people to take risks to try new things, inviting people to include those who are important to them in their planning, and offering people opportunities to discuss their spiritual needs when they wish. These results are similar to results found in previous TIEMH administrations of the ROSA including the 2021 peer workforce survey (Lodge et al., 2021), a workforce survey of mental health peer specialists (Lodge et al., 2017) and a survey of COSP member outcomes (Peterson et al., 2020), all of which found that trauma-specific services and opportunities to discuss spirituality were among the least frequently delivered while modeling hope, being open about services, and believing that people can grow and recover were among the most frequently delivered.

In comparing the overall ROSA mean to previous administrations of the ROSA, results indicate a higher mean ROSA score of 4.24 compared to the 2021 peer workforce survey which had an overall mean ROSA score of 4.10 (Lodge et al., 2021) and the 2016 workforce survey of mental health peer specialists which had an overall mean ROSA score of 3.85 for currently employed peer specialists and 3.36 for previously employed peer specialists (Lodge et al., 2017). This may reflect a shift towards a more recovery-oriented system.

Recommendations

- Employer organizations should take steps to more frequently provide trauma-specific services, encourage people in services to take risks to try new things, invite people in services to include those who are important to them in their planning, and offer people in services opportunities to discuss their spiritual needs.

Role Tasks, COVID-19, and Role Clarity

Survey respondents reported that the tasks they most commonly provide are connecting people to resources (85%), one-on-one support (84%), and advocating for people in services (82%). The least commonly reported tasks were medication management and monitoring (14%), psychosocial rehabilitation (19%), and supervision (25%). These most commonly and least commonly reported tasks are similar to job tasks reported in previous peer surveys (Lodge et al., 2017; Lodge et al., 2021; Stevens Manser et al., 2019).

Respondents reported on average spending 35% of their time on administrative tasks (down from 38% in 2021) and 60% of their time providing peer support (up from 57% in 2021; Lodge et al., 2021). Most respondents reported providing services to adults and, on average, respondents reported that they provide services to 18.8

people in an average week (down from 20.7 in 2021; Lodge et al., 2021). In terms of documentation formats or programs, survey respondents most commonly reported using progress notes (42%) and recovery wellness plans (24%).

More than half (52%) of survey respondents who responded to a question on how they deliver services has changed since the coronavirus (COVID-19) pandemic reported that the way they provide services has not changed or that this question is not applicable to them. Among those who did experience changes to the way they deliver services, the most common change was providing virtual and/or telephonic services, including both one-on-one and group services. Other changes included attending virtual meetings, connecting individuals in services to resources, COVID-19 education, virtual trainings, and adhering to COVID-19 protocols (e.g., mask wearing).

On average respondents rated their supervisor frequency of providing role clarity for them through accurate job descriptions and advising them when role ambiguity or role confusion arises as a 4.20 (on a scale where 4 is often and 5 is always). Although this indicates that supervisors often provide role clarity for peers, this was one of the lowest rated supervisor competencies (as discussed in the next section on supervision).

This is important because research on role clarity suggests that peer specialists whose job duties more closely align to peer work are more satisfied with their jobs compared to peers whose job duties involve more administrative and clinical work tasks (Cronise et al., 2016). Supervisor job role understanding is also particularly important for job satisfaction among peers (Kuhn et al., 2015).

Recommendations

- Peers need access to training on providing peer support virtually, including training on how to virtually build rapport with individuals receiving services. The South Southwest Mental Health Technology Transfer Center (MHTC) offers peer training on healing-centered virtual facilitation.
- Peer supervisors may need more support (e.g., training and TA) on providing role clarity to peers. Research suggests that job satisfaction is higher for peers whose job duties more closely align to peer work (compared to those doing more administrative or clinical tasks; Cronise et al., 2016) and for those whose supervisors understand their role (Kuhn et al., 2015). Ongoing review to ensure role clarity and fidelity to the peer role may be especially important when peers work in clinical settings.

Supervision

Most respondents reported receiving weekly or monthly supervision. In terms of in-person supervision, peers most commonly reported always receiving in-person supervision (30%). Only 6% of peers reported never receiving in-person supervision. In terms of online supervision, peers most commonly reported receiving online supervision often (32%).

Respondents were asked if they receive several types of supervision; the most commonly received include: problem resolution (64%), professional growth (62%), and administration supervision (58%). The least common forms include peer competencies supervision (47%) and provision of peer services (43%). In a separate survey, Peer Specialist Supervisor survey respondents also reported on the types of supervision they provide (Lodge et al., 2023). The most commonly provided types of supervision included problem resolution, review of cases and activities, and peer ethics. The least commonly provided (although still frequently provided) included administrative supervision, supervision for special issues or circumstances, and peer competencies supervision.

Sixty-four percent of respondents reported that their supervisor is a peer specialist; this is up from 2021 when 48% reported having a peer specialist supervisor (Lodge et al., 2021) as well as up from 2016 when only about one-quarter of mental health peers were supervised by a peer specialist (Lodge et al., 2017).

Peers were asked to indicate how frequently their supervisor practices 19 peer supervisor core competencies. The three most frequently practiced supervisor competencies included: supporting peers ongoing training and education, supporting meaningful peer roles, and promoting a recovery orientation. These findings are similar to findings from a separate survey of peer supervisors who reported that the most frequently practiced supervisor competencies were supporting training and education for peers, supporting meaningful peer roles, and maintaining professional boundaries and confidentiality with peers (Lodge et al., 2023).

The three least frequently practiced competencies (although still frequently practiced) were: facilitating access to community resources by finding and sharing community resource information with peers, providing role clarity for peers through accurate job descriptions and advising peers when role ambiguity or role confusion arises, and providing quality peer services supervision rather than only administrative or clerical supervision. Findings from the Peer Specialist Supervisor survey found that supervisors reported that some of the least frequent supervision competencies are providing role clarity, assisting with professional system navigation, maintaining supervision appointments, and engaging in equitable hiring and employment practices (Lodge et al., 2023).

Additionally, independent sample t-tests for significance were run to determine if there were any statistically significant differences in supervisor competencies between peers who are and who are not supervised by a peer specialist. There were significant differences in mean scores for nine supervisor competencies: peers with peer supervisors rated competencies higher than peers with non-peer supervisors in terms of supporting meaningful peer roles, promoting a recovery orientation, advocating for peer-delivered services, navigating workplace and community settings safely, understanding the peer role, practicing strengths-based, person-centered supervision, finding and sharing community resource information, providing role clarity, and providing quality peer services supervision rather than solely administrative or clerical supervision.

Recommendations

- Peer supervisors may need more support (including more training and TA as well as a lower administrative burden) to provide certain types of supervision including peer competencies supervision and the provision of peer services as well as sharing community resource information with peers, providing role clarity for peers, and providing quality peer services supervision rather than only administrative or clerical supervision.
- Employer organizations should (continue to) employ peer specialists in supervisory positions, particularly given findings that peers who are supervised by peers rate their supervisor as more competent on nine different dimensions including promoting a recovery orientation, advocating for peer-delivered services, understanding the peer role, and providing role clarity.
- Training entities may consider prioritizing training peers who are eligible and wish to attend the Texas Medicaid-endorsed Peer Specialist Supervisor Training, for example, by offering financial assistance or waiving registration fees for peers.

Limitations

There are some limitations of this research. First, these results cannot be generalized to peer specialists in Texas because the study sample is not a representative sample. These findings only represent the 15% of peer specialists who responded to the survey. We are unable to know if or how these study sample peers may be different from

the population of peers in Texas. Another limitation is that these results are based on self-report survey items and are therefore subject to self-report bias.

Conclusion

Texas faces a considerable behavioral health workforce shortage (HHS, 2020). Increasing access to peer support services has been identified as an effective and cost-effective strategy to address this workforce shortage (HHS, 2020; HHSC, 2016). The data in this report provide information on steps that can be taken to increase access to peer support services in Texas by attracting and retaining a diverse peer workforce. Some of the most significant recommendations made in this report include creating full-time peer support positions that pay living wages and offer robust employee benefit packages; offering online and in-person trainings on crisis work, motivational interviewing, mental health and recovery, group facilitation, trauma, peer ethics, and documentation; offering resiliency-focused supervision; and providing additional support for peer supervisors to enable them to more often provide peer competencies supervision, provision of peer support supervision, community resource information, role clarity for peers, and supervision that goes beyond administrative or clerical concerns. Considerable evidence suggests that peer support improves the lives of individuals who receive peer services, which in turn reduces health care costs. Therefore, investment in the peer support workforce promises not only to improve the lives of Texans who receive behavioral health services but to also improve community well-being and save the state of Texas money.

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Appendix: Survey Questions

Peer Specialist Workforce Survey – FY2023

[SURVEY BLOCK 1: CONSENT FORM]

Consent Form

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

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

- You are being asked to complete an online survey that will take approximately 20 minutes to complete.
- Your participation is voluntary. You do not have to participate in this survey if you choose not to, and you can stop the survey at any time. If you choose to participate, you do not need to answer every question. Your name, email address, and IP address will not be included or connected with responses you provide. Your decision to participate or not will not have any effect on your employment or your relationship with the State, peer specialist certification or training entities, or the University of Texas at Austin.
- This survey is confidential and the records of the survey will be kept private. No identifiers linking you to this survey will be included in any sort of report that might be published. Data will be reported such that no identifying information will be revealed.
- If it becomes necessary for the Institutional Review Board to review the study records, information that can be linked to you will be protected to the extent permitted by law. Your research records will not be released without your consent unless required by law or a court order. The data resulting from your participation may be made available to other researchers in the future for research purposes not detailed within this consent form. In these cases, the data will contain no identifying information that could be associated it with you, or with your participation in any study.
- After participating in this survey, you may register for a drawing to win 1 of 25 $25 gift cards. Although you will receive no other direct benefit from participating in this survey, the information from this survey will contribute to a better understanding of how to support peer specialist workforces in Texas.
- The risks associated with this survey are minimal, and are no greater than risks ordinarily encountered in daily life.

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

This study has been reviewed and approved by The University of Texas at Austin Institutional Review Board (UT-IRB) and the HHSC Institutional Review Board #2 (IRB#2). If you have questions about your rights as a study participant, or are dissatisfied at any time with any aspect of this study, you may contact – anonymously, if you wish – the UT-IRB by phone at (512) 232-1543 or email at irb.austin.utexas.edu or the HHSC-IRB#2 by email at IRB2@hhsc.state.tx.us

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

[START OF SURVEY BLOCK 2: TRAINING AND CERTIFICATION]

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

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

2. Regarding certification as a peer specialist: (Select all that apply)
   - I am currently certified as a Mental Health Peer Specialist (MHPS)
   - I am a Mental Health Peer Specialist (MHPS) intern
   - I am currently certified as a Recovery Support Peer Specialist (RSPS)
   - I am a Recovery Support Peer Specialist (RSPS) intern
   - My certification as a Mental Health Peer Specialist (MHPS) is lapsed
   - My certification as a Peer Recovery Support Specialist (PRSS) is lapsed
   - My certification as a Recovery Support Peer Specialist (RSPS) is lapsed

[Display question if "My certification as Mental Health Peer Specialist is lapsed" and/or "My certification as a Peer Recovery Support Specialist is lapsed" and/or "My certification as a Recovery Support Peer Specialist (RSPS) is lapsed" is selected on "Regarding certification as a peer specialist:]"

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

   _____

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

   - Prior to 2009
   - 2009
   - 2010
   - 2011
   - 2012
   - 2013
   - 2014
   - 2015
   - 2016

- 2017
- 2018
- 2019
- 2020
- 2021
- 2022
- 2023

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

5. Are you currently employed as a peer specialist?
    - Yes
    - No

[Display question if "yes" on "Are you currently employed as a peer specialist"]

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

[Display question if "no" on "Are you currently employed as a peer specialist"]

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

    _____

    _____

[Display question if "no" on "Are you currently employed as a peer specialist"]

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

[Display question if "no" on "Are you currently employed as a peer specialist"]

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

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

10. Which of the following benefits do (or did) you receive from your employer? **(**Select all that apply):
    - I do not receive any benefits
    - Medical insurance for myself

- Medical insurance for my family
- Dental insurance
- Retirement
- Disability insurance
- Paid vacation
- Paid sick leave
- Personal Time Off (PTO)
- Vision coverage
- Other (specify:) _____

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

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

13. How long have you worked (or did you work) at this organization? (Note: if you are or were most recently employed at multiple organizations, please answer this and the following questions with the organization which you primarily worked for in mind).
    - Years: [drop down menu 0 to more than 50]
    - Months: [0 to 11]

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

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

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

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

18. What tasks do you (or did) you perform in your work? (Select all that apply)
    - Administrative tasks
    - Advocating for people in services
    - Connecting people to resources
    - Education
    - Facilitating support groups
    - Goal-setting
    - Helping people advocate for themselves
    - Housing supports
    - Medication management and monitoring
    - Mentoring or serving as a role model
    - One-on-one support
    - Outreach / Engagement
    - Patient navigation
    - Providing assistance in finding community resources and services
    - Providing supervision to other peer specialists
    - Psychosocial rehabilitation
    - Recovery and wellness support
    - Serving on work groups and committees
    - Skill Building
    - Supporting clients during transition from inpatient
    - Transportation assistance
    - Vocational assistance
    - Wellness Recovery Action Planning (WRAP)
    - Working on a treatment team
    - Other (specify): _____

19. Since the coronavirus (COVID-19) pandemic, have there been any changes to the way you deliver services? [open-ended]

20. Does (or did) your organization bill Medicaid for any of the services you provide?
    - No

- Yes
- I don't know

[Display question if "Yes" is selected on "Does your organization bill Medicaid for any of the services you provide?"]

21. What Medicaid code(s) does (or did) your organization use to bill for the services you provide? (Select all that apply)
    - Peer specialist services code
    - Psychosocial rehabilitation services
    - Other (please specify): _____
    - I don't know

22. Which of the following do you use to you document for peer services (Select all that apply)?
    - Case note
    - Collaborative documentation
    - COSP Form N
    - CMBHS
    - Custom note
    - DAP note
    - SAMHSA GPRA
    - In the Driver's Seat
    - Progress note
    - Recovery Wellness Plan
    - SOAP note
    - SWOT note
    - WRAP plan
    - Other (Specify):_____

23. What topics or specific trainings would enhance your peer support practice? [open-ended]

24. From whom do you get peer-related trainings or other continuing educational opportunities? [open-ended]

25. Please indicate how you get your peer-related trainings or continuing educational opportunities and which formats you prefer (Select all that apply).
    - In person trainings
    - Online trainings
    - In person conferences
    - Online conferences
    - Workshops
    - Other (Please specify):_____

26. How frequently do (or did) you receive supervision? (Select the option that most closely aligns with how often you receive or received supervision).
    - Daily
    - Weekly

- Monthly
- Annually
- Never

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

28. Which of the following types of supervision do you receive (Select all that apply):
    - Internal supervision (my supervisor works at my organization)
    - External supervision (my supervisor works outside of my organization)
    - I don't know

29. How frequently do you receive in-person supervision?
    a. Always
    b. Often
    c. Sometimes
    d. Rarely
    e. Never

30. How frequently do you receive online supervision?
    a. Always
    b. Often
    c. Sometimes
    d. Rarely
    e. Never

31. What does (or did) supervision look like for you? (Select all that apply)
    - Administrative supervision
    - Peer competencies supervision
    - Peer ethics supervision
    - Problem resolution
    - Professional growth
    - Provision of peer services
    - Review of cases and activities
    - Skill building
    - Supervision for special issues or circumstances
    - Other (specify): _____

SUPERVISOR CORE COMPETENCIES How frequently does your supervisor practice the following supervisor core competencies?

32. My supervisor understands the peer role.
    - Always
    - Often

- Sometimes
- Rarely
- Never

33. My supervisor advocates for peer-delivered services.
    - Always
    - Often
    - Sometimes
    - Rarely
    - Never

34. My supervisor promotes a recovery orientation (e.g., hope, mutuality, person-first language, strengths-based approach).
    - Always
    - Often
    - Sometimes
    - Rarely
    - Never

35. My supervisor supports meaningful peer roles (e.g., instilling hope, client advocacy, and system navigation).
    - Always
    - Often
    - Sometimes
    - Rarely
    - Never

36. My supervisor recognizes the importance of addressing trauma, social inequity, and health care disparity.
    - Always
    - Often
    - Sometimes
    - Rarely
    - Never

37. My supervisor supports my ongoing training and education.
    - Always
    - Often
    - Sometimes
    - Rarely
    - Never

38. My supervisor guides me in adhering to relevant laws and regulations.
    - Always
    - Often

- Sometimes
- Rarely
- Never

39. My supervisor facilitates access to community resources by finding and sharing community resource information with me.
    - Always
    - Often
    - Sometimes
    - Rarely
    - Never

40. My supervisor provides role clarity for me through accurate job descriptions and advising me when role ambiguity or role confusion arises.
    - Always
    - Often
    - Sometimes
    - Rarely
    - Never

41. My supervisor practices strengths-based, person-centered supervision.
    - Always
    - Often
    - Sometimes
    - Rarely
    - Never

42. My supervisor cultivates peer competencies (e.g., active listening, supporting self-efficacy).
    - Always
    - Often
    - Sometimes
    - Rarely
    - Never

43. My supervisor supports me in engaging in self-care.
    - Always
    - Often
    - Sometimes
    - Rarely
    - Never
44. My supervisor guides me in navigating ethical dilemmas and boundary issues that arise in my work.
    - Always
    - Often
    - Sometimes

- Rarely
- Never

45. My supervisor provides quality peer services supervision rather than only administrative/clerical supervision.
    - Always
    - Often
    - Sometimes
    - Rarely
    - Never

46. My supervisor maintains regular supervision appointments with me.
    - Always
    - Often
    - Sometimes
    - Rarely
    - Never

47. My supervisor is consistently availability to me.
    - Always
    - Often
    - Sometimes
    - Rarely
    - Never

48. My supervisor promotes professional development and advancement opportunities to me.
    - Always
    - Often
    - Sometimes
    - Rarely
    - Never

49. My supervisor supports me to navigate workplace and community settings safely.
    - Always
    - Often
    - Sometimes
    - Rarely
    - Never

50. My supervisor engages in equitable hiring and employment practices (e.g., ADA accommodations, grievances, employee rights).
    - Always
    - Often
    - Sometimes
    - Rarely

- Never

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

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

52. . Please answer the following questions about your experience with your job:

	Strongly Disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly Agree (5)
All in all, I am satisfied with my job.	○	○	○	○	○

My job meets the expectations I had when I took it.	○	○	○	○	○
I frequently think about quitting this job.	○	○	○	○	○
My work is personally rewarding.	○	○	○	○	○
If I had to decide all over again, I would still take this job.	○	○	○	○	○
I will probably look for a new job in the next year.	○	○	○	○	○
My coworkers respect the work that I do.	○	○	○	○	○
I would recommend this job to a friend.	○	○	○	○	○

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

_____

_____

_____

[START OF SURVEY BLOCK 4: DEMOGRAPHIC DATA]

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

54. What is your work zip code?

55. What is your gender identity (Select all that apply):

- ○ Genderqueer, gender fluid, or non-binary
- ○ Man
- ○ Trans man
- ○ Trans woman
- ○ Woman
- ○ Additional gender category/identity (specify): _____

56. What is your age range?

- ○ 18 – 24
- ○ 25 – 34
- ○ 35 – 44
- ○ 45 – 54
- ○ 55 – 64
- ○ 65 or older

57. What race/ethnicity do you consider yourself to be? (Select all that apply)

- American Indian or Alaska Native
- Asian or Asian American
- Black or African American
- Hispanic or Latino
- Native Hawaiian or other Pacific Islander
- White
- Other (specify): _____

58. 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
    - 2-year Associate degree
    - 4-year college degree
    - Post-college graduate training

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

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

You are now eligible to be entered into a drawing for a chance to win 1 of 25 $25 gift cards. Your responses to the survey will remain anonymous and will not be linked to your contact information if you choose to be entered into the gift card drawing.

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

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