Peer-to-Career Needs Assessment Report

The Peer Workforce Pipeline

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Executive Summary

Purpose and Scope of the Needs Assessment

To increase access to peer specialist services for individuals impacted by the opioid crisis in Texas, RecoveryPeople is launching the Peer-to-Career project. As an initial step, and to guide the project, RecoveryPeople collaborated with the Texas Institute for Excellence in Mental Health (TIEMH), to conduct a needs assessment with the purpose of identifying recruitment and retention challenges impacting the peer specialist workforce.

As the assessment evolved, it became evident that a limited focus would be insufficient to inform long-term workforce planning. Accordingly, the scope was broadened to support a comprehensive, statewide Recovery Support Peer Specialist (RSPS) workforce development strategy, recognizing that the Peer-to-Career project represents only one component of a larger, system-wide effort. At the same time, the assessment intentionally focused on peer specialists who primarily support individuals with opioid use disorder and other substance use disorders (OUD/SUD). As a result, it does not fully capture the peer workforce serving individuals with primary mental health needs or family members. Comparable, population-specific assessments are recommended to ensure workforce strategies are responsive to the full range of peer support roles and service populations.

This needs assessment begins by establishing the importance of the peer specialist workforce in the behavioral health system and for those experiencing the effects of mental health and substance use challenges, particularly opioid misuse. The contextual factors that influence the need and demand for the peer specialist workforce are explored and explained. This report describes what is known about the current supply of the peer specialist workforce and explains how this supply does not meet current need, much less demand that will come with population growth.

Then, the report examines what impacts the peer specialist workforce and the workforce pipeline, such as resources, challenges and barriers. Peer specialists, as well as trainers, supervisors, and employers of peer specialists, provide insights into challenges and barriers at each stage of the peer specialist career path. This report highlights significant workforce attrition and the associated costs of individuals who enter the pipeline but are lost at various stages along the career path. Solutions to address the barriers and challenges are offered. The report then delves into the cost of attrition and explores the peer specialist career mobility. Lastly, this report offers solutions and recommendations related to the findings.

Key Findings

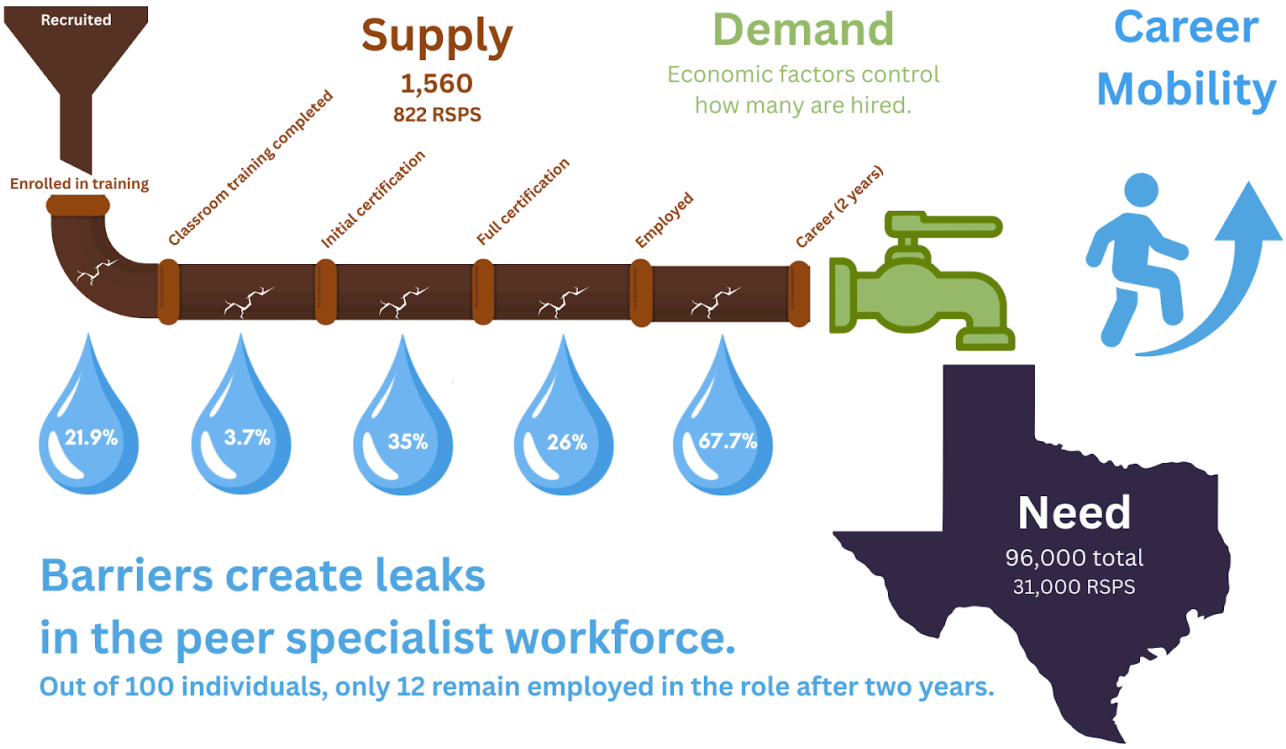
Peer specialists are a distinct workforce role within the behavioral health system who draw on lived experience of recovery from mental health and/or substance use challenges, combined with

specialized training, to deliver recovery-oriented support services. A growing body of evidence indicates that peer specialist services improve outcomes and cost savings through better service engagement, retention, and continuity.

The role originated in peer-run programs and organizations and was later formalized through federally supported initiatives focused on recovery-oriented systems change. In 2007, the Centers for Medicare & Medicaid Services (CMS) authorized Medicaid reimbursement for peer specialist services. This action not only accelerated their integration into clinical and publicly funded systems, but drove professionalization through credentialing, supervision requirements, ethical standards, and defined scopes of practice, thus mirroring the professionalization of other behavioral health roles.

While professionalization has strengthened workforce legitimacy, accountability, and sustainability, it has also raised concerns that modeling peer roles too closely on clinical workforce frameworks may diminish the distinctive contributions of peer specialists and blur important differences between services delivered in clinical or medical settings and those rooted in community-based, peer-run programs. To what extent these concerns help explain high attrition and turnover is not fully understood. Nevertheless, peer specialist services have demonstrated effectiveness in improving treatment engagement, retention, satisfaction, and recovery outcomes, firmly establishing peer specialists as a vital component of the behavioral health workforce.

Figure 1. Peer Specialist Workforce Pipeline.



- **Need** represents the optimal number of qualified peer specialists required to meet statewide service needs. Based on SAMHSA's 2021 Behavioral Health Workforce Plan, adjusted for Texas's share of the U.S. population (8.7%), Texas is estimated to need approximately **96,000 peer specialists, including 31,000 Recovery Support Peer Specialists (RSPS)** with expertise in supporting individuals with opioid use disorder (OUD) and other substance use disorders. This includes an estimated **3,000 peer specialists needed to support opioid treatment programs alone**. Workforce need is not evenly distributed across the state; it varies by population density, opioid impact, and regional service utilization, and continues to grow as Texas's population expands.
- **Demand** reflects how many peer specialists employers are willing and able to hire at a given time. It is shaped by economic and policy factors such as reimbursement structures, funding availability, integration into service systems, and demonstrated value. Demand for peer specialists across Texas is difficult to quantify due to limited labor market data. Grassroots data collection at the community level is crucial for accurately assessing local demand as part of workforce development planning. Evidence suggests demand is **likely to increase as funders shift to value-based payment models and systems recognize the economic value of peer support services** in improving engagement, coordination, outcomes, and cost efficiency.
- **Supply,** for this assessment, is defined as individuals holding Texas credentials eligible for Medicaid reimbursement, as these represent the largest, most widely recognized, and best-documented segment of the workforce. As of May 2025, approximately **1,560 individuals** in Texas held at least one active, Medicaid-billable peer specialist credential, including Recovery Support Peer Specialists (RSPS), Mental Health Peer Specialists (MHPS), and Certified Family Partners (CFP). Of these, **822 were RSPS**, and 16% held multiple credentials. Peer specialists are concentrated in metropolitan areas, and the extent to which they serve rural populations remains unclear.

Based on estimated need and documented supply, Texas currently has only **about 2.65% of the Recovery Support Peer Specialists (RSPS)** required to adequately serve individuals with OUD/SUD, resulting in a statewide shortfall of **approximately 30,178 RSPS**. This gap exists within a broader behavioral health workforce crisis, as **78% of Texas counties are designated Mental Health Professional Shortage Areas (HPSAs)**. Importantly, this RSPS shortage estimate reflects ideal need and does not account for economic, policy, or service-capacity constraints that limit effective demand. Consequently, expanding the workforce alone will not resolve service capacity gaps in regions where few organizations are positioned to employ and sustain peer specialists. Reports of certified peer specialists struggling to secure employment, despite the documented shortage, likely reflect regional

mismatches, demand-side constraints, and labor market inefficiencies rather than an overall surplus of qualified workers.

The supply of peer specialists depends on the availability of critical resources, including federal and state funding, supportive policies, certification and training programs, supervision, statewide initiatives, professional networks, research-based guidelines and peer recovery organizations. Reductions in federal funding have constrained these resources, limiting the state's ability to grow the peer specialist workforce. Funding from the Opioid Abatement Fund councils for peer-to-peer workforce expansion will help offset these federal cuts and support the development of a more robust peer specialist workforce.

Increasing the supply of peer specialists is both challenging and costly when attrition occurs at every stage of the workforce pipeline. In Texas, the pipeline is complex and inefficient, shaped by a multitude of barriers and challenges that impede progress from recruitment and training through certification, hiring, and long-term employment. Rather than a single point of failure, these cumulative losses reflect systemic inefficiencies, where each "leak" compounds the next, driving high attrition, inflating workforce development costs, and limiting the state's ability to convert training investments into a stable, careered peer specialist workforce. In a scenario with no attrition, the estimated cost of supporting one peer specialist from training through a two-year work anniversary is approximately $14,843. However, because of high attrition, only about twelve (12) of every 100 trainees reach the two-year milestone, raising the effective cost per retained peer specialist to at least $56,505 and resulting in an estimated $454,322–$585,617 in lost investment per 100 trainees.

Importantly, attrition and turnover should not be viewed solely as system failure. For many individuals, peer specialist roles function as an on-ramp to broader career mobility, supporting skill development, recovery, and progression into other roles. Distinguishing between negative attrition and positive career mobility is essential for accurate workforce planning and for designing career pathways that honor the role's dual function as both a career and a launch point.

Recommendations

Strengthening Texas's peer specialist workforce requires a comprehensive, labor-market–informed strategy that addresses workforce need, employer demand, and supply simultaneously. Training alone is insufficient. High attrition across the workforce pipeline limits the state's ability to translate investments into a stable, careered workforce.

1. **Advance the Evidence and Fill Knowledge Gaps** - Peer specialists improve engagement, recovery, and outcomes for individuals with mental health and substance use challenges. Yet critical gaps remain in understanding the workforce role, its mechanisms of impact, and strategies to sustain it. Ongoing research is essential to guide workforce policy and investment.

2. **Adopt Comprehensive, Data-Driven Workforce Metrics** - Workforce development must track outcomes across the full pipeline (e.g., recruitment, training, certification, employment, retention, and performance) rather than training completions alone. Data-driven monitoring identifies where attrition occurs, evaluates program effectiveness, and ensures investments result in meaningful workforce growth and improved behavioral health outcomes.
3. **Expand Supply and Demand Through Policy** - Sustainable workforce growth requires coordinated policy strategies that increase both the supply of trained peer specialists and the availability of meaningful employment, particularly in regions most affected by opioid misuse and behavioral health workforce shortages.
4. **Invest Strategically to Maximize Impact** - Use a weighted scoring rubric to balance applicants from high-need and high-demand regions, ensuring a smarter use of public dollars and maximizing impact and sustainability. Focusing only on need may place specialists where jobs are scarce, while focusing only on job availability may leave high-need areas underserved. Progressively grow into high-need regions as demand expands. This balanced approach both strategically targets resources and aligns workforce supply with regional demand.
    a. **Strategically Allocate Resources with Regional Prioritization** - Resources should be targeted, focusing on areas with high opioid-related harms and severe mental health workforce shortages. Beyond population-based resource allocation, indexes, such as the Opioid Use Disorder (OUD) index and Health Professional Shortage Area (HPSA) index, should be used to prioritize investments.
    b. **Align Workforce Supply with Employer Demand** - Even in high-need regions, workforce expansion is ineffective without employment opportunities and practical experience. Engaging regional employers (e.g., behavioral health agencies, hospitals, criminal justice programs, and community organizations) ensures supply aligns with local demand, supports sustainable funding, and reinforces the value of peer specialists in improving engagement, retention, and outcomes.
5. **Reduce Attrition and Pipeline Inefficiencies** - Attrition at every stage, from recruitment to long-term employment, represents systemic inefficiency, driving up workforce development costs and limiting the impact of training investments. Addressing barriers at each stage and creating structured pathways for career progression are critical to building a stable, effective workforce.
6. **Track Success with Key Performance Indicators -** Leverage a dashboard of performance metrics to monitor progress, guide decision-making, and drive continuous quality improvement.

a. **Allocation Index:** A composite score reflecting the proportion of applicants placed where both community need and employment opportunity align, calculated using a weighted rubric.

b. **Outcomes Index:** Measures the percentage of participants achieving credential and career advancement targets, capturing progress in workforce development and professional growth.

c. **Volume Index:** Tracks the number of participants served and program activities completed relative to established benchmarks. This metric highlights gaps, monitors growth, and informs resource allocation to ensure community demand is met efficiently.

d. **Satisfaction Rating:** The percentage of participants reporting satisfaction or high satisfaction with peer-to-career support.

Conclusion

Research indicates that opioid misuse and other behavioral health challenges are a huge economic burden and peer specialist services improve both outcomes and cost-effectiveness, which has driven their integration across diverse service settings and underscores the need for an expanded peer specialist workforce in Texas. Investing in training alone, without addressing broader workforce dynamics, is not an effective workforce development strategy. Barriers at every stage of the pipeline contribute to a significant portion of trained individuals leaving before establishing a two-year career.

Gaps in service funding and regional capacity limit employment opportunities, even in communities with high needs. It is unrealistic to expect peer specialists to remain in low-wage positions long-term or for entry-level roles to single-handedly transform clinical organizations into recovery-oriented settings. Misalignment between role expectations and the realities of clinical environments may contribute to job dissatisfaction, burnout, and higher turnover among peer specialists. In the context of a workforce shortage of over 30,000 additional Recovery Support Peer Specialists (RSPS) needed in Texas, overly restrictive eligibility policies are inefficient and counterproductive. Excluding individuals based on past convictions eliminates many highly qualified candidates with lived experience that employers seek and directly aligns with the needs of the populations being served.

Findings from this assessment underscore the need for a labor-market informed, coordinated peer-to-career approach that strategically supports recruitment, training, certification, employment, supervision, and ongoing professional development, while also strategically engaging employers and community partners. By aligning workforce supply with demand and supporting career pathways, such an approach can reduce attrition, maximize return on investment, and expand the capacity of Texas's behavioral health system to effectively address opioid use and broader behavioral health

challenges. While not all recommendations can be implemented solely through Peer-to-Career programs, the framework presented here provides a strategic roadmap for statewide collaboration and coordination, integrating policy, funding, and practice to strengthen and sustain a balanced, responsive peer specialist workforce over time.

Introduction

Purpose and Goals

To increase access to peer support for individuals impacted by the opioid crisis in Texas, RecoveryPeople is launching the Peer-to-Career project. The purpose of the project is to:

- Implement strategies to increase the number of individuals in the peer-to-peer workforce;
- Remove barriers to enrollment in and completion of peer certification programs; and
- Provide resources and assistance in obtaining and retaining employment for peers in the workforce.

To inform these goals, RecoveryPeople collaborated with the Texas Institute for Excellence in Mental Health (TIEMH), to conduct a needs assessment to identify recruitment and retention challenges that impact the peer workforce by region, county and population. Specifically, the following areas were explored:

- The current workforce and workforce needs;
- Barriers to completing and maintaining peer specialist certification;
- Pay and compensation structures for certified peer specialists and peer specialist supervisors;
- Specific challenges related to recruiting, certifying, and retaining peer specialists by region, county, and population;
- Gaps in training and continuing education opportunities for peer specialists and organizations employing peer specialists;
- Strategies for recruiting individuals into the field;
- Strategies for retaining peer specialists in the workforce; and
- Resources available to support the peer-to-peer workforce.

The needs assessment included data collection from multiple sources. Government and research reports were reviewed. Existing data from government entities and data sets available to the research partner were utilized. Further, to tap into the wisdom of the peer specialist workforce, a survey and focus groups were conducted with four stakeholder groups, including:

- **Peer Specialists.** Individuals who are currently working, or in the past worked, as peer specialists;
- **Trainers of Peer Specialists.** Trainers, training facilitators, continuing education providers, and training entities who currently guide and prepare, or in the past guided and prepared, peer specialists in the peer workforce;
- **Supervisors of Peer Specialists.** People who directly supervise, or in the past supervised, peer specialists; and

- **Employers of Peer Specialists.** Leaders, human resources staff, or program directors of organizations that currently employ, previously employed, or are considering employing peer specialists.

This needs assessment report weaves together data and peer specialist workforce experiences; the results achieve not only the original stated purpose, but illuminate the structures, policies, and processes that support and challenge the peer specialist workforce. Beyond informing the Peer-to-Career program and performance measures, the findings lend impetus to broader policy and practice considerations that would not only better support the peer specialist workforce, but bring health and wellness to the people of Texas.

Method Summary

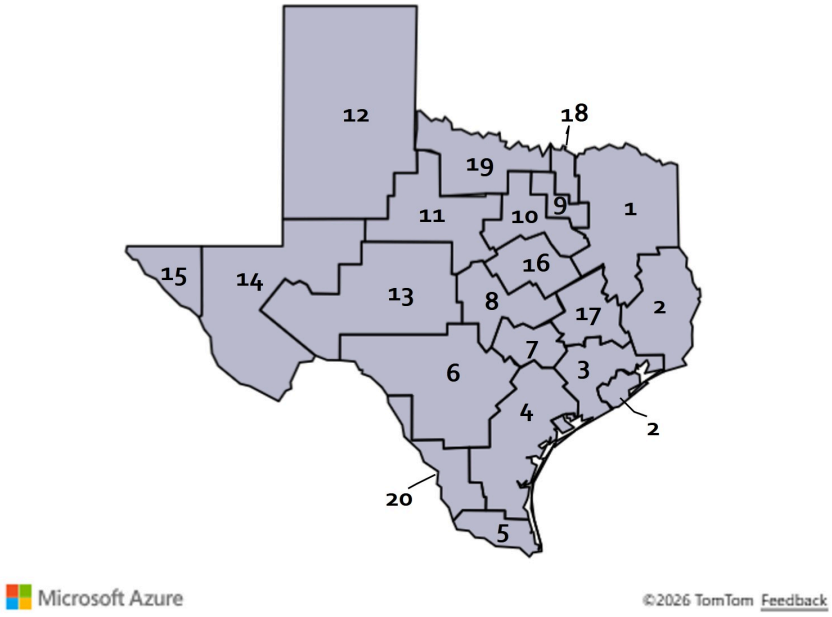
This section summarizes the data collection and analysis processes used for this needs assessment. For a detailed description of the research method used for all data sources, please see Appendix A: Needs Assessment Method.

The needs assessment included data collected from multiple sources:

- Existing research literature and reports,
- Publicly available data sets,
- Data sets available to TIEMH from previous projects,
- A survey distributed to the four stakeholder groups, and
- Focus groups conducted with each of the four stakeholder groups.

The Opioid Abatement Fund Council (OAFC) requested that findings be reported for regions, counties, and populations. Regional analysis was to be based on the Regional Healthcare Partnership (RHP) areas (Figure 2). A list of the counties in each region is provided in Appendix B.

Figure 2. Regional Healthcare Partnership (RHP) Areas.



To ensure the data could be analyzed and reported for regions, counties, and different populations, TIEMH researchers examined:

- **Completeness**. Was data *available* for each county, region, and population?
- **Representation.** Were the representative instances of a measure in the available data *adequate*?

TIEMH researchers determined that some data lacked completeness and representation at the county level, and in some cases at the regional level. To address lacking data and to protect confidentiality, data were aggregated (that is, combined) and analyzed at the regional or state level, depending on the data source. Full details of data review, aggregation, and analysis are described in Appendix A.

Existing Literature and Reports

The authors of this report reviewed published reports and journal articles. The research partner, TIEMH, recently conducted research and developed reports addressing peer specialist workforce related topics, such as:

- The utilization of the peer support Medicaid benefit,
- Peer specialist workforce turnover in Local Mental Health Authorities and Local Behavioral Health Authorities, and
- Cost-benefit analysis of services provided by peer-run organizations.

Additional literature includes research published in peer-reviewed journals and by government entities, such as the Substance Abuse and Mental Health Services Administration (SAMHSA) and Texas Health and Human Service (HHS). These sources provided contextual information that validated many of the findings from other needs assessment data sources.

Existing Data

Data Collection. Data were collected and compiled from publicly available websites and data sets available to TIEMH. Existing data utilized for this needs assessment included:

- A data set from a survey of the Texas peer specialist workforce conducted by TIEMH (Lodge & Stevens Manser, 2025).
- Texas peer specialist certification data, including the numbers of specific certifications, duration of certification, initial and full certification status, and expired certifications (Texas Certification Board [TCB], personal communication, 2025);
- Texas peer specialist trainer and training entity data, including the numbers of each, what certification training is offered, and whether virtual training is available (TCB, 2025a).
- Substance use treatment providers, including organizations that currently offer recovery coach and peer support services (SAMHSA, 2025a);
- Measures of the impact of opioid misuse including 1) five-year rates of opioid prescriptions; 2) five-year rates of medical services utilization (i.e., emergency medical service calls, hospital emergency department visits, and inpatient hospitalizations); and 3) five-year rates of deaths related to opioid overdose (Centers for Disease Control and Prevention [CDC], 2025; HHS, 2025; CDC National Center for Health Statistics, 2025).

Data Analysis. The data from existing sources were cleaned and aggregated using Excel. Descriptive analysis of the *TWFS Data* was conducted using a business intelligence platform, Power BI, to answer the following questions:

- What training areas would enhance peer support practice?
- What is the average and range of hourly pay for peer specialists and peer specialist supervisors?
- What barriers do peer specialists encounter when looking for a job?
- How long do peer specialists remain employed in their jobs?
- For what reasons are peer specialists not renewing their certifications?
- Why are peer specialists leaving the workforce?

The numbers of certified peer specialists, certified Peer Specialist Supervisors, trainers and training entities, substance use treatment providers, and organizations that offer recovery coach or peer support services were aggregated into the RHPs for analysis. Maps were created to visualize this data.

Researchers created a *Composite Indicator Framework* to combine and score the individual measures representing the impact of opioid misuse. To do this, the following steps were taken:

1. The county-level data for each of the measures were combined into the RHPs.
2. Measures were calculated as rates per 100K.
3. These rates were sorted into five equal groups (called *quintiles*); this step helped rank the rates from lowest to highest among the regions.
4. The five quintiles were scored from 1 to 5, with a score of 1 applied to the first quintile (or lowest 20%) and a score of 5 applied to the highest quintile (or highest 20%).
5. The scores for each measure were added together into a composite score.
6. The composite scores were again organized into quintiles and scored from 1 to 5, with higher scores representing higher impact of opioid misuse in a region.

Figure 3 is a diagram illustrating this process for the Composite Indicator Framework for the Impact of Opioid Misuse (CIF-IOM).

Figure 3. Calculation of Scores for Composite Indicator Framework: Opioid Misuse.

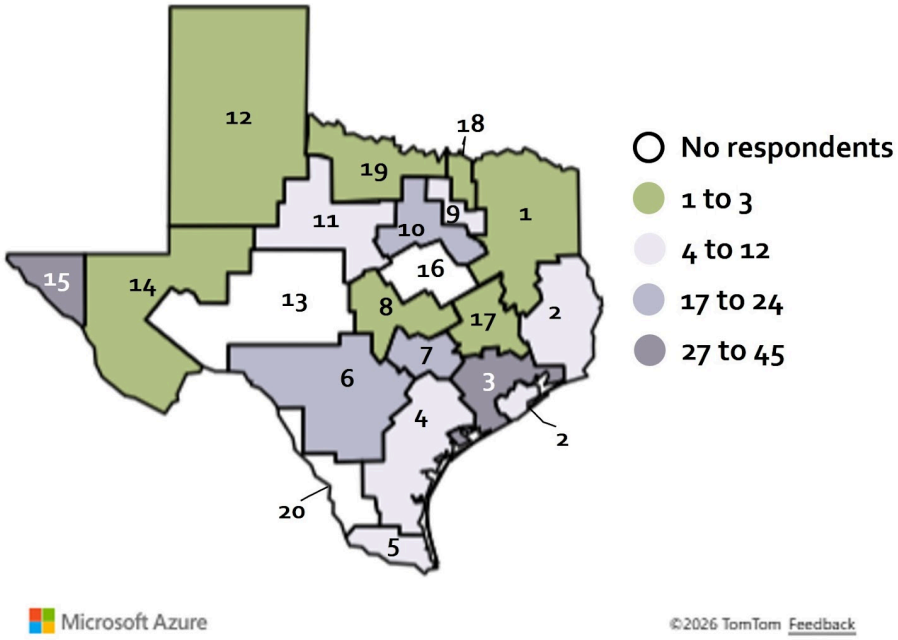
Survey

Data Collection. The Peer-to-Career Needs Assessment Survey was divided into sections for each of the stakeholder groups previously described. The survey questions were developed to explore the experiences of each stakeholder group (Appendix C: Survey Questions). The survey was distributed online using the Qualtrics survey software (Qualtrics, Provo UT). RecoveryPeople emailed a survey link through their email distribution system (i.e., MailChimp). The survey was sent twice over a two-week period from October 11 to October 25, 2025. The survey received 189 responses, representing a response rate of 4.2%.

Data Analysis. The survey data were downloaded from the Qualtrics platform into Excel, where the data were cleaned and prepared for analysis. Descriptive analysis was conducted using Power BI. Data were organized into frequency and distribution tables and visualized using charts and graphs.

Participants. Survey participants represented 35 of the 254 Texas counties and 17 of the 20 RHPs (Figure 4).

Figure 4. Map of Needs Assessment Survey Respondents by RHP.



Most respondents identified their gender as female (n=113, 63%). Fifty-seven (32%) responded that their gender is male. In terms of race and ethnicity, most reported being White (n=99, 55%), followed by Black or African American (n=40, 22%), and Hispanic or Latino/a (n=37, 21%). Table 1 summarizes demographics of the respondents to the needs assessment survey.

Table 1. Needs Assessment Survey Participant Demographics.

Response	N Ind. n=179	% Ind
Gender		
Female	113	63%
Male	57	32%
Prefer not to answer	7	4%
Gender not listed	2	1%
Race/Ethnicity*		
American Indian or Alaska Native	5	3%
Asian	2	1%
Black or African American	40	22%
Hispanic or Latino/a	37	21%
Native Hawaiian or Other Pacific Islander	1	1%

White	99	55%
Another race or ethnicity	2	1%
Prefer not to answer	7	4%

*Respondents could select more than one race or ethnicity option.

Respondents were asked to indicate with which stakeholder group or groups they identified; multiple selections were allowed (Table 2). Most survey respondents indicated they were peer specialists (n=160, 85%), followed by employers of peer specialists (n=56, 30%), supervisors of peer specialists (n=53, 28%), and then trainers of peer specialists (n=50, 26%).

Table 2. Stakeholder Group With Which Needs Assessment Survey Respondents Identified.

Response	N Ind n=189	% Ind
Peer specialist	160	85%
Employer of peer specialists	56	30%
Supervisor of peer specialists	53	28%
Trainer of peer specialists	50	26%

Focus Group

Data Collection. Four virtual focus groups were conducted via Zoom (version 6.6.5) with the four stakeholder groups. Email invitations were sent to a selected group of potential participants by RecoveryPeople. The email invitations included a link to a registration form, allowing the recipients to select which focus group or groups reflected their role or roles related to the peer workforce. The questions centered on identifying challenges impacting training, certification, recruitment, and retention of peer specialists, as well as strategies to address these challenges (Appendix D: Focus Group Questions). The focus groups were recorded and transcriptions were developed utilizing the built-in features of the Zoom platform.

Analysis. Focus group analysis was guided by a grounded theory approach to qualitative data whereby codes emerged directly from the data and were not pre-determined prior to analysis (Charmaz, 2006) and was completed using NVivo qualitative data analysis software Version 15. All four focus group transcripts were read through line-by-line to develop codes. Codes were developed iteratively and constantly refined – some codes were merged while others were disaggregated as more data were analyzed. These final codes were then organized into broad categories for reporting (e.g., compensation structure).

Participants. To maintain the confidentiality of the focus group participants, no demographic or geo-location data are reported. A total of 51 individuals were invited to participate in the focus groups. Twenty-six unique individuals registered. Nineteen of these individuals registered for one focus group and seven registered for multiple focus groups. A total of 20 individuals participated. Fifteen

individuals participated in one focus group and five participated in multiple focus groups. Table 3 summarizes the registrations and participation for each focus group.

Table 3. Registrations and Participation in the Four Stakeholder Focus Groups.

Focus Group (FG)	Registrations			Participants		
	N	One FG	Multiple FGs	N	One FG	Multiple FGs
Peer Specialists	8	4	4	7	4	3
Trainers of Peer Specialists	10	3	7	9	5	4
Supervisors of Peer Specialists	10	4	5	5	1	4
Employers of Peer Specialists	13	8	5	6	5	1
Overall - Unduplicated	**26**	**19**	**7**	**20**	**15**	**5**

Limitations

This needs assessment report is subject to several limitations that should be considered. For instance, the published literature and reports may not be completely representative of the peer specialist workforce in Texas. Also, the data in published reports and journal articles may be out-of-date. Some of the data sources used to describe the impact of opioid misuse were incomplete due to data suppression practices, which may impact the scores for some areas. Not all RHPs were represented by the needs assessment or TIEMH workforce surveys. Both of these surveys may not be representative of all the peer specialist workforce and stakeholders in Texas. The focus group data may only be representative of the experiences of the specific focus group participants.

Regional analysis also has its limitations because borders often do not match labor markets. For example, a peer specialist who lives in rural Jim Hogg County (Region 20) is employed by an organization based in Hidalgo County (Region 5) and serves individuals in Brooks County (Region 4).

Peer Specialist and Supervisor Workforce Roles

A peer specialist is a distinct, professional workforce role within the behavioral health system. A peer specialist supervisor is a role that is trained and qualified to provide peer specialists with oversight, guidance, and support to ensure quality of care, ethical and legal compliance, professional development, and accountability within service systems.

Peer specialists are individuals with lived experience of recovery from mental health and/or substance use challenges who are trained to use that experience alongside recovery-oriented competencies to support others in achieving their own recovery goals. The role is grounded in mutuality, empathy, and shared experience, reflecting a belief that recovery is possible and strengthened through authentic connection rather than clinical authority.

The peer specialist role originated in peer-run, mutual aid, and "prosumer" recovery programs, where individuals both received and delivered support outside of formal service systems. This legacy has contributed to the ongoing conflation of the peer specialist role with peer support as an intervention, even as the workforce has been formalized and professionalized. As peer specialists and their reimbursable services have expanded within clinical and publicly funded systems, their prominence has increasingly overshadowed other peer roles and peer-led services. As a result, the literature often uses the term "peer" to refer narrowly to professionalized peer specialists, rather than the broader population of individuals with lived experience engaged in mutual support. Similarly, "peer support" is frequently used to describe peer specialist–delivered services, despite encompassing a wide range of informal, community-based, and peer-run practices beyond the certified workforce.

> ***Seeing someone text me, reach out, and say "I'm here." That's peer support at its best.***
>
> *Focus Group, 2025*

Over time, peer specialists have been integrated into clinical, behavioral health, and other institutional settings and shaped in the image of clinical workforce roles through formal certification, defined scopes of practice, Medicaid reimbursement, the establishment of peer specialist supervisors, and structured supervision requirements similar to those used for clinical staff. This professionalization has supported workforce legitimacy, accountability, and sustainability. The integration of peer specialists into clinical and institutional settings has helped make these systems more recovery-oriented and, in many cases, more cost-effective by improving engagement, continuity of care, and outcomes.

At the same time, there are growing concerns that modeling peer roles too closely on clinical roles may undermine the unique contributions and effectiveness of peer support. In addition, the context and setting of services is also being considered. While peer specialists are able to improve the

recovery-oriented of clinical, acute care, or institutional environments, that is not equivalent to peer specialists supporting individuals in community-based, non-clinical, peer-run settings.

Peer Specialists

History

For centuries, people in recovery from mental health and substance use challenges have supported one another through mutual-aid groups, community-based recovery organizations, and social movements that emphasized empowerment, choice, self-determination, and non-clinical support. Peer specialists are one of several peer roles that emerged from these peer-led programs, grassroots organizations, and advocacy movements.

In the late 1990s and 2000s, the Substance Use Mental Health Services Administration (SAMHSA) began formally investing in recovery-oriented approaches and systems change through initiatives such as the Recovery Community Support Program (RCSP), Access to Recovery (ATR) grants, Recovery-Oriented Systems of Care (ROSC), the Bring Recovery Support Services to Scale Technical Assistance Center (BRSS TACS) programs, and the Mental Health Transformation State Incentive Grants. These efforts accelerated the development of peer-led service models, including mental health Consumer-Operated Service Providers (COSPs) and substance-use focused Recovery Community Organizations (RCOs), as well as the peer workforce roles, such as peer specialists and recovery coaches, embedded within them. During this period, COSPs, RCOs and the first peer specialist curricula and credentialing programs began to emerge across the U.S. and in Texas.

In 2007, the Centers for Medicare and Medicaid Services (CMS) authorized Medicaid reimbursement for peer support services delivered by peer specialists as a distinct workforce role, rather than through peer-led service models such as COSPs or RCOs. This policy shift enabled Medicaid-billing providers to employ peer specialists directly, driving the integration of peer specialist services into clinical, behavioral health, and other publicly funded service systems. It also catalyzed the professionalization of the peer specialist role, prompting states to establish regulations defining peer specialists and the services eligible for reimbursement.

The professionalization of the role has matured with credentialing standards, ethical codes, supervision requirements, clearer role definitions, and integration into disciplinary teams. This professionalization, along with formal recognition, has increased credibility, standardized competencies, and expanded funding opportunities.

At the same time, many advocates caution that excessive professionalization risks diluting the central value of lived experience, potentially eroding the authenticity, mutuality, and relational power that distinguish peer support from clinical services; particularly as peer specialists are increasingly integrated into non-recovery and clinical settings. These concerns mirror earlier workforce roles that

evolved into clinical professionals, such as the evolution of licensed chemical dependency counselors (LCDCs).

Balancing these dynamics requires intentional safeguards to ensure that professionalization does not dilute the foundational values of peer support. As peer specialists are integrated into clinical service systems, their distinct role must be maintained and not changed into one that is more clinical. One promising approach is the expansion of models in which peer specialists are supervised and supported by peer-run organizations (PROs) that contract with public systems to deliver services across community settings. This structure helps preserve fidelity to peer support principles while expanding access to recovery support through trusted, community-rooted infrastructure.

In recent years, the peer specialist role has expanded significantly in response to the opioid epidemic. Peer specialists with lived experience of opioid use disorder have been integrated into emergency departments, harm reduction programs, correctional settings, and community-based outreach initiatives. Their ability to engage individuals immediately following overdose, incarceration, or treatment discharge has positioned peer specialists as a critical bridge between acute care, medication for opioid use disorder, and sustained recovery support.

Although peer specialists and recovery coaches were active in Texas prior to 2017, the passage of House Bill 1486, known as the "Peer Specialist bill", during the 85th Texas Legislative Session fundamentally reshaped the landscape. The law formally defined Medicaid billable peer specialist services in Texas and directed the Health and Human Services (HHS) to adopt rules governing the training, certification, supervision, and the scope of peer specialists services.

Definition

As defined by Texas Administrative Code (TAC), a peer specialist must:

1. be at least 18 years of age;
2. have lived experience;
3. have a high school diploma or General Equivalency Diploma (GED);
4. be willing to appropriately share his/her own recovery story with recipients;
5. be able to demonstrate current self-directed recovery; and
6. pass criminal history and registry checks as described in §354.3201 of this subchapter (relating to Criminal History and Registry Checks; 1 Tex.Admin. Code §354.3051 (2024)).

Call out box

The degree of "look-back" restrictions that affect Texas peer specialist certification create a barrier for many individuals in recovery from mental health (MH) and/or substance use disorders (SUD) who also have criminal backgrounds. This is particularly counterproductive because they are uniquely positioned to support a portion of the population with high prevalence of behavioral health

challenges and risks. An estimated 65% of individuals in U.S. prisons meet criteria for a substance use disorder (SUD; Centers for Disease Control [CDC], 2020), which corresponds to a study that indicates 64% of inmates in Texas state jails fit the criteria for substance use disorder diagnosis (Bronson & Berzofsky, 2017). Research shows that opioid overdose rates among people released from prison are substantially higher than among the general population, and that the greatest risk period is during the first two weeks after release (Grella, et al., 2021). About 34% of people in Texas jails and prisons have a diagnosed mental health disorder, according to state mental health system and criminal justice reports (Meadows Foundation, 2015).

Overly restrictive peer specialist eligibility policies are inefficient and counterproductive. Excluding individuals based on past convictions—particularly when those convictions are unrelated to current circumstances and job performance—disqualifies many highly qualified candidates whose lived experience is directly aligned with the needs of the populations being served.

Scope of Work

Peer specialists provide non-clinical social support, which is defined in state law and administrative codes across the nation. The TAC requires:

- Peer specialist services to be recovery-oriented, person-centered, relationship-focused, and trauma-informed.
- Participation in peer specialist services is voluntary.
- These peer specialist services may be provided individually or in a group and may include: 1) recovery and wellness support, which includes providing information on and support with planning for recovery; 2) mentoring, which includes serving as a role model and providing assistance in finding needed community resources and services; and 3) advocacy, which includes providing support in stressful or urgent situations, and helping to ensure that the recipient's rights are respected (1 Tex. Admin. Code §354.3013, 2024).

Certifications and Training

HHS has named the Texas Certification Board (TCB) as a peer specialist certification entity as per the TAC. TCB offers multiple peer specialist certifications, including credentials that predate HB 1486 legislation, those established in response to the passage of HB 1486 legislation, and certifications designed to serve specific populations.

Table 4 outlines the various peer certifications in Texas and highlighting which ones are required to be Texas Medicaid billable. Although emphasis is often placed on certifications that are Medicaid billable, only 5% of the employer survey respondents indicated that they bill Medicaid to fund peer specialists services.

Table 4. Peer Specialist Certifications in Texas.*

Certification	Description	Medicaid billable
Peer Recovery Support Specialists (PRSS)	• Predates Texas legislation; • Specializes in supporting persons with substance use issues; • Has reciprocity across multiple states via IC&RC • Requires RSPS and IC&RC exam completion	No
Recovery Support Peer Specialist (RSPS) RSPS Intern	• Established in response to HB 1486; • Specializes in supporting persons with substance use issues • Intern designation is for person who cannot pass the background check	Yes
Mental Health Peer Specialists (MHPS) MHPS Intern	• Established in response to HB 1486; • Specializes in supporting persons with mental health challenges • Intern designation is for person who cannot pass the background check	Yes
Peer Specialist Supervisor (PSS)	• Established in response to HB 1486 • Supports peer specialists promoting professional development, self care, role fidelity and ethics	Required to bill Medicaid
Certified Family Partner (CFP)	• Supports caregivers and parents of children with mental health challenges • Training is only available to and for organizations that bill Medicaid	Yes
Veteran Enhanced Mental Health Peer Specialist (MHPS)	• Supports military veterans and their families. • Includes additional supports such as mental health first aid and suicide prevention	Yes

Justice Involved / Reentry Peer Specialist (JI-RPS)	• Supports individuals transitioning out of incarceration, a period associated with heightened risk for overdose, housing instability, and recidivism. • Currently on hold as a credential as of December 2025 - per TCB	No

(*) Currently, there is no pathway to obtain any full Texas peer specialist certification without undergoing a background check.

Achieving Legitimacy through Certification and the Exception Process

Although both the National Association for Addiction Professionals (NAADAC) and the International Certification & Reciprocity Consortium (IC&RC) offer peer specialist credentials with interstate reciprocity and no criminal background check requirement, Texas policy requires individuals to first obtain a state credential that **does** require a background check under the Texas Administrative Code (though not statute). This unnecessarily constrains the size and capacity of the peer specialist workforce and undermines employers from hiring individuals who are uniquely qualified to serve target populations.

> ***"I did the entire exam, testing, ICRC for the PRS.....and it felt like I was achieving something that was viewed as being legitimate."***
>
> Focus Group, 2025

One needs assessment focus group participant described completing peer training, testing, and the IC&RC process as a moment of legitimacy and professional identity: *"I did the entire exam, testing, IC&RC for the PRS…and it felt like I was achieving something that was viewed as being legitimate."* However, in Texas, there is currently no pathway to obtain a full peer specialist certification without undergoing a background check. While the National Certified Peer Recovery Support Specialist (NCPRSS) credential can be obtained through the NAADAC, TCB must approve applicants to sit for this recognized exam. In practice, the state only accepts the IC&RC exam after the applicant has first obtained the RSPS credential (which requires a background check). TCB does not recognize the National Certification Commission for Addiction Professionals (NCCAP) exam, nor is it offered in Texas. Consequently, all available Texas peer specialist certifications that confer full professional status require a background check.

Peer specialists may find their certification applications rejected because of background check restrictions, but only after they apply for certification. There is an exception process applicants may

pursue that can result in the "Intern" designation, which is assigned to MHPS or RSPS, after additional steps in the application process are taken. The applicant remains in Intern status for the duration of the credential, thereby leaving no route for individuals with certain types of justice involvement to achieve full certification. Other justice-involved peer specialists complete required training and successfully perform peer roles yet remain excluded from certification due to background check requirements, others prefer not to take a background check for various reasons.

> *...Talking about being recognized by organizations and statewide. I'm in a space where I just... I want to be encouraging, but now I find myself...Like, why it doesn't seem like it's set up to want people to succeed?*
>
> Focus Group, 2025

This exclusion, and lack of access to attaining a state-recognized certification, limits career advancement, prevents participation in HHS funded workforce development initiatives, impacts continuing education access, and contributes to workforce attrition. While background checks are required for Medicaid billing compliance, only 5% of surveyed employers providing peer specialist services currently bill Medicaid, raising questions about the proportional workforce impact of this requirement.

Texas' criminal background exclusions and lookback rules regarding peer specialists may uncharacteristically reflect over regulation. In 2022, a comparative analysis of states' peer specialist certification requirements was conducted by reviewing information on certification entity websites; of the 49 states that offer certification, only ten states indicated background checks as a requirement to attain certification and five indicated individuals must self-disclose any criminal background (Peer Recovery Center of Excellence [PRCOE], 2022). Notably, the authors of this report suggested the lack of information for the remaining 34 states could be attributed to either 1) the requirement existing but not on public facing websites, or 2) background checks not being a requirement. Regardless, the authors of the PRCOE report recommended that background checks be clearly indicated on the certification website, that disqualifying offenses be clearly indicated, and that those offenses do not disqualify people who may have legal history common with those who may need support (PRCOE, 2022). Also notably, TCB does list the offenses and lookback timeframes on its website (TCB, 2025b).

TCB also accredits continuing education providers that offer ongoing professional development for peer specialists as well as the training entities authorized to deliver peer specialist curricula, which are developed and approved by the HHS's Peer and Recovery Services Unit.

Peer Specialist Supervisors

Supervision is a fundamental component of clinical and medical workforce development, and it has been extended to peer specialists as a key element of the role's professionalization. It is a formal

process where experienced professionals guide less experienced individuals to ensure quality care, foster growth, and meet regulatory requirements. It often involves case review, skill development, ethical guidance, and emotional support in a confidential setting, which is crucial for both professional development and client safety.

In Texas, certified Peer Specialist Supervisors (PSS) are essential to both the certification process and ongoing professional practice. To achieve full certification, peer specialists must complete 250 hours of field experience under weekly supervision from a qualified PSS. Those providing Medicaid–billable services are also required to receive ongoing supervision. Under the TAC, supervision focuses on service delivery, skill development, case review, and professional growth, and may be conducted individually or in groups, either face-to-face or via teleconference (1 Tex. Admin. Code §354.3103, 2024).

Individuals must meet specific qualifications to become a certified PSS. For example, they must be a Qualified Credentialed Counselor (QCC), a Licensed Practitioner of the Healing Arts (LPHA), or a Qualified Mental Health Professional (QMHP) who is supervised by a QCC or LPHA (1 Tex. Admin. Code §354.3105, 2024). In addition, TAC 1 Tex. Admin. Code §354.3105 stipulates that a Qualified Peer Specialist (QPS) may serve in a supervisory role if they have at least four years of work experience as a peer specialist, or two years of experience if they hold an associate degree or higher; furthermore, QPSs who are pursuing certification as a PSS must receive ongoing supervision from an individual who meets QCC or LPHA qualifications (2024).

QPS eligibility provides peer specialists with a career ladder to becoming a PSS and earning a higher salary. Whereas the average salary of a peer specialist in Texas is $42,057.60 ($20.22 per hour), job posting searches indicate that roles responsible for supervising peer specialists earn from $45,000 to $65,000 annually. This salary is relatively modest, especially in cities with high cost of living. However, organizations with larger programs or additional administrative and supervisory responsibilities may offer toward the higher end of this range or above.

Need for Peer Specialist Workforce

Workforce need describes the optimal number of qualified workers necessary to provide a service that meets the needs of people throughout the state. Based on the Substance Abuse and Mental Health Services Administration's (SAMHSA's) 2021 *Behavioral Health Workforce Plan*, adjusted for Texas' population size, the state is estimated to need approximately 96,000 peer specialists, including 31,000 Recovery Support Peer Specialists (RSPS) with expertise in supporting individuals with opioid use disorder and other substance use disorders.

The need for RSPS varies across Texas and continues to shift over time. As Texas's population expands, the need for peer specialists increases accordingly. However, this need is not evenly distributed statewide. Differences in population density and the prevalence of opioid misuse result in some regions needing more RSPS than others.

Estimated Statewide Need

In 2021, SAMHSA published a report detailing the numbers of behavioral workforce providers needed to support:

- Adults *diagnosed* with serious mental illness (SMI),
- Youth *diagnosed* with serious emotional disturbance (SED), and
- Adults *diagnosed* with opioid use disorder (OUD) and other substance use disorders (SUD).

Estimated National Need
1.1 million Peer Specialists

777K	350K
For People Diagnosed with SMI	For People Diagnosed with SUD and OUD

This report examined 17 different mental health and substance use treatment programs and calculated the number of providers based on established staffing models, which included peer specialists (SAMHSA, 2021).

Estimated Need in Texas
96K Peer Specialists

68K	31K
For People Diagnosed with SMI	For People Diagnosed with SUD and OUD

The estimated number of peer specialists needed nationally was 1.1 million, including 777K peer specialists to support adults diagnosed with SMI or youth diagnosed with SED, and 350K to support people diagnosed with OUD/SUD (SAMHSA, 2021).

For this needs assessment report, an estimate of the number of peer specialists needed in Texas was calculated based on the state's share of the U.S. population in 2021 (8.7%). This percentage was multiplied by the number of peer specialists needed for each of the 17 program models

described in the SAMHSA report (Table 5). This provides a *rough estimate* of the peer specialist workforce needed in Texas as of 2021.

The total estimated number of peer specialists needed in Texas as of 2021 was 96K, including 68K to support adults diagnosed with SMI or youth diagnosed with SED and 31K to support people diagnosed with OUD/SUD. To support people enrolled in opioid treatment programs alone, the number of peer specialists needed was approximately 3,000.

Table 5. Estimated Number of Peer Specialists Needed in Texas Based on Staffing for Specific Models of Care.

Model of Care	Model indicated for SMI, SED, SUD or OUD	Adult or Youth	Number of Peer Specialists
Assertive Community Treatment (ACT) or Assisted Outpatient Treatment (AOT)	SMI	Adult	1,957
Partial Hospitalization Program	SMI	Adult	3,915
Intensive Outpatient Program	SMI	Adult	3,915
Mobile Crisis Teams	SMI	Adult	226
Coordinated Specialty Care Model	SMI	Adult	98
Certified Community Behavioral Health Clinics or Community Mental Health Center	SMI	Adult	28,378
Inpatient Care and Psychiatric Hospitals	SMI	Adult	508
Long-term Acute Care Hospitals	SMI	Adult	647
Supported Living Communities	SMI	Adult	3,777
Children/Youth Intensive Outpatient Program	SED	Youth	17,352
Children/Youth Inpatient Care and Psychiatric Hospitals	SED	Youth	716
Youth Residential Treatment	SED	Youth	556
Children/Youth School-based Mental Health Services	SED	Youth	5,581
Intensive Outpatient Programs	SUD	Adult	20,436
Intensive Outpatient Programs for OUD	OUD	Adult	1,702
Residential Programs	SUD	Adult	7,211
Opioid Treatment Program	OUD	Adult	1,057

SAMHSA provided an important assessment of the peer specialist workforce needed for 17 models of mental health and substance use treatment in 2021. Further, the authors emphasized that peer specialists are important for supporting people through treatment and toward recovery (SAMHSA, 2021). However, these calculations provide only *conservative estimates*; the numbers represent selected models of care and a point-in-time count of people *diagnosed* with mental illness and substance use disorders. The programs described do not include peer run organizations or other settings in which peer specialists may provide support, sometimes to individuals who do not receive formal diagnosis. Thus, these numbers may underrepresent the true workforce need.

Regional Need Adjusted for Population

All else being equal, more populous areas require a larger peer specialist workforce. As of July 1, 2024, the population of Texas was estimated to be 31.3 million (Texas Demographic Center [TDC], 2025a). By 2050, Texas may comprise up to 11% of the total U.S. population, with projections estimated between 44 and 47 million residents by 2060. The state is home to several large, densely populated metropolitan areas, while also containing the highest number of rural counties and the largest rural population of any state. This unique mix of urban concentration and widespread rural communities creates a diverse and uneven need for peer specialists across the state.

Population, Population Growth, and Population Density

The populations of the Regional Healthcare Partnership (RHP) areas were determined by aggregating estimated 2024 county populations (TDC, 2025a; Figure 5). This map shows that the western half of Texas is less populous than the central and eastern portions of the state. RHP 12 is the most populous region in the western half of the state, however this region also includes the most counties of all RHPs (n=47). In the southern portion of Texas, RHPs 20 and 4 are less populous than the surrounding regions. RHP 16 is less populous than other regions in the central and eastern portions of the state.

Figure 5. Populations of the RHPs as of 2024.

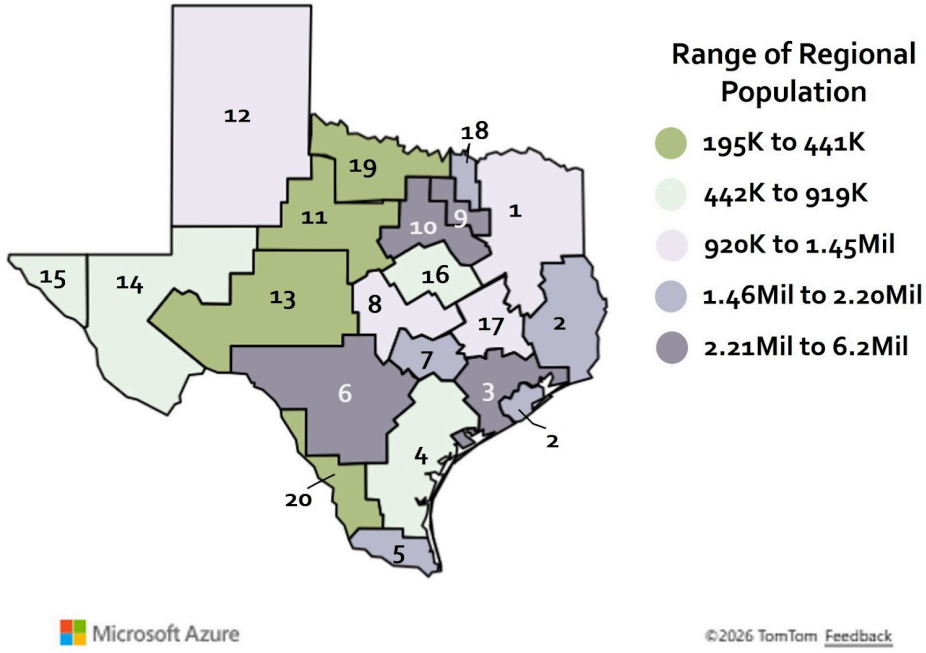
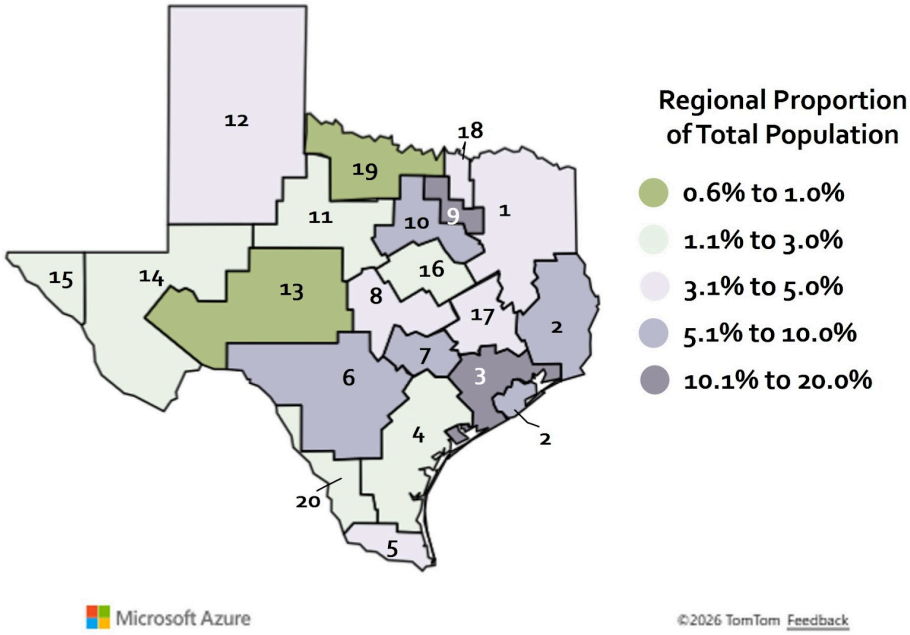


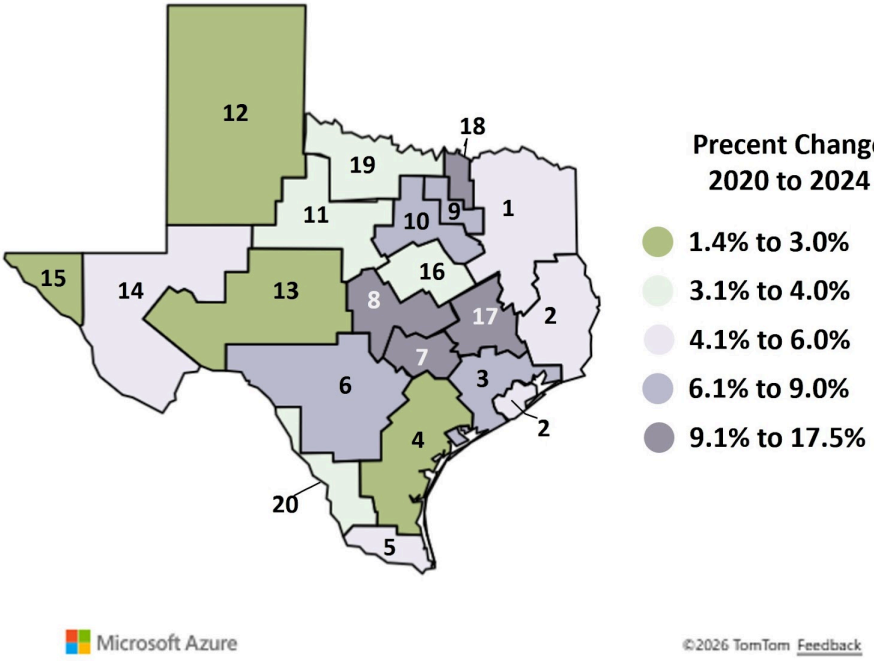
Figure 6 visualizes what percentage of the 2024 estimated population reside in each RHP. The regions that comprise the greatest proportion of population are RHPs 9 and 3. RHPs 13 and 19 have the smallest proportions of the 2024 Texas population.

Figure 6. Percentage of Total Population for each RHPs.



Since the 2020 Census, the population of Texas increased from 29.1 million, representing an overall growth of 6.9%. However, the rate of population change varied from region to region (Figure 7). The regions with the largest population changes include RHPs 7, 8, 17, and 18. The regions with the smallest percent change in population include RHPs 4, 12, 13, and 15.

Figure 7. Regional Percent Change in Population from 2020 to 2024.



Metropolitan and Non-Metropolitan Areas in Texas

The Texas Comptroller (2023) utilizes the Core Based Statistical Areas (CBSA) classification system of Metropolitan Statistical Areas, Micropolitan Statistical Areas, or Outside Core Based Statistical Areas. The definitions of these areas are as follows:

- **Metropolitan Statistical Areas** have "at least one urban area with a population of 50,000 or more and include adjacent counties with a high degree of social and economic integration" with the urban area or areas, referred to as the core.
- **Micropolitan Statistical Areas** include "at least one urban area with a population of 10,000 to 50,000 and adjacent counties with a high degree of social and economic integration" with the core urban area or areas.
- **Outside Core Based Statistical Areas** are counties that "do not qualify for inclusion in CBSA" which are the Metropolitan and Micropolitan Statistical Areas (Office of Management and Budget [OMB], 2021).

For the purposes of this report, and to describe county and regional level differences, the counties are divided into "metropolitan" and "non-metropolitan" counties. Metropolitan counties correspond to the Metropolitan Statistical Areas, and non-metropolitan counties refer to Micropolitan and Outside Core Statistical Areas (Texas Comptroller, 2023).

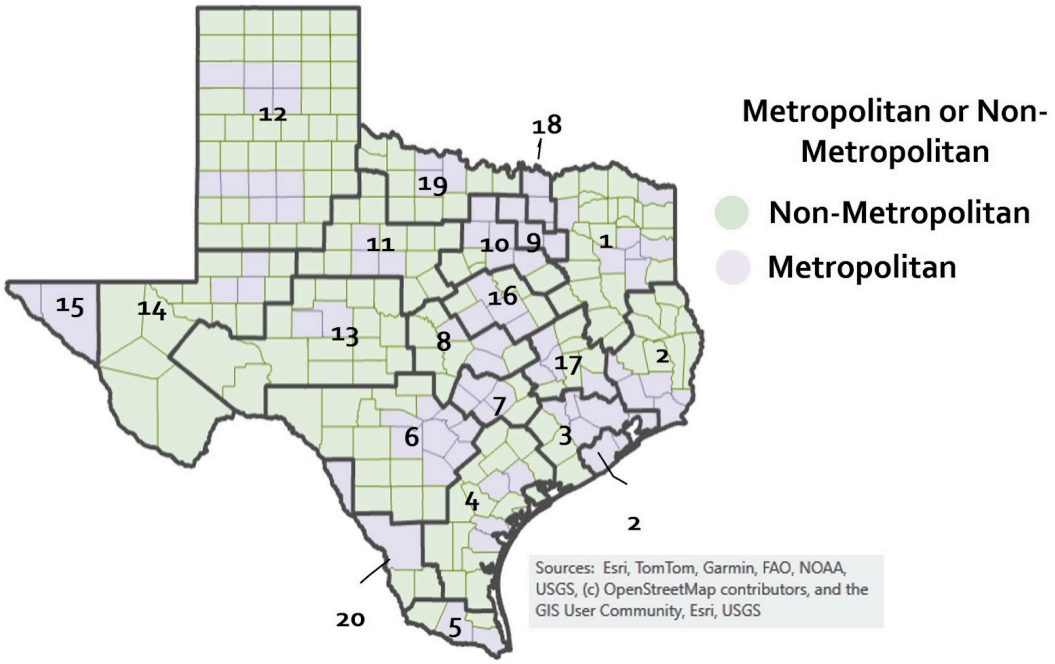
Table 6 lists the RHPs in order of percentage of counties that have metropolitan designation. Nine RHPs have 50% or more counties designated as metropolitan. Eleven RHPs are mostly made up of counties with non-metropolitan designation. RHPs 9, 15, and 18 are wholly made up of counties designated metropolitan. While no RHP is wholly non-metropolitan, 75% or more of the counties in RHPs 11, 12, 13, 14, and 19 are designated non-metropolitan.

Table 6. RHPs in Order of Percentage of Counties with Metropolitan Designation.

RHP	N Counties	N Metro	% Metro	N Non-Metro	% Non-Metro
RHP 9	3	3	100%	0	0%
RHP 18	3	3	100%	0	0%
RHP 15	2	2	100%	0	0%
RHP 7	6	4	67%	2	33%
RHP 16	7	4	57%	3	43%
RHP 3	9	5	56%	4	44%
RHP 10	9	5	56%	4	44%
RHP 5	4	2	50%	2	50%
RHP 20	4	2	50%	2	50%
RHP 17	9	4	44%	5	56%
RHP 2	16	7	44%	9	56%
RHP 6	20	8	40%	12	60%
RHP 8	9	3	33%	6	67%
RHP 4	18	5	28%	13	72%
RHP 1	28	7	25%	21	75%
RHP 19	12	3	25%	9	75%
RHP 12	47	11	23%	36	77%
RHP 11	15	3	20%	12	80%
RHP 14	16	3	19%	13	81%
RHP 13	17	2	12%	15	88%

Figure 8 is a map that illustrates the location of the core Metropolitan Statistical Areas for the RHPs.

Figure 8. Map of Metropolitan and Non-Metropolitan Counties with RHP Boundaries.



Overall, this map illustrates that much of the state is classified as non-metropolitan (69% of all counties). However, 90% of the population resides in metropolitan counties, according to 2022 population estimates (Texas Comptroller, 2023). Comparing this map to the map that depicts population growth in the previous section, it appears much of the growth may correspond to metropolitan areas.

69% of Texas counties are non-metropolitan.

90% of Texans live in metropolitan areas.

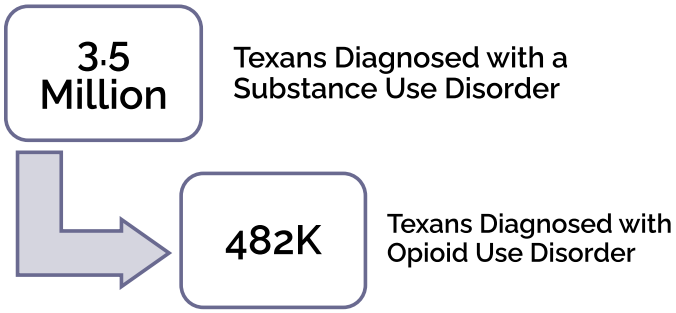
Regional Need Adjusted for Opioid Misuse

Because all things are *not* equal, population size and growth projections alone are insufficient for prioritizing resource allocations to address opioid misuse. Variation in the prevalence of opioid use disorder (OUD) across communities reflects a complex interplay of socioeconomic conditions, access to and quality of healthcare, prescribing and treatment practices, and broader social and environmental factors. These factors become evident when the impact of opioid use is examined.

Prevalence of Diagnosed Substance Use in Texas

SAMHSA conducts the National Survey on Drug Use and Health (NSDUH) to provide information about the prevalence of tobacco, alcohol, and drug use, as well as diagnosed mental illness to monitor trends with the purpose of informing policy (NSDUH, 2025). The most recent survey, conducted in 2023, identified that for all Texans aged 18 or older:

- 2.7 million (12%) reported using any illicit drug in the past month and 788K (4%) reported opioid misuse in the past year;
- 4.7 million (21%) were diagnosed with a mental illness and 1 million (5%) were diagnosed with a severe mental illness (e.g., schizophrenia); and
- 3.5 million (16%) were diagnosed with a substance use disorder and 482K (2%) were diagnosed with opioid use disorder (SAMHSA, 2023a).



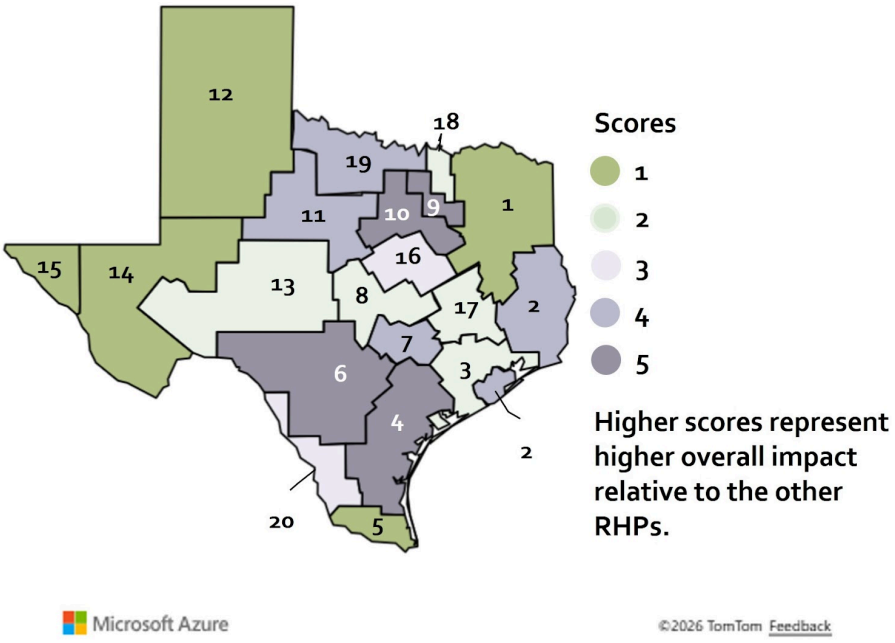
Impact of Opioid Misuse

A Composite Indicator Framework of the Impact of Opioid Misuse (CIF-IOM) was developed to better understand the impact of opioid misuse across RHPs. This framework examined the five-year rates of the following measures:

- Opioid prescriptions filled,
- Non-fatal opioid overdose-related emergency medical services calls,
- Opioid overdose-related emergency department visits,
- Opioid overdose-related inpatient hospital stays, and
- Opioid overdose-related deaths.

Using the process described in the Method section, the CIF-IOM provides a way to score the relative impact of opioid misuse among the 20 RHPs. Figure 9 shows the regional scores. ***Higher scores represent a higher overall impact of opioid misuse.*** Regions with the highest scores include RHPs 4, 6, 9, and 10, followed by RHPs 2, 7, 11, and 19. The regions with the lowest scores RHPs 1, 5, 12, 14, and 15 had the lowest scores.

Figure 9. Scores for the Composite Indicator Framework of the Impact of Opioid Misuse.



There are a few things to note about the CIF-IOM. First, the scores represent a comparison between regions - low scores do not mean there is no impact due to opioid misuse. Further, the public health data utilized to develop this framework are subject to suppression practices, which means when there are very few incidents at the county level, the number is not reported to protect privacy and therefore the rate cannot be calculated. The inclusion of multiple years is intended to account for this, and further details about this limitation are detailed in Appendix A: Method.

Overall, the CIF-IOM provides a layer of understanding and consideration. The scores for the CIF-IOM do not seem to correspond to population or metropolitan designation. While the CIF-IOM provides a way to examine the impact of opioid misuse, community level work should be considered to better understand the meaning behind the scores.

Overall Need for Peer Specialists

Table 7 summarizes the regional findings for this section, focusing on the regional percentage of population and the scores for CIF-IOM. If peer specialists were allocated solely based on population size, regions disproportionately impacted by opioid misuse would be under-resourced.

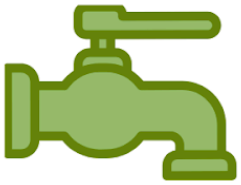
Regions that emerge with the highest CIF-IOM score (4 or 5), include RHPs 2, 4, 6, 7, 9, 10, 11, and 19. Of these, RHPs 6, 9, and 10 have higher percentages of the overall population. However, less than 1% of the population resides in RHP 19, and less than 3% of the population resides in RHPs 4 and 11.

Table 7. Summary of RHPs.

RHP	N Counties	% Population	CIF-IOM Score
RHP 1	3	4.5	1
RHP 2	3	5.2	4
RHP 3	2	19.8	2
RHP 4	6	2.5	5
RHP 5	7	4.6	1
RHP 6	9	9.5	5
RHP 7	9	6.0	4
RHP 8	4	4.0	2
RHP 9	4	12.5	5
RHP 10	9	9.9	5
RHP 11	16	1.1	4
RHP 12	20	3.0	1
RHP 13	9	0.6	2
RHP 14	18	1.5	1
RHP 15	28	2.8	1
RHP 16	12	1.5	3
RHP 17	47	3.9	2
RHP 18	15	4.9	2
RHP 19	16	0.8	4
RHP 20	17	1.1	3

Demand for Peer Specialist Workforce

Whereas workforce need represents the ideal number of staff required to provide a service, workforce demand reflects how many workers employers are actually willing and able to hire at a given time. In this sense, demand acts like a water valve. It controls whether the market place can absorb the number of peer specialists in a region towards the ideal need.



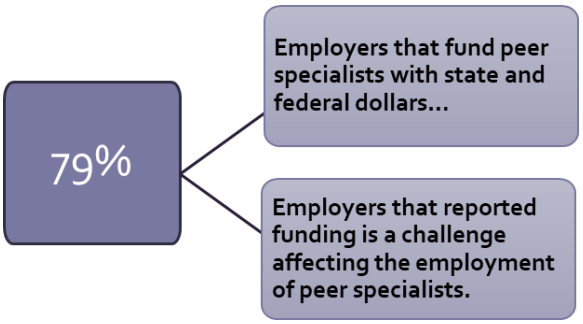
Because of limited data, it is not currently possible to determine how many peer specialists Texas employers have or are willing and able to hire. Peer specialists do not have a Standard Occupational Classification (SOC) code; this workforce is consolidated with community health workers, obscuring labor statistics that would inform demand (U.S. Bureau of Labor Statistics, 2025). In addition, our survey found that many peer specialists are recruited informally, further obscuring hiring patterns. Even so, we can understand whether more or fewer peer specialists will be employed by examining the factors that open or close "the water valve" -- in other words, economic factors that increase or decrease their demand such as system costs of opioid misuse, funding, performance, and integration. Given the demonstrated economic value of integrating peer specialist services across systems to address the impacts of opioid misuse, demand for peer specialists is expected to grow, particularly as funders reward improved outcomes, care coordination, and cost savings.

Economic Impact of Opioid Use

Because of their expertise in supporting persons with substance use issues, the demand for Recovery Support Peer Specialists (RSPS) is driven by the cost of opioid misuse and their ability to lower those costs. Nationally, the total cost of the opioid epidemic has been estimated to be $2.7 trillion (The White House, 2025). In a legislative report, Texas HHS (2025b) reported that opioid related services cost over $100 million in FY 2024. Another report estimated that the total cost in Texas was $187 billion, with a cost of $477 thousand for each person experiencing opioid misuse (Avalere Health, 2025). These astounding costs factor in loss of life, loss of quality of life, healthcare, reduced labor, and justice system costs.

Funding

Employers' willingness and capacity to hire peer specialists, particularly at a living wage, has been largely determined by funding. The needs assessment survey found that 79% of peer specialist positions in Texas are funded through state and federal contracts and grants. Consistent with this, 79% of employers cited funding as



a barrier to employing peer specialists. A separate survey of organizations providing peer and recovery services reported that government funding accounts for at least 76% of annual budgets for 64% of organizations (Earley et al., 2022). This heavy reliance on state and federal funding creates sustainability challenges for peer specialist services, especially when government priorities continually shift, as is currently occurring.

Medicaid and private insurance may be more stable funding sources for those qualifying organizations, but utilization of these sources is limited by low reimbursement and administrative requirements. Currently, the Medicaid reimbursement rate for individual (one-on-one) peer support services is $45.00/hour, which from the organizational perspective must account not only for the peer specialist's salary, but indirect administrative costs as well.

A recent report by Garuda and Stevens Manser (2025) analyzed the utilization of the peer specialist Medicaid benefit by 29 Local Mental Health Authorities and Local Behavioral Health Authorities in Texas; this study examined the total number of billed peer specialist encounter hours and the proportion of those hours that were billed under the Medicaid peer support benefit. Findings suggest that the utilization of the peer support benefit increased over a six-year period (2019 to 2024) from 39% of all billed peer specialist encounter hours to 57% (Garuda and Stevens Manser, 2025). However, there remains a significant proportion of peer specialist services billed to other peer specialist eligible Medicaid service codes. Low Medicaid reimbursement rates in Texas for peer specialist services may drive organizations to assign peer specialists to higher-reimbursing services, such as psychosocial rehabilitation, rather than to peer-specific services most aligned with the peer specialist role.

Of the respondents to our survey, only 5% of employers utilize Medicaid reimbursement to fund peer specialist positions. Most of the respondents to our survey were peer-run organizations, which historically have reported challenges meeting the administrative requirements to bill Medicaid and other insurances.

Another survey of organizations that offer peer and recovery services found that while 67% bill Medicaid and 65% bill private health insurance, this funding makes up 25% or less of the annual budget for 62% of the organizations (Earley, et al., 2022).

Performance and Savings

Demand for peer specialists is also driven by their potential to improve organizational performance and generate cost savings, essentially "paying for themselves". This becomes increasingly important as payment systems shift from fee-for-service to value-based reimbursement models. However, a key challenge remains: clearly quantifying the economic value peer specialists deliver so employers can recognize their impact and justify competitive wages.

Peer specialists strengthen and improve the effectiveness of the treatment system. They can play a critical role in engaging individuals in care, which is especially important given that many people who need treatment never access it or disengage. A recent review by Eddie, et al. (2025) found strong evidence that peer specialists are effective at linking people to care and supporting sustained engagement, largely due to their unique ability to build trust and rapport. By increasing engagement, retention, and continuity of support, peer specialists enhance overall system performance, leading to better outcomes and higher levels of client satisfaction. Moreover, cost-effective peer specialist support allows higher-paid clinicians to focus on tasks requiring their licenses, maximizing both efficiency and quality of care.

Whereas peer specialist is a workforce role, their portability, meaning their ability to deliver effective support across diverse settings, makes their services challenging to study as a discrete intervention. However, a growing body of evidence shows that the services they provide consistently add value and cost-effectiveness across a wide range of contexts.

In Texas, two studies of peer specialist services revealed potential cost savings and return on investment for organizations, communities, and society:

- The first looked at the integration of peer specialist services across state funded substance use treatment, community-based program and peer recovery organization settings. Mangrum et al. (2017) found that for 1,123 participants who received 12 months of recovery coaching, healthcare utilization decreased, which resulted in a savings of $3.2 million in healthcare costs, representing a 74% reduction in total costs. It should be noted that all the grantees in this study were required to participate in technical assistance programs that promoted recovery-oriented policies and workplaces.
- The second specifically looked at Texas peer-run organizations (PROs). Singh and Stevens Manser (2025) conducted cost-benefit analysis of three PROs that provide peer support services; the results indicated that for every dollar invested, $5.47 in economic benefits is generated.

Moreover, Castedo de Martell et al. (2025a) developed a cost-effectiveness calculator. Their analysis found that post-treatment Peer Recovery Support Services (PRSS) were cost-effective across all commonly accepted thresholds and analytic perspectives (Castedo de Martell et al., 2025).

Infrastructure to Potentially Support Demand

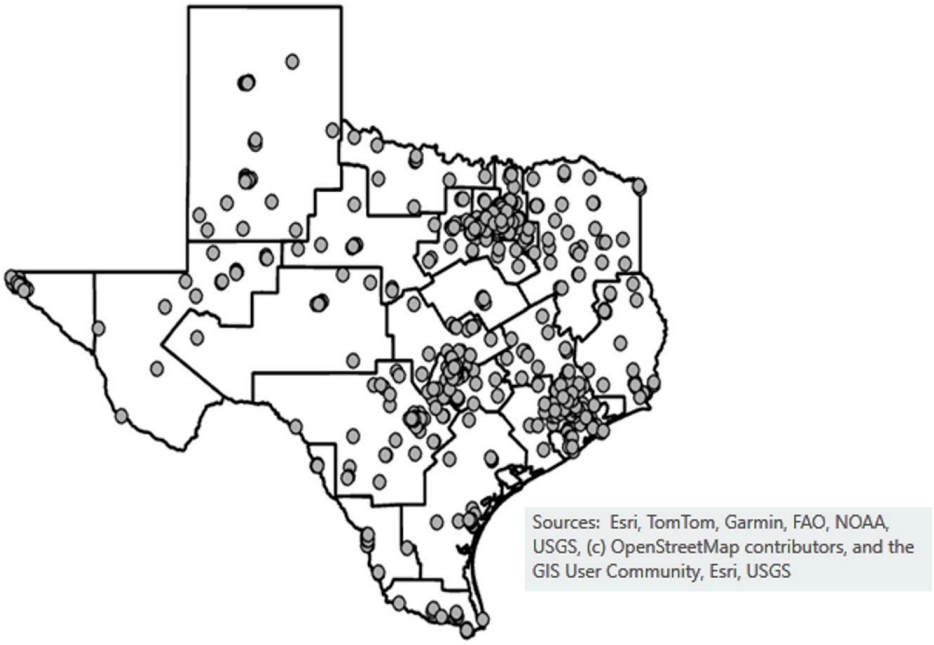
Substance and Opioid Misuse Treatment Providers

The more employers become aware of the benefits of hiring peer specialists the more organizations will seek to employ peer specialists and the greater they are in demand. This contributes to

differences in the number of employment opportunities across regions and in turn, local demand for peer specialists. Just as there can be a regional shortage of peer specialists, there can be a regional shortage of employers to hire them.

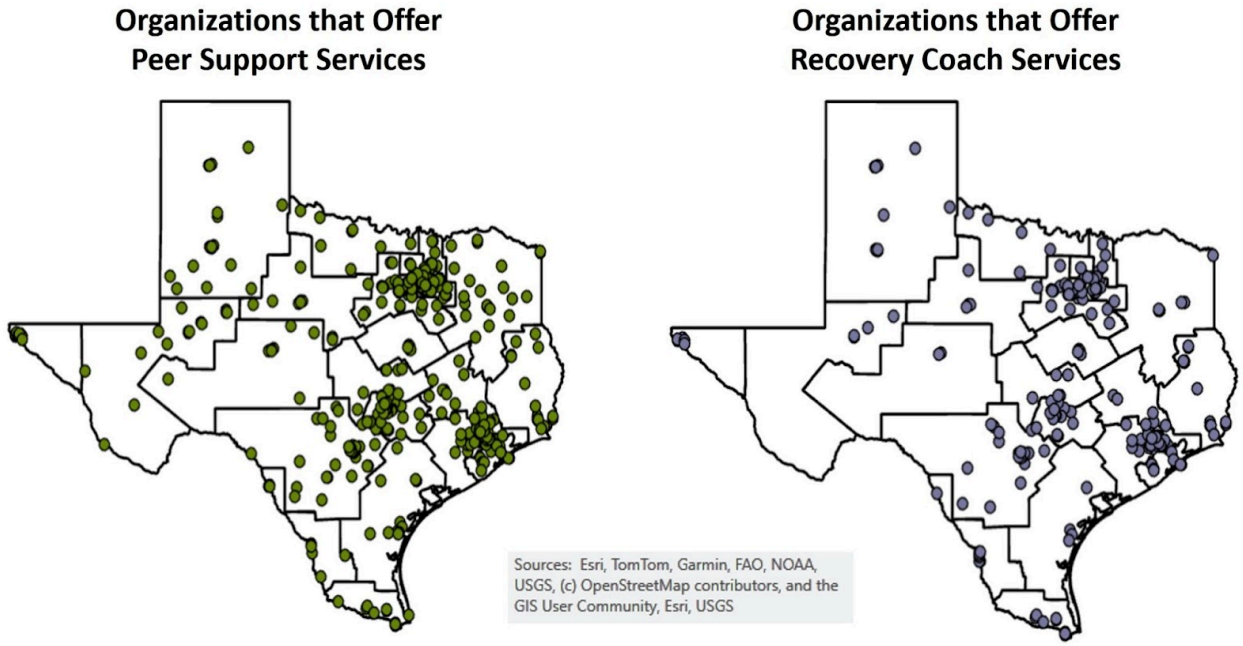
The Substance Abuse and Mental Health Services Administration (SAMHSA, 2025a) maintains a web-based directory of providers that offer substance and opioid misuse treatment. To have information reported on this site, organizations complete an application, providing their location and organizational details, including the services offered (SAMHSA, 2025b). The data were reviewed, and the organizations that offer treatment for substance and opioid misuse were identified (n=695; Figure 10). The clusters of organizations correspond to the most populous areas of Texas, where there is relatively greater demand for substance and opioid misuse services overall, as well potentially demand for peer specialists.

Figure 10. Locations of SAMHSA Find Treatment Substance and Opioid Use Treatment Providers.



Further review of the data identified which organizations offer peer specialist and recovery coach services. Of the 695 organizations, 466 (67%) offer peer support services and 228 (33%) offer recovery coach services (SAMHSA, 2025a). Figure 11 shows the locations of the organization that offer peer support (green dots) and recovery coach services (purple dots). Every region has at least one organization that offers peer support or recovery coach services. However, the maps show that the organizations are concentrated in regions with the largest Texas cities, including Houston, San Antonio, Dallas, and Fort Worth. More organizations offer peer specialist services. Several regions have relatively sparse numbers of organizations that offer recovery coach services, in particular.

Figure 11. Regional Maps of Organizations that Offer Peer Support and Recovery Coach Services.



Because these data are self-report, and organizations apply to be included, this information may not be comprehensive. However, the maps show that the most populous areas have the most providers, suggesting that demand is driven by population. Further, as will be demonstrated in the Shortage and Surplus section of this report, the clusters exist in areas where there are *not* mental health care provider shortages. Thus, the lack of demand - and the shortage of the workforce - may correspond to a shortage of employers in some regions.

Integration Across Settings

While peer specialists originally emerged within peer recovery organizations, they are increasingly integrated into a wide range of service settings that support individuals with mental health and substance use challenges.

A recent survey of 430 peer specialists identified a multitude of settings where peer specialists are employed in Texas (Figure 12; Lodge and Stevens-Manser, 2025). Flexible modeling is needed to account for diverse roles and work settings.

Figure 12. Settings where Peer Specialists Reported they are Employed in Texas.

Another recent report provided insight into how Texas Local Mental Health and Behavioral Health Authorities utilize peer specialists in various programs and settings, including:

- Crisis triage centers,
- Jail diversion centers,
- Integration in programs for specific populations, such as women and veterans,
- Community-based settings including libraries and food banks, and
- Co-response teams with law enforcement and mental health deputies (HHS, 2024a).

Some of these programs and settings where peer specialists were integrated emerged from state and federal funded initiatives. These initiatives demonstrated how funding, particularly for innovation, supports demand.

Regions that lack service provider capacity may have less demand, but not less need. Unaddressed behavioral health issues shift away from healthcare to different sectors, such as criminal justice. In rural areas, this adds further stress to limited resources. However, the potential of the peer specialist workforce lies in their ability to offer support in non-traditional and non-clinical settings. Peer specialists inherently meet people where they are at. The milieu of peer support can be anywhere people congregate in their community, including churches, feed stores, gas stations, libraries, and so on. Demand, created through funded innovative initiatives, serves to activate the potential of the workforce.

Supply of Peer Specialist and Supervisor Workforce

For the purpose of this needs assessment, peer specialist supply is defined by the number of individuals who hold Texas credentials eligible for Medicaid reimbursement. Although multiple peer support certifications exist, the state prioritizes Medicaid-billable credentials, which represent the largest, most widely recognized and best documented segment of the certified peer specialist workforce. Texas Medicaid-billable peer specialist credentials include: Recovery Support Peer Specialists (RSPS), Mental Health Peer Specialists (MHPS), and, as of March 1, 2025, Certified Family Partners (CFP). Although peer specialists can be found across the state, they are concentrated in metropolitan areas. The extent to which peer specialists who live in metropolitan areas are serving individuals who live in non-metropolitan areas is unknown.

Supply of Peer Specialists

As of May 2025, approximately 1,560 individuals in Texas held at least one active, full peer specialist certification that qualifies their services to bill Texas Medicaid, including RSPS, MHPS, and CFP credentials, according to Texas Certification Board (TCB) data. Of these, 248 (16%) held multiple credentials (TCB, personal communication, May 29, 2025). Table 8 provides a breakdown by certification type, including 822 RSPS with specialization in opioid use and other substance use disorders.

Table 8. Number of Peer Specialists with Active, Full Certification By Type.

Texas Medicaid billable credentials	N Certifications	% of All Certifications
Recovery Support Peer Specialists (RSPS)	822	45%
Mental Health Peer Specialists (MHPS)	819	45%
Certified Family Partners (CFP)	167	9%
Total credentials	1,808	100%

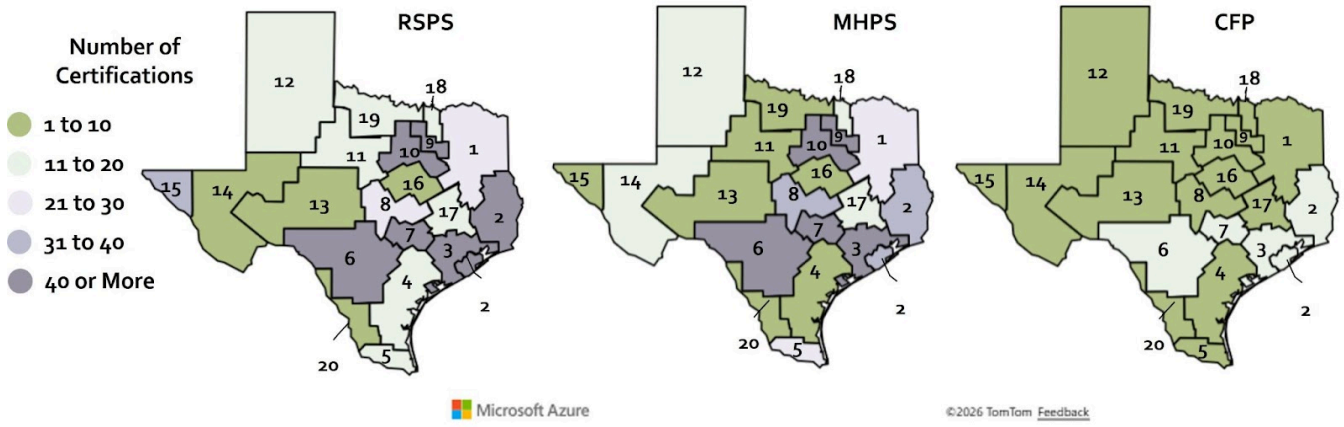
In addition, TCB (personal communication, May 29, 2025) reported 19 RSPS-Interns and 7 MHPS-Interns. Intern is provisional designations given to individuals who did not pass the background check which allows them to be credentialed and employable (B Sepulveda, personal communication, December 10, 2025). Since they are not fully credentialed, Interns' services are not Texas Medicaid billable.

Distribution of Peer Specialists

As expected, peer specialists are more heavily concentrated in regions with larger populations. Figure 13 illustrates the regional distribution of fully certified RSPS, MHPS, and CFP. Peer specialists are present across all regions of Texas, with the highest concentrations of RSPS and MHPS located in

Regional Health Partnerships (RHPs) 3, 6, 7, 9, and 10, and more moderate concentrations in RHPs 2 and 8. Notable regional variations exist, for example, include a higher concentration of RSPS than MHPS in RHP 15 and a higher concentration of MHPS than RSPSin RHP 8.

Figure 13. Regional Distribution of Active Peer Specialist Certifications.



Further analysis examined whether peer specialists with active certifications are in areas designated as metropolitan or non-metropolitan (Table 9). The majority of all certified peer specialists (85%) reside in metropolitan areas. The percentages of individual certification types that reside in metropolitan areas range from 79 to 95%. Relatively fewer CFPs reside in metropolitan areas (79%).

Table 9. Metropolitan or Non-Metropolitan Designation of Active Peer Specialist Certifications.

Certification	Metropolitan		Non-Metropolitan	
	N*	%	N	%
RSPS	748	95%	40	5%
MHPS	721	93%	53	7%
CFP	110	79%	29	21%
TOTAL Unduplicated	1356	93%	104	7%

*Location data were not provided by all individuals.

As highlighted in Table 9, the supply peer specialists living in non-metropolitan areas of Texas remains extremely limited, a challenge magnified by the fact that Texas has the nation's largest non-metropolitan geography and one of the largest non-metropolitan populations. This shortage reflects broader gaps in the state's behavioral health infrastructure and service capacity in non-metropolitan communities, which are frequently served through telehealth or satellite sites affiliated with clinical parent organizations based in metropolitan areas.

As a result, most individuals holding fully certified, Texas Medicaid-billable peer specialist credentials are concentrated in metropolitan regions. This distribution is expected given higher population density, greater availability of resources that support certification, such as training entities, qualified supervisors, field placement opportunities, and a wider range of employment options in metropolitan

markets. However, this pattern also underscores a structural mismatch between where peer support is most needed and where the peer specialist workforce is currently able to be trained, certified, supervised, and sustained, limiting the reach and effectiveness of peer services in non-metropolitan and frontier communities. The disparity in supply cannot be solved by increasing the number of peer specialists in a region, when there is no organization where to employ them.

The extent to which non-metropolitan and frontier populations (that is, areas of very low population and remoteness from metropolitan areas; HHS,2025c) in Texas are being served by peer specialists who reside in metropolitan areas remains largely unknown due to limited workforce and service delivery data. However, this needs assessment captured several anecdotal stories that illustrate how peer support is currently being accessed into non-metropolitan communities.

First, individuals living in non-metropolitan areas frequently travel to metropolitan regions to access behavioral health services, including peer support, reflecting longstanding gaps in local service availability. Similarly, many Local Mental Health Authorities (LMHAs) and Federally Qualified Health Centers (FQHCs) operate with a centralized administrative and clinical hub in a metropolitan area, supplemented by satellite clinics in non-metropolitan or frontier communities that offer services on a limited schedule, often only a few days per week. Peer specialists employed by these organizations commonly commute from the metropolitan-based central office to multiple satellite locations, providing intermittent in-person services across a wide geographic area.

In some regions, a single peer specialist based in a metropolitan area is responsible for covering multiple surrounding non-metropolitan and frontier communities, effectively functioning as a traveling workforce. Telehealth has emerged as a practical and increasingly relied-upon solution to extend peer support in these contexts, allowing peer specialists to remain located in metropolitan areas while serving clients in their homes, at satellite clinics, or in nontraditional settings. This approach has proven particularly relevant for populations such as oil field workers, agricultural workers, and long-haul truck drivers, whose work schedules and mobility make consistent, place-based services difficult.

For institutionalized individuals, including those in correctional settings, peer specialists have also adapted service delivery models through low-tech approaches such as structured letter-writing campaigns, as well as through email and secure online platforms where permitted. These modalities show additional promise by enabling peer specialists and participants to engage across geographic boundaries, and in some cases across time zones, further decoupling service delivery from physical proximity.

Finally, managed care organizations increasingly utilize telehealth-based peer specialists as part of network adequacy and care coordination strategies, reinforcing the role of remote peer support in reaching underserved areas. Collectively, these case examples suggest that while metropolitan-based peer specialists are playing a critical role in extending services into non-metropolitan Texas, reliance

on commuting, telehealth, and remote models raises important questions about service intensity, continuity, cultural relevance, and the long-term sustainability of non-metropolitan peer support without locally rooted workforce capacity.

Peer Specialist Supervisors

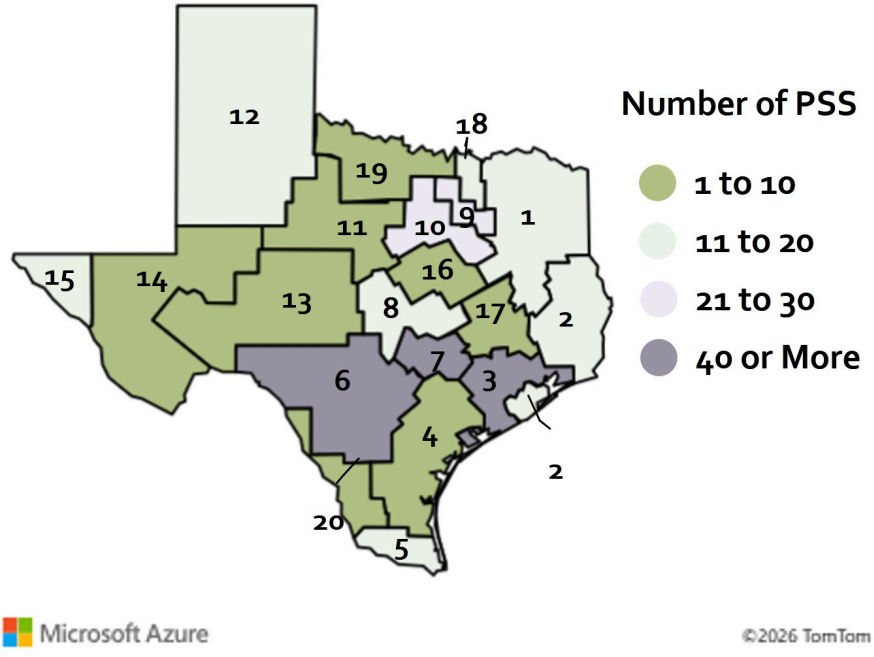
Supervision in the behavioral health workforce is a structured process in which an experienced professional guides and evaluates a less experienced colleague to ensure quality care, promote professional growth, and meet regulatory requirements. It emphasizes skill development, ethical practice, and self-care through regular sessions, case reviews, and ongoing support. Certified Peer Specialist Supervisors (PSS) play a critical role at two points: during the 250 hours of work experience required for full certification, and continuously throughout a peer specialist's employment, especially when providing Texas Medicaid–billable services.

367

Certified Peer Specialist Supervisors (PSS)

As of May 2025, there were 367 certified PSS (TCB, personal communication, May 29, 2025). Most of these PSS are in RHPs 3, 6, and 7, with a smaller concentration in RHPs 9 and 10 (Figure 14). All regions have at least one certified PSS. The majority of PSS are in metropolitan counties (N=326, 93%). Virtual supervision is allowed, which means that peer specialists in one region can access qualified supervision from a PSSsomeone in another region.

Figure 14. Certified Peer Specialist Supervisors.



Peer focus group participants pointed out the importance of supportive supervisors for peer specialists. For example, one participant said: "I have been fortunate enough to work for an organization with supervisors that are supportive. I learn from them and lean on them when needed." Research has found that supportive supervisors who understand the peer specialist job role are key to peer specialists job satisfaction (Kuhn et al., 2015).

Resources

A key factor influencing the supply of peer specialists is the availability of resources that support the workforce. Conversely, shortages of these resources can limit the number of peer specialists in certain areas. Peer specialists rely on a variety of supports to complete training and certification, advance professionally, and provide effective services. Essential resources for supporting the peer specialist workforce include federal and state funding, supportive policy, certification and training programs, statewide initiatives, professional networks, gatherings, research-based guidelines, advocacy and awareness efforts, and peer recovery organizations. However, reductions in federal funding have limited the availability of some of these resources, constraining efforts to expand and sustain the supply of qualified peer specialists.

Federal and State Support

The growth of the peer specialist workforce has been driven largely by leadership and investment from federal and state governments, which function as critical resources that set professional standards, financed training and certification, and created sustainable reimbursement pathways that enable workforce expansion.

Federal Support

At the federal level, the Substance Abuse and Mental Health Services Administration (SAMHSA):

- Elevated peer specialist services as an evidence-based practice;
- Developed core competencies and incorporated the role into national behavioral health strategies; and
- Initiated grant programs and workforce development initiatives.

The Centers for Medicare & Medicaid Services (CMS) accelerated expansion by authorizing Medicaid reimbursement for peer specialist services in 2007, creating a sustainable financing pathway for peer-delivered care in Medicaid authorized organizations. More recently, from 2020 to 2024, the Health Resources and Services Administration (HRSA) awarded $25,140,848 into Texas organizations through its Behavioral Health Workforce Education and Training (BHWET) Program, which explicitly included peer specialists, strengthening training pipelines and workforce capacity across the state (Table 10). In addition, HRSA awarded a $900,000 Opioid Workforce Expansion Program (OWEP) grant to the University of Texas Health Science Center in Houston to increase the number of peer specialists in Texas from 2019 to 2023 (University of Texas Houston, 2019).

Table 10. HRSA BHWET Program Funding, 2020 to 2024.

HRSA Behavioral Health Workforce Education and Training Program (M01)					
2020	2021	2022	2023	2024	Total
$4,003,792	$6,429,445	$5,313,235	$4,924,996	$4,469,380	$25,140,848

However, recent federal funding cuts will reduce the very resources that have driven peer workforce expansion. As these resources decline, the capacity to recruit, prepare, and sustain peer specialists is constrained, slowing workforce growth and limiting the system's ability to respond to rising behavioral health and substance use needs.

The SUPPORT for Patients and Communities Reauthorization Act of 2025 (H.R. 2483), signed into law on December 1, 2025, extends critical substance use disorder and mental health programs through FY2030, including support for the professional development of peer support specialists. However, funding for these programs depends on future appropriations, and without dedicated funding, the resources necessary to sustain and grow the peer workforce remain uncertain.

State Support

At the state level, agencies have translated federal guidance into action:

- The Texas Health and Human Services (HHS) system has funded and implemented multiple peer specialist initiatives. Within HHS, The Peer and Recovery Services Programs, Planning, and Policy Unit was established to provide centralized guidance, oversight, and resources for the expanding peer workforce. HHS has utilized multiple federal grant programs, state grants, and state general revenue to fund peer specialist services across a range of clinical and nonclinical settings as well as supported peer specialist workforce development.
- The Texas Veterans Commission (TVC) provides training, technical assistance, and certification for Military Veteran Peer Network (MVPN) coordinators and partners with Local Mental Health Authorities (LMHAs) who employ the peer staff, creating a statewide peer-to-peer support system funded through grants like the Fund for Veterans' Assistance (FVA).
- The Texas Department of Criminal Justice (TDCJ) Rehabilitation and Reentry Division has a specific Peer Support Services program aimed at developing qualified peer support specialists to work within correctional and community settings. As part of reentry efforts, TDCJ coordinates with other agencies and contracted vendors to provide peer support services to individuals transitioning back into the community.
- The Texas Workforce Commission (TWC) provides financial aid for MHPS and RSPS training through the skills development fund (TWC, 2025).

- In 2025, the Opioid Abatement Fund Council (OAFC) awarded RecoveryPeople a grant of up to $10 million to implement strategies that will increase the number of individuals in the peer-to-peer workforce, remove barriers to enrollment in and completion of peer certification programs, and provide resources and assistance in obtaining and retaining employment for peers in the workforce.

These resources collectively strengthen and expand the peer specialist workforce across systems and communities.

Certification and Training Programs

Certification boards and training programs are vital resources for supporting the workforce. Credentialing ensures that peer specialists meet professional standards, provide high-quality services, and safeguard the public. Formal training programs equip individuals with the knowledge, skills, and competencies needed to earn certifications such as Recovery Support Peer Specialist (RSPS), Mental Health Peer Specialist (MHPS), and Certified Family Partner (CFP).

Certification Board

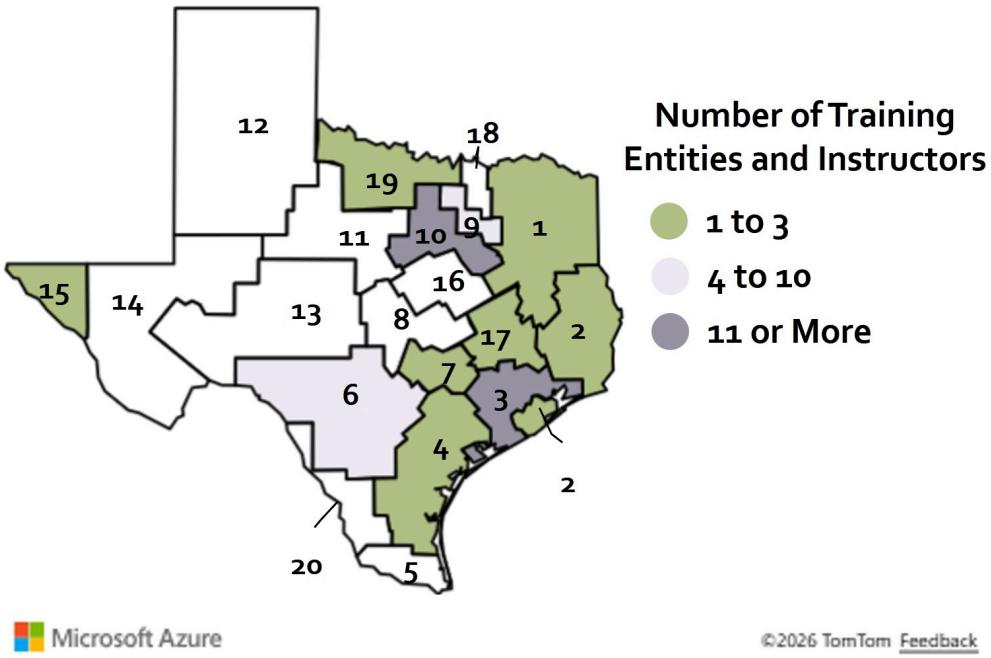
The Texas Certification Board (TCB), an independent arm of the Texas Association of Addiction Professionals (TAAP), is committed to setting professional standards and protecting the public interest. In addition to certifying peer specialists, TCB accredits training programs and continuing education providers. Participants in the needs assessment focus groups recognized TCB as a supportive organization, noting that it "does a good job with minimal staff."

Training Entities

Only TCB approved instructors or training entities can provide Medicaid billable peer specialist and peer specialist supervisor training (i.e., MHPS, RSPS, and PSS). TCB publishes an updated list of approved instructors and training entities on a monthly basis; however, this list fluctuates considerably over time (TCB, 2025a). This ongoing variability may create confusion for prospective students and contribute to challenges in identifying currently approved training options and available class schedules.

As of December 2025, there are 50 approved instructors and training entities, of which 10 are instructors, 39 are training entities, and one is both. Figure 15 maps them across Texas. Most are located along the south-central and eastern areas of the state; regions 3, 6, and 10 have the most training entities. While most training entities seem to be in metropolitan areas, 48% offer virtual training. *This means Regions with no training entities still have access to training.*

Figure 15. Training Entities and Instructors.



Beyond TCB approval, at least one person from each training organization must be eligible for and complete a Training of Trainers (ToT) on the latest version of each curriculum. While this requirement supports quality, it can create a bottleneck when curriculums are updated. Consequently, the number of training organizations able to offer Medicaid-billable peer specialist and supervisor training may be lower than the total number of approved entities.

Statewide Workforce and Leadership Development

Several statewide initiatives have helped individuals advance toward credentialing and career development, whether as peer specialists, managers of peer recovery organizations, or policy specialists.

- **PeerForce** is a workforce development initiative supported by Form Communities and funded by HHS, which offers a free resource hub for the mental health and substance use peer workforce. It helps individuals build careers using lived experience in recovery by connecting them with training, certification support (MHPS, RSPS, CFP, PSS), financial aid, job listings, and internships. Acting as a central coordinator, PeerForce guides both aspiring peer specialists and organizations through the TCB process, provides one-on-one career support, links to certified trainers, offers vouchers for training and supervision, and helps employers find and hire qualified peer specialists—all at no cost. PeerForce provides training scholarships and apprenticeship stipends; provides extensive information and access to resources that support

peer specialists through the entirety of the training and certification process; and connects peer specialists to supervisors and employers (PeerForce, 2025a).

- Peer Organization Growth Academy (POGA) was a peer-led capacity-building initiative that strengthened peer-run organizations and advanced leadership pathways within the peer workforce from 2021 to 2025. POGA equipped peer leaders with skills in organizational development, governance, financial sustainability, advocacy, and systems navigation by enabling peers to move into supervisory, executive, training, and systems-level roles and expanding career mobility beyond direct service positions. POGA was developed by peer-run organization leaders in partnership with the Texas Institute for Excellence in Mental Health (TIEMH) and funded through HHS.
- Peer Policy Fellowship was a part of a statewide initiative by the Hogg Foundation for Mental Health aimed at increasing the role of people with lived experience of mental health and/or substance use conditions in public policy and advocacy work in Texas. The policy fellowship program started in 2015 and ended in 2025.
- Peer-to-Career is a comprehensive workforce development program that supports people in recovery from mental health and substance use challenges in achieving their peer certification and advancing their careers. As the name implies, the program engages peers early in the process and supports them through credentialing and on to employment. The program provides financial assistance to cover training, supervision, and certification fees. Beyond financial support, Peer-to-Career Specialists offer personalized, one-on-one guidance. An online Resource HUB provides learning materials, continuing education, and practical guidance, while a dedicated network fosters virtual learning communities and mentorship opportunities to strengthen professional connections and growth. Because a rewarding career is the ultimate goal and demand can vary fromRegion toRegion, Peer-to-Career also partners with employers to connect participants with meaningful field experience and employment opportunities. Peer-to-Career is funded by the Opioid Abatement Council ...
- Peer and Recovery Organization Sustainability, Planning, Education and Research (PROSPER) is a statewide initiative led by RecoveryPeople, supported by a SAMHSA Center for Substance Abuse Recovery Community Services Program-Statewide Network (CSAT RCSP-SN) grant, that strengthens the capacity of Peer and Recovery Organizations (PROs) through leadership development, training and technical assistance.
- Transformational Leadership Development Program is a leadership development initiative focused on cultivating peer leaders, supervisors, and system-level changemakers with lived experience. The program strengthens the peer workforce by supporting career mobility beyond entry-level roles, preparing peers for positions in supervision, training, advocacy,

organizational leadership, and systems transformation across urban and rural regions. This program is funded by and continues to be offered by HHS.

Associations

Several labor and employer associations provide peer specialists with opportunities for advocacy, networking, skill development, and/or knowledge sharing. Some of these associations are already strong supporters of the peer workforce, while others represent emerging resources as they begin hiring more peer specialists and expanding their engagement in peer-focused initiatives.

- **American Association for the Treatment of Opioid Dependence (AATOD)** is the national professional association representing more than 1,400 opioid treatment programs in the U.S., with state chapters including Texas. AATOD strongly supports peer specialists as vital members of the treatment team, viewing them as essential for promoting recovery, building hope, and helping individuals develop their own recovery plans by sharing lived experience in non-clinical roles, complementing formal treatment, and improving patient engagement and outcomes in opioid treatment programs (OTPs).
- **Association of Substance Abuse Programs (ASAP)** is a nonprofit membership association representing community-based substance use prevention, treatment, and recovery organizations across Texas. The association provides access points for providers and peer specialists to engage in advocacy, professional education, networking, and shared learning focused on strengthening the substance use workforce. Through conferences, training, and policy engagement, ASAP supports workforce development and collaboration to improve service quality and outcomes for individuals and families affected by substance use disorders.
- **Employee Assistance Professionals Association (EAPA)** is the largest membership organization for employee assistance professionals in the U.S. It has local chapters across Texas that promote best practices, professional development, training, networking, and high standards in the EAP field.
- **Texas Association of Accountable Care Organizations (TXAACOs)** is a statewide association supporting organizations that deliver value-based, coordinated care. While membership extends beyond managed care organizations, many members engage with managed care networks or operate within managed care frameworks, contributing to the transformation of care delivery across Texas.
- **Texas Association of Addiction Professionals (TAAP)** is a 501(c)(6) nonprofit that unites and empowers addiction counselors, prevention specialists, and recovery support professionals (e.g., MHPS, RSPS, PRSS, JI-PS) across Texas. Through advocacy, education, certification, and ethical standards, TAAP works to improve treatment and recovery for people with substance

use disorders. The organization influences policy, provides professional development, and maintains a network of local chapters that host regular meetings and events. TAAP also organizes an annual state conference, which includes a peer specialist track and, starting in 2025, a peer specialist career fair. Historically, HHS has provided funding to help peer specialists attend the conference. In partnership with the Association of Substance Use Programs and RecoveryPeople, TAAP advocates for workforce policy and hosts events such as the ABCs of Advocacy and Recovery Day at the Capitol.

- **Texas Association of Community Health Centers (TACHC)** is a non-profit organization that serves as the primary care association (PCA) for the state of Texas. TACHC's members include federally qualified health centers in the state and other providers who strive to meet the health care needs of the uninsured and underserved.
- **Texas Association of Community Health Plans (TACHP)** represents Medicaid and CHIP managed care plans that are owned by Texas public or nonprofit health systems. It focuses on collective efforts to improve accessible, quality, and cost-effective care for Texans.
- **Texas Association of Health Plans (TAHP)** is the statewide trade association representing health insurers, health maintenance organizations, and Medicaid managed care organizations operating in Texas. It engages in advocacy, policy, and networking on behalf of its member plans.
- **Texas Association of Pretrial Services (TAPS)** is a non-profit professional organization in Texas focused on pretrial justice and pretrial services—the part of the criminal justice system that deals with individuals after arrest but before trial. Its goal is to support, improve, and advocate for fair, constitutional, and evidence-based pretrial practices across Texas.
- **Texas Council of Community Centers (Texas Council)** represent the 39 public Community Centers, including Local Mental Health Authorities (LMHA) and Local Behavioral Health Authorities (LBHA) throughout Texas that provide services and support for people with intellectual and developmental disabilities or mental health and substance use challenges. Its membership is one of the largest employers of peer specialists in Texas. The Texas Council Conference invites peer specialists to earn required CEUs and connect with others and offers some opportunities for peer specialist presentations and collaboration. Historically, HHS has provided funding to help peer specialists attend the conference.
- **Texas Hospital Association (THA)** is a nonprofit trade organization representing over 85% of hospitals and health care systems in Texas. Its member hospitals increasingly recognize the value of peer specialists—individuals with lived experience in mental health or substance use recovery—who provide support, advocacy, and care navigation services to patients, helping improve outcomes and patient engagement across clinical and community settings.

- **Texas Peer Professionals (TPP)** - Peer specialists from across the mental health and substance use recovery communities held organizing meetings in 2025 to explore the creation of a peer professional association or labor union. This statewide initiative aims to strengthen peer professional identity and workforce capacity by centering lived experience, leadership, and recovery-oriented peer support across Texas.
- **Texas Managed Care Alliance (TMCA)** is a formal alliance of Medicaid health plans (i.e., managed care organizations) in Texas that work together to support high-quality care for vulnerable Texans, strengthen the Medicaid managed care model, and advocate for fair and competitive contracting policies and practices.
- **United States Association of Opioid Treatment Providers (USAOTP)** is a nonprofit association with roots in Texas and a long history of representing opioid treatment providers. It began in the early 1990s when methadone treatment providers in Texas came together to form what was originally the Texas Methadone Treatment Association to advocate for and support treatment programs. Over time, the organization expanded its scope beyond Texas and became USAOTP to reflect a broader membership of opioid treatment professionals.

Statewide Meetings and Events

Peer specialists often seek out networking groups and professional meetings because these spaces provide critical opportunities for connection, learning, and support. Working in the behavioral health field can be challenging and isolating, and peer specialists benefit from sharing experiences, strategies, and resources with colleagues who understand the unique demands of the role. Networking groups and meetings also offer avenues for skill development, mentorship, and staying up to date on best practices, certification requirements, and workforce initiatives. By participating in these communities, peer specialists strengthen their professional competencies, enhance service quality, and build a sense of shared purpose and support within the workforce.

- **commUNITY Conference**, co-hosted by Unity Recovery in 2025, brought together peer support workers, people with lived experience, recovery community organization staff, advocates, policymakers, and other stakeholders focused on peer-designed and peer-led recovery services. The conference includes plenary sessions, workshops, and presentations on peer recovery support services, harm reduction, peer-run housing, workplace readiness, supervision, advocacy, and other workforce-relevant topics. The 2026 conference will be held in Philadelphia.
- **PeerFest** is an educational and celebratory gathering hosted by the Hogg Foundation for Mental Health created by and for individuals with lived experience of mental health challenges. Rather than a traditional clinical or provider-led conference, it emphasizes wellness, recovery, connection, and community. Launched in 2015, PeerFest was designed to create a supportive

space in Texas where people on their recovery journeys can learn from one another and build practical tools for wellness. The event elevates lived experience as a form of expertise, with individuals who have navigated mental health challenges playing a central role in shaping, planning, and leading the event.

- **Peer Visioning Summit** is a workforce-focused convening for peer specialists and family partners to come together, share perspectives, and shape the future of peer roles and recovery-oriented services. It is supported by HHS in partnership with the Addiction Research Institute.
- **Virtual meetings** hosted by HHS include monthly peer and recovery services calls that center the peer specialist workforce, providing a statewide space for information sharing, updates, and limited workforce dialogue.

Research and Evidence-Based Guidelines

Multiple universities across Texas have collaborated with peer specialists and peer-run organizations by providing evaluation and research support, serving as fiscal agents for peer specialist related funding, developing training resources, expanding the evidence base for peer support practice, and partnering to strengthen workforce infrastructure.

- **Addiction Research Institute (ARI),** part of the University of Texas at Austin School of Social Work, aims to drive system change across the addiction recovery continuum through innovative research, education and training, advocacy, and partnerships. ARI developed and launched newly revised peer specialist CORE, Recovery Support Peer Specialist (RSPS), Mental Health Peer Specialist (MHPS), and Peer Specialist Supervisor (PSS) curricula, designed to be more closely aligned with peer specialist values. As of December 2025, the Certified Family Partner (CFP) training is still under development. ARI also serves as a South Southwest Addiction Technology Transfer Center, providing technical assistance to the field.
- **Latino Alcohol and Health Disparities Research & Training Center (LAHDR)** supports peer-informed practice by conducting culturally grounded research and community-engaged training focused on reducing alcohol-related health disparities among Hispanic/Latinx populations, informing peer support strategies in border, rural, and underserved communities.
- **Meadows Mental Health Policy Institute** supports the peer specialist workforce and individuals with substance use disorders through research-driven policy, system design, and implementation support. MMHPI elevates the role of peer specialists and community health workers as workforce extenders, advances integrated mental health and substance use care in primary and justice-health settings, and promotes crisis and diversion models that reduce justice involvement and improve access to recovery-oriented services.

- **Peer Recovery Innovation Network (PRIN)** at the University of Texas Health Science Center at San Antonio (UT Health San Antonio) is a recovery science initiative designed to expand the evidence base for peer recovery support services (PRSS) and recovery support services (RSS) through research, training, and stakeholder engagement. PRIN establishes a Recovery Science Collaboratory that brings together scientists, peers with lived experience, and community partners to accelerate innovation in recovery science; offers training, telementoring, and webinars to grow a skilled recovery science and peer support workforce; and disseminates research findings to inform policy, practice, and workforce development statewide.
- **Texas Institute for Excellence in Mental Health (TIEMH)**, part of the University of Texas at Austin School of Social Work, leverages state expertise to strengthen the workforce, expand knowledge of effective mental health practices, and share research-supported strategies for promotion, prevention, and intervention. TIEMH has conducted numerous evaluations and published research on peer specialists, focusing on workforce development in Texas, employment outcomes, and the effectiveness of peer support services. Before recent funding cuts, TIEMH served as a South Southwest Mental Health Technology Transfer Center, providing technical assistance to the field. TIEMH currently serves as the Southwestern Plains Hub of the Center for Mental Health Implementation Support.
- **UTHealth Houston's School of Public Health** is actively conducting research and developing programs to expand the RSPS workforce in Texas. Through the BHWET Recovery Support Peer Specialist Fellowship Program, researchers collaborate with community partners to address critical shortages of certified peer specialists, particularly in underserved rural and urban areas. Research associated with the program is generating data on training effectiveness, workforce integration, and the impact of peer specialists on patient engagement and recovery outcomes, informing evidence-based strategies for scaling the peer support workforce statewide.

Advocacy and Awareness

- **ABCs of Advocacy** is a training event designed to build and strengthen advocacy skills, especially within the recovery community. It's a practical, interactive program that helps participants learn how to effectively influence policy and communicate with lawmakers and decision-makers. It is offered biennially (every two years) and is co-hosted by organizations such as RecoveryPeople, the TAAP, and ASAP.
- **Big Texas Rally for Recovery** are community-focused celebrations and awareness events held across Texas each September during National Recovery Month to honor and uplift people in recovery from substance use and mental health challenges across Texas.

- **Humanly Possible** is a documentary series that highlights the history of recovery in Texas and elevates lived experience and recovery leadership through compelling storytelling. New episodes premiere each September during National Recovery Month.
- **Recovery Day at the Capitol** is an annual advocacy event held during the state's legislative session that brings together people in recovery, family members, providers, and allies from across the state to champion policies and funding that support substance use prevention, treatment, recovery, and related services. Co-sponsored by major recovery advocacy groups: It is organized by RecoveryPeople, ASAP, and TAAP, uniting a broad coalition working to influence public policy in Texas.
- **Texas Coalition for Healthy Minds** is a statewide advocacy coalition founded informally in 2011 and more formally organized in 2015 to coordinate behavioral health policy efforts across Texas. It includes more than 35 member organizations representing a broad array of stakeholders working together to improve mental health and substance use disorder systems, workforce capacity, and access to care through policy education and legislative engagement.

Peer Recovery Organizations

Peer Recovery Organizations (PROs) are a collection of peer-led, community-based business models that provide mental health and/or substance use (MH/SU) recovery support services. These organizations were the originators of many peer roles; for instance, peer specialists first emerged from recovery community organizations (RCOs) and consumer-operated service providers (COSPs). PROs serve as a valuable resource for peer specialists seeking personal growth, professional development, and career support. They also provide an important bridge for clinical and institutional organizations that may lack recovery-ready workplaces or cultures, offering the ability to contract PROs to deliver peer specialist services and integrate lived-experience expertise into their programs.

PROs can generally be categorized based on their governance structures and the socio-ecological environments in which they operate. Drawing on Oldenbury's framework, these environments can be understood as: First Place—where individuals live; Second Place—where they work; and Third Place—where, how, or with whom they connect around shared interests or activities. Examples of each are listed below (Figure 16).

Figure 16. PRO Categories.

Peer Recovery Organizations (PROs)				
How they're governed	"First Place" Where you live	"Second Place" Where you learn or work	"Third Place" Where, how or with whom you connect	
Recovery Community Organizations (RCOs) Consumer Operated Service Providers (COSPs)	Recovery housing Peer respites	Recovery high schools Collegiate recovery centers and programs Recovery social enterprises	Recovery cafes Community centers Clubhouses	Activity groups Youth groups Professional groups

Shortage/Surplus

Texas faces a significant shortage of peer specialists. Based on the data presented earlier, Texas needs 96,000 peer specialists, including 31,000 Recovery Support Peer Specialists (RSPS), while the documented supply is only 1,560, including 822 RSPS. Although this gap does not account for economic factors that may limit demand, the well-documented mental health workforce shortage further reinforces that Texas is critically lacking peer specialists.

Nearly all of Texas is experiencing a mental health workforce shortage, meaning there are more available positions than qualified workers. However, these shortages do not always align with a region's population size or opioid impact, so decisions about workforce development resources allocation should consider the degree of workforce shortage.

Some unemployed individuals seeking work as peer specialists may question the workforce shortage, citing difficulty finding employment and wondering if regional pockets exist where the supply of peer specialists exceeds available jobs. Despite clear evidence of an overall shortage, certain factors appear to limit employment for some peers. Further research is needed to better understand whether this is due to low demand, inefficient labor markets or other barriers.

Shortages of Providers

The Health Resources and Services Administration (HRSA) is an office of the U.S. Department of Health and Human Services that oversees funding and programs that build the health infrastructure, train healthcare providers, and provide needed services (HRSA, 2025a). One program monitors shortages of healthcare providers and designates areas as Health Professional Shortage Areas (HPSAs); when shortages exist, HPSAs may be designated for primary care, dental, or mental health care providers (HRSA, 2023). States Primary Care Offices (PCOs) apply for shortage designations through the HRSA website (HRSA, 2025b). The Texas Primary Care Office is housed within the Texas Department of State Health Services (HHS, 2025c).

HRSA identifies shortage areas in three ways:

- **Geographic HPSA** – represents a shortage of providers in a defined geographic area (e.g., county);
- **Population HPSA** – represents a shortage for a group of people within a geographic area (e.g., low-income populations); and
- **Facility HPSA** - represents a shortage in facilities in areas (HRSA, 2023).

This report presents only the Geographic HPSAs (i.e., counties) for mental health care providers, because it is the most relevant to peer specialists, and because policy planning initiatives typically name peer specialists as a workforce to develop to alleviate mental health provider shortages (U.S. Council of State Governments, 2024). Moreover, the use of Geographic Health Professional Shortage Areas (HPSAs) provides a more standardized and defensible method for prioritizing workforce shortages in rural and underserved regions. This approach improves upon simplistic methods that subtract theoretical regional need from existing supply without accounting for economic demand,

service utilization, or market feasibility, and allows shortages to be identified in a way that is more consistent with established health workforce planning practices.

In Texas, 199 (78%) of the 254 counties are designated HPSAs for mental health care providers. For 197 counties, the designation applies to the whole county. Two counties, Lubbock and Nueces, have portions of the county designated, but are still considered Geographic HPSAs. Figure 17 illustrates the HPSA designated counties within the Regional Healthcare Partnership (RHP) areas.

Figure 17. Map of Mental Health Care HPSA Geographic Areas (Counties) within RHPs.

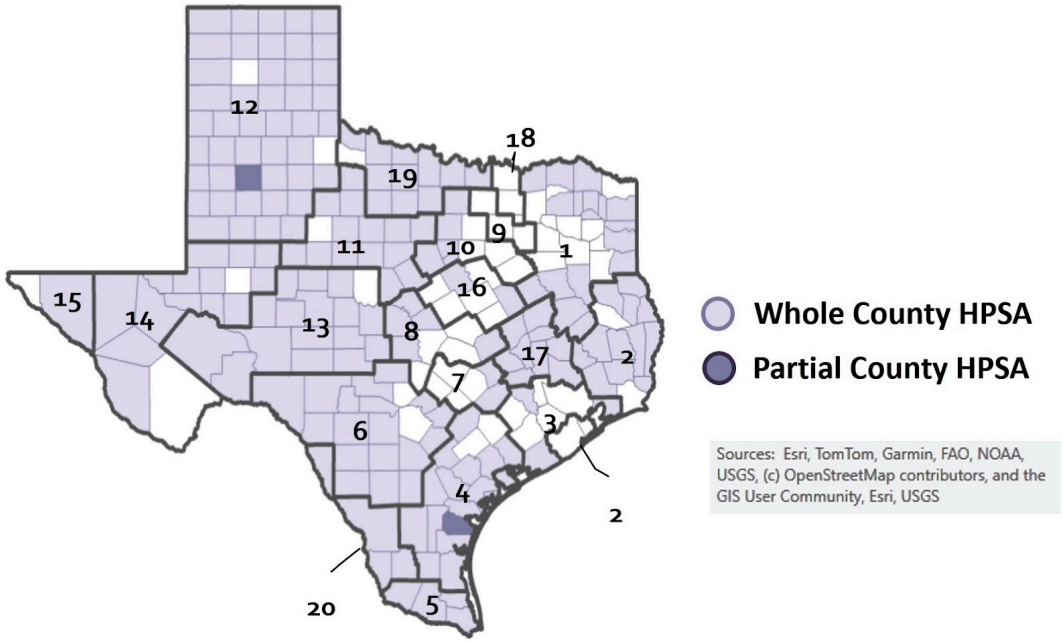


Table 11 lists the number and percentage of counties in each RHP designated as a HPSA for mental health care providers. Fifteen regions have at least half or more of the counties that are designated HPSAs. For three regions, all counties are designated HPSAs (RHPs, 5, 17, and 20). RHPs 6, 11, 12, 13, and 19 have 90% to 96% of the regions' counties designated as HPSAs. Two regions, RHPs 9 and 18, have no counties that are designated HPSAs.

Table 11. RHP Counties with Mental Health Care HPSA Designation.

RHP	N Counties	N HPSA Counties	% HPSA Counties
RHP 5	4	4	100%
RHP 17	9	9	100%
RHP 20	4	4	100%
RHP 12	47	45	96%
RHP 13	17	16	94%
RHP 11	15	14	93%
RHP 19	12	11	92%
RHP 6	20	18	90%
RHP 4	18	16	89%
RHP 14	16	14	88%
RHP 2	16	12	75%
RHP 1	28	17	61%
RHP 8	9	5	56%
RHP 10	9	5	56%
RHP 15	2	1	50%
RHP 3	9	4	44%
RHP 7	6	2	33%
RHP 16	7	2	29%
RHP 9	3	0	0%
RHP 18	3	0	0%

The findings show that areas with larger populations do not always have greater workforce shortages. However, there may be a link between how rural an area is and the presence of workforce shortages. RHPs with more non-metropolitan counties tend to have more counties labeled as Health Professional Shortage Areas (HPSAs). This suggests that allocating resources based only on population size is not the most effective approach. Other factors should be considered.

The National Institutes of Health and the U.S. Department of Labor note a strong link between behavioral health workforce shortages and the opioid epidemic. Limited access to vital treatment, especially in rural areas, both contributes to the crisis and is worsened by it, creating a cycle of unmet needs. However, the findings also show that workforce shortage scores do not always match opioid impact scores. For example, RHPs 9 and 18 have no counties labeled as HPSAs, yet they had the highest CIF-IOM scores. This suggests that there are factors in these communities that the indexes do not capture. Workforce development funding should not be allocated or limited based solely on opioid impact. As with the other findings, engaging directly with communities and employers is essential to understanding how mental health provider shortages affect each region and the demand for more peer specialists.

Surplus of Peer Specialists

A workforce surplus occurs when there are more qualified applicants than available jobs, and some in the peer community wonder if this is happening in certain areas. Although data shows a significant workforce shortage, many people trying to work as peer specialists do not see this reflected in their own experience, which could lead them to believe there is a local surplus.

A survey of 535 peer specialists in Texas highlights this disconnect. Sixteen percent of respondents who completed training and certification have never worked as a peer specialist. Additionally, 26% reported facing barriers to employment, including few available positions, low pay, and a competitive job market (Lodge & Stevens Manser, 2025). Many expressed frustration at the lack of employers hiring or job postings in their area. Others said the pay was "insufficient" or "not a living wage."

The tough job market has real consequences. Several respondents reported applying to many positions but never being hired. This could help explain why on average Texas peer specialists allow their certification to lapse after 2 years. Our survey also found that, among 158 peer specialists, 35% are not currently employed in peer specialist roles, and 16% have never worked in the field. Of those not currently employed, over half (54%) are actively looking for work, highlighting the frustration of trained workers who cannot find positions—even though there is an overall shortage of peer specialists in Texas.

More research is needed to understand why some peer specialists are unable to find employment. It could be that economic factors are limiting demand, meaning fewer employers are hiring and creating local surpluses. Or, it may not be about a surplus at all, but rather labor market inefficiencies or other barriers that are explored further in the next section.

Barriers and Challenges

As discussed, Texas faces a significant shortage of Recovery Support Peer Specialists (RSPS) and other peer specialists, even after considering economic constraints. Efforts to build a stable workforce, much less meet growing demand, are hampered by attrition throughout the recruitment-to-career pipeline, with barriers at each stage compounding inefficiencies. This section explores these barriers and challenges using survey and focus group data, as well as relevant literature, forming the basis for solutions and recommendations.

Recruitment into the Peer Workforce

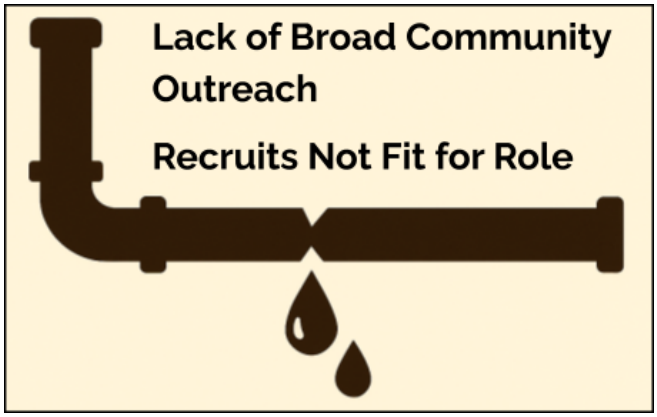
The needs assessment survey identified that peer specialists are most often recruited into the workforce by a peer specialist or colleague (53%). Employers reported that they recruited through internal referrals or word of mouth (81%), through community organizations or recovery programs (51%), or that they transitioned people who completed services into peer specialist roles (51%). These practices potentially bring people who have experienced peer support into the workforce, which reflects the grass-roots nature of the role. One participant in the employer focus group expressed that they've experienced success recruiting people who completed services:

> *That's where I identified and hired people, the graduates of the peer recovery program... So that's been the best resource that we've had in our community. Especially since many of these people are rooted in the community, they're going to be here for the long haul.*

However, focus group participants suggested the need for a more diverse workforce. One focus group participant noted:

> *We're missing different languages, different worldviews, different communities and backgrounds and races and everything in so many different ways. I need to go to every neighborhood and recruit people out of the neighborhoods...We need experts from those communities.*

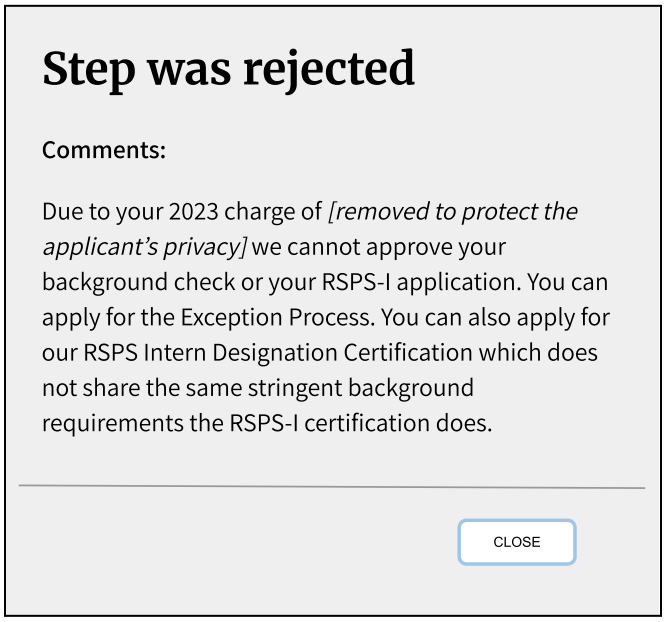
This comment highlights that recruiting individuals from within a community results in peers who are best positioned to serve that community, while also indicating that community outreach may be limited. Specifically, it is unclear how, or whether, training entities conduct outreach. Given that survey participants who are trainers or represent training entities noted that funding to provide training is limited, outreach may also be a challenge.



Not everyone is a good fit for the peer specialist role, as was pointed out by a participant in the supervisor focus group, which impacts employment and retention further down the pipeline. Despite both PeerForce and HHS having detailed web pages that explain what a peer specialist does and the ethics of peer support, the focus group participant's comment highlights the importance and opportunity to orient recruits to the role in multiple ways.

Not everyone recruited into peer specialist training is eligible for all types of peer credentials. Individuals with a history of legal-criminal system involvement may not learn that they cannot pass the background check of the Texas Medicaid billable certifications until they submit their application. The self-assessment and orientation process does not clearly identify background-check eligibility, resulting in many applicants learning they are ineligible only after rejection, often without clear guidance on next steps or available options. The peer specialist is often confused and uncertain of what to do next or what options are available. The image (Figure 18) below is of the only communication a recent new applicant received, with no additional information and option or details on who to contact for support. After receiving the message below, the peer specialist trainee reached out to RecoveryPeople with the message below.

Figure 18. Rejection Notice and Request for Support from a Peer Specialist.



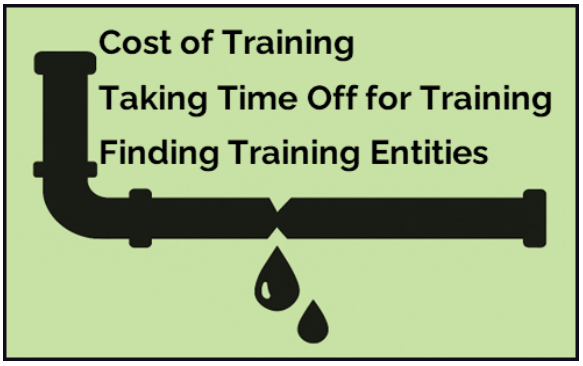
"I am reaching out to see if you are able to help me with this. I tried to look up exception process but am not able to figure it out."

Overall, recruitment could benefit from broader outreach into communities and mechanisms to support identifying individuals who are the best fit for the role. In addition, there are challenges that occur further along the pipeline that ultimately impact recruitment, including barriers to training, certification, and employment.

Training Enrollment and Graduation

Following recruitment, peer specialists then embark on the training process. The didactic, or classroom, training is available in both virtual and in-person formats. Peer specialists seeking RSPS and Mental Health Peer Specialist (MHPS) certification must 1) complete an online orientation, 2) complete the 3-day Texas Peer Specialist Core Training, 3) participate in the 40-hour supplemental training course, and 4) must pass a post training knowledge assessment with a minimum score of 70%, in that order.

According to our survey, 51% who completed the RSPS and MHPS training and 55% who completed the CFP, JI-RPS, Peer Recovery Support Specialists (PRSS), or Recovery House Manager (RHM) training experienced no challenges.



Those that did experience challenges reported that affording the cost of training (38% RSPS and MHPS; 33% CFP, JI-RPS, PRSS, RHM) was a common challenge. This challenge seemed more impactful for those who took the JI-RPS training, with 77% naming this as a common challenge. Notably, this barrier was reported by individuals who participated in the training. Therefore, cost of the training may be a barrier that prevents recruited peer specialists from enrolling in the training. Further, if this is more of a barrier to those with more specialized lived experience, such as JI-RPS, training cost could be a factor limiting the diversity of the workforce.

As of December 2025, the JI-RPS credential is no longer counted in the HHS reports. According to the Texas Certification Board (TCB), right now, that certification is currently on hold as the Board determines how to move forward with the certification now that Via Hope has closed. As a result, this training is not currently being offered, despite continued workforce need for peer specialists with lived experience in the legal-criminal system. The pause in this credential could further limit access and representation within the peer specialist workforce, particularly for individuals who may face additional barriers to traditional certification pathways.

Trainers and training entity survey respondents noted that affording the training is a barrier for participants (47%). While there are resources to subsidize peer specialist training, a participant in the training entity focus group identified that obtaining a scholarship voucher may be challenging:

They want the voucher from PeerForce or they want some type of scholarship. But we're only allotted a certain amount of vouchers per cycle… and they go so quickly… I wouldn't have become a peer specialist if I didn't have that opportunity. So, I hate to think about how many people aren't given the opportunity only because of money.

Taking time off from work to participate in 8 days of training was also a challenge according to peer specialists (24% RSPS and MHPS; 20% CFP, JI-RPS, PRSS, RHM). Taking time off often requires using up PTO or forgoing wages. Students may begin the training but then drop out because they must return to work or address health issues. These individuals may have few opportunities to make up missed classes at a later date. Of the trainers and training entities, 40% acknowledged this challenge, noting that participants face barriers accessing training whether in-person or online.

While less common, peer specialists also identified difficulty finding training entities, particularly those offering classes that aligned with their schedules (12% RSPS and MHPS; 12% CFP, JI-RPS, PRSS, RHM) and accepting or offering scholarships. The limited availability of training opportunities may reflect a combination of administrative and economic barriers, which may also help explain the significant month-to-month fluctuation observed in the training entity directory.

- Training entities must maintain annual accreditation through the TCB, which involves ongoing recordkeeping.
- In addition, authorized instructors are required to have an active certification in the role and to complete a Training of Trainers (ToT) course of the most recent curriculum either through an accredited training entity or through the Addiction Research Institute (ARI). The curriculum is periodically offered by ARI and continually evolves. Further, ARI restricts training to individuals who are connected with an accredited training entity.
- One trainer focus group discussion included difficulties in achieving the necessary experience for their organization to become a training entity. The process to become a training entity is limited, requiring the applicant to have previously trained the curriculum, however the applicant cannot train the curriculum to gain the required experience unless they provide the training under a certified training entity. This highlights a need for a mentoring process for organizations to become training entities.
- For certain funding streams, such as the Opioid Abatement Fund Council (OAFC), training entities are required to carry substantial levels of liability insurance that may exceed what they would otherwise maintain or what is proportionate to the opportunity. These requirements can deter participation by smaller or community-based organizations, contributing to instability in the training provider landscape.
- At the same time, training entity focus group participants described the need for more funding for training entities. Our survey found that 47% of the trainer or training entity respondents no

longer offer peer specialist training, citing the lack of funding as a challenge. Some of the training entities (20%) who responded to our survey cannot afford the cost of the facilities or technology to provide the training.

Altogether, these findings suggest that peer specialists experience economic barriers to enrolling in and graduating from training. Likewise, trainers and training entities report administrative and economic barriers that led some to cease offering training and others ineligible to begin offering training.

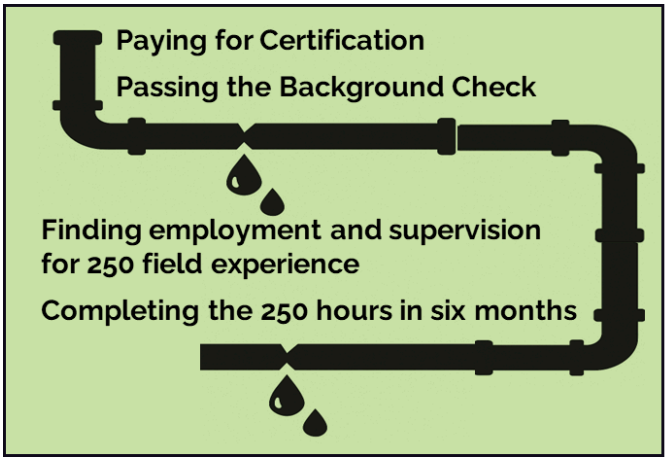
Certification

After training, peer specialists must complete the certification process. Certification bridges a peer specialist's step into employment. This process varies depending on the certification type, which is confusing to participants. Some certifications only require an application, training verification, and letters of recommendation. For example, PRSS must complete 500 hours of supervised work experience. In contrast, the Texas Medicaid billable peer specialists credentials, RSPS and MHPS, must complete a complex, two-step process that includes an initial 6-month certification before receiving full certification as stipulated by the Texas Administrative Code.

Certification Process for RSPS and MHPS

Obtaining Initial Certification

RSPS and MHPS must complete an initial 6-month certification process before applying for full certification. Our survey found that 67% of RSPS and MHPS experienced some sort of challenge with the process. Several experienced challenges related to submitting the application: 20% experienced challenges paying for the certification and 17% encountered barriers related to having a history of involvement with the legal-criminal system.



A training entity focus group participant noted that prospective peer specialists are not always clear about the requirements to pass the background checks. When individuals do not pass the background check, they cannot proceed to obtain full certification, which is necessary to bill Medicaid for providing peer specialist services. This limits their employability. Peer specialists who do not pass the background check may apply for a provisional certification, RSPS or MHPS-Intern. They may be employed with this certification, but this certification is not Medicaid billable.

> "As a result, motivated peers (peer specialist applicants) are left stalled, momentum is lost, and both the workforce and the communities we serve are negatively impacted."

In addition, the time required to process an application can pose a significant barrier for individuals who cannot begin accruing the required field experience hours until their application is approved. According to TCB, processing typically takes 30–60 days from the submission of a complete application. While this timeline is likely tied to funding and affordability constraints, the resulting delay effectively functions as a policy barrier. Training entities report that it leaves motivated peers stalled, eroding momentum and negatively impacting both the workforce and the communities they serve. Advocates recommend changing the policy to allow individuals to advance in their field experience while their application is under review. This barrier is particularly frustrating for those who have already secured field experience or employment.

Working Toward Full Certification

Once their application for initial certification is approved, RSPS and MHPS have six months to complete 250 hours of supervised work experience. If the process is not completed in six months, RSPS and MHPS with initial certification may apply for a six-month extension. After that, they must take the training again, and then reapply for initial certification (PeerForce, 2025b). Of the needs assessment survey respondents, 20% experienced challenges completing the initial certification within six months.

The field experience must also be supervised by a certified Peer Specialist Supervisor (PSS). Our survey found that 19% of RSPS and MHPS experienced challenges finding adequate supervision. Similarly, 18% of supervisors reported they experienced challenges providing the required 250 hours of supervision.

If they are fortunate enough to be employed while obtaining their field experience hours and that employer has a qualified peer supervisor on staff, individuals can receive supervision through their employer at no direct cost. Others are forced to pay for private supervision or use voucher programs (e.g., $400 vouchers provided by PeerForce). Survey data and practitioner reports suggest that about 15% of candidates pay for supervision themselves, with some supervisors charging $700 or more for the credentialing supervision component. While this creates a funding opportunity for PSS, it is not affordable for most peer specialists, which creates a barrier to full certification. Considering the median peer specialist wage in Texas, covering supervision costs would require approximately 22 hours of peer work for a $400 fee and 39 hours for a $700 fee (Lodge et al., 2024).

Qualified supervisors are in short supply and must hold PSS certification. Non-clinical organizations who offer field experience or employment opportunities to peer specialists often do not have certified

PSS on staff, resulting in roles being filled by individuals who may not meet the qualifications required to effectively supervise peer specialists.

> **"Mostly, people cannot find a place to do their [required 250 field experience] hours."**
>
> *Focus Group, 2025*

Survey respondents also experienced challenges finding employment or volunteer opportunities for the 250 hours of field experience (20%). Training entity focus group participants noted, "Mostly people just can't find a place to do their hours." In a Texas study of individuals pursuing an RSPS, only 43.3% of participants found internship placement. A survey of 535 peer specialists in Texas also found that completing the 250 hours of field experience was a challenge; either people could not find paid positions or the volunteer positions did not fulfill the time or task requirement, and the data suggest these did not seek employment as peer specialists (Lodge & Stevens Manser, 2025).

Many peer specialists never attain full certification. A review of expired certifications from January 2019 through May 2025 identified that initial RSPS certifications make up 35% of all expired RSPS certifications, and initial MHPS certifications make up 39% of all expired MHPS certifications.

Expired Certifications That Did Not Attain Full Certification

35% RSPS	39% MHPS

Initial certification is provisional. It allows peer specialists to work in the role and gain experience, but until full certification is attained, Medicaid cannot be billed for any services they provide. This limits the peer specialists' employability as well as the organizations' ability to fund positions. While volunteering to fulfill the hours is an option, this scenario creates challenges for organizations in terms of allowable services a volunteer can provide and the privacy and confidentiality of people who receive services; organizations perceive liability when utilizing volunteers.

A participant in the trainer focus group expressed that organizations and peer specialists face myriad challenges and suggested: "There needs to be funding for people to be able to get those hours and the duties at which they can get those hours probably needs to be re-examined as well."

Lastly, perhaps further complicating the process, RSPS and MHPS noted challenges related to the processing time for certification once all steps were completed (22%) and communicating with the certification entity (17%). This could point to the accrediting body being under-resourced, limited by the amount they can charge and still keep certification affordable to peer specialists.

Certification Process for CFP, JI-RPS, PRSS, and RHM

Barriers experienced by RSPS and MHPS reflect those pursuing other peer certifications as well. For the survey, participants that participated in the CFP, JI-RPS, PRSS, and RHM certification, the most common challenges were paying for certification (22%), completing the administrative steps for

certification (20%), and understanding the certification process (20%). Those with JI-RPS experienced greater burden paying for certification (50%) and completing admin steps (43%).

Understanding Certification Challenges

For some peer specialist certifications, the certification process is complex, and mirrors the licensing processes of degreed professionals, such as social workers and counselors. However, peer specialists entering the workforce have significantly less earning potential. Initial certification limits employability. Many have to fulfill the hours in a volunteer position, which in turn limits a peer specialist's ability to pay for supervision. These factors contribute to many not completing initial certification. Even for the certifications that do not have to complete these steps, certification costs are a burden when entering the field.

Employment

Barriers to Entering the Workforce

Employment in the peer-specialist workforce is the goal of the pipeline. However, some peer specialists encounter barriers when entering the workforce. A survey of 535 peer specialists in Texas found that 16% who completed training and certification never worked in a peer specialist role; the same survey identified that 26% of peer specialists encountered barriers to obtaining employment, including a lack of jobs, inadequate compensation, and a competitive job market (Lodge & Stevens Manser, 2025). Peer specialists noted that there were no employers hiring and no job postings for peer specialists in their area. They expressed, too, that the salary was "insufficient" or "not a living wage." In terms of the tough job market, several peer specialists noted that they applied to multiple positions but never were hired. One peer specialist, after an extensive time of applying for employment, ended up letting their certification lapse.

"We can't eat the same as our clients!"

(Lodge and Stevens-Manser, 2025)

Our survey identified that out of 158 peer specialists, 35% are not currently employed as peer specialists. 16% were never employed as a peer specialist. However, 54% of those not currently employed are looking for a job as a peer specialist.

Barriers to Hiring Peer Specialists

To understand the employer perspective, our survey asked whether employers currently employ peer specialists. Of the 55 employers that responded to the survey, 29% never employed peer specialists and 13% employed peer specialists in the past. The most common reason organizations do not employ peer specialists is a lack of funding to support peer specialist positions (48%). Two additional and related reasons highlight the possibility that organizations may need to learn more about peer support: employers reported that peer support is not currently a part of the service model (33%) and that their organization lacks understanding of the peer specialist role (24%).

Career – Retention of Peer Specialists to 2 Years and Beyond

Peer specialists who become employed should have a clear path to making peer support a career. However, one research study found that one year after certification, only 56% remain employed in a peer specialist role; after three years, this number drops to 48% (Ostrow et al., 2025). Retention challenges are slightly more pronounced in Texas. Among peer specialists employed by Local Mental Health Authorities and Local Behavioral Health Authorities (LMHA/LBHAs), just over half (53.1%) reach a tenure of at least one year, and fewer than one-third (32.3%) remain employed for two years or longer (Garuda & Stevens Manser, 2024; Garuda & Stevens Manser, 2025).

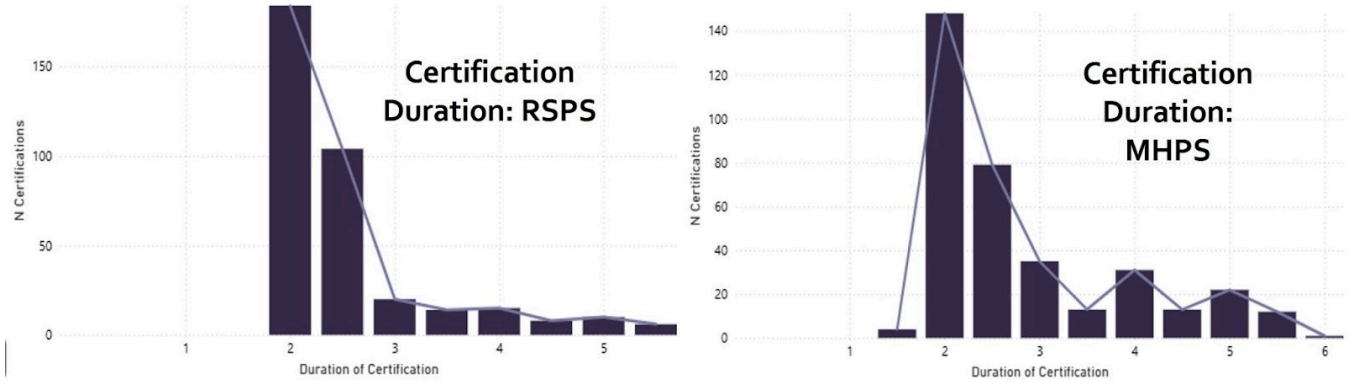
Only
32.3%
remain employed for two years or longer.

Indicators of Retention

Duration of Certification

Since 2019, 1,183 RSPS achieved full certification and of these 361 (31%) have expired. For MHPS, 1,174 have received full certification; of these 355 (30%) have expired. Duration for these expired certifications were examined to identify how long peer specialists with full certification remain certified before letting their certification lapse. For RSPS, the average certification duration was 2.6 years (SD 1.4 years) and for MHPS, the average duration was 2.8 years (SD 1.7 years). Figure 19 visualizes the distribution of durations of expired full RSPS and MHPS certifications. The graphs show that for both MHPS and RSPS, most peer specialists allow their certifications to expire after two years and did not seek recertification.

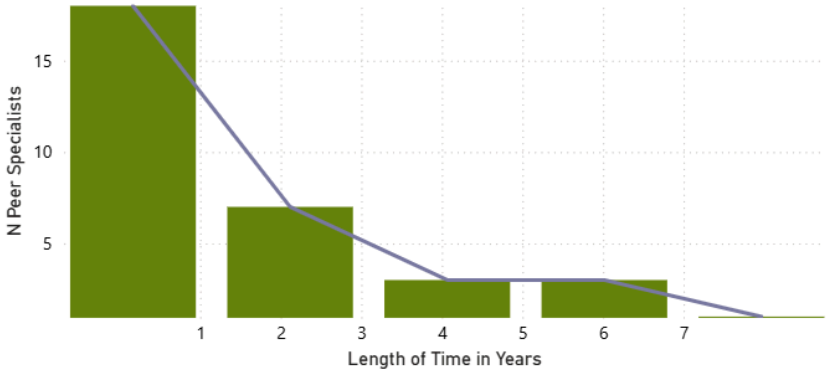
Figure 19. Duration of Expired Full RSPS and MHPS Certifications.



Employment Tenure

To explore how long peer specialists remain in the peer specialist role, the employment duration of 48 peer specialists who are no longer working in the role were examined (Lodge & Stevens Manser, 2025). The average duration for this group was 2.5 years (SD 2.0 years). Figure 20 visualizes the employment duration of peer specialists no longer working in the role. This graph shows that most peer specialists were employed for two years or less.

Figure 20. Duration of Employment for Peer Specialists No Longer Working in the Role.



Factors that Potentially Support Retention

Support in the Role

On the needs assessment survey, 53% of peer specialists named burnout as the most common challenge experienced while working in the role. Additionally, 37% of survey respondents noted that

they lack time for self-care, which may be a contributing factor to burnout. Research has shown that burnout can be reduced with burnout prevention training and supportive supervision, particularly when the supervisor is a peer specialist (Castedo de Martel et al., 2025; Chu et al., 2025; SAMHSA, 2023b).

Adequate Compensation

Adequate compensation is important for supporting the peer specialist workforce (Castedo de Martel, et al., 2025; Chu et al., 2025; SAMHSA, 2023b). Better pay supports both satisfaction and retention (Castedo de Martel, et al., 2025). A survey of the peer specialist workforce found that the mean hourly wage for peer specialists is $20.22, and wages range from $7.25 (minimum wage) to $78.50 (Lodge & Stevens Manser, 2025).

38

% of peer specialists that work additional jobs to make ends meet

The needs assessment findings suggest that the wages are not entirely adequate. Most peer specialists (50%) reported that one challenge they experienced working as peer specialists was having to work multiple jobs to make ends meet. Of the respondents to our survey that are currently employed as peer specialists, 38% also have additional employment. One focus group participant expressed:

> *Of all the peer-run organizations that I'm aware of, no one just has one job. It's like a hustle all the way around … even with the peers that haven't moved into that role yet, same thing, multiple jobs…That's a quick way to burn out … some of my peers are almost drowning.*

Supportive Supervision

Supervisors are important to the peer specialist workforce (Castedo de Martel et al., 2025; Chu et al., 2025; SAMHSA, 2023b). Supervisors provide guidance, support, and validation, particularly if they understand the peer specialist role (Chu et al., 2025). In Texas, supervisors of those with RSPS and MHPS certifications must also be trained and certified as Peer Specialist Supervisors (PSS) to meet state requirements to bill Medicaid. On the needs assessment survey, 42% of supervisors noted that paying for training and certification was a challenge.

Our survey also found that most supervisors (80%) experienced challenges providing supervision to peer specialists, namely having time to provide adequate supervision (43%), supporting the professional development of peer specialists (33%) and supporting peer specialist fidelity (29%). Participants in the supervisor focus group expressed that continuing education could address these challenges. It was discussed in the supervisor focus group that the peer specialist supervisor training is more of a review of the core training, and geared toward clinicians, than what is required to supervise peer specialists. There are currently very few courses that are specific to the ongoing training of peer specialist supervisors, and one of the requirements of the recertification every two years for all peer

specialist supervisors, is six continuing education credit hours in the domains of leadership and supervision.

> *I was kind of surprised, honestly, at how much I feel like I didn't learn when I went through the PSS training. I was like, this sounds like a big review of almost like the core. It's like it is for clinicians. It's like teaching someone who doesn't know what peer support was, is what I felt like. And I didn't feel like it was giving me direction on how to actually move into this new position with new responsibilities."*

It was also noted thatPSS are not required to complete any continuing education for recertification in peer specialist ethics, while peer specialists are required to take at least 3 hours of peer specialist ethics every 2 years.

> **"We're not required to take any peer support ethics, continuing education....that should be required...That's the purpose of a peer specialist supervisor, to be the sounding board for ethical situations."**
>
> *Focus Group, 2025*

Ongoing Training, Recertification, and Career Advancement

Ongoing training helps to improve knowledge and confidence of peer specialists (Castedo de Martel, et al., 2025). For peer specialists, ongoing training serves the purpose of fulfilling requirements for recertification. Peer specialists and peer specialist supervisors in Texas must complete 20 hours of continuing education units for recertification.

The needs assessment survey found that most peer specialists (76%) experienced challenges with continuing education. Most (56%) had difficulties finding entities that provide ethics courses. The peer specialist supervisors focus group identified that PSS experience challenges with finding entities that provide supervision and leadership courses. The lack of low cost or free courses was also a challenge for many (54%). Peer specialists seeking recertification as JI-RPS and RHM were more likely to experience overall challenges with the continuing education process, as were peer specialists who were no longer employed. The lack of free or low-cost courses was a burden for most people who reported they were female.

Most peer specialists (74%) also experienced challenges with the recertification process, including the processing time once all steps are completed (35%) and paying for re-certification (33%). Focus group participants reported additional challenges with the recertification process, including the lack of clarity about accepted CEUs; unclear recertification requirements; and challenges with scheduling background checks for multiple recertifications.

Peer specialists report that limited opportunities for career advancement within the role pose a significant barrier to workforce retention(Castedo de Martel et al., 2025). For the peer specialists that participated in the needs assessment, professional development interests include becoming a certified Peer Specialist Supervisor (55%), participating in a refresher certification training course (48%), and contributing to research on peer support (47%). Survey participants also expressed interest

in participating in a peer specialist conference or retreat (69%) and developing a structure for a peer specialist career ladder (50%).

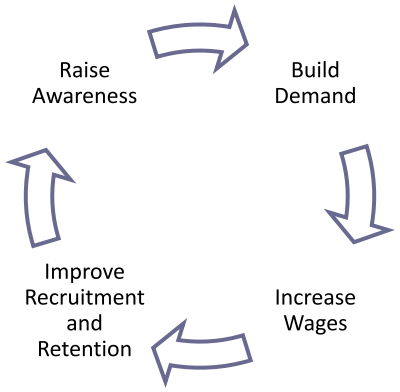
Solutions from the Surveys and Focus Groups

In addition to highlighting barriers and challenges, survey and focus group participants were asked to propose solutions. Their suggestions spanned the entire pipeline from recruitment to employment. By considering solutions across every stage, these insights provide a roadmap for addressing attrition, increasing efficiency, and building a stronger, more sustainable peer specialist workforce in Texas.

Recruitment

Successful recruitment starts with making peer specialist roles attractive and ensuring that prospective applicants clearly understand eligibility requirements, including how their criminal history might affect their ability to complete certification.

In a needs assessment survey (n=177), respondents most frequently identified offering competitive wages and comprehensive benefits (72%) and ensuring a livable wage (71%) as key factors to support recruitment. Given the short supply of peer specialists, their compensation is primarily driven by the underlying economic factors of demand, such as funding for peer specialist services and the number of employers integrating peer specialists across settings. Both can be influenced by other survey responses: public awareness campaigns about peer support (71%), increasing organizational and system awareness of peer specialist roles (59%), and building recognition and respect for lived experience (55%). Another recommended and related strategy would be to reduce stigma around substance use and mental health (55%).



Short of changing state law that restricts individuals with certain criminal records from obtaining RSPS and MHPS certifications, recruitment efforts must better inform and guide applicants so they do not spend time on a process they may not be eligible to complete. Individuals who experience background check challenges, should receive education and support through exceptions and appeals processes where possible. Additionally, alternative peer specialist credentials, such as re-entry peer specialist certifications, for individuals with the criminal legal system involvement are needed for individuals whose lived experience make them uniquely positioned to support others transitioning from the criminal justice system.

Training Enrollment and Graduation

Participants in our survey indicated that training needs to be more affordable (57%) and more accessible (40%) to support recruitment of a peer specialist workforce. While existing grants and programs subsidize training for some, these funds are limited. Training entities are businesses that may have multiple service lines; if the cost and time burden of training conflict with operations, or the classes do not fill up because people cannot afford them, training becomes a non-viable service to offer. Peer specialists, trainers, and training entities indicated that more funding is the solution.

Certification

Needs assessment survey participants offered solutions related to certification that would bolster recruitment of peer specialists into the workforce. Recommendations included simplifying the certification process (31%), as well as removing barriers to certification, such as education requirements and history of criminal justice involvement (49%). Survey respondents also suggested providing a more affordable certification process (48%), which may be accomplished by building on another recommendation offered, which was to partner with workforce development programs (53%). Currently, the Texas Workforce Commission already supports training; negotiating financial support for certification may be a logical strategy to explore with this entity. Notably, PeerForce offers vouchers for the certification application as well as supervision (2025). However, findings from this report suggest these vouchers do not match the demand.

Another strategy suggested was to offer paid peer specialist internships or apprenticeships (59%). Focus group participants also recommended more funding for RSPS and MHPS with initial certification to complete the required supervised field experience.

A training entity suggested a policy change that would allow participants to begin their field experience hours while their initial certification application is being processed. This will help maintain momentum and motivation for individuals who have already established field experience or employment opportunities.

Employment

Training entity focus group participants recognized the challenges peer specialists face, particularly when it comes to entering the job market; the strategy offered was to grow networking and communication channels across the state for recruitment and job placement support. For example, one participant suggested creating positions to help with job recruitment and placement for peers: "Navigators to help across the state…opening it up to get the word out to the community where the employers understand where they can go to find trained peer supporters."

For employers, the strategies of building awareness about peer support system wide, as recommended in recruitment, may improve the impetus to employ peer specialists. Needs assessment survey respondents offered additional recommendations that may support building understanding of the role: for instance, one strategy may be to have peer specialist role models or a mentorship program promote the role (50%), and another strategy may be to promote peer support through recovery programs and community organizations (53%).

Career Retention

Support in the Role

Addressing burnout could potentially help with retention. Survey respondents suggested supporting work-life balance and self-care (61%) and offering mentorship and peer-to-peer support networks (52%). Another possible strategy is to offer flexible work schedules and part-time opportunities (50%), which could provide breaks when people may be approaching burnout.

Adequate Compensation

Survey respondents recommended offering a livable wage (79%). Supervisors and employers both reported that increasing pay is an effective recruitment and retention strategy; employers also described providing full benefits packages and other financial incentives as effective recruitment and retention strategies.

Supportive Supervision

Needs assessment survey respondents noted that one way to support peer specialist retention is to ensure the supervisor understands and supports the peer specialist role (52%). To assure supervisors can be as supportive as possible, participants in the supervisor focus group suggested that supervisors need specific training to meet the needs of peer specialists and that specific continuing education options for PSS need to be available. Focus group participants recommended that the topics include: supervision core competencies, ethics, mentoring, supervising someone that used to be your peer, supervising from a place of mutuality without creating boundary issues, team-building strategies, and administrative versus developmental supervision.

Ongoing Training, Re-Certification, and Career Advancement

Survey respondents identified providing ongoing professional development and training opportunities as a way to retain peer specialists (54%). Peer specialist focus group participants recommend that peer-specific continuing education units need to be developed. Specific topics identified include: trauma informed peer support, co-occurring disorders, Intentional Peer Support, peer support for

individuals with co-occurring disorders, and leading and facilitating support groups (Lodge & Stevens Manser, 2025).

Creating opportunities for career advancement is another recommendation for retention offered by needs assessment survey respondents (80%). Training is one way that peer specialists are prepared for advancing their career. Structuring training so that it creates opportunities for career advancement may be a strategy for retention.

Cost of Attrition and Turnover

To better understand the financial impact of attrition and turnover within the peer specialist workforce, a hypothetical cohort of 100 individuals was developed using available research, illustrating the costs in concrete financial terms at each stage of the workforce pipeline.

Table 12. Illustration of Hypothetical Costs of Attrition and Turnover.

([spreadsheet](#))

Milestone	Enrolled	Graduate	Initial Cert	Full Cert	Employed	Career	Total
Attrition (%)	0.0%	21.9%	3.7%	35.0%	26.0%	67.7%	
Peers per stage (#)							
• Begin (#)	100	100	78	75	49	36	
• Leave (#)	0	22	3	26	13	24	88%
• Complete (#)	100	78	75	49	36	12	12%
Investment ($/#)	$1,321	$464	$112	$2,651	$9,539	$757	$14,843
• Opportunity cost	$41	$464		$2,001		$145	18%
• Fees (tuition, cert...)	$1,280	$0	$112	$650	$0	$612	18%
• New hire					$9,539		64%
Total Retained Investment ($)	$132,111	$36,238	$8,396	$129,599	$345,072	$8,841	$660,258
Cumulative Investment ($/#)	$1,321	$1,785	$1,897	$4,548	$14,086	$14,843	
• Total Loss - Min ($)	$0	$28,932	$5,481	$17,110	$57,804	$344,994	$454,322
• Total Loss - Max ($)	$0	$39,094	$5,481	$119,713	$57,804	$363,525	$585,617

Given the assumptions, a minimum of $14,843 is needed to support one individual from enrollment in peer specialist training through their two-year work anniversary. This includes:

- $9,536.66 (64%) in employment-related costs (e.g., recruitment and onboarding)
- $2,651.11 (18%) in opportunity costs assuming minimum wage ($7.25 per hour)
- $2,653.28 (18%) in training, (re)certification, and background check fees

However, the current Texas peer specialist workforce pipeline is very inefficient. This case estimates that for every 100 individuals who begin training, only about twelve (12) reach the two-year career milestone. The other 88 exit at various points due to barriers that hinder their progression. This

attrition rate significantly increases the actual cost of supporting a peer specialist in Texas to a two-year career to at least $56,505, which is 3.8 times more than $14,843. This figure reflects the total investment made in individuals who remain at each stage in the pipeline ($660,258) divided by the twelve individuals—out of the original 100—who ultimately achieve the two-year milestone.

Total Investment ($)	$660,258
2-Year Career Milestone (#)	12
Investment ($/#)	$56,505

Moreover, each time one of the 88 exits the pipeline, the cumulative investment made up to that point is lost. As a result, for every 100 individuals who enroll in Texas peer specialist training, an estimated $454,322 to $585,617 in lost investment before twelve individuals reach the two-year career milestone. While these resources still build recovery capital and support individuals in pursuing other jobs or career paths, Texas urgently needs more qualified providers to deliver Medicaid-billable peer specialist services. For this reason, the investment is considered "lost"—not because it lacks value, but because it does not increase the stable supply of careered staff providing Medicaid billable peer specialists services.

There is a significant opportunity to improve the efficiency and cost-effectiveness of the Texas peer specialist workforce development pipeline by reducing barriers and attrition, especially around full certification and employment. Doing so would strengthen the workforce and better meet statewide demand. The following sections examine each milestone within the pipeline, detailing the assumptions and projections behind this analysis, incremental and cumulative costs, losses due to attrition, barriers, and potential solutions.

Recruited

Incremental Costs and Cumulative Investment

The average cost of recruiting eligible individuals into peer specialist training in Texas may be substantial; however, because this cost is unknown, it was not included in our analysis. As a result, the total project cost of supporting a peer to at least 2 years of employment (aka a career) as a peer specialist is underestimated. Recruitment expenses vary across training entities based on their marketing and outreach strategies.

Attrition-Related Losses

Recruitment outcomes also depend heavily on the strategy, capacity, and marketing skill of each training entity, and conversion rates are typically low. MailChimp, a widely used digital marketing platform, reports that a "good" conversion rate varies by industry but generally ranges from 2% to 5%, implying an expected abandonment rate of 95% to 98%. Because we lack data on the actual

marketing strategies and performance of Texas training entities, attrition-related recruitment losses could not be incorporated into our analysis, resulting in an underestimation of true costs.

Enrolled

Incremental Cost and Cumulative Investment

The estimated cost of enrollment for individuals pursuing RSPS certification is $1,321.11 per RSPS trainee, which reflects both opportunity costs and training tuition fees.

- Opportunity costs: Before enrolling, candidates must complete an online self-assessment and a self-paced orientation. Based on average reading-speed estimates and a review of the program webpage and linked PDF materials, these requirements take approximately 5.67 hours to complete. Using the Texas minimum wage of $7.25 per hour, the resulting opportunity cost is $41.11, which is included in the total enrollment cost.
- Training tuition: Students typically either pay tuition directly or rely on scholarships to cover the cost of training. The average tuition for the core and supplemental training is approximately $1,280 per student.

Since this is the first stage in the process for which we were able to assign a value, the cumulative investment at this point is also $1,321.11.

Attrition-Related Losses

The attrition rate between beginning the self-paced orientation and completing enrollment is unknown because peer specialist training in Texas is decentralized across accredited training entities and instructors. These entities are not required to report enrollment data to a central system, leaving the number of candidates who start orientation versus those who complete enrollment untracked. For the purposes of this analysis, we assume a 0% attrition rate—an assumption we recognize is unrealistically low and likely understates the true costs and investment loss at the enrollment stage.

Graduate

Incremental Cost and Cumulative Investment

The cost for an individual to complete (i.e., "graduate" from) the classroom training is $464.00, which reflects the opportunity costs of attending the sessions. This estimate is conservative, as it assumes virtual training via platforms such as Zoom, which eliminates travel and related expenses. Since the COVID-19 pandemic in 2020, peer specialist training has frequently been offered in a virtual format.

- Core curriculum: 21.5 hours as of January 2025, typically requiring three days (24 hours) away from work. At the Texas minimum wage of $7.25 per hour, participants forgo approximately $174 in earnings.
- Supplemental curriculum: 40 hours as of November 2025, equivalent to roughly one week of missed work. At $7.25 per hour, participants forgo approximately $290 in earnings.

Including the cost of graduation and all prior investments in the process, the total cumulative investment per participant to complete the didactic training is $1,785.11.

Attrition-Related Costs/Losses

The attrition rate between enrollment and completing (graduating) the classroom training is 21.9%, based on a Texas study of 448 individuals enrolled in RSPS courses funded by a federal grant (Castedo de Martell et al., 2024). This means that for every 100 students who begin peer specialist training, approximately 78 complete the training and 22 did not.

The study used several statistical models to identify factors linked to successful training completion. Across all models, participants who finished the training were more likely to have previously received support from a peer specialist, held at least a bachelor's degree, and were older than those who did not complete the program. In some models, being a woman, being a veteran, and having basic access to technology also increased the likelihood of completion. Conversely, shorter recovery time and lower quality of life were associated with a lower likelihood of completing the training.

The cumulative investment of someone completing the classroom training is $1,785.11. However, to calculate the lost investment of the 22 participants that do not graduate, we need to consider that some may withdraw at the beginning of classes, meaning they do not incur the opportunity cost. Because of strict rules, some may be denied graduation even when they have attended almost all class hours, because there are no guaranteed makeup days. Depending on when they stop going to classes, the cumulative lost investment is between $28,932.25 and $39,093.85 for the 22 who did not graduate

Initial Certification

Incremental Cost and Cumulative Investment

The cost for an individual to gain their initial certification is $111.64, which reflects application and background check fees.

- Application fee - The cost of a peer specialist application with the Texas Certification Board is $60.

- Background check - The cost of an FBI background check at Identigo is $51.64. The time and travel cost to obtain a FBI background check was not included because it is highly variable depending on where the individual lives in proximity to an Identigo location.

Including the cost associated with obtaining an initial certification and all prior investments, the total cumulative investment per participant is $1,896.75.

Attrition-Related Losses

The exact number of individuals who completed classroom hours but do not receive initial certification, and the specific reasons, is unknown. However, survey findings indicate that failure to pass the background check is one contributing factor. According to Texas Certification Board data, approximately 3.7% of individuals in the certification database hold either an "Intern", a designation held by those who cannot pass a background check, or a Certified Reentry Specialist, a credential pursued by those with a criminal justice history because it does not require a background check. This percentage can be used to approximate those who graduated training but may be unable to pursue a Medicaid-billable credential due to their criminal background. In our example of 100 who enrolled in training and 78 who graduated, 3 are likely to be denied an initial certification due to their criminal justice background.

Using the cumulative investment of $1,896.75 per individual who applied for initial certification multiplied by the 3 participants likely to be denied, we can project an additional $5,481.03 in lost investments.

Full Certification

Incremental Cost and Cumulative Investment

The cost for an individual to gain their full certification is $2,651.00, which reflects opportunity and supervision costs.

- Opportunity costs: Within six months of initial certification, individuals must complete 250 hours of field experience, receiving at least one hour of weekly supervision. Because Texas Medicaid reimburses services only from fully certified peer specialists, those with initial certification often face challenges in securing full-time and paid field experience placements. As a result, many must work part-time or volunteer to complete the requirement and frequently request an additional six-month extension. Assuming weekly supervision over six months in addition to the 250 hours of field experience, and using a minimum wage of $7.25 per hour, the estimated opportunity cost is $2,001.
- Supervision costs: Individuals often are forced to choose a field experience setting where qualified supervision may not be available. This requires individuals to seek supervision from a

Certified Peer Specialist Supervisor elsewhere. Supervision costs can vary, ranging from a flat fee to an hourly rate. For the purposes of our cost projections, we assume a rate of $25 per hour over 26 weeks, resulting in an estimated supervision cost of $650.

Including the cost of full certification and all prior investments in the process, the total cumulative investment per participant to complete this stage is $4,547.75.

Attrition-Related Losses

Based on Texas Certification Board (TCB) data from January 2019 through May 2025, 35% of RSPS and 39% of MHPS initial certifications expire. In our example of 100 individuals who enrolled in RSPS training, 49 individuals obtain full RSPS certification and 26 do not. Depending on when they dropped out of the process, the 26 individuals who did not gain full certification in the time allotted translates to an additional $17,110 to $119,713 in lost investments. The low estimate assumes they did not incur any opportunity costs and the high estimate assumes they incurred all of it.

Employed

Incremental Cost and Cumulative Investment

According to the U.S. Department of Labor recruiting and onboarding a new employee costs approximately 21% of their annual salary and benefits (Boushey & Glenn, 2012; Tracey & Hinkin, 2008). In Texas, peer specialists earn an average of $20.22 per hour, or $42,057.60 annually, and most receive employer-sponsored insurance—medical (63%), dental (62%), and vision (57%), according to Lodge and Stevens Manser (2025). Using 8% of total compensation as a proxy for employer health-insurance expenditures, we estimate insurance benefits at $3,364.60 annually. Taken together, the estimated annual salary and benefits is $45,422.20 and the cost of hiring a new peer specialist in Texas is approximately $9,538.66.

Including the cost of hiring a new peer specialist and all prior investments, the total cumulative investment per individual at this stage of the process is $14,086.41.

Attrition-Related Losses

According to a TIEMH workforce survey, 26% of participants reported difficulty obtaining employment as a peer specialist. The most frequent mentioned reasons include lack of jobs, inadequate compensation and a tough job market. In our example of 100 individuals who enrolled in training, 36 individuals are likely to find employment as a peer specialist whereas 13 may not.

Whereas the cumulative investment of someone who is newly employed is $14,086, the 13 individuals who could not find employment do not carry $9,539 recruitment and onboarding expense. However, their exit adds to the cumulative loss by $57,804.

2-Year Career

Incremental Cost and Cumulative Investment

The cost for an individual to work for 2 years as a peer specialist is $756.64, which reflects opportunity and recertification costs.

- Opportunity costs: To maintain their credential, peer specialists must re-certify every 2 years. Using a minimum wage of $7.50 per hour, the estimated opportunity cost associated with obtaining the required 20 hours of continuing education is $145.00.
- Recertification costs: Recertification and background check fees are $60 and $51.64 respectively. The National Association for Addiction Professionals charges $25 per CEU multiplied by 20 hours equaling $500.

The cumulative investment of supporting someone from enrolling in RSPS training to 2 years of employment as a peer specialist is $14,843.05.

Attrition-Related Losses

As one of the largest employers of peer specialists in Texas, LMHA/LBHAs data can be used to project employment turnover and attrition. Among peer specialists employed by LMHA/LBHAs, 46.9% exit within the first year of employment, and 67.7% leave within two years, leaving only 32.3% employed beyond the two-year mark (Garuda & Stevens Manser, 2024; Garuda & Stevens Manser, 2025). This turnover rate is costly—both in direct expenses and in the strain it places on remaining staff, which can lead to burnout and even more turnover.

This challenge is not limited to LMHA/LBHAs. In a survey of 454 peer specialists, 42% said they were thinking about leaving their current job, and 44% of those planned to leave within a year (Lombardi et al., 2024). Key reasons included not earning enough to meet financial needs, being asked to take on extra tasks, low job satisfaction, and burnout. This further explains why most peer specialists allow their certification to expire after 2 years.

To retain this essential behavioral health workforce, Texas needs organizational and policy changes that address burnout, compensation, workload, and overall workplace support. Research across 20 studies also shows that supportive supervision and professional development help peer specialists feel more satisfied and stay longer. In contrast, low pay and stigma weaken the stability of the workforce (Bell et al., 2025). On an individual level, difficulties with setting boundaries and lack of self-care increase burnout and reduce job satisfaction.

In our example of 100 individuals who enrolled in training and 36 hired as a peer specialist, as few as 12 will make it to two years of employment as a peer specialist. Depending on when their employment ended, the 24 (67.7%) individuals who did NOT make a 2 year work anniversary represent $344,994 to

$363,525 in additional lost investments. The lower estimate assumes they did not incur recertification and opportunity costs, whereas the higher estimate does.

Needs Assessment: Career Mobility

High attrition and turnover among peer specialists are often cited as workforce challenges; however, these trends may also signal peer specialist career mobility rather than disengagement and system failure. Many individuals enter peer specialist roles to strengthen their own recovery, expand their professional skills, and gain experience that can serve as a springboard into other positions or career paths, rather than remaining indefinitely in an entry-level role. While a career ladder typically implies a structured, linear progression within an organization, career mobility offers a broader perspective, encompassing flexible, lateral, and non-linear moves that reflect diverse pathways for growth, skill development, and long-term professional advancement. Recognizing career mobility as a core feature, rather than a flaw, of the peer specialist role helps reframe turnover data, highlights the role's value as a workforce on-ramp, and underscores the need for clearer career pathways, advancement opportunities, and data systems that distinguish between negative attrition and positive professional progression.

> *The more I talk to them, it's like I'm talking to myself, and I'm building myself. It's just awesome to me what peer-to-peer support does.*
>
> Focus Group, 2025

Becoming a peer specialist is commonly understood as an entry-level or early-career role in the mental health and substance use recovery workforce, especially for individuals with lived experience who may not yet have formal credentials or who are seeking a career path that is more conducive to their personal recovery. Evidence suggests that working as a peer specialist can support one's own recovery by strengthening self-awareness, resilience, and confidence through helping others. These factors may contribute to personal growth and professional identity development. In a longitudinal study of peer specialists, participants reported learning more about their condition and personal strengths over the course of employment (Poremski, et al., 2022). As their recovery and resiliency deepens, they may naturally look toward further professional and career growth.

For many individuals, becoming a peer specialist is one of the first opportunities to translate personal recovery into paid, professional work, offering early exposure to systems of care, workplace expectations, and interdisciplinary collaboration. Peer specialist positions span a wide range of settings, including outpatient programs, hospitals, community mental health agencies, and peer-run organizations. This provides individuals with meaningful, hands-on experience in service delivery

while working alongside multidisciplinary teams. Through this work, peer specialists gain exposure to organizational culture, clinical and non-clinical roles, and system-level operations, while also building professional relationships with supervisors, clinicians, and community partners. These environments naturally support professional networking, which is a critical yet often under-recognized benefit of peer employment.

As in many human services fields, employers frequently rely on internal hiring and professional referrals when filling vacancies (Chan, et al., 2023). Serving as a peer specialist can therefore function as a trusted entry point into an organization or the broader behavioral health workforce. For many individuals in recovery, peer employment represents the proverbial "foot in the door"; a role that offers paid experience, credibility, and visibility, while opening pathways to advancement or transition into other positions within the same organization or industry.

"I get to use my cert, but I'm in a director role."

The career mobility framework does not supplant the need for peer specialist career ladders: clear, structured career pathways, supervision, and training supports have been recommended to enhance retention while acknowledging career growth trajectories (Lombardi, et al., 2025). Yet rigorous longitudinal research is still needed to fully understand long-term career outcomes, wage progression, and the specific conditions under which peer work most effectively supports sustainable career growth within the behavioral health field.

Case Studies

Until more comprehensive studies are available, the following real-world case studies collected through this needs assessment offer valuable insights.

Case Study 1: Cross-Sector Career Mobility Following Peer Specialist Certification

In this case study, a peer specialist completed training and certification and applied for a jail-based peer specialist role but was deemed ineligible due to a background check, despite meeting all competency requirements. This reflects a common systemic barrier in justice-adjacent settings, where policies can exclude qualified peer specialists even when lived experience is directly relevant.

"I was promoted at the company I was working as a peer support specialist to an outreach trauma specialist."

Rather than exiting the workforce, the peer specialist leveraged transferable peer specialist skills and secured employment with an insurance provider, applying peer-informed practices to support individuals navigating stress, recovery, and life

transitions. Through this work, the individual identified a calling to faith-based service and later became credentialed as a Chaplain.

This trajectory demonstrates how peer certification functions as a portable workforce credential, enabling cross-sector mobility when traditional peer specialist roles are inaccessible, and highlights the broad applicability of peer competencies across healthcare, corporate, and community support settings.

Case Study 2: Peer Support as a Catalyst for Career Advancement

In this case study, an individual entered peer support while working toward a credential as a certified welder. Through facilitating group peer support, they developed confidence in communication, leadership, and teaching. While supporting others, the individual recognized their ability not only to practice a trade, but to share knowledge and mentor others.

As a result, the peer specialist transitioned into a role as a welding instructor, applying peer specialist-informed skills such as encouragement, strengths-based feedback, and trauma-aware engagement in a technical education setting. This case demonstrates how peer specialist support can surface latent leadership capacity and serve as a bridge from skilled labor roles into instructional and supervisory careers.

Case Study 3: Training as a Bridge to Workforce and Self-Determination

In this case study, an individual completed Peer Recovery Support (PRS) training while incarcerated. Although they did not yet have a GED and were ineligible for certification at the time of release, the training provided foundational skills, a professional identity, and increased confidence.

After returning to the community, they applied for an outreach worker position at a Recovery Community Organization (RCO) and were hired based on their training, lived experience, and demonstrated readiness for the role. While employed, they were able to work toward completing a GED with workplace support.

Through paid, professional experience, the individual gained financial stability and self-confidence. Over time, they chose to pursue additional professional training outside the peer support field and became a commercial truck driver in order to better support their family.

This case illustrates how peer support training, when offered during incarceration and outside traditional certification pathways, can function as a meaningful bridge to employment, self-determination, and long-term economic mobility.

Case Study 4: Peer Support as a Pathway to Creative Entrepreneurship

In this case study, an individual with an artistic background became a certified peer specialist and contributed to recovery efforts by designing flyers, logos, and t-shirts for community events. Through this work, the peer specialist gained confidence, professional visibility, and experience translating creative skills into community impact.

Recognizing the marketability of their artwork, the individual leveraged these peer-supported opportunities to launch an independent tattoo shop and recovery t-shirt line. This case illustrates how peer specialist roles can uncover entrepreneurial potential, support small business development, and enable economic mobility while remaining rooted in recovery and community connection.

Case Study 5: Peer-to-Career Mobility in Practice

This case study illustrates peer support as both a workforce on-ramp and a career mobility pathway. The individual entered recovery in a residential setting with limited formal education, significant trauma, and no expectation of career advancement. Through exposure to peer-centered practices and being intentionally invited into service, they transitioned from volunteering to a paid peer specialist role at a local Recovery Community Organization (RCO).

Over time, the peer specialist advanced into roles including crisis support, jail-based services, program coordination, grant development, harm reduction leadership, and workforce supervision. Despite barriers such as unclear certification pathways, limited access to qualified supervisors, and extended credentialing timelines, the individual became a certified Peer Specialist Supervisor and later a program director.

This case demonstrates how structured peer specialist roles, mentorship, and opportunity support skill development, leadership growth, and long-term economic mobility, even when individuals ultimately move beyond direct peer specialist roles while continuing to apply peer support principles and lived experience.

Case Study 6: Peer Support as a Bridge to Education and Career Advancement

In this case study, an individual in a recovery center without a GED graduated the program and began working as an outreach worker. With encouragement and structured support, they pursued and obtained their GED and later became a certified peer specialist. Peer training and supervision strengthened their confidence, communication skills, and professional identity.

They subsequently advanced into an instructor and project coordinator role and are now pursuing a bachelor's degree in communications, while maintaining their project coordinator role. This case demonstrates how peer specialist roles can support educational attainment, credentialing, and

sustained career progression, particularly for individuals who enter the workforce with limited formal education.

Recommendations

Strengthening Texas' peer specialist workforce requires a comprehensive, labor-market–informed approach that goes beyond training alone to systematically assess ideal service needs, demand-side constraints, and workforce supply at the regional level. Workforce investments that fail to address reimbursement structures, supervision requirements, hiring practices, and other policy barriers risk creating misalignment between trained peer specialists and available employment opportunities. In addition, high levels of inefficient attrition and turnover at multiple points in the peer specialist pipeline, from training and certification to tenured employment, undermine workforce stability, reduce return on public investment, and limit the effectiveness of peer services.

Effective statewide workforce development must therefore be grounded in data-driven regional assessments and implemented in partnership with a broad network of stakeholders, including employers, payers, training entities, state agencies, and peer-led organizations. Addressing both structural policy barriers and avoidable workforce losses requires coordinated action across these stakeholders to ensure that peer specialists can be hired, reimbursed, supervised, and retained in sustainable roles.

A comprehensive peer-to-career approach offers a solution by intentionally linking peer specialist training, certification, employment, supervision, and ongoing professional development into a coordinated and sustainable pathway. This approach reduces unnecessary attrition, supports retention and career advancement, and ensures that individuals in recovery are equipped with the skills, supports, and career mobility needed to sustain long-term employment as peer specialists. At the same time, it expands the capacity of Texas' behavioral health system to respond effectively to the opioid crisis by aligning workforce supply with employer demand and service delivery needs.

While these efforts aim to strengthen the peer specialist workforce statewide, priority should be given to regions experiencing the most severe opioid-related harms and the greatest behavioral health workforce shortages. The following recommendations focus on removing policy barriers, strengthening regional workforce infrastructure, integrating peer services across care settings, and maximizing both the clinical and economic impact of peer specialists in addressing opioid-related challenges across Texas.

Advance the Evidence and Fill in Knowledge Gaps

A growing body of research highlights the value and impact of peer specialists in behavioral health and related systems. Studies increasingly demonstrate that peer-delivered services improve engagement, support recovery, and enhance outcomes for individuals with mental health and substance use challenges. Despite these advances, critical gaps remain in our understanding of the workforce role.

Recommended areas of continued and future study include:

1. **Labor-Market and Economic Factors**
    a. Quantify regional demand for peer specialists and project the impact of investments in service capacity
    b. Quantify the economic value peer specialists deliver so employers can better evaluate their impact and justify competitive wages.
2. **Attrition, Retention and Unemployment Factors**
    a. Investigate the underlying causes of attrition across the workforce development pipeline.
    b. Identify approaches that increase retention across the workforce development pipeline including their impact on lowering costs.
    c. Identify why many are unemployed given the shortage of certified peer specialists.
    d. Investigate how the recovery orientation and readiness of the organizations impact peer specialists retention and performance.
    e. Investigate how policy agendas added to the peer specialist curriculum have impacted frustration, burnout and attrition
3. **Career Mobility and Workforce Development**
    a. Conduct a literature review of peer specialists career ladders and career mobility
    b. Investigate the degree to which the peer specialist role functions as a transitional position versus a sustainable long-term career. If so, what career trajectory are most common.
    c. Examine how training, certification, and experience in the peer specialist role influence career readiness, advancement opportunities, and professional trajectories.
    d. Assess organizational and systemic factors that support or hinder long-term retention and career growth.
4. **Impact of Service Context**
    a. Evaluate how different service settings (e.g., clinical, community-based, telehealth, and institutional) affect both client recovery outcomes and workforce outcomes for peer specialists.
    b. Evaluate the degree to which non-metropolitan populations are being served by peer specialists living in non-metropolitan communities as opposed to those living in metropolitan settings or with metropolitan backgrounds and how this impact outcomes

c. Determine the role of employer support, supervision, and organizational culture in facilitating effective peer support and workforce retention.

5. **Peer Specialist as an Intervention**
    a. Study how engaging in peer specialist training and work contributes to the individual's own recovery capital, resilience, and personal recovery trajectory.
    b. Explore whether development as a peer specialist itself serves as a therapeutic or recovery-promoting intervention across different populations.
6. **Health and Recovery Outcomes**
    a. Collect standardized data on the effectiveness of peer specialists in improving behavioral health outcomes, including opioid use disorder recovery, engagement in care, and quality-of-life measures.
    b. Identify service gaps and determine how workforce distribution and training affect access and outcomes in underserved populations.
7. **Data Standardization and Evaluation**
    a. Develop frameworks for consistent measurement of peer specialist service delivery, workforce effectiveness, and client outcomes to enable cross-study comparisons and policy-relevant insights.

Comprehensive, Data-Driven Workforce Development

"What gets measured is what gets achieved." If the goal is to increase the number of peer specialists employed, then workforce development initiatives should ultimately be measured in terms of employment rate, although there is valuable data to be collected along the workforce pipeline. This will ensure that investments in the peer specialist workforce translate into real-world improvements in access, engagement, and behavioral health outcomes. It is critical to monitor not only training completions but also employment, retention, and performance. Historically, workforce development programs have focused primarily on the number of individuals trained. While tracking training outputs provides insight into participation, it does not indicate whether these individuals secure employment, remain in the field, or meaningfully contribute to improved outcomes. Effective workforce development requires performance metrics that capture the full pipeline, from recruitment and training to certification, employment, and long-term retention, so that resources support a functional, sustainable workforce capable of meeting the needs of Texas communities. By tracking these outcomes, initiatives can identify where attrition occurs, evaluate the effectiveness of strategies, and make data informed adjustments to maximize impact. To that effect, performance metrics are offered in the following recommendations.

Policy Strategies to Expand Peer Specialist Supply and Demand

The labor market for peer specialists in Texas is shaped by policies that influence both the supply of trained professionals and the demand for their services, and in turn their employment. Sustaining and expanding this workforce requires coordinated policy strategies that ensure sufficient numbers of qualified peer specialists are available and that meaningful employment opportunities exist; particularly in regions most affected by opioid misuse and behavioral health workforce shortages.

Supply-Focused Strategies – Expanding the Workforce:

Policies that influence supply increase the number of qualified peer specialists entering the workforce:

- **Funding for Training and Certification:** Expand state and federal funding to cover training, supervision, stipends, and certification costs, prioritizing programs serving underserved communities.
- **Career Advancement Incentives:** Support professional development, advanced certifications, and peer-to-supervisor career pathways to reduce attrition and strengthen retention.
- **Support progression:** Update policies to allow individuals to start accruing their field experience hours once they submit their initial certification application as long as they have qualified supervision. This will remove the 30 to 60 day stall that occurs between when individuals submit all the required documentation and when they can start their field experience hours.
- **Qualified Peer Supervisors:** Update Texas Administrative Code in alignment with the Centers for Medicare and Medicaid Services (CMS) guidance by removing the added clinical supervision requirement for Qualified Peer Supervisors.
- **Justice-Involved / Re-entry:** Reduce policy barriers for individuals with criminal backgrounds who otherwise meet eligibility requirements, thereby broadening the candidate pool and enabling employers to make workforce decisions based on program needs and the populations they serve. Maintaining a single foundational curriculum and credentialing pipeline that branches into multiple specialty tracks, including roles for which there are criminal background restrictions, is not relevant and counterproductive. Reinstate an existing certification (e.g., re-entry peer specialist) or create a new pathway (e.g., forensic peer specialist) with no or reduced "lookback" periods, specifically designed to serve individuals with criminal-legal involvement and histories of institutionalization. Where appropriate, leverage nationally recognized credentials with interstate reciprocity by removing unnecessary prerequisite state credentials.

Demand-Focused Strategies – Creating Jobs and Increasing Compensation:

Policies that drive demand ensure there are meaningful employment opportunities and adequate compensation:

- **Service Funding:** Increase funding streams for peer specialist services to create new positions.
- **Reimbursement Rates:** Raise fee-for-service reimbursement rates for peer specialist services to incentivize hiring.
- **Value-Based Payment Models:** Expand use of value-based payment approaches that financially reward organizations for integrating peer specialists and achieving improved outcomes.

By implementing policies that expand supply and demand, Texas can develop a robust, sustainable peer specialist workforce that meets both community needs and the economic realities of service systems.

Invest Strategically to Maximize Impact

Use a weighted scoring rubric to balance applicants from high-need and high-demand regions, ensuring a smarter use of public dollars and maximizing impact and sustainability. Focusing only on need may place specialists where jobs are scarce, while focusing only on job availability may leave high-need areas underserved. This balanced approach both strategically targets resources and aligns workforce supply with regional demand.

Strategically Allocate Resource with Regional Prioritization

Given peer specialists' demonstrated ability to cost-effectively address opioid use and other behavioral health challenges, third-party funders, particularly government agencies, have made substantial investments in peer specialist workforce development and expansion. To serve as responsible stewards of public funds, these resources should be allocated judiciously and strategically to maximize impact, sustainability, and return on investment.

All else being equal, regional need for peer specialists might suggest allocating resources strictly based on population. However, some regions face disproportionately high impacts from opioid misuse, while others experience more severe mental health workforce shortages, such as rural counties. To address these disparities, strategic resource allocation incorporates both the Opioid Use Disorder (OUD) index and the Health Professional Shortage Area (HPSA) index to adjust regional targets and investments.

Align Workforce Supply with Regional Employer Demand

Expanding the peer specialist workforce is essential to addressing opioid misuse and behavioral health challenges in Texas. However, workforce growth alone is insufficient if field experience and job opportunities are not available to support full certification and employ peer specialists at a living wage. Even in regions with the greatest shortages and highest opioid-related impacts, the absence of employment options (demand) limits the effectiveness of workforce development efforts.

To ensure that peer specialists training translates into meaningful impact, it is critical to engage regional employers, including behavioral health agencies, hospitals, criminal justice programs, and community-based organizations, in workforce planning. This engagement helps align the supply of peer specialists with local demand, supports sustainable funding for positions, and reinforces the value of peer specialists in improving client engagement, retention, and outcomes.

Effective partnerships with employers can strengthen the peer specialist workforce at every stage of the pipeline:

- **Recruitment:** Collaborate with employers and community organizations to identify motivated candidates and raise awareness of the benefits of hiring peer specialists.
- **Enrollment:** Prioritize applicants with employer recommendations to ensure alignment between training and available job opportunities.
- **Training & Certification:** Support students in developing success plans, connect them with employers offering field experience and qualified supervision, and reinforce training-employment alignment.
- **Employment:** Facilitate job placement through career fairs, job boards, structured onboarding, and highlighting labor market data such as wages and benefits.
- **Career Retention:** Provide employers with mentoring around recovery ready workplaces and continuing education, learning communities, and resources to support staff retention. Encourage subcontracting peer recovery organizations as a cost-effective strategy to reduce turnover and attrition.

By engaging employers strategically at each stage, the workforce pipeline can better align supply and demand, improve job readiness, and enhance retention of peer specialists.

Reducing Attrition and Inefficiencies Across the Peer Specialist Pipeline

Investing in workforce development without addressing attrition is like pouring water into a bucket full of holes; no matter how much is added, much of it is lost before it can create impact. Attrition at every

stage of the peer specialist workforce pipeline, from recruitment and training to certification and employment, represents a significant challenge to building a stable, effective workforce. High turnover not only limits the availability of peer specialists in regions with the greatest need but also drives up the costs of workforce development, as resources invested in recruitment, training, and supervision are lost when candidates or employees exit prematurely.

Workforce development initiatives must address barriers at each stage of the pipeline to support progression toward a tenured career as a peer specialist. Recommendations include:

Recruitment

- Target priority regions and engage employers and community partners.
- Use media and digital marketing to raise awareness in targeted communities.
- Screen applicants for alignment with career goals and readiness for certification.

Enrollment

- Lower barriers through scholarships and a clearinghouse of training opportunities.
- Offer flexible scheduling, online modules, and supplemental coaching.
- Provide mentoring and ongoing support for emerging instructors and training entities.

Training

- Require peer-to-career success plans linking students to employers, field experience, and short-term goals.
- Conduct regular check-ins to identify challenges early.
- Offer flexible training formats to accommodate work and caregiving responsibilities.

Initial Certification

- Provide technical assistance navigating applications and background checks.
- Underwrite application and background check fees as needed.

Full Certification

- Ensure access to field experience and qualified supervision.
- Connect peer specialists with affordable virtual peer specialist supervisors when necessary.

Employment

- Host career fairs, job boards, and employer networking events specific to peer specialist roles.
- Foster employer engagement to support structured onboarding and ongoing supervision.

Career Retention

- Focus training, continuing education, and supervision on core competencies rather than political or public health agendas.
- Support professional development, career advancement, and mobility plans.
- Maintain mentorship, communities of practice, and regular check-ins to address workplace challenges.
- Implement strategies to reduce burnout, such as wellness programs, peer supervision, and supportive employment networks.
- Consider financial incentives, repayment programs, and recognition initiatives where feasible.

Track Success with Key Performance Indicators

Leverage a dashboard of performance metrics to monitor progress, guide decision-making, and drive continuous quality improvement.

Allocation Index

A composite score reflecting the proportion of applicants placed where both community need and employment opportunity align, calculated using a weighted rubric.

Outcomes Index

Measures the percentage of participants achieving credential and career advancement targets, capturing progress in workforce development and professional growth.

Volume Index

Tracks the number of participants served and program activities completed relative to established benchmarks. This metric highlights gaps, monitors growth, and informs resource allocation to ensure community demand is met efficiently.

Satisfaction Rating

The percentage of participants reporting satisfaction or high satisfaction with peer-to-career support.

Appendices

The following appendices will be published with the final report.

Appendix A: Method

Appendix B: Regional Healthcare Partnership Areas and Counties

Appendix C: Survey Questions

Appendix D: Focus Group Questions

Appendix E: Consolidated Indicator Framework - Impact of Opioid Misuse

Appendix F: Needs Assessment Data Report

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