REPORT / CERTIFIED FAMILY PARTNERS

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Assessing the Status of the Certified Family Partner Workforce

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Introduction

The family partner peer support model emanated from the field of health care in the 1970s (Robbins et al., 2008). Parent peer support groups, or parent advisory groups (PAG), specifically for those with children who have mental health concerns and emotional disturbances were developed shortly thereafter (Stroul & Friedman, 1986; Young, McMenamy, & Perrin, 2001). Since then, individual and group parent peer support models have proliferated in the public mental health system (Collins & Collins, 1990; Hoagwood, 2005; Lopez, Cohen, & Szlyk, 2014). A growing body of evidence suggests that when parents with lived experience provide parent peer support, recipients of these services felt less isolation (Slowik, Willson, & Loh, 2004), had lower anxiety (Ireys & Sakwa, 2006), showed increased engagement with other health/mental health services (Koroloff & Friesen, 1991), and that service quality overall was higher (Stroul, 1996).

In Texas, a Certified Family Partner (CFP) is "a parent or guardian who has lived experience raising a child with mental or emotional challenges and who has learned to successfully navigate the systems of care" (Via Hope, 2017, para. 1). Via Hope has been the certifying body of Family Partners (FP) in Texas since 2011. Via Hope is a non-profit organization that provides education and training and is responsible for providing programs for the certification of peer support providers and family partners in Texas, as well as endorsement trainings that act as ongoing education to peers and family partners (Via Hope, 2017). Endorsement trainings for FP include The Wraparound Process, Special Education, Juvenile Justice, and Nurturing Parenting trainings (see Via Hope, 2017 for descriptions of these endorsement trainings). Via Hope is primarily funded by grants from the Texas Health and Human Services Commission (HHSC) and the Hogg Foundation for Mental Health.

Most family partner services are funded through general revenue and block grant funding, within the performance contract between DSHS/HHSC and local mental health authorities. In 2014, the Texas Department of State Health Services (DSHS) issued a statement that the Centers for Medicare and Medicaid Services (CMS) approved a proposed amendment to the Texas State Medicaid Plan, to include CFPs as providers of certain rehabilitative services (Lakey, 2014). This allowed CFPs to be one of the allowable providers able to provide parent skills training, utilizing the required evidence-based curriculum. CFP services to become reimbursable. Requirements set forth by DSHS mandated that FPs must attend Via Hope training and become certified to qualify as an eligible provider. Family peer support is funded, in part, through the Youth Empowerment Services 1915(c) Medicaid Waiver (YES Waiver), a Home and Community-Based Services Waiver serving families of children at risk of psychiatric hospitalization, residential placement, or parental relinquishment (Lopez, 2013). One goal of the YES Waiver is "to ensure families have access to parent partners and other flexible non-traditional support services as identified in a family-centered planning process" (Texas Institute for Excellence in Mental Health [TIEMH], 2017). The YES Waiver does not require certification for the provision of Family Support Services.

Researchers from TIEMH implemented two prior surveys of FPs to examine and better understand the state of the workforce (Lopez et al., 2014). The current survey is an extension of this task.

Prior Surveys

2013.

In 2013, the TIEMH summarized existing literature on parent peer support services prior to their addition to the list of eligible providers of reimbursable services (Lopez, 2013). For this report, a survey of Texas CFPs, supervisors, and program administrators was conducted to determine the structure of CFP employment, including employee benefits, training and supervision, and core functions of CFPs from the perspective of the respondents. Results of this survey were included in the 2013 report, along with recommendations to strengthen the positive impact of CFP services across the state. Additionally, the report included information from state administrative data, including the number of individuals in CFP services at each Community Mental Health Center (CMHC), volume of service encounters, and changes in the amount of CFP and support group services provided over three years. This report established that overall, CFPs felt that they had received adequate training and support in their employment. However, there were some concerns that supervision was problem-oriented rather than focused on skill development. Additionally, the following areas for future examination and improvement were identified:

- Difficulty with recruitment and retention
- Differences in capacity for providing CFP services across the state
- Limited opportunities for professional development
- Concerns that productivity standards may negatively impact service quality
- Concerns that administrators & supervisors have differing views on CFP priorities
- Concerns that families may confuse the role of CFPs given their involvement in different aspects of agency tasks
- Concerns about the discretionary nature of financing CFP services, outside of the YES Waiver

2014.

In 2014 TIEMH developed and implemented a survey of CFPs to examine their level of job satisfaction within workforce (Lopez et al., 2014). Additionally, analysis of state administrative data was employed, to test the impact of policy changes that took place in fiscal year 2014 on services provided by CFPs. Given the increased focus on productivity and larger caseloads, stakeholders were concerned that policy changes and low job satisfaction might impact turnover rates (Lopez et al., 2014). Findings of the survey suggested that job satisfaction was primarily related to the CFP's perception of their impact on the families they serve and percent of time they spend in direct contact with those families. Additionally, overall job satisfaction was related to intention to maintain employment at their current agency. One recommendation for employers of CFPs was to strategically maximize the number of direct contact time and minimize the amount of time CFPs are assigned to complete administrative tasks.

The Current Survey

Based on findings from the 2013 study, in November 2016 TIEMH implemented a survey to assess CFP training and employment outcomes including:

- Training and certification
- Opportunities for professional development

- Productivity standards and caseload size
- Supervision content
- Supervisor supportiveness and understanding
- Funding mechanisms
- Organizational Recovery Orientation

The 2016 CFP survey was based on the existing Certified Peer Specialist Training and Employment Outcomes Survey. As peer provider roles are further developed and expanded in the state, the HHSC wanted to examine the outcomes of CFPs in relation to the outcomes of CPSs on similar items. Although the roles of family partners and peer specialists in the behavioral health workforce have some differences that make direct comparison of results difficult, examining the responses of both CFPs and CPSs can provide the state and others with insight into future workforce improvements.

Methods

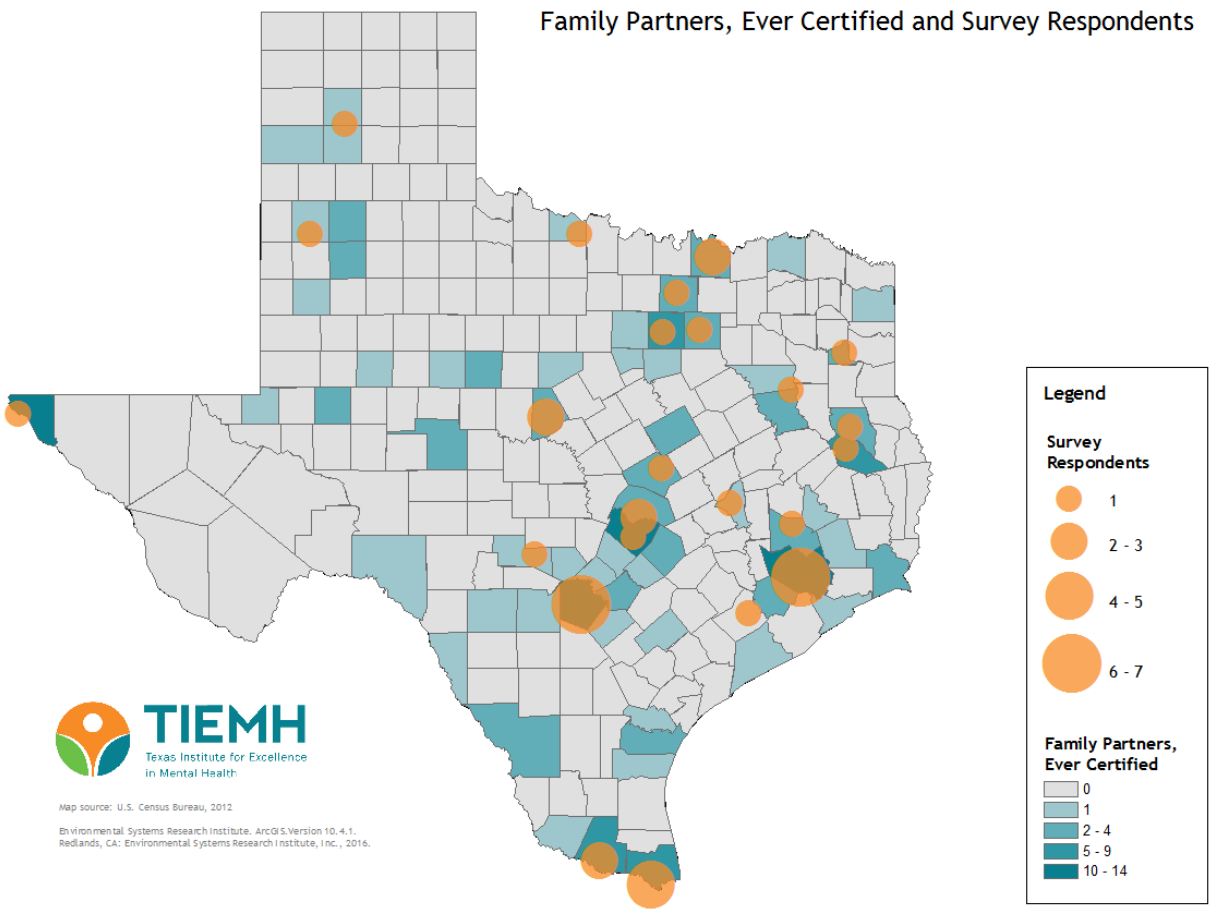
Via Hope maintains a list of CFPs that have received training through their organization. As of 2016, a total of 175 people had received CFP training. Among these, 123 were actively certified FPs and 52 were previously certified (inactive) FPs. Figure 1 shows the geographic distribution of trainees across Texas.

A survey was created in Qualitrics to elicit feedback and generate a deeper understanding of CFP employment, including on the topics of: CFP training, certification, vocational status, employment environment and satisfaction, and organizational recovery orientation. Survey development was based on the existing Certified Peer Specialist Training and Employment Outcomes survey. The survey was distributed via MailChimp to all family partners on the Via Hope distribution list with valid email addresses (n = 155). The survey was open for approximately three weeks, from November to December of 2016. Three reminder emails sent were sent during this period.

Results

Sixty-one CFPs responded to the survey (response rate = 39.0%). Figure 1 shows the geographic representativeness of survey respondents (orange) compared to the total number and geographic distribution of CFPs (blue). Overall, survey respondents were representative of most regions where CFPs have been trained. However, the west and most of the southwest border region had little to no representation in survey responses, despite the number of active and inactive CFPs that live and work in that region.

Figure 1. *Geographic representation of CFPs and survey respondents.*



CFP respondents were employed in 49 zip codes. They represented 21 of the 39 Texas local mental health authority (LMHA) service areas, 9 of 10 public health regions, and 28 counties across the state. Many CFP respondents were employed in rural regions with a metropolitan area within 100 miles (29.5%, *n* = 13). Large (21.3%, *n* = 11), medium (18.0%, *n* = 11) and small (11.5%, *n* = 7) metropolitan regions were also represented in the responses. Rural regions with no nearby metropolitan areas also had representation in the responses (3.3%, *n* = 2).

Respondent Characteristics

Of the CFP respondents, 44 were actively certified and two had inactive certification (15 did not report their certification status). All respondents who reported their gender identified as female (*n* = 52). This is representative of the CFP workforce; of the 180 total CFPs, only 3 men have completed the training through Via Hope. Descriptive information on respondents is provided in Table 1. Fifty-three percent of respondents were White (*n* = 24), 17.8% were African American (*n* = 8), 4.4% were American Indian/Alaskan Native (*n* = 2), and 26.2% of respondents were of Hispanic or Latino origin. Among the CFP respondents, 24.6% had a high school diploma or GED and 59.3% reported having some college or post high school education.

Table 1. *Descriptive information on CFP respondents.*

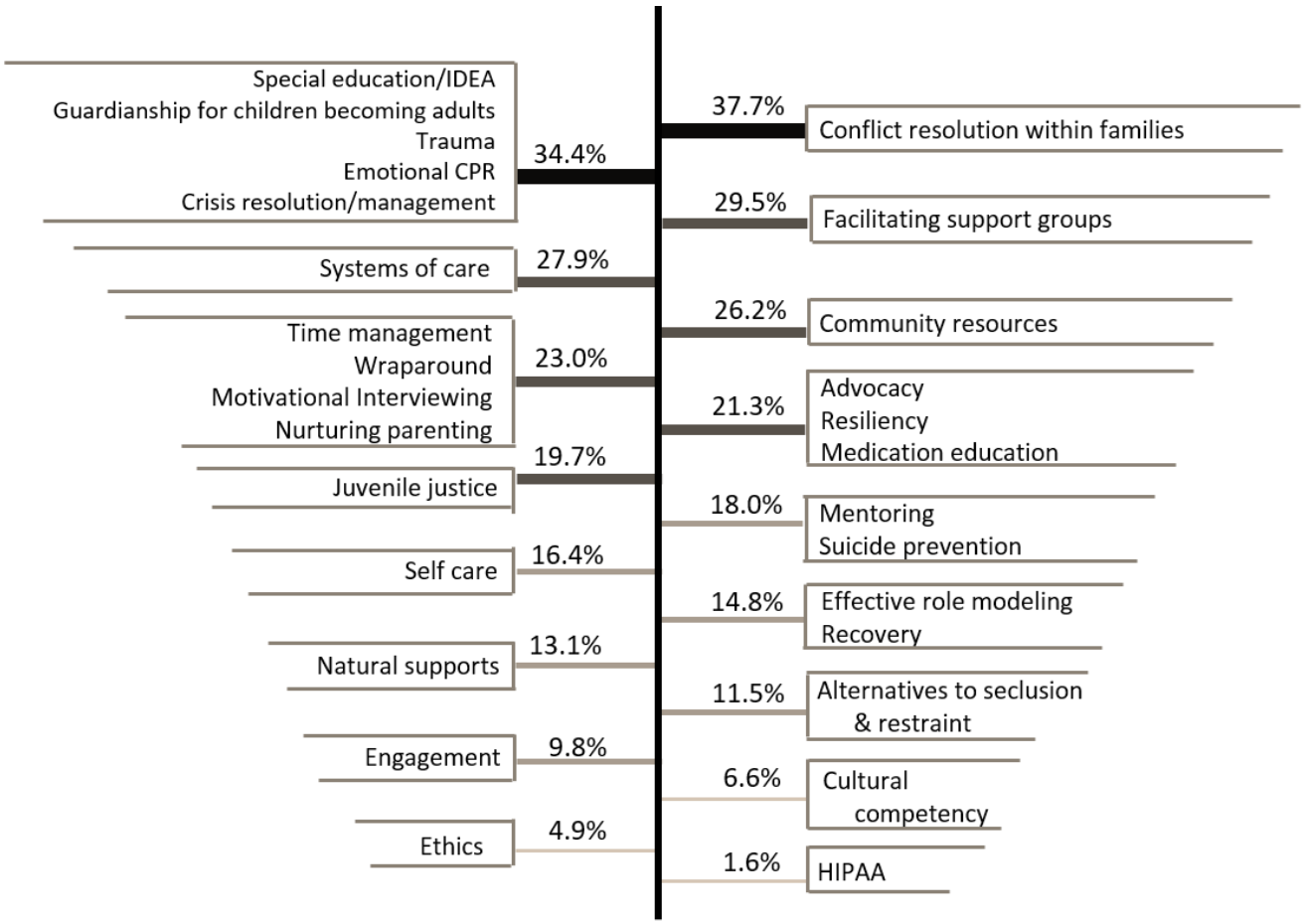
Age in years	Number	Percent
18 to 25	0	–
26 to 29	2	3.3
30 to 39	13	21.3
40 to 55	21	34.4
56 or older	16	26.2
Sex		
Female	52	100.0
Race/Ethnicity		
White	24	53.3
African-American	8	17.8
American Indian/Alaskan Native	2	4.4
Latino/Hispanic	16	26.2
Highest education obtained		
Less than 12th grade	0	0.0
High school diploma / GED	15	24.6
Some college or post-high school training	19	31.1
2-year Associate degree	5	8.5
4-year college degree	8	13.1
Post-college graduate training	4	6.6

Most CFPs were the primary caretaker of their child (or children) with behavioral, emotional, or mental health challenges (70.5%). Of these, the majority lived with their child in the home (79.1%). Overall, the majority of CFPs lived with four or more people in the household (62.4%), though some lived alone (3.3%), with one other person (6.6%), or with 2 other people (11.5%).

Training and Certification

In addition to Via Hope certification, 42.6% of CFPs reported receiving a variety of trainings, from general training provided by employers (e.g. Health Insurance Portability and Accountability Act [HIPAA] training, cardiopulmonary resuscitation [CPR] certification, and violence reduction courses) to more elective trainings. Elective trainings included: advocacy training through Partners Resource Network, Parent Training and Information Center (PTI) training, Motivational Engagement, Pharmacological, Satori Alternative to Managing Aggression (SAMA), and Applied Suicide Interventions Skills Training (ASIST). Endorsement trainings attended by the respondents included Wraparound Process, Special Education, Juvenile Justice, and Nurturing Parenting trainings. Additionally, and importantly, 44.3% of CFPs reported that they were able to observe or shadow a more experienced family partner as a part of their employee training. Many CFPs reported interest in attending additional trainings (see Figure 2).

Figure 2. *Percent of respondents that were interested in additional trainings on selected topics.*



CFPs also reported that they had attended several types of training and conferences (see Table 3). One respondent each reported attending: the Texas Advanced Leadership and Advocacy Conference, Trauma Informed Care conference, and the Family-Run Executive Director Leadership Association.

Table 3. *Types of trainings attended by respondents.*

Training attended	Number	Percent
Nurturing parenting	32	52.5%
Wraparound endorsement training	31	50.8%
Special education endorsement training	30	49.2%
Mental Health First Aid	26	42.6%
Strengthening Youth and Families conference	18	29.5%
Parent to Parent conference	12	19.7%

NAMI Basics	6	9.8%
Partners in Prevention conference	3	4.9%

Employment Status, Salary, and Benefits.

Most respondents were fully (67.2%) or part-time employed (6.6%). Four respondents were employed as contract workers either full (4.9%) or part-time (1.6%). One respondent was a part-time volunteer. Almost 10.0% of respondents reported working more than 40 hours per week. Most worked 40 hours per week (55.7%). Respondents salaries averaged $14.09 per hour (*SD* = $3.90). Reported hourly salary ranged from $8.90 to $25.50. Most respondents reported receiving some type of employee benefits (see Table 4). Three respondents reported that they received no employee benefits. The number of CFPs receiving each type of benefit has decreased since the original 2013 survey of family partners (Lopez, 2013), but additional information from respondents is required to understand this change. Additionally, five respondents reported that their employers provided access to other benefits, including employee assistance programs, FSA accounts, vision insurance, and holiday pay.

Table 4. *Employer provided benefits.*

Benefits Provided	Number	Percent
Paid vacation	40	85.1%
Dental insurance	39	83.0%
Medical insurance (employee)	35	74.5%
Paid sick leave	33	70.2%
Retirement	32	68.1%
Disability insurance	24	51.1%
Medical insurance (employee and family)	12	25.5%

Type of Employment and Job Tasks.

Most respondents worked for a Local Mental Health Authority (LMHA). Two respondents worked in other settings. Respondents had worked at their current organization from 10 months to 25 years (*M* = 6 years, *SD* = 5.6 years). Respondents served an average of 14 families per week (*M* = 13.52, *SD* = 7.14). Three outliers were excluded from this average; two reported a caseload of 0 (which may suggest they were employed as supervisors) and one reported an average caseload of over 80 families, which is also notable.

Respondents reported responsibility for a range of activities (see Table 5). Most respondents reported that they inspired hope for a better future (57.4%) and served as a role model (55.7%) on a daily basis. Other tasks completed on a daily basis included engaging families in services (47.5%) and providing social support (45.9%). CFPs also reported spending a lot of their daily and weekly time helping families access community

resources, teaching advocacy skills, and assisting in planning services and supports. Many respondents reported that they never facilitated team meetings (24.6%). About half of respondents (49.2%) reported that they facilitated parent support groups on a monthly basis.

Table 5. *Frequency that respondent completed the following job tasks.*

How frequently do you perform each of the following tasks?	Daily	Weekly	Monthly	Quarterly	Yearly	Never
Inspiring hope for a better future	**57.4%**	13.1%	4.9%	1.6%	0%	0%
Serving as a role model	**55.7%**	11.5%	3.3%	1.6%	1.6%	0%
Engaging the family in services	**47.5%**	18.0%	4.9%	3.3%	0%	1.6%
Providing social support	**45.9%**	21.3%	6.6%	1.6%	0%	1.6%
Identifying community resources	**39.3%**	19.7%	8.2%	3.3%	0%	3.3%
Providing education about mental health and service options	**37.7%**	19.7%	13.1%	4.9%	0%	1.6%
Helping access community resources	**36.1%**	26.2%	9.8%	1.6%	0%	3.3%
Teaching advocacy skills to families	**34.4%**	21.3%	14.8%	1.6%	0%	3.3%
Assist in planning services & supports	**34.4%**	21.3%	9.8%	3.3%	1.6%	3.3%
Assist families in navigating other systems (e.g. school)	**32.8%**	26.2%	11.5%	3.3%	0%	3.3%
Sharing personal story	29.3%	23.0%	4.9%	4.9%	1.6%	1.6%
Teaching parenting skills	24.6%	24.6%	14.8%	4.9%	0%	6.6%
Educating families about policy issues affecting their families	19.7%	26.2%	13.1%	8.2%	1.6%	4.9%
Assisting family in transitioning out of or to less intensive services	16.4%	6.6%	24.6%	14.8%	1.6%	8.2%
Responding to crisis events	9.8%	23.0%	23.0%	6.6%	1.6%	11.5%
Serving on work groups/committees	6.6%	8.2%	26.2%	9.8%	4.9%	16.4%
Facilitating team meetings	4.9%	6.6%	24.6%	4.9%	1.6%	24.6%
Facilitating parent support groups	1.6%	6.6%	**49.2%**	4.9%	4.9%	8.2%

Career Development.

Most respondents (50.8%) reported that their organization did provide opportunities for career development. Others reported that there were no such opportunities (13.1%) or that they were unaware whether there were supported opportunities for career development (9.8%). Opportunities for development that respondents specified included: endorsement trainings, conferences, staff development, webinars, outside CEUs, Via Hope events, and YES training. One respondent also reported tuition assistance with their Master's degree program was an employer provided benefit. Another reported that they received 40 hours of paid educational leave per year.

Supervision.

Respondents were asked to respond to several items related to supervision frequency. Respondents most frequently met with their supervisors on a monthly basis (34.4%), followed by weekly (15.4%) and quarterly (8.2%). In addition, the same number of respondents reported meeting daily, yearly, and never (4.9%).

The content of respondents' supervision meetings largely reflected this (see Table 6). Discussing assigned families (41.0%), administrative tasks (41.0%), and reviewing fidelity information (36.1%) were the most frequent content of monthly supervision. Discussing wellness and self-care (19.7%), learning and practicing skills (21.3%), and discussing case documentation (23.0%) were frequent topics of weekly supervision. Almost 12.0% of respondents reported that they "never" discuss their personal wellness and self-care during supervision meetings.

Table 6. *Topics and frequency of supervision.*

Frequency of activities during supervision	Daily	Weekly	Monthly	Quarterly	Yearly	Never
Discuss/review assigned families	3.3%	18.0%	**41.0%**	6.6%	1.6%	4.9%
Discuss/review case documentation	3.3%	23.0%	**32.8%**	6.6%	1.6%	8.2%
Discuss/review administrative tasks	3.3%	14.8%	**41.0%**	9.8%	0%	6.6%
Discuss your wellness and self-care	1.6%	19.7%	**31.1%**	6.6%	1.6%	11.5%
Learn or practice skills	4.9%	21.3%	**34.4%**	1.6%	4.9%	6.6%
Review fidelity information	3.3%	14.8%	**36.1%**	6.6%	1.6%	9.8%

Many CFPs reported that their supervisor observes their work with families (45.9%). Fewer reported that their supervisor never observes their work (23.0%). A small number reported that this was not applicable to their employment situation (6.6%). Additionally, many respondents reported that their supervisor had completed training as a family partner supervisor (37.7%). The remainder reported that their supervisor had not (21.3%) or that they were unsure (16.4%).

Productivity Expectations.

A majority of respondents reported that they have specific productivity expectations (63.9%). Some reported having no expectations for productivity (11.5%). For those that reported they did have productivity expectations, the average percent of direct contact hours relative to work hours was 44.0% (*SD* = 25.5). These productivity standards were primarily defined by face-to-face contact hours (82.1%).

Reimbursement and Billing.

Streams through which family partner services were reimbursed were diverse. More than half of CFPs reported that their organization billed Medicaid through the YES Waiver for at least part of their caseload (52.5%). Some respondents (8.2%) reported that services provided to 100.0% of the families on their caseload were reimbursed through the YES Waiver. Other CFPs who provided services through the YES Waiver (44.0%) reported that their funding was partially derived from it. For these CFPs, the percentage of services to families which were reimbursed through YES Waiver ranged from 5.0% to 80.0% (*Mdn* = 33.0%).

Other funding sources reported as open-ended responses included general revenue, DSHS funds, and Managed Care Organizations (MCOs). In addition to the YES Waiver, 39.5% of organizations billed Medicaid through their Skills Training and Nurturing Parenting programs. Another 18.0% sought reimbursement through the 1115 Waiver. Some CFPs (16.4%) reported that they were not sure which sources of revenue their organizations billed for their services.

Collaboration with Coworkers.

Most respondents (78.0%) worked at organizations that employed multiple family partners. Of these, the number of other family partners employed at the respondents' organization ranged from 1 to 14 (*Mdn* = 3.5). Among organizations that employed more than one family partner, 11.4% of respondents reported that they rarely (annually) or never collaborate with other family partners (see Table 7). Those respondents who reported that they *do* collaborate with other family partners at their agency, collaborations most frequently occurred on a daily (37.1%) or monthly (31.4%) basis.

Most collaborations between family partners and non-family partners were conducted on a daily basis (49.2%), followed by weekly (14.8%) and tapered down in levels of frequency. No family partner responded that they never collaborate with non-family partner staff at their organization.

Table 7. *Frequency of collaboration with other family partners and non-family partners within their organization.*

Collaboration frequency	Daily % (#)	Weekly % (#)	Monthly % (#)	Quarterly % (#)	Yearly % (#)	Never % (#)
With other family partner(s)	37.1% (13)	14.3% (5)	31.4% (11)	8.6% (3)	5.7% (2)	5.7% (1)
With non-Family partner	49.2% (30)	14.8% (9)	6.6% (4)	1.6% (1)	1.6% (1)	0.0% (0)

Understanding and Supportiveness of Supervisors and Coworkers.

Respondents were asked to rank how understanding and supportive their supervisors and coworkers are (see Table 8). On a scale from one-to-ten, where ten was "excellent" and one was "poor", most respondents reported that their supervisor's *understanding of the family partner job role* was good (*M* = 7.84, *SD* = 2.45). However, five respondents rated their supervisor's understanding of the family partner's role on the lower "poor" end of the spectrum (1-4). Additionally, on a scale from one-to-ten, where ten was "very supportive" and one was "not at all supportive" most respondents rated their supervisors' *overall level of supportiveness* as very good (*M* = 8.21, *SD* = 2.36). Three reported that their supervisor was in the "not at all supportive" range (1-4). These results are similar to those reported by certified peer specialists who have explained that their supervisor may be extremely supportive of them but still not fully understand their role.

In contrast, family partners found non-family partner staff at their organizations to be less *understanding of the family partner job role* (*M* = 6.40, *SD* = 2.70). Eleven respondents reported that their coworkers had an understanding on the "poor" level of the spectrum (1-4). They also ranked their coworkers lower on their *overall level of supportiveness* (*M* = 6.93, *SD* = 2.9), when compared with the family partner's supervisor. Here, nine respondents rated their coworker's supportiveness on the "not at all supportive" range (1-4). These responses are also similar to responses from certified peer specialists, indicating a need for general education on the role of peer providers in the behavioral health workforce.

Table 8. *Family partner ratings of their supervisors' and co-workers' understanding and supportiveness of the family partner role.*

Supervisor Ratings			
Understanding	#	Supportive	#
1- Very poor	1	**1**- Not at all supportive	1
2	1	**2**	0
3	2	**3**	2
4	1	**4**	0
5- Neutral	3	**5**- Neutral	5
6	0	**6**	0
7	9	**7**	5
8	2	**8**	4
9	10	**9**	6
10- Excellent	14	**10**- Very supportive	20

Co-worker Ratings			
Understanding	#	Supportive	#
1- Very poor	2	**1**- Not at all supportive	3
2	2	**2**	1
3	5	**3**	4
4	2	**4**	1
5- Neutral	4	**5**- Neutral	4
6	4	**6**	2
7	7	**7**	6
8	7	**8**	8
9	3	**9**	1
10- Excellent	7	**10**- Very supportive	13

Satisfaction in Employment

Respondents were asked to rate several items related to employment satisfaction (see Table 9). Most respondents reported that they either "agree" or "strongly agree" that they are valued and respected by their coworkers and supervisors, that they are able to perform their job well, that their supervisor outlines the family partner's job tasks and requirements well, and they are satisfied with their overall job experience. There may be some room for improvement in writing job descriptions, as the "neutral" response for this item was highest (18.0%) for any question, indicating that the written job description and actual job duties may not be aligned. Many respondents reported that they do not feel stigmatized by co-workers; however, more than one-quarter (26.2%) reported that they do, or that they were "neutral". Additionally, almost 15.0% of respondents were neutral as to whether their boss listens to their suggestions, ideas, and opinions, and felt neutral as to whether their coworkers accepted and respected them.

Table 9. *Family partner's ratings of aspects related to employee satisfaction.*

Please indicate your level of agreement with the following statements:	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
I feel I am able to do my current job well.	**39.3%**	24.6%	6.6%	0%	1.6%
My supervisor listens to my suggestions, ideas, and opinions.	**31.1%**	21.3%	14.8%	0%	3.3%
I am satisfied with my overall job experience.	**31.1%**	**29.5%**	8.2%	0%	3.3%
Working in my current position has positively impacted my family.	**29.5%**	24.6%	13.1%	3.3%	1.6%
I feel accepted and respected by my colleagues.	24.6%	26.2%	14.8%	3.3%	3.3%
My job description realistically reflects my actual job duties.	21.3%	26.2%	18.0%	1.6%	4.9%
My supervisor explains the skills or procedures I am expected to perform.	24.6%	27.9%	11.5%	4.9%	3.3%
I feel stigmatized as a result of the actions or words of my co-workers.	4.9%	9.8%	11.5%	19.7%	26.2%

Support in Employment

Participants were also asked to rate their level of agreement with several items related to their feeling of being supported in their employment (see Table 10). The most polarizing question was on the topic of training. While the majority of respondents reported that they "agree" or "strongly agree" that they received adequate training to be competent in their roles, over 23.0% of respondents reported that they strongly

disagreed. The majority reported that they did receive adequate supervision (54.1%). Additionally, the majority agreed that coworkers understood the role and value of the family partner within the organization (50.9%), and almost half (49.1%) reported that directors and managers did, too.

Similar to a previous item on career development, more respondents disagreed and strongly disagreed (31.1%) that they had adequate opportunities for career advancement than agreed and strongly agreed (26.3%). Almost half of respondents felt that they did have adequate opportunities for professional development (42.7%), though many were neutral (14.8%) or ranged in disagreement (14.7%). Many respondents felt that they did have adequate opportunities to network with other family partners (39.3%).

Table 10. *Family partner's ratings of aspects related to employee support.*

Please indicate your level of agreement with the following statements:	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
I have adequate supervision to be competent in my role as a family partner.	29.5%	24.6%	9.8%	3.3%	3.3%
I have adequate training to be competent in my role as a family partner.	26.2%	32.8%	8.2%	1.6%	23.3%
I have adequate support from my agency to be a successful family partner	21.3%	19.7%	21.3%	6.6%	3.3%
My coworkers within my organization understand and value the work that I do.	23.0%	27.9%	11.5%	4.9%	4.9%
Directors or managers within my organization understand and value the work that I do.	18.0%	31.1%	11.5%	8.2%	1.6%
I have adequate opportunities to network with other family partners either at my organization or in similar organizations.	18.0%	21.3%	16.4%	4.9%	11.5%
I have adequate opportunities for professional development.	14.8%	27.9%	14.8%	9.8%	4.9%
I have adequate opportunities for career advancement.	11.5%	14.8%	14.8%	18.0%	13.1%

Organizational Recovery Orientation

In the final section of the survey, respondents were asked to relate the extent to which they believe the organization they work for provides recovery-oriented services using the staff version of the revised Recovery Self-Assessment (RSA) (Lodge et al., 2016). Responses were recorded and ranked (see Table 11). Overall, most responses to items on the RSA were positive. Two items tied with the fewest "rarely" and "never" responses (0.0%, and 1.6%), indicating the highest overall rates of occurrence: "models hope" and "partners

with people to discuss progress towards their goals". Items that most often "always" occurred included "believes people can grow and recover" (39.3%), "respect's people decisions about their lives" (37.7%), and "is open with people about all matters regarding their services" (37.7%).

During RSA revision (Lodge et al., 2016), peer consultants specifically suggested two items be added to the shortened version of the instrument, including one to measure the provision of trauma-informed services. In the current survey of family partners, the RSA item with the most "never" responses measured how often the respondent's organization provided trauma-specific services (4.9%). An additional 9.8% of respondents reported that their organization "rarely" did so. This also relates back to the respondents' most-desired additional training topics which is further discussed in the next section of this report.

Table 11. *Family partner ratings of elements of their organizations' recovery orientation.*

Our organization…	Always	Often	Sometimes	Rarely	Never
Believes people can grow and recover.	**39.3%**	21.3%	6.6%	1.6%	1.6%
Respects people's decisions about their lives.	**37.7%**	19.7%	11.5%	1.6%	1.6%
Is open with people about all matters regarding their services.	**37.7%**	19.7%	9.8%	3.3%	1.6%
Models hope.	**34.4%**	19.7%	16.4%	0%	1.6%
Focuses on partnering with people to meet their goals.	**34.4%**	19.7%	13.1%	3.3a%	1.6%
Partners with people to discuss progress towards their goals.	**34.4%**	23.0%	13.1%	0%	1.6%
Offers people a choice of services to support their goals.	**34.4%**	23.0%	9.8%	1.6%	1.6%
Invites people to include those who are important to them in their planning.	**34.4%**	16.4%	14.8%	4.9%	1.6%
Provides trauma-specific services.	**31.1%**	16.4%	9.8%	9.8%	4.9%
Asks people about their interests.	29.5%	18.0%	19.7%	3.3%	1.6%
Offers people opportunities to discuss their spiritual needs when they wish.	29.5%	16.4%	18.0%	4.9%	3.3%
Offers services that support people's culture or life experience.	29.5%	21.3%	16.4%	1.6%	3.3%
Introduces people to peer support or advocacy.	29.5%	13.1%	21.3%	4.9%	3.3%
Supports people to develop plans for their future.	26.2%	26.2%	14.8%	3.3%	1.6%
Encourages people to take risks to try new things.	16.4%	18.0%	24.6%	8.2%	3.3%

Additional Thoughts and Comments

Finally, participants were asked to provide any additional comments and feedback related to their employment. Broadly, these comments covered their 1) desire for additional training, support, and education; 2) satisfaction with their employment; 3) thoughts on compensation and career advancement; and 4) thoughts on their professional titles, roles, and responsibilities.

In close accordance with several items on the survey, the desire for additional trauma-informed care trainings was the point most frequently specified. There was a strong trend in appealing for additional trainings and skills, overall. Some respondents reported that they have difficulty attending out of town trainings and were encouraged by recent opportunities to earn CEUs via webinars. Finally, one respondent felt that Via Hope could do more to assist in ongoing training and education.

Many respondents described their satisfaction with their job, overall. They reported feeling that they made a difference. One respondent reported that FP integration within the organization was smooth, and that they felt like a valuable employee. Another stated that they felt many aspects of their employment were especially rewarding.

Respondents also commented further on their level agreement with the previous measures of satisfaction with employment (from Table 10), especially related to compensation and career advancement. Here, one respondent reported that they were unaware if even the *opportunity* for increased compensation and job advancement existed. Several respondents reported that their level of compensation suggested that their work may be of lower value than other employees, despite equal or additional responsibilities and productivity standards.

Finally, respondents commented further on various elements related to their professional titles, roles, and responsibilities. Two respondents reported that they were expected to fundraise or pay for components of parent support groups (e.g. materials and food/meals) out of their own pockets, and await reimbursement because CFPs did not have an organizational budget allocated for these expenses. Uncertainty about the source of funding for group and staff meetings and other job tasks were reported to induce stress and contribute to burnout. Additionally, one respondent identified the importance of examining the impact of CFP services from an evidence-based practice perspective. One respondent reported that they had experienced a smooth integration with other team members, and that they were working to build more connections. Another reported that they believe all supervisors should attend Via Hope's FP supervisor training in order to further support FPs, which might also improve integration, supportiveness, and understanding of the FP job role and value.

Discussion

The fiscal year 2017 survey was intended to assess and report on the current status of the family partner workforce. Some changes have occurred since the most recent survey in 2014. In terms of the overall features of employment, fewer family partners are receiving several employee benefits, including individual health insurance (78.1% →74.5%), family health insurance (56.3% → 25.5%), sick leave (78.1% → 70.2%),

and retirement contributions (84.8% → 68.1%) than were in the 2014 report. Full-time employment status accounted for the difference in rates of individual health insurance being offered; this was actually higher in the current survey than in 2014, at 85.0% among full-time respondents. But it did not account for decreases in family health insurance, sick leave, and retirement contributions. Additionally, the respondent family partners had a strong rate of tenure within their agencies, averaging 6 years of employment at their current organization. So this is also unlikely to be the cause of the decrease. In addition, almost 10% of respondents were unsure as to whether their employer offered benefits. This trend should be explored further, to determine what actions can be taken to ensure that family partners are afforded the same benefits as other full-time employees.

There were some similarities between the current survey and results from the 2013 report. Respondents from both surveys were responsible for a range of caseload sizes. Additionally, there was a wide variety of expectations for productivity. The continued array in caseload size may partially demonstrate the representativeness of respondents; it is possible that those respondents who reported their caseload was "0" may be CFP supervisors. Additionally, among each category of employee status (full time, part time, volunteer, etc.), caseload size was highly variable. Given the variety of responses, in the future it may be possible to examine other factors as a function of caseload size, for example to determine if job satisfaction is related to caseload size.

In addition to uncertainty about their eligibility for employee benefits, there were some topics related to their employment that FPs reported were unclear. Approximately 15% of respondents did not know if their supervisor had attended FP supervisor training. Another 16% were unsure about billing and funding mechanisms for their position. These suggest there is room for improvement in communication of important aspects of employment. Both of these points could be clarified during the employee onboarding process. They also might make good points for discussion during supervision.

In a previous survey, Lopez (2013) found that FPs felt more supervision time was spent on case reviews and was problem-oriented, rather than focused on FP skill-building. In the current survey, this gap appears to be closing; almost the same number of FPs reported that time in supervision was spent building skills (60.6%) as was on discussing assigned cases (62.3%). Additionally, skill-building during supervision occurred approximately as often as administrative tasks (59.1%) and reviewing documentation (59.1%). This may be a sign of improvement. However, there might still be room to increase the number of skill-building opportunities, both in supervision and in outside trainings. Over 20% of respondents reported that they very infrequently (3-12 months) or never discuss their self-care during supervision. This could have implications for FP employment and practice. However, whether or not this is problematic requires additional investigation. It is important to note that respondents rated their supervisors moderately highly on "level of supportiveness" (8.21/10.0) and "understanding of role" (7.84/10.0). So, the current rate of discussion of self-care may be sufficient to FPs.

In order to assist agencies in writing accurate job description, the Via Hope CFP manual lists major responsibilities of the position. It also specifically recommends that agencies provide FPs with a budget for food and materials for groups meetings they lead. However, in the current survey almost 25% of respondents reported that they were neutral, disagreed, or strongly disagreed that their job description accurately reflects the work that they do. Additionally, two respondents reported that they lacked a budget for group meetings and were required to pay out of pocket for expenses and await reimbursement. Responses to the open-ended survey item suggests that some respondents are accountable for additional tasks that are

beyond those essential to their role as a FP, including fundraising and cooking food for group meetings that they lead. Results from a previous survey (Lopez et al., 2014) suggested that designated job duties responsibilities were important for both employee satisfaction and retention; in the prior study, job satisfaction and intention to quit were related to the percentage of time FPs spent in direct contact with families they serve, and with their perception of impact on families. One recommendation from the 2014 report was for supervisors and employers to strategically maximize direct contact time and to minimize the time dedicated to administrative and other tasks. It remains that reducing the amount of time FPs spend on auxiliary, unrelated tasks should be of interest to organizations.

One of the largest themes of the current survey was the desire for additional trainings, as well as more opportunities to attend them. This was evident in the survey sections related to additional trainings, but it was also brought up several times in the "final thoughts" section, as well as in the "recovery orientation" section. Many respondents (25%) felt that they had not received adequate training to be proficient in their role. This may, in part, be due to the additional roles that FPs are asked to take on within their agencies. However, several respondents reported that they needed more trainings on trauma, crisis resolution, and conflict resolution in order to efficiently support other families. Overall, FPs reported that their organizations did provide recovery-oriented services, with the exception of providing trauma-informed services. This suggests that family partners may be searching to acquire additional tangible and pragmatic skills, as opposed to attending administrative trainings or focusing on theoretical knowledge building. There has also been growing interest in advancing and improving the provision of trauma informed care in the field of peer support (non-family partner). Thus, it may be very beneficial for Via Hope or another organization to add a peer provider endorsement training on trauma-informed or trauma-specific services to their roster.

Another subject that respondents found important to emphasize in multiple sections of the survey was that of career advancement. When asked whether they felt they had adequate opportunities for career advancement, almost half of respondents (31%) disagreed or were neutral (15%). In response to the open-ended item at the end of the survey, it was clear that opportunities for career advancement was also a point of ambiguity: some FPs were unsure if there was even *possibility* of a raise and advancement in the position, despite attempts to clarify with their employer. Given the rate at which the FP workforce will continue to grow (Lopez et al., 2014), and how closely career advancement is related to employee retention and satisfaction (Society for human Resource Management [SHRM], 2016), this is an issue that must be addressed. Organizations need to seek feedback and assistance from their employees, and perhaps Via Hope or HHSC, to determine ways to improve opportunities for career advancement.

Final Recommendations

Results of the current survey suggests that some recommendations from the previous two reports should be carried over. These include:

- Developing communication tools targeting policy makers, administrators, and other behavioral health professionals, in order to highlight core activities and the critical role FPs play.
- Minimize time spend on administrative tasks and maximize the role of direct contact with families, in order to increase FP employee retention.
- Via Hope and TIEMH should work to identify or develop tools to support coaching of family partner skills development, either by a supervisor or external coach.

Additionally, the following new recommendations arose from results of the current survey:

- Opportunities to attend training with support by employers should be explored. In particular, a trauma-informed services endorsement training should be developed so that CFPs can better meet the needs of families they work with.
- Via Hope should work with organizations to increase the number of their FP supervisors that attend the FP supervisor training and to ensure that CFP job description aligns with their work.
- Via Hope and HHSC should work with organizations to promote their recommendation that FPs be given adequate funding to facilitate group meetings.
- In CFP certification, FPs should receive training on ways to improve transparency in the onboarding process and throughout supervision, to advocate for themselves to receive parity with other care providers at their organizations.
- Similar to findings with certified peer specialists, it would be helpful to include family partners as trainers in new employee orientation and onboarding processes so new staff are familiar with the role CFPs serve and the specific services they provide.
- Also similar to findings with certified peer specialists, opportunities for career advancement in their organizations and in the CFP field in general should be developed.
- The state of the CFP workforce should be assessed regularly, to identify trends, areas of improvement, and new recommendations for improvement and retention of this workforce.
- Some issues identified by this survey (e.g. reduction in employee benefits, supervisor or other staff understanding of the CFP role, billing mechanisms, self-care, and skill development during supervision) would benefit from further investigation.

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