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Predictive Relationship Between Family Support Partners and Caregiver Empowerment Levels

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Walden University
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Abstract

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by

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MA, Webster University, 2003

BA, University of Arkansas Little Rock, 2000

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

In recent years, family support partners (FSPs) have been hired to work in the behavioral health care system for the state in which this study was conducted. FSPs are legacy caregivers, meaning they have raised a child with a mental health illness. At the time of this study, there was not a set criterion in the state to measure the effectiveness or benefits of FSPs working with families. The purpose of this quantitative, correlational study was to determine whether a caregiver's level of empowerment, as measured by the Family Empowerment Scale (FES), was increased through working with an FSP. Social learning theory provided the framework for the study. Survey data were collected from 93 caregivers using the FES. Simultaneous multiple regression analysis was conducted to examine the predictive relationship between the caregiver's gender, age, ethnicity, length of time as a caregiver of a child or youth with a mental health illness, and length of time the caregiver worked with an FSP, and the level of caregiver empowerment on the family, service system, and community/political levels. On the family level, caregiver age and length of time the caregiver worked with an FSP were statistically significant predictors. On the service system level, length of time the caregiver worked with an FSP was a statistically significant predictor. On the community/political level, caregiver age, ethnicity, and length of time the caregiver worked with an FSP were statistically significant predictors. Length of time the caregiver worked with an FSP was the only variable shown to be statistically significant on all 3 levels. Findings may be used to support peer specialists in the state this study was conducted and other states, not only in the mental health field, but in additional fields as well.

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Acknowledgments

“Nothing in the world is worth having or worth doing unless it means effort, pain, difficulty.… I have never in my life envied a human being who led an easy life. I have envied a great many people who led difficult lives and led them well.”

Theodore Roosevelt

First and foremost, I would have never made it this far without the love and support of God, my family, and my friends. My children and family sacrificed and encouraged me constantly. When I began this journey, it was to demonstrate to my children that no matter what happens in life, good can come from the most difficult challenges. Throughout this process, I have met amazing colleagues and friends, one of whom passed away during her doctoral journey. I remember her always and dedicate my work in honor of her memory. To God, my family, and my friends, I thank each of you for your love, support, and guidance as I strove to reach my goals in life. I am excited for this next chapter in my life to be able to reach my dream of making a difference in the lives of families every day.

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Chapter 1: Introduction to the Study

This study developed from a personal observation while working with a client in a *wraparound* team meeting. The goal of providing wraparound services is to keep a child and/or youth with a mental health diagnosis receiving behavioral health services in their school, home, and community setting. This can be accomplished through working with an entire team, including school professionals, therapeutic team members, family members, department of human services case workers, and department of youth services staff members, in addition to other stakeholders. A need was uncovered for a mother to seek mental health services for herself. When this need was discussed during a wraparound team meeting, the mother decided not to accept the recommendation. However, after a family support partner (FSP) started working with the mother and shared her own experiences, the mother decided to seek mental health treatment. This revelation was stunning. Although I was unaware of the exact conversation that occurred between the client and the FSP, I suspected that sharing similar experiences breaks down stigma toward mental health treatment and leads to a more collaborative relationship.

From this experience, I endeavored to determine why the comments made by the FSP made a difference. I feel more research is needed to explore possible benefits for caregivers who work with peer support professionals. The idea of peer support is not a new concept in the behavioral health field. There is currently a psychosocial rehabilitation movement promoting the idea that people with similar lived experiences can assist and support others in their recovery (Clark, Barrett, Frei, & Christy, 2015). According to the “Peer specialist/peer support training: Participant manual” (2012), there have been major shifts in the behavioral health system to support recovery over the past 10-15 years. The movement recognizes the value of the narratives of adults with lived experience of mental health illness (Daley, Newton, Slade, Murray, & Banerjee, 2013).

The next logical step was to determine how to gather data for this study. Empowerment is a variable that needs further research. Originally, a qualitative design was considered for this study. Qualitative approaches allow for an exploration of common themes (Pallaveshi, Balachandra, Subramanian, & Rudnick, 2014). Qualitative research indicated numerous benefits through working with a peer support professional (Pallaveshi et al, 2014; Shilling et al., 2013; Stanhope & Henwood, 2014). However, through an exhaustive literature review, I found that quantitative data did not offer the same conclusions as the qualitative results. I determined that quantitative studies were needed to determine whether peer support involvement improves outcomes on many different levels.

A quantitative study was conducted to determine whether working with an FSP increases a caregiver’s level of empowerment. The length of time as a caregiver of a child or youth with a mental health illness, the length of time working with an FSP, and the caregiver’s age, gender, and ethnicity were variables examined in the study. A gap in the knowledge of peer support professionals in the mental health field was addressed.

Background

Often, families may not feel they have a voice in their child’s mental health care. In reality, families are the key in making decisions about their child’s care (Davis, Garazzi, Scheer, & Uppal, 2011). Families may terminate therapeutic services early after they see improvements or feel that their child is no longer in need of services (Saxon, Ricketts, & Heywood, 2010). In many instances, families may terminate individual, family, and group therapy due to being dissatisfied with therapy or other barriers preventing them from participating in therapy sessions (Saxon et al., 2010). Potential communication barriers include feeling misunderstood and not feeling valued. Communication may not exist between important treatment team members, including psychiatrists, therapists, and school officials. In addition, clients or family members may feel that their mental health care worker is not culturally or spiritually sensitive to their needs.

Involvement with many systems can result in ineffective, uncoordinated, and fragmented services (Mendenhall & Frauenholtz, 2014). Effective collaboration with the many systems involved with children diagnosed with a serious emotional disturbance (SED) is imperative to the wraparound approach. According to Mendenhall, Kapp, Rand, Robbins, and Stipp (2013), approximately 5% of children in the United Stated have a SED; only 50% of these children have contact with specialty mental health professionals, which suggests a significant gap in the children’s mental health system. To be diagnosed with a SED, a child or adolescent needs to have an inability to learn that cannot be explained by intellectual, sensory, or health factors; an inability to build and maintain relationships with others; inappropriate types of behaviors or feelings under normal circumstances; a general pervasive mood of unhappiness; or a tendency to develop physical symptoms or fears associated with personal or school problems (Forness & Knitzer, 1992). These conditions occur over a long period of time and can adversely affect school performance (Forness & Knitzer, 1992). A necessary step for bridging any communication gap includes inviting all treatment members to the table to work as a team. Through this process, youth and their families can see the support of their team members and can use their voices to ensure everyone is on the same page.

Mainstream thinking does not seem to embrace the idea of peers working alongside families and mental health professionals. Utilizing peer partners requires a major shift from previous processes. One of the barriers is that many peer partners do not hold a specific professional license. However, peer partners are meant to walk alongside the family member and complement the treatment team. They can understand the families they work with on a different level due to their shared experiences. The impact a peer can have on a family member must not be discounted due to lack of credentials. The lived experience the peer partner brings to the team is invaluable.

Problem Statement

To improve mental health services and resources for families across the state this study was conducted in, a subgrant through the Division of Behavioral Health Services was awarded to implement a statewide process named System of Care (SOC) wraparound several years ago (L. Nelson, personal communication, June 10, 2014). Behavioral health agencies across the state submitted requests to oversee the subgrant. At the time of this study, there were 14 sites across the state implementing the SOC wraparound. Each site identified a mental health agency that was in charge of overseeing the subgrant. The SOC wraparound process identifies services and supports to build meaningful partnerships with families and youth. Wraparound services promote personal strengths and natural supports in the community to wrap services and supports around youth and their family ("S.O.C. - It's a Wrap!", n.d.).

Within the past several years in the state in which this study was conducted, individual peer support specialists have been introduced to work in the behavioral health system as advocates who serve as a source of encouragement. All the 14 designated sites are required to hire an FSP to work directly with caregivers in their local communities. FSPs are caregivers who have raised children with a mental health diagnosis and have learned to navigate the behavioral health care system. They may have also worked with other agencies such as the Department of Human Services and the Department of Youth Services. In some instances, the youths in FSPs' families have exited the behavioral health care system, or they may be actively participating in services. FSPs receive intensive training through the state Department of Behavioral Health Services in which this study was conducted. At the time of this study, there was not a set criterion in this state to measure the effectiveness or benefits of an FSP working with a family member.

Purpose of the Study

The purpose of this quantitative, correlational study was to determine whether a caregiver's level of empowerment is increased through working with an FSP. Drawing on social learning theory, I hypothesized that sharing lived experiences motivates others. The dependent variable in this study was the level of empowerment felt by a caregiver of a child with a mental health illness. The dependent variable was measured on a continuous scale using the Family Empowerment Scale (FES), a 34-item questionnaire used to assess empowerment in parents and other caretakers whose children have emotional disabilities (see Koren, DeChillo, & Friesen, 1992). The independent variables in this study were the length of time as a caregiver of a child or youth with a mental health illness, the length of time working with an FSP, and the caregiver's age, gender, and ethnicity. I conducted a multiple linear regression to analyze the relationship between the predictors and the dependent variable.

Research Questions and Hypotheses

Findings from this study may help drive the need for additional peer support partners in the state in which this study was conducted and other states, not only in the mental health field, but in additional fields as well. The research questions and hypotheses used to guide in this study were as follows:

RQ1: Does the length of time a person has been a caregiver of a child or youth with a mental health illness predict the level of empowerment felt when working with an FSP and controlling for the length of time working with an FSP, the caregiver's age, gender, and ethnicity?

H_o1: The length of time a person has been a caregiver of a child or youth with a mental health illness does not predict the level of empowerment felt when working with an FSP and controlling for the length of time working with an FSP, the caregiver's age, gender, and ethnicity.

H_a1: The length of time a person has been a caregiver of a child or youth with a mental health illness does predict the level of empowerment felt when working with an FSP and controlling for the length of time working with an FSP, the caregiver's age, gender, and ethnicity.

RQ2: Does the length of time working with an FSP predict the level of empowerment felt by a caregiver and controlling for the length of time a person has been a caregiver of a child or youth with a mental health illness, the caregiver's age, gender, and ethnicity?

H_o2: The length of time working with an FSP does not predict the level of empowerment felt by a caregiver and controlling for the length of time a person has been a caregiver of a child or youth with a mental health illness, the caregiver's age, gender, and ethnicity.

H_a2: The length of time working with an FSP does predict the level of empowerment felt by a caregiver and controlling for the length of time a person has been a caregiver of a child or youth with a mental health illness, the caregiver's age, gender, and ethnicity.

RQ3: Does the caregiver's age predict the level of empowerment felt when working with an FSP and controlling for the length of time a person has been a caregiver of a child or youth with a mental health illness, the length of time working with an FSP, and the caregiver's gender and ethnicity?

H_o3: The caregiver's age does not predict the level of empowerment felt when working with an FSP and controlling for the length of time a person has been a caregiver of a child or youth with a mental health illness, the length of time working with an FSP, and the caregiver's gender and ethnicity.

H_a3: The caregiver's age does predict the level of empowerment felt when working with an FSP and controlling for the length of time a person has been a caregiver of a child or youth with a mental health illness, the length of time working with an FSP, and the caregiver's gender and ethnicity.

RQ4: Does the caregiver's gender predict the level of empowerment felt when working with an FSP and controlling for the length of time a person has been a caregiver of a child or youth with a mental health illness, the length of time working with an FSP, and the caregiver's age and ethnicity?

H_o4: The caregiver's gender does not predict the level of empowerment felt when working with an FSP and controlling for the length of time a person has been a caregiver of a child or youth with a mental health illness, the length of time working with an FSP, and the caregiver's age and ethnicity.

H_a4: The caregiver's gender does predict the level of empowerment felt when working with an FSP and controlling for the length of time a person has been a caregiver of a child or youth with a mental health illness, the length of time working with an FSP, and the caregiver's age and ethnicity.

RQ5: Does the caregiver's ethnicity predict the level of empowerment felt when working with an FSP and controlling for the length of time a person has been a caregiver of a child or youth with a mental health illness, the length of time working with an FSP, and the caregiver's age and gender?

H_o5: The caregiver's ethnicity does not predict the level of empowerment felt when working with an FSP and controlling for the length of time a person has been a caregiver of a child or youth with a mental health illness, the length of time working with an FSP, and the caregiver's age and gender.

H_a5: The caregiver’s ethnicity does predict the level of empowerment felt when working with an FSP and controlling for the length of time a person has been a caregiver of a child or youth with a mental health illness, the length of time working with an FSP, and the caregiver’s age and gender.

Theoretical Framework for the Study

One of the most recent approaches to addressing people in need and applying theory to human problems within a social context involves social learning theory (Chavis, 2011). This theory is one of the most influential theories of learning and human development (Chavis, 2011). Social learning theory was used as a framework to describe the idea underlying the concept of peer support.

Social learning theory is used to explain that people learn from one another and that they can learn new information and behaviors by observing other people (Chavis, 2011). According to Abbassi and Aslinia (2010), viewing a behavior contributes to learning and subsequent use of observed behaviors. Modeling can be used to help people develop positive (or negative) behaviors (Kretchmar, 2016). One example that can be used to demonstrate modeling involves a child watching his or her mother stick out her tongue. Afterwards, the child repeats the behavior of sticking out his or her tongue. Another example involves a peer specialist modeling how to make a phone call to schedule an appointment for the client to learn to set up future appointments. Another example involves a peer specialist helping a parent learn to reconcile a bank statement so he or she can learn to independently balance future bank statements.

According to Brauer and Tittle (2012), learning occurs through both direct and vicarious behavioral reinforcement and imitation. Reinforcement plays a central role in the causal process of social learning (Brauer & Tittle, 2012). For example, if a peer specialist works with a caregiver to create a chore chart, it will be up to the caregiver to follow through with implementing the chart at home. If the chart is implemented, the youth may begin to be responsible for the chores on the chart. If the chart is not implemented, there may be no change in the youth's behavior.

Most human behaviors are learned within a social context, including family, school, socializing institutions, and other community organizations (Rew, Arheart, Thompson, & Johnson, 2013). Recent research concerning social learning theory includes decision-making and learning processes influenced by social information gathered by others (Biele, Rieskamp, & Gonzalez, 2009). According to Vest and Simpkins (2013), the behavior of adolescents is shaped by the behaviors of those around them. For example, a child's actions are often modeled after parental behaviors (Rew et al., 2013).

Moral development is believed to be largely learned by observing others (Kretchmar, 2016). For example, a youth who attends church may develop his or her moral belief system based on the information learned and observed during those services. Researchers have found that people do not rely exclusively on either their own judgment or on advice they receive, but a combination of both (Biele et al., 2009).

In addition to the social context, culture has also been found to shape human behavior and the social environment (Chavis, 2011). The social environment has many challenges and warrants the use of evidence-based practices that focus on culture to meet the needs of clients seeking help with problem behaviors (Chavis, 2011). More information on cultural influences is included in Chapter 2.

I conducted a quantitative study addressing the influence of a peer support program in the behavioral health care system in the state in which this study was conducted. Empowerment was chosen as a study variable due to the importance for caregivers to use their voices to address their needs and their child's needs. According to Koren et al. (1992), family empowerment is a central goal to improve services for families with children with disabilities. Almost all helping professions who serve families of children with disabilities have adopted the concept of family empowerment, and it is beginning to emerge as a common value across disciplines (Koren et al., 1992).

Nature of the Study

I considered both a correlational and a causal design. I chose a correlational design to provide evidence for or against the hypotheses. This correlational design can also be used to replicate the study and predict outcomes of peer specialist programs in other states. The participants of the study resided in a southern state. Participants were caregivers of a child or youth under the age of 22 who has been diagnosed with a mental health illness and is receiving mental health services. All the participants were involved with the wraparound process. I spoke directly with the community care directors who oversee wraparound at each of the agencies regarding permission to conduct the study. For active clients who have access to the Internet, a Survey Monkey link was created to send to participants. For active clients who do not have access to the Internet, a hard copy of the letter and FES was mailed, along with a self-addressed stamped envelope to return the scale. The letter was used to explain that participation in the study is voluntary. I also attached instructions for completing the FES. The directors were asked to forward these materials to all their active clients. The demographic section was placed at the top of the scale and included the following:

- caregiver name, gender, age and ethnicity;
- caregiver address and e-mail address (if available);
- length of time as a caregiver of a child or youth with a mental health illness;
- whether the caregiver is working with an FSP; and
- how long the caregiver has been working with an FSP.

I asked that the FES be returned within 1 month of the date on the instructions. Study participants were sequentially numbered beginning with “1N” to represent the clients who have not worked with an FSP and “1W” to represent clients who have worked with an FSP. Once the completed instrument was returned, I sent a debriefing letter. The letter was used to indicate the purpose of the study, confidentiality of the data, instructions on how to receive a final report of the study, and contact information.

Definitions

The dependent variable in this study is the level of empowerment felt by a caregiver of a child or youth with a mental health illness. The FES scores empowerment on three levels: family, service system, and community/political. The family level includes questions about activities at home, such as managing daily situations. The service system level includes questions about professionals and agencies that provide services to the caregiver’s child. The community/political level includes questions about the caregiver's advocacy among policymakers, agencies, and community members who influence services for children with emotional disorders (Koren et al., 1992). Other important terms used in the study were defined as follows:

Empowerment: A person's ability to make decisions about daily life activities and treatment decisions, the willingness to search for needed resources, the ability to advocate for yourself and your child(ren), the willingness to ask questions and ask for help. Empowerment can be expressed through attitudes, knowledge, and behaviors (Koren et al., 1992). Empowerment occurs when an individual no longer needs to rely on others to complete certain tasks (Koren et al., 1992).

Lived experience: The personal experience a family encounters as they navigate through the behavioral health care system. Lived experience is the knowledge and insights that can only be developed by raising a child with a mental health illness ("The Family Support Partner," n. d.). Having lived experience means peer support workers can understand clients in a way that is real and empathetic (Jacobson, Trojanowski, & Dewa, 2012).

Wraparound: A process in the state in which this study was conducted that refers to wrapping services and supports around a family of a child or youth with a mental health illness and receiving mental health services. Families identify members to serve on their wraparound team, who may include a therapist, teacher, school counselor, juvenile probation officer, and case worker. The team creates a wraparound plan to identify strengths and needs and to brainstorm ways to meet those needs.

Assumptions

There were several claims made in this study that could not be demonstrated to be true. The first assumption was that the respondents would answer each question on the FES truthfully. Another assumption was that the caregivers participated in the wraparound process. The next assumption was that the active caregivers in wraparound have a good rapport with the agency in which they are affiliated. Another assumption was that the FSP communicates consistently with the caregivers.

The regression analysis included eight key assumptions. One assumption was that the variables were normally distributed. Another assumption was that a linear relationship existed between the independent and dependent variables. Multiple regression analysis assumes variance in all the predictors. Further, multiple regression assumes the independent variables are not highly correlated with each other. The next assumption was that the variables were measured without error. I assumed that the variance of errors was the same across all levels of the independent variable. In addition, the regression analysis requires little or no autocorrelation in the data. In a multiple regression, it is assumed that the residuals are normally distributed (Williams, Gomez Grajales, & Kurkiewicz, 2013).

Scope and Delimitations

Participants in the study included caregivers of a child or youth diagnosed with a mental health illness under the age of 22 participating in the wraparound process in the state in which this study was conducted. I considered several related topics when designing this study. A qualitative study was first considered. However, the personal stories of the FSPs were not needed to answer the research questions. In addition, the professional opinions of FSPs were not considered in this study.

I also considered researching barriers that may prevent caregivers from accepting help from a peer support partner. Furthermore, I thought about researching whether clients with peer support workers improved their compliance with therapy and whether any therapeutic outcomes were improved as a result of working with peer support workers. There are many reasons why clients fail to adhere to their suggested therapeutic treatment recommendations. These reasons were addressed in this study.

Empowerment is a variable that needed further research due to the possibility that it may significantly improve overall quality of life. Determining whether working with an FSP increases the caregivers' level of empowerment may lead to funding of additional peer support partners across the United States. Findings from this study have the potential to be generalized across multiple disciplines. Due to the scale chosen to evaluate empowerment, caregivers were the respondents. However, caregivers do not have to be limited to the behavioral health system. For example, this study could be replicated with caregivers who work with peer partners in the juvenile justice system.

Limitations

A correlational design does not offer good internal validity because a correlation does not mean causation. Maturation effects were not likely to be of major concern. However, the mood the participant was in could have affect his or her responses to the scales. The participant may also have been struggling with focus. Instrumental decay was not an identified issue. Experimental mortality was a possibility during the study. However, if a scale was not returned, the participant was not included in the study.

The major threats to conclusion validity were that other factors besides working with an FSP could have been responsible for the outcome in this study. The factors that can affect the level of empowerment are unique to everyone. A threat to external validity also existed. Situation factors such as time and location may have been a threat to external validity because the participant decided when and where to complete the scale. Any scales received back after the 1-month time frame were not included in the study.

Another limitation was that not all areas of the state in which this study was conducted were represented in this study. I currently work in two areas of the 14 sites. Originally, to avoid a conflict of interest, I did not include caregivers and FSPs from my two areas in the study. However, approval was granted later to include these individuals. Future researchers may choose to focus only on local regions of a state.

Another limitation was that all the FSPs employed in the state in which this study was conducted at the time of this study were female. There were no males working as FSPs in any of the 14 areas at the time of the study. Future studies may address male peer support workers in the mental health care system.

Employing peer support workers is a relatively new venture. However, future research may need to address states that have employed peer support workers for a longer period. This study included FSPs who have worked with a family for at least 1 month. Researchers in future studies may choose to increase the time frame for working with families.

Significance

The peer support approach was inspired by the belief that people who have similar experiences can offer more authentic empathy (Repper & Carter, 2011). Peer support focuses on the positive aspects of people and their abilities to function effectively and supportively (Repper & Carter, 2011). The peer support process exists to complement the therapeutic team and additional agencies involved in reaching mutual goals (Repper & Carter, 2011). The process also addresses barriers to treatment. In the current study, I examined the peer support approach in the behavioral health field in the state in which this study was conducted. It was necessary to determine whether caregivers are empowered through working with a peer support partner to provide a rationale to employ additional peer workers.

Currently in the state in which this study was conducted, the number of peer support workers in the mental health field is limited. The main barrier to hiring and training additional peer support workers is funding. Many states have used the Medicaid system to provide the necessary funding to allow peer support as a reimbursable service. At the time of this study, the state in which this study was conducted had not approved the use of Medicaid funds to offer peer support services. Officials may use findings from this study to increase the number of peer support workers across the state in which this study was conducted through Medicaid funding streams.

Summary

I designed this study to explore possible benefits for caregivers who work with a peer support partner in the mental health field in the state in which this study was conducted. I sought to determine whether working with an FSP increases a caregiver’s level of empowerment. Social learning theory provided the theoretical foundation for this study.

A stigma exists around the behavioral health system. Mental health care is looked on in a negative, sometimes degrading view (Rüsch, 2014). During a medical crisis, it is not uncommon for individuals to seek treatment from a medical doctor and to strictly adhere to the recommendations cited. Treatment for behavioral health concerns may not be viewed in the same manner as medical health concerns. The stigma associated with a mental health diagnosis prevents individuals from seeking treatment and adhering to the recommended treatment plan. Using peer support workers to offer authentic empathy could begin to break the stigma associated with mental health illness. Not only would clients be able to work with others who have been impacted by a mental health illness, but they would also able to witness recovery from them. Clients can witness recovery in action when they work with peers (Austin, Ramakrishnan, & Hopper, 2014). Peer support workers model how to maintain stability and wellness and navigate a variety of social interactions and roles (Austin et al., 2014). The literature review for this study is presented in Chapter 2.

Chapter 2: Literature Review

Peer-delivered services are recent additions to the mental health field (Cronise, Teixeira, Rogers, & Harrington, 2016). According to the "Peer specialist/peer support training: Participant manual" (2012), until around the 1980s, the dominant belief in the mental health system was that people diagnosed with a mental health illness would not recover. The best that could be expected was stabilizing people and maintaining them in supervised environments where they would not harm themselves or others. However, by 1990, the idea of recovery began to emerge in many programs across the United States ("Peer specialist/peer support training: Participant manual," 2012). Hiring consumers as providers of mental health services originated in the early 1990s (Moll, Holmes, Geronimo, & Sherman, 2009). Trained peer support specialists and peer-operated organizations have become an integral part of the public mental health service system within the last decade (Ostrow & Adams, 2012).

There has also been an international shift toward more recovery-based services including a greater involvement of mental health consumers to support fellow consumers (Lawn, Smith, & Hunter, 2008). Family education and support services provided by peer family members are used by about one third of families (Hoagwood et al., 2010). Peer support is becoming a valuable component of mental health service delivery (Moll et al., 2009). According to Salzer et al. (2013), a growing behavioral health care workforce essential in recovery-oriented environments includes certified peer specialists. Scott, Doughty, and Kahi (2011) concluded that peer support could be the fastest growing type of service in mental health systems throughout the world over the next 20 years.

The consumer/survivor movement has paved the way for mental health consumers to become involved in advocacy, program planning, and service delivery (Singer, 2011). Peer providers can work alongside mental health professionals on psychiatric wards, help facilitate groups in hospitals, and educate patients in consumer-run services (Moran, Russinova, & Stepas, 2012). In the updated version of the original consensus statement, the Substance Abuse and Mental Health Services Administration (SAMHSA) included peer support as a guiding principle of recovery (Alberta, Ploski, & Carlson, 2012). According to Ostrow and Adams (2012), SAMHSA identified peer supports as one of the 10 components of recovery. Studies have shown the positive benefits of peer support to clients and that peer support should be considered best practice (Salzer et al., 2013). Consumer survivors described peer support as a resource that facilitated their recovery (Coatsworth-Puspoky, Forchuk, & Ward-Griffin, 2006).

Shifts in thinking and processes take time. Research on all aspects of peer support services is needed to encourage continued workforce growth (Cronise et al., 2016). Additional research for using peer support partners as treatment team members is needed to demonstrate benefits and create additional peer support positions. This research study addressed whether working with an FSP in the behavioral health care system in the state it was conducted in increases the caregiver’s level of empowerment. Findings may be used to support the peer role in the behavioral health care system (see Cronise et al., 2016).

In Chapter 2, I outline the strategy used to gather research. I will describe the qualifications of a peer support specialist and present information pertaining to lived experiences. Early training efforts for the state in which this study was conducted are highlighted and examples of peer support activities are given. The benefits of peer support for the caregiver and peer specialist are also reviewed. I discuss challenges incorporating the peer support approach and compare empathy in the therapeutic setting to the peer support model. Social learning theory is used to explore, compare, and contrast literature addressing the peer support approach.

Literature Search Strategy

Several studies have been conducted about peer support workers. Little research exists to provide detailed documentation of the services rendered by peer support providers and their impact ("Family and Youth Peer Support," 2013). No studies have addressed the impact of family peer support in Wraparound ("What's the Evidence on Family and Youth/Young Adult Peer Support in Wraparound," n.d.).

A quantitative, correlational research study was conducted in the state in which this study was conducted to examine FSPs and the level of empowerment of caregivers participating in wraparound. Literature was systematically searched using several sources of information. The literature search strategy included a wide range of databases to identify all relevant studies. A review of references used by previous authors was conducted to locate additional resources the general search did not discover. At the time of this study, there were 14 sites in the state in which this study was conducted using FSPs to provide services to family members.

I used the Family Empowerment Scale (FES) to determine whether there is an increase in a caregiver's level of empowerment resulting from working with an FSP. I contacted the mental health agencies in the state in which this study was conducted that provide wraparound and employ FSPs. I requested permission to conduct this study with several of the families in wraparound. The details of the study, including the method of data collection, were presented for the agency to review. A copy of the FES was provided to the agencies. Once permission from the agency was received, I recruited participants through the agency's community care directors who supervise the FSPs.

The Walden University library site was used to access several research databases:

- Academic Search Complete,
- Business Source Complete,
- ERIC,
- MEDLINE with Full Text,
- PsycARTICLES, and
- PsycTESTS.

The key search terms included *peer support and mental health*. Additional search terms included *peer support in wraparound, peer support in mental health and empowerment, peer support in mental health and quality of life, family support partners in mental health, peer support and social learning and mental illness,* and *peer support and social learning theory*. Peer-reviewed articles published from 2006 to 2018 were searched. Most of the literature addressed the peer support approach. Although the scope of this study involved peer support in mental health, it was intriguing to locate several articles discussing peer support efforts in other capacities, such as the military veteran population. Most of the research did not address peer support among families receiving wraparound. Wraparound is one avenue that connects families with peer support specialists.

The first idea I explored was to determine the qualifications for the title of peer specialists, peer support workers, or peer partners. Cronise et al. (2016) reported that a lack of understanding concerning the varied roles performed by peer support partners may affect evidence to the effectiveness of peer-delivered interventions. Further, Cronise et al. found that most peer support studies lacked specific information about the role, tasks, and work activities of the peer support specialists.

General peer specialists in mental health are individuals in recovery who provide peer support and a holistic approach to behavioral health concerns beyond managing symptoms (Clark et al., 2015). An example is a story of a 62-year-old female diagnosed with schizoaffective disorder. She shared that she believed she was incapable of healing due to her mental health illness (Lipfird, 2015). Eventually, she trained as a vet-to-vet facilitator and a National Alliance on Mental Illness (NAMI) peer-to-peer facilitator, which boosted her self-confidence (Lipfird, 2015). She began working as a VA peer support specialist assisting others in their recovery from mental and/or substance abuse concerns (Lipfird, 2015). She felt her role allowed her to begin telling others of her mental illness (Lipfird, 2015).

Locally, the Veterans Health Care System of the Ozarks includes peer support specialists to work with their veteran population. In this role, the peer support specialist is a fellow veteran working as a member of the mental health team (Mental Health Summit, 2015). The peer support specialist is an experienced problem solver and coach (Mental

Health Summit, 2015). The peer support specialist is a mentor who has developed life skills through recovery and who advocates for fellow veterans through individual and group interactions (Mental Health Summit, 2015).

Peer support specialists are now being used in several different arenas. Peer counseling has been used in oncology departments, HIV/AIDS departments, and with survivors of sexual assault (Oulanova, Moodley, & Séguin, 2014). Studies indicated that people with, or at risk of, diabetes can benefit from the support of another person diagnosed with this medical condition (Simmons, 2013). Peer counseling has also been used for suicide survivors. According to Oulanova et al. (2014), peer counselors play an important role in facilitating healing for other survivors. In one psychiatric emergency department, peer support specialists are asked to assist the patients with understanding policies and procedures (Migdole et al., 2011). In addition, they are asked to help ensure that patients are treated with dignity and respect (Migdole et al., 2011). They were used as liaisons with hospital staff and they inform staff of the needs of their patients (Migdole et al., 2011).

Various companies around the world have begun implementing the peer support approach. In 2012, NAV Canada created a new peer support mental health program, entitled Light the Way (Bergstrom, 2015). This program did not replace professional counseling; the focus was on giving employees hope (Bergstrom, 2015). The program was designed to reduce sick leave, improve retention, and improve employee engagement (Bergstrom, 2015).

FSPs are different from mental health peer support partners who have experienced recovery. FSPs have experience raising a child within the behavioral health system. They are peer counselors who come from legacy families using their lived experience, training, and skills to help identify goals that promote resiliency and recovery ("The Family Support Partner," n. d.). A legacy family has multiple experiences with behavioral health and other social service systems that often span generations of family members ("The Family Support Partner," n. d.).

The premise behind the peer support approach is that every need of people with a mental illness cannot be met by professionals alone (Moll et al., 2009). According to Moyers and Miller (2013), the counselor providing treatment is one of the most influential determinants of client outcomes. However, researchers are examining the outcomes between a peer support worker and a traditional mental health clinician. There is evidence that the outcomes of services working with peer support staff are like those delivered by professional staff (Alberta et al., 2012). Lawn et al. (2008) reported consumer provider services are as effective as non-consumer delivered services. Studies have shown that peer support workers produce outcomes comparable with their non-peer colleagues, and in some instances, are more effective (Walker & Bryant, 2013).

However, results are mixed. For example, a systematic review of 11 experimental studies was conducted that compared peer supporters to professionals in similar roles within mental health services or adding peer supporters to services. Researchers included peer support, coaching, advocacy, case management or outreach, crisis worker or assertive community treatment worker, and social support in the review. Researchers excluded independent peer-run programs or organizations. Researchers found no significant differences in psychosocial outcomes, mental health symptoms, client satisfaction, ratings of relationship, and service utilization or attrition. They found a small reduction in crisis and emergency service use (Pitt et al., 2013).

Chinman et al. (2014) systematically reviewed 20 studies of varying methodological quality, which were scored using three levels of evidence (high, moderate, and low). Eleven were experimental studies, six were quasi-experimental studies, and three were correlational or descriptive studies. Researchers in these studies focused on peer support workers hired as a person in recovery from a serious mental illness as an employee to offer services or supports to others. Researchers included peers added to traditional services, peers assuming a regular provider position, and peers delivering structured curricula. Researchers excluded independent peer run programs, online peer support, studies of services for smoking cessation, studies of peer support for individuals with developmental disabilities, and studies that focused on children and adolescents. Researchers found mixed evidence; effectiveness varied by service type. Quasi-experimental and correlational studies of peer added service type generally had more positive outcomes than the experimental studies. Consistent peers were at least as effective in providing services as non-peers (Chinman et al., 2014).

Peer support is beneficial to combine it with services provided by disciplinary professionals (Jacobson et al., 2012). Peer support workers are “street smart” and build rapport more easily with people in recovery than their non-peer staff (Walker & Bryant, 2013). Peer support workers can help challenge the use of professional jargon and improve communication between staff and clients (Oldknow, Gosling, Etheridge, & Williamson, 2014). Lawn et al. (2008) revealed partnering with non-consumer providers produces better outcomes. Further research is needed to examine outcomes when a client works with both a mental health clinician and a peer support worker.

Researchers are also describing ways the peer support process is different. Peer support workers have something unique and valuable to offer (Moll et al., 2009). They are hired from their personal experience, rather than their professional training (Moll et al., 2009). It is fundamental for the peer support specialist to have shared life experiences (Clark et al., 2015). Lived experience within the behavioral healthcare system is the personal experience a family has encountered as they navigated through the system. It is the knowledge and insight that can only be developed by raising a child with a mental illness (“The Family Support Partner,” n. d.). Jacobson et al. (2012) reported a common element in everything peer support workers do is drawing upon their own life experiences to share knowledge.

Having lived experience means peer support workers can understand clients in a way that is real and empathetic (Jacobson et al., 2012). Peer support workers draw on their lived experiences and offer nuanced expertise, empathy, and credibility to their interactions with clients (Austin et al., 2014). Per Barlow et al. (2010), peer support is described as the social, instrumental, or emotional support of people that share similar life challenges provided to each other in a reciprocal fashion. Peer support workers can uniquely solve problems, embody hope and resilience, and cultivate self-advocacy in their clients (Austin et al., 2014). Through shared experience, a new way of connecting is made possible (Scott et al., 2011). Shared life experiences can include having a child that has been admitted into a residential unit, experiencing problems at school, and/or diagnosed with a developmental delay. Due to personal experiences, peer family workers have credibility with parents, able to gain trust easier, and can enable parents to become more actively engaged in their child's services (Hoagwood et al., 2010).

Sharing similar life experiences may decrease feelings of social isolation, increase people's social networks, and foster a sense of community (Adame & Leitner, 2008). Peer support workers can more authentically understand their clients' perspectives (Austin, Ramakrishnan, & Hopper, 2014). During one qualitative study, the sharing of common experiences encouraged the other participants, that previously felt uncomfortable, to speak to their providers about their problems (Stanhope & Henwood, 2014). It was the realization of shared experiences that normalized the process and changed the interaction within the healthcare system (Stanhope & Henwood, 2014). Per Lawn et al. (2008), consumers felt more trusting of someone who knew what symptoms were like, valuing the peer approach and non-medicalized language, and perceiving that they were genuinely being listened to.

The parent peer support partner uses their personal story as their most significant tool ("NWIC's Model of Parent Peer Support," 2015). Adame and Leitner (2008) conveyed that the peer support model is rooted in the idea that significant interpersonal relationships and a shared sense of community lay the foundation for the process of healing to occur. Peer support workers have a heightened capacity for empathy and developing relationships with other consumers because of their experiences (Lawn et al., 2008). Schechter and Goldblatt (2011) define empathy as the ability to understand and feel intuitively the perspective and experience of another. Per Imel et al. (2014), empathy refers to the ability to both understand and experience the feelings of another person.

Empathy can be described in three processes: emotional simulation, perspective taking, and emotion regulation (Imel et al., 2014). Emotional simulation describes the mirroring of the other person’s experience (Imel et al., 2014). Empathy has been conceptualized as a process of mirroring where a person learns how others feel by experiencing a representation of a similar state (Imel et al., 2014). Perspective taking involves understanding the client (Imel et al., 2014). Emotion regulation is defined as soothing interpersonal distress (Imel et al., 2014). Kemp and Henderson (2012) reported that the belief underlying the peer support approach is that people who have faced, endured, and have overcome adversity can offer support, encouragement, and hope to others facing similar situations.

Traditionally, it can be difficult to engage families that may have developed distrust for the behavioral healthcare system, or who may feel alone in their struggles. The strength of this approach is that it underlies the meaning of authentic empathy from a peer perspective. However, mental health clinicians too can offer empathy. The empathy shown by therapists is important in most approaches to therapy (Mlotek & Paivio, 2014). Brock et al. (2015) reported clinician empathy is a major underlying aspect of all medical therapies. Schechter and Goldblatt (2011) conveyed empathy as a critical component of the therapeutic alliance. Research describes empathy shown by the therapist accounting for as much, or more, outcome variance than therapeutic alliance or a specific intervention (Moyers & Miller, 2013). Results from studies have shown higher levels of empathy contributed to greater levels of client engagement and a reduction in trauma symptoms (Mlotek & Paivio, 2014). Per Moyers and Miller (2013), there is no known therapeutic approach where low empathy has been linked to better outcomes in any area of healthcare. Therapists that show high-empathy appear to have higher success rates (Moyers & Miller, 2013). Clients may feel the therapist is empathetic, yet not able to offer authentic empathy; that is, having been through similar experiences. For example, a therapist that has never been married cannot authentically understand the pain of a client that is going through a divorce. In addition, many clinicians are taught to only divulge personal information if it would benefit the client. This thought process differs from the peer support approach that encourages sharing their personal stories. The current study does not rate the level of empathy a caregiver receives from a peer support worker; however, authentic empathy is hypothesized to be a contributing factor related to positive outcomes in the peer support approach.

Discussions over peer support in the state in which this study was conducted began in September 2011 when the Substance Abuse and Mental Health Services Administration (SAMHSA) awarded the Bridging Recovery Supports to Scale Technical Assistance Center Strategy (BRSSTACS) to encourage the widespread adoption of recovery-oriented services and systems of care across the United States. In 2013, the state in which this study was conducted was awarded a BRSS TACS used to convene a workgroup, implement community conversations, visit other states with peer specialist programs, train recovery coaches, and attend a conference to look at alternative recovery methods (Brannin, 2018). During this time, the definition of recovery was formed in the state in which this study was conducted after a series of community meetings around the state and meetings with key stakeholders, such as service providers and people with lived experience. The definition is as follows:

> Recovery is the journey of healing and learning to improve individual life skills so that a person can reach his/her highest potential as a productive member of our community by gaining a sense of meaning, a positive identity, the capacity to cope with adversity, and with recognition of the gifts and lessons learned through the transitional process. Recovery is individual to each person and requires a partnership of support, community, and resources (Brannin, 2018, slide 3).

To understand the training FSPs receive in the state in which this study was conducted, I became certified as a family support partner. The researcher fulfilled the requirements of a legacy family member; having a child diagnosed with an Anxiety Disorder and Autism Spectrum Disorder. The training occurred in two phases: three days one week and three days the next week. The first three days of the training process included an in-depth study of NAMI Basics. NAMI Basics is a free educational program for parents and family caregivers of children and youth that have been diagnosed with a mental health illness or who are experiencing symptoms ("NAMI Basics," 2015). The course is taught by a trained team with lived experience ("NAMI Basics," 2015). Participants learn how to manage crises, solve problems, and to communicate effectively ("NAMI Basics," 2015). In addition, participants learn about current treatments, including evidence-based practices, medications, and side effects ("NAMI Basics," 2015). A section is covered to encourage advocating for the child’s rights at school and in health care settings (“NAMI Basics,” 2015). After the first three days, participants were awarded a certificate for completing the course.

The next three days of the training focused on reviewing the peer support manual written by Patricia Miles. The lessons in the manual helped participants practice telling their own stories and identifying their own encounters with bias (Miles, 2001). The importance of having a non-adversarial advocacy role within the system was emphasized throughout the training (Miles, 2001).

Class participates practiced role playing during the training. Peer support workers need to develop interpersonal skills to be able to work with their clients. Role playing is a teaching methodology used to foster interpersonal skills for peer providers (Oh & Solomon, 2014). Role playing is also useful to allow peer workers to alternate playing the peer role and the client role, which encourages empathy and the ability to adopt different viewpoints (Oh & Solomon, 2014). As peer services expand, peers will need opportunities for active and experiential learning, as found in the process of role-playing (Oh & Solomon, 2014). Role playing also allows peers to practice their skills within the safety and supervision of an instructor, without the risk of harming actual clients (Oh & Solomon, 2014).

At the end of the 6-day training, participants were certified as FSPs. The family support partner coordinator with the Division of Behavioral Health Services has plans to offer ongoing support and assistance to all the FSPs working across the state. Technical assistance includes conference calls and site visits.

The current literature provides limited guidance for documenting peer support activities (Davis et al., 2011). There have been no studies found that examine the relationships between specific activities of peer support partners and outcomes obtained (Davis et al., 2011). The Department of Human Services through the Division of Behavioral Health Services in the state in which this study was conducted reviewed family support data for the fiscal year 2015. The FSPs participate in numerous activities with their clients. Providing support in the home and family relationships domain is an area where family support workers offer their assistance ("FY15 Family Support Data").

One activity of an FSP involves connecting the family with community resources ("FY15 Family Support Data"). Per Austin, Ramakrishnan, and Hopper (2014), the peer support worker's experience as a client allows distinct awareness and knowledge of the resources within the mental health system. Peer support workers not only offer peer support, but also provide help in obtaining housing, employment, recreation, and socialization opportunities (Hodges, 2006). Per Hodges (2006), peer support workers are significantly more aware of services than non-users.

Families are key in making decisions about their children's care (Davis, Gavazzi, Scheer, & Uppal, 2011). Peer support providers can increase the likelihood that care plans fit the individualized needs of children and their families (Davis et. al, 2011). In addition, peer support workers assist clients in achieving their goals (Hodges, 2006). Peer support workers assist clients to identify resources and supports to accomplish recovery goals (Landers & Zhou, 2011). An important element of support is the exchange of useful, practical information (Shilling et al., 2013). Consumer-survivors reported an increase in hope, motivation and social networking because of working with peer support workers (Walker & Bryant, 2013). Participants in one study described peer support as an arena for identification, normalization, connection, and being important to others (Schon, 2010).

Consistently, researchers in qualitative studies suggest that parent to parent support is beneficial across different types of conditions (Shilling et al., 2013). However, benefits from peer support for parents are less substantiated in quantitative studies (Shilling et al., 2013). Shilling et al. (2013) presented a systematic review of peer support studies. Four themes were identified through the qualitative review, including a shared social identity, learning from the experience of others, personal growth, and supporting others (Shilling et al., 2013). The concept behind the benefits of a shared social identity is that people that have not been in similar situations cannot truly understand (Shilling et al., 2013). Having a shared social identity fosters a sense of belonging, support, and empowerment (Shilling et al., 2013). Through a shared social identity, parents feel that they are better able to cope, feel less isolated, and have a reduced sense of guilt (Shilling et al., 2013). In addition, parents feel they have a safe environment for support (Shilling et al., 2013). Researchers in some studies reported that shared social identities enabled parents to expand their social and support networks (Shilling et al., 2013). Researchers also revealed the importance of perceived similarities in their children's situations, parents' personalities, and social backgrounds; the more closely these items matched, the more successful the peer support (Shilling et al., 2013).

Parents in several studies reported that giving support was as important as receiving it (Shilling et al., 2013). Shilling et al. (2013) confirmed that parents that offer support to others led to a realization that they needed less support for themselves, in addition to an increase in their own self-worth. Some parents reported that providing peer support brought back difficult memories; however, these experiences allowed them to see how far they had come in their own journey (Shilling et al., 2013).

There is recent evidence pointing to the effectiveness of structured peer-led interventions (Johnson et al., 2014). During one study conducted by Travis et al. (2010), outcomes of a telephone-based mutual peer support intervention for individuals with depressive symptoms were explored. Participants were partnered with another patient and expected to call their partner at least once a week for a 12-week period (Travis et al., 2010). Measures of psychological health, disability, and quality of life improved because of the peer support intervention (Travis et al., 2010). Johnson et al. (2014) indicates that studies on the effects of peer support are increasing, but results are equivocal. Several studies indicate that peer support is helpful in engagement and empowerment, when added to traditional services (Johnson et al., 2014). However, there are other studies where researchers have not found superior outcomes (Johnson et al., 2014).

Swarbrick, Gill, and Pratt (2016) introduced a new term defined as peer wellness coaching that seeks to improve the wellness and physical health of people with serious mental health disorders by assisting people to better understand their experiences, motives, and needs. Researchers in a study revealed improvements in physical health, general health, and perceived health (Swarbrick et al., 2016). Peer wellness coaching is a cost-effective and scalable intervention that can reach many at-risk individuals (Swarbrick et al., 2016).

Scott and Doughty (2012) presented a study discussing self-determination and empowerment as a major way work of a peer specialist is differentiated from clinical approaches. In fact, recovery strategies include choice, empowerment, and self-determination at the center of practice (Scott & Doughty, 2012). The most commonly expressed theme that emerged from the data was a focus on empowerment (Scott & Doughty, 2012). Blixen et al. (2015) conveyed that peer interaction is an important road to empowerment. Peers can be effective in empowering and motivating people with serious mental illness (Blixen et al., 2015). Peers can normalize illness experiences, promote hope and increase feelings of self-esteem and empowerment (Blixen et al., 2015).

Similar to the methodology of this study, Shilling et al. (2013) presented eight studies contributing quantitative data on peer support. Five studies revealed information on family function, which included evidence towards improvement with peer support on a measure of acceptance and family adjustment to a disability (Shilling et al., 2013). Researchers in several studies found peer support to be more beneficial to parents with higher numbers of stressful life events, higher anxiety, poorer maternal health, or with lower coping skills (Shilling et al., 2013). Little or no change was reported on the ‘Impact on Family’ scales (Shilling et al., 2013). In one report, 89% of parents receiving peer support found it helpful (Shilling et al., 2013). Specifically, parents that received peer support made more progress towards resolving the main problem that directed them to join the study than the comparison group (Shilling et al., 2013). One study found weak evidence of an increase in the use of community resources by parents receiving the peer support (Shilling et al., 2013). While qualitative studies have revealed numerous benefits of working with a peer specialist, the quantitative studies did not substantiate those perceived benefits (Shilling et al., 2013). However, none of these studies investigated the costs of peer support, the experience of the peer support specialist, the impact of peer support on parents' relationships with health care professionals, or the long-term impact of peer support (Shilling et al., 2013).

As previously stated, a shift in belief systems takes time and research to uncover the benefits for the change in thinking. Therefore, this study will address the many benefits of working with peer support workers unearthed from previous research. Peer support workers participate in activities that promote socialization, recovery, wellness, self-advocacy, development of natural supports, and maintenance of community living skills (Landers & Zhou, 2011). Providing social support to people with mental illness can change the way in which they view themselves to include more than solely being a patient (Bouchard, Montreuil, & Gross, 2010). Peer support providers can attend therapy sessions and other important meetings, including meetings for individualized education plans to help empower the families. Peer support workers can help to increase self-esteem, self-efficacy and quality of life. They provide an understanding of life situations and feelings of being appreciated. In addition, they can help to decrease emotional and social isolation, feelings of loneliness, and feelings of shame (Bouchard et al., 2010). Per

Jacobson et al. (2012), numerous studies found peer support assists people to become more engaged and empowered.

Peer specialists can assist clients with parenting needs. Peer specialists may share their personal parenting experiences and listen to concerns (McLaren, n.d.). Peer specialists may also direct their clients to local parenting resources (McLaren, n.d.). Peer specialists can remind their clients that their role as a parent serves as motivation towards personal recovery (McLaren, n.d.). Peer specialists may use role modeling and role play exercises to practice communication techniques, establish healthy discipline, and identify appropriate boundaries for children (McLaren, n.d.). Peer specialists can emphasize the importance of self-care as an essential part of good parenting (McLaren, n.d.). Peer specialists assure the families they work with that they are not alone (McLaren, n.d.). Additional benefits to caregivers include feeling more confident, more in control, less isolated, less depressed, and less guilty (Shilling et al., 2013).

Peer support specialists can be beneficial after discharge from an inpatient hospitalization stay. After discharge, patients may feel anxious from losing the support of staff and may discontinue treatment, experience relapse, readmit themselves back into the hospital, and possibly attempt suicide (Simpson et al., 2014). Researchers found a main factor in re-admission into a hospital is not a person's illness symptoms, rather a lack of community support (Lawn et al., 2008). Researchers have shown peer support specialists can reduce patient's symptoms and hospitalizations (Jacobson et al., 2012). Per Austin et al. (2014), one of the benefits of peer support includes a reduction in psychiatric hospitalizations. Researchers reflect that social support, consumer delivered services, and peer support services are associated with reduced psychiatric admissions and crisis episodes (Landers & Zhou, 2011). Peer support workers have also assisted clients in transitioning back into the community after hospitalization (Landers & Zhou, 2011).

Consumers who actively utilize peer support report fewer psychiatric symptoms, greater time on the job, an increase in effort in education, and greater income than those who did not utilize a peer support worker (Biegel, Pernice-Duca, Chang, & D'Angelo, 2013). Peer support is linked to improved outcomes for consumers such as increased community tenure, decreased hospitalization, improved quality of life, and improved social functioning (Moll et al., 2009). In addition, consumers relying on peer support were more likely to use crisis stabilization services than those without peer supports (Biegel et al., 2013). This research suggests that consumers with peer support workers learn better symptom management skills and to effectively acknowledge and utilize acute psychiatric stabilization support (Biegel et al., 2013).

There are proven health benefits associated with participation with peer support specialists. Researchers concluded in one study that a formalized peer support intervention could help those suffering from a mental illness improve their physical health (Bouchard et al., 2010). Researchers also found that using peer support interventions as an adjunctive therapy to professional care can decrease alcohol use for people with a severe mental illness and criminal history (Bouchard et al., 2010).

Lloyd-Evans et al. (2014) conducted a systematic review of 18 experimental studies. These studies were aimed at informing policy recommendations, addressing gaps in research, and influencing funding policies for peer support. Researchers in these studies included mutual support programs, peer support services, and peer-delivered services. Researchers in these studies excluded residential and inpatient peer-run programs, peer support programs focusing exclusively on areas other than overall mental health recovery, and interventions led by mental health professionals. Researchers found little or no evidence that peer support was associated with positive effects on hospitalization, symptoms, and satisfaction with services. However, there was evidence for positive effects on hope, recovery, and empowerment. Limitations of this study included substantial variation between trials in participants' characteristics and program content, outcomes were incompletely reported, and there was a high risk in bias (Lloyd-Evans et al., 2014).

Engaging with peers in a social support network reduces risk factors associated with poor mental and physical health (McDonald & Brown, 2008). Regular peer group participation may reduce psychological morbidity and mortality (McDonald & Brown, 2008). Research has found that low levels of social support increased the probability of an onset of mental health impairment and decreased the probability of recovery (Biegel, et al., 2013). Researchers in one longitudinal study found that natural supports, such as family and friends, were associated with less depressive symptoms from baseline to a three-month follow-up (Biegel et al., 2013). Researchers found that an increase in natural supports leads to increases in professional support (Biegel et al., 2013). Peer support workers can give useful support, hope, and concrete advice to others that have endured similar situations (Schon, 2010). Researchers reveal peer support can lead to improved coping skills, increased hopefulness, improved mental health and wellness, increased social connectedness, and a reduction in stress for caregivers of children with serious mental health challenges (“What’s the Evidence,” n.d.).

There are economic benefits for training and hiring peer support workers. Certifying individuals to work as peer specialists has brought previously unemployed individuals into the labor market (Salzer et al., 2013). Some peer support workers viewed their working role as a stepping stone back into employment and an opportunity to reintegrate back into the community (Walker & Bryant, 2013). Peer support workers indicated enhanced recovery due to their training and experience on the job (Salzer et al., 2013). In addition, peer support workers reported acquiring new knowledge and skills (Oulanova et al., 2014). Researchers found that hiring peer support specialists also generated enough income for a large portion of respondents surveyed to reduce or eliminate dependence on social security benefits (Salzer et al., 2013). Agencies also receive benefits from employing peer support workers. One benefit includes decreased stigma to mental health problems because the peer support worker role is a positive example to other sectors in the community (Walker & Bryant, 2013). Despite the benefits of peer support reported in the literature, peer support interventions are not commonly part of the mental health treatment plan (Bouchard et al., 2010).

Peer providers also find benefits in their roles. Research has been conducted to determine the benefits of working as a peer support professional to the workers themselves. Firmin, Luther, Lysaker, and Salyers (2015) found that little research has been conducted on the impact of helping other people that are in the recovery process. However, several researchers found that parents realized giving support was as important as receiving it (Shilling et al., 2013). Peer support has been found to improve the subjective well-being of both the clients and peer support specialists (Jacobson et al., 2012). In addition, peer providers had an increase in their self-esteem, confidence, hope, and quality of life (Jonikas et al., 2010). Peer support workers experience increased confidence in their own capabilities, empowerment, and hope (Proudfoot et al., 2014). By offering others mutual support, peer providers experienced reduced reliance on psychiatric hospitalization (Jonikas et al., 2010). Additional areas of benefit for peer providers include enhanced social support, productivity, and career skills (Jonikas et al., 2010).

One benefit of working as a peer support worker includes improved wellness. Evidence exists that peer employees experience an improved quality of life (Moll et al., 2009). Peer counselors reported personal growth, psychological healing, and spiritual healing (Oulanova et al., 2014). Peer support workers reported an increase in their confidence level and self-esteem (Walker & Bryant, 2013). Peer support workers gain perspective and reflexivity about their own illness and develop their own narrative (Austin et al., 2014). Peer support workers gain a feeling of accomplishment when they help their clients achieve success (Austin et al., 2014). Another benefit of working as a peer support specialist is an increase in social networks. Peer support workers can fellowship with other peer support workers (Walker & Bryant, 2013). Opportunities for vocational and interpersonal skill development also occurred (Moll et al., 2009). Peer support workers reported numerous benefits including improved self-esteem, physical health, empowerment, coping skills, mental health, self-concepts, recovery, and hope because of working in their role (Firmin et al., 2015).

Despite all the benefits of working with peer specialists, there are situations that will be beneficial to plan for if they occur in the consumer-practitioner model. Challenges for peer support workers include negotiating the learning curve, negotiating the challenges of being a role model, transitioning identity from consumer to provider, and being accepted into the workplace (Moll et al., 2009). One concern to consider involves a peer staff experiencing a psychiatric crisis and needing to receive services through the emergency department where they have been employed (Migdole et al., 2011). The possibility of relapse makes the management of peer workers a difficult endeavor (Oh & Solomon, 2014). Clients receiving peer support could be vulnerable to increased distress because receiving support has the potential to be a threat to self-esteem, if it elicits feelings of dependence, inferiority, failure, and powerlessness (Bracke, Christiaens, & Verhaeghe, 2008).

Another potential concern is a lack of role clarity for both the peer support specialist and other employees (Kemp & Henderson, 2012). Per Jacobson et al. (2012), the literature has identified a lack of clarity in peer role expectations as a concern. Poorly defined job roles are barriers for peer support workers (Jacobson et al., 2012). In addition, other workers often are not clear on the duties of the peer support worker. Vagueness of the peer role leads to some staff not feeling clear on how to relate to the peer worker (Jacobson et al., 2012). Per Kemp and Henderson (2012), some supervisors did not clearly understand the peer support worker role. For example, peer specialists are not hired to file paperwork; they are employed to work directly with families. Role conflict and confusion is the result of poorly defined job tasks (Jacobson et al., 2012). It also can occur when non-peer staff is not prepared to receive a peer colleague to their staff (Jacobson et al., 2012).

Another need is for peers to be better integrated into their workplace teams (Jacobson et al., 2012). Peer providers have experienced discrimination from non-peer staff with respect to their ability to work (Moll et al., 2009). Some peer support workers report being treated as a patient rather than a colleague by non-peer staff (Walker & Bryant, 2013). Some peer support workers reported not being invited to certain work and non-work activities (Walker & Bryant, 2013). Peer workers can alter negative attitudes of non-peer staff through participating in staff meetings and modeling successful performance (Moll et al., 2009). For example, during staff meetings, peer workers can bring the family voice to the table. Peer workers can add value by bringing a consumer perspective to program planning (Moll et al., 2009). According to Walker and Bryant (2013), because of working with peer support workers, non-peer staff gained a belief in recovery (Walker & Bryant, 2013). In addition, non-peer staff developed increased empathy and understanding towards people in recovery (Walker & Bryant, 2013).

An environmental challenge involves integrating peer support staff into organizations built around professionally credentialed staff members and their culture (Alberta et al., 2012). An individual set of challenges involves peer support staff members entering a setting with unfamiliar working conditions (Alberta et al., 2012). Peer support workers need to understand how to define and establish roles (Moll et al., 2009). One concern is around professionalizing peer support, which includes becoming certified, operating under state standards, partnering with traditional providers, and accepting reimbursement conditional on medical necessity from managed care companies (Ostrow & Adams, 2012). In addition, there has been concern regarding the inadequacy of remuneration for their work (Moll et al., 2009). Some difficulties peer support workers have faced include low pay and the opportunity to only work a few hours (Walker & Bryant, 2013).

Role conflict for peer support workers is another potential concern (Moll et al., 2009). Peer support workers may feel pressure from two competing demands (Kemp & Henderson, 2012). For example, administrative requirements can compete with maintaining contact with clients (Kemp & Henderson, 2012). Some peer support workers may find it difficult to transition their role as a critic of the mental health system to a member of it (Moll et al., 2009). Additionally, it is important to balance the tensions between peer versus staff role (Moll et al., 2009). The social location of peer workers is between clients and staff members (Moll et al., 2009).

Boundary issues are another potential concern for peer support workers. Peer support workers can struggle with unclear boundaries perpetuated by the dual role of service provider and friend (Coatsworth-Puspoky et al., 2006). Researchers have found in some studies that consumer providers may be torn between being a friend and acting like a professional (Moll et al., 2009). It is also important to know when to self-disclose personal information to a client (Kemp & Henderson, 2012). Peers use their experience through purposeful disclosure. By disclosing information about themselves they can earn credibility that permits them to guide clients along in their recovery (Austin et al., 2014). Disclosing too much information has the potential to take the focus off the client.

Hiring peer support workers can be complicated because employers do not have well established criteria to use to identify strong candidates for these positions (Oh & Solomon, 2014). Peers require no formal credentials or work history (Oh & Solomon, 2014). The aim of peer services is for peers to use their experiences to promote recovery in clients (Oh & Solomon, 2014). Peer support workers also reported some barriers of working with their clients. For example, some parents found it difficult to divulge personal information to a stranger (Shilling et al., 2013). Additionally, some parents did not want to make contact because they were nervous about getting upset about the potential comparison between their own and another child (Shilling et al., 2013).

Peer support workers stand somewhat outside the institutional hierarchy (Jacobson et al., 2012). Peer support is not explicitly based on psychiatric models of illness and may not be highly specified or theory-driven (Lloyd-Evans et al., 2014). Professional supervision for personal development as a peer support worker is essential (Kemp & Henderson, 2012). To effectively integrate peer support requires consideration of the work role, the unique needs of the worker, and the overall workplace environment (Moll et al., 2009). Employers should consider the extent to which the peer support role will be supplementary, complementary, or an alternative to existing services (Moll et al., 2009).

Empowerment is the variable under review for this study. There is an ancient truism that describes the concept of simply giving fish to a man or teaching a man to fish so that he will become self-sustaining (Burrus, 2015). While both ideas support the man, only one seeks to ensure sustainability. This concept can be true for clients, caregivers and families in general. Assisting a person in developing their own solutions to a problem and guiding them to community resources will prepare them for future concerns that may develop. Empowering a person teaches them not only how to “bait a hook,” but also how to “cast their nets.”

Future research is needed to develop and describe clear models of peer support (Lloyd-Evans et al., 2014). Future researchers should investigate clinical perspectives on recovery to specifically explore how peer work and clinical care can complement each other (Austin et al., 2014). Additional studies could focus on how clients respond to peer support specialists and how it influences their recovery over time (Austin et al., 2014). Furthermore, researchers can concentrate on peer support partners assisting clients in the transition from the hospital to their home.

Theoretical Foundation

The peer support model can be viewed through the lens of social learning theory. Chavis (2011) describe social learning theory as one of the most influential theories of learning and human development. Scientists describe social learning theory as people observing, imitating, and modeling the behaviors of others (Deaton, 2015; Kretchmar, 2016; Chavis, 2011). Researchers can use Social Learning theory to explain the reasoning behind how and why the peer support approach works.

While conceptualizing the current study, I found it important to consider factors that may lead to a change in a person’s perception of their level of empowerment. Examining the tasks a peer support worker performs led me to the realization that they utilize the social learning theory in their everyday duties. Researchers found that exchanging practical information and solving problems together is an important element of support (Shilling et al., 2013). Parents can be empowered through learning from social comparisons and shared situations (Shilling et al., 2013). Researchers cite multiple studies reflecting personal growth from peer support, including developing new skills, feeling motivated, and affirming their expertise as parents (Shilling et al., 2013).

Social learning theory, first called a theory of observational learning, is mostly associated with the work of Albert Bandura, a Stanford professor. Ideas underlying this theory occur from both behaviorism and cognitive theories of learning (Kretchmar, 2016). Behaviorism was the dominant theory of learning in the 1950s and 1960s; cognitive theories of learning gained popularity in the 1970s (Kretchmar, 2016). Bandura believed behaviorism had limitations on explaining human learning; human learning occurred more rapidly than behaviorists believed (Kretchmar, 2016). Behaviorists felt learning occurred gradually through trial and error, with the aid of reinforcement (Kretchmar, 2016). However, Bandura believed learning could take place all at once by observing others without any practice or reinforcement (Kretchmar, 2016). Further, Bandura felt that operant conditioning is an insufficient theory for explaining observational learning (Kretchmar, 2016). During operant conditioning, a behavior is emitted first and is then shaped by a reinforcement or punishment (Kretchmar, 2016). Bandura felt imitation of behavior and subsequent reinforcement is often delayed and learning often occurs in the absence of reinforcement (Kretchmar, 2016). He believed just watching other people reinforced for their behaviors was an incentive for people to perform the behaviors themselves (Kretchmar, 2016).

Ronald Akers' describes social learning theory of crime as having four key elements, including imitation, definitions, differential associations, and differential reinforcement (Cochran, Sellers, Wiesbrock, & Palacios, 2011). The extent to which a person exhibits the behavior of role models refers to imitation (Cochran et al., 2011). Models that are perceived to have power and prestige are more likely to be imitated (Kretchmar, 2016). In addition, when the model's behavior is relevant to the observer, behaviors are more likely to be imitated (Kretchmar, 2016). For example, imitation may be more likely to occur between a peer support partner and client that are both mothers of a child diagnosed with a developmental disability, in comparison to a peer support partner with no children. As behaviors are imitated, it is hypothesized that the client becomes more empowered to independently perform the imitated behaviors.

The attitudes and values people hold regarding the morality of the law, in general, describe definitions in social learning theory (Cochran et al., 2011). The influence of the attitudes and behaviors of significant others describes differential association in social learning theory. Exposure to the attitudes and behaviors of other people can have a powerful effect on a person's own attitude and behavior (Cochran et al., 2011). Bandura felt that people's judgments about good and bad are largely learned by observing others. He believed moral reasoning is learned through observation (Kretchmar, 2016). Keeping these ideas in mind, peer support workers could also hinder clients if they display negative attitudes during their interactions. It is critical to screen and properly train peer support workers on the importance of demonstrating a good attitude and a non-judgmental demeanor.

Differential reinforcement refers to the anticipated costs and rewards associated with a given behavior; those acts that yield rewards are more likely to be repeated (Cochran et al., 2011). In children, real-life experiences and exposures shape behavior and the processes by which this learning occurs includes imitation and reinforcement (O'Connor, Matias, Futh, Tantam, & Scott, 2013). According to social learning theory, individuals behave in a manner that maximizes rewards and minimizes punishments (Brauer & Tittle, 2012). Therefore, if working with a peer support specialist leads to benefits, such as a higher level of empowerment, the client would be more likely to continue to imitate the behaviors learned during their interactions with the peer support worker. However, if the work leads to a perceived punishment, the client would be less likely to imitate the behaviors learned. For example, suppose a peer support specialist, that is a mandated reported, reports a client to the local child endangerment agency due to suspected abuse or neglect. The client may blame the peer support worker and discontinue working with them because of the report made. To challenge the social learning theory in this instance, while the client may discontinue services with the peer support specialist, it is still believed that something the client observed during the interaction with the peer support worker made an impact on their perceived level of empowerment. Such as, if the peer support worker attended a school meeting with the caregiver and modeled advocating for a cool down spot in the classroom. The caregiver may feel more empowered to ask for additional needs in the classroom for their child.

Even though the work relationship ended with a perceived punishment, the caregiver gained advocacy skills that could affect their level of empowerment. Building upon existing theory, a seed can be planted with any interaction with a caregiver. Perhaps authentic empathy can be included as an important factor in social learning theory. Thus, while it is believed that a caregiver may choose to either imitate the behaviors observed based upon a reward or punishment, the authentic empathy shown from a peer support worker still afforded them the opportunity to become more empowered.

Motivation, including anticipation of a reinforcement, is another principle of observational learning; people must be motivated to imitate the behavior they learn (Kretchmar, 2016). Bandura believed self-efficacy has a significant impact on motivation; a person will work hard if they believe they are good at a task and are more likely to give up if they doubt their abilities (Kretchmar, 2016). Peer support workers can encourage caregivers to keep working towards their goals. Bandura also held that learning theory must include internal cognitive variables (Kretchmar, 2016). Bandura thought behaviors observed must be retained, through either an image form, a visual picture, or verbal form of a series of instructions (Kretchmar, 2016). Holding true to the peer support approach, peer support workers often model encouraging behaviors.

One of the most famous studies utilizing social learning theory is the bobo doll study, which demonstrated that aggression can be learned by observing aggressive behaviors in others (Kretchmar, 2016). This experiment asked children to watch a short film of an adult punching, kicking, shouting, etcetera at a large, inflatable rubber doll (Kretchmar, 2016). Next, the children were assigned to three groups; the first group witnessed the model rewarded for the aggressive behavior, the second group saw the model punished, and the third group observed the model receiving no consequences (Kretchmar, 2016). Finally, the children were given a chance to play with the doll; the children that saw the model rewarded or receiving no consequences demonstrated the most aggression (Kretchmar, 2016). Another phase of the study asked the same children to exhibit the behavior of the model and were told that they would be rewarded; all the children could imitate the aggressive behavior, suggesting all the children learned the behavior, but not all had demonstrated it, depending on which consequence they observed (Kretchmar, 2016).

Peer support offers experiential learning and helps connect families ("Family and Youth Peer Support," 2013). An effective way to learn something is to teach it (Boyce, 2011). Per the helper/therapy principle, people learn from others how to meet the needs of people in similar situations to their own and then teach others how to meet their own needs in the same ways (Schutt & Rogers, 2009). Parents can learn from the experience of other parents through partnerships and solving problems together (Shilling et al., 2013). For less experienced parents, learning through social comparison and shared situations can be empowering and reassuring (Shilling et al., 2013). Through several studies, researchers found that parents were empowered through peer support and enabled to develop new skills, feel motivated, and affirm their expertise as a parent (Shilling et al., 2013). Hodges (2006) concluded that peer support workers help increase client empowerment, hope, and satisfaction with formal mental health services. Involvement in a peer support program has been positively correlated with higher appraisals of social support, greater involvement in external community activities, and improved quality of life over time (Biegel et al., 2013).

Summary and Conclusions

The peer support approach has been established as a growing profession in the mental health field. The many benefits for a caregiver were discussed, as well as the benefits received from the perspective of the peer support worker. Several challenges of incorporating peer support workers were also revealed. The meaning behind authentic empathy was explained in this study, as well as the similarity and differences for an empathetic approach for a mental health professional versus a peer support specialist. Comparing the peer support approach to social learning revealed the reasoning underlying the concepts behind why and how peer support can reach a caregiver on a different level than a traditional mental health professional that may work with a client on a time-set limit.

From the review of the literature, several gaps were identified relating to the peer support approach. Among the gaps revealed included more research needed to evaluate outcomes when pairing a peer support worker with a mental health provider. Further gaps included researching different settings that can incorporate peer support workers. Some examples include peer support in detention centers, hospitals, and even companies.

Exploring culture in the peer support approach is an additional need. People carry with them their cultural experiences that affect all aspects of behavior (Chavis, 2011). Per Chavis (2011), culture shapes human behavior and the social environment. Social and cultural contexts include the culture, community, family, and school (Chavis, 2011). To be effective with individuals and families who come from varied cultural backgrounds, professionals need to acquire knowledge about the cultures, values, beliefs, practices, and worldviews (Chavis, 2011).

Additional research is needed to demonstrate that hiring peer support specialists can save money on many different levels. The use of natural resources, such as parent peers, may be an important factor towards sustaining prevention programs and reducing mental health costs (Cavaleri, Olin, Kim, Hoagwood, & Burns, (2011). Cavaleri et al., 2011). Lawn et al. (2008) conveyed that using peers to provide support to clients at the stage of their recovery seems highly effective as an adjunct to mainstream mental health services.

As previously stated, additional quantitative studies that examine the peer support approach are needed to support or reject the claims discovered during qualitative studies. Detailed documentation is needed to verify peer support services and their impact. There are many ways researchers can quantitatively examine outcomes of peer support work. Perhaps the most logical start is to examine the perceived benefits; one of which may be an increase in the level of caregiver empowerment. Exploring if there is a link between caregiver level of empowerment as a result of working with an FSP can potentially lead to additional sources of funding across the nation to employ peer support specialists in a variety of settings.

Chapter 3: Research Method

As the peer support approach has gained popularity in the mental health field, a need was discovered to conduct quantitative studies addressing this emerging dynamic. Social learning theory was used to describe the underlying belief that many human behaviors are learned within a social context (Chavis, 2011). If study findings indicated that working with an FSP in the behavioral health care system in the state in which this study was conducted increased a caregiver’s level of empowerment, the findings could be used to increase funding for additional peer support specialists across the United States.

I explain the research methodology and design in this chapter. I define the participants of the study and the measures used to collect the data. I explain the ethical procedures for the participants and the procedures used for collecting the data. The dependent variable in this study was the level of empowerment felt by a caregiver of a child or youth with a mental health illness, as measured by the Family Empowerment Scale (FES). Empowerment is a variable that needs further research due to the implication to significantly improve a person’s overall quality of life. The independent variables in this study were the length of time as a caregiver of a child or youth with a mental health illness, the length of time working with an FSP, and the caregiver’s age, gender, and ethnicity. The goal of this study was to determine whether a caregiver’s level of empowerment is affected by working with an FSP. Drawing on the foundation of social learning theory, the assumption was that sharing lived experiences motivates others (Shilling et al., 2013). This study included a correlational design to determine whether having an FSP affects the level of caregiver empowerment.

Research Design and Rationale

More quantitative studies are needed to determine whether peer support involvement improves outcomes on many different levels. Empowerment was chosen as a variable in this study due to its potential to improve a person's overall quality of life. Empowerment affects the ability to make decisions about daily life activities and treatment decisions, the willingness to search for needed resources, and the ability to advocate by asking questions and requesting help.

The main time constraint for this study was the amount of time it took to receive permission from the agencies to conduct the study with their clients. The amount of time it took to gather the data was also a time constraint. Financial resources were another barrier. Originally, I wanted to offer each participant a $20 gift card. However, due to financial constraints, participants received a $10 gift card for participating in this study.

Methodology

Population

The target population in this study was caregivers of children or young adults diagnosed with a mental health illness in the state in which this study was conducted below the age of 22. Approximately 24.1% of the population in the state in which this study was conducted who received mental health treatment in 2014 was under the age of 18 years (Arkansas State Epidemiological Outcomes Workgroup, 2014). An approximate target population size is 17,437 (Arkansas State Epidemiological Outcomes Workgroup, 2014).

Sampling and Sampling Procedures

I requested permission to access clients from the mental health agencies offering wraparound at their sites. I currently work for one agency that oversees four of the 14 wraparound sites in the state in which this study was conducted. I supervise the program for two of those four sites. To avoid a potential conflict of interest, the two sites I oversee were not included in this study.

Random sampling was conducted in this study. Each of the 12 sites that provide wraparound received an introduction letter and FES. There was a demographic section at the top of the FES. For active clients who had access to the Internet, I created a Survey Monkey link to send to potential participants. For active clients who did not have access to the Internet, I mailed a hard copy of the letter and FES, along with a self-addressed stamped envelope to return the FES. The sample population was based on the number of FESs received from the Survey Monkey link and hard copies. There was not enough FESs returned; therefore, stratified sampling did not occur. Respondents were divided into two groups. The first group was defined by the exclusion criteria: the caregivers who were not working with an FSP. The second group was defined by the inclusion criteria: the caregivers who were working with an FSP. Because I did not receive enough FESs back, random sampling from each group did not occur. The sampling frame was active wraparound clients within each of the 12 out of 14 sites in the state in which this study was conducted.

I performed an a priori power analysis to determine the sample size and reduce the likelihood that a Type II error would occur. The alpha level was .05. Because beta was unknown, a standard power of .80 was used. The power analysis was calculated using G*Power software. In a multiple regression model with five predictor variables, there was an 80% chance of correctly rejecting the null hypothesis when the multiple R-squared value equals zero with 92 participants.

Procedures for Recruitment, Participation, and Data Collection

The participants of this study resided in a southern state. Participants were caregivers of a child or youth under the age of 22 years who had been diagnosed with a mental health illness and was receiving mental health services. All the participants were involved with the wraparound process. I spoke directly with the community care directors at each of the agencies regarding permission to conduct the study. For active clients who had access to the Internet, I created a Survey Monkey link to send to participants. For active clients who did not have access to the Internet, I mailed a hard copy of the letter and FES, along with a self-addressed stamped envelope to return the scale. The letter indicated that participation in the study was voluntary. Instructions for completing the instrument were included. The community care directors were asked to forward these materials to all their active clients. I placed the demographic section at the top of the scale. It included the following items:

- caregiver name, gender, age, and ethnicity;
- caregiver address and e-mail address (if available);
- length of time as a caregiver of a child or youth with a mental health illness;
- whether the caregiver is working with an FSP; and
- how long the caregiver has worked with an FSP.

Originally, I asked that the FES be returned within 1 month from the date on the instructions. However, the time frame was increased. Study participants were sequentially numbered beginning with 1N to represent the clients who had not worked with an FSP and 1W to represent clients who had worked with an FSP. Once the completed instruments were returned, I sent out a debriefing letter to the participants. The letter indicated the purpose of the study, confidentiality of the data, contact information, and instructions on how to receive a final report of the study.

Instrumentation and Operationalization of Constructs

Both groups, including caregivers who had worked with an FSP and caregivers who had not worked with an FSP, were given the Family Empowerment Scale (FES). The consumer movement emphasizes self-help and self-reliance. This movement includes models focusing on family strengths and incorporating empowerment values within public policies and programs. In addition, this movement recognizes that services can be delivered in ways that promote self-efficacy (Koren et al., 1992). Empowerment has been an elusive research construct, and there has been little agreement about what specific dimensions distinguish it from other constructs (Koren et al., 1992). The need to develop a measure to provide a general picture of family members’ empowerment is increasingly important due to the number of service delivery models featuring empowerment as a major goal (Koren et al., 1992). This scale was chosen for this study to determine whether the level of empowerment differs between a caregiver who works with an FSP and a caregiver who does not work with an FSP.

Test content can be reproduced and used for noncommercial research and educational purposes without seeking written permission (Koren et al., 1992). The scale was only given to participants engaged in the study. Standard scale construction techniques were used to develop the FES (Koren et al., 1992). The FES includes an item pool to measure concepts related to each of the nine cells in the framework; three to four items per cell were chosen based on clarity, simplicity of wording, and relevance of content (Koren et al., 1992). Twenty-eight items resulted from this process, which contained a statement and five response alternatives that ranged from “not true at all,” scored as “1,” to “very true,” scored as “5” (Koren et al., 1992).

Pilot testing occurred with 94 parents of children with emotional disabilities who were contacted through local parent support groups and a national conference attended by many family members (Koren et al., 1992). Twenty-nine of these parents participated in a focus group that addressed readability, clarity, and content of the items (Koren et al., 1992). Seven parents were included in the focus group; they received child care, dinner, and a consultation fee for their participation (Koren et al., 1992). Revisions were then made to the existing items, as well as adding other items, resulting in the current version of the 34-item instrument (Koren et al., 1992).

The internal consistency of the scale was examined through the computation of alpha coefficients for the three subscores that ranged from .87 to .88. These scores compared well with accepted standards of reliability (Koren et al., 1992). Test-retest reliability was also examined by correlating two sets of matched-item subscores based on responses from 107 family members who completed the FES a second time, three to four weeks following the first administration. The Pearson correlations ranged from .77 to .85 (Koren et al., 1992). These correlations provided support for the stability of subscores over a short time interval. In addition, two sets of subscores were compared with paired *t* tests for mean differences. No significant differences were found, suggesting that the subscores did not systematically increase or decrease over the time interval (Koren et al., 1992).

The FES has been used in mental health services for children who have emotional and behavioral disorders. To assess validity, 25 professionals who had advanced degrees in the social or behavioral sciences served as raters. Kappa coefficients for multiple raters were computed for each category. The coefficients were .83, .70, and .77; the overall coefficient was .77 (Koren et al., 1992). Kappa coefficients above .75 are considered indicative of substantial agreement, resulting in the determination that raters classified items in a largely similar fashion (Koren et al., 1992). Kappa coefficients were also computed for the item classification scheme. Coefficients ranged from .47 to 1.00; 84% of the coefficients exceeded .75, and the average was .83 (Koren et al., 1992). These two analyses provided support for the correspondence of FES item content to the constructs underlying the instrument (Koren et al., 1992).

Operationalization

Empowerment was measured using the FES. A sample question on the FES is, “I feel that I have a right to approve all services my child receives.” Respondents answered, “not true at all,” “mostly not true,” “somewhat true,” “mostly true,” and “very true.” Each statement corresponded with a number. For example, “not true at all” corresponded to

“1,” and “very true” corresponded to “5.” Scoring of the FES was accomplished by adding responses from items within the family (12 questions), service system (12 questions) and community/political (10 questions) levels, yielding three subscores (Koren, et al., 1992). A higher score indicated relatively greater empowerment in each respective area.

Data Analysis Plan

Using IBM SPSS software, I conducted a simultaneous multiple linear regression analysis to determine whether the independent variables had a correlational effect on the dependent variable. I also conducted data screening. The caregiver had to meet the following criteria to be included in the study:

- a resident in the state in which this study was conducted,
- a caregiver of child or young adult diagnosed with a mental health illness,
- the caregiver’s child or young adult must be under the age of 22 years,
- the caregiver’s child or young adult must be receiving mental health services, and
- the caregiver’s child or young adult must be involved with the wraparound process.

Exclusion criteria for participation in the study included the following:

- The caregiver is not a resident in the state in which this study was conducted.
- The child or young adult has not been diagnosed with a mental health diagnosis (including developmental disabilities only).
- The child or young adult is the age of 22 or older.

- The child or young adult is not receiving mental health services.
- The child or young adult is not involved with the wraparound process.

I performed an examination of missing information. Respondents completed demographic information on the scale they received, including their age, gender, ethnicity, the time they had been a caregiver of a child or youth with a mental health illness, and the amount of time they had worked with an FSP. If a caregiver skipped any of the questions on the scale, my original intent was not to include their data in the data set. However, do to the lack of surveys received, these were included in the data set. In addition, if I would have identified any outliers, they would have been removed from the study.

The research questions and hypotheses to guide this study were as follows:

RQ1: Does the length of time a person has been a caregiver of a child or youth with a mental health illness predict the level of empowerment felt when working with an FSP and controlling for the length of time working with an FSP, the caregiver's age, gender, and ethnicity?

H_o1: The length of time a person has been a caregiver of a child or youth with a mental health illness does not predict the level of empowerment felt when working with an FSP and controlling for the length of time working with an FSP, the caregiver's age, gender, and ethnicity.

H_a1: The length of time a person has been a caregiver of a child or youth with a mental health illness does predict the level of empowerment felt when working with an

FSP and controlling for the length of time working with an FSP, the caregiver's age, gender, and ethnicity.

RQ2: Does the length of time working with an FSP predict the level of empowerment felt by a caregiver and controlling for the length of time a person has been a caregiver of a child or youth with a mental health illness, the caregiver's age, gender, and ethnicity?

H_o2: The length of time working with an FSP does not predict the level of empowerment felt by a caregiver and controlling for the length of time a person has been a caregiver of a child or youth with a mental health illness, the caregiver's age, gender, and ethnicity.

H_a2: The length of time working with an FSP does predict the level of empowerment felt by a caregiver and controlling for the length of time a person has been a caregiver of a child or youth with a mental health illness, the caregiver's age, gender, and ethnicity.

RQ3: Does the caregiver's age predict the level of empowerment felt when working with an FSP and controlling for the length of time a person has been a caregiver of a child or youth with a mental health illness, the length of time working with an FSP, and the caregiver's gender and ethnicity?

H_o3: The caregiver's age does not predict the level of empowerment felt when working with an FSP and controlling for the length of time a person has been a caregiver of a child or youth with a mental health illness, the length of time working with an FSP, and the caregiver's gender and ethnicity.

H_a3: The caregiver’s age does predict the level of empowerment felt when working with an FSP and controlling for the length of time a person has been a caregiver of a child or youth with a mental health illness, the length of time working with an FSP, and the caregiver’s gender and ethnicity.

RQ4: Does the caregiver’s gender predict the level of empowerment felt when working with an FSP and controlling for the length of time a person has been a caregiver of a child or youth with a mental health illness, the length of time working with an FSP, and the caregiver’s age and ethnicity?

H_o4: The caregiver’s gender does not predict the level of empowerment felt when working with an FSP and controlling for the length of time a person has been a caregiver of a child or youth with a mental health illness, the length of time working with an FSP, and the caregiver’s age and ethnicity.

H_a4: The caregiver’s gender does predict the level of empowerment felt when working with an FSP and controlling for the length of time a person has been a caregiver of a child or youth with a mental health illness, the length of time working with an FSP, and the caregiver’s age and ethnicity.

RQ5: Does the caregiver’s ethnicity predict the level of empowerment felt when working with an FSP and controlling for the length of time a person has been a caregiver of a child or youth with a mental health illness, the length of time working with an FSP, and the caregiver’s age and gender?

H_o5: The caregiver’s ethnicity does not predict the level of empowerment felt when working with an FSP and controlling for the length of time a person has been a caregiver of a child or youth with a mental health illness, the length of time working with an FSP, and the caregiver's age and gender.

H$_a$5: The caregiver's ethnicity does predict the level of empowerment felt when working with an FSP and controlling for the length of time a person has been a caregiver of a child or youth with a mental health illness, the length of time working with an FSP, and the caregiver's age and gender.

Threats to Validity

In this research, I followed statistical conclusion validity to reveal the degree the conclusions about the relationship among the data are reasonable. This research ensured an adequate sampling procedure, appropriate statistical tests, and reliable measurement procedures. There was potential for numerous additional covariates. For example, a monetary increase in family household income could affect empowerment.

There are several threats to internal validity that could have occurred in this study. A correlational design does not offer good internal validity, because a correlation doesn't necessarily mean causation. Maturation effects are not likely to be of major concern. However, the mood the participant is in could affect their responses to the FES. The participant may also be struggling with focus. Instrumental decay is not an identified issue. Experimental mortality was a possibility during the study. However, if a scale was not mailed back, the participant was not included in the study.

The major threats to conclusion validity were that other factors, besides working with an FSP, that could have been responsible for the outcome in this study. The factors that can affect the level of empowerment are unique to everyone. A threat to external validity also existed. Situation factors, such as time and location, could have been a threat to external validity because the participant decides when and where to complete the scale. Originally, any scales received back after the 1 month time frame was not going to be included in the study. However, the time frame was extended per approval of the IRB. The significance threshold was set at .05 and the confidence interval at 95%. An odds ratio was computed to determine if the presence or absence of an FSP is associated with empowerment levels.

Ethical Procedures

Signed agreements to gain access to participants from each agency is included in Appendixes B through D. This study was deemed to be of minimal risk to respondents. The probability and magnitude of harm, or discomfort, anticipated in the research was not greater than any situation encountered in daily life. This study was compliant with the U. S. Department of Health and Human Services Code of Federal Regulations, 45 CFR § 46.102(2009Th). Walden University's approval number for this study was 08-30-17-0246744 and it expired on August 29, 2018.

I provided a letter clearly explaining the purpose of the study to potential respondents. The letter explained that the data collected will remain confidential and their identification will not be available to others, apart from myself, at any time during or after the study. The letter outlined that participation in the study was voluntary and participants were free to withdraw from the study at any time. Respondents were told in the letter that any identifying information will be kept in a locked storage container and shredded approximately five years after the completion of the study. Potential participants decided if they wanted to participate in the study by responding to the Survey Monkey or mailing a hard copy of the scale back.

Summary

To determine if a caregiver’s level of empowerment is affected by working with an FSP, a quantitative research study was developed to test the hypotheses. The target population in this research study is caregivers of children or youth diagnosed with a mental health illness. The dependent variable in this study is the level of empowerment felt by a caregiver of a child or youth with a mental health illness. The independent variables in this study are the length of time a person has been a caregiver of a child or youth with a mental health illness, the amount of time a caregiver has worked with an FSP, the caregiver’s age, gender, and ethnicity. I describe the data collected in Chapter 4.

Chapter 4: Results

Researchers in a variety of fields have been engaged in conversations about the use of peer support professionals. Beyond those conversations, early researchers using qualitative approaches have demonstrated beneficial outcomes regarding working with peer professionals. However, the results have not been as convincing in quantitative studies. Numerous factors have influenced how empowered individuals feel, including family support, training, education, and environment. In the current study, I used quantitative data to determine whether the independent variables were predictors of the dependent variable. The dependent variable in this study was the level of empowerment felt by a caregiver of a child or youth with a mental health illness. The independent variables in this study were the length of time as a caregiver of a child or youth with a mental health illness, the length of time working with an FSP, and the caregiver’s age, gender, and ethnicity. Social learning theory provided the foundation to explore the idea that sharing lived experiences motivates others.

In this chapter, I describe the data collection strategy in detail. Descriptive statistics were used to describe the participants in the study. The results and statistical tests were interpreted to answer the following five research questions (RQs) and their corresponding null and alternative hypotheses:

RQ1: Does the length of time a person has been a caregiver of a child or youth with a mental health illness predict the level of empowerment felt when working with an FSP and controlling for the length of time working with an FSP, the caregiver’s age, gender, and ethnicity?

H_o1: The length of time a person has been a caregiver of a child or youth with a mental health illness does not predict the level of empowerment felt when working with an FSP and controlling for the length of time working with an FSP, the caregiver’s age, gender, and ethnicity.

H_a1: The length of time a person has been a caregiver of a child or youth with a mental health illness does predict the level of empowerment felt when working with an FSP and controlling for the length of time working with an FSP, the caregiver’s age, gender, and ethnicity.

RQ2: Does the length of time working with an FSP predict the level of empowerment felt by a caregiver and controlling for the length of time a person has been a caregiver of a child or youth with a mental health illness, the caregiver’s age, gender, and ethnicity?

H_o2: The length of time working with an FSP does not predict the level of empowerment felt by a caregiver and controlling for the length of time a person has been a caregiver of a child or youth with a mental health illness, the caregiver’s age, gender, and ethnicity.

H_a2: The length of time working with an FSP does predict the level of empowerment felt by a caregiver and controlling for the length of time a person has been a caregiver of a child or youth with a mental health illness, the caregiver’s age, gender, and ethnicity.

RQ3: Does the caregiver’s age predict the level of empowerment felt when working with an FSP and controlling for the length of time a person has been a caregiver of a child or youth with a mental health illness, the length of time working with an FSP, and the caregiver’s gender and ethnicity?

H_o3: The caregiver’s age does not predict the level of empowerment felt when working with an FSP and controlling for the length of time a person has been a caregiver of a child or youth with a mental health illness, the length of time working with an FSP, and the caregiver’s gender and ethnicity.

H_a3: The caregiver’s age does predict the level of empowerment felt when working with an FSP and controlling for the length of time a person has been a caregiver of a child or youth with a mental health illness, the length of time working with an FSP, and the caregiver’s gender and ethnicity.

RQ4: Does the caregiver’s gender predict the level of empowerment felt when working with an FSP and controlling for the length of time a person has been a caregiver of a child or youth with a mental health illness, the length of time working with an FSP, and the caregiver’s age and ethnicity?

H_o4: The caregiver’s gender does not predict the level of empowerment felt when working with an FSP and controlling for the length of time a person has been a caregiver of a child or youth with a mental health illness, the length of time working with an FSP, and the caregiver’s age and ethnicity.

H_a4: The caregiver’s gender does predict the level of empowerment felt when working with an FSP and controlling for the length of time a person has been a caregiver of a child or youth with a mental health illness, the length of time working with an FSP, and the caregiver’s age and ethnicity.

RQ5: Does the caregiver’s ethnicity predict the level of empowerment felt when working with an FSP and controlling for the length of time a person has been a caregiver of a child or youth with a mental health illness, the length of time working with an FSP, and the caregiver’s age and gender?

H_o5: The caregiver’s ethnicity does not predict the level of empowerment felt when working with an FSP and controlling for the length of time a person has been a caregiver of a child or youth with a mental health illness, the length of time working with an FSP, and the caregiver’s age and gender.

H_a5: The caregiver’s ethnicity does predict the level of empowerment felt when working with an FSP and controlling for the length of time a person has been a caregiver of a child or youth with a mental health illness, the length of time working with an FSP, and the caregiver’s age and gender.

Data Collection

Originally, the time frame for the surveys to be returned was within 1 month. However, at the end of the month deadline, only seven surveys had been received: five paper copies and two from Survey Monkey. The survey design relied on the directors for Wraparound to distribute the research materials to their families. Some of the individuals were too busy to distribute the surveys. One director had to have surgery and was unable to send out the surveys.

A change request was submitted to Walden’s IRB to extend the research guidelines to collect more data. The IRB approved the request to recruit participants from clients who had been transitioned from Wraparound within the last year. Furthermore, additional data collection avenues were considered. The IRB also approved a consent letter to send to potential participants through the State Child Adolescent Service System Program (CASSP) Council e-mail distribution list and newsletter, which reached all directors for Wraparound in the state and many family members. However, the state decided not to allow the letter into the State CASSP Council e-mail distribution list or newsletter. In addition, approval was granted from the IRB for me to travel around the state to Wraparound sites during family events to recruit more participants for the study and to extend the deadline to receive the surveys to 3 months. Letters of cooperation were collected from the sites where I attended the family events.

Six months after the first round of research material was distributed, the number of surveys needed had still not been met. Once again, a change request form was submitted to the IRB to collect surveys from the parts of the state where I worked. To keep the respondents anonymous, the materials and collection protocol were changed. The demographic contact information was removed so that I could not identify the respondents. During family events, I let participants know that if they were interested in participating in this study, they could pick up a packet on the designated table at the event. The packets included a consent form and the Family Empowerment Scale. Implied consent occurred when the caregivers filled out the surveys and dropped them in the designated locked box. No deadline was added at this stage of data collection. Eight months after the initial research material was distributed, the number of surveys needed was achieved. Due to receiving only 93 surveys, I was not able to divide the groups. All 93 surveys were used in the data set. Originally, my plans were to not include the scales with missing responses. Once again, due to the number of scales received, the scales with missing data were included in the final data set.

Description of the Participants

I collected a total of 93 surveys. Frequencies and percentages for participant demographics are presented in Table 1. There were 90 individuals who reported their gender. There were 74 females and 16 males who completed the survey. Thus, 79.6% of respondents were female, and 17.2% of the respondents were male.

A total of 91 individuals reported their age. One respondent reported being under the age of 18 (1.1%), one respondent was between the ages of 18 and 25 (1.1%), 39 respondents were between the ages of 26 and 40 (41.9%), 32 respondents were between the ages of 41 and 55 (34.4%), and 18 respondents were over the age of 18 (19.4%). The mean was 3.71, and the standard deviation was .834.

Table 1

Frequencies and Percentages for Participant Demographics

	Demographic	*n*	%
Gender	Female	74	79.6
	Male	16	17.2
	Missing values	3	3.2
Age	Under 18	1	1.1
	18-25	1	1.1
	26-40	39	41.9
	41-55	32	34.4
	Over 56	18	19.4
	Missing values	2	2.2
Ethnicity	White	65	69.9
	African American	22	23.7
	Hispanic	3	3.2
	Other	3	3.2
Time as caregiver	Under 1 year	8	8.6
	1-5 years	17	18.3
	6-16 years	48	51.6
	17-25 years	13	14
	Over 26 years	4	4.3
	Missing values	3	3.2
Ever worked with an FSP?	Yes	63	67.7
	No	30	32.3
Time worked with an FSP			
	Never	30	32.3
	Under 1 month	1	1.1
	1-3 months	9	9.7
	4-6 months	9	9.7
	7 months-1 year	15	16.1
	Over 1 year	27	29
	Missing values	2	2.2

Note. FSP = family support partner.

All individuals reported their ethnicity. There were 65 individuals that identified themselves as White (69.9%). There were 22 participants that identified themselves as African American (23.7%). There were three participants that identified themselves as Hispanic (3.2%). In addition, there were three participants that identified themselves in the other category (3.2%).

There were 90 individuals that reported on their length of time as a caregiver with a child with a mental health illness. There were eight individuals who had been a caregiver for a child or youth with a mental health illness for under 1 year (8.6%). Seventeen caregivers had been caring for a child or youth with a mental health illness between 1 and 5 years (18.3%). There were 48 caregivers who had cared for a child or youth with a mental health illness between 6 and 16 years (51.6%). There were 13 caregivers who had cared for a child or youth with a mental health illness between 17 and 25 years (14%). Four caregivers reported caring for a child or youth with a mental health illness over 26 years (4.3%). The mean was 2.87, and the standard deviation was 0.927.

All individuals reported whether they had ever worked with an FSP. There were 63 (67.7%) caregivers who had worked with an FSP, and 30 (32.3%) caregivers who had not. There were 91 individuals that reported on their length of time working with an FSP (if they had ever worked with one). Thirty caregivers never worked with an FSP (32.3%). One (1.1%) caregiver worked with an FSP for under 1 month. Nine (9.7%) caregivers worked with an FSP for 1 to 3 months. There were 15 (16.1%) caregivers that worked with an FSP for 4 to 6 months. Twenty-seven (29%) caregivers worked with an FSP over 1 year. The mean was 2.65, and the standard deviation was 2.094.

Cronbach’s alpha was conducted to measure internal consistency. Guidelines from George and Mallery (2010) were used to assess the reliability. The scale had a high level of internal consistency, as determined by a Cronbach’s alpha of 0.914. All three levels presented excellent reliability (>.90). Thus, consistent responses existed among the groups of questions. Table 2 shows the descriptive statistics for the composite scores.

Table 2

Cronbach’s Alpha and Descriptive Statistics for Composite Scores

	A	*N*	*M*	*SD*	Skew	Kurtosis
Family	.914	87	47.90	7.21	-.240	-.686
Service system	.914	87	50.25	7.92	-.582	-.555
Community/political	.914	90	34.48	8.20	.065	-.796

Skewness and kurtosis were used to describe the shape of the distribution, whether normal or abnormally shaped for all three levels. Once the kurtosis had been reviewed, the measures revealed the tail-heaviness of the distribution, which helped to determine possible outliers. Figures 1 through 3 show the frequency distributions of the levels.

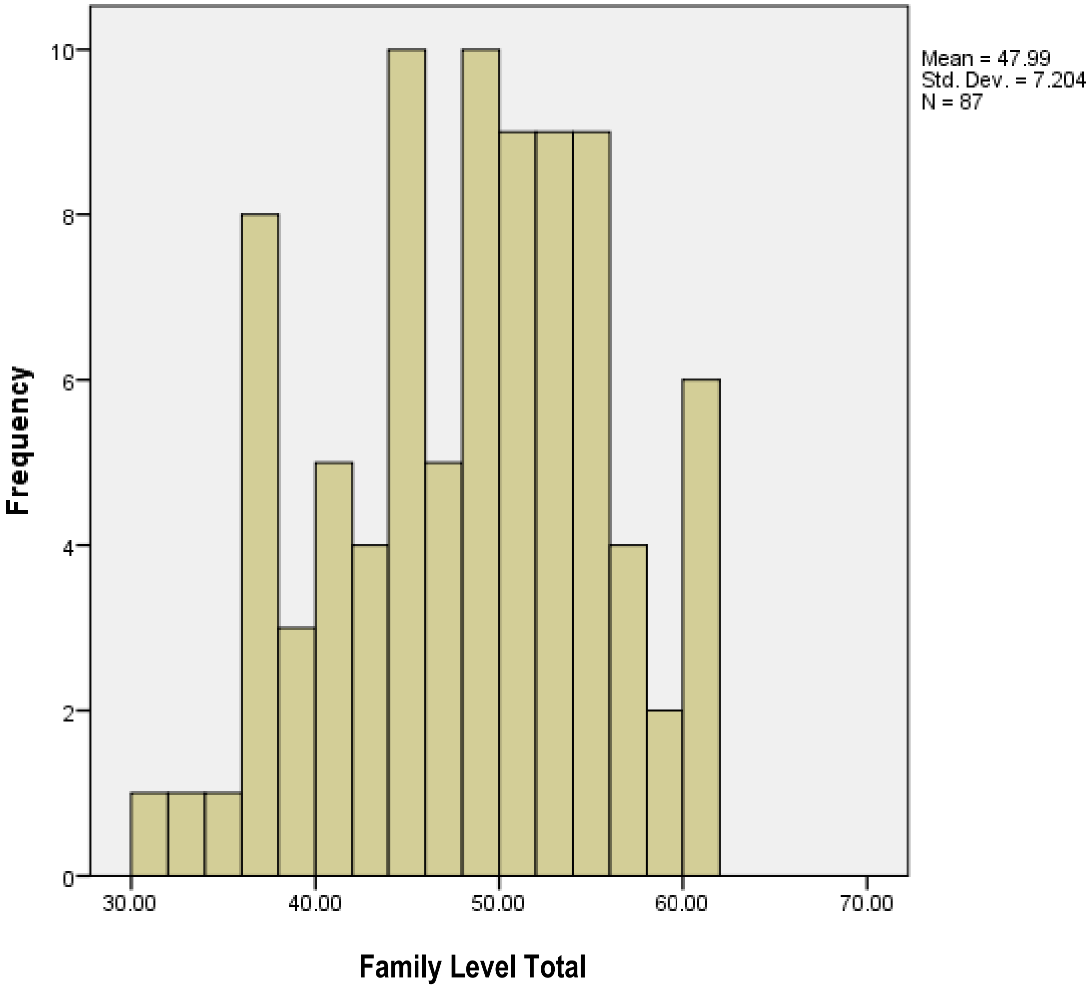

Figure 1. Frequency distribution of the family level.

Skewness was reviewed to determine the dataset’s symmetry. The skewness on the family level was -.240. Figure 1 shows the negative skewness since the left-hand tail is longer than the right-hand tail. Since the skewness was between -0.5 and 0.5, the distribution was approximately symmetrical. The kurtosis in this level was -.686. Since the kurtosis was less than 0, the result of this distribution was a light tail, referred to as a platykurtic distribution, and confirmed the lack of outliers.

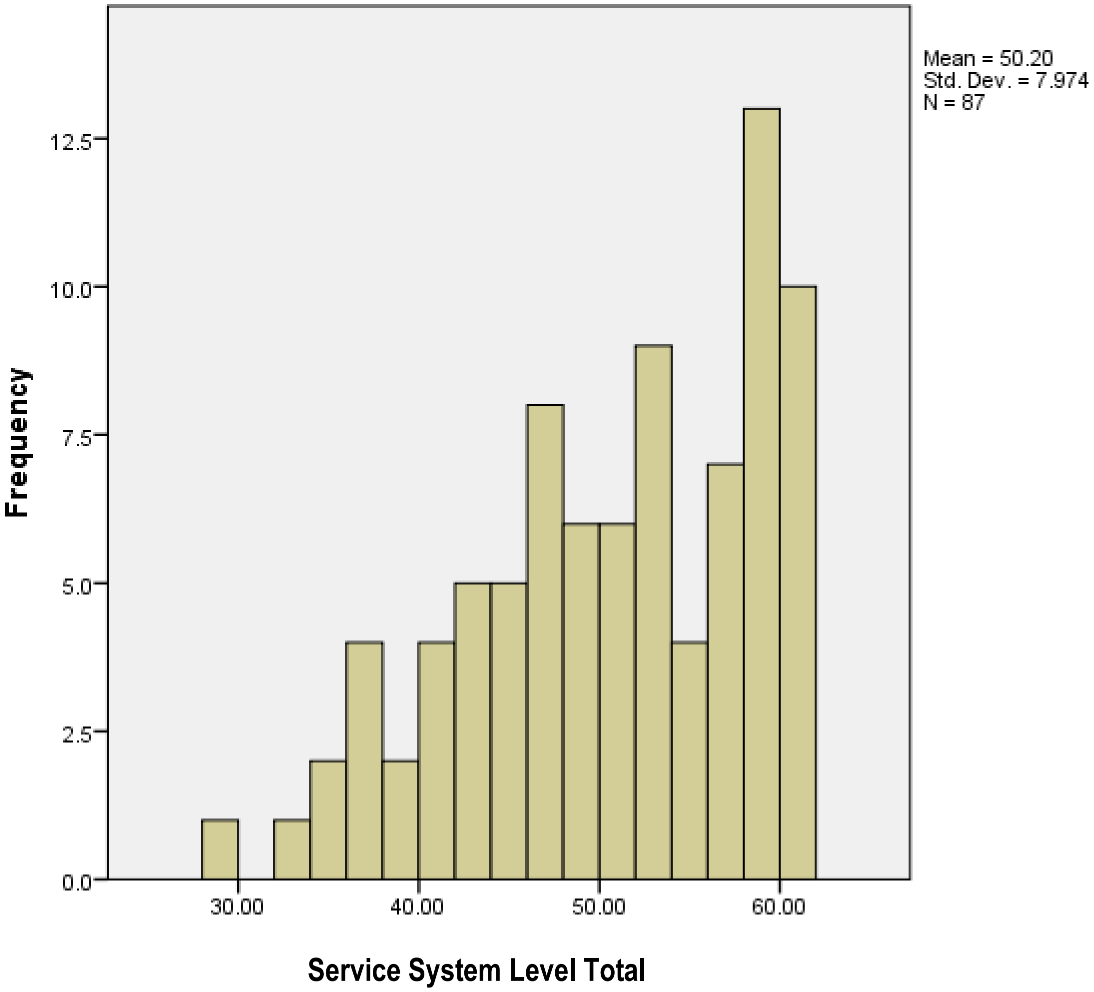

Figure 2. Frequency distribution of the service system level.

Figure 2 shows the frequency distribution of the service system level. It shows a skewness of -.582. The above histogram confirmed the negative skewness since the left-hand tail is longer than the right-hand tail. Since the skewness is between -1 and -0.5, the distribution was proven to be moderately skewed. This kurtosis on this level is -.555. As previously noted, since the kurtosis was less than 0, the distribution was proven to be a light tail distribution, which confirmed a lack of outliers.

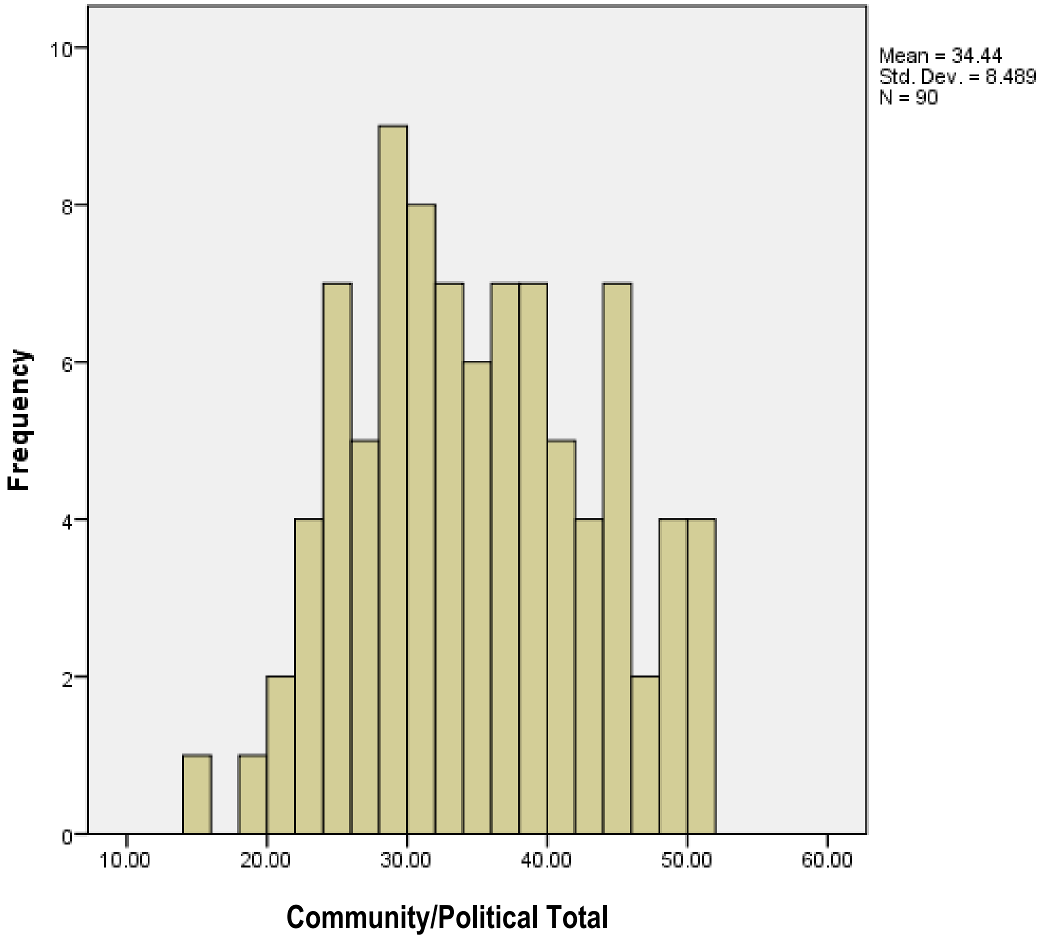

Figure 3. Frequency distribution of the community/political level.

Figure 3 shows the frequency distribution of the community/political level. The skewness for this level is .065. The histogram shows the positive skewness, since the right-hand tail is longer than the left-hand tail. Since the skewness is between -0.5 and 0.5, the distribution was found to be approximately symmetrical. The kurtosis for this level is -.796. Once again, since the kurtosis was less than 0, it was found to represent a light-tail distribution, which confirmed a lack of outliers.

Results

The variables were entered simultaneously into the model using no stepwise procedures. The decision not to use backward or forward regression was due to the possibility that it could cause severe biases in the resulting multivariate model fit, while losing variable predictive information from deleting marginally significant variables. Several problems may be encountered if stepwise procedures were used, including the possibility of the R^2 value being biased on the high end. In addition, the *F* statistic and chi-square tests do not have the claimed distribution. Also, the standard errors of the parameter estimates are too small. The confidence intervals around the parameter estimates are too narrow. Furthermore, the *p* values are too low and are difficult to correct. The parameter estimates are biased high in absolute value, and collinearity problems are exacerbated (Steyerberg, 2016). By entering all independent variables into the model simultaneously, all five null hypotheses were tested together.

A multiple regression analysis was chosen to run on the data set to determine how much (if any) of the variation in the dependent variable was explained by the independent variables. The first step to complete a multiple regression was to consider eight assumptions. The first assumption was met because the study had one dependent variable that is a continuous measure. The dependent variable in this study is the level of caregiver empowerment measured by the Family Empowerment Scale (FES). The FES scored responses on three levels: family, service system, and community/political. Therefore, I decided to perform three multiple regressions using each of these levels as dependent variables.

The second assumption was met because the study involved two or more independent variables that were measured either at the continuous or nominal level. The first independent variable, the length of time an individual had been a caregiver of a child with a mental health illness is a continuous variable. The second independent variable, the length of time a person worked with an FSP also represents a continuous variable. The third independent variable, the caregiver's age, is a continuous variable as well. The fourth and fifth independent variables, the caregiver's gender and ethnicity, are nominal variables. The caregiver's gender represents a dichotomous variable, where the caregiver's ethnicity is a polytomous variable. The nominal variables were not readily interpretable since they have no intrinsic, numeric order.

To check the third assumption, a standard multiple regression procedure was run to inspect for residuals. The following variables were considered: unstandardized predicted values, studentized residuals, studentized deleted residuals, Cook's Distance values, and leverage values. The independence of observations was checked using the Durbin-Watson statistic (see Table 3). On the family level, there was independence of residuals, as assessed by a Durbin-Watson statistic of 1.566. On the service system level, there was independence of residuals, as assessed by a Durbin-Watson statistic of 1.922. On the community/political level, there was independence of residuals, as assessed by a Durbin-Watson statistic of 2.123.

Table 3

Summary of Durbin-Watson Statistics

	Durbin-Watson Statistic
Family	1.566
Service system	1.922
Community/Political	2.123

The fourth assumption, linearity was tested through observed partial regression plots between each independent and dependent variable. The categorical independent variables, such as gender were ignored. The partial regression plots for all three levels demonstrated a linear relationship (see Figures 4a-6d).

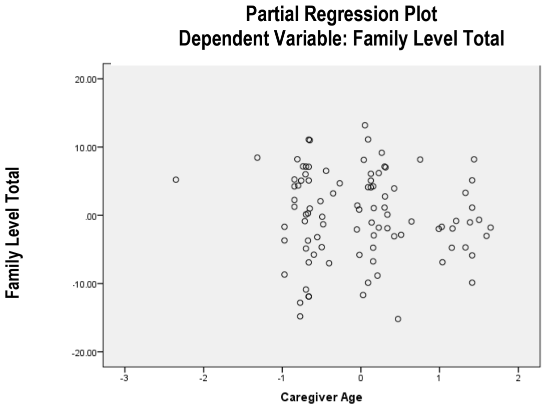

Figure 4a. Family level partial regression plot for caregiver age.

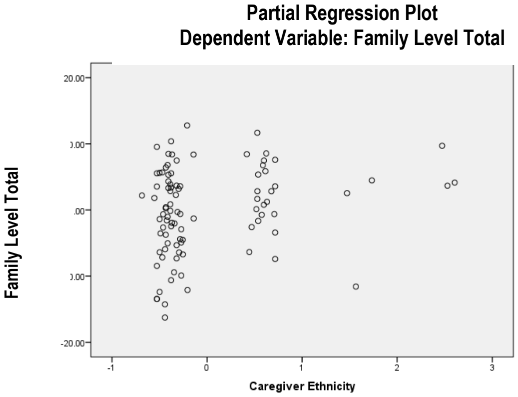

Figure 4b. Family level partial regression plot for caregiver ethnicity.

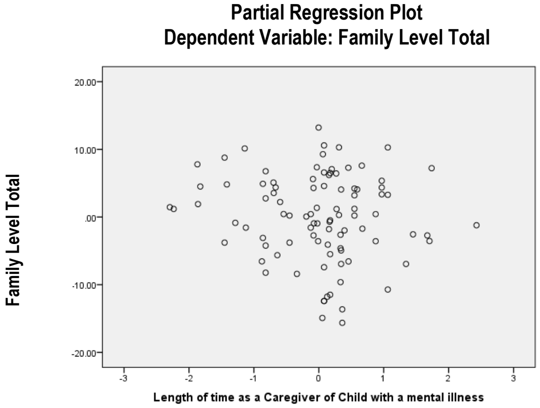

Figure 4c. Family level partial regression plot for length of time as a caregiver of a child with a mental illness.

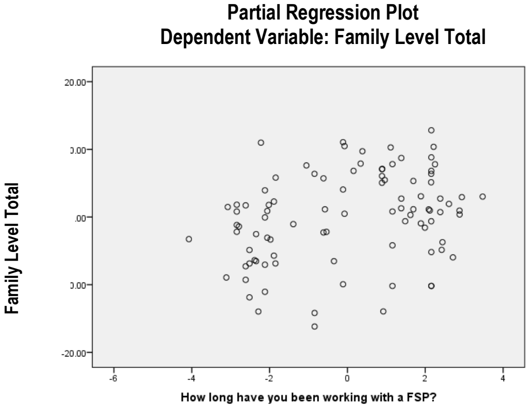

Figure 4d. Family level partial regression plot for length of time working with an FSP.

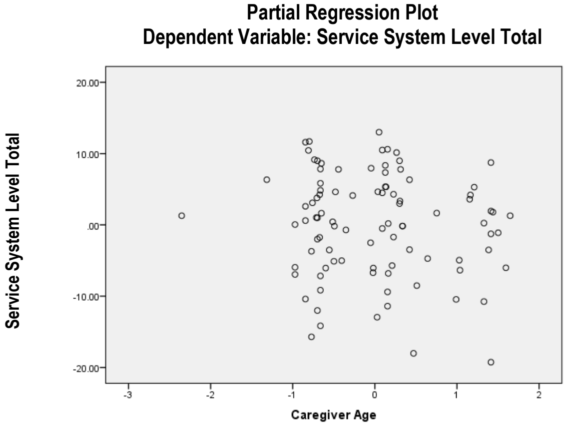

Figure 5a. Service system level partial regression plot for caregiver age.

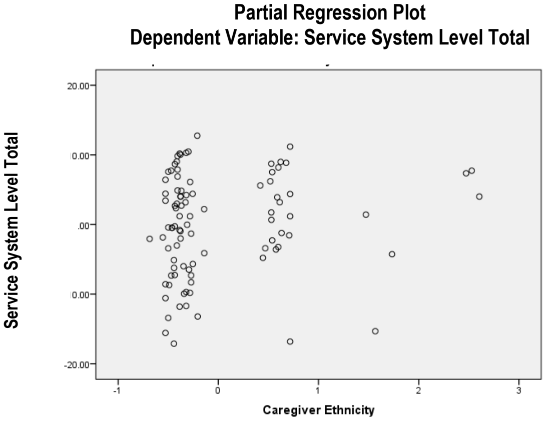

Figure 5b. Service system level partial regression plot for caregiver ethnicity.

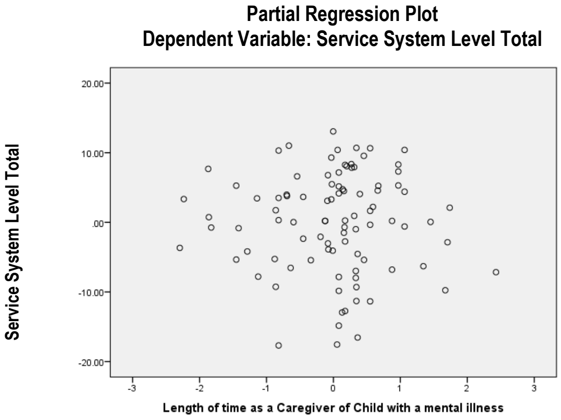

Figure 5c. Service system level partial regression plot for length of time as a caregiver of a child with a mental illness.

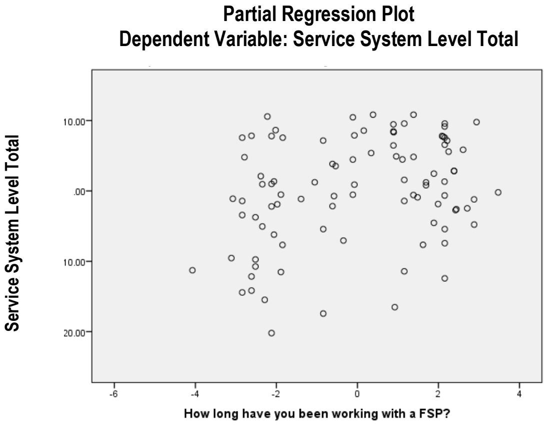

Figure 5d. Service system level partial regression plot for length of time working with an FSP.

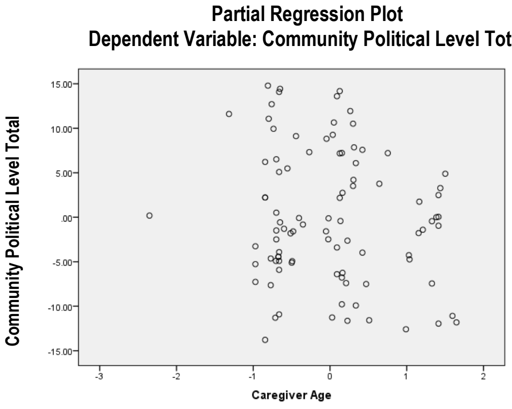

Figure 6a. Community/Political level partial regression plot for caregiver age.

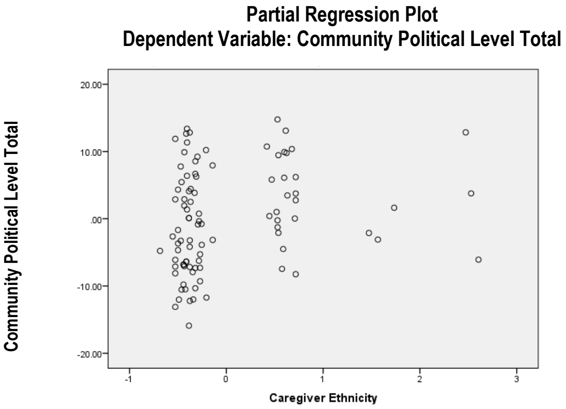

Figure 6b. Community/Political level partial regression plot for caregiver ethnicity.

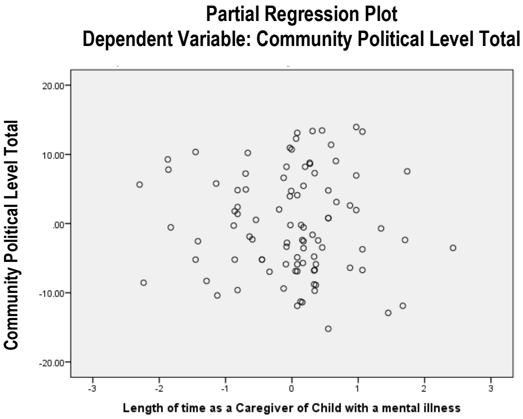

Figure 6c. Community/Political level partial regression plot for caregiver of a child with a mental illness.

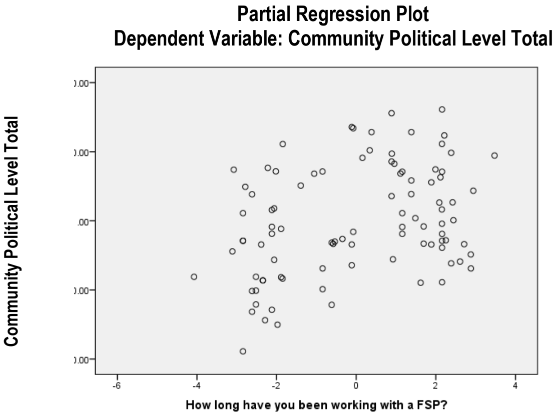

Figure 6d. Community/Political level partial regression plot for length of time working with an FSP.

To check for assumption five, homoscedasticity, the studentized residuals were plotted against the unstandardized predicted values. There was homoscedasticity as assessed by visual inspection of a plot of studentized residuals versus unstandardized predicted values. The residuals in the plot showed an approximate rectangular distribution (see Figure 7) and thus the assumption was met.

To check for assumption five, homoscedasticity, the studentized residuals were plotted against the unstandardized predicted values. There was homoscedasticity as assessed by visual inspection of a plot of studentized residuals versus unstandardized predicted values. The residuals in the plot showed an approximate rectangular distribution (see Figure 7) and thus the assumption was met.

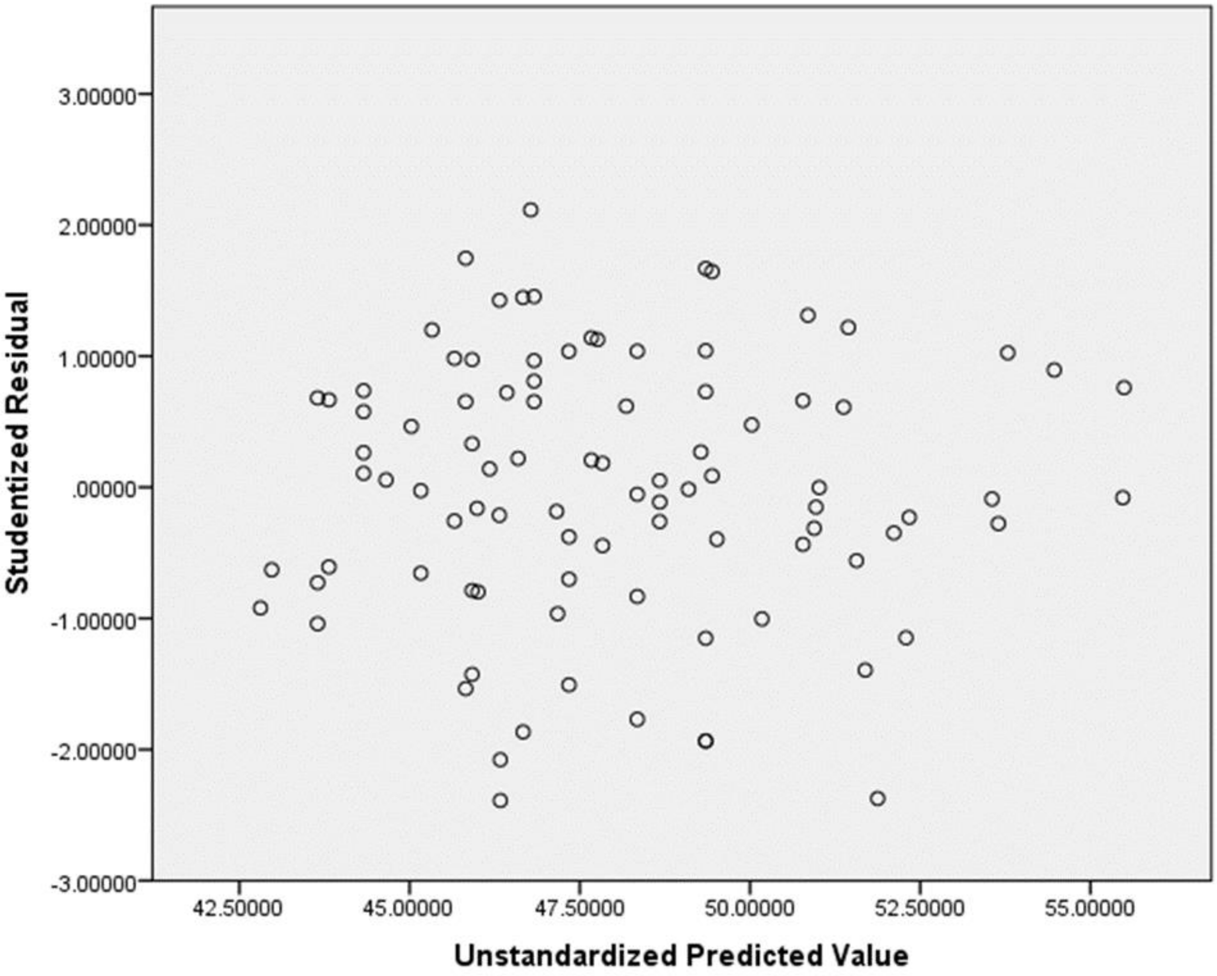

Figure 7. Homoscedasticity plot of residuals and predicted values.

The sixth assumption involved the importance of having no multicollinearity. There were no independent variables that have correlations larger than 0.7 under the correlations table for all three levels as shown in Appendixes F through H. In addition, the tolerance values for all three levels were greater than 0.1, which indicated there was not any problem with collinearity (see Table 4).

Table 4

Tolerance Values

	Family	Service system	Community/political
Gender	0.978	0.978	0.978
Age	0.947	0.947	0.947
Ethnicity	0.980	0.980	0.980
Time as caregiver	0.915	0.915	0.915
Time worked with an FSP	0.942	0.942	0.942

The seventh assumption checked to see if significant outliers existed. All cases on all three levels had standardized residuals less than ±3, since no table was produced as part of the SPSS Statistics output. Appendix E shows the studentized deleted residuals, leverage values and Cook’s Distance values. After the studentized deleted residuals were reviewed, there were no values less than ±3, which indicated no outliers existed for all three levels. For all three levels, the values were no higher than 0.2, which indicated a safe leverage level. Cook’s Distance values for each case checked for influential points. There were no Cook’s Distance values above 1 for all the levels; thus, none of the cases needed to be investigated further.

Assumption eight involved the assumption of normality. Reviewing the histograms in Figures 8a-8c for all three levels revealed that the standardized residuals appeared to be approximately normally distributed.

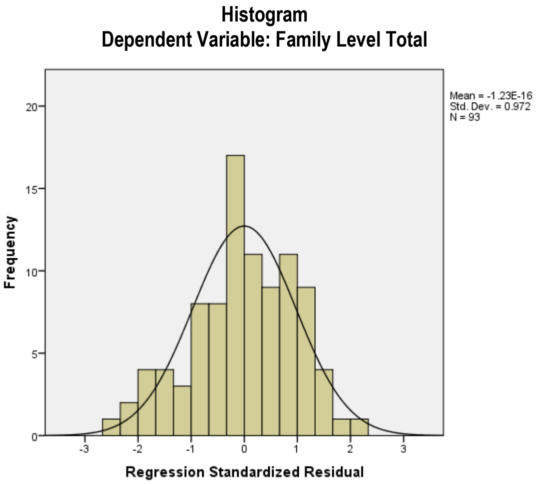

Figure 8a. Frequency distribution of the regression standardized residual on family level.

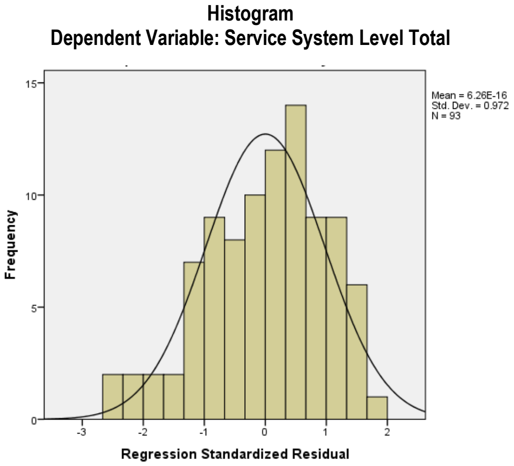

Figure 8b. Frequency distribution of the regression standardized residual in service system level.

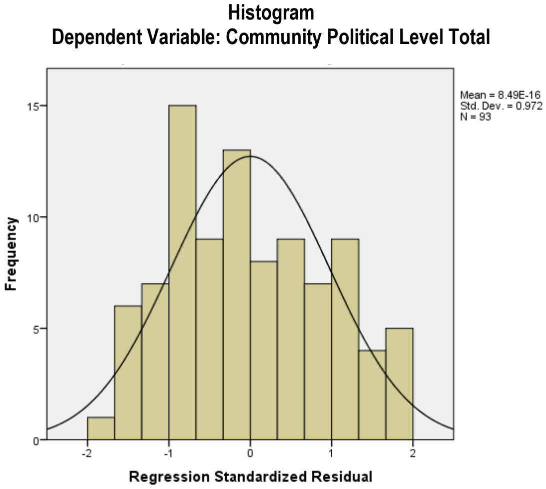

Figure 8c. Frequency distribution of the regression standardized residual on community/political level.

The assumption of normality was also assessed by viewing the P-P Plot. Reviewing the P-P Plot confirmed this result since the points were aligned along the diagonal line for all three levels and did not show a large deviation from normality (see Figures 9a-9c). No transformations or otherwise needed to take place since the assumption of normality was not violated.

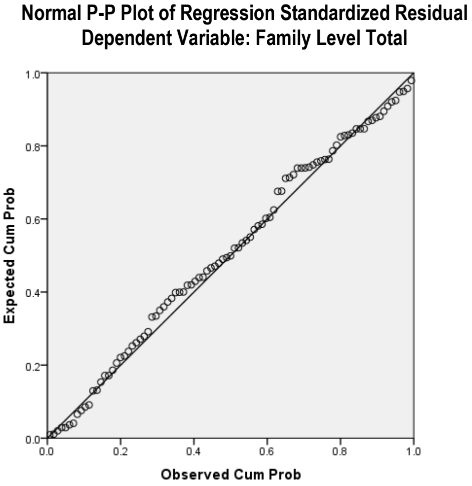

Figure 9a. P-Plot family level.

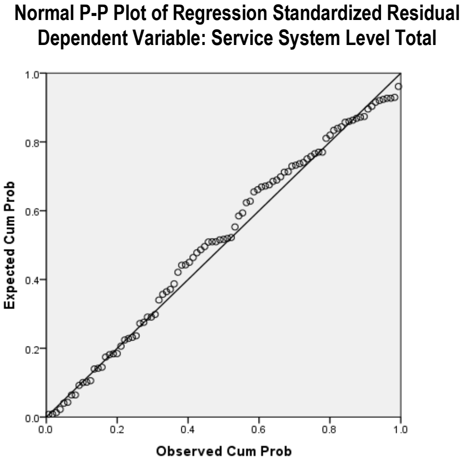

Figure 9b. P-Plot service system level.

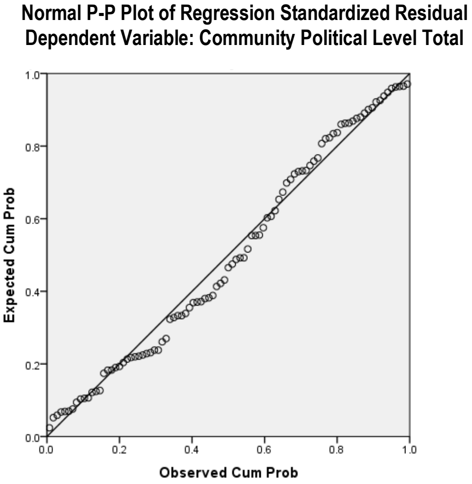

Figure 9c. P-Plot community/political level.

Next, predictions of the dependent variable based on values of the independent variable were made. For example, predicting the level of empowerment for Caucasian, 30-year-old males who had been a caregiver of a child with a mental health illness for under 1 year and had worked with an FSP for under 1 month would register the following syntax, LMATRIX=ALL 1 1 30 1 1 1, which produced the predicted value of the dependent variable at these specified values of the independent variables. Table 5 shows the mean, standard error and confidence intervals of the prediction for each level.

Table 5

Summary of Predictions

	M	*SE_B*	*CI- Lower*	*CI- Upper*
Family	31.415	24.845	-15.080	83.909
Service system	20.387	27.608	-34.610	75.383
Community/political	-2.907	26.597	-56.586	50.772

Note. *M* = Mean**;** *SE$_B$* = standard error; *CI* = Confidence Intervals.

The mean level of caregiver empowerment for the family level was predicted as 31.415 (95% *CI*, -15.080 to 83.909). The standard error of this prediction was 24.845. The mean level of caregiver empowerment for the service system level was predicted as 20.387 (95% *CI*, -34.610 to 75.383). The standard error of this prediction was 27.608. The mean level of caregiver empowerment for the community/political level was predicted as -2.907 (95% *CI*, -56.586 to 50.772). The standard error of this prediction was 26.597.

The first step for interpretation of the multiple regression was to determine whether the model was a good fit for the data set. Tables 6a-6c show the results of the multiple linear regressions.

Table 6a

Summary of Multiple Regression Analysis Family Level

	B	*SE$_B$*	*β*	*t*	*p*
Intercept	46.767	3.940		11.870	0.000
Gender	3.017	1.815	0.164	1.662	0.100
Age	-0.675	0.846	-0.080	-0.798	0.427
Ethnicity	2.103	0.967	0.214	2.175	0.032
Time as caregiver	-0.840	0.779	-0.110	-1.079	0.283
Time worked with an FSP	1.005	0.338	0.299	2.976	0.004

Note. ***** $p < .05$; *B* = unstandardized regression coefficient; *SE$_B$* = Standard error of the co-efficient; *β* = standardized coefficient; *t* = *t* values; FSP = Family Support Partner.

On the family level, the length of time as a caregiver of a child or youth with a mental health illness, length of time working with an FSP, caregiver age, gender, and ethnicity explained a significant proportion of variance in caregiver empowerment levels, $R^2 = .126$, $F(5, 87) = 3.66$, $p < .05$. Since significance was found in the model, further analysis was conducted on the individual predictors. On the family level, caregiver gender did not significantly predict caregiver empowerment levels, $b = .164$, $t(89) = 1.662$, $p > .05$. On the family level, caregiver age did not significantly predict caregiver empowerment levels, $b = -.080$, $t(90) = -.798$, $p > .05$. On the family level, caregiver ethnicity significantly predicted caregiver empowerment levels, $b = .214$, $t(92) = 2.175$, $p < .05$. On the family level, time as a caregiver with a child or youth with a mental health illness did not significantly predict caregiver empowerment levels, $b = -.110$, $t(89) = -1.079$, $p >.05$. On the family level, time working with an FSP significantly predicted caregiver empowerment levels, $b = .299$, $t(92) = 2.976$, $p < .05$.

Therefore, of the predictors, caregiver ethnicity and length of time working with an FSP were significant on the family level. Reviewing the results revealed that caregiver empowerment levels increased by 2.103 points between ethnic groups on the family level. In addition, after I reviewed the results, I found that caregiver empowerment levels increased by 1.005 points the longer a caregiver worked with an FSP in the family level. Since significance was found on the family level for caregiver ethnicity and the length of time working with an FSP, null hypothesis 2 and 5 were rejected in favor of the alternative hypothesis. However, null hypotheses 1, 3 and 4 were not rejected, as significance was not found.

Table 6b

Summary of Multiple Regression Analysis Service System Level

	B	SE_B	β	*t*	*p*
Intercept	49.390	4.476		11.305	.000
Gender	.677	2.062	.033	.328	.744
Age	-1.008	.961	-.108	-1.049	.297
Ethnicity	1.421	1.098	.131	1.294	.199
Time as caregiver	-.178	.885	-.021	-.201	.841
Time worked with an FSP	1.115	.384	.300	2.908	.005

Note. * $p < .05$; *B* = unstandardized regression coefficient; SE_B = Standard error of the co-efficient; β = standardized coefficient; *t* = *t* values; FSP = Family Support Partner.

On the service system level, the length of time as a caregiver of a child or youth with a mental health illness, length of time working with an FSP, caregiver age, gender, and ethnicity explained a significant proportion of variance in caregiver empowerment levels, $R^2 = .129$, $F(5, 87) = 2.588$, $p < .05$. Since significance was found in the model, further analysis was conducted on the individual predictors. On the service system level, caregiver gender did not significantly predict caregiver empowerment levels, $b = .033$,

$t(89) = .328$, $p > .05$. On the service system level, caregiver age did not significantly predict caregiver empowerment levels, $b = -.108$, $t(90) = -1.049$, $p > .05$. On the service system level, caregiver ethnicity did not significantly predict caregiver empowerment levels, $b = .131$, $t(92) = 1.294$, $p > .05$. On the service system level, time as a caregiver with a child or youth with a mental health illness did not significantly predict caregiver empowerment levels, $b = -.021$, $t(89) = -.201$, $p >.05$. On the service system level, time working with an FSP significantly predicted caregiver empowerment levels, $b = .300$, $t(92) = 2.908$, $p < .05$.

Therefore, of the predictors on the service system level, length of time working with an FSP was the only one found to be significant. The results showed caregiver empowerment levels increased by 1.115 points the longer a caregiver works with an FSP on the service system level. Since significance was found on the service system level for the length of time working with an FSP, null hypothesis 2 was rejected in favor of the alternative hypothesis. However, null hypotheses 1, 3, 4 and 5 were not rejected, as significance was not found.

Table 6c

Summary of Multiple Regression Analysis Community/Political Level

	B	*SE*$_B$	β	*t*	*p*
Intercept	46.767	3.940		7.223	.000
Gender	3.017	1.815	.164	2.210	.030
Age	-.675	.846	-.080	-1.439	.154
Ethnicity	2.103	.967	.214	2.125	.036
Time as caregiver	-.840	.779	-.110	-.461	.646
Time worked with an FSP	1.005	.338	.299	3.502	.001

Note. ***** $p < .05$; *B* = unstandardized regression coefficient; *SE*$_B$ = Standard error of the co-efficient; β = standardized coefficient; *t* = *t* values; FSP = Family Support Partner.

On the community/political level, the length of time as a caregiver of a child or youth with a mental health illness, length of time working with an FSP, caregiver age, gender, and ethnicity explained a significant proportion of variance in caregiver empowerment levels, $R^2 = .178$, $F(5, 87) = 4.984$, $p < .001$. Since significance was found in the model, further analysis was conducted on the individual predictors. On the community/political level, caregiver gender significantly predicted caregiver empowerment levels, $b = .211$, $t(89) = 2.210$, $p < .05$. On the community/political level, caregiver age did not significantly predict caregiver empowerment levels, $b = -.140$, $t(90) = -1.439$, $p > .05$. On the community/political level, caregiver ethnicity significantly predicted caregiver empowerment levels, b = .203, t(92) = 2.125, p < .05. On the community/political level, time as a caregiver with a child or youth with a mental health illness did not significantly predict caregiver empowerment levels, $b = -.046$, $t(89) = -.461$, $p >.05$. On the community/political level, time working with an FSP significantly predicted caregiver empowerment levels, $b = .341$, $t(92) = 3.502$, $p < .05$.

Therefore, of the predictors on the community/political level, caregiver gender, ethnicity, and the length of time working with an FSP were found to be significant. The results showed that caregiver empowerment levels increase by 4.665 points between genders on the community/political level. After reviewing the results, I found that caregiver empowerment levels increased by 2.389 points between ethnic groups. In addition, caregiver empowerment levels increased by 1.375 points the longer caregivers worked with an FSP on the community/political level. Since significance was found on the community/political level for caregiver gender, ethnicity, and the length of time working with an FSP, null hypothesis 2, 4, and 5 were rejected in favor of the alternative hypothesis. However, null hypotheses 1 and 3 were not rejected, as significance was not found.

A follow-up ANOVA was conducted to determine if the level of caregiver empowerment was different for various ethnic groups since statistical significance was found between the groups on the family and community/political levels. Participants were classified into four different groups: White, African American, Hispanic, and Other. Tables 7a and 7b show the description of the ANOVA for the family and community/political levels.

Table 7a

ANOVA Descriptions for Family Level

Ethnicity	*N*	*M*	*SD*	*CI- Lower*	*CI- Upper*
White	62	46.74	7.15	44.93	48.56
African American	19	51.42	6.26	48.41	54.44
Hispanic	3	45.67	8.09	25.59	65.75
Other	3	54.33	4.93	42.08	66.59

Table 7b

ANOVA Descriptions for Community/Political Level

Ethnicity	*N*	*M*	*SD*	*CI- Lower*	*CI- Upper*
White	64	32.83	8.25	30.77	34.89
African American	20	39.20	7.84	35.53	42.87
Hispanic	3	32.67	3.06	25.08	40.26
Other	3	39.00	11.00	11.67	66.33

There was homogeneity of variances on all three levels, as assessed by Levene's test for equality of variances: family level ($p = .547$), service system level ($p = .281$), and community/political level ($p = .347$). Data is presented as mean ± standard deviation. On all three empowerment levels, the African American participants and participants that identified as "other" had the highest mean scores (see Figures 10a-10c).

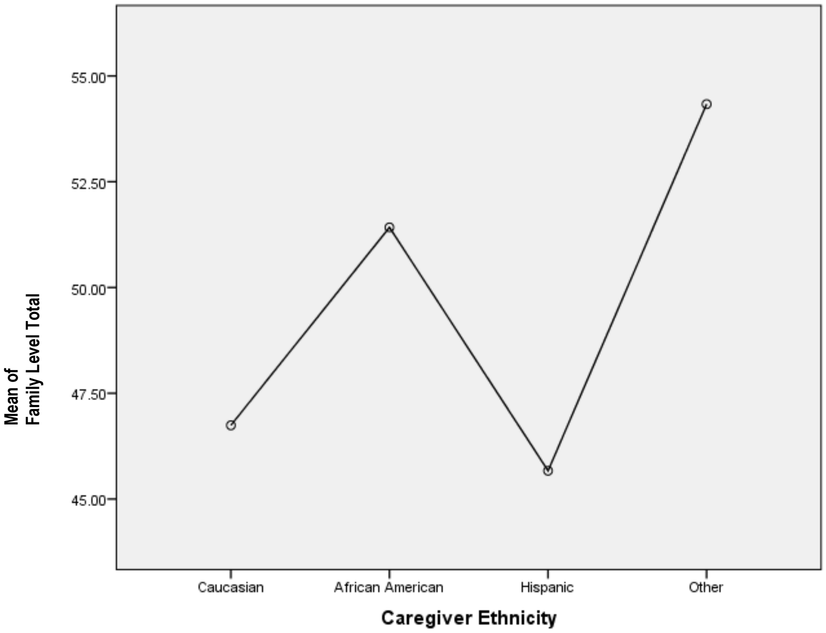

Figure 10a. Caregiver ethnicity mean on the family level.

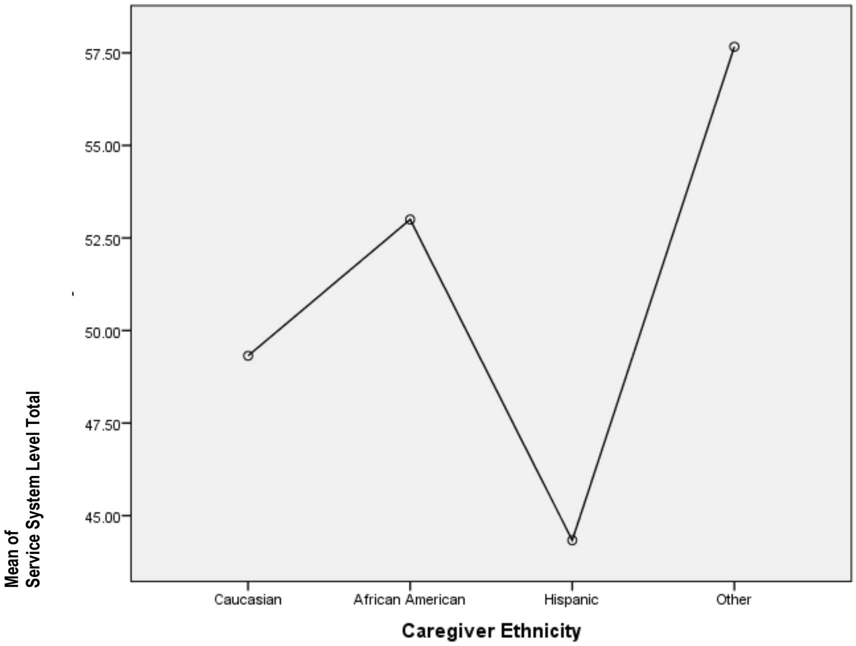

Figure 10b. Caregiver ethnicity mean on the service system level.

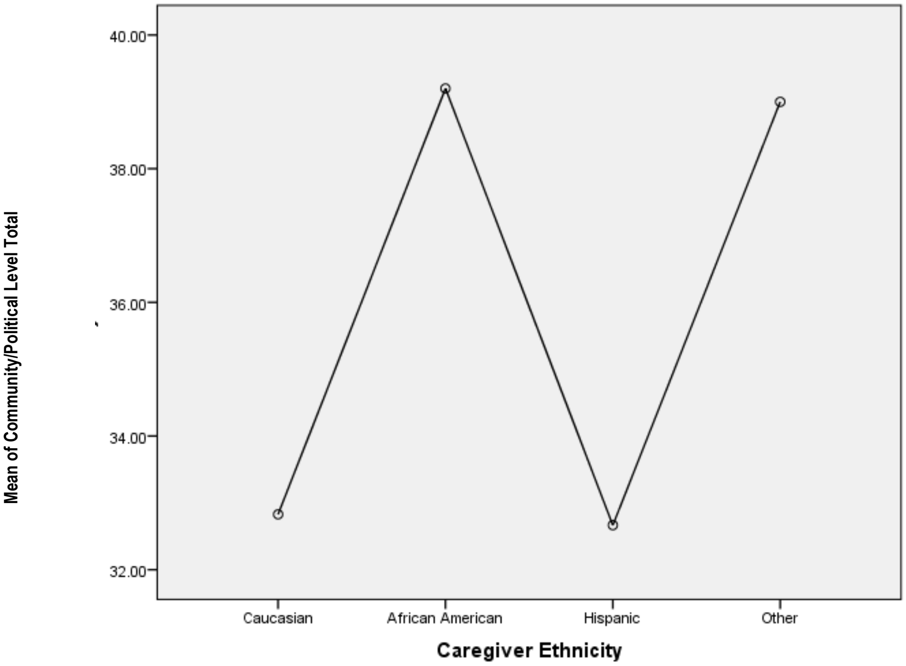

Figure 10c. Caregiver ethnicity mean on the community/political level.

On the family and community/political level, the standard deviation for each group was not similar. On the service system level, the Caucasian and African American participants had similar standard deviations. The standard deviation for the other category was lower on the family and service system levels. The standard deviation was highest on the other category on the community/political level. Also, on the community/political level, the Hispanic group yielded the lowest standard deviation on all three empowerment levels.

The level of caregiver empowerment on the family level was statistically significantly different for the various ethnic groups, $F(3, 83) = 2.546$, $p < .05$. The level of caregiver empowerment on the service system level was not statistically different for the various ethnic groups, $F(3, 83) = 3.157$, $p > .05$. The level of caregiver empowerment on the community/political level was statistically significantly different for the various ethnic groups, $F(3, 86) = 3.462$, $p < .05$. Since the F statistic for all three empowerment levels were >1, I determined the smaller the overlap between the groups indicating there was a real difference. Thus, these results were not just due to sampling error. Tables 8a and 8b show the ANOVA results for the family and community/political empowerment level.

Table 8a

ANOVA Results for Family Level

	Sum of Squares	*df*	*Mean Square*	*F*	*p*
Between groups	457.15	3	152.38	3.16	.029
Within groups	4005.84	83	48.263		
Total	4463.00	86			

Table 8b

ANOVA Results for Community/Political Level

	Sum of Squares	*df*	*Mean Square*	*F*	*p*
Between groups	691.25	3	230.12	3.46	.020
Within groups	5722.98	86	66.55		
Total	6414.22	89			

The Tukey Honest Significant Difference (HSD) analysis revealed statistical significance in the Community/Political level between Caucasian and African American ethnic groups (*p* > .05). No other group differences were statistically significant (see Tables 9a-9c).

Table 9a

Multiple Comparisons for Family Level

Ethnicity	Ethnicity	*Mean Diff.*	*Standard Error*	*CI- Lower*	*CI- Upper*	*p*
White	African American	-4.68	1.82	-9.46	.10	.057
	Hispanic	1.08	4.11	-9.69	11.84	.994
	Other	-7.60	4.11	-18.36	3.18	.258
African American	White	4.68	1.82	-.10	9.46	.057
	Hispanic	5.75	4.32	-5.56	17.07	.545
	Other	-2.91	4.32	-14.23	8.40	.906
Hispanic	White	-1.08	4.11	-11.84	9.69	.994
	African American	-5.75	4.32	-17.07	5.56	.545
	Other	-8.67	5.67	-23.54	6.21	.426
Other	White	7.59	4.11	-3.18	18.36	.258
	African American	2.91	4.32	-8.40	14.23	.906
	Hispanic	8.67	5.67	-6.21	23.54	.426

Table 9b

Multiple Comparisons for Service System Level

Ethnicity	Ethnicity	*Mean Difference*	*Standard Error*	*CI- Lower*	*CI- Upper*	*p*
White	African American	-3.68	2.08	-9.13	1.76	.293
	Hispanic	4.98	4.59	-7.05	17.02	.699
	Other	-8.35	4.59	-20.38	3.68	.272
African American	White	3.68	2.08	-1.76	9.13	.293
	Hispanic	8.67	4.84	-4.03	21.34	.286
	Other	-4.67	4.84	-17.37	8.03	.770
Hispanic	White	-4.98	4.59	-17.02	7.05	.699
	African American	-8.67	4.84	-21.37	4.03	.286
	Other	-13.33	6.34	-29.96	3.29	.161
Other	White	8.35	4.59	-3.68	20.38	.272
	African American	4.67	4.84	-8.03	17.37	.770
	Hispanic	13.33	6.34	-3.29	30.00	.161

Table 9c

Multiple Comparisons for Community Level

Ethnicity	Ethnicity	*Mean Difference*	*Standard Error*	*CI- Lower*	*CI- Upper*	*p*
Caucasian	African American	-6.37	2.09	-11.85	-.90	.016
	Hispanic	.16	4.82	-12.46	12.79	1.000
	Other	-6.17	4.82	-18.80	6.45	.578
African American	Caucasian	6.37	2.09	.90	11.85	.016
	Hispanic	6.53	5.05	-6.70	19.80	.570
	Other	.20	5.05	-13.03	13.43	1.00
Hispanic	Caucasian	-.16	4.82	-12.80	12.46	1.000
	African American	-6.53	5.05	-19.78	6.70	.570
	Other	-6.33	6.66	-23.78	11.12	.777
Other	Caucasian	6.17	4.82	-6.45	18.80	.578
	African American	-.20	5.05	-13.43	13.03	1.000
	Hispanic	6.33	6.66	-11.12	23.78	.777

Summary

In this chapter, I discussed the analysis of my data. A simultaneous multiple regression was completed to predict the level of caregiver empowerment (in three empowerment levels) from gender, age, ethnicity, length of time as a caregiver with a child or youth with a mental health illness, and length of time working with an FSP. On the family level, caregiver ethnicity and length of time working with an FSP showed statistical significance. On the service system level, length of time working with an FSP showed statistical significance. On the community/political level, caregiver gender, ethnicity, and length of time working with an FSP showed statistical significance. Length of time working with an FSP was the only variable shown to be statistically significant in all three levels. A follow-up ANOVA revealed statistical significance in the Community/Political level between Caucasian and African American ethnic groups.

In the final chapter, I compare these results with previous findings from the literature review. The findings were analyzed in the context of the theoretical and conceptual framework. In addition, I present the limitations of the study. Finally, I offer recommendations for further research and ways this study could be expanded.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this quantitative, correlational study was to determine whether a caregiver’s level of empowerment was increased through working with an FSP. Drawing on the foundation of social learning theory, I assumed that sharing lived experiences motivates others. The dependent variable in this study was the level of empowerment felt by a caregiver of a child with a mental health illness. The independent variables in this study were the length of time as a caregiver of a child or youth with a mental health illness, the length of time working with an FSP, and the caregiver’s age, gender, and ethnicity.

This correlational design may be used to replicate the study and predict outcomes of peer specialist programs in other states. The participants in the current study resided in a southern state and were caregivers of a child or youth under the age of 22 years who has been diagnosed with a mental health illness and was receiving mental health services. All the participants were involved with the wraparound process.

I conducted a multiple regression analysis to determine the influence of gender, age, ethnicity, length of time as a caregiver with a child or youth with a mental health illness, and length of time working with an FSP on the level of caregiver empowerment at the family, service system, and political/community levels. On the family level, caregiver age and length of time working with an FSP were statistically significant predictors. On the service system level, length of time working with an FSP was a statistically significant predictor. On the community/political level, caregiver age, ethnicity, and length of time working with an FSP were statistically significant predictors. Length of time working with an FSP was the only variable shown to be statistically significant on all three levels. Findings supported the use of peer specialists in the state in which this study was conducted and other states, not only in the mental health field, but in additional fields as well.

Interpretation of the Findings

The FES instrument was used to operationalize the research variables for this study. This scale has been used in mental health services for children who have emotional and behavioral disorders. There was no aspect of the scale that seemed to exert any influence over the obtained data.

Regarding the relationship between level of empowerment and the length of time a person has been a caregiver of a child or youth with a mental health diagnosis, the results indicated no correlation between these two variables. No previous research was found citing a positive correlation between these two variables.

Regarding the relationship between level of empowerment and the length of time a caregiver has worked with an FSP, researchers alluded to possible connections between empowerment levels and working with peer support specialists. For all three levels in the current study, there was statistical significance found between these two variables. These findings indicated a linear relationship between these variables, suggesting that they are strongly associated with each other. Findings indicated that increases in the amount of time a caregiver works with an FSP are associated with increases in the caregiver's level of empowerment.

Regarding the relationship between level of empowerment and the caregiver's age, on the family and community/political levels, caregiver age showed statistical significance. This finding suggested that the age of the caregiver is related to his or her level of empowerment. However, the service system level did not indicate this result. One possible reason for this result may be due to the nature of the questions. For example, the service system questions may not elicit any variations in responses across the different age groups. The older age groups may not understand the new systems put in place, especially if they are grandparents raising their grandchildren.

Regarding the relationship between level of empowerment and the caregiver's gender, gender was not associated with the caregiver's level of empowerment on any of the levels. Although most respondents were female, there were several male respondents. According to the data, gender did not predict levels of empowerment. This may be due, in part, to the fact that both males and females have similar caregiver responsibilities in the population sampled.

Regarding the relationship between level of empowerment and the caregiver's ethnicity, ethnicity showed statistical significance on the family and community/political levels. Because significance was found, I conducted a follow-up ANOVA to determine whether the level of caregiver empowerment was different for the various ethnic groups. The only statistically significant group differences were found on the community level between the White and African American groups. Once again, the reason for this result may be found in the type of questions on the FES. Questions on the community/political level asked caregivers about their abilities to contact government officials and willingness to seek legislative change. An individual's ethnicity may affect how comfortable they feel with participating in political discussions.

Limitations of the Study

A correlational design does not offer good internal validity because a correlation does not mean causation. However, this design was important to this study to make predictions about the variables. I distributed the survey instrument in two forms: an electronic Survey Monkey link and paper copy. The electronic Survey Monkey link had limited distribution (*n* = 2; 2%), while the paper copies were completed by most of the participants (*n* = 91; 98%). The nature of access to the Survey Monkey link and confidentiality measures made it impossible to monitor or control who completed the scales. Clarification that may have been beneficial to the participant was not possible. It was not clear whether the participants understood the instructional letter provided to them. Distorted results could have occurred if the respondents were not sure how to fill out the scale.

Completing the FES required the participant to rate his or her experiences on a Likert scale ranging from "1" to "5". Respondents circled "1" to indicate the statement was not true at all, "2" to indicate the statement was mostly not true, "3" to indicate the statement was somewhat true, "4" to indicate the statement was mostly true, and "5" to indicate the statement was very true. The presentation of the scale, with the headings for the scale only on the first page, may have confused some respondents leading to reversals of their score. Furthermore, the nature of circling the corresponding numbers repetitively could have led some participants to not fully have read the entire statement. However, there was no direct evidence that either of these potential limitations occurred. The inability to focus and/or the mood of the participant could have affected the responses to the scale. For example, if a crisis was occurring within the family at the time of completing the scale, the data may have been skewed based on emotions. Another limitation included the gender of the FSPs. At the time of this study, all FSPs employed in the state in which this study was conducted were female. Additionally, not all areas across the state in which this study was conducted participated. Originally, I was not going to include the two areas in the state in which this study was conducted where I worked as the community care director. However, a change was requested from the Walden IRB to include these areas to gain access to additional respondents.

Recommendations

There are widespread opportunities for future research studies to address peer support efforts. Future research is needed to develop and describe clear models of peer support (Lloyd-Evans et al., 2014). While exploring different models, researchers can take a variety of topics into consideration, such as the economic factors and challenges for hiring and training peer support workers. In addition, future research is needed to evaluate outcomes when pairing a peer support worker with a mental health provider. Further research could also address different settings that include peer support specialists, such as detention centers and hospitals. Researchers could focus on evaluating peer support transition programs in the different settings.

Exploring culture among caregivers as it relates to the peer support approach is an additional research need. For example, people from some cultures may look unfavorably on accepting help from another peer. Furthermore, researchers may choose to address the lack of male peer support workers in the mental health care system. Future studies could include primarily male caregivers. It may also be beneficial for researchers to consider longitudinal studies. For example, researchers could look at data over extended periods of time working with a peer support specialist. Additionally, future research could address different states that have employed peer support workers for a longer period.

Implications

As I began to work on my final study, the state in which this study was conducted underwent a behavioral health transformation. Part of the transformation included adding Medicaid reimbursement to peer support services. The state identified three different peer support positions, including certified family support partners, certified youth support specialists, and certified peer support specialists.

With the addition of peer support as a reimbursable code through Medicaid in the state in which this study was conducted, the next steps will involve developing models to apply this new service within the behavioral health field. Though specific challenges exist anytime there is a change in systems operation, the potential benefits of merging peer support in the mental health care system are exponential. Peer support specialists are tasked with aiding individuals in their recovery by sharing their own stories and modeling behaviors that have moved them into recovery. Supporting a person in need can influence not only the individual, but the entire family as well. Through nonjudgmental listening, peer support specialists may be able to offer guidance to resources that could help families stay together and out of crisis situations.

From an organizational perspective, peer support provides an additional service to clients that can enhance traditional services. The premise behind social learning theory is that sharing lived experiences motivates others. An additional level of support could help to improve outcomes and possibly improve discharge times. Peers in recovery assisting others could also help reduce the stigma associated with mental health.

Conclusion

For many individuals, the stigma associated with a mental health diagnosis prevents them from seeking treatment and/or adhering to the recommended treatment plan. The strategy of using peer support specialists to offer authentic empathy could reduce this stigma. Not only would people be able to work with others who have been impacted by a mental health illness, but they would also be able to witness recovery in action. Lucy Ingram, depression and bipolar support alliance training and program manager, stated, “learning to build authentic relationships…[is] at the core of peer support, and realizing we have the power to turn our struggles, shame, and self-stigma into sources of strength, inspiration, and hope” (“DBSA peer specialist training,” 2017, para. 4).

The peer support approach is an emerging strategy in the mental health field, not only in the state in which this study was conducted, but across the United States. In this study, I attempted to gain a deeper understanding of how peer support specialists influence empowerment levels of caregivers. Though several factors can lead to improved empowerment levels among caregivers, this study provided empirical evidence that an FSP walking alongside an individual, sharing his or her own recovery story, increases a caregiver’s level of empowerment in the state in which this study was conducted.

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Appendix A: Survey Instrument

Family Empowerment Scale (FES)

Caregiver Name:					
Cavegiver Gender:	Male	Female	Other:		
Caregiver Age:	Under 18	18-25	26-40	41-55	over 56
Caregiver Ethnicity:	Caucasian	African American	Hispanic	Other:	
Caregiver Address (House Number, Street, City, State, Zip Code):					
Caregiver Email (if available):					
Length of time as a caregiver of the child/youth with a mental illness?	Under 1 year	1-5 years	6-16 years	17-25 years	Over 26 years
Has the caregiver ever worked with a Family Support Partner?	Yes	No			
* If the answer is "Yes" to the previous question, for how long? (Please leave blank if the answer is "No" to the previous question).	Under 1 month	1-3 months	4-6 months	7 months-1 year	Over 1 year

Instructions: Below are 34 statements that describe how a parent or caregiver of a child with an emotional, behavioral and/or developmental challenge may feel about his or her situation. For each statement, please circle the response that best describes how the statement applies to you.

Family Empowerment Scale Statements	**Not True at all**	**Mostly Not True**	**Somewh at True**	**Mostly True**	**Very True**
1. I feel that I have a right to approve all services my child receives.	1	2	3	4	5
2. When problems arise with my child, I handle them pretty well.	1	2	3	4	5
3. I feel I can have a part in improving services for children in my community.	1	2	3	4	5
4. I feel confident in my ability to help my child grow and develop.	1	2	3	4	5
5. I know the steps to take when I am concerned my child is receiving poor services.	1	2	3	4	5
6. I make sure that professionals understand my opinions about what services my child needs.	1	2	3	4	5
7. I know what to do when problems arise with my child.	1	2	3	4	5
8. I get in touch with my legislators when important bills or issues concerning children are pending.	1	2	3	4	5
9. I feel my family life is under control.	1	2	3	4	5
10. I understand how the service system for children is organized.	1	2	3	4	5
11. I am able to make good decisions about what services my child needs.	1	2	3	4	5
12. I am able to work with agencies and professionals to decide what services my child needs.	1	2	3	4	5
13. I make sure I stay in regular contact with professionals who are providing services to my child.	1	2	3	4	5
14. I have ideas about the ideal service system for children.	1	2	3	4	5
15. I help other families get the services they need.	1	2	3	4	5
16. I am able to get information to help me better understand my child.	1	2	3	4	5
17. I believe that other parents and I can have an influence on services for children.	1	2	3	4	5
18. My opinion is just as important as professionals' opinions in deciding what services my child needs.	1	2	3	4	5
19. I tell professionals what I think about services being provided to my child.	1	2	3	4	5
20. I tell people in agencies and government how services for children can be improved.	1	2	3	4	5
21. I believe I can solve problems with my child when they happen.	1	2	3	4	5
22. I know how to get agency administrators or legislators to listen to me.	1	2	3	4	5
23. I know what services my child needs.	1	2	3	4	5
24. I know what the rights of parent and children are under the special education laws.	1	2	3	4	5
25. I feel that my knowledge and experience as a parent can be used to improve services for children and families.	1	2	3	4	5
26. When I need help with problems in my family, I am able to ask for help from others.	1	2	3	4	5
27. I make efforts to learn new ways to help my child grow and develop.	1	2	3	4	5
28. When necessary, I take the initiative in looking for services for my child and family.	1	2	3	4	5
29. When dealing with my child, I focus on the good things as well as the problems.	1	2	3	4	5
30. I have a good understanding of the services system that my child is involved in.	1	2	3	4	5
31. When faced with a problem involving my child, I decide what to do and then do it.	1	2	3	4	5
32. Professionals should ask me what services I want for my child.	1	2	3	4	5
33. I have a good understanding of my child's disorders.	1	2	3	4	5
34. I feel I am a good parent.	1	2	3	4	5

The current scoring procedures for the FES is based on a simple, unweighted summation of the items within three construct areas: Family, Service System and Community/Political. These areas are described in the original article (Koren, Dechillo, and Friesen, 1992).

Appendix B: Values for Studentized Deleted Residuals, Leverage, and Cook's Distance

Case numbers	Studentized deleted residuals	Leverage values	Cook's distance values
Family level			
1	2.15877	.18502	.07447
2	1.76855	.16766	.06304
3	1.68654	.15806	.04927
4	1.66138	.15761	.04926
5	1.46454	.15397	.03936
6	1.45687	.15215	.02969
7	1.43522	.12298	.02903
8	1.31652	.12020	.02806
9	1.22243	.11609	.02783
10	1.20294	.11052	.02705
11	1.14145	.09744	.02559
12	1.12746	.09711	.02548
13	1.04272	.09589	.02548
14	1.03863	.08960	.02371
15	1.03750	.08813	.02122
16	1.02565	.08678	.02003
17	.98329	.08527	.01944
18	.97297	.08340	.01895
19	.96551	.08340	.01842
20	.89320	.08340	.01631
21	.80776	.08290	.01440
22	.75718	.07824	.01423
23	.73426	.07779	.01350
24	.72684	.07315	.01302
25	.71990	.07014	.01263
26	.67874	.06804	.01127
27	.66412	.06804	.00917
28	.65826	.06804	.00902
29	.65077	.06804	.00893
30	.65071	.06747	.00883
31	.61557	.06722	.00854
32	.60860	.06680	.00850
33	.57473	.06356	.00739
34	.47369	.06274	.00698
35	.46188	.05850	.00690
36	.32965	.05850	.00670
37	.26775	.05611	.00598

(table continues)

Case numbers	Studentized deleted residuals	Leverage values	Cook's distance values
38	.26245	.05222	.00562
39	.21922	.05020	.00550
40	.20575	.04816	.00538
41	.18227	.04563	.00523
42	.13909	.04273	.00522
43	.10581	.04082	.00494
44	.08647	.03803	.00491
45	.05576	.03773	.00460
46	.05068	.03773	.00457
47	-.00260	.03773	.00420
48	-.01525	.03773	.00413
49	-.02573	.03634	.00362
50	-.05330	.03634	.00361
51	-.07931	.03373	.00354
52	-.08833	.03373	.00337
53	-.11180	.02884	.00320
54	-.15055	.02848	.00317
55	-.15928	.02848	.00304
56	-.18317	.02848	.00295
57	-.21227	.02848	.00283
58	-.22804	.02848	.00273
59	-.25593	.02848	.00267
60	-.26011	.02763	.00257
61	-.27512	.02704	.00248
62	-.31091	.02627	.00247
63	-.34638	.02627	.00213
64	-.37594	.02627	.00205
65	-.39456	.02607	.00159
66	-.43397	.02607	.00157
67	-.44312	.02607	.00154
68	-.55754	.02512	.00143
69	-.60508	.02463	.00142
70	-.62703	.02463	.00116
71	-.65305	.02418	.00085
72	-.69848	.02418	.00071
73	-.72559	.02418	.00059
74	-.78519	.02316	.00045
75	-.79725	.02297	.00042
76	-.83197	.02297	.00041

(table continues)

Case numbers	Studentized deleted residuals	Leverage values	Cook’s distance values
77	-.91984	.02194	.00040
78	-.96373	.02186	.00033
79	-1.00355	.01957	.00029
80	-1.04106	.01957	.00026
81	-1.15042	.01957	.00022
82	-1.15363	.01957	.00021
83	-1.40229	.01789	.00017
84	-1.43568	.01789	.00013
85	-1.51866	.01731	.00012
86	-1.54809	.01731	.00010
87	-1.79157	.01604	.00006
88	-1.89379	.01409	.00004
89	-1.96650	.01284	.00002
90	-1.96650	.01284	.00001
91	-2.11912	.00870	.00001
92	-2.44005	.00870	.00000
93	-2.45776	.00808	.00000
Service System			
1	1.86413	.18502	.08998
2	1.56424	.16766	.08031
3	1.50025	.15806	.04763
4	1.49207	.15761	.04682
5	1.46671	.15397	.04402
6	1.44069	.15215	.03647
7	1.42930	.12298	.03378
8	1.33214	.12020	.02925
9	1.27627	.11609	.02923
10	1.16972	.11052	.02847
11	1.15359	.09744	.02513
12	1.13963	.09711	.02198
13	1.11105	.09589	.02158
14	1.09573	.08960	.02065
15	1.09144	.08813	.01884
16	1.06715	.08678	.01750
17	1.02984	.08527	.01678
18	.98898	.08340	.01588
19	.93122	.08340	.01529
20	.92962	.08340	.01399
21	.75205	.08290	.01281

(table continues)

Case numbers	Studentized deleted residuals	Leverage values	Cook's distance values
22	.75010	.07824	.01251
23	.74900	.07779	.01214
24	.71121	.07315	.01196
25	.70932	.07014	.01148
26	.66174	.06804	.01118
27	.66067	.06804	.01097
28	.62917	.06804	.01091
29	.61559	.06804	.01033
30	.60948	.06747	.00920
31	.57309	.06722	.00873
32	.56801	.06680	.00871
33	.50142	.06356	.00831
34	.49220	.06274	.00817
35	.47123	.05850	.00794
36	.45043	.05850	.00775
37	.44867	.05611	.00711
38	.43541	.05222	.00679
39	.42298	.05020	.00675
40	.34660	.04816	.00673
41	.32166	.04563	.00666
42	.24087	.04273	.00655
43	.22100	.04082	.00651
44	.13375	.03803	.00646
45	.05804	.03773	.00636
46	.04910	.03773	.00608
47	.04683	.03773	.00577
48	.03908	.03773	.00548
49	.02449	.03634	.00529
50	.02449	.03634	.00523
51	.02311	.03373	.00484
52	-.01118	.03373	.00471
53	-.03482	.02884	.00460
54	-.05643	.02848	.00415
55	-.09399	.02848	.00364
56	-.13125	.02848	.00347
57	-.14971	.02848	.00346
58	-.16012	.02848	.00345
59	-.20028	.02848	.00319
60	-.29325	.02763	.00319

(table continues)

Case numbers	Studentized deleted residuals	Leverage values	Cook's distance values
61	-.33491	.02704	.00294
62	-.36975	.02627	.00240
63	-.37073	.02627	.00229
64	-.41732	.02627	.00225
65	-.55420	.02607	.00207
66	-.55984	.02607	.00201
67	-.60112	.02607	.00186
68	-.61278	.02512	.00169
69	-.62266	.02463	.00126
70	-.75049	.02463	.00107
71	-.75788	.02418	.00098
72	-.77475	.02418	.00093
73	-.78638	.02418	.00088
74	-.84501	.02316	.00087
75	-.91477	.02297	.00082
76	-.91795	.02297	.00072
77	-.98412	.02194	.00061
78	-1.00388	.02186	.00050
79	-1.08091	.01957	.00032
80	-1.11195	.01957	.00030
81	-1.12812	.01957	.00013
82	-1.27815	.01957	.00013
83	-1.32502	.01789	.00009
84	-1.35444	.01789	.00009
85	-1.36238	.01731	.00007
86	-1.56179	.01731	.00002
87	-1.57277	.01604	.00002
88	-1.76670	.01409	.00001
89	-1.84447	.01284	.00001
90	-2.08433	.01284	.00001
91	-2.31721	.00870	.00000
92	-2.54071	.00870	.00000
93	-2.59364	.00808	.00000
Community/ Political level			
1	1.96377	.18502	.13332
2	1.87256	.16766	.04513
3	1.86167	.15806	.04107
4	1.83432	.15761	.03736

(table continues)

Case numbers	Studentized deleted residuals	Leverage values	Cook's distance values
5	1.79420	.15397	.03498
6	1.65831	.15215	.03494
7	1.59328	.12298	.03407
8	1.48427	.12020	.03375
9	1.47185	.11609	.03311
10	1.39034	.11052	.03146
11	1.35806	.09744	.03063
12	1.29381	.09711	.02689
13	1.20822	.09589	.02676
14	1.19418	.08960	.02493
15	1.18322	.08813	.02431
16	1.17193	.08678	.02392
17	1.11149	.08527	.02349
18	1.10063	.08340	.02136
19	1.00496	.08340	.02090
20	1.00092	.08340	.02056
21	.98992	.08290	.01965
22	.98121	.07824	.01947
23	.88070	.07779	.01736
24	.73878	.07315	.01577
25	.72255	.07014	.01499
26	.67783	.06804	.01473
27	.67327	.06804	.01467
28	.63105	.06804	.01215
29	.62199	.06804	.01165
30	.61569	.06747	.01056
31	.55665	.06722	.00957
32	.52412	.06680	.00936
33	.46219	.06356	.00883
34	.40075	.06274	.00862
35	.31534	.05850	.00861
36	.27997	.05850	.00853
37	.26558	.05611	.00753
38	.19526	.05222	.00739
39	.14303	.05020	.00720
40	.13749	.04816	.00720
41	.13749	.04563	.00703
42	.04345	.04273	.00673
43	-.01977	.04082	.00651

(table continues)

Case numbers	Studentized deleted residuals	Leverage values	Cook’s distance values
44	-.02008	.03803	.00638
45	-.03084	.03773	.00628
46	-.06378	.03773	.00588
47	-.08882	.03773	.00580
48	-.17966	.03773	.00544
49	-.19884	.03634	.00523
50	-.23341	.03634	.00513
51	-.28672	.03373	.00497
52	-.30697	.03373	.00483
53	-.32604	.02884	.00452
54	-.33073	.02848	.00439
55	-.33897	.02848	.00439
56	-.36337	.02848	.00429
57	-.38897	.02848	.00423
58	-.43770	.02848	.00415
59	-.45280	.02848	.00393
60	-.45348	.02763	.00348
61	-.45489	.02704	.00291
62	-.46447	.02627	.00290
63	-.64236	.02627	.00286
64	-.65185	.02627	.00271
65	-.72829	.02607	.00263
66	-.72829	.02607	.00259
67	-.76025	.02607	.00257
68	-.76596	.02512	.00213
69	-.77404	.02463	.00138
70	-.78705	.02463	.00127
71	-.79660	.02418	.00126
72	-.81192	.02418	.00117
73	-.81982	.02418	.00113
74	-.84173	.02316	.00113
75	-.88231	.02297	.00112
76	-.92132	.02297	.00071
77	-.92276	.02194	.00068
78	-.93812	.02186	.00064
79	-.98005	.01957	.00058
80	-1.17239	.01957	.00048
81	-1.20278	.01957	.00047
82	-1.22542	.01957	.00046

(table continues)

Case numbers	Studentized deleted residuals	Leverage values	Cook’s distance values
83	-1.27276	.01789	.00031
84	-1.29217	.01789	.00029
85	-1.34245	.01731	.00019
86	-1.37711	.01731	.00016
87	-1.48252	.01604	.00016
88	-1.52051	.01409	.00007
89	-1.55751	.01284	.00004
90	-1.57108	.01284	.00002
91	-1.61198	.00870	.00001
92	-1.83735	.00870	.00000
93	-2.06617	.00808	.00000

Appendix C: Family Level Correlations

	Family total	Gender	Age	Ethnicity	Time as caregiver	Time worked with an FSP
Family total	1.000	.114	-.125	.238	-.059	.292
Gender	.114	1.000	.087	-.076	.096	-.052
Age	-.125	.087	1.000	-.093	.183	-.064
Ethnicity	.238	-.076	-.093	1.000	-.039	.084
Time as caregiver	-.059	.096	.183	-.039	1.000	.193
Time worked with an FSP	.292	-.052	-.064	.084	.193	1.000
Sig. (1-tailed)						
Family total		.137	.117	.011	.286	.002
Gender	.137		.204	.236	.180	.309
Age	.117	.204		.188	.040	.272
Ethnicity	.011	.236	.188		.354	.213
Time as caregiver	.286	.180	.040	.354		.032
Time worked with an FSP	.002	.309	.272	.213	.032	

Appendix D: Service System Level Correlations

	Service sys. total	Gender	Age	Ethnicity	Time as caregiver	Time worked with an FSP
Service sys. total	1.000	-.004	-.140	.164	.015	.312
Gender	-.004	1.000	.087	-.076	.096	-.052
Age	-.140	.087	1.000	-.093	.183	-.064
Ethnicity	.164	-.076	-.093	1.000	-.039	.084
Time as caregiver	.015	.096	.183	-.039	1.000	.193
Time worked with an FSP	.312	-.052	-.064	.084	.193	1.000
Sig. (1-tailed)						
Service sys. total		.485	.090	.058	.442	.001
Gender	.485		.204	.236	.180	.309
Age	.090	.204		.188	.040	.272
Ethnicity	.058	.236	.188		.354	.213
Time as caregiver	.442	.180	.040	.354		.032
Time worked with an FSP	.001	.309	.272	.213	.032	

Appendix E: Community/Political Level Correlations

	Community/ political total	Gender	Age	Ethnicity	Time as caregiver	Time worked with an FSP
Community/ Political total	1.000	.161	-.170	.230	.007	.347
Gender	.161	1.000	.087	-.076	.096	-.052
Age	-.170	.087	1.000	-.093	.183	-.064
Ethnicity	.230	-.076	-.093	1.000	-.039	.084
Time as caregiver	.007	.096	.183	-.039	1.000	.193
Time worked with an FSP	.347	-.052	-.064	.084	.193	1.000
Sig. (1-tailed)						
Community/ Political total		.061	.051	.013	.473	.000
Gender	.061		.204	.236	.180	.309
Age	.051	.204		.188	.040	.272
Ethnicity	.013	.236	.188		.354	.213
Time as caregiver	.473	.180	.040	.354		.032
Time worked with an FSP	.000	.309	.272	.213	.032	