AFTERCARE FOR FAMILIES TRANSITIONING
FROM RESIDENTIAL CARE

A Research Practicum Report
Submitted to the Faculty of Social Work
In Partial Fulfillment of the Requirements
For the Degree of
Master of Social Work
University of Regina

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Abstract

The following research practicum was created to gather information on aftercare issues specific to Ranch Ehrlo Society’s Family Treatment Program (FTP). Although the FTP is based in the city of Regina, Saskatchewan, it provides intensive family reunification services to families that reside in communities across Canada. The program has identified a gap in the aftercare component of their service continuum, and as such a qualitative, collective case study approach to research was conducted in order to gather data on aftercare experiences. Data was collected from two groupings of participant samples: the Discharged Client sample and the Family Therapist sample. Eight participants were interviewed from the Discharged Client sample and six participants from the Family Therapist sample responded to electronic questionnaires. The results of the data analysis produced four themes with varying responses found within each group. Ultimately, the findings of this project demonstrate that aftercare services are viewed as needed by both participant groups. Several implications are considered for the provision of aftercare services tailored for the Family Treatment Program. Five recommendations are presented to direct this process within the framework of an intensive family reunification services model that has been developed by the National Family Preservation Network.
Acknowledgements

First and foremost, to my husband, Andrew, and two little girls, Madeline and Lucy, you deserve an extended thank you for your patience, support and unconditional love that you showed me throughout this enormous task. Your efforts to provide me with the time and energy to complete this project are lovingly appreciated and I could not have completed it without your encouragement. I do not think that I can thank you enough.

A special thanks to my professional associate, Patricia Petrucka, as your guidance and knowledge assisted me to direct this research practicum from the beginning. I would also like to thank you for creating access and space for me to work at the Family Treatment Program, as I know that has been a challenge. You have also been gracious in sticking with me when stressful circumstances arose – I really appreciate it.

To my research practicum committee: Dr. Nuelle Novik, who was my academic supervisor, thank you for agreeing to monitor and assist in this research process. Your encouragement and insight has been invaluable and I thank you for being direct and sincere in your position to support the course of this project and its completion. I would also like to thank Dr. Doug Durst, for your advice and input in this research project as a committee member.

Finally, I would like to thank all of the individuals that participated in this project. I recognize that efforts were made to allow for the time to discuss potentially difficult situations, and for that I am very grateful. I hope that your experiences are effectively portrayed and that ultimately your voices have been heard.
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Chapter One: Introduction

Having been employed with Ranch Ehrlo Society for 14 years, my role has evolved from a ‘front line’ worker who attempted to influence the daily functioning of at-risk youth within a residential treatment setting, to a more clinical perspective as a caseworker who is involved in more of a holistic intervention process that includes family and community-oriented approaches. In 1997, I was initially employed at Ranch Ehrlo Society (RES) as a child care worker and had an opportunity to develop positive relationships with young people through interactions and sharing some enjoyable experiences. Over the years, it has been difficult to see many of these young people return home to conditions that had ultimately resulted in their removal from their home and community in the first place. Neglect, abuse, addictions, and cognitive disabilities coupled with mental health concerns and poverty, were common features facing young people when they returned to their homes after spending many months in residential care.

As a clinical caseworker, I have observed that these issues continue to persist; however, with the development of RES’s Family Treatment Program (FTP), there has been optimism in not only reuniting families, but assisting them with the reunification process in an effort to produce more positive outcomes for these children. Within my current role, my responsibilities have included the facilitation of healthy family connections and the assessment of the families of my clients for referral into the FTP. I have always had an interest in working with families, and saw this project as an opportunity to not only learn more about the FTP for the purpose of making appropriate referrals, but to learn more about family-oriented approaches to practice. Initial discussions with my Professional Associate led to the conclusion that further research into the subject of aftercare was required. I knew from my experience within the residential group homes, that aftercare was an area that warranted research and development.
This report consists of an in-depth examination of the existing aftercare practices, aftercare service gaps, barriers to accessing aftercare, and recommendations for the provision of potential aftercare services within Ranch Ehrlo Society’s Family Treatment Program in Regina, Saskatchewan. This project was carried out from May, 2011 to September, 2011. It is anticipated that the information obtained from this project will assist Ranch Ehrlo’s Family Treatment Program in educating referring agents regarding aftercare issues and the effects of aftercare, and to develop a model for aftercare service delivery. This project will also enhance my professional development in my role as a clinical caseworker within one of Ranch Ehrlo Society’s residential group homes by honing my skills to engage, motivate and provide a sense of hope to reunified families post-discharge. As such, it is key to discuss the importance of family reunification and family reunification services offered by the Family Treatment Program.

1.1 Context

Family reunification services have been a focus for development within child welfare agencies within recent years. As Wulczyn (2004) expresses, “reunification has to remain the primary goal of child welfare services until a permanent decision regarding parent’s abilities to carry out their responsibilities can be made” (p. 96). The success of reuniting children in care with family members has been linked to the provision of post-reunification services, such as intensive family reunification services (National Family Preservation Network [NFPN], 2003; Wulczyn, 2004). These services are defined as, “... short-term, intensive, family-based and designed to reunite families when children are likely to remain in out-of-home placement for longer than six months without this intervention” (NFPN, 2003, Executive Summary).

In 2006, Ranch Ehrlo Society introduced a new initiative to assist families by utilizing intensive family reunification services. Information on the history of the Family Treatment
Program that was published by Ranch Ehrlo Society (2011a) discusses the development of the Family Treatment Program to address the need for family-based, residential treatment services. The term “residential” within the FTP refers to the provision of services for families within one of five affordable homes throughout Regina that is provided through partnerships with Ranch Ehrlo Society, Gabriel Housing and other community agencies (Ranch Ehrlo Society, 2011b). Families residing within Regina or residing in a community within traveling distance also may be offered services within their own home. By providing treatment within a home setting, the Family Treatment Program offers a continuum of support for vulnerable children and families to reunify within a healthy family environment (Petrucka, 2006). Since its inception, many agencies have recognized the value of the reunification services being provided by the FTP, and families are now being referred from child welfare agencies throughout the province and the country.

The Family Treatment Program’s family-centered residential services seek to encourage family connections by drawing on their strengths, and adjusting programming to meet each family’s individual needs. This unique program provides reunified families with concrete services such as housing, transportation, basic needs and respite care when required, to allow families to focus on rebuilding bonds and re-establishing a healthy family system. The FTP also offers a variety of therapeutic services such as counselling, group therapy, Equine Therapy, skills development, and 24/7 in-home support that enable all family members to develop and thrive in a safe, therapeutic environment. The services provided are consistent with the central concepts of the Homebuilders® program (NFPN, 2002), which provides home and community-based intensive family preservation services intended to avert unnecessary out-of-home placements of children and youth. The objectives of the Homebuilders® program are to reduce abuse and
neglect, family conflict and child behaviour problems as well as to teach families the skills that are needed in order to successfully reunify (Kinney, Haapala & Booth, 2004).

By developing a greater understanding of family reunification and the intensive family reunification services offered by the Family Treatment Program, the importance of research in this field was magnified for this researcher. The following section will discuss how this research project was narrowed to focus on aftercare.

1.2 Purpose

In preparing for this research project, initial discussions with the Family Treatment Program manager (and Professional Associate) revealed that there was a gap in the agency’s continuum of services, as many families continued to contact the Family Treatment Program post-discharge requesting support (P. Petrucka, personal communication, January 5, 2011). It was also determined that the core rationale that aftercare services were not being utilized is a result of funding limitations and staff time constraints (P. Petrucka, personal communication, January 5, 2011). It was suggested that an aftercare model incorporating creative solutions to bridge some of the identified barriers the FTP and discharged clients were facing may provide referring agents with a resource to assist with the family’s transition back to their home communities. The information discussed with the Family Treatment program manager was taken into consideration, and it was decided that the purpose of this research project should include focus upon: (a) what the FTP is currently practicing with regards to providing aftercare services, (b) the discharged client’s need for aftercare supportive services, (c) the actual barriers to receiving/providing aftercare services, and (d) recommendations for the development of an aftercare model of services.
By outlining the purpose of the research project, specific objectives were then identified by this researcher and will be delineated in the subsequent section.

1.3 Project Objectives

The primary objective of this research practicum was to develop clear practice recommendations for an aftercare program to address the issues pertaining to families transitioning to home communities following family-based residential treatment within Ranch Ehrlo Society’s Family Treatment Program. In order to meet this objective, the following goals were established: 1. Completing an extensive review of literature with a focus upon aftercare services for children and families leaving care, the development of aftercare program models and aftercare program evaluations, and a review of systems theory in order to incorporate a systems perspective into discussions and recommendations. 2. Exploring the concepts of family reunification and family therapy within the FTP including gathering information regarding its policies and practices. 3. Preparing and facilitating interviews with individuals (adult) who discharged from the FTP. 4. Preparing, delivering and receiving questionnaires for individuals who were identified as past or current Family Therapists of the FTP. 5. Accessing, reviewing and analyzing archived files/documents related to the FTP’s current aftercare planning, documented methods and follow up reports. 6. Completing various resource lists containing information on available resources within the communities of the participants in this research project.

The following project outline section provides an overview of the research process beginning with acquiring ethics approval.

1.4 Project Outline

This section will briefly outline the ethical procedures that were completed and the configuration of the research project as it was developed within this practicum. Ethics approval
was mandatory for the University of Regina Research Ethics Board as well as Ranch Ehrlo Society’s Research Review Committee prior to commencing the research practicum. The Application for Approval of Research Procedures was submitted to the University of Regina Research Ethics Board, and approval was obtained on May 3, 2011 (see Appendix A). Ethics approval procedures for Ranch Ehrlo Society’s Research Review Committee included preparing a brief project proposal and presenting the proposal to the agency’s Research Review Committee on June 7, 2011. Ethical approval was granted verbally on the same date, and a written summary of the committee meeting was subsequently forwarded via email to Ranch Ehrlo Society’s CEO and President, Geoff Pawson (see Appendix B).

Upon acquiring the appropriate ethics approval, the following details provide an outline of this research project. Contact information was obtained from the Family Treatment Program, and a sample of eight participants was generated who are representative of discharged clients of the Family Treatment Program. Data was collected from a Discharged Client sample of eight participants through three face to face interviews and five telephone interviews. A sample of six participants that are representative of the family therapists employed with the FTP was obtained. Data was gathered from the Family Therapist sample via electronic questionnaires. All collected data were analyzed using a qualitative, collective case study approach. Analysis was also aided by the use of Nvivo 9, a computer software program developed for qualitative research data management (QSR International Pty. Inc., 2011).

The context, purpose, project objectives, and project outline discussed within this chapter have outlined the elements needed in order to develop this research project. The proceeding literature review chapter elaborates on the value of aftercare programs and services, and examines current research on various aftercare programs.
Chapter Two: Literature Review

This literature search initially targeted aftercare programming, which revealed resources within various systems of care including health/medical programs, corrections, and psychiatric and child welfare systems. Although some practices may be considered and potentially altered to conform to the intensive family reunification services of the Family Treatment Program, many of these aftercare initiatives did not seem appropriate for the scope of this project. There was some documentation that reviewed aftercare models and programming for families that will subsequently be focused on, but a large portion of aftercare research is related to older youth exiting an out-of-home placement or a correctional facility. This has been supported by the NFPN in their statement reflecting that programs that have focused on intensive family reunification services are relatively new; therefore, research within this specific area is limited (NFPN, 2011). This literature review will initially focus on defining aftercare and reporting evidence that appears to authenticate the need for aftercare services.

2.1 Aftercare

Kott (2010) describes residential treatment as “a system of care and services provided outside of the home, within the child welfare system” (p. 15). Residential interventions are typically targeted at children and adolescents who exhibit multiple behaviour difficulties, poor school functioning, and problems within relationships (Walter & Petr, 2008). Family structures typically include low-income single parent, adoptive or step parent families, and many children and adolescents within these families have had frequent placements and experience poor family interactions. Families with children in care have also experienced various life stressors such as substance abuse, physical abuse, mental health concerns or justice system involvement, as well as few social supports (Walter & Petr, 2008). This illustration of the life circumstances of young
people placed in residential care continues to be of concern post-discharge as these children transition back into the homes of their parents.

There has been recognition of the importance of the development and support of aftercare programming over recent years. These recently initiated aftercare programs have been generally targeting youth who have been involved in out-of-home placements (Trout et al., 2010), as well as juvenile correctional programs (Wiebush, McNulty, & Le, 2000) as they are transitioning back to their home communities. According to the literature, detachment from natural/family supports, limited resources and opportunities, loneliness, poor academic results, criminal involvement and inadequate employment were many circumstances young people have faced after leaving care (Chance, Dickson, Bennett, Marrone, & Stone, 2010; Leichtman & Leichtman, 2001; Trout et al., 2010). Several studies discuss the ever-increasing need for aftercare services to be implemented within a continuum of care that allows children to return home with supports readily available for their families to foster an environment that will prevent future out of home placements (Chance et al., 2010; CWLA, 2005; Leichtman & Leichtman, 2001; Mendes, 2009; Trout et al., 2010).

Mendes (2009) states that, “leaving care is a major life event and process that involves transitioning from dependence on state accommodation and supports to self-sufficiency” (p. 388). Another study advocates that “transition is a critical time where they must learn to reintegrate into community, work force, school and for many, the home setting” (Trout et al., 2010, p. 69). Formalized aftercare proposes to assist with such a transition and has been depicted as the use of various services to maintain treatment gains after discharging from care and preventing further out-of-home placements (Trout et al., 2010). These services have reportedly included in-home assistance, case management, parent education, mentoring, crisis intervention,
respite and ongoing monitoring. Establishing linkages to various community systems including school resources and various child welfare agencies involved have also been portrayed as essential aftercare services, while other aftercare features included facilitating the development of social networks, providing employment assistance, and the development of community resources such as support groups (Kott, 2010; Mendes, 2009; Mendes, 2011; Nelson & Nash, 2008; Trout et al., 2010; Walter & Petr, 2008). That being said, it is imperative to examine the effectiveness of such services by reviewing aftercare program summaries and evaluations that have been generated in the literature.

2.2 Aftercare Programming

A search of relevant aftercare programs and services revealed many instances of family-oriented residential programming that incorporated aftercare practices. For the purposes of this project, the family-oriented residential programs will be discussed, as they do attempt to facilitate aftercare programming involving a holistic, systemic approach. Other aftercare programs that were found to potentially incorporate some elements relevant to this project will also be discussed. Finally, the evaluation of an aftercare program for an intensive family preservation intervention will be discussed as it offers valuable information regarding the effectiveness of its aftercare services.

Family-oriented interventions have been reportedly transforming residential treatment services to include parents or caregivers in the treatment process in order to foster connections and prepare for children to return home within a shorter time frame (Chance et al., 2010). Knecht & Hargrave (2002) discuss a family-oriented program in California called Familyworks, where staff members provide services in the center throughout the week and work within families’ homes on weekends in an attempt to transfer learning to their natural environment.
Aftercare components in this particular program include continuing intensive family therapy, family advocacy, and providing support for the family in their natural environment. Community-based efforts are also a large part of aftercare service planning and delivery, and these supports are established prior to discharge (Knecht & Hargrave, 2002). Such community-based efforts share commonalities with “wraparound” models of service as described by Cox, Baker and Wong (2010). Wraparound services are essentially programs that represent a team-oriented, collaborative approach to service planning and implementation based on need and focusing on strengths to integrate youth and families into the home or community (Cox, Baker & Wong, 2010).

A review of several family-oriented programs was the focus of one article in particular that suggested that providing ongoing support and aftercare services when the child returns home is a central factor in the success of such programs (Walter & Petr, 2008). This study reported insights from families, youth and professionals that recommended close links with community-based services to ensure support and aftercare. Families testified that family therapy was an important aftercare service, and that therapy provided over the telephone was useful (Walter & Petr, 2008). Suggestions were made to implement in-home programming, to offer family support groups, and to recruit mentors from other families that could mitigate the sense of isolation for those located in rural communities or those with few social supports (Walter & Petr, 2008). Another recommendation was to locate home and community-based support in residential centers and expand residential respite options. There was also an emphasis on developing models that serve the whole family before, during and after transition home (Walter & Petr, 2008).

Mendes (2009) discusses “specialist leaving care services” in Australia that has contributed to improved outcomes for young people. St. Luke’s Anglicare established aftercare
support services for young people leaving care that includes holistic assistance such as case management, links to education and training and family support to rebuild connections with immediate and extended family. Other services include practical and material support, links to housing, transition units and life skills education. The program also emphasizes strengthening family and community links as well as cultural needs (Mendes, 2009). St. Luke’s Anglicare has developed a mentoring program as a result of the lack of social supports for the young people leaving care. The mentoring program promotes social, recreational and leisure activities that are supervised by a mentoring coordinator. The coordinator recruits, screens and matches individuals as well as supports the mentors. Mendes (2011) describes this mentoring program as useful for facilitating new avenues for social contact, friendships and improving self confidence.

An aftercare pilot project through the Methodist Children’s Village was also documented by Trout et al. (2010), where services were identified as in-home family assistance, case management, creating links to supports, generating links to schools, crisis intervention, goal setting, and the provision of parent training. Some positive feedback from families was reported one month after discharge from this program, but there is little evidence determining the effectiveness of the Methodist Children’s Village aftercare programs on youth outcomes. Suggestions for practice included models designed to: (a) maintain skills learned, (b) work with families as children return home, and (c) identify social, emotional and education supports to assist with the transition process. Applying various levels of aftercare interventions were also recognized, as the aftercare needs of youth exiting the residential program have been found to be diverse (Trout et al., 2010).

A children’s mental health center found in Calgary, Alberta has piloted an aftercare program over the past year. Aftercare services advertised for Woods Homes (2011) have
included assisting youth in utilizing skills learned in treatment, providing clinical support, providing in-home support and parent training, providing recommendations for treatment and other needs, and providing community training and education. In telephone discussions with one of the aftercare program developers, positive outcomes were indicated and were measured in a variety of ways including the use of assessment tools and interviews (J. Foreman, personal communication, Sept. 13, 2011).

The most relevant program that was discovered in this literature search was that of an intensive family preservation program that offered aftercare services (Nelson & Nash, 2008). The aftercare component of this intensive family preservation program was targeted at African American families in the United States and was provided for up to one year after the completion of intensive services. The program was founded and developed by community residents and is staffed largely by African Americans. Two aftercare coordinators provide longer term services to families who are assessed by family coordinators as being in need of aftercare. The aftercare component adheres to key elements of the Homebuilders® model: low caseloads, flexible services provided in a short period of time, emphasizes skill building and assists in establishing and repairing relationships (Kinney et al., 2004). The aftercare coordinator monitors the progress of each family, coordinates services, establishes a long term plan with the family to develop self-reliance, and plans a graduation celebration when the family’s goals are met. The program also provides activity outings that encourage bonding with each other and other families and a weekly parent support group. Direct contact (face to face) is gradually reduced from three hours per week to one hour per month (Nelson & Nash, 2008). A review of the effectiveness of this particular aftercare program will be provided in the subsequent section.
2.3 The Effectiveness of Aftercare

There was little information found within the literature that specifically evaluated aftercare programs in order to demonstrate the effectiveness of aftercare services offered. The intensive family preservation program that developed aftercare services as discussed by Nelson and Nash (2008) is one exception that did accomplish an evaluation. This aftercare program was indeed found to be effective, as there was a decrease in placement rates found for families receiving aftercare versus a control group. Other outcomes of the program included contributions to child well-being and improved family functioning. Unfortunately, the optimal length and content of the provision of aftercare services were not identified. The study also discusses that families with three or more episodes of neglect had little or no improvement with additional aftercare, and may require further intensive services (Nelson & Nash, 2008). This model has some similarities to the intensive family reunification services model that was developed by the National Family Preservation Network, and is discussed in further detail in the following section of this chapter.

2.4 Aftercare Model for Intensive Family Reunification Services

A model for the provision of aftercare services proceeding intensive family reunification services was documented within a report by the National Family Preservation Network. The report produced by the NFPN reviewed findings and implications for practice for intensive family preservation services and intensive family reunification services (NFPN, 2011). The findings that were reviewed were outcomes measured from two sites that provided intensive family reunification services. Findings from the study revealed that between 12% and 23% of
families continue to have moderate or serious problems at case closure and that intensive family reunification programs tend to have families with a higher percentage of moderate to serious problems at discharge and a higher probability of further out-of-home placements (NFPN, 2011). As a result of these findings, one of the main implications for practice is the need for what the NFPN (2011) referred to as ‘step down’ or aftercare services to target families within this range.

The proposed intensive family reunification services model reported by the NFPN (2011) discusses variables such as caseloads and number of service hours. Other features of the model represent a variety of service implementation suggestions such as: services for reunification only, services for reunification and full step down for all families, reunification and full step down for 25% of families, reunification and partial step down for all families, reunification and partial step down for 25% of families, full step down only, and partial step down only (see Appendix C for the complete table). The report also discusses a reduced caseload for workers who require travelling long distances. The model proposes that step down services are received by families who are rated as having moderate or serious problems, or have incurred negative change at discharge as indicated by scores on the North Carolina Family Assessment Scale for Reunification (NCFAS-R®) (NFPN, 2007). This assessment scale provides a measure of family functioning and will be discussed further within the Research Methods chapter of this report. Service hours are approximated at 16-20 hours for a maximum of 60 days, which may be initially provided by the original worker and then completed by a paraprofessional after a family has stabilized. The NFPN (2011) report discusses enhancing parenting skills, providing social support, connecting families to basic community resources, and continuing to address children’s behaviour and emotional well-being following intensive reunification services as the rationale.

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1 These percentages were generated from families’ scores on the North Carolina Family Assessment Scale for Reunification (NCFAS-R) that was administered upon discharge from intensive family reunification programs (NFPN, 2011).
for aftercare in order to prevent future out-of-home placements. Further follow up was noted to occur following step down services in the form of a monthly home visit in 90 days (NFPN, 2011).

This model provides convincing rationales for the provision of aftercare services. The following section on systems theory provides a framework to reference in order to enhance understanding of the interpretations that are made by this researcher within this project. A systems theoretical approach to providing aftercare services may also enhance the concepts that are proposed within the intensive family reunification services model discussed above.

### 2.5 Systems Theory

This description of systems theory is intended to assist the readers of this report in obtaining an understanding of the theoretical foundation that this project is based on. Systems theory presents an appropriate lens with which to view this qualitative research project, as it involves investigating the interactions of various social systems as well as the individuals within them (Norlin & Chess, 1997). Understanding the roles and experiences of individuals within systems is key for preparing families for their transition from residential treatment to their home communities, as well as recognizing interactions with their environment and other systems. Assisting family members in understanding these systems and their role within them may also provide the necessary support to meet their needs (Norlin & Chess, 1997).

A general description of systems theory as it applies to individuals and families, involves viewing the relationship between individuals and their social environment (Anderson, Carter, & Lowe, 1999). Of course other systems exist on many levels (community, organization, group, etc.) that may potentially be linked to one another depending on the existence of a relationship. These links are depicted as conduits of energy or information, or as links through which
resources are accessed and obtained (Bailey, 2001). The exchange of reciprocal energy transfers between systems is identified as feedback loops, and could potentially have the “power to effect change” (Anderson et al., 1999). However, some families may have difficulty when they don’t negotiate successfully within their own micro-level systems, which may include individuals, couples, and families; and mezzo-level systems which are relationships that are less intimate than those associated with family life but more meaningful than relationships with agency representatives (Hepworth, Rooney, Dewberry Rooney, Strom-Gottfried, & Larson, 2006).

Phelan (2004) discusses that when families are unable to resolve issues within these systems, they may also have a limited view of their connection to others. This is where a systemic approach can be useful, as workers can assist families in understanding the systemic influences in their lives by “coaching them to understand the mutual influence process that occurs” (Phelan, 2004, p. 71).

Bailey (2001) discusses various features of a system and will subsequently be briefly described. One of the main features of a system is whether the boundaries that define the system are closed or open. A closed system is shut off to the flow of information from the environment, whereas an open system does receive and provide information (Bailey, 2001). Subsystems are also known to be internal components of a system that perform a function in order for the system to survive. When a subsystem does not perform its function and its function is not picked up by another subsystem, then the equilibrium or balance within that system is compromised (Bailey, 2001). If the system does reach a point of disorganization, they must try to adjust by assimilating to incoming information or by accommodating information and resources (Anderson et al., 1999). Families are described as the only system interwoven with all other systems, which would
This literature search produced minimal results on aftercare programs offered to families that have been involved in an intensive family reunification residential program such as that of the Family Treatment Program at Ranch Ehrlo Society. However, it has generated some valuable information focusing on the philosophy and approach that many child welfare agencies are taking to provide supports post-discharge, as this period of time is considered to be a transition that is vital in determining outcomes. An examination of the post-discharge experiences of families that have participated in the Family Treatment Program at Ranch Ehrlo Society was therefore identified as essential in directing a serviceable aftercare model. The following chapter will discuss the research methods that were utilized to collect information from past clients of the Family Treatment Program and from staff members in order to generate an account of post-discharge experiences following intensive family reunification services.

Chapter Three: Research Methods

The intention of the previous chapter is to generate an awareness of current aftercare issues and practices as well as to describe a model for aftercare following intensive family reunification services. It is through this literature search that a decision by the researcher was made to achieve a greater understanding of aftercare issues for the Family Treatment Program. Discussions with the Family Treatment Program manager assisted in directing the approach to obtaining knowledge of aftercare experiences through gaining the perspective of families that have discharged from the program as well as the perspectives of the staff members.

Ranch Ehrlo Society (2011b) created the The Family Treatment Program “to improve family safety, family functioning, and child well-being so families can remain together” (p. 4).
Therefore, it is important to recognize: (a) if there is a need for aftercare supports for the FTP clients, (b) what services and supports do FTP clients require post-discharge, (c) what are the barriers to accessing services, and (d) what recommendations can be delineated for an effective aftercare program model for Ranch Ehrlo Society’s Family Treatment Program. It became apparent that an appropriate approach to gain an understanding of aftercare for the Family Treatment Program was to choose a qualitative method of inquiry that would reflect the individual stories of those that would be impacted the most (Silverman, 2005).

3.1 Qualitative Research

As mentioned above, qualitative research seeks to illustrate the perspectives of individuals through rich descriptions of their social experiences and the meaning that they give to these experiences (Denzin & Lincoln, 2003). Qualitative approaches to research generally collect data “in situ”, or within the natural setting of the people and places under enquiry. This approach also produces an inductive analysis including the point of view of the participants, demonstrates the reflexivity of the researcher, provides an interpretation of the issue or phenomenon, and adds to existing literature or calls for action (Creswell, 2007). Silverman (2005) simply depicts one of the main objectives of qualitative inquiry as seeking a deep understanding of the social phenomena under study.

Interpretations of the data that is collected through qualitative approaches are informed by the researcher’s background, history, context and prior understanding of the issue at hand. This interpretation is developed using various forms of communication, and a rich, complex description of the problem is generated from the diverse ideas of the participants (Creswell, 2007; Denzin & Lincoln, 2003). The details found within the participants’ understanding of the problem are described in their original language in order to convey their perspective. It is in this
manner that meaningful conclusions are reached, a deeper understanding is provided, and useful results are reported (Trochim, 2005).

Trochim (2005) discusses various qualitative traditions or approaches to conducting qualitative research. Traditions such as narrative, grounded theory, ethnography, phenomenological and case study approaches describe the purpose of the qualitative study, the role of the researcher, the phases of research and the method of analysis (Creswell, 2007). In order to elicit relevant information to achieve the desired research practicum objectives, a collective case study approach to inquiry was selected and will be discussed further in the following section.

3.2 Collective Case Study Approach

In order to achieve a greater understanding of the post-discharge experiences of families that have participated in the Family Treatment Program, an effective research approach to studying this phenomenon was required. The book entitled *Multiple Case Study Analysis* by Robert Stake (2006) discusses studying the phenomenon of interest by demonstrating the issue in a collection of cases, and refers to this method as a multi-case study. For the purposes of this report, the researcher will refer to this study of multiple cases as a collective case study approach to qualitative research. Collective case study methods are generally used to seek various perspectives on issue(s), and to illustrate varying views. These diverse angles may be consistent or contradictory, but may all increase the researcher’s understanding of the issue(s) under study (Stake, 2006). The cases have at least one issue in common or share some link, and contributions to understanding the phenomenon are made by studying the issue(s) across cases (Goddard, 2010; Stake, 2006). Cases are chosen on the basis that they will contribute to the researcher’s understanding of the issue, and they are illustrated comprehensively (Stake, 2006).
A collective case study approach was chosen as an effective method of study for this research project in order to generate an awareness and understanding of a gap in the continuum of services that may exist post-discharge for families exiting the Family Treatment Program. By attending to several instances of varying post-discharge experiences, case comparisons are made to allow for an in-depth understanding of these experiences (Gondo, Amis, & Vardaman, 2010). The cases that were selected for this research project were chosen based on their ability to provide ample information about varying characteristics and features of post-discharge experiences (Bleijenbergh, 2010). These cases were identified as discharged clients and staff members of the Family Treatment Program, as they are the cases that were acknowledged as being able to offer the most relevant information regarding aftercare.

The cases selected consisted of several individuals found within two bounded systems, which are systems that have identifiable boundaries such as a group or organization (Creswell, 2007). The first bounded system was identified as a sample of clients that had discharged from the Family Treatment Program that is named the Discharged Client (DC) sample throughout this report. The boundaries of this sample were delineated by their participation within the Family Treatment Program, their discharge from the Family Treatment Program, and by their experiences with aftercare post-discharge. The second bounded system was identified as a group of staff members that were employed with the Family Treatment Program. This sample was named the Family Therapist (FT) sample, and they were bounded by their employment as family therapists within the Family Treatment Program. These samples will be described in further detail within the Participant Samples section of this report. It is important that these two samples are distinguished as the intention of the collective case analysis is to provide information on
aftercare issues as viewed by the discharged clients as well as gathering information from the family therapists’ perspectives (Creswell, 2007).

The study and analysis of multiple cases is based on a thorough and methodical approach. Each individual case needs to be studied and understood, but are always considered within the collection of cases (Stake, 2006). Data collection procedures are generally completed through observation or learning from the observations of others; and through locating evidence within reports, documents or artefacts that assist in describing what happened or that suggest what happened (Stake, 2006). The data collection methods used throughout this project included semi-structured interviews, semi-structured questionnaires, an examination of relevant literature, and reviews of archived documents. These procedures will be described in detail within the Data Collection section of this chapter.

Analysis within a collective case study treats each case as its own entity (Goddard, 2010). The researcher initiated analysis of the collected information from this project via content analysis, which is used to establish the existence and meaning of concepts, terms or words within recorded communications (Stan, 2010). Several categories were constructed as words with similar meanings and implications are organized. The categories were then deconstructed to search for new meanings, ideas or views (Stan, 2010). Further analysis was composed within case and cross-case comparisons, which is vital for collective case studies in order to determine commonalities across cases and develop relevant themes (Goddard, 2010). Several themes emerged from both bounded systems that provided a more in-depth understanding of the aftercare phenomenon. The analysis of archived documents also provided a new dimension to the cases as it offered some evidence of aftercare planning for discharged clients.
The findings are subsequently interpreted, and open for readers to create their own understanding as well (Stake, 2006). Results of the project also follow a process of analytic generalization. Analytic generalization includes demonstrating how the findings bear upon the involvement of aftercare services after exiting the Family Treatment Program. Similar situations may then be implicated where comparable events, such as a lack of aftercare resources, might occur (Yin, 2010). Analysis will be discussed in-depth within this chapter; however detailed information regarding data collection procedures is warranted prior to the discussion of analysis. This information is provided in the following section.

3.3 Data Collection

As discussed previously, data collection procedures incorporated several methods, which are consistent with a collective case study approach to analysis (Creswell, 2007; Silverman, 2005; Stake, 2006). Gathering information through literature searches, semi-structured interviews, semi-structured questionnaires, and reviewing archived documents were the methods used within this project. Semi-structured interviews and semi-structured questionnaires were chosen largely because the researcher was not in a position to observe post-discharge experiences; therefore, an inquiry process was required pertaining to observations and experiences of those that did participate in or observe post-discharge situations. The data recorded from the observations of others is meaningful in describing what the case’s activities are and what the perceived effects of the activities appear to be (Stake, 2006).

Data was subsequently gathered from the two groups of participants that were discussed in the previous section of this chapter. Information was collected from the Family Therapist (FT) sample and the Discharged Client (DC) sample for three general purposes. First of all, it was anticipated that the FT sample would have knowledge of experiences from a variety of
circumstances, as they have worked with multiple families from diverse locations and backgrounds. Second, the perspective of the FT sample on the Family Treatment Program’s aftercare practices is firsthand information in identifying any program gaps in this area. Finally, the experiences of the DC sample are essential in order to illustrate what challenges Family Treatment Program clients encounter post-discharge. The data collection procedures were slightly altered for each group, as the DC sample was invited to participate in a semi-structured interview and the FT sample was invited to complete an electronic questionnaire. The questions were structured in the same manner, but the wording was slightly altered for each group in order to ensure comprehension and relevance (see Appendices F and H for copies of the questionnaires). A detailed description of procedures used to gather information from each participant group is provided in the subsequent sub-sections.

3.3.1 Semi-structured interview

Information from the Discharged Client sample was collected through two face to face semi-structured interviews and five semi-structured telephone interviews. A semi-structured interview was the method selected for this sample of participants as interviews allow researchers easier access to participants, and they are able to be completed quickly (Trochim, 2005). It is also important to learn from the experiences of the DC participants by inquiring about their observations as discussed by Stake (2006). One of the face-to-face interviews occurred at the Family Treatment Program office building, and the other occurred at the home of the participant (the participants were given the option of venue for the interview for their convenience). Attempts were made to schedule the telephone interviews; however, only two of the five interviews occurred upon first contact with the participants due to convenience and scheduling.

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2 Only two interviews were face to face due to geographic barriers and to accommodate participants.
issues. The remaining five telephone interviews were scheduled for a later date when the participants were initially contacted. All telephone interviews occurred in the offices of the Family Treatment Program or Ranch Ehrlo Society between June 14 and July 30, 2011.

Prior to all interviews, the participants within the DC sample were informed of the purpose and use of a digital recording device, and consent to record the interviews was obtained from all individuals. The participants were provided with a copy, or were read the DC information sheet (Appendix D), and consent form (Appendix E). Two copies of the consent form were signed and one was provided to the participants in the face-to-face interviews. Consent was signed by the researcher on behalf of the participants for the telephone interviews, and was subsequently mailed to them. Some demographic information was collected prior to beginning the semi-structured, informal interview.

The interview was guided by a total of 12 items. The first four questions were reflective of aftercare planning and services received from the Family Treatment Program, and the remaining 8 questions were developed in conjunction with the North Carolina Family Assessment Scale for Reunification (NCFAS-R®). The NCFAS-R® is a primary assessment tool used by the Family Treatment Program that reflects family functioning in the domains of Environment, Parental Capabilities, Family Interactions, Family Safety, Child Well-being, Caregiver/child Ambivalence, and Readiness for Reunification post-discharge (NFPN, 2007). The NCFAS-R® was utilized to develop a questionnaire guide for the following reasons: 1. It is a research-based instrument that provides an overall assessment of family functioning in seven domains related to family preservation and family reunification. 2. It is utilized by the Family Treatment Program at the initial assessment phase in treatment as well as at discharge, and it would convey areas of focus regarding aftercare support and services. 3. It is easily understood
as it clearly communicates impairments as well as strengths within and between various systems and subsystems (see Appendix F for the interview guide). The interviews ranged in length from approximately one hour to two hours. All interviews were transcribed verbatim by the researcher.

### 3.3.2 Semi-structured questionnaire

Data was collected from the Family Therapist sample via electronic semi-structured questionnaires. Questionnaires were chosen as an effective method for collecting information from the FT sample largely because they would be able to fill it out at their own convenience and it allows the participants ample time to respond (Trochim, 2005). All participants were contacted directly by the researcher or the professional associate prior to receiving the questionnaire by interoffice email. One email was sent to a personal email account, as this potential participant that was identified was on a leave of absence at the time.

A participant information sheet (Appendix G), consent form (Appendix E) and an 11 item questionnaire (Appendix H) were emailed to each Family Therapist participant. The participants were directed to return the consent form and questionnaire by email or fax when completed. The questionnaire contained 11 open-ended questions. The first 3 questions pertained to the Family Treatment Program’s current aftercare practices. The final seven questions enquired on how to best serve clients post-discharge, based on measures within the domains contained in the NCFAS-R®. All questionnaires were returned within six weeks.

### 3.3.3 Review of archived documents

The final data collection process for this project was to access the Discharged Client sample’s archived files in order to review documentation related to follow-up and aftercare procedures. This method of research was chosen in order to gather data on: (a) aftercare methods
and planning used by the Family Treatment Program, (b) the content of aftercare plans (if the recommendations within the aftercare plans were concrete or abstract), (c) information recorded in 6 and 12 month follow up interviews\(^3\) (which would reveal accuracy of interview information), and (d) any other details or demographics not divulged in the interview process (such as ethnicity, dates of admission/discharge, and reasons for service). The archived files were accessed by obtaining permission from the Executive Vice President and Director of Education at Ranch Ehrlo Society and then by contacting the record keeper for access. All but one file was found, and the missing file was suspected to be stored at another Ranch Ehrlo campus. Out of the files that were found, only three of them contained the relevant information.

The data collection procedures would not have occurred without first selecting a sample of participants. A description of the individuals that participated in this research project will be provided in the following section.

### 3.4 Participant Samples

Data collection procedures were directed by the sample of participants selected for study. Stake (2006) discusses that when selecting a case(s) for a collective case study we must choose to study its circumstances, and that cases within a collection should be linked. Creswell (2007) also states that the cases that are selected should be representative. Purposeful sampling methods were selected for this project in order to achieve an in-depth study of chosen cases that would provide rich information about the issues that are central to the phenomena to be studied (Fletcher & Plakoyiannaki, 2010). Discussions with the Family Treatment Program manager and staff members assisted in identifying potential participants that would be: (a) geographically and possibly ethnically representative of all clients that have participated in the Family Treatment

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\(^3\) 2, 6 and 12 month follow up interviews are mandated within Ranch Ehrlo Society policy, and illustrate client outcomes (Ranch Ehrlo, 2010)
Program, (b) receptive to contact from the FTP, and (c) discharged from the FTP. It is in this manner that maximum variation is utilized, which entails collecting information on diverse situations and recognizing important commonalities and patterns (Creswell, 2007). The following subheadings discuss the sampling criteria for this project’s participants.

3.4.1 Discharged client sample

A purposeful sample of individuals from the Discharged Client sample was chosen from contact information that was provided by the Professional Associate and her administrative assistant. Since the program has only had a small number of actual participants since its opening in 2006, there was only a pool of approximately 40 potential participants to draw a sample from. Contact was attempted with 20 discharged clients, as the remaining list of potential participants did not have any viable contact information (some contact information had been difficult to access due to changes in the agency’s database). Direct contact was obtained with 11 individuals. Potential participants that were directly contacted by the researcher were provided information about the project and invited to participate in a semi-structured, informal interview.

Arrangements were made for 10 interviews, as one potential participant elected not to participate. There were three interviews that were scheduled (one face-to-face and two by telephone) that did not occur due to participant dropout. These potential participants did not answer their telephone at the time of the scheduled interview; and in one case a household member stated that they were no longer accepting phone calls for the potential participant (this individual resided in a neighbouring home and did not have the direct telephone services in their own home). Ultimately, the DC sample of participants consisted of seven interviews that were representative of four distinct geographic locations and three diverse ethnic backgrounds. Out of the final eight participants, seven were female caregivers and one was a male caregiver (one face
to face interview was with both caregivers present). It is important to address questions pertaining to the gender of the participants due to the majority of information being offered by females. A brief gender analysis will be provided in the proceeding sub-section.

**Gender analysis**

Several questions featuring the gender of the sample of participants may be posed by readers of this report. Questions regarding the quantity of male caregivers and family therapists sampled and sufficiently portraying the perspective of male caregivers that are a part of the family system of the participants are the most important questions that come to the mind of this researcher. McKeganey and Bloor (1991) have documented the importance of acknowledging gender in research, but also caution issuing too much value in gender interpretations. This section will be viewed reflexively by this researcher in order to acknowledge the gender issues that may be of concern to various audience members.

One of the main features of data collection for this research project was to invite participants to engage in a semi-structured interview as described previously. Initial contact was largely made with women. Out of the seven women that agreed to participate in an interview, two were single-parent, primary caregivers which indicated that there were no male caregivers to invite as participants with these two women. Two other female participants identified a male spouse that they were currently residing with; however, these men did not participate in the Family Treatment Program, which was one of the identified boundaries for the Discharged Client sample. The three remaining participants did have male spouses that participated in the Family Treatment Program.

Of the three eligible male participants, only one potential male participant had a discussion with this researcher upon initial contact which was actually the male that ended up
participating in the project. This researcher did have a telephone discussion with another potential male participant when the researcher called this individual’s home to follow up on a missed interview appointment. It was within this discussion that the researcher learned that this potential male participant worked night shifts, which made it difficult to schedule an interview that included him. This individual’s female spouse did participate in a telephone interview at a later date. The final male that may have potentially been interviewed was from a community in Nunavut. The impression of this researcher was that the female caregiver in the family would provide the most relevant information regarding aftercare; however in hindsight, additional efforts should have been made to include all of these gentlemen in the interview process.

In terms of the Family Therapist sample, all six participants were female. The central explanation for an all-female cast of FT participants was, first of all, that there were only two identified male family therapists that were employed with the Family Treatment Program since the program was launched in 2006. Secondly, the two male therapists that were identified as potential participants were no longer employed with the FTP, and it was believed that they may not possess information relevant to this project. Again, greater efforts should have been made to include a number of male participants in order to establish a balance in gender-based perspectives. Any supplemental research should take gender variances into consideration. That being said, a description of the Family Therapist participant sample is provided in the next section.

3.4.2 Family therapist sample

Six individuals (all female) of the Family Therapist sample were selected by their role description (they were identified as family therapists). These women were selected to participate in this project because they are perceived to have a pertinent clinical perspective and
understanding of any aftercare issues from their experiences with various families. The FT participants included individuals that were previously employed with the program as well as currently employed with the program. Years of experience ranged from one year to three years of employment with the Family Treatment Program. The FT’s were recruited by the researcher and Professional Associate as mentioned previously, and all six individuals that were identified as potential participants agreed to complete the semi-structured electronic questionnaire as discussed in the *semi-structured questionnaire* section above.

All sampling and data collection procedures require careful consideration of potential research issues and ethical responsibilities. The following section offers a discussion on various ethical concerns that arose throughout this research practicum experience.

### 3.5 Ethical Considerations

There were a number of ethical considerations to take into account throughout the process of this research practicum. One of the first ethical questions that required consideration was conducting research within the agency that this researcher is currently employed with. Creswell (2007) discusses the nature of studying within your own “backyard” and discusses how such a study poses a risk to the investigator, to the participants, and to the Family Treatment Program as power issues may surface. This researcher was confident that there was no risk to anyone who participated in this research practicum, as the research topic chosen has not been implemented within the agency. An assessment of minimal risk was also concluded due to the support received from the Family Treatment Program, as the research project was embraced as a means for the program to develop and grow. However, it is important to point out that researcher bias should be considered when conducting research within the agency with which the researcher is employed. Researcher bias may enable interpretations and recommendations that are made
from the values and political views of the researcher which has the potential to impact the agency (Silverman, 2005).

Other ethical considerations involved procedures for obtaining the appropriate consents. Prior to any data collection procedures, the purpose of the study, role of the participant and general information about the study were clearly outlined within a participant information sheet (see Appendices D and G) as recommended within the research process (Creswell, 2007). Ethically, informed consent procedures were completed by obtaining verbal consent to record all interviews, by obtaining signed and verbal consents from participants to discuss their experiences, by informing the participants that their identity will be protected through the use of pseudonyms, and by stating that findings will be presented in general terms. The limitations of the anonymity of the participants were also delineated through informed consent procedures as advised by Creswell (2007).

There was a notable ethical dilemma that this researcher was faced with throughout the course of this project. While conducting one of the face-to-face interviews, the participant’s children were in the home and were in proximity of the interview. At one point, the participant stated that they didn’t mind if the child was in the room and that the child would likely have some input. This researcher could appreciate the circumstances of the participant, as they were one of the single parents involved in the project; however, this researcher was required to inform them that ethical approval did not include interviewing children within the research project.

Although ethical concerns are carefully considered prior to obtaining participant samples and gathering data, many issues may arise throughout the research process. There are some examples of ethical considerations that have been provided within this section of this report. The analysis phase of the research process is not excluded, as investigators should remain mindful of
ethical issues such as researcher bias that was discussed earlier within this section. Analysis procedures will now be described in detail.

3.6 Analysis Procedures

Qualitative analysis procedures follow three general strategies as outlined by Creswell (2007). Data management is discussed as the initial analysis strategy which is comprised of organizing data and converting text units for analysis, which is also identified as content analysis (Creswell, 2007; Stan, 2010). The second strategy for analysis is outlined as coding and categorizing the data collected and reducing the codes into patterns or themes. The final strategy for qualitative data analysis is to identify larger meanings from the themes that have emerged and create a point of view within a theoretical framework (Creswell, 2007). A collective case study approach to analysis takes further steps in outlining several levels of analysis that include a rich description of the case; content analysis; coding; categorical aggregation; within case comparisons; cross-case comparisons; establishing patterns or themes; and providing interpretations or naturalistic generalizations (Creswell, 2007; Goddard, 2010; Stake, 2006).

The initial phase of analysis generally begins with a description of the case or cases by ‘stating the facts’ or setting the context (Creswell, 2007). This level of analysis entailed presenting demographic details, delineating information on the child’s current placement status, disclosing the amount of time spent in the home after discharge and the amount of time spent within the Family Treatment Program, and by discussing resources that were accessed by the families. Information detailing the Family Treatment Program aftercare practices was also subject to setting the context for successive phases of analysis.

The data management analysis strategy used for this project was assisted with the use of *Nvivo 9*, which is a computer program designed for qualitative research and analysis (QSR
International Pty. Inc., 2011). The interviews that were transcribed were read several times in order to obtain statements that provided meaning relevant to the research issues. This involved downloading transcripts onto files within the program, which made coding easier to manage. The coding process included extracting text segments from transcripts and categorizing them into patterns or themes that best described the common meaning of all statements. This process is also known as categorical aggregation, which calls for grouping thoughts, ideas and meanings that support emerging themes (Creswell, 2007; Stake, 2006). This researcher was able to develop 16 categories from examining transcripts of interviews from Discharged Client sample participants, studying questionnaires completed by the Family Therapist sample of participants and reviewing archived files.

The subsequent analytic strategy included making within-case comparisons and cross-case comparisons, as described within collective case study analysis procedures (Creswell, 2007; Goddard, 2010; Stake, 2006). Within-case analysis searches for evidence within a single case in order to discern any processes or patterns that support, contest, or expand the understanding of the issues under study (Paterson, 2010). This researcher followed this approach by generating categories from the transcripts of each participant within the DC sample, and then from the questionnaires of each participant within the FT sample. Since the FT sample and DC sample have been identified as bounded systems, an analysis within these two systems was also warranted and considered when categories within each group of samples were constructed as mentioned previously. However, a cross-case analysis was also utilized to examine the themes across the Family Therapist sample and Discharged Client sample. Cross-case analysis is generally completed to support generalizability within multiple or collective case study designs (Burns, 2010). After completing the initial step in analysis of studying each case for patterns,
examining the other cases for similarities and differences occurs (Burns, 2010). Many similarities were found within the collection of the two bounded systems within this research project, as well as some disparities.

Upon the completion of a cross-case analysis, the common themes that materialized from all relevant data sources were reduced to four general concepts related to all post-discharge experiences. These themes were entitled: Post-discharge support, Aftercare methods/planning, Barriers (to receiving aftercare services), and Proposed aftercare. Many details were found that supported these themes from the preceding analytic phases and are provided as evidence within the results.

The final stage in data analysis is characterized by the researcher’s interpretation, which is a product of the personal perspective of the researcher as well as within terms of theory or ideas found in the literature (Creswell, 2007). This strategy of analysis was approached by conveying results within a systems theory lens, which was described within the Literature Review section of this report. Interpretations were also formed based on some concepts found within the literature. Naturalistic generalizations may be created based on what can be learned from the cases or how the cases may appeal to professionals and readers who can relate to the experiences shared by participants (Creswell, 2007; Torrance, 2005). Naturalistic generalizations therefore invite the audience to relate their experiences with those revealed in the case descriptions (Melrose, 2010). The interpretation of the results of this research project will be discussed in the subsequent chapters. Prior to illustrating the results, a discussion of the project’s limitations will occur.
3.7 Limitations

Several limitations of this research project should be considered prior to the interpretation process. Purposive sampling, access limitations, communication barriers, participant drop out and time constraints have all been identified as restrictions on findings that ultimately impact interpretation margins, which are provided within the discussion section of this report. The following text describes these limitations in further detail.

Purposive sampling is generally utilized within qualitative research as it allows the researcher to choose individuals or cases to illustrate the issue that is of interest. Silverman (2005) describes purposive sampling as a process of selecting case samples after careful consideration of the boundaries that have been identified for the participants that are to be studied. The sample within this project was chosen due to the sampling criteria described previously, which intended to portray the perspectives of diverse individuals. Unfortunately, there were several access barriers that this researcher was unable to overcome, and some valuable sources of information may not be represented in the findings of this project. These sources included the perspectives of discharged clients from rural communities within Saskatchewan.

Several attempts were made to engage individuals to participate in the project from various remote communities within Saskatchewan. Unfortunately, no participants were recruited from any rural Saskatchewan regions due potentially to the following restrictions: (a) an inability to contact potential participants as many of them did not have access to a telephone or did not provide a contact address; (b) where potential participants did have access to a telephone, they did not return the researchers phone calls; and (c) where the potential participant did have access to a telephone and did have contact with the researcher, they did not follow through with a
scheduled interview (did not keep the interview appointment, did not answer follow up phone calls). Creswell (2007) describes access as a common limitation as persuading individuals to participate, developing a rapport and encouraging a response are typical challenges. It is unfortunate that this researcher was unable to provide any post-discharge experiences of this group of individuals, as they would potentially benefit from aftercare services due to limited access to resources. This limitation may suggest that additional research from other populations that have discharged from the Family Treatment Program may be beneficial.

Another limitation of this project was generated due to data collection methods. As a researcher, having the opportunity and ability to conduct interviews face-to-face may provide essential data via body language, facial expressions, gestures, etc. (Creswell, 2007). Since this researcher was limited to only two face-to-face interviews as a result of geographic barriers and scheduling issues, gathering information from direct observations was restricted.

One final consideration in terms of limitations surrounding the research process was time management around data collection procedures. Due to the processing of ethics approval for the agency, time quickly became an issue as this researcher was forced to access participants quickly and complete interviews within a limited time frame. This issue limited the sample of participants as other individuals could have been contacted and encouraged to participate in the research project. Scheduling limitations would also have been more flexible, which would have made a difference in obtaining at least one more face-to-face interview with a discharged client. Although these limitations were identified as impacting this project, the findings portray ample information provided by the Discharged Client sample and Family Therapist sample. These findings are reported in the following chapter.
Chapter Four: Findings

As previously discussed, the findings within this report reflect the themes that have emerged from a collective case study approach to this research project. It was important to divide the findings between the two participant sample groups, as each sample has diverse post-discharge experiences. As such, results will be illustrated through the demarcation of themes within the Discharged Client sample followed by relevant themes that were found within the Family Therapist sample. Due to the similar nature of the research instruments used, the themes that emerged from the data were the same for each group but do have some diverse interpretations. Various text segments are provided as evidence to support the specified themes as the stories of the participants are enmeshed within the assertions.

The findings of this research project will commence by ‘stating the facts’, as outlined in the analysis section of this report. It was perceived as appropriate and substantive to gather demographic details for analysis to get a sufficient depiction of the discharged clients and family therapists that participated in the research process.

4.1 Discharged Client Sample

The Discharged Client (DC) sample consisted of eight participants from various geographic locations and ethnic backgrounds that had diverse backgrounds. Some of the sample’s distinctions were identified as the amount of time spent within the Family Treatment Program, the year that they discharged, and their family structure. Of the eight participants, seven were female and one was male (one interview was completed with both caregivers from one family unit). Two of the participants reported that they were single mothers; while the other six participants reported having a partner of the opposite sex (it is unclear if these couples were married or common-law). Out of the eight participants, five were biological parents, two were
step-parents and one was a maternal grandmother. One family identified themselves as a First Nations family; one participant stated that they had a ‘mixed’ ethnic background (one parent being Inuit and the other was ‘from the south’); one participant was identified as Inuvialuit; three families were Caucasian; and the ethnic origins of the remaining families were unidentified. The age range for the participants is not provided because information on this demographic was incomplete.

The participants from the DC sample also resided in diverse geographic locations, as this was a circumstance of our purposeful sample in an effort to reflect the communities served within the Family Treatment Program. Four of the eight participants were from the City of Regina; two participants were from Newfoundland; one was from Nunavut; and one was from the Yukon. The communities of origin also ranged in size from populations of 1300 inhabitants; to 25,000; 100,000; and the largest community is reported at approximately 200,000 residents.

The DC sample also varied in terms of the amount of time spent within the Family Treatment Program and their date of discharge. Participants reported that the time spent within the FTP ranged from two weeks to six months (participation typically occurs in four to six month periods and only one family reported that they had received services for only two weeks). Reported discharge dates from the FTP included one discharge in 2007, two in 2008, one in 2009, one in 2010 and two in 2011. The ages of the children targeted for reunification ranged from 11 to 16 years at the time of discharge from the Family Treatment Program.

4.2 Family Therapist Sample

The Family Therapist (FT) sample consisted of six female participants that were currently employed or previously employed in the role of family therapist within the Family Treatment Program. Out of the six participants, two were currently providing services as FT’s, one was on a
leave of absence, and two were previously employed as FT’s but were currently providing services within another area of the Family Treatment Program. The final participant was also previously employed with the FTP, but at the time this research was conducted she was employed within a counselling agency. Within the FT sample, years of experience with the Family Treatment Program ranged from one and a half to three years.

The descriptions of the Discharged Client sample and Family Therapist sample provide a description of the diverse backgrounds and characteristics of the individuals within each bounded group. It is anticipated that these descriptions will assist in the reader’s understanding of the consequent interpretation of the themes that are created.

4.3 Major Themes

The four themes that were identified from the data analysis were divided to align with the perspectives of the two participant sample groups. The Discharged Client sample experiences will be discussed first, followed by the post-discharge experiences of the Family Therapist sample.

4.3.1 Discharged client sample experiences

The information collected within the Discharged Client sample was assembled and reduced to four major themes. The concepts of these themes transpired from common meanings and ideas that were interpreted as relevant to the understanding of aftercare that this researcher sought to illustrate. The themes that will be described are entitled: Post-discharge Support, Aftercare Methods and Plans, Barriers, and Proposed Aftercare as represented below.

Post-discharge support

There may be various explanations behind a recognized lack of support from social systems that interact within the discharge environment of the Family Treatment Program’s
cliente. This lack of support was evident post-discharge as family caregivers participating in this study reported feelings of failure, frustration, abandonment, isolation, powerlessness and confusion. These feelings were recognized after the Family Treatment Program withdrew its services, as some participants described the transition as challenging. Evidence that was provided within the Discharged Client sample interviews included some participants who stated that they required additional support in order to transition from the Family Treatment Program to their home communities. Participant B remarked, “...because I think they shut it down way too early and we still needed aftercare. We didn’t know what to do”. As discussed within the Literature Review chapter of this report, families require support during times of transition as well as when change occurs within the family structure (Shaw & Garfat, 2004).

Some participants reported that they directly requested support from various community agencies (including the FTP), only to be denied access. Participant F reported, “Yeah, but the thing is I lived here, and so I wanted to do it by phone [participate in the parent support group] but they wouldn’t let me and I was really choked about that.” Another participant reported that access to Aboriginal-specific resources was requested, but that these resources were not provided. Participant G stated, “no, at the end social services didn’t approve for a First Nations counsellor until it was too late”. These remarks demonstrate the desire that parents have to try and make positive changes only to be limited access in order to assist with change. It should be reiterated that as social workers, a central role responsibility is to assist clients in connecting with the resources that they require (Hepworth et al., 2006).

A lack of family and social supports was also categorized under post-discharge supports due to several instances of reported little to no family or natural supports. This idea was clearly portrayed within Participant C’s statement as follows, “I have no family. Well all my family’s
here, but I don’t have any support from them.” The sudden loss of support from the Family Treatment Program was also difficult for some families to cope with, as Participant A stated that, “it was a lot to lose, and [the FT] never came around anymore and that was a lot to lose”. This loss of support can be even more precarious as some families viewed their relationship with their family therapist as within the boundaries of their family system as reported by Participant B, “I know I personally took them [family therapist] in as part of my family”. Relationship building is a central value within Ranch Ehrlo Society’s philosophy, and even more so for the Family Treatment Program (Petrucka, 2006). Hill and Garfat (2004) also discuss the valuable nature of relationships with family workers, as they were described as trusting and supportive, and they offer families opportunities to try new ways of functioning in their presence. By providing individuals and families with a warm, secure relationship with a supportive professional, Stein and Dixon (2006) also suggest that resiliency and positive outcomes are enhanced.

Some DC participants also identified requiring support for all family members versus focusing on the targeted child, as all family members’ well-being was viewed as being at risk due to changes within the family system. Two of the participants reported that having their reunified child re-placed was difficult for them and their family to cope with, and that they needed support. This was described by Participant A when it was stated, “the way [the child] was pulled a lot of services were cut and it threw the kids off, and it threw them off pretty bad...like we had our own issues after [the child] left – with the little ones”. Other participants discussed personal struggles coping with their own mental health issues as well as mental health issues of family members. Reports of increasing behaviour difficulties of non-targeted children within some of the participant’s families also describe situations that may require assistance from other resources. Participant C discusses their child’s (this is not the child that
was targeted for reunification) behavioural difficulties within this statement, “[the child], yes—it’s really bad. Like when we were in the treatment program, time outs worked on him, you know he was listening, he’d get praises, and.....and now nothing’s working with him”.

Isolating feelings that were a result of receiving no aftercare support from any external systems post-discharge were also described by DC Participant B, “I think the biggest thing that the agency down here [did was] not back us up with that support we needed for her”. Participant H also relayed feelings of abandonment by a support system that was in place one day and gone the next, “the big downfall to us leaving the program was the fact that the family that we still have was left pretty much like – here’s an island, here’s 10 days worth of food, enjoy. Bye. See you. Survive now”. This is a challenge that many families face after a transition from the Family Treatment Program where they receive abundant supportive services, to moving back into their home environments where such supports are substantially diminished.

The above theme was created out of the many statements that were interpreted by this researcher as a lack of resources being transferred between these families and other systems. The following section discusses concepts relative to aftercare planning that was produced for the discharged client participants and their families.

Aftercare methods/plans

Prior to questioning discharged client participants about circumstances that may require additional support and services; the interviews were directed by questions that referred to aftercare methods and planning that were completed by the Family Treatment Program. Some of the Discharged Client participants stated that the Family Treatment Program employed aftercare methods such as receiving phone calls from FTP staff for follow-up purposes. Participant C recalled being invited to continue to participate in the parent support group as they said, “yep, I
can go to any of the sessions whether I’m in the treatment program or not. The door is open. If I have any questions – phone them. And they’re really good”. Participant D also discussed being encouraged to contact the FTP as they said, “well, they gave us phone numbers. If we needed to call, we could’ve called”.

When participants were asked about their aftercare plan that was developed with the Family Treatment Program, they initially did not comprehend what the term ‘aftercare plan’ was. After some clarification by this researcher, participants did discuss a general awareness of their aftercare or discharge plans that were reviewed with them and their family services worker at their discharge meeting just prior to leaving the Family Treatment Program. Participant F discussed one of the features of their aftercare plan that they recalled, “well we had a meeting, [and] we had a phone conference. And I did do the parenting program. I finished the parenting program by phone”. Another interview question specifically asked participant’s if they recalled what their aftercare plans were. Some participants recalled plans that were concrete (such as the parenting program mentioned in the previous quote); and some participants discussed plans that were implemented as discussed by Participant C, “…they got me involved in the Women’s Center right across the street. So I go to them for counselling”. However, some participants reported that service requests or post-discharge plans were not implemented, were not effective, or were not followed up on as reflected in this comment by Participant B when they spoke of aftercare planning for their child,

Really, you know what, there was nothing prepared for [the child] in Newfoundland. It was all talk. I didn’t expect Regina to put these things in place because really it wasn’t their place to put these in place for when she was coming back home. But to be honest, really nothing was in place.
Issues with implementation of aftercare supports were also described by Participant G, “yeah we had plans, but it took them so long to get that done and by then we started having trouble with [the child] and kinda got fed up with his actions. They were offering way after”.

The concept of aftercare methods/plans was interpreted as a group of ideas from participant statements reflecting that some aftercare methods were effective as well as ineffective. The following theme entitled barriers offers the perspective of the DC sample participants on their experiences with obstacles to receiving aftercare.

**Barriers**

Many barriers to receiving aftercare services were identified from transcribed Discharge Client sample interviews. The main obstacles reported by the DC participants were financial barriers, geographic/isolation barriers, communication/contact barriers, and the ability of the family to maintain change in their home environment.

There are substantial statements found within transcribed text regarding financial barriers to accessing aftercare services, particularly those involving a lack of funding from referring agencies. The Family Treatment Program advertises the provision of aftercare services to families in their home communities (Ranch Ehrlo Society, 2011b); however, as mentioned earlier in this report, referring agencies have not been willing to fund these services (P. Petrucka, personal communication, January 5, 2011). Discharged client participant B also illustrates their thoughts on funding issues through the following statement, “now financially if the government agency here would support that – I don’t think they would”.

A lack of resources was also acknowledged in rural and remote communities as identified by DC Participant D, “no, there’s no professional social worker here, and hasn’t been for over a year. They’ll have people filling the position of social worker, but they’re not trained as social
workers”. This DC participant also revealed that the professional resources in their community are not even accessible throughout the year as they state, “we don’t always have a mental health worker here either. We do have one probably about 6, 7 months out of the year”. These statements are congruent with findings within the literature that discuss difficulty employing and retaining professional social service providers in remote and rural locations (Schmidt, 2008).

As reviewed within the data analysis section of this report, many families that participate within the Family Treatment Program reside in communities that are located in various provinces and territories across Canada. Geographic distance from the FTP has been identified as a huge barrier to accessing aftercare supports, as proximity to connections within the Family Treatment Program were no longer readily available. As Participant B indicated, “I think that having that constant support that basically, and I know it’s gotta end sometime, like leaving and going halfway across Canada to come back home to nothing. That is hard”. The acknowledged comfort of support groups was also highly valued as pointed out by Participant F,

Because I had nobody to talk to here. About what [the child] and what I went through.... Now these other families knew what that was like, and so I just wanted to keep connected to that group and talk about what a horrible day I had with [the child] and get some suggestions, and it was really a great group.

There were several reports of families’ inability to maintain change post-discharge, particularly when they returned to their home communities and were faced with environmental and familial issues that existed prior to entering the Family Treatment Program. Many DC participants stated that it is easy to return to old habits and coping mechanisms particularly when their family therapist was no longer there to support them as discussed by Participant D,
You know sometimes it’s just difficult changing the way we always have been, that’s always a challenge because it’s so much easier to go back to what’s familiar, what worked for a long time, right.

This researcher’s interpretation of barriers that restricted the provision of aftercare support and services generates a powerful illustration of the situations that some DC participants find themselves to be in. Since discharged clients are the experts of their own circumstances, it is essential that information is gathered to form an understanding of what aftercare supports and services they desired. This collection of information is offered within the next theme and subsection.

**Proposed aftercare**

As some interview questions were designed to discuss desired aftercare services, the Discharged Client sample strongly recommended implementing a variety of aftercare services and provided valuable information on what they would like aftercare services to look like for their families.

All DC participants disclosed that their families required some level of support through their transition home from the Family Treatment Program. More specifically, two participants identified that any aftercare services provided would have likely ensured a successful transition as articulated in the following statement by Participant B,

I think if we had the person come back with us, we’d still have that confidence, and with that being in a new place moving from Regina to here - even though it’s not a new place - it’s a new environment that we’re coming from as opposed to a child twisted out of her mind on drugs and in prostitution, to coming back to earth and trying to fit in. If we would’ve had somebody come back and the
support of the departments here to encourage it, that key worker to help see about her getting into school and so forth, I think we would’ve definitely succeeded. I really do.

This sentiment was also shared by Participant F as found in this remark,

Unfortunately we don’t have a program here on the island like the Ranch, so we have to send kids away. But there has to be something to integrate the kids back into their own community.

Many participants from the DC sample also described what they thought aftercare services should look like. Some responses entailed the involvement of the Family Therapist or ‘key worker’ over an extended period of time as indicated by Participant B,

I think it would’ve been beneficial if I had my key worker, or a Ranch worker come down even for the first 6 months, and work through the dynamics, because we’re looking at a different area, and we’re looking at getting back into a routine.

Other participants within the DC sample did not feel that their families required an intensive level of aftercare support and discussed other potential services that would be beneficial.

Participant D reveals this opinion by stating,

In our situation, maybe just coming back and having a session once a month would’ve probably been fine for us, and then that would still have kept the relationship going with the people we were working with there - other people may have needs for once a week, or more often. It just depends as everyone’s situation is different.

While making case comparisons, this researcher also found it important to highlight one
participant’s desire to receive culturally competent services as Participant G disclosed, “like [the
parent] had requested too to have an Aboriginal counsellor, you know ‘cause that’s who we felt
comfortable with...”. Cafferty and Leichtman (2001) also suggest that cultural and religious
value systems adopted by family members must be considered carefully when working with
families, while other reports also discuss the importance of enhancing cultural sensitivity

The previous four subsections offer a description of how this researcher had identified
with the post-discharge experiences that were provided by the Discharged Client participants.
The following section now shifts to the description of the results from the data collected within
the Family Therapist sample.

4.3.2 Family therapist sample experiences

Readers of this report will recognize that there are also four main concepts that were
formed from information collected within the Family Therapist sample of participants. These
concepts are interpreted by this researcher as having the same or similar grouping of thoughts
and ideas as those found within the Discharged Client sample. However, there is some diversity
between the perspectives of the Family Therapist participants and the perspectives of the DC
participants. The analysis of the data collected from the FT participants is presented below
within the same thematic titles of Post-discharge Support, Aftercare Plans and Methods,
Barriers, and Proposed Aftercare.

Post-discharge support

Inclinations of Discharged Client participants requiring post-discharge support was
congruent with information reported from Family Therapist participants. FT sample sources
provided ample evidence of discharged clients requiring ongoing support as Participant B
suggested that, “it is difficult to go from a high level of support to none”. Participant A also stated that discharged clients required supportive aftercare services within this statement, “it would be helpful for staff to support the parents in adjusting the skills to the new environment as they will likely face new challenges in the home environment...”.

Some of the Family Therapist participants discussed that a connection to healthy supports is vital for families post-discharge. One FT participant provided their opinion of maintaining connections that were made in the Family Treatment Program by proclaiming, “it is essential for these parents...to remain connected with the healthy supports they created in their support groups or in the Family Treatment Program...”. Another FT participant provided an illustration of the importance of the family therapist’s role in post-discharge support by adding, “it is a must for the Family Treatment Program therapists and the family to connect with mental health professionals in their home community for continued observation and assistance”. This theme is supported through the rationale provided for “step down” services by the National Family Preservation Network. The rationale for the provision of step down services asserts that parenting skills and social support will be enhanced; families will be connected to basic resources; and addressing the child’s behaviour and emotional needs will all assist in averting re-placement (NFPN, 2011).

This researcher’s understanding of the FT participant’s views on aftercare support is that aftercare services for discharged families is required and strongly recommended. It is therefore important to present findings relevant to aftercare methods that are currently being implemented by the Family Treatment Program.

**Aftercare methods/planning**

The current aftercare methods of the Family Treatment Program were found to be congruent with some of the information that was provided by the Discharged Client participants.
Some Family Therapist sample participants did discuss ongoing efforts to assist families post-discharge by offering various services to those who contact them in need of support. One FT participant discussed providing aftercare support within the following statement:

- It is not uncommon for FTP staff to hear from families that have discharged from the program when they begin to struggle in their home communities. When staff receive these phone calls they may provide emotional support, information on supports around them and/or in some cases it may be beneficial for the staff to contact the referring agency to inquire about solutions for the families’ current issues.

Although telephone contact is encouraged (as stated previously by Discharged Client Participants C and D), this researcher found other aftercare planning efforts made through aftercare recommendations within archived documents.

Evidence of aftercare planning was found throughout archived Aftercare Plan documents. These documents recommend additional support or needs in areas of: placement or residence; family supports; medical and mental health services; educational and/or vocational needs; cultural, spiritual and recreational needs; legal information; and community safety issues. Several FT participants referred to aftercare documents as a method of aftercare planning implemented by the Family Treatment Program, as stated by Participant F, “the aftercare plan is created during the assessment period (first month) and is updated throughout the treatment process”. However, some aftercare plans that were developed by the Family Treatment Program were perceived by this researcher as general and abstract, as one of the documents contained a recommendation that stated, “the [family surname] family will require parenting support to address complex issues, such as ADHD, custody concerns and issues related to family
reunification”. This researcher’s perceptions of general recommendations made by family therapists within the Family Treatment Program’s aftercare documents appear to lack exploration of community resources. Participant A reported a similar idea when they responded, “[aftercare plans should have]...more value placed on them...[and the FT’s should] develop a realistic aftercare plan with resources available in [the family’s] communities”. Incorporating community supports from admission and working within a team approach has been identified by Wiebush, McNulty and Le (2000). By introducing community supports early on, service needs will be identified and continually addressed into aftercare as they are related to various community and social systems involved. This idea will be elaborated within the Discussion chapter of this report.

It is the understanding of this researcher that the ideas presented within Aftercare Methods and Planning should strongly be considered to align with the discharge environment that families face upon exiting the Family Treatment Program. Within this process, any barriers that may be construed as obstacles for healthy family functioning post-discharge should be well understood and challenged. A discussion on the FT participant’s perceptions of barriers faced by families post-discharge will resume under the subsequent theme.

**Barriers**

Many Family Therapist participants addressed barriers to designing, implementing and following up on aftercare plans. Some Family Therapist participants illustrate challenges such as communities with few resources to draw from and difficulty making community connections. Funding issues were also disclosed by participants within the FT group as Participant B states, “there is the option for Family Treatment Program therapists to accompany the family back to the home community....however, due to funding; this is not a possibility for a majority of our families”.
Many participants within the Family Therapist sample shared the sentiments of Discharged Client respondents on their depiction of resource availability within remote communities. One FT participant reported, “it is difficult to implement aftercare plans developed for families living in isolated communities as a result of the lack of programming and healthy supports available”. This idea is a common theme between the Family Therapist sample of participants and the Discharged Client sample of participants.

As noted previously, contact and communication barriers for families that reside in rural and isolated communities are also described by FT participants. Contact barriers were evident when this researcher attempted to recruit participants for this research project, as many did not have access to telephone services. This type of access barrier is consistent with this FT participant statement, “I have also encountered issues with following up with families, as reaching families by telephone can be difficult in communities where communication is limited”. This barrier can be quite challenging to surmount, as it may be reflective of the economic struggles that are faced particularly by rural and remote Aboriginal communities (Wilson & Macdonald, 2010).

Another barrier that is imperative to consider is time constraints that are inherent in the current role of the Family Therapist within the Family Treatment Program. Current caseloads for the FTP range from 2-3 families per family therapist, and depending on the phase of treatment that each family is experiencing, several hours are dedicated to working in-home, preparing interventions, ongoing assessment, training and professional development opportunities, report writing and so on. One FT participant provided evidence that committing more time to providing aftercare services would be difficult to balance and that again, funds are not readily available,
I often want to remain in contact with my discharged families and help navigate through difficult situations, however, due to busy schedules and full caseloads it is often very difficult to provide these services. We are not provided with any hours to provide aftercare services for our clients.

As documented in the Literature Review chapter of this report, The National Family Preservation Network (2011) provides a flexible model for Intensive Family Reunification Services that incorporate step down services to best meet the needs of the program structure that is implemented. Modifications in staffing hours are made for providing both intensive in-home services and step down services simultaneously. Managing staff caseloads and hours is attributed to workers that may be required to travel, or who need to allot more time to families who are experiencing serious difficulty (NFPN, 2011).

Barriers within family systems and social systems were also identified by Family Therapist participants as well as Discharged Client sample participants. The evidence provided by the DC sample that reveal the difficulties families face in maintaining treatment gains was mirrored by some responses of the FT participants. One Family Therapist disclosed that, “often people within the extended family system are part of these barriers/pressures, pressuring them to return to old habits and ways of living”. Unfortunately, as mentioned within the DC collection of interpretations, the unhealthy lifestyle choices of family members is viewed as another difficult barrier to overcome, which is supported by the perspective that families need to have a viable family structure to support individuality as well as a sense of belonging (Minuchin & Fishman, 1981).

There was an important barrier that was identified by several of the Family Therapist group of participants that was not a concern for any Discharged Client participants. Housing
issues were an identified barrier within the FT group, as one participant stated that, “housing or lack of appropriate housing is often another barrier...a difficult challenge considering the housing issues faced in many communities”. It is interesting that there was no evidence of similar concerns found within the responses of the DC sample. In fact, the DC participants’ responses were contradictory, as all DC participants commented that housing was not a concern for them post-discharge. It is important to keep in mind that the FT group are providing information that is based on a multiple circumstances of post-discharge experiences that they have encountered with several families. The responses of the FT participants demonstrate that housing is a barrier that requires closer examination for all discharged clients served. Further research in this area may assist with resolving this concern as there are literature sources that discuss housing programs that have been implemented as a post-discharge service as a result of a growing need for this service (Mendes, 2009).

The barriers discussed by the Family Therapist participants illustrate some commonalities as well as some important differences in comparison to the understanding of barriers that was described for the Discharged Client sample. It is important to consider the barriers from a collective perspective in order to begin to make some type of generalizations about barriers for families discharging from the FTP. That being said, a discussion on the perspective of Proposed Aftercare made by the FT participants will also need to be contrasted to views on the same matter that are made by the DC sample. This discussion occurs within the following section.

**Proposed Aftercare**

The Family Therapist sample disclosed that aftercare services are viewed as essential for families to transition home after discharge from the Family Treatment Program. One FT participant stated that, “aftercare services would make the transition less intimidating for the
family as the additional support may lower the stress...”. It understood by this researcher that within this statement, aftercare concerns for families were validated. However, there does appear to be some discrepancy between the two samples of participants in terms of the potential aftercare protocol and procedures that are suggested.

The FT sample identified several aftercare services that may be beneficial for FTP families post-discharge. Some of the suggested services included re-establishing structures and routines in the home environment, ongoing assessment, encouragement, collaborating with communities, advocating for the development of new resources where resources are limited, connecting families to support groups and counselling services, providing education, or to return to the program for ‘a refresher course’. One FT participant stated that, “the [FTP or aftercare services] could improve by providing supportive services such as parenting support...and encouraging families to rely on their strengths and tools learned...[as well as]...giving families positive feedback as they use newly acquired skills in [the] home environment – encouragement and support is key in ensuring continued success back home”.

Although DC sample participants suggested the provision of in-home aftercare services over an extended period of time, FT respondents discussed recommendations of the provision of in-home services to be less intensive. Participant F stated,

staff could possibly spend time in the family’s home community to act as a support and advocate for the family. [For example], driving to the family’s community and spending small intervals of time there over a four or six or eight week time period. [Another example might be] spending a day or two in community during the first week the family is home – then spending a day two weeks later etc. During that time support the family using new skills in the home
environment as well as meeting with the family and other agencies to advocate or educate supports such as school...

This statement has some conflicting ideas on how the family therapists may implement aftercare services as compared to some of the suggestions that were made by DC participants. As discussed within the DC participant themes, one participant stated that they would need in-home services for several months. Conversely, the above FT statement discussed the same type of services being provided for a few days. It should be noted that aftercare suggestions of the FT sample are largely based on information that was provided to them by discharged clients and may not adequately reflect the actual needs and services required by some discharged families. Although the FT participants have had experience with post-discharge issues, they may not be in a position to assume an optimal length and content of aftercare services that families may require.

The findings of this research project have illustrated several important view points and perspectives that require consideration and further discussion. Reflections of the results will be presented within the following Discussion chapter.

Chapter Five: Discussion

The previous chapter has provided a thorough description of diverse post-discharge experiences from the point of view of clients that have discharged from the Family Treatment Program, as well as from the perspective of some of the program’s family therapists. Interview and questionnaire responses clearly express the need for the provision of aftercare services for clients discharging from Ranch Ehrlo Society’s Family Treatment Program. The main tenet that supports this assumption is viewed as the marked lack of support as reported by Discharged
Client participants. The following discussion will include addressing issues related to the lack of supports available to clients that discharge from the Family Treatment Program, and incorporate a systems theoretical approach in assisting with these issues. Other factors to consider include what aftercare needs have been identified and what aftercare services would look like for the Family Treatment Program. The barriers that have been identified by both participant samples and the challenges these barriers present for aftercare practice within the Family Treatment Program will also be addressed. It is important to include a discussion surrounding generalization, and areas requiring further examination as they are features that should be considered prior to implementing recommendations that are provided in the subsequent chapter. The concepts mentioned above are presented in the following sections beginning with a discussion on the identified lack of support.

5.1 Addressing Support

The collection of information that was provided by Discharged Client participants within the interviews that were facilitated by this researcher illustrate an understanding that aftercare supports and resources for clients exiting the Family Treatment Program are needed and wanted. However, this may not be the case for all discharged clients, as only a small sample of discharged clients were interviewed. This generalization issue may be interpreted in several ways, but one question that arose from the research methods and findings of this research project was acknowledged as “are all families willing to receive aftercare support post-discharge?”.

The questions surrounding the willingness of some discharged clients to participate in this project may be interpreted from the non-response phenomena as suggested by Seale, Gobo, Gubrium and Silverman (2004) that provides some explanation as to why individuals may not participate in research. These explanations included: (a) a lack of contact (person has moved,
changed address, no telephone service, etc.), (b) they refused to be interviewed, and (c) they refused because some questions may be too sensitive to answer (Seale et al., 2004). However, Seale et al. (2004) also stated that a non-response rate of approximately 30% is typical in conducting research.\(^4\) Further research may wish to survey all discharged families regarding their feelings of in-home services, particularly if they are willing to receive aftercare services. Due to the nature of non-response from some of the potential participants for this research project, the willingness of discharged clients to receive ongoing supportive services from the Family Treatment Program or social services in general may be questioned. Further investigation within this area is warranted.

It is the understanding of this researcher that all of the Discharged Client participants within this project would have preferred to receive some form of aftercare services from the Family Treatment Program post-discharge. These services may be provided in various ways and through various mediums; however, literature sources have illustrated that thinking and working systemically is essential when working with young people and their families. Phelan (2004) and Pierpont & McGinty (2004) describe employing methods that require coordination and collaboration with various systems that may assist families in maintaining progress that was made in treatment. Resources from school systems, community systems and family systems need to be approached to engage in supporting change within families. An example of this is proposed by Phelan (2004), as he discusses how some families may have a limited view of their connection to others, and that workers may find that a systemic approach can be useful. Systems theory applications may offer a framework that will assist families in understanding the systemic influences in their lives by “coaching them to understand the mutual influence process that occurs” (Phelan, 2004, p. 71).

\(^4\) Non-response rate for this project was approximately 36%.
Pierpont and McGinty (2004) have illustrated a systems perspective through a “system of care” approach that provides family-oriented and community-based services. Many aftercare needs that have been presented within the Findings chapter of this report focus on family functioning within the family system and community, as well as family functioning between other systems within its environment. A system of care approach suggests that the child and family are of focus, community-based services are sought and utilized, and cultural competency is a priority (Pierpont & McGinty, 2004). A system of care approach to providing aftercare services may be essential in successfully integrating families back into their home communities. The research results of this project illustrate that there should be a focus on the family as a whole, that there needs to be further exploration and development into community services, and that culturally relevant services should be accessible.

Addressing the understood lack of aftercare support for discharged clients may entail further exploration that includes the perspective of more individuals; however a systems theory framework may assist in accessing necessary resources. The following section discusses this researcher’s perspective on pursuing the development of aftercare services for the Family Treatment Program.

**5.2 Aftercare Development**

Prior to addressing the various concepts that are relevant to pursuing the development of aftercare services that are found within this research project, it is important to attend to questions that view the Family Treatment Program as providing an essential aftercare service itself. One of the discussions that emerged from this research practicum’s presentation revealed that the Family Treatment Program was developed to curtail some of the very aftercare concerns that have been discussed within this report (P. Petrucka, personal communication, September 13, 2011). This is
also an important aspect to consider prior to designing an appropriate aftercare model, as questions surrounding the effectiveness of the FTP may arise as well as concerns regarding how services may be implemented for the proposed aftercare program. As discussed previously, the National Family Preservation Network recommends a step down process for families that continue to display moderate to severe levels of functioning upon discharge (NFPN, 2011). By specifying the step down process and integrating community-based aftercare services into the continuum of services umbrella, assistance may be provided to families that are identified as truly in need of aftercare support.

The current aftercare practices of the Family Treatment Program were perceived by this researcher to be insufficient as indicated within the findings of this project. In order for aftercare development to occur, it is essential to reassess the value of aftercare planning and services, and to examine what services are needed. The views of the Discharged Client participants and Family Therapist participants on the implementation of aftercare services are also key. Several factors are taken into consideration for aftercare development.

Both participant samples discussed some form of in-home, community-based service delivery approach to aftercare. Although there were conflicting views on an optimal length of service delivery, both groups did agree that a family therapist or Family Treatment Program team member should lead in delivering post-discharge services within the home of the family. This is an important concept to pursue, as this researcher has found that the role of social work professionals is portrayed as limited in assisting families to navigate through the transition challenges within their home communities. For the purposes of this discussion, the term ‘social workers’ refers to persons occupying the role of the social services case manager.
Hill and Garfat (2004) have discussed the significance of exerting professional guidance in obtaining and accessing resources from various systems within the family’s environment. This responsibility would likely be assumed to be directed by the family’s social worker or social service case manager. Participants within this research project have suggested that some social workers have been reluctant, remiss, unorganized and possibly even incapable of supporting families in their transition home. Just considering the limited availability of some social workers illustrates a challenge that they face in providing aftercare as they often close files after intervention services are completed, or have caseloads that are too large for them to be able to commit time to sufficient aftercare practice. Other sources discuss engagement and motivation issues, as Freundlich and Avery (2006) also portray the frustration of social workers when clients are not willing to comply with aftercare planning. Another literature source reported confusion surrounding the role and responsibilities of social workers when it comes to implementing aftercare planning (Pavkov, Lourie, Hug, & Negash, 2010). These responsibilities may be more effectively delegated to a professional who is largely involved with the coordination and collaboration of the various systems available to families and is a trusted and reliable support (Stein & Dixon, 2006). Consideration of a specialized role in the aftercare area of family treatment should be given due attention.

Another area that deserves further discussion is the discrepancy within the responses of the Discharged Client participants and the Family Therapist participants with regards to the amount of time that should be spent in-home with families post-discharge. This researcher was unable to find sufficient research on an optimal length of time for aftercare interventions to proceed, however the National Family Preservation Network (2011) discusses an intensive
family reunification services model that addresses time frame implications for aftercare interventions.

Resource and community development are also areas that may assist with providing aftercare support. The findings of this project have identified the development of parent support groups would be beneficial and creating social supports through social networking may be valued. Developing mentor programs may assist parents and families with accessing supportive individuals that provide links to the community beyond those that are provided by social workers through social, recreational and leisure networks (Mendes, 2011).

This section has discussed the various perspectives on aftercare development that has emerged from the data collected within this project. Varying levels of aftercare have also been identified, as DC participants discuss a range of supports that each of their families may require. Although both participant samples were able to readily suggest ideas for aftercare development, many barriers are also identified. Addressing the various barriers that have been introduced by the DC and FT participant samples will require ongoing effort and resources as discussed below.

5.3 Addressing Barriers

Although there are many indications that aftercare is perceived as valuable, there will continue to be questions that emerge that pertain to addressing barriers to receiving aftercare. From a systems theory perspective, the barriers identified within this research project have had an impact on the disorganization of the Discharged Client participants’ families. This disorganization may be due to the limited availability of information and resources (or they are insufficient) to meet the demands of families. Another possibility is that families are not reasonably organized to obtain information or resources from other systems. Yet another explanation pertaining to why families may not be able to access resources may be due to a
disruption in communication, or it may be that the environment is a disorganizing influence on
the family (issues such as crime, poverty, unemployment, etc.) (Anderson et al., 1999).

Communication barriers and socioeconomic circumstances were viewed as participant
access challenges. Geographic barriers and financial limitations are huge barriers to the provision
of in-home aftercare services that were discussed by several DC and FT participants. Some DC
and FT participants also discussed family pressure to revert to unhealthy behaviours as a difficult
barrier to overcome. These barriers were all perceived to contribute to struggles that families
faced in adjusting and adapting their newly acquired skills to their home and community
conditions. There continue to be many questions with regards to addressing barriers that are
beyond the scope of this project, but must continue to be acknowledged through discussions
within the agency, with referral sources, with families, and on a community level. It is
anticipated that in recognizing various obstacles, services may be targeted more effectively.

Other questions may be generated through an examination of this research project and
should be addressed through ongoing research. As mentioned previously within this chapter,
generalization issues may invite further research of aftercare within the Family Treatment
Program. The following discussion on the generalization of findings within this research project
may contribute to decisions on future research.

5.4 Generalization

Issues of generalization are commonly addressed when qualitative research methods are
utilized. Qualitative research methods do not seek to generalize data findings, but instead seek to
hear the point of view of the participants in order to create a clear picture and understanding of
the problem that is under examination for the targeted audience (Torrance, 2005). Alternatively,
naturalistic generalizations are appropriated in order to appeal to the reader to relate to the
case(s) that are being described instead of the case(s) representing a population (Creswell, 2007; Torrance, 2005). Naturalistic generalizations may very well engage many readers as they may be able to identify with the struggles that some of the Discharge Client participants have illustrated when their families transitioned from an intensive, supportive environment to their home communities.

Goddard (2010) discusses generalization within a collective case study approach to research. He states that the main reason for conducting a collective case study is to view cross-case comparisons and infer generalizations from the collection of cases. As described earlier, when conducting a cross-case analysis, examining several perspectives may persuade readers to generalize from the cases in order to achieve a greater understanding of the phenomenon (Goddard, 2010). Therefore, there may be some ability by the audience to make some generalizations.

The circumstances of eight discharged clients have been illustrated and the perspectives of six family therapists have been considered in discussing pertinent aftercare issues. This researcher has also presented a perspective of the post-discharge needs, suggestions and barriers that have been identified by participating discharged clients as well as those that have been identified by the Family Therapist participants. The information gathered within this project has been analyzed to generate several recommendations that may direct an aftercare practice model for the Family Treatment Program. These recommendations are revealed in the subsequent chapter.

**Chapter Six: Recommendations and Conclusion**

The discussion that was presented within the preceding chapter was directed by the overall purpose of this research project. The introductory chapter of this report revealed that the
The purpose of this project is to examine the current aftercare practices of the Family Treatment Program, to assess the discharged client’s need for aftercare services, to identify barriers to receiving and providing aftercare services, and to develop recommendations for the development of an aftercare model for the Family Treatment Program.

First and foremost, the adoption of the aftercare component of the intensive family reunification services model (referred to in the model as “step down”) that has been developed by the National Family Preservation Network (2011) is suggested. The intensive family reunification services framework is compatible with the mandate of the Family Treatment Program and provides ample rationales for the provision of aftercare services that are needed by families (NFPN, 2011). Within this framework, five recommendations were comprised to assist in the development of an aftercare model for the Family Treatment Program:

1. Employ an aftercare “specialist”.
2. Create aftercare training and education opportunities.
3. Develop effective communication strategies.
4. Contribute to community resource development.
5. Further research is required.

These recommendations will be discussed in further detail within the following sections of this chapter, beginning with a more detailed discussion on the adoption of the National Family Preservation Network’s intensive family reunification services model.

6.1 Intensive Family Reunification Services Model

In addressing the Discharged Client participant’s and Family Therapist participant’s illustrated need for aftercare services, the intensive family reunification services model developed by the National Family Preservation Network (2011) would provide a compatible
framework to direct aftercare practice for the Family Treatment Program. Implementing aftercare services as suggested by the model would assist approximately 12-23% of families that continue to have moderate or serious difficulties at case closure after receiving intensive reunification services (NFPN, 2011). The NFPN (2011) report also indicates that any moderate or serious problem domain (according to North Carolina Family Assessment Scale for Reunification ratings) at case closure was related to a high probability of an out of home placement. The Family Treatment Program should consider employing full aftercare services for those families that do have NCFAS-R® measures that are indicative of moderate or serious problems, as well as partial aftercare services for all other families. The suggested recommendation for partial aftercare services for all families is warranted as per the responses from the DC participants with regard to wanting some form of follow-up and continuity of care.

The remaining suggestions lay within adopting the framework of the NFPN’s intensive family reunification model. The first recommendation that is presented discusses employing an aftercare “specialist”.

6.2 Employ an Aftercare “Specialist”

The NFPN (2011) model for intensive family reunification suggests that aftercare or step down services may be provided by family service workers in conjunction with intensive family reunification interventions, or may be the sole responsibility of the family service worker. The issue of who is responsible for implementing aftercare services has been identified within comments from participants of this project, as a level of confusion exists between family service workers and the Family Treatment Program staff in identifying who is responsible for implementing aftercare services. Pavkov et al. (2010) found that there was a significant level of role confusion between service providers and case managers when it came to aftercare planning.
responsibilities. These issues need to be clarified and aftercare accountability should be clearly delineated. This may be accomplished by employing a professional that is responsible solely for the provision of aftercare services.

Employing a “specialist” aftercare worker should be considered as there is value in training a professional, preferably with a social work background, to provide aftercare services. An aftercare worker was identified by Stein and Dixon (2006) as being more helpful than parents, social services social workers, foster parents, residential workers, teachers and friends when it came down to preparing individuals post-discharge. The support from an aftercare worker was documented as more likely to be frequent, sustaining, reliable and available versus the support received from a social services case manager (Stein & Dixon, 2006). “Specialist” aftercare services were also reported as making positive contributions to outcomes and would potentially eliminate role confusion regarding aftercare responsibilities as indicated previously (Stein, 2006). An aftercare worker would also reduce the staff time constraints that were identified within the findings of this project, as the aftercare worker would be the individual responsible for aftercare planning, implementation and follow-up versus the family therapist.

Other implications in the development of a new role within the Family Treatment Program are that it may “provide new professional opportunities for campus based child care workers to learn how to be available to families in the community during and after treatment” (CWLA, 2005, p. 2).

The role of a specialized aftercare worker could assist in bridging the gap between various agency, family, and community systems that require organization on behalf of the family. A specialist aftercare worker would also be available to provide in-home supports, which are reported within this project as valuable to families. Pierpont and McGinty (2004) discuss a
“coaching” process that has been viewed as integrating best practice standards based on in-home training programs that allow an aftercare worker to observe the family in their natural environment. As an observer, an aftercare worker would have an opportunity to intervene at strategic points and utilize shared difficult moments to instantly reveal potentially supportive interventions for families (Phelan, 2004; Pierpont & McGinty, 2004). Other researchers have also acknowledged that families’ success should link their home and family (Hill & Garfat, 2004). Participants within this research project overwhelmingly stated that they would prefer in-home supports with the worker that was connected to them in the Family Treatment Program. The aftercare worker would be a member within a team that works with the family from the time of admission. By employing a “specialist” aftercare worker, sufficient aftercare training will need to be accessed as discussed in the next recommendation.

6.3 Create Aftercare Training and Education Opportunities

By incorporating the intensive family reunification model developed by the National Family Preservation Network, sufficient and effective training opportunities will need to occur. The Family Treatment Program should consider providing aftercare training opportunities for all program staff, and specific aftercare development for “specialist” aftercare service providers. Providing staff members with information and an understanding of current aftercare issues, such as the aftercare issues that have been identified by this project’s participants, will assist in facilitating ideas and validate the importance of collaboration with other resources throughout the treatment process (Pierpont & McGinty, 2004). Furthermore, enhancing the Family Treatment Program staff’s understanding of aftercare needs and issues that are illustrated by participants within this report may enhance contributions to aftercare planning and the transition process. One form of aftercare training was offered by Woods Homes, which is a residential
Providing information and education around aftercare issues for referring agencies should also be implemented by the Family Treatment Program. Pierpont & McGinty (2004) discuss that efforts should be made to educate funding agents on the benefits of providing family and community based treatments. Pierpont and McGinty (2004) also state that professionals need to maintain efforts that demonstrate the efficacy of family and community-based treatment and continue to pursue funding. Considering that this is a barrier found to be consistent for many of the participants within this project, priority should be afforded to providing agencies with information (such as the information within this report) so they are not only aware of aftercare issues experienced by discharged clients, but also to have a greater understanding of how these concerns may be addressed.

Geographic distance is a substantial barrier that affects the ability of discharged families to maintain communication with the Family Treatment Program service providers. There may be some communication strategies that can be employed to assist with this concern as recommended below.

6.4 Communication Strategies

Many DC participants indicated that they had limited natural supports within their home communities and that they would have appreciated ongoing contact with supportive networks that were created while they were participants in the Family Treatment Program. Due to the vast geographic distances between the FTP and discharged families, this is a difficult obstacle to overcome. Walter and Petr (2008) have indicated that families do value therapeutic benefits over

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5 The aftercare program developer offered to facilitate an aftercare workshop in Regina (J. Foreman, personal communication, Sept. 13, 2011).
the telephone. However, telephone communication is also acknowledged as difficult where families do not have access to telephones or other technological services. Brownlee, Graham, Doucette, Hotson and Halverson (2010) discuss the use of Telehealth and Telepsychiatry services in rural populations. Unfortunately due to limited technological services, they were not routinely accessed by Canadian northern communities (Brownlee et al., 2010). Other literary sources have reported that the quality of interaction on the telephone has many pros and cons, but another resource that has been utilized for direct treatment by psychologists is the internet-based program, Skype™. This resource has the ability to reduce geographic barriers through web conferencing (Fishkin, Fishkin, Leli, Katz, & Snyder, 2011).

Creative solutions will need to be identified and employed to enable aftercare workers to reach those in remote communities to continue to engage and motivate families to maintain treatment gains. Face to face contact would be ideal, but in the event that this may not be accomplished utilizing social media, email strategies may be effective in providing outreach to some families as was indicated by one of the DC participants in this project. Writing letters or providing all discharged clients with regular newsletters may also assist in targeting those that are hard to reach and may provide them with pertinent ‘refresher’ information, which was also indicated as important by a DC participant. Mobilizing and creating community resources may also contribute to post-discharge monitoring. The creation of support networks and resources within isolated communities is detailed in the following recommendation.

6.5 Community and Resource Development

Community resources should be identified upon admission, and initiatives toward creating community resources where there is a clear deficit should be pursued. Utilizing a systems of care approach, which is described as integrating systems of family oriented and
community-based services, may assist with initiating collaboration and resource development at the community level (Pierpont & McGinty, 2004). Creating partnerships with various community stakeholders would enhance the systems of care philosophy while creating connections to valuable community resources (Pierpont & McGinty, 2004). Information reported by Wiebush, McNulty and Le (2000) discusses traditional barriers that have been recognized between various institutional service providers. The awareness of existing traditional role barriers have allowed some professionals to attempt coordinated efforts to work together, and the perceptions of their roles and interactions with one another have improved as found by Wiebush, et al. (2000). This was accomplished through consistent communication, frequent contact between aftercare service providers and the institution providing treatment, coordinated transition activities, and joint training that demonstrated each agency had complementary roles (Wiebush, et al., 2000). Creating such relationships between the Family Treatment Program and referring agencies would assist in maintaining monitoring post-discharge and would ensure communication with all parties involved. This type of collaborative relationship would also provide family service workers with additional tools to assist discharged families as they transition home. Stein and Dixon (2006) also indicate that corporate and interagency arrangements have been assessed as positive and have increased access to range of services.

Incorporating community training into the development of community resources is also essential for many communities that lack appropriate services for discharged families. Parent training workshops and education groups may assist in refreshing parenting skills or life skills training that were received within the Family Treatment Program. Opening workshops to community members who have not participated in the Family Treatment Program may also be a proactive opportunity for families that are facing many challenges. Community support training
on aftercare and networking such as developing mentorship programs have also been applied to some aftercare programs found within the literature (Mendes, 2011). Support groups for families and children leaving care are also a feature of community-based practice that requires endorsing (Walter & Petr, 2008). Parent support groups are of particular importance as indicated through findings within this report, as they provide opportunities to meet with individuals that share similar difficulties and involve supportive people that may also enhance cultural sensitivity (Pierpont & McGinty, 2004). The use of peer support has also been discussed by Brown, et al. (2010) as a means to improve family well-being by serving as a community resource and by providing support through their presence at service planning and implementation.

The above strategies discuss collaboration and communication in an organized and effective manner with various systems. Further research into sufficient and effective strategies for aftercare practice that were indicated within the above recommendations will need to be explored as many questions surrounding aftercare remain. Implications for future research are examined in the subsequent section.

### 6.6 Future Research and Development

As indicated within the Discussion chapter of this report, further research and development surrounding aftercare is required. Ongoing research in the form of surveying all discharged families may answer questions such as, “are discharged clients willing to accept additional services within their home communities post-discharge?” (at this point, we do not know that all families requiring aftercare would be receptive). Gathering information from referring agencies to answer the question, “are agencies willing to fund aftercare services post-discharge?” is vital. Collecting data within communities to understand how aftercare services can best be designed and implemented based on the needs of all families that reside within that
community may be of concern. Incorporating discussions with Ranch Ehrlo Society administrators as well as with the Family Treatment Program team members may also assist in designing a model appropriate to meeting the needs of all parties involved. The information provided within this report has addressed general aftercare questions and concerns; however specific information is required to elucidate answers to questions that were generated throughout this research project. These questions are beyond the scope of this project, but do require clarification in order to proceed with implementing an aftercare initiative.

It is anticipated that the five recommendations that have been discussed within this chapter will provide Ranch Ehrlo Society’s Family Treatment Program with a framework within which to build a model for the provision of aftercare services. The following concluding remarks illustrate the impressions that remain for readers of this report to consider.

6.7 Conclusion

Having the opportunity to explore and report findings on data concerning aftercare issues for the Family Treatment Program has been challenging, but rewarding. The information that was provided by the various participants within this project is relevant and quite thought provoking. The knowledge that was offered by the participants has also afforded a greater awareness of the needs required for the families who exit the Family Treatment Program, an awareness of obstacles that limit access to resources, and an awareness of what may be pursued to assist discharged families. Although the experiences of all discharged clients from the Family Treatment Program were not obtained, there was a clear illustration presented by the participants that many families require a continuity of reunification services in times of transition. It is the view of this researcher that one of the best ways to assist families post-discharge includes the
collaboration, cooperation and communication of all systems involved with the family if the
continuum of care is to improve.
References


Residential Treatment for Children & Youth, 27(2), 127-148.

doi:10.1080/08865711003738522


Appendix A: University of Regina Research Ethics Board Approval Memo

OFFICE OF RESEARCH SERVICES
MEMORANDUM

DATE: May 3, 2011

TO: Christal Gerrand
   4153 Princess Street
   Regina, SK S4S 3N4

FROM: Dr. Bruce Plouffe
      Chair, Research Ethics Board

Re: Aftercare for Families Transitioning from Residential Treatment (File # 90S1011)

Please be advised that the University of Regina Research Ethics Board has reviewed your proposal and found it to be:

☐ 1. APPROVED AS SUBMITTED. Only applicants with this designation have ethical approval to proceed with their research as described in their applications. For research lasting more than one year (Section 1F), ETHICAL APPROVAL MUST BE RENEWED BY SUBMITTING A BRIEF STATUS REPORT EVERY TWELVE MONTHS. Approval will be revoked unless a satisfactory status report is received. Any substantive changes in methodology or instrumentation must also be approved prior to their implementation.

☐ 2. ACCEPTABLE SUBJECT TO MINOR CHANGES AND PRECAUTIONS (SEE ATTACHED). Changes must be submitted to the REB and approved prior to beginning research. Please submit a supplementary memo addressing the concerns to the Chair of the REB. ** Do not submit a new application. Once changes are deemed acceptable, ethical approval will be granted.

☐ 3. ACCEPTABLE SUBJECT TO CHANGES AND PRECAUTIONS (SEE ATTACHED). Changes must be submitted to the REB and approved prior to beginning research. Please submit a supplementary memo addressing the concerns to the Chair of the REB. ** Do not submit a new application. Once changes are deemed acceptable, ethical approval will be granted.

☐ 4. UNACCEPTABLE AS SUBMITTED. The proposal requires substantial additions or redesign. Please contact the Chair of the REB for advice on how the project proposal might be revised.

Dr. Bruce Plouffe

cc: Dr. Nuelle Novik – Faculty of Social Work

** supplementary memo should be forwarded to the Chair of the Research Ethics Board at the Office of Research Services (Research and Innovation Centre, Room 109) or by e-mail to research.ethics@uregina.ca

Phone: (306) 585-4775
Fax: (306) 585-4515
www.uregina.ca/research
Appendix B: Ranch Ehrlo Society Ethics Approval

From: 'hslammer@sasktel.net' David Rivers [mailto:david.rivers@ranchehrlo.ca]
Sent: June 9, 2011 5:29 PM
To: Geoff Pawson
Subject: research review committee

Dear Dr Pawson,

This email is to serve as your notification that the Ranch Ehrlo Research Review Committee recommends your acceptance of Christal Gerrand’s MSW Research Practicum, “Aftercare for Families Transitioning from Residential Treatment”. Christal will be interviewing workers and families discharged from the Family Program to identify the type of aftercare services families believe they need to succeed. I’ve attached the minutes of our committee meeting.

Chair

Harvey Lammer
Research Review Committee Minutes,

Date: June 7, 2011

Christal Gerrand’s MSW Research Practicum:

“Aftercare for Families Transitioning from Residential Treatment”.

Members present: Chairperson, Harvey Lammer, David Rivers, Nick Crighton, Barb Ryan.

Regrets: Cyril Kesten (who received electronic copies of the proposal to review)

Researcher present Christal Gerrand

Minutes

1) The RRC mandate was reviewed with committee members
2) Christal reviewed her practicum research proposal with committee members.
3) Committee members asked clarification questions and made 4 suggestions or non-mandatory recommendations:
   a. to carefully explain the title and purpose of the research project to participants;
   b. to select participants so the study sample adequately reflects the families served;
   c. to attempt face to face interviews whenever possible and consider using SKYPE or other technologies on other cases;
   d. to ensure all identifying information during and after the research project be kept at the family program office.
4) Committee members agreed to recommend acceptance of the research proposal to the CEO of Ranch Ehrlo Society.

Minutes by:

David Rivers
Appendix C: NFPN IFRS Model Matrix

The matrix shown here provides a guide for determining reasonable caseloads and is based on a worker providing 24 hours of direct service (phone, face-to-face) per week over 11 months of the year:

<table>
<thead>
<tr>
<th>IFRS Service Hours (90 days)</th>
<th>Step-Down Service Hours (60 days)</th>
<th>Maximum Caseload/Year</th>
<th>Maximum Caseload at One Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reunification Only</td>
<td>48–60</td>
<td>0</td>
<td>20–25</td>
</tr>
<tr>
<td>Reunification Plus Full Step-Down (for all families)</td>
<td>48–60</td>
<td>16–20</td>
<td>15–19</td>
</tr>
<tr>
<td>Reunification Plus Full Step-Down (for 25% of families)</td>
<td>48–60</td>
<td>16–20</td>
<td>19–23</td>
</tr>
<tr>
<td>Reunification Plus Partial Step-Down (for all families)</td>
<td>48–60</td>
<td>8–10</td>
<td>17–22</td>
</tr>
<tr>
<td>Reunification Plus Partial Step-Down (for 25% of families)</td>
<td>48–60</td>
<td>8–10</td>
<td>19–24</td>
</tr>
<tr>
<td>Full Step-Down (Only)</td>
<td>0</td>
<td>16–20</td>
<td>60–75</td>
</tr>
<tr>
<td>Partial Step-Down (Only)</td>
<td>0</td>
<td>8–10</td>
<td>120–150</td>
</tr>
</tbody>
</table>

* Straight mathematical extension of the Maximum Caseload/Year to Maximum Caseload at One Time actually results in caseloads of 10–12 for the Full Step-Down model, and 20–25 for the Partial Step-Down model. However, caseloads that high are impractical for this type of work, and the recommended caseloads have been adjusted downward to increase the likelihood of success of the step-down service and to achieve manageability of the caseloads. Therefore, additional workers (at a ratio of 10:9, that is, one additional worker for every 9 workers in Full Step-Down and 5:4, that is, one additional worker for every 4 workers in Partial Step-Down) will be needed to cover caseloads in the Full Step-Down (only) and Partial Step-Down (Only) models.
Appendix D: General Information for Participants (Discharged Client Sample)

GENERAL INFORMATION FOR PARTICIPANTS
(DISCHARGED CLIENT GROUP)

Researcher: Chrystal Gerrand, MSW Student
Faculty of Social Work
University of Regina

Supervisor: Nuelle Novik, MSW, PhD, RSW
Faculty of Social Work
University of Regina

Project Title: Aftercare for Families Transitioning from Residential Treatment

The purpose of this research project is to provide suggestions for aftercare services for Ranch Ehrlo Society’s Family Treatment Program. Aftercare services are intended to assist and support families who have participated in residential treatment as they move back to their home communities. These services may include connecting families to services such as counselling, legal, medical, community based services, etc.; providing support and encouragement; educating communities; and refreshing skills already learned through residential treatment. The main goal of an aftercare program is to assist with healthy family functioning and child well-being after discharge. This means closing the gap between residential care and family functioning within the home. The suggestions for aftercare will focus on ongoing services and advocacy for families that are in need of such support, while also attempting to decrease interventions such as continuous out-of-home placements. Aftercare continues to grow for various residential treatment programs, as studies have found that aftercare services have assisted in decreasing relapses toward unhealthy behavior, in providing additional care during an important move from residential treatment back to home communities, and in general providing a source of support for those that may truly need it.

The findings of this project will be reported and include suggestions for aftercare services that are consistent with the FTP’s philosophy, values, standards and long term planning for the families served. The results will be presented within a formal report as well as an informal presentation within the agency. To obtain results from the study, please contact the researcher at c.hein@sasktel.net.

Any information given will be confidential, and the secrecy of the participants will be protected by the use of pseudonyms (false names). Unfortunately, secrecy may not be guaranteed, as a quote or detail may identify a participant to others. Any audio recordings and interview information will be kept within a locked cabinet at the Family Treatment Program for five years, and will then be destroyed/deleted.

You have the right to withdraw from the study at any time and refuse to answer any questions even after signing a letter of consent. Any information provided will be destroyed if requested by the participant. Whether you choose to participate or not will have no effect on how you will be treated (in terms of access to services).

This project has been approved on ethical grounds by the Ranch Ehrlo Society Research Review Committee and the U of R Research Ethics Board. Any questions regarding your rights as a participant may be addressed to the committee at [585-4775 or research.ethics@uregina.ca]. Out of town participants may call collect.
PARTICIPANT CONSENT FORM

Aftercare for Families Transitioning from Residential Treatment (Research Practicum)

Researcher: Christal Gerrand, BA, BSW, RSW, MSW Student
Faculty of Social Work
University of Regina
(306)352-0634
c.hein@sasktel.net

Supervisor: Nuelle Novik, MSW, PhD, RSW
Faculty of Social Work
(306)585-4573
nuelle.novik@uregina.ca

The purpose of this research project is to provide program specific recommendations for an aftercare model that will address issues pertaining to families transitioning back to their home communities following residential treatment. The primary goal of an aftercare program is to minimize the decrease in family functioning and child well-being post discharge.

Information will be gathered through face to face interviews as well as telephone interviews (due to geographical barriers). A purposeful sample of adult only participants will be contacted to arrange for interviews. Face to face interviews will occur at the home of the participant, or at the Family Treatment Program, whichever is comfortable for the participant. Interviews will take approximately one hour. Interviews will be recorded with a digital recording device (with the consent of the participant) to ensure accuracy of information. Please feel free to ask questions regarding the procedures and goals of this project or your role.

Any information disclosed will be confidential, and the anonymity of the participants will be protected by the use of pseudonyms. Unfortunately, anonymity may not be guaranteed, as a quote or circumstance may identify a participant to others. Any audio recordings and interview information will be kept within a locked cabinet at the Family Treatment Program for five years, and will then be destroyed/deleted.

You have the right to withdraw from the study at any time and refuse to answer any questions even after signing this letter of consent. Any information provided will be destroyed if requested by the participant. Whether you choose to participate or not will have no effect on your employment (Family Therapist Group); or will have no effect on how you will be treated (in terms of access to services for the Discharged Client Group).
To obtain results from the study, please contact the researcher.

This project has been approved on ethical grounds by the Ranch Ehrlo Society Research Review Committee and the U of R Research Ethics Board. Any questions regarding your rights as a participant may be addressed to the committee at [585-4775 or research.ethics@uregina.ca]. Out of town participants may call collect.

Your signature below indicates that you have read and understand the description provided and consent to participate in the research project.

__________________________________________________________________________
Name of Participant                     Signature                      Date

A copy of this consent will be left with you, and a copy will be taken by the researcher

TELEPHONE INTERVIEWS

Oral Consent: Participants will be informed that consent will be audio-taped and signed by the researcher prior to telephone interviews.

I read and explained this Consent Form to the participant before receiving the participant’s consent, and the participant had knowledge of its contents and appeared to understand it.

__________________________________________________________________________
Name of Participant                     Researcher’s Signature         Date

A copy of this consent will be mailed to participants that are interviewed by telephone.
Appendix F: Discharged Client Questionnaire

DISCHARGED CLIENT QUESTIONNAIRE

Aftercare for Families Transitioning from Residential Treatment

The purpose of this questionnaire is to explore what your experience was like after discharging from Ranch Ehrlo Society’s Family Treatment Program. These questions will be asked in an interview format. The questionnaire should take about one hour to complete, and your participation is completely voluntary. You may refuse to answer any questions at any time. A Participant Consent Form will be read to you prior to the interview, and the researcher will ask to sign it on your behalf if you choose to participate. The consent form will remain with the researcher and a copy will be mailed to you. This project was approved by the Research Ethics Board of the University of Regina and the Research Review Committee of Ranch Ehrlo Society. If you have any questions regarding this research project, please contact Christal Gerrand at (306)539-0769 (email: c.hein@sasktel.net), or Dr. Nuelle Novik, Faculty Supervisor, at (306)585-4573 (email: nuelle.novik@uregina.ca).

1. Are you aware of the Family Treatment Program’s (FTP) staff completing any planning with your family for when you were to discharge and return to your home community? Please describe.

2. If there were post-discharge plans, were these plans followed when you returned home? If they were not followed, what is your understanding of why they were not followed?

3. How confident were you that you would be able to manage your family and issues without the support of the FTP after discharge? Is that still the case?

4. How do you think that aftercare services would have been beneficial to your family?

5. What were some of the environment challenges that you and your family faced after discharging from the FTP? (i.e.: home/housing, community safety, income/employment, food/nutrition, hygiene, finances, transportation, learning environment)

6. After discharging from the FTP, did you have any struggles with your children based on your abilities as a parent? Please describe. (i.e.: supervision, discipline, provision of development/enrichment opportunities, caregiver mental/physical health, and caregiver use of drugs/alcohol).

7. What were some of the challenges and strengths regarding your family interactions since your discharge from the FTP? (i.e.: bonding with child(ren), communication with child(ren), marital relationship, expectations of child(ren), mutual support)

Questions 5 to 11 were developed in correspondence with the North Carolina Family Assessment Scale for Reunification (NCFAS-R) Scale & Definitions (v.R2.0) from the National Family Preservation Network (2007).
8. Have there been any safety concerns for your family since discharge? (i.e.: physical/sexual abuse, neglect, domestic violence). Have they been handled? If so, how?

9. Were there any challenges for you to ensure your child(ren)’s overall well-being since returning to your home community? (i.e.: physical/mental health, behavior, school performance, relationships with caregiver/siblings/peers, motivation/cooperation, alcohol/substance abuse, sexual/emotional abuse).

10. How would aftercare support from the FTP help you with any uncertainty about reuniting with your family post-discharge? (i.e.: parent to child ambivalence, child to parent ambivalence, ambivalence from substitute caregiver, disrupted attachment)

11. What issues has your family faced that requires assistance from other individuals, from your community through organizations or groups, or from other agencies in order for your family to remain intact? How was this assistance achieved? (i.e.: resolution of CPS risk factors, completion of case service plans, resolution of legal issues, parent understanding of child(ren)’s treatment needs, establish back-up supports or service plans).

12. What were the most significant barriers you faced in regards to receiving support and assistance for your family following discharge that has not been discussed in this interview?
Appendix G: General Information for Participants (Family Therapist Sample)

GENERAL INFORMATION FOR PARTICIPANTS
(FAMILY THERAPIST GROUP)

Researcher: Christal Gerrand, MSW Student  
Faculty of Social Work  
University of Regina

Supervisor: Nuelle Novik, MSW, PhD, RSW  
Faculty of Social Work  
University of Regina

Project Title: Aftercare for Families Transitioning from Residential Treatment

The purpose of this research project is to provide program specific recommendations for an aftercare model that will address issues pertaining to families transitioning back to their home communities following residential treatment at Ranch Ehrlo Society's Family Treatment Program. The primary goal of an aftercare program is to minimize the decrease in family functioning and child well-being post discharge. This entails bridging the gap between residential care and improved outcomes of family functioning within the home. The recommendations for aftercare will be directed at providing the appropriate ongoing services and advocacy for families that are in need of such support, while also attempting to minimize social costs of resorting to expensive interventions such as continuous out-of-home placements. Aftercare continues to be an emerging development for various residential treatment programs. Various studies have suggested that aftercare services have assisted individuals in decreased recidivism rates, in providing a continuum of care during a significant transition period, and in general providing a source of support for those that may truly require it. Due to the unique nature of the FTP in the sense that it serves the whole family and not just the individual, there is an amplified motive to ensure a successful transition upon discharge.

The findings of this project will be reported including suggestions for model development that are consistent with the FTP’s philosophy, values, standards and long term planning for the families served. The results will be presented within a formal report as well as an informal presentation within the agency. To obtain results from the study, please contact the researcher at c.hein@sasktel.net.

Any information disclosed will be confidential, and the anonymity of the participants will be protected by the use of pseudonyms. Unfortunately, anonymity may not be guaranteed, as a quote or circumstance may identify a participant to others. Any audio recordings and interview information will be kept within a locked cabinet at the Family Treatment Program for five years, and will then be destroyed/deleted.

You have the right to withdraw from the study at any time and refuse to answer any questions even after signing a letter of consent. Any information provided will be destroyed if requested by the participant. Whether you choose to participate or not will have no effect on your employment.

This project has been approved on ethical grounds by the Ranch Ehrlo Society Research Review Committee and the U of R Research Ethics Board. Any questions regarding your rights as a participant may be addressed to the committee at [585-4775 or research.ethics@uregina.ca]. Out of town participants may call collect.
Appendix H: Family Therapist Questionnaire

FAMILY THERAPIST QUESTIONNAIRE

Aftercare for Families Transitioning from Residential Treatment

The purpose of this questionnaire is to explore your experiences working with families within Ranch Ehrlo Society’s Family Treatment Program and your views of post-discharge challenges. This questionnaire will take approximately one hour to complete. Your participation is completely voluntary, and you may refuse to answer any questions. A Participant Consent Form is provided with the questionnaire, and it is required that you take the time to review and sign it if you choose to participate. The consent form is to be returned to the researcher along with the questionnaire in a stamped, addressed envelope or via email. A copy of the Participant Consent Form is for you to keep. This project was approved by the Research Ethics Board of the University of Regina and the Research Review Committee of Ranch Ehrlo Society. If you have any questions regarding this research project, please contact Christal Gerrand at 539-0769 (email: c.hein@sasktel.net) or Dr. Nuelle Novik, Faculty Supervisor, at (306)585-4573 (email: nuelle.novik@uregina.ca).

1. How would you define Ranch Ehrlo Society’s Family Treatment Program (FTP) aftercare planning process?

2. Do you believe that there are issues with the FTP’s current aftercare plans? Please describe.

3. Do you believe that there are any issues with implementation and follow-up of aftercare plans? Please describe.

4. What are some of the barriers faced by families in terms of their environment post-discharge? How can aftercare services address this identified issue?  

5. Do you believe that aftercare services could assist families in the area of parenting capacity? If so, how would the FTP accomplish this?

6. In your opinion, is there a need for aftercare supports to assist with family interaction difficulties post-discharge? Please explain.

7. Do you believe that there is a need for the FTP to provide aftercare services for families experiencing safety concerns? Please elaborate.

8. How can a FTP aftercare program provide services to families for the purposes of the child(ren)’s overall well-being?

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7 Questions 4 to 10 were developed in correspondence with the North Carolina Family Assessment Scale for Reunification (NCFAS-R) Scale & Definitions (v.R2.0) from the National Family Preservation Network (2007).
9. Do you believe that aftercare supports might address any apprehension about reunification post-discharge? Please discuss.

10. How can aftercare services address recurring removal risk factors and maintain family permanency planning to minimize the risk of removal of children from the home? (i.e.: resolution of CPS risk factors; completion of case service plans; resolution of legal issues; parent understanding of child treatment needs; established back-up supports/service plans)

11. Are there other areas of need that you can think of for the implementation/follow-up of aftercare services for families post-discharge?