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Developing aftercare: Phase I Consumer feedback

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ABSTRACT

For many adolescents with disabilities the reintegration into the home and school settings following a stay in out-of-home care is fraught with difficulties. Although many return to environments that do not facilitate school success, few services and supports are available. As a result these youth are more likely to demonstrate poor homework completion, academic failure, and dropout prior to graduation. To date, no known empirically based intervention exists to address these risks and support these youth and their families during this critical reintegration period. This article reports the findings from Phase 1 in the development of an academic-based aftercare for adolescents reintegrating into the home and community school settings following a stay in out-of-home care. Data were collected from 31 youth, parents, and school professionals through 9 structured nominal group technique focus groups to determine factors that would contribute to participant buy-in and long-term participation. Common themes identified include the desire for program flexibility, 24-hour on-call support, and well trained, supportive staff. Service and training implications, study limitations, and future research are discussed.

1. Introduction

Reintegrating youth with high-incidence disabilities into the home and school settings following a stay in out-of-home care is a challenge for administrators, teachers, families, and children. Estimates suggest that over half-a-million children and youth are served in out-of-home care (Casey Family Programs, 2003; Swann & Sylvester, 2004), and anywhere from 30 to 85% are diagnosed with a disability (Children's Defense Fund, 2005; Clark, 1998; Yancey, 1998). Coupled with the risks common to this population (e.g., poverty, psychological distress, limited family involvement and parent educational support, high rates of mobility that interrupt the special education identification process, elevated levels of school dropout, and overall poor educational outcomes; Blome, 1997; Cook, 1994; Foster & Gifford, 2005; Whiting-Blome, 1997; Zetlin, Weinberg & Kimm, 2004) the degree of challenges faced by these children and their families during this transition is considerable.

Because out-of-home care is generally not a permanent placement, most of these children and youth return to their home and community school settings (Courtney & Barth, 1996; Keeping Families Together, 1993). As such, this reintegration period is critical because it presents a unique opportunity to increase the child's chances at attaining educational success (Zetlin, Weinberg and Kimm, 2005). Unfortunately, for many youth with disabilities departing from out-of-home care, there is little communication between the educational service providers at departure and few reintegration services or programs are available upon return (Altshuler, 2003). Moreover, although parents can play a critical role in reintegration success, few family supports are available (Walton, Fraser, Lewis, Pecora & Walton, 1993). With limited school and family resources, it is of no surprise that reintegration outcomes are often poor (Courtney & Barth, 1996; Foster & Gifford, 2005). For example, in recent studies evaluating the educational effects of out-of-home care, 75% of youth performed below grade level, and over half had been retained at least once in their educational career (Parrish et al., 2001). These youth were more than twice as likely to drop out of school as the general school population, and few (11%) continued on to post-secondary education (Cook, 1994; Zetlin, 2004).

Given the poor educational outcomes of youth in out-of-home care, one may expect that attempts have been made to identify effective aftercare services and supports to prevent school failure. However, despite the wealth of evidence demonstrating negative academic outcomes and failed reintegration efforts for youth with high-incidence disabilities in out-of-home care (Foster & Gifford, 2005; Miller, Fisher, Fetrow & Jordan, 2006; Rosenfeld & Richman, 2003; Whiting-Blome, 1997) research on best practice for reintegration is limited (Walter & Petr, 2004).

1.1. Reintegration and aftercare literature

Over the past decade, significant amounts of attention and research have been given to the transition of youth with disabilities from the

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educational setting to work or post-secondary education (e.g., Eisenman, 2003; King, Baldwin, Currie & Evans, 2005; Mellard & Lancaster, 2003). With regard to reintegration, however, far less is known. The topic of reintegration has been widely noted as a critical missing element in the continuum of child welfare services for decades (e.g., Allerhand, Weber & Hoag, 1966), and this sentiment repeatedly suggests that the lack of aftercare services including community supports, school connections, and family supports may play a significant role in the deterioration of skills or gains made by children and youth while in out-of-home care (e.g., Barratt, 1987; Lieberman, 2004; Leichtman & Leictman, 2002a,b).

In child welfare, aftercare services are generally defined as supports or services designed to maintain gains following departure from out-of-home care and to prevent the need for additional out-of-home placements (Guterman, Hodges, Blythe & Bronson, 1989). Although the research on aftercare services is scant (Guterman et al., 1989), professionals in education and child welfare have identified dropout prevention, parent involvement and support, and home-school academic involvement as key areas that may play a critical role in the successful educational outcomes of youth following reintegration (Altshuler, 1997, 2003). These areas have been found to contribute to school success or failure, and are supports frequently noted as lacking for children and youth during the reintegration process.

1.2. Developing an academic aftercare model

Because no known aftercare models have been systematically studied and evaluated to promote the academic achievement of youth with disabilities reintegrating into the home and school communities following a stay in out-of-home care, the purpose of this study was to begin to address this limitation by identifying service needs and wants of youth, parents, and school personnel who interact with these youth during the reintegration period. Specifically, because aftercare services are viewed as necessary, but not mandated services, we were interested in determining (a) what factors would increase participant buy-in and long-term service use, and (b) what are the desired skills, experiences, and/or characteristics of direct service providers.

2. Method

2.1. Setting

Participants included youth, parents, and teachers of youth who had discharged from a residential Treatment Family Home services program in Omaha, Nebraska. Youth participating in the program live in a family-style, community based residential program that provides comprehensive mental and physical health, behavioral, and educational services. Youth are referred to the program for a variety of reasons (e.g., abuse, neglect, maladaptive behaviors), and enter as state wards, court wards, or as private placements. Each year, nearly 400 youth enter the program, and over half (69%) return to their family following departure (Trout et al., in press).

2.2. Participant identification procedures

All study procedures were approved by the University's and the residential program's institutional review boards (IRB). Inclusion criteria included school-aged youth between the ages of 14 and 18 who had departed the program within the past year and had reintegrated into home (biological or adoptive parent or kinship care) and community school (local public or private school) settings within a 90-mile radius of campus. Youth were identified by program staff as at-risk for a disability (via clinical cut-off scores on the *National Institute of Mental Health Diagnostic Interview Schedule for Children — IV* [DISC-IV; Shaffer, Fisher, Lucas, Dulcan & Schwab-Stone, 2000] or the Child Behavior Checklist [CBCL; Achenbach & Rescorla, 2001]) or were previously school identified with a high-incidence disability (i.e., learning disability, behavior disorder, mild mental retardation). We also sought to contact youth's parents and teachers or other school professionals (e.g., counselors, probation officers, paraeducators) who had worked with the youth during the reintegration process.

Because youth receiving services at the residential Treatment Family Home program return to a large number of communities and school districts across the nation, the initial contact information about teachers was requested from the youth and parents at the start of the focus group session. Specifically, after the written consent and demographic forms were completed, parents and youth were asked to complete a teacher recruitment form requesting the names and contact information (e.g., grade taught, school, district) of teachers or school professionals that they had interacted with during their reintegration. To expand our possible participant pool, we also contacted the local district offices for names of teachers and school professionals who were known to have worked with youth during the reintegration process.

The identification procedures yielded a sample pool of 147 possible participants. Of the 147 youth, parents, and school professionals meeting eligibility, 57 (38.5%) agreed to participate. Forty (27%) declined or were not available (e.g., in juvenile detention, left the state), and 50 (33.7%) did not respond to the contacts or could not be reached with the contact information provided (e.g., contact phone numbers were disconnected). Of the 57 youth, parents, and teachers agreeing to participate, 31 (54%) attended the groups (10 youth, 10 teachers/school personnel, and 11 parents).

2.3. Focus group procedure

Participants attended one of 9 scheduled two-hour focus groups (3 parent, 3 youth, and 3 school personnel). To promote attendance, the meetings were held in two different locations and were offered both during the day and evening. With the exception of location, time, and the completion of the teacher recruitment form (described above), all focus group procedures were held constant. First, participants were provided with a brief overview of the purpose of the meeting and were asked to provide written consent. Second, participants watched a brief 10-minute power-point presentation about a proposed aftercare program. The presentation included a description of the 3 primary model components (drop-out prevention, parent training, and homework support). Time commitments, efforts of all participants, and additional supports were also presented. At the conclusion of the presentation, participants were provided with an example youth/family scenario. Time was also provided prior to the start of the focus group to allow for participant questions regarding the proposed program and services.

2.4. Nominal group technique procedures

Following the presentation and question and answer session, the nominal group technique (NGT; Delbecq, Van de Ven & Gustafson, 1986) decision-making process was conducted. NGT is a structured focus group procedure that combines both qualitative and quantitative methods to collect client or consumer feedback in a timely, efficient manner (Johnson & Turner, 2003; Tuffrey-Wijne, Bernal, Butler, Hollins & Curfs, 2007). The NGT procedure was selected because it has been widely used for the identification of consumer needs, problems, and opinions across broad populations (e.g., severely physically disabled, intellectually disabled, educators of students with high-incidence disabilities, traumatic brain injury and stroke patients; Elliott & Shewchuk, 2002; Larkins, Worrall & Hickson, 2004; Nelson, Jayanthi, Brittian, Epstein & Bursuck, 2002; Sackley & Pound, 2002; Tuffrey-Wijne et al., 2007), and has been identified as an important first step in the development of client oriented services, interventions, and programs (Elliott & Shewchuk, 2002).