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Families Healing Together: Exploring a Family Recovery Online Course

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Abstract

Family members who are trying to support their loved one are often overburdened with stress, and health issues. Research has shown that families who receive family psychosocial education and support can have a dramatic impact on recovery outcomes and their family's overall well-being. Family psychoeducation is not common. Families Healing Together (FHT) is an online family mental health recovery program that was developed to address this critical gap in family mental health care services. Using an exploratory case study methodology to understand how the program's philosophy and practice impacts the program's participants as well as how the participants perceive the benefits and limitations of the program. Findings suggest that the strengths of the program lie in the individual customization of the program to the consumer as well as the underlying message of hope of the program.

Keywords

Family Recovery, Mental Health, Case Study, Thematic Analysis, Qualitative Research

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Families Healing Together: Exploring a Family Recovery Online Course

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Family members who are trying to support their loved one are often overburdened with stress, and health issues. Research has shown that families who receive family psychosocial education and support can have a dramatic impact on recovery outcomes and their family's overall well-being. Family psychoeducation is not common. Families Healing Together (FHT) is an online family mental health recovery program that was developed to address this critical gap in family mental health care services. Using an exploratory case study methodology to understand how the program's philosophy and practice impacts the program's participants as well as how the participants perceive the benefits and limitations of the program. Findings suggest that the strengths of the program lie in the individual customization of the program to the consumer as well as the underlying message of hope of the program. Keywords: Family Recovery, Mental Health, Case Study, Thematic Analysis, Qualitative Research

Mental health in the United States has undergone several changes over the years. The World Health Organization website (WHO) defines mental health as: “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (World Health Organization, 2014). Holloway (2003) deemed the President's New Freedom Commission on Mental Health as the most “comprehensive study of the nation's public and private mental health delivery system since President Jimmy Carter's 1978 Mental Health Commission” in the United States (p. 20). The primary emphasis of this commission was to reduce the stigma associated with a mental health illness, and for mental health care to become “consumer-driven” (p. 20). The importance of research in mental health can be quantified by national statistics. For example, the National Alliance for Mental Health (NAMI) states that one in four adults, that is approximately 61.5 million Americans, experience a mental health issue such as schizophrenia or depression (NAMI, 2013). Additionally, the National Institute of Mental Health (NIMH) reports that in the year 2006, the most recent report on their website, Americans spent \$57.5 billion dollars in mental health services (NIMH, 2014); likewise, in the year 2005 the United States government spent \$113 billion on mental health treatment (Mark, Levit, Vandivort-Warren, Buck, & Coffey, 2011). There is also the human cost of mental health illnesses such as suicide being the tenth leading cause of death in the United States (NAMI, 2013). Most recently in 2013, the National Survey on Drug Use and Health (NSDUH) conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA) stated that 4.0% of the adults who responded to the survey had contemplated suicide while 0.6% had made attempted suicide. Furthermore, among the findings of the NSDUH are that one in five adults in the United States had experienced mental illnesses during the past year. Moreover, one in ten adolescents reported a having experienced mental illness during the past year. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and the Affordable Care Act of 2010 allowed millions of people access to services that were not available due to caps in their psychiatric and substance abuse insurance benefits. Likewise, the Affordable Care

Act allowed uninsured people with mental health or substance abuse issues access to health care (Mark, Levit, Vandivort-Warren, Buck, & Coffey, 2011). The passing of these acts open the door for consumers to a variety of mental health treatments and resources.

Purpose of the Study

Currently, mental health practitioners and consumers have a need for better understanding regarding how access of psychoeducation or therapy via technology, such as the Internet, would support the expansion of these services in the field. Family members are often eager to tell their story, to describe "the saga of caring for the ill relative" (Bloch, Szmukler, Herrman, Benson, & Colussa, 1995, p. 416). Spaniol and Nelson, (2015) state, "Common reactions include, 'What is happening? I don't understand'. 'These are not ordinary behaviors of the person I have known'" (p. 762). Unfortunately, there is a lack of research focusing on online psychoeducation of families of individuals facing mental health challenges. In fact, Glynn et al. (2008) stated that "a cornerstone of the recovery movement is easy access to appropriate interventions" (p. 438), yet research focused on family support is sorely lacking in the literature.

Families Healing Together is a program created with the purpose to address this critical gap in family psychoeducation research. The program consists of an eight-week course delivered online designed to support families as they strive to help their loved ones to cope with a mental health challenge. Accordingly, the purpose of the proposed intrinsic case study approach is to explore the Families Healing Together online psychoeducation program (Stake, 1995). Schramm (1971; as cited by Yin, 2009) states that the gist of case study research is to explore "a decision or set of decisions" meaning why were these decisions made, the implementation of such decisions and the consequences (p. 17). Hence, the purposes of the proposed study are (a) to explore the motivation of the founders and staff to create the online psychoeducation program, (b) to explore the impact on participants of the program, (c) to understand the perspectives of mental health experts on the program.

Literature Review

The very definition of recovery has suffered changes over the years. In the early 1990s, Anthony (1993) defined recovery as a "deeply personal, unique process of changing one's attitudes, values, feelings and goals, skills and roles. It is a way of living a satisfying, hopeful, and contributing life even with the limitations caused by the illness" (p. 15). Additionally, Deegan (1998) reflected on the differences between recovery and rehabilitation. Deegan (1998) states that individuals who have a psychiatric disability are never rehabilitated, but instead they recover and learn "a new and valued sense of self and of purpose" (p. 1). Furthermore, Deegan (1998) reserves the word rehabilitation for services and technologies. These services and technologies may be available to people with mental health challenges, yet this does not guarantee recovery.

Often, the journey of individuals with mental health challenges is not a solitary one. Mental health challenges often occur simultaneously with drug or alcohol problems which are considered concurrent disorders (CD; O'Grady & Skinner, 2012). Relatives of family members, who face mental health challenges are often overburdened with financial stress, as well as health issues (Pitschel-Walz, Leucht, Bäuml, Kissling, & Engel, 2001). People facing mental health challenges such as schizophrenia often rely on their family members for emotional and financial support (Dixon, Adams, & Lucksted, 2000). Additionally, people suffering from a mental health illness may be parents themselves. Seeman (2015) writes "Mental illness does not disqualify parents from parenting nor does it absolve them of that

responsibility” and calls for enlisting family members in recovery (p. 3). Furthermore, research supports that family members of individuals, who face mental health challenges, are under constant stress and in need of support themselves. When first learning of their family member being diagnosed with a mental health challenge, such as schizophrenia, many family members find themselves feeling angry, anxious, as well as feeling helpless (Spaniol, Zippel, & Lockwood, 1992).

During the late 1980s and early 1990s, clinical professionals were not trained to provide support to family members (Spaniol, Zippel, & Lockwood, 1992). In recent years, the role of family in recovery is undeniable and widely accepted as good clinical practice (Cohen et al., 2008). Psychoeducation is defined as the “systematic, structured, didactic information” on both the illness, treatment and emotional impact of the illness so that patients and family members learn to cope with the mental health challenge (Rummel-Kluge, & Kissling, 2008, p. 1067). Several studies have shown that the involvement of family members in the recovery process can decrease the likelihood of relapse and readmission to mental health facilities for those individuals in need (Randolph et al., 1994; Tarrier, Barrowclough, Vaughn, Bamrah, Porceddu, Watts, & Freeman, 1988). The importance of these findings led to a line of research of family psychoeducation with therapeutic goals: (a) educate participants in order to enhance understanding and coping skills, and (b) improve communication and problem solving skills (Glynn, Cohen, Dixon, & Niv, 2008). Psychoeducation is usually performed with groups of people, yet family members and patients are separated during the course of the sessions (Rummel-Kluge & Kissling, 2008). Additionally, family psychoeducation has been explored in many different settings in order to establish evidence-based practice, procedures, and recommendations for treatment and education about mental health (Cohen et al., 2008). The accumulation of research on psychoeducation and family education is the empirical base to develop family programs.

As with every other aspect of today’s life, technology has now a place in psychoeducation and within the mental health field. The practice of online mental health services has been given different labels such as etherapy, online therapy, Internet therapy, or cybertherapy. Yet, there is still some debate on the use of the Internet interventions in mental health; the primary argument against the Internet is the lack of verbal communication (Barak, Hen, Boniel-Nissim, & Shapira, 2008). However, it is the lack of eye-contact and the virtual anonymity that users find the most useful when it comes to online therapy (Barak, Boniel-Nissim, & Suler, 2008). Another concern was the dependency on technology in order to provide therapy given that not having access to technology may prevent some individuals from receiving help (Barak, Hen, Boniel-Nissim, & Shapira, 2008). Online psychotherapy is not without advantages. First, online psychotherapy can reach individuals that may be not be reached by traditional means (King, Spooner, & Reid, 2003). Second, Internet-based interventions (IBIs) offer consumers an increased privacy and anonymity via a cost-effective method that may reach minority populations as well as people in isolated geographical (Changrani, Lieberman, Golant, Rios, Damman, & Gary, 2008; Kuester, Niemeyer, & Knaevelsrud, 2016). For example, Knaevelsrud, Brand, Lange, Ruwaard, and Wagner (2015) were able to offer Internet-based innervations for posttraumatic stress disorder (PTSD) in areas of conflict in Iran. Health promotion using the Internet can reach consumers in their own home and with personalized messages in their own time (Dedding, van Doorn, Winkler, & Reis, 2011). As well as in different formats such as videos and audio vignettes, interactive training and tailored feedback to consumers (Kuester, Niemeyer, & Knaevelsrud, 2016).

Researcher Stance

I have been part of the evaluation team for the FHT program for at least three years. Furthermore, as a woman with a physical disability, I understand the struggle of families when taking care of a child with a disability, physical or mental. I conducted the interviews, transcribed the interviews, and performed the analysis of the data. Moreover, Stake (1995) states, “All evaluation studies are case studies. The program, person or agency is the case” (p. 95) while my primary purpose is to explore the inner workings of the program, I do hope to find patterns that reveal the strengths and weaknesses, successes and failures of the psychoeducation program known as Families Healing Together. Furthermore, I wish to understand the limitations and benefits of the program; in a sense, I want to evaluate the program.

Method

I chose the case study methodology for this study. Creswell (2012) defines a case study as a “bounded system, such as a process, an activity, an event, a program or multiple individuals,” in the same manner, Creswell supports the use of case study as a methodology for situations where the boundaries are clear (p. 120). Case studies serve the purpose of shedding light into the phenomenon of interest (Merriam, 1998). In the case of the present study the multiple cases studied are bounded by their relationship to the online psychoeducation program called Families Healing Together (Yin, 2009). Further, Families Healing Together is an eight-week online course offered to family members of individuals facing mental health challenges. Families Healing Together is one of a kind in the sense that the course delivers online psychoeducation, as well the philosophy behind the program is unique. In this study, I seek to understand how the program philosophy, and work impact the class participants as well as how the participants perceive the benefits and limitations of the program. These types of questions can only be answered with an exploratory case study (Yin, 2009). Finally, the methods for this study are (a) semi-structured interviews with multiple cases, (b) documents in the form of an evaluation report, and (c) examination of the website and virtual setting of the FHT program.

Research Questions

The research questions addressed by the present study are:

1. What are the characteristics of an online psychoeducation program such as Families Healing Together?
2. How does the founder and staff, participants and mental health experts describe the characteristics, advantages and disadvantages of the online psychoeducation program Families Healing Together?

The Participants

Maximum variation sampling is a popular sampling tool in qualitative research (Creswell, 2012). The Qualitative Research Guidelines of the Robert Wood Johnson Foundation define maximum variation sampling as a “method the researcher selects a small number of units or cases that maximize the diversity relevant to the research question.” In order to achieve a maximum variation sample, I collected data from four different participants. One participant was the founder and staff of the program, one participant had

completed the pilot course while two participants were related to FHT through their respective public and mental health organizations.

Participant one in this study is part of the original staff of Families Healing Together. This participant created PracticeRecovery.org and through this website she delivers the curriculum of Families Healing Together through courses known as Recovering Our Hope and Recovering Our Families. The first participant in this study had worked with the curricula of Families Healing Together for over ten years. While she no longer identifies with the diagnosis given to her at an early age, her own experiences shaped the philosophy.

Participant two of the present case study participated in the pilot course of the program. I consider the second participant in this study the “gate-keeper” of my study given that she helped me contact the FHT staff. The second participant became involved with FHT as a result of her child facing a mental health challenge. She enrolled in the course, participated in the class and helped evaluate the program.

Finally, participant three and participant four were recruited using snowball sampling and referrals from the staff of FHT, both of these participants are involved with the FHT program through their respective mental health related organizations and have a background in the facilitation of family, and mental health resources and field.

Setting

Families Healing Together is an eight-week online family mental health recovery program. Three out of the four interviews for the present study were conducted online, via Skype and/or email. The interview with participant one, the staff of FHT, took place via Skype, as well, we maintained communication via email in order to have member checks and triangulate the information of the interviews (Patton, 2002). Holt (2010) studied the use of telephone interviews in qualitative research. While Holt argued that there are cost/benefits elements to using telephone interviews, it is possible to lose some subtle elements in a telephone conversation; however, this method the researcher to avoid imposing his or her own impression on the data being collected. Further, Hanna (2012) argued that the same can be said of interviews using technology such as Skype, “the use of telephone interviews can be expanded to the use of Skype as a new research medium with the additional benefit of enabling the ‘visual’ in the interview setting” (p. 241). Additionally, the interview with participant two was a face-to-face interview, and took place in the participant’s office. Finally, the interviews with participant three and four took place via email.

Case studies are rich, thick descriptions of empirical information of “particular instances” usually based on different sources of data (Eisenhardt & Graebner, 2007). Furthermore, Yin (2009) considers multiple sources of evidence one of the three principles in case study research. Additionally, Yin (2009) states that it is possible to collect data by combining communicative and observational approaches such as interviews, evaluation reports, and website as a form of artifact.

Data Collection

This study was approved by the Institutional Review Board (IRB) before any data collection began. Data was collected in three forms (a) semi-structured interviews with multiple cases, (b) documents in the form of evaluation report, and (c) examination of the website and virtual setting of the Families Healing Together program (Merriam, 1998). The initial tentative questions for these interviews can be found in Appendix A. The order of interviews was as follows: (a) participant one, staff of Families Healing Together, (b) participant two, interview with participant of the Families Healing Together program, (c)

participant three, representative of a mental health organization, (d) participant four, second representative of different mental and public health organization. For the Skype interview, informed consent was provided via Qualtrics © where the participant could select the radio button to agree or not agree to participate in the interview (<http://www.qualtrics.com/>). For the second participant where the interview was face-to-face, an informed consent in paper version was given to the participant for a signature. Participants three and four consented to participate in the interview via Qualtrics as well.

Artifacts and Documents

In a chapter dedicated to data collection Yin (2009) defines physical artifacts as a “technological device,” an instrument or device that can be collected as part of a case study (p. 113). The present case study utilized the website participants of the course *Recovering Our Families* as an artifact. The documents in this study were in the form of an evaluation report prepared by participant two, as well as a document describing the curricula of *Families Healing Together* provided by the first participant.

Study Rigor

Trustworthiness for the proposed study was supported in multiple forms. First, I used triangulation in order to achieve credibility for the proposed study (Lincoln & Guba, 1985). To triangulate I utilized different forms of data, which have already been discussed, three forms will be my focus in this study: (a) semi-structured interviews with multiple cases, (b) documents in the form of evaluation report, and (c) examination of the website and virtual setting of the *Families Healing Together* program. Credibility was also established by asking participants to check the accuracy of my interpretations of the data (Patton, 2002). Second, transferability for the proposed study is sustained by having a rich, thick description of the bounded system that is the online course *Families Healing Together* within the allotted pages for the present project, as well as having a maximum variation in the sample. Third, reliability of the proposed study was supported by triangulation, and member check of the emerging findings of the study. Member check was established by giving the first two interviews with participants one and two, were transcribed and given to them to be able to read, examine and evaluate. A fellow graduate student and faculty reviewed the themes and categories and provided an overall peer check of the data (Merriam, 1998). I altered details such as names and locations at the request of the participants in order to preserve confidentiality.

The Findings

Identifying information such as names and locations were removed from the transcripts in order to preserve confidentiality. The recorded interviews were transcribed by me, the main researcher, then the transcription was uploaded to the RQDA (R Qualitative Data Analysis) software where I performed thematic analysis (Version 0.2-7, Huang, 2014). Thematic analysis was performed by identifying and constructing categories that captured some recurring pattern in the data (Taylor & Bogdan, 1984). The procedure consisted of reading through each transcript, and identifying patterns; finally, I was able to establish themes or categories to synthesize the information.

After analyzing the data, six major categories were concluded from the interviewees' responses (a) recovery oriented psychoeducation, (b) Online format of psychoeducation, (c)

Curriculum and class mechanics, (d) Need for the program, (e) Future program direction (f) Limitations of the program.

Theme One: Recovery Oriented Family Psychoeducation

The theme of Recovery Oriented Family Psychoeducation comprises of recurring themes where the participants of this study discuss the unique approach of FHT, and the emphasis on hope toward recovery for the family members of individuals facing mental health challenges. The hope message conveyed by FHT is especially emphasized as a characteristic of the program in contrast to what the participants refer to as the medical perspective. Participant one said the following regarding psychoeducation:

Is really strange how popular the recovery model is, but yet there is no family work that is recovery oriented, like most psychoeducation groups have like one module that is recovery oriented and then the rest is like “the symptoms of schizophrenia, the medications used to treat bipolar disorder.”

When discussing psychoeducation, participant three mentioned:

The philosophy and approach are unique. Many family support programs focus on psychoeducation related to symptoms, medication and treatment, and often do not include important messages related to hope and recovery. In FHT, multiple perspectives on the causes of mental distress are given as well as a critical perspective on the mental health system.

Within the recovery oriented theme, it is important to note the hope is an important part of the program as viewed by the participants in this study. Participant three said, “There is an emphasis on recovery and hope, and how families can create an environment to promote recovery. The focus on the family member, their emotions and their well-being is also unique.” Furthermore, participant two also mentioned hope message conveyed by FHT:

You get the sense that recovery is really not possible, you just have to deal with the illness and just cope with the illness and just get used to having a kid with a disability and they are never going to fully recover and that is the kind of message you get. That isn't a very hopeful message and I think recovery is possible and I ... you know our son has recovered in a way that has been pretty miraculous, but he would not have recovered that way he has without that class.

Theme Two: Online Format of Psychoeducation

The second recurrent theme in this study discusses the format of online psychoeducation. From an evaluator perspective, I consider the accessibility of the program via the Internet one of its strengths and it was interesting to find the theme in the participant's words. On creating the psychoeducation course online, participant one said, “I know a lot of people who create online classes, and who create online therapeutic communities I don't know anyone else in the world who does recovery work for families which still is shocking to me.” On her decision of choosing the online format for the program and courses, participant one explain that the reasons come from personal experiences with online communities and mental health challenges:

I was diagnosed with bipolar when I was 16 and when I was 20 I became a mom, and in being such a young mom none of my friends had kids. I didn't have community around being a parent, and I don't identify as someone with bipolar anymore but I do identify as somebody that has to navigate mood states, extreme mood states. And not having community, and generally being a young mom, and hormones it was just really lonely. And I found community online.

Participant two attended face-to-face workshops and compares and contrast the differences between face-to-face workshops and the online class:

We never got helped from them because often times there were other families involved that were in a crisis mode ... and we would have to sit there and listen, the issues that they had to deal with, the issues that they were bringing up in a group therapy were issues around the parental use of substances, parental chaotic marriage relationships and we very rarely got to the point where we would deal with the issues of mental health challenges your family member was dealing with. We have to drive for two hours, it was a four –six hour trek out of our day ... we would have to drive all the way there spend one hour a meeting, group therapy meeting, it just took forever we just didn't have the time number one, but then we would drive all the way and not one thing would help us.

In contrast, participant two compares the hassle of face-to-face workshops to the being enrolled in the FHT online course:

For busy people we can just log in, try to scan what they offer and pick and choose what we needed to really dig deeper with, and that was really helpful because I didn't have to drive anywhere and I was really busy and I can just pick and choose from the menu of options and the blog component of the class was really helpful because people shared in a blog at a much deeper level. I think there is a much more kind of a feeling of anonymity with the blog that people are more willing to share.

A recurrent subtheme in the overarching theme of online psychoeducation format would be anonymity. Participant two states:

You log in with an ID, and you can disclose as much as you want, but I think the anonymity makes people feel safe and I think people share at a much deeper level when they have to write something down than they do in a group. Verbalizing it face to face you know that is really intimidating but in a blog you have this anonymity. I learned so much from the blog.

Examining the website, one of the artifacts for this study, I find the crisp and bright color palette quite cheerful. The menu has the topics for the eight weeks the course will last. In the first week's topic I find a video of participant one of this study introducing herself to the class and encouraging the participants to introduce themselves in the comments section and share why they are in the class. This single post has 116 comments, where the participants share their stories, and receive comments from the classmates. However, I am surprised at what was considered "anonymous" from the participants in my own study. The

fact is, the participants in the class can disclose their first name; in fact, many seem to have chosen their first name as their username and they can also chose to use a photograph of themselves as an avatar which is included in every comment they make. Exploring the tools section allows me to get a glimpse of how the class works. The tools are everything from worksheets, graphics, and audio posts. A progress bar at the top of the page lets me know how much of the week's topic material I have completed.

Theme Three: Curriculum and Class Mechanics

The third theme in this study consists of the participant's descriptions of how the class works. Understanding the class mechanics of FHT provides an insight as to why the participants find the program useful. There is also a discussion as to why they believe the curriculum is effective in helping family members coping with their relative's mental health challenge. As part of the class composition diversity is mentioned by the participants. This is an important characteristic of the program given it serves international populations. Participant one describes the class mechanics and how they were created:

I wrote all of the curriculum, and other people's work is included in it too, other people's work is referenced too. They can download other people's articles; it is not all my words. There are articles that are given as homework. It is basically all written. There are short videos now, me talking introducing the topic that week.

Furthermore, participant one described the basis of the curriculum of FHT is based on 10 years of the founder's career's as family counselor in mental health:

It is very well honed, because we used to use that curriculum in live groups, so there was a lot of testing that happened about what kinds of things were good for people, what did people respond to, what don't they respond to. So in that class the Recovering Our Families class, that's the cream of the crop, tried and true solid curriculum.

Participant three mentioned that "I really like the curriculum and think it offers something for everyone. My real measure is how our customers like it and we have received wonderful feedback from a variety of people around the world." Furthermore, participant two mentioned the diversity in the program: "in terms of the demographics of participants we are seeing more and more families from across the world accessing the program." Additionally, the 2013 evaluation report of FHT serves as one of the documents examined for this study. Class participants are asked to complete an online survey in Qualtrics © at the beginning and after the eight weeks of the course. The demographics available from 2013 where Caucasian was the predominant ethnicity, yet it is important to note that this demographic information comes from an evaluation report that participants of the course may or may not complete. Survey results need to be interpreted with caution given that small number of individuals complete the survey. The response rate of the survey was 26%. The demographics of participants who have enrolled in a FHT course in the year 2013 are: females were 89.8% of the participants in the course, 40.4% of the participants were between 51 and 60 years old, the primary ethnicity of participants was Caucasian (90.8%) (Rue, Estrada, Floren, & MacKinnon, 2016). Furthermore, mothers comprise the majority of the survey respondents (58.7%). Knowledge of these demographics prompted the question "Do families take the class together?" participant one responded:

Sometimes they do it together, sometimes we will have three people like mom, dad and son taking the class together. It's nice when that happens and sometimes ...there's one mom who has actually taken the class three times because she just likes...obviously she already has the curriculum, but she likes to have the community to talk about the curriculum so she's taken it three times and her daughter has taken it two times.

Examining the website, I find the environment between the participants extremely friendly. The class participants share and describe their personal experiences, within the second module of the class, I can observe participants acquiring new language. A language that is recovery and hopefulness oriented, as participant one responds to one of her class members "State of mind' vs ...'illness'" is a big shift in meaning, hope, and nuance." She then goes on to elaborate on what the difference means in her own words, "Illness' sounds like suffering and has a more chronic nuance, whereas "state of mind" is more curious, exploratory, hopeful, transient, malleable, changeable, and feels more in our power to affect." Participant one also gives meaningful responses to almost every post made by class members. She quotes her class members responses in order to show that she is "listening" to their stories. She also offers advice, and examples of previous situations similar to those the class members are experiencing. Class members also actively respond to each other sharing their own experiences. At the time when I wrote this paper, the class was in the middle of week five of the eight-week course. As I read the posts on the weekly topic, I found that the number of comments had diminished to 35. I also noticed that the names and avatars from previous weeks have become constants, the interaction is friendlier and now class members encourage each other.

Theme Four: Need for the Program

The participants in this study discussed the need for the program in the spectrum of mental health services. The program has many facets that are innovative, these are discussed in this theme offering insight, to me as an evaluator, and to practitioners and researchers in the mental health field. Participant one said "there is obviously demand for our curriculum, there is obviously a demand for this perspective." Participant one also comments on where the need for the curriculum came:

When we would talk about our program people would always, say "that sounds amazing, I'd love to see your curriculum, I wish we had more recovery oriented curriculum for families" and so we would do. We would get asked to do presentations a lot and we would do our best to share our work with people as a government funded organization in Canada. We had specific things we were funded to do and public education wasn't really our mandate. We would go to conferences, we would talk to people and there was a high demand for our curriculum around the world. Specifically, around Canada also but we just didn't have the capacity or the resources.

Participant one was surprised that the curriculum has yet to become popular:

I am kind of amazed that no one else has kind of started do this kind of curriculum. What has happened a lot of mainstream organization staff will

take the class, and will contact me trying to incorporate this into my local NAMI chapter, or I wish my organization would do more recovery oriented family work.

Participant two conveyed how the class was necessary for her own specific situation:

The class gave us that freedom to set those boundaries and I don't think we would have done it without that class. I didn't know I could. I thought I was responsible to keep my son, keep society protected from my son by housing him in my basement. And I realized that is not my responsibility and I can't. It is not physically possible because it is his choice that he has to make.

Additionally, participant two comments on her experiences with NAMI family programs, "I don't think NAMI the way those parent programs are structured would have ever gotten us to that level of skill building." Finally, participant three said, "It is a unique, innovative program that offers so much to families supporting someone experiencing mental health distress." As mental health challenges are diverse, so should be the available resources to family and friends of people facing mental health challenges.

Theme Five: Future Program Direction

The fifth theme in this study addresses the future of the program. Participant one mentioned that she would like to have companies sponsor scholarships for people to be able to participate in the class. Likewise, participant three said "*Spread the word that FHT exists*" by the way of social media, also encourage a FHT fund, and scholarships for people who want to participate in the class. Participant two said:

I think getting out there, so more people can have awareness of it. So that more people can benefit the way we did, because I don't think NAMI is, I mean, I think NAMI helps a few people but I think the philosophy is different. I think there needs to be choices if we could get awareness about this class and that is accessible.

Likewise, participant four discussed her future expectations for FHT:

I would like to see FHT continuing to spread across the world with more people accessing the program. I would like to see mental health organizations offering this to their families when they do not provide in house family support, to ensure that all family members are given opportunities for education and support. I would also like to see an expansion of the courses available to FHT, perhaps with a course focused on training for mental health workers in how to support families.

However, it is important to note that participant one has developed a second course, "I just wrote this class called 'Recovering Our Hope' and I only ran it once so I did 'like a pilot' and it went really well. So that class, we only ran it that one time, and it has not really ran since then, in 2015 is going to be running six times." However, at the moment there are no evaluation reports about Recovering Our Hope course. Perhaps in the future, it would be of interest to the stakeholders of FHT as well as researcher to evaluate the impact of the new course.

Theme Six: Limitations of the Program

Participants in this study also discussed the limitations of FHT such as health care coverage and fees. When asked if participants of the online course are tracked over time once the course is completed participant one said, “no, and that is a serious flaw on the program but that’s something, that’s coming you know, it is very evident that they need that and they want that and that would be helpful but it is just a matter of building it also the business model.” Participant one also discussed possible reasons preventing people from enrolling in FHT:

The way the health care system works in Canada is very, is not so likely for us to get a “ton” of Canadian clients because they can get services for free. They just get free counseling. Also Canadians are so used to get health care for free that they are really reluctant to spend money on health care related services.

Additionally, participant four mentioned the service fee of the course as a limitation:

One limitation of the program is the fee for service, which is not the norm in Canadian health care. I would like to see the program grow to be able to offer scholarships to families who cannot afford the fee but would benefit from the program. Improving access would be an important long term goal for myself.

The evaluation report from the year of 2013 which contains the results of the pre and post-test survey indicates that the participants are moving in the right direction in constructs deemed “Hopefulness toward Recovery” and “Capacity to Support (their family member).” These results indicate that the program is effectively helping those program participants. These statistics seem to support positive results from completing in the program (Rue, Estrada, Floren, & MacKinnon, 2016).

Discussion of the Findings

Throughout the completion of the present case study, I discovered the support family members of individuals facing mental health challenges are in need. Furthermore, one of the most important findings in this case study is the variety of different resources for family members, yet according to the participants of this study what makes FHT unique is the focus on hope and recovery. Two participants discussed NAMI, a national organization that also provides support to family members and individuals with mental health challenges. Yet, as participant two stated, this type of program did not work in her case. Furthermore, the second participant’s stated that a major advantage of a program such as FHT is the customization of the program. This is the same advantage cited by Kuester, Niemeyer, and Knaevelsrud, (2016) of IBIs. After completing this case study, I believe that the key may be in the variety of options and resources available to the family. In addition to these findings, as I examined one of the artifacts of the study, the website where participants of FHT gather together to complete the course, I discovered a significant attrition date over the course of eight weeks. In a follow up interview with the first participant she mentioned sometimes participants do not complete the last modules of the course. Additional measures on how to maintain the participants of FHT engaged throughout the course may become the focus of the program’s staff.

Limitations of the Study

One of the major findings of this case study is how participants felt the current available resources, for example those from NAMI, were not helpful due to the singularity of their own situation. This is an important finding as an evaluator and to researchers and practitioners of mental health field: the accessibility and flexibility of FHT via the Internet can be replicated for different psychoeducation programs. In fact, the first participant indicated that FHT has been approached by counselors who wish to incorporate the curricula in their local NAMI chapters. Other international, national and regional mental health organizations may consider a similar approach. In the same manner, additional research in the delivery techniques may be of interest to researchers. With the growing use of mobile devices, and “apps” it is important to plan ahead for Internet-based psychoeducation through these devices and to study the effectiveness of the programs. Additionally, the program’s fee became a recurrent theme because the program serves international populations even in countries with universal health care the program fee may be viewed as the program’s weakness.

During the completion of the present case study, I had access to the course and participant’s blog posts and online conversations. As an observer I found the content of the blog posts and information could provide rich, meaningful data that could be used to triangulate the findings in this study. However, due to the fact that the class participants had not consented to participate in my study, I could not use their blog post without their explicit consent. Future research for this case study may consist of submitting an IRB document in order to further collect data from within the FHT setting.

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Appendix A – Tentative Interview Questions

Demographic Questions

1. Can you tell me your position at your organization?
2. Can you tell me about your organization?

Narrative Questions

3. Can you tell me how you first became involved with Families Healing Together (FHT)?
4. Can you talk about the connection between [specific organization] and FHT?
5. Are you familiar with the participants of FHT? Is there anything you can say regarding the participants? Or who would you like to have access to FHT?
6. What in your opinion makes FHT different from other organizations that support family members of people facing mental health challenges?

Thank you for your time and enjoy the rest of your day.

PROBES: Would you explain further?

Tell us more.

Can you give me an example?

Is there anything else?

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